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Impact of Internal Claims/Appeals and External Review Process Regulations on United Methodist Health Plans

Introduction

The Patient Protection and Affordable Care Act (PPACA) amends the Internal Revenue Code to make certain provisions of the Public Health Service Act (PHSA) applicable to self-insured group health plans, *including church plans*.

On July 23, 2010, the Department of Health and Human Services (HHS), Department of Labor (DOL) and Internal Revenue Service (collectively, the Departments) published *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act* (the **Regulations**) in the *Federal Register*. The Regulations establish requirements for group health plans regarding claims and appeals processes under §2719 of the PHSA. Generally, the Regulations apply to coverage starting on or after September 23, 2010 (January 1, 2011 for calendar-year plans).

The Regulations standardize both internal and external processes that participants can use to appeal adverse health plan decisions. Currently, most health plans have a process that allows participants to appeal a decision within the plan through an "internal appeal." However, depending on state laws and a plan's insured status (i.e., fully insured or self-insured), the processes can vary significantly. If a participant loses the internal appeal, he or she may not be able to seek an "external appeal" to an independent reviewer.

Grandfathered Plans Exempt

Section 1251 of the PPACA exempts certain plans existing on March 23, 2010 (i.e., Grandfathered Plans) from many provisions of the PPACA and PHSA. Grandfathered Plans do not have to comply with these Regulations. You can read more about Grandfathered Plans **here**.

Internal Claims and Appeals

The Regulations require group health plans, regardless of whether or not they are subject to the Employee Retirement Income Security Act of 1974 (ERISA), to incorporate the internal claims and appeals processes established by the DOL under ERISA (the "**DOL Claims Procedures**"). Most church plans are not subject to ERISA, so this requirement could cause a substantial change in claims and appeals processes for annual conference health plans. However, many self-insured church plans rely on third-party claims administrators that use claims processes that are substantially similar to the DOL Claims Procedures.

The DOL Claims Procedures apply to any "adverse benefit determination," which includes a denial, reduction, termination of, or a failure to make a payment (in whole or in part) for a benefit. Such adverse

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benefit determination may be based on: eligibility; a determination that a benefit is not covered by the plan; imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion or other limitation; or determination that a benefit or service is experimental, investigational, or not medically necessary or appropriate.
Claims must be decided within a specific time limit, depending on whether the claim is an: (i) *urgent care,* (ii) *pre-service,* or (iii) *post-service claim*. Urgent care claims (claims that require quicker decisions because health could be threatened) must be decided as soon as possible, taking into account medical needs, but no later than 72 hours after the plan receives the claim. Generally, pre-service claims (claims requiring pre-approval) must be decided within 15 days after the plan has received the claim. The plan may extend the time period up to an additional 15 days in certain circumstances. Post-service claims must be decided within a reasonable period of time, but no more than 30 days after the plan has received the claim. Most claims are post-service claims.

If a claim is denied, the plan must send notice, either in writing or electronically, with a detailed explanation of why the claim was denied and a description of the appeal process. Whatever the reason for denial, a claimant has at least 180 days to file an appeal. A plan can require up to two levels of review of a denied claim to exhaust the plan's claims process.

Regulations' Additions to the DOL Claims Procedures

The Regulations set forth six additional requirements for claims and internal appeals:

- "Adverse benefit determination" is expanded to include a rescission[1] of coverage.
- A plan must notify a claimant of a benefit determination (whether adverse or not) with respect to an urgent care claim as soon as possible, but no later than 24 hours (rather than 72 hours, the current standard) after the receipt of the claim, unless the claimant fails to provide sufficient information.
- A plan must provide a claimant, free of charge, any new or additional evidence considered or generated by the plan and any new rationale in connection with the claim.
- A plan must ensure the independence and impartiality of the persons involved in making the decision. Hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator) must not be based upon the likelihood that the individual will support a denial of benefits.
- A plan must provide notice to enrollees in a culturally and linguistically appropriate manner. Any notice of adverse benefit determination must include the date of service, health care provider, claim amount, diagnosis code (such as an ICD-9 code, ICD-10 code or DSM-IV code), treatment code (such as a CPT code), and the meanings of these codes. A plan must also ensure that the reason for the adverse benefit determination includes the denial code (such as a CARC and RARC) and its meaning. It must also include a description of the plan's standard that was used in denying the claim (for example, medical necessity). The Departments intend to issue model notices in the very near future.
- In the case of a plan or issuer that fails to strictly adhere to all the requirements of the internal claims and appeals process, a claimant is deemed to have exhausted the internal appeals process. The claimant may initiate an external review and pursue litigation.

