Claims and Appeals Under the Affordable Care Act

New Claims and Appeals Procedures Are Unappealing

For more information regarding this or any other employment-related issue, please contact your Vorys attorney or a member of the Vorys Labor and Employment Group by calling 614.464.6400.

On July 23, 2010, new interim final regulations were issued providing some of the details for the claims and appeals procedures that will apply to all non-grandfathered group health plans beginning with the plan year starting on or after September 23, 2010, or a later loss of grandfathered plan status (available at http://www.dol.gov/ebsa/healthreform/). These rules do not apply to grandfathered plans.

Many of the requirements in these regulations are problematic and you will want to take that into account in deciding about plan changes that would result in loss of grandfathered status. Since most claims adjudication is outsourced, you may also want to consult with your third-party administrator or insurer to find out when and how it will be prepared to meet the new requirements (including whether it will change its process for all plans).

The regulations change the current claims and appeals procedures and provide a framework for the new mandatory external review.

Changes to the current claims and appeals procedures

- Disputes of eligibility for coverage and rescissions will be subject to the claims and appeals procedures. Up to now, questions of eligibility involving employment status may have been resolved informally.
- The time frame for responding to an urgent care claim is shortened from 72 hours to 24 hours.
- A claimant must be allowed to review the claim file and to present evidence and testimony. Before making a final decision on an appeal, a claimant must be given any new or additional evidence considered or generated by or for the plan and an explanation of any new or additional rationale for a denial. This information has to be given to the claimant sufficiently in advance of the decision so as to give the claimant a reasonable opportunity to respond.
- The hiring, compensation, promotion and termination of individuals involved in the process cannot be based upon the likelihood that they will support benefit denials.
- Notices of decisions on claims and appeals must include:
  - identification of the claim involved. Except for disputes as to eligibility or rescission where no service or supply is requested or incurred, the notice must include the date of service, the health care provider, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
  - reasons for denial including the denial code and its corresponding meaning, as well as a description of the standard that was used in denying the claim.
  - a description of internal appeals and external review process.
  - availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman.

The agencies intend to publish model notices that could be used to satisfy the notice requirements. When published, the model notices will be available at http://www.dol.gov/ebsa.

- Notices must be "culturally and linguistically appropriate" meaning that if 10% (or 500) or more of your participants are literate only in the same non-English language, English-language notices must include a prominent notice of the availability of notices in the other language. (If your plan covers fewer than 100 participants, the threshold is 25%.) Upon request, all future notices must be provided in the other language, along with customer service in the other language. This leaves you with the issue of gauging plan participants' English and foreign language literacy.

The regulations require that a plan "provide continued coverage pending the outcome of an appeal." It is not clear whether this is limited to termination of an ongoing course of treatment. It may, when coupled with the prohibition on rescissions, result in a troubling increase in payments on behalf of ineligible individuals and/or for ineligible claims.

Any mistake in meeting these requirements allows the claimant to forego the balance of the claims and appeals procedures and proceed to court where his or her claim would be decided under a de novo standard (i.e., without deference to any decision by the plan).

New external review

- If your plan is insured: state external review process. If your plan is insured, the insurer is already required to comply with state insurance law mandates on external review. (Both insured and self-insured plans sponsored by state and local governmental entities may also be subject to state insurance law mandates on external review.) For plan years starting on or after July 1, 2011, compliance with state insurance law on external review will be sufficient only if state insurance law includes specified consumer protections in the Uniform Health Carrier External Review Model Act created by the National Association of Insurance Commissioners (NAIC Uniform Model Act, available at http://www.dol.gov/ebsa/healthreform/). The extra year is to give states time to amend their insurance laws to include the specified consumer protections. If state law does not include the specified consumer protections in a plan year starting on or after July 1, 2011, the insurer will have to follow the federal external review process.

- If your plan is self-insured: federal external review process. The regulations provide only a general framework for the federal external review process. More guidance is expected "in the near future." The process will be "similar" to the process set forth in the NAIC Uniform Model Act and will include: minimum qualifications for independent review organizations (IROs); a process for approving IROs; a process for random assignment of external reviews to approved IROs; requirements for plans to turn over records to IROs; and standards for IRO decision-making. An IRO decision is binding on the plan but the claimant still has the right to bring suit after the external review. In one small concession to employer-sponsored plans, disputes related to an individual's eligibility for coverage (e.g., worker classification or employment status) are not subject to external review. The preamble to the regulations hints (but does not promise) that the additional guidance may include a transition period effectively pushing back the date by which non-grandfathered self-insured plans must provide external review.

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