July 21, 2011

Update: The Claims and Appeals Procedures Required by Healthcare Reform Have Been Amended

By Yana S. Johnson

On June 24, 2011, some of the provisions of the interim final regulations under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (together, the "Healthcare Reform Act" or the "Act") regarding claims and appeals procedures of group health plans were amended. Guidance was also issued regarding the required external review processes following plan internal claims and appeals. This Alert focuses on amendments to the claims, appeals, and review procedures that apply to insured and self-funded nongrandfathered group health plans maintained by nongovernmental employers and that require immediate action.

The Healthcare Reform Act provides that many existing group health plans are "grandfathered"; such plans are not subject to the claims and appeals requirements of the Act. Nongrandfathered plans, however, have been subject to the new claims, appeals, and review requirements of the Act effective for plan years beginning on or after September 23, 2010, but with a good-faith compliance grace period until July 1, 2011.[1] During the grace period, the Department of Labor, IRS, and Department of Health and Human Services did not undertake any enforcement action against a health plan that was working in good-faith on implementing the additional claims and appeals and external review requirements. In late June 2011, the interim final regulations under the Act governing the claims and appeals procedures for nongrandfathered group health plans were amended, new technical guidance was issued regarding external appeals, and the grace period for implementing portions of the new requirements was extended. The amendments and guidance clarify, alter, and in some ways relax, the Healthcare Reform Act requirements applicable to employer health plans.

The grandfathering rules were covered in more detail in our prior Client Alert, but we set forth the basics here. For purposes of analyzing the status of a plan, the coverage that was in effect on March 23, 2010, is the measuring point: in many cases, changes to the March 23, 2010 coverage for 2011 or later plan years will cause a plan to lose its grandfathered status. Each type and provider of benefit is considered separately when determining whether grandfathered status is maintained. A single group health plan may have both grandfathered and nongrandfathered benefit packages. The following modifications will cause a benefit package to lose grandfathered status: elimination of all or substantially all benefits for a particular condition; any increase in percentage cost-sharing or co-insurance requirements; an increase in fixed-amount cost-sharing requirements by more than the specified medical inflation rate plus 15%; an increase in copayment requirements greater than $5 or the specified medical inflation rate plus 15%; a

[1] The grace period applied to the following portions of the new claims and appeals rules: (1) 24-hour time frame for making urgent care claims decisions (now reverted back to 72 hours); (2) provisions of notices in a culturally and linguistically appropriate manner; (3) inclusion of broader content and specificity in notices; and (4) determination of when a claimant will be deemed to have exhausted the plan's or issuer's internal claims and appeals process due to the failure to strictly adhere to all the requirements of the interim final regulations.

decrease in employer contribution rate by more than 5 percentage points; the addition of a new policy, certificate, or contract of insurance effective before November 15, 2010; or certain changes in annual limits.

As amended, the interim guidance under the Healthcare Reform Act governing claims and appeals requires the following:

INTERNAL CLAIMS AND APPEALS

- The party reviewing claims and appeals must be must be impartial and independent from the plan or insurer so as to avoid potential conflicts of interest (***unchanged***). A decision-maker cannot be hired, promoted, or paid a bonus based on the likelihood that the benefit denial will be upheld (***unchanged***).
- Claimants must be notified of a determination relating to urgent care as soon as possible based on the medical exigencies involved, but in any event within 72 hours after receipt of the claim, whether or not the determination is adverse; this reverts to the time frame required prior to the Healthcare Reform Act (***amended***). There is a grace period for good-faith compliance until plan years beginning on or after January 1, 2012 for this time frame.
- The definition of "adverse benefit determination" is expanded to include a rescission (i.e., a retroactive denial, reduction, or termination of coverage) (***unchanged***).
- Coverage must be continued for claimants pending the outcome of the appeals process (***unchanged***).
- Claimants must be allowed to present evidence and testimony in the appeals process (although it is unclear whether this must be oral (i.e., a hearing is required) or written testimony) (***unchanged***).
- To provide a "full and fair review" of a claim, if the reviewer either considers, relies on, or creates new or additional evidence, or determines that it may deny the appeal based on a new or additional rationale, then it must automatically provide a copy of such new evidence to the claimant free of charge (***unchanged***). The reviewer also must notify the claimant of any new or additional rationale for denial sufficiently in advance of the adverse determination so that the claimant has time to respond before the adverse determination is finalized (***unchanged***).
- A plan participant may seek immediate external *de novo* review or seek redress from a court if the plan fails to adhere strictly to all claims and appeals procedures regulations, unless the violation was (1) *de minimus*; (2) non-prejudicial; (3) attributable to good cause or matters beyond the plan's control; (4) part of an ongoing good-faith exchange of information; and (5) not reflective of a pattern of noncompliance (***amended***). The claimant, in this situation, is entitled upon written request to an explanation of the claim reviewer's basis for asserting that the reviewer meets this exception (***amended***). There is a grace period for good-faith compliance until plan years beginning on or after January 1, 2012 for this provision.
- Additional information must be provided in notices of denial for both claims and appeals: denial notices must notify participants of their right to request and receive diagnosis and treatment codes and their meanings, and in the case of a final internal determination of denial, a discussion of the decision must be included; a description of available internal appeals and external review processes, including how to initiate an appeal, must be provided; and contact information for the applicable office of health insurance consumer assistance or ombudsman, who may assist enrollees with internal and external claims and appeals, must be disclosed (***amended***). Amended model notices were also provided. There is a grace period for good-faith compliance until plan years beginning on or after January 1, 2012, for the portion of this requirement regarding the notification of diagnosis and treatment codes; the grace period for the rest of these requirements expires earlier, at the beginning of the first plan year beginning on or after July 1, 2011.

