Health Care Reform: Claims & Appeals Process

Timeline

**March 23, 2010:** President Obama signs PPACA & HCERA into law (the Patient Protection and Affordable Health Care Act and the Health Care and Education Reconciliation Act of 2010) on 3/23/2010. Many provisions have an effective date six (6) months later, or 9/23/2010, and are therefore applicable for the first plan year after 9/23/2010. Many calendar year plans, for example, will need to comply as of 1/1/2011.

**July 23, 2010:** Interim Final Rules relating to Internal Claims and Appeals and External Review Processes under PPACA and HCERA were issued by the Departments of Health and Human Services (HHS), Labor (DOL), and the Treasury (IRS). These requirements do not apply to Grandfathered plans.

**August 26, 2010:** The IRS/DOL/HHS announced the availability of guidance about the interim procedures for the Federal external review process and provided three (3) new Model Notices for internal claims & appeals and for the external review process under PPACA.

Internal & External Appeal/Review Process

Group health plans (and health insurance issuers) need to establish internal and external review processes for “adverse benefit determinations". For internal claims and appeals processes, group health plans must comply with existing ERISA claims procedures and regulations along with six (6) new requirements.

1 Adverse Benefit Determination: can be a denial before treatment, a denial of coverage during treatment and even a denial for additional treatment sessions/visits, now broadened to include rescission of coverage too. See, also, DOL Claims Procedure, Definition of Adverse Benefit Determination at: http://www.dol.gov/dol/allcfrebsa/title_29/Part_2560/29CFR2560.503-1.htm


Note about Model Notices. Use of model notices provides the safe harbor and satisfies the disclosure requirements detailed in the implementation regulations. SPD language should also be updated to inform plan participants that the internal claims and appeals and external review procedures will be provided “in the future.”

DOL Model Notice 1: Final Internal Adverse Benefit Determination http://www.dol.gov/ebsa/IABDModelNotice1.doc

DOL Model Notice 2: Adverse Benefit Determination http://www.dol.gov/ebsa/IABDModelNotice2.doc


What are the potential penalties for a Plan’s failure to comply? The IRS, DOL & HHS will impose federal excise tax penalties of $100 per day per patient upon the Plan Sponsor for failure to comply with these regulations. See IRS Form 8928: http://www.irs.gov/pub/irs-pdf/i8928.pdf

What is an IRO? An Independent Review Organization, a third party, separate and apart from the employer/plan sponsor, the Plan and the carrier (or ASO claims payer) that has the requisite professional expertise to conduct an impartial review of an adverse benefit determination.

What does URAC stand for? The Utilization Review Accreditation Committee (URAC) located in Washington, DC, is an independent, nonprofit organization that evaluates and accredits IROs, among other health care systems and quality measures.
Timeline continued

The Act’s new provisions add requirements that did not previously exist for group health plans. While ERISA did include some general requirements in this regard, there were no specific penalties for failure to comply with review procedures. By contrast, the new requirements subject a health plan sponsor to $100 per day per patient per violation, assessed through an excise tax imposed by the IRS.

These regulations:
1. broaden the definition of “adverse benefit determination” to include rescission of coverage;
2. shorten the current 72-hour timeframe for notifying a claimant of a benefit determination involving urgent care to “as soon as possible”, but not later than 24 hours after receipt of the claim;
3. provide additional criteria to ensure that a claimant receives a full and fair review;
4. provide new criteria with respect to avoiding conflicts-of-interest;
5. provide new standards regarding notice to enrollees, requiring the notice to be provided in a “culturally and linguistically appropriate” manner; and
6. require strict adherence to all requirements of the internal claims and appeals process, or the claimant will be deemed to have exhausted the process.

New Notice Standards
The notice must include information sufficient 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. The reason for denial must include the denial code and its corresponding meaning or a description of the plan’s standard used for/in denying the claim. The plan must describe the available internal appeals and external review process. And, the plan must provide the contact information for any applicable office of health insurance consumer assistance or ombudsman to assist with internal claims and appeals and external review processes.

“Culturally and Linguistically Appropriate” Manner of Notice
Notices must be provided (upon request) in another language based upon an established threshold: (a) for plans with less than 100 participants (at the beginning of the plan year), the threshold is 25% of all plan participants being literate in the same non-English language; (b) for plans with more 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 only in the same non-English language. Once notices are provided in a non-English language, all subsequent notices must also be provided in that same language.

