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Extended Grace Period For Some, But Not All New Affordable Care Act Health Claims & Appeals Rules Gives Qualifying Plans, Insurers Limited & Imperfect Relief

The Departments of Labor, Health & Human Services and Internal Revenue Service are extending a previously announced enforcement grace period under which the agencies will not take enforcement against health plans or health insurers that attempt to operate in good faith compliance with, but fail to meet certain new requirements for handing medical claims and appeals enacted as part of the Patient Protection and Affordable Care Act (Affordable Care Act).

While health plans and insurers working in good faith to comply with the new requirements may find the enforcement relief helpful for dealing with some areas of uncertainty concerning the interpretation of certain requirements, it is important to keep in mind that the enforcement grace period provides only limited and somewhat imperfect relief. As a consequence, health plans, health insurers and those responsible for their design and administration are encouraged to continue to move forward on efforts to comply with the new requirement in thoughtful and well-documented manners despite the announced grace period extension.

New Requirements & The Announced Grace Period

As signed into law on March 23, 2010, the Affordable Care Act generally requires that health plans and health insurance policies that are not "grandfathered" to begin complying with a series of new requirements by the first day of the first plan year that begins after September 22, 2010. These new requirements include a number of new requirements about the way that nongrandfathered health plans and health insurance policies handle medical claims and appeals. For instance, the Affordable Care Act as construed by the agencies in interim final regulations published by the agencies on July 23, 201 will require that non-grandfathered group health plans and insurers issuing non-grandfathered health insurance plans and policies:

- Implement specified internal and external review procedures that among other things mandate independent external review of medical judgment based decisions in accordance with the regulations for reviews of appeals of medical judgment based denials;
- Provide a broad range of new information in notices regarding claims and do so in a culturally and linguistically appropriate manner;
- Provide continued coverage pending the outcome of an internal appeal; and
- Comply with a laundry list of additional criteria for ensuring that a claimant receives a full and fair review in addition to complying with the requirements of existing Labor Department claims and appeals procedures.

After the agencies jointly published interim final regulations defining and implementing these requirements on July 23, 2010, last September the agencies announced that they would not

enforce certain elements (but not all) of the new requirements set forth in the interim final regulations against covered health plans or health insurers seeking to comply in good faith with the new requirements through July 1, 2011. In the March 18, 2011 announcement, the Department of Labor said that the agencies now have agreed to extend this reprieve from agency enforcement of the requirements listed in the guidance against plans seeking to comply in good faith with the new requirements until plan years beginning on or after January 1, 2012.

While offering welcome relief, covered health plans and insurers, their sponsors and issuers should not over-estimate the reach and protection provided by this new guidance. For instance:

- First, in order to qualify for the enforcement grace period, efforts must be made to administer the health plan or health insurance policy in good faith compliance with the new requirements during the enforcement grace period.
- Second, the enforcement grace period provides only limited relief. The extension to 2012 only four of a series of new requirements set forth in the interim final regulations. Nongrandfathered plans and their administrators and insurers remain accountable for prudently administering claims and appeals in accordance with all other requirements of the Affordable Care Act as well as pre-existing claims and appeals regulations set forth in 2000 claims regulations issued by the Department of Labor pursuant to the Employee Retirement Income Security Act.
- Third, the enforcement grace period guidance only means that the agencies will not exercise their power to take action against a non-compliant plan. It does not prevent plan members, health care providers with benefit assignments or other plan beneficiaries from bringing lawsuits against health plans, health insurers or their administrators for failing to comply with the new requirements during post- September 22, 2010 plan years even if the enforcement grace period otherwise protects the plan or insurer from agency enforcement action. This means that health insurers and health plans may still run the risk that plan members or beneficiaries will ask courts to reverse claims or appeals denials or impose other penalties and sanctions against plans or their fiduciaries for failing to meet the new requirements for post-September 22, 2010 plan years.
- Finally, and perhaps most significantly, the grace period guidance requires nongrandfathered plans and insurers to make "good faith" efforts to comply with the requirements covered by the relief during the grace period in order to be eligible to claim the relief offered by the enforcement grace period guidance.

Consequently, despite the relief announced March 18, nongrandfathered health plans still have significant work to do to comply with the new Affordable Care Act claims and appeals requirements even during the announced enforcement grace period.

For Help With Affordable Care Act or Other Employee Benefits or HR Needs

If you have any questions or need help responding to the Affordable Care Act or other any other health plan or insurance employee benefit, compensation, workforce or internal control concerns, please contact the author of this update, Cynthia Marcotte Stamer **here** or at (469)767-8872.

