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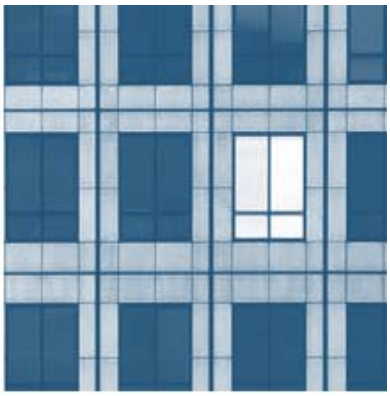
On the Subject



Health Industry Advisory

July 29, 2010

Recently issued interim final rules clarify the scope of the internal claims and appeals procedures and external review processes, and provide details on the external review requirements under the Patient Protection and Affordable Care Act.

Health Care Reform: Guidance on Claims and Appeals Rules

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (PPACA), generally requires non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage to comply with specific internal claims and appeals procedures and external review processes, effective for the first plan year commencing on or after September 23, 2010. The U.S. Departments of Health and Human Services, Labor and the Treasury recently issued interim final rules which clarified the scope of the internal claims and appeals procedures and external review processes, and provided details on the external review requirements under PPACA.

Internal Claims and Appeals Processes

Under PPACA, group plans and insurers offering group coverage must implement internal claims and appeals processes that comply with the claims and appeals procedures requirements under Section 503 of the Employee Retirement Income Security Act (ERISA), if they are not already subject to those requirements (e.g., church and governmental plans). In addition, the interim final rule creates the following six new requirements for group health plans and insurers:

1. A rescission of coverage is now treated as an adverse benefit determination for purposes of applying the internal appeals requirements. Previously, the ERISA claims and appeals procedures only applied to benefit denials.

2. Urgent care claims now must be decided (and the claimant notified) within 24 hours after the plan or insurer receives the claim (under the ERISA claims procedures, the plan has 72 hours to decide such claims). As under the ERISA claims procedures, an exception exists for situations where the claimant does not provide sufficient information to make the determination as to what extent benefits are covered or payable.

3. Upon review of a claim denial, claimants must be allowed to review their file and present evidence and testimony. Plans or insurers must provide, free of charge, any new or additional evidence considered, relied upon or generated by the plan or insurer in connection with the claim. In addition, the plan or insurer must make the claimant aware of any new or additional rationale before the rationale can be used to issue a final internal adverse benefit determination so as to allow the claimant notice of the new rationale and a reasonable opportunity to respond to the new evidence or reasoning.

4. Plans and insurers must take steps to avoid conflicts of interest in the appeals process and ensure independence and impartiality of the individuals making claims decisions. For example, decisions involving hiring, compensation and other similar matters must be made without regard to the likelihood that an individual would support benefit denials.

5. Plans and insurers must notify individuals of the availability of internal appeal and external review processes in a culturally and linguistically appropriate manner, which could include providing plan summaries and other documents in multiple languages depending upon the census of the group at issue (for a plan that covers less than 100 participants at the beginning of the plan year, the threshold is 25 percent of all plan participants being literate in the same non-English language; for a plan that covers greater than 100 participants at the beginning of the plan year, the threshold is the lesser of 500 participants or 10 percent of all plan participants being literate in the same non-English language). In addition, claims and appeals notices must include (i) sufficient information to identify the claim involved (including the date of service, health care provider, claim amount, diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning); (ii) the denial code and its corresponding meaning; (iii) a description of the plan's or

insurer's standard that was used in denying the claim; (iv) a description of available internal and external review processes, including information on how to initiate an appeal; and (v) a statement about the availability of, and contact information for, any office of health insurance consumer assistance or ombudsman available to help enrollees with the appeals process. Model notices will be issued on the U.S. Departments of Labor and Health and Human Services websites.