Also, these regulations require the plan to continue to provide coverage pending the outcome of the internal appeal.

External Review

Fully Insured Plans
Plans must either comply with the new external review process established by a State (if it includes the broad range of elements from the NAIC Uniform Model Act) or with the new Federal external review process as outlined below. State external review processes are deemed to “meet” this requirement for plan years beginning before 07/01/2011. If a patient’s internal appeal is denied, the patient will then be allowed to appeal to a reviewer that is not employed by their health plan or insurer. And, the affected group plans and health insurers must pay for the external reviews. While participants can generally be charged, up to $25 per external review, they cannot be charged more than $75 in any one plan year, regardless of the number of external reviews requested.

Self-Funded Plans - Preliminary Review
Group health plans must permit a claimant to file a request for external review for a period of four (4) months after the date of receipt of an adverse benefit determination. Next, a preliminary review must be conducted within five (5) business days following the claimant’s request for external review. The group health plan will determine whether: the claimant is/was covered at the time the claim was incurred/requested/provided; the adverse benefit determination does not relate to the claimant’s failure to meet the requirements for eligibility under the plan’s terms; the claimant has exhausted the plan’s internal appeal process; and that the claimant has provided all the information and forms necessary to process an external review.

The plan is then required, within one (1) business day after completion of the preliminary review, to issue written notification to the claimant.

DOL Technical Release

The Department of Labor’s August 23rd Technical Release (Number 2010-01) provides interim procedures for Federal external review relating to internal claims and appeals and for external review under PPACA. This interim enforcement directive provides safe-harbor for non-grandfathered self-insured group health plans (that are not subject to State external review processes).

Church plans and governmental review processes and must comply with one or the other, subject to some specific guidance.

During the Safe Harbor period, neither the IRS nor the DOL will take any enforcement actions against a self-funded plan that complies with either the federal process or a compliant state process. The Federal process is based upon the NAIC (National Association of Insurance Commissioners) Model Act of July 23, 2010.

Remember, these regulations are not applicable to Grandfathered plans and are only effective for the first plan year (or policy year) beginning on or after 09/23/2010.

Requirements and Timing

Plans that fail to strictly adhere to these regulations will quickly learn that the claimant will be deemed to have “exhausted” the internal claim and appeal process, even if the plan substantially complied with the process or if an error was only a very minor one. At that point, the patient/claimant is entitled to pursue any available remedies under ERISA or state law. If the claimant pursues remedies under ERISA, the claim/appeal is deemed “denied” on review without exercise of discretion by an appropriate plan fiduciary.

State Standards

Applicable state external review processes will apply to insured coverage and non-ERISA self-funded plans (such as governmental plans and church plans), provided the state process satisfies the NAIC (National Association of Insurance Commissioners) Uniform Model Act related standards, as in effect on July 23, 2010. Generally, if the state process does not satisfy the NAIC Uniform Model Act standards, then affected plans must comply with the federal external review process instead. However, in order to provide states with sufficient time to conform with the Model Act’s standards, the regulations provide a transition period for plan years that begin before July 1, 2011 (to use a state’s external process that is not 100% congruent with the Model Act). After July 1, 2011, either the state’s process will conform to the NAIC model, or plans will be forced to follow the Federal process.

Based on the NAIC Uniform Model Act, a State’s external review process must:

- Allow review of decisions based on medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit;
- Require written notice of external review rights;
- Allow the exhaustion rules for internal appeals to be waived in certain limited situations;
- Require the insurance issuer (or the plan) to pay the cost of an Independent Review Organization (IRO) for conducting the review;
- Not require a minimum dollar amount for external review;
- Allow an individual at least four months to request an external review;
- Provide that the IRO will be assigned on a random basis or in another impartial manner and provide a list of approved IROs;
- Make the IRO decision binding on the insurance issuer and plan, subject to other available legal remedies;
- Require the decision from the IRO within 45 days of receipt of the external review request by the IRO. Expedited review may occur in certain circumstances, requiring a decision within 72 hours of receipt of the request;
- Require insurance issuers to describe the external review process in pertinent plan documents (for example, a summary plan description); and
- Require the IRO to maintain written records regarding external reviews; and follow certain procedures for review of experimental and investigative treatments.

Federal Standards

Non-Grandfathered Plans that are not subject to a State external review process (for example, self-funded ERISA plans) must comply with the federal external review process.