Ms. Stamer helps businesses, employee benefit plans and other organizations solve problems, develop and implement strategies to manage people, processes, and regulatory exposures to achieve their business and operational objectives and manage legal, operational and other risks. Board certified in labor and employment law by the Texas Board of Legal Specialization, with more than 23 years management-focused human resource and employee benefits experience, Ms. Stamer helps businesses manage their people-related risks and the performance of their internal and external workforce though appropriate human resources, employee benefit, worker's

compensation, insurance, outsourcing and risk management strategies domestically and internationally.

Recognized in the International Who's Who of Professionals and bearing the Martindale Hubble AV-Rating, Ms. Stamer also is a highly regarded author and speaker, who regularly conducts management and other training on a wide range of labor and employment, employee benefit, human resources, internal controls and other related risk management matters. Her writings frequently are published by the American Bar Association (ABA), Aspen Publishers, Bureau of National Affairs, the American Health Lawyers Association, SHRM, World At Work, Government Institutes, Inc., Atlantic Information Services, Employee Benefit News, and many others. For a listing of some of these publications and programs, see here. Her insights on human resources risk management matters also have been quoted in The Wall Street Journal, various publications of The Bureau of National Affairs and Aspen Publishing, the Dallas Morning News, Spencer Publications, Health Leaders, Business Insurance, the Dallas and Houston Business Journals and a host of other publications. Chair of the ABA RPTE Employee Benefit and Other Compensation Committee, a council member of the ABA Joint Committee on Employee Benefits, and the Legislative Chair of the Dallas Human Resources Management Association Government Affairs Committee, she also serves in leadership positions in numerous human resources, corporate compliance, and other professional and civic organizations. Her insights on these and other matters appear in the Bureau of National Affairs, Spencer Publications, the Wall Street Journal, the Dallas Business Journal, the Houston Business Journal, World At Work, the ICEBS, SHRM and many other national and local publications. For additional information about Ms. Stamer and her experience or to access other publications by Ms. Stamer see **here** or contact Ms. Stamer directly.

Other Helpful Resources & Information

If you found this article of interest, you also may be interested in reviewing other Breaking News, articles and other resources available at **www.CynthiaStamer.com**.

If you or someone else you know would like to receive future updates about developments on these and other concerns, please be sure that we have your current contact information – including your preferred e-mail – by creating or updating your profile **here**. For important information concerning this communication click **here.** If you do not wish to receive these updates in the future, unsubscribe by updating your profile **here.** THE FOLLOWING DISCLAIMER IS INCLUDED TO COMPLY WITH AND IN RESPONSE TO U.S. TREASURY DEPARTMENT CIRCULAR 230 REGULATIONS. ANY STATEMENTS CONTAINED HEREIN ARE NOT INTENDED OR WRITTEN BY THE WRITER TO BE USED, AND NOTHING CONTAINED HEREIN CAN BE USED BY YOU OR ANY OTHER PERSON, FOR THE PURPOSE OF (1) AVOIDING PENALTIES THAT MAY BE IMPOSED UNDER FEDERAL TAX LAW, OR (2) PROMOTING, MARKETING OR RECOMMENDING TO ANOTHER PARTY ANY TAX-RELATED TRANSACTION OR MATTER ADDRESSED HEREIN.

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Evolving Regulations & Court Decisions Tightening Standards For Health Plan Claims Handling

Cynthia Marcotte Stamer
Managing Shareholder

As sponsors, administrators and insurers of non-grandfathered health plans and policies prepare to implement and apply the "effective internal claims and appeals processes" ("ACA Rules") required by the Patient Protection and Affordable Care Act ("ACA"), recent Labor Department guidance and court decisions concerning claims and appeals regulations effective since 2000 under the Employee Retirement Income Security Act of 1974 ("ERISA") are a clear sign that all health plan sponsors, insurers and fiduciaries should audit and strengthen their claims and appeals practices to promote the sustainability of claims and appeals decisions and safeguard their plan and its plan administrators and fiduciaries against potential administrative penalties, judgments and other liabilities.

Evolving federal claims and appeals standards and guidance create the need for sponsors, insurers, and administrators of most employer-sponsored health plans and health insurance policies to update and strengthen their claims and appeals processes and related plan terms and documentation.

Evolving Regulations Impact All ERISA Health Plans

Since its enactment, ERISA has required the plans and their fiduciaries decide and administer covered health plan claims and appeals prudently using "reasonable claims and appeals procedures" that comply with Labor Department regulations and other ERISA standards. As updated and effective for all covered health plans since 2000, however, Labor Regulation § 2560.503-1 ("2000 Claims Regulation") defines the conditions that the Labor Department require be met before it will view a claims or appeals decision to comply with ERISA's reasonable claims and appeals procedures including a series of highly timelines, notification, conflict of interest and other requirements applicable when claims or appeals involve 'medical judgment" decisions.