[1] A rescission is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions toward the cost of coverage on a timely basis. You can read more about rescissions **here**.

In addition, a plan must provide continued coverage pending the outcome of an internal appeal. Individuals in urgent care situations may be allowed to proceed with expedited external review at the same time as the internal appeals process.

External Appeals

The Regulations establish rules for determining whether state external review laws or a new federal external review process apply to a plan. For plans subject to existing state external review processes, the Regulations allow the plan to follow currently applicable external review processes until July 1, 2011. The Departments will work with states to add consumer protections to state processes for later years. A federal process will apply to self-insured plans (generally not subject to existing state external review processes), beginning January 1, 2011.

Notably, the Regulations do not preclude a state external review process from applying to a self-insured group health plan under some circumstances. The preamble to the Regulations notes that, because ERISA does not apply (to pre-empt state law), *self-insured church plans could be subject to a state external review process* if the process includes the consumer protections in the National Association of Insurance Commissioners (NAIC) Uniform Model **Act** and is made applicable to the plan by state law.

Under these interim final regulations, any plan not subject to a state external review process must comply with the forthcoming federal external review process. A plan is also subject to the federal external review process where the applicable state external review process does not meet the minimum consumer protections in the NAIC Uniform Model Act or where there is no applicable state external review process.

The NAIC standards call for:

- external review of plan decisions to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit;
- clear, written notice about internal and external appeals in the standard plan materials (summary plan description, certificate, etc.) and at the time of a claim denial;
- expedited access to external review in cases of emergency situations and experimental treatments, or cases where the health plan did not follow the internal appeals rules;
- plans pay the cost of external appeals under state law, and states may not require consumers to pay more than a nominal fee (i.e., $25 per appeal);
- no minimum amount for a claim to be eligible for external review (e.g., a $500 minimum threshold);
- allowing at least 4 months after notice of a final internal adverse benefit determination to request an external review;
- an independent review organization (IRO) that is assigned by the state (not the plan or claimant), meets certain accredited standards, keeps written records, and is not affected by conflicts of interest;
- 45 days to decide generally; and
- binding final decisions so, if the claimant wins, the plan must pay the denied benefit.

PHSA §2719(b)(2) requires the Departments to establish a federal external review process applicable to certain plans (e.g., self-insured plans not subject to state law, and plans in states without external reviews). The Regulations establish that adverse benefit determinations including rescissions will be subject to the federal external review process, but that an adverse benefit determination that relates to a participant's eligibility under the terms of the plan (i.e., worker classification and similar issues) is not subject to the

federal external review process. The Departments will issue further regulatory guidance about the Federal external review process in the near future.

Notice Provisions

The Regulations require that notices about internal and external review processes be provided in a culturally and linguistically appropriate manner. Plans are considered to provide notices in such a manner if they are provided in a non-English language based on certain thresholds of the participants who are literate in the same non-English language. For example, for a plan that covers 100 or more participants, the threshold is the lesser of 500 participants, or 10% of all plan participants. If an applicable threshold is met, the plan must provide notice in the non-English language upon request. In addition, the plan must also include a statement in the English versions of all notices, prominently displayed in the non-English language.

Impact on United Methodist Health Plans

Beginning in 2011, if an annual conference determines that its health plan cannot maintain Grandfathered Plan status, the plan will have to comply with the Regulations. The impact may not be significant if the plan's current claims and appeals processes comply substantially with the DOL Claims Procedures, for example by being delegated to its claims administrators. In addition, plans that currently have voluntary external review processes based on state law could be modified relatively easily to comply with the Regulations' external review requirements. Plans that do not have external review processes will require an amendment to adopt the forthcoming federal standard or an applicable state standard. This would involve some changes for the plan's claims administrators and perhaps some associated marginal cost increases. It would also require revising and updating the plan's written claims and appeals procedures. Moreover, the annual conference may need to analyze and determine whether the new federal process would be more favorable than a process based on state law.

HealthFlex Plan Sponsors

Wespath is examining the impact of these Regulations on HealthFlex as it considers the plan's Grandfathered Plan status. We will provide you with more information soon.

For More Information

You can find more information about the Regulations at **www.healthcare.gov/center/regulations/index.html**. You also can find more about health care reform and all the regulations issued by the Departments at **www.healthcare.gov**. More information about how health care reform may affect annual conference health plans is available on Wespath's **website**. If you have additional questions, please e-mail us at **healthcarereform@gbophb.org**.

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