- The Federal Standard does not follow 100% of the NAIC Model Act. For example, the DOL has not designated a specific agency that will certify IROs, nor have they made clear the minimum consumer protections that will be required of IROs. However, in addition to the processes described above, the Federal process will:

3 Even though these procedures are based on the NAIC Model Act, they do not include all the consumer protections of the NAIC Model Act. For example, the procedures set forth in this notice do not include the special provisions for claims relating to experimental or investigational treatment and do not include a government agency certifying and assigning IROs. The DOL advises that future guidance will address the minimum consumer protections required under the Federal external review process after the interim enforcement safe harbor period. The NAIC Model Act is available at http://www.dol.gov/ebsa/pdf/externalreviewmodelact.pdf
Federal Standards continued

- Describe how a claimant initiates an external review
- Detail procedures for a preliminary review to determine eligible claims
- Require that a Plan have and retain three (3) IROs to conduct external reviews
- Require that a Plan assign external reviews to the IROs on a rotating basis
- Provide for expedited external review of certain claims
- Provide additional consumer protections for claims involving experimental or investigative treatments
- IRO review must be provided for adverse benefit determinations that are based on medical necessity, appropriateness, setting, level of care, or effectiveness
- Make the IRO decision binding on the plan, subject to other available legal remedies
- Establish external review reporting requirements for IROs

Referral to an IRO

Assuming the claimant is/was eligible and the required information/forms are present, the plan assigns a URAC approved IRO (or by a similar nationally-recognized accrediting organization) to conduct the external review. The plan will insure independence and non-bias on the part of the IRO. Contracting with at least three (3) IROs, the plan will assign external reviews to the IRO on a rotating basis (or incorporate other independent, unbiased methods for assigning work to the IROs, such as random selection, etc.). The IRO may not be eligible for any financial incentives based upon the likelihood that that IRO will support the denial of benefits. Plans must provide the IROs (within five (5) days of assignment) with copies of all the necessary documents and information used/needed to make the adverse determination.

Contracts with IROs must provide that the IRO:

- utilize legal experts (where appropriate) to make coverage determinations under the plan
- notify the claimant in writing of the request for and acceptance of the external review, providing ten (10) business days for the claimant to submit additional writings for consideration (and once received provide copies to the plan)
- can review all timely received documents and additional information including claimant’s medical records, attending health care professional’s recommendation, etc.
- provide written final notice of the external review’s decision (including everything used to make its determination) within 45 days after the IRO received the assigned external review
- must maintain records of all claims and notices for six (6) years, and make them available, as appropriate to federal/state oversight where appropriate under privacy laws.

The IROs reversal of the plan’s decision is binding and requires the plans to immediately provide coverage or payment for the contested claim.

Conflict of Interest Ban

This new guidance makes clear that entities (that make group health benefit plan decisions) cannot base hiring, compensation, termination, bonuses, promotions, or other employment decisions on the likelihood that an individual will deny benefits. Also, plans are required to hire medical experts for their professional skills and abilities and not base a decision to retain them upon their predilection for denying claims. Plan Sponsors, Third-Party Administrators and Group Health Insurers will need to make adjustments to their employment policies, possibly to their job descriptions and ultimately with their third-party service agreements.
Next Steps

First, carefully determine the effective date of your plan. While your medical/Rx plan may renew each March 1st, the fact that your Plan runs on a calendar year basis, and is described that way in your Summary Plan Description (SPD) and reported that way on your Form 5500, may mean that you need to comply on 1/1/2011 and not on 3/1/2011.

Second, discuss, in detail, your plan’s Grandfathered status. Do you plan to change the cost-sharing ratios that you use to determine the payroll contributions you will require from your employees? If those cost-sharing ratios increase by more than 5%, you will lose your Grandfathered status and will need to comply with these (and other) regulations now (or much sooner then 2014 when the rest of Health Reform’s changes will effect Grandfathered Plans).

Third, begin to make changes to any employment policies and job descriptions to make sure they are free from conflicts of interest. And, update your SPD, and claim procedures/notice, and require enhancements to your Medical/Rx EOBS (Explanation of Benefit statements).

Finally, in coordination with your Sales Executive and Account Manager, select three (3) IROs to work with and begin to document how the review process will work, outline any responsibilities, timelines and how matters will be coordinated.

Please contact your representatives here at Crawford Advisors to discuss any questions, comments or concerns that you may have in regard to this Chronicle, the topic in general or anything else.

Crawford Advisors News References