Under current law, all ERISA-covered health plans generally must administer any denial, reduction, termination of, or a failure to provide payment (in whole or in part) ("Benefit Claim" in conformity with the requirements of the 2000 Claims Regulation – whether or not the plan is a grandfathered plan under ERISA. Ten years later, many health plans, and their insurers and administrators still have not adequately updated their health plan claims and appeals policies and practices to comply fully and consistently with the requirements of these 2000 Claims Regulations.

Labor Department official statements clarifying the Labor Department's interpretation of the current 2000 Claims Regulations and announcements of plans to update the 2000 Claims Regulations in connection with its implementation of the 2010 ACA Rules[i] make it clear the Labor Department sees room to improve the claims and appeals processes and conduct of both grandfathered and non-grandfathered health plans. These statements indicate that the Labor Department likely will tighten further the requirements of the 2000 Claims Regulations in the near future.

Therefore, group health plan sponsors, insurers, fiduciaries and administrators of all group health plans should review and tighten their claims and appeals procedures in response to the guidance recently published in connection with the 2010 ACA Rules. Consequently, whether or not a health plan qualifies as grandfathered under ACA, health plans should be reviewed and updated as necessary to comply with current or future requirements of the 2000 Claims Regulation as they become applicable to the health plan.

Health Care Reform Brings Added Changes

Beyond complying with the 2000 Claims Regulations, ACA Section 2719 requires that for all plan years beginning after September 21, 2010, non-grandfathered health plans and health insurers claims and appeals also must administer adverse benefit determinations involving Benefit Claims or a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time) in accordance with ACA's new requirements for internal claims and appeals and external review. As implemented by interim final implementing regulations ("2010 ACA Rules") jointly published by the Departments of Labor, Health & Human Services, and Treasury on July 23, 2010[ii]:

When applicable, the new 2010 ACA Rules among other things will require that non-grandfathered group health plans and insurers issuing non-grandfathered health insurance plans and policies:

- Implement specified internal and external review procedures that among other things mandate independent external review of medical judgment based decisions in accordance with the regulations for reviews of appeals of medical judgment based denials;
- Provide continued coverage pending the outcome of an internal appeal; and
- Comply with the 2010 ACA Rules' additional criteria for ensuring that a claimant receives a full and fair review in addition to complying with the requirements of existing Labor Department claims and appeals procedures.

Highlights of some of these fair review requirements include:

- Timely allowing a claimant to review the claim file and to present evidence and reasonable opportunity to respond as part of the internal claims and appeals process;
- Before issuing a final internal adverse benefit determination based on a new or additional rationale, timely proving the claimant free of charge, with the rationale and a reasonable opportunity to respond;
- Impose new conflict of interest rules for the hiring, compensation, termination, promotion, or other arrangements with a claims adjudicator or medical expert to reduce to promote the independence and impartiality of the persons involved in making the decision; and
- Dictate that plans provide more information and other disclosures in claims and appeal denial notifications and that those notifications be provided in a culturally and linguistically appropriate manner; and
- Automatically deem a claimant to have exhausted the plan's required internal claims and appeals procedures whenever the plan or insurer fails to strictly fulfill all applicable claims

and appeals procedural requirements of the governing regulations, regardless of whether the compliance defect materially impacted the outcome of the claims or appeals decision.

While Labor Department and other ACA enforcement agencies have granted non-grandfathered plans temporary relief against agency enforcement of some but not all of these new requirements as the agencies finalize further refinements to the 2010 ACA Rules and the 2000 Claims Rules, it is critical that plan sponsors, insurers and administrators not over-estimate the scope of this announced relief.

The agencies delay of agency enforcement of the identified requirements until July 1, 2011 announced on September 20, 2010 in Technical Release 2010-02 (T.R. 2010-02) as modified and extended on March 18, 2011 by Technical Release 2011-01 (T.R. 2011-01) (the "Grace Period Guidance") only temporarily protects plans and their administrators against enforcement by government regulators of a subset of the ACA requirements until certain impending clarification to the 2000 Claims Regulations and 2010 ACA Rules impacting the specifically listed ACA requirements covered by the Grace Period Guidance relief.

The Grace Period Guidance does not bar plan members or health care providers with benefit assignments or other plan beneficiaries from asking courts to sanction violations of the 2010 ACA Rules or 2000 Claims Regulations committed during the agency granted grace period by overturning health plan claims or appeals denials or imposing other penalties and sanctions against plans or their fiduciaries.