- If a plan covers enrollees who reside in a county in which a significant portion of the population is literate only in the same non-English language,[2] then all communications about the appeal processes must include a notice in that language explaining that communication relating to claims and appeals are available in that language (***amended***). Also, each notice to a claimant in such a county must include a sentence in the applicable language explaining the availability of language services (***amended***). Language services must include, upon request, translated written notices and verbal assistance in the applicable language (i.e., a telephone hotline) (***amended***). This language requirement appears to apply to all plan notices, not just those regarding appeals and denials (***amended***). There is a grace period for good-faith compliance until plan years beginning on or after January 1, 2012, for this requirement.

EXTERNAL REVIEW

- Claimants are entitled to a review by an independent review organization for claims involving medical judgments[3] and rescissions (***amended***). (This amendment applies to claims for which external review has not been initiated by September 20, 2011.)
- Group healthcare plans must comply with the decision of the external reviewer by providing benefits or payments regardless of whether the plan intends to seek review from the courts and until a court rules against the claimant (***amended***).
- Each plan must contract with at least two external review organizations by January 1, 2012, and at least three by July 1, 2012, and must rotate among them (***amended***).
- Fully-insured plans must comply with each state's external review requirements, while self-insured plans must comply with the external review standards set by the Secretary of Health and Human Services (***amended***).

The following revised model notices have been released: Adverse Benefit Determination, Final Internal Adverse Benefit Determination, and Final External Adverse Benefit Determination.

RECOMMENDATIONS

Employers sponsoring nongrandfathered health plans are advised to review their claims and appeals procedures and denial notices to ensure that their documentation complies with the amended regulations, and update their administrative procedures and notices for these changes to the Healthcare Reform Act. Denial notices must be updated as soon as possible for the amended regulations, but no later than the first day of the next plan year beginning on or after July 1, 2011. Claims and appeals procedures set forth in plan documentation (including plan documents, summary plan descriptions, and related insurance certificates and policies) for nongrandfathered plans must be amended to comply with the new requirements as soon as possible, but no later than January 1, 2012. Grandfathered plans may find that these relaxations of claims and appeals requirements make the loss of grandfathered status more palatable. Employers are also advised to keep in mind that the Healthcare Reform Act requires an updated summary plan description or summary of material modifications to be provided to participants at least sixty days prior to the effectiveness of any material changes to all group health plans, whether or not grandfathered.

As we noted at the outset, this Alert does not attempt to address all of the provisions of the Act that became effective in 2011 or beyond, and employers and others working with group health plans should be sure to carefully analyze the Act to

[2] For this purpose, a "significant portion" of the county's population is equal to 10 percent of the residents in each county, per the U.S. Census.

[3] Medical judgment includes such decisions as determining whether inpatient or outpatient care is appropriate, medical necessity, emergency or urgency of treatment, preexisting conditions, and other types of medical judgments set forth in the guidance, but excludes contractual or legal interpretation.

identify any other requirements that may require action.

If you have any questions, contact your Morrison & Foerster attorney or any member of the Compensation, Benefits + ERISA Group.

Contact:

Mike Frank
Palo Alto
(650) 813-5627
mfrank@mofo.com

Paul Borden
San Francisco
(415) 268-6747
pborden@mofo.com

Yong Yeh
Palo Alto
(650) 813-5672
yyeh@mofo.com

Jessica L. Rice
San Diego
(858) 720-5144
jrice@mofo.com

Yana S. Johnson
San Francisco
(415) 268-7136
yjohnson@mofo.com

Sonja K. Johnson
San Francisco
(415) 268-7694
sjohnson@mofo.com

Ali U. Nardali
Palo Alto
(650) 813-5619
anardali@mofo.com

About Morrison & Foerster:

We are Morrison & Foerster—a global firm of exceptional credentials in many areas. Our clients include some of the largest financial institutions, investment banks, Fortune 100, technology and life science companies. We've been included on *The American Lawyer*'s A-List for seven straight years, and *Fortune* named us one of the "100 Best Companies to Work For." Our lawyers are committed to achieving innovative and business-minded results for our clients, while preserving the differences that make us stronger. This is MoFo. Visit us at www.mofo.com.

Because of the generality of this update, the information provided herein may not be applicable in all situations and should not be acted upon without specific legal advice based on particular situations.