6. A claimant will be deemed to have exhausted the internal claims and appeals process, and therefore will be eligible to pursue remedies under ERISA, if a plan or insurer fails to comply with any aspect of the internal appeals requirements with respect to a claim, regardless of whether the plan or insurer asserts that it substantially complied with these requirements or that any compliance error was *de minimis*. In essence, the new regulations impose a strict liability standard to following the internal and external review procedures and replace the substantial compliance standard that previously existed. If a claimant chooses to bring suit under ERISA, no deference will be given to the plan's decision if these internal and external review procedures were not followed.

External Review Process

Group health plans and insurers must also comply with new external review processes added by the regulations. The regulations require group health plans and insurers to comply with any applicable external review process in states that have implemented such a process if the state's external review process applies to and is binding on an issuer of health insurance coverage and includes, at a minimum, the consumer protections set forth in the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners (the NAIC Model Act) that was in effect on July 23, 2010.

Self-insured plans that are not subject to state insurance regulation, and (beginning the first day of the first plan year beginning on or after July 1, 2011) self-insured or fully insured plans that are not subject to a state external review process that meets the minimum standards, must comply with a federal external review process that will be detailed in future guidance. These standards will be similar to those in the NAIC Model Act which can be found at http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf.

The secretaries of the U.S. Departments of Health and Human Services, Labor and the Treasury have the ability to determine whether a plan's or insurer's external review process is in compliance with PPACA and the interim final rule. The interim final rule contains a lengthy list of requirements for state external review processes, designed to provide minimum consumer protections similar to those contained in the NAIC Model Act. The appeals rules created by PPACA are effective for plan years beginning on or after September 23, 2010, but under a transition rule, a state external review process applicable to a plan or insurer is deemed to meet these requirements for plan years beginning before July 1, 2011.

Most self-insured group plans will not be subject to state law and, thus, will be subject to the federal external review process. Fully insured group health plans and self-insured group plans that are subject to state external review processes (*i.e.*, self-insured church and governmental plans not subject to ERISA, and multiple employer welfare arrangements) will be required to follow state review processes, assuming they comply with the NAIC model. While the new external review procedures will assist in reducing existing conflicts of interest in deciding benefit claims internally, the new external review procedures will add more administrative cost to benefit claim administration and add to the difficulty in timely adjudicating administrative benefit claims.

Additional Considerations

- Under PPACA and the interim final rule, plans and insurers are required to continue coverage pending the outcome of an internal appeal of an adverse benefit determination relating to an ongoing course of treatment. This requirement already applies to plans subject to the ERISA claims and appeals rules. There is no requirement under current guidance to continue coverage pending external review.

- The interim final rule contains detailed requirements for determining whether a notice is written in a culturally and linguistically appropriate manner. The rules for group plans or coverage are slightly different from those applicable to individual coverage.

- The internal appeals and external review requirements do not apply to grandfathered plans, retiree-only plans or excepted benefit plans. However, these plans are still subject to any pre-PPACA claims procedures (such as those under ERISA).

- For insured plans, both the plan and the insurance issuer are responsible for complying with the external review rules. As long as the insurer complies with its state-imposed external review process (assuming it complies with the NAIC Model Act), the plan is relieved of responsibility.

- Reviews of determinations that a claimant fails to meet the eligibility requirements of a group health plan are not eligible

for the federal external review process. This exception does not apply to health insurance issuers offering individual coverage.

Next Steps

Group health plans and insurers subject to the new requirements should review their current internal claims and appeals procedures, and revise them as necessary to avoid potential liability and loss of deference upon judicial review. Group health plans and insurers should also begin to evaluate how they will comply with the new external appeal procedures. If an insurer is currently complying with a state-mandated external appeal procedure, the insurer will need to verify that the procedure complies with the NAIC Model Act. Non-grandfathered, self-insured group health plans will be required to comply with the new federal external review requirements yet to be issued. Plan administrators and insurers will be required to update existing plan documents, summary plan descriptions, internal claim and appeal guidelines, claim and appeal response letters, and other plan documentation to reflect these new claims and appeals processes.

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