Additionally, the Grace Period only offers agency enforcement relief from certain new 2010 ACA Rules requirements. Specifically, the Grace Period only applies to agency enforcement of the 2010 ACA Rules shortening the allowable time for making urgent care claims decisions and that plan claims and appeals related notices include more information and be culturally and linguistically appropriate. Non-grandfathered plans and their administrators and insurers remain accountable for prudently administering claims and appeals in accordance with all other requirements of the 2010 ACA Rules and the 2000 Claims Regulations.

Finally, and perhaps most significantly, the Grace Period Guidance does not give non-grandfathered plans and insurers license make no effort to comply with the requirements covered by the relief during the Grace Period. On the contrary, the Grace Period Guidance expressly limits the availability of the Grace Period relief to plans that are working in "good faith" during the Grace Period to implement the required practices and policies covered by the Grace Period.

In the meanwhile, Labor Department guidance and commentary published in connection with the 2010 ACA Rules and the Grace Period Guidance clearly reflect that the Labor Department views the currently effective requirements of the 2000 Claims Regulations and other applicable requirements of ERISA also already to hold health plans and their insurers, plan administrators and fiduciaries accountable for complying with broader and more detailed standards of performance than currently applied by many group health plan administrators or fiduciaries in several respects including:

- The specificity of evidence and other analysis considered in reviewing and deciding claims and appeals and the notification about this to claimants;
- The specificity of the applicable standards governing the claims decisions and the notifications about these requirements and their implications included in notifications of claims denials provided to claimants; and
- The scope of evidence that plan administrators and other fiduciaries making claims or appeals decisions must make available to claimants in connection with the claims and appeals process.

Plan sponsors, insurers and administrators that fail to take steps to ensure that claims and appeals administered under their health programs are administered in compliance with applicable requirements of the 2000 Claims Rules and, in the case of non-grandfathered plans, the 2010 ACA Rules and to tighten up written plan terms, plan communications and other practices clearly leave their plans and their sponsors, insurers, and administrators and other fiduciaries to greater costs and other liability risks.

Court Decisions Also Signal Advisability of Tighter Policies, Practices & Regulations

Beyond the ACA and other regulatory changes, judicial precedent already demonstrated the need for many health plans, insurers and their administrators to strengthen the defensibility of their health plan claims and appeals practices and the plan language and documentation administered with these practices.

The existing precedent clearly documents that substantial compliance with the timelines, claims investigation and processing and notification procedures detailed in the 2000 Claims Regulations helps promote the cost-effective defensibility of health and other employee benefit plan decisions.[iii] Since 2000, courts increasingly have pointed to non-compliance with the 2000 Claims Regulations or other procedural irregularities in the administration of claims or appeals practices, administration or documentation as justification for overturning health care or other medically based claim or appeals decisions,[iv] imposing civil penalties and other remedies against plan administrators and other fiduciaries under ERISA Section 502(c)[v] or even in some cases, holding a plan administrator or other fiduciary liable for breach of fiduciary duties.[vi] Consequently, when evaluating the adequacy and defensibility of their health plan's claims and appeals procedures health plan sponsors, insurers, fiduciaries and administrative service providers mistakenly presume their existing claims and appeals practices meet the 2000 Claims Regulations. Consequently, in addition to responding to the Labor Department's 2010 ACA Rules, employer and other health and employee benefit plan sponsors, insurers, fiduciaries and administrators also should consider tightening and strengthening their claims and appeals decision-making, documentation and notice processes and procedures to reduce the risk that the courts will overturn benefit denials to guard against the growing willingness of federal courts to overturn benefit denials based upon their findings of process, documentation, notification, conflict of interest or other deficiencies that make the decision "arbitrary or capricious" or otherwise unsustainable under ERISA.

ERISA-covered health plans, their plan sponsors, insurers and administrators should heed these and other Federal court decisions and the tightening of federal claims and appeals rules as clearly signaling the advisability of strengthening claims and appeals documentation and practices, the precision of plan language and communications, the clarity of claim fiduciary and other selection, engagement and oversight, and other prudent steps to preserve and promote the defensibility of claims and appeal decisions. As existing claims and appeals requirements and this emerging judicial precedent affect all ERISA-covered group health plans whether or not the plan is grandfathered from the obligation to comply with the 2010 ACA Rules, the time to begin reviewing and strengthening of plan language, claims and appeals processes and documentation and other defenses already has arrived for all health plans.

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[i] See, e.g. T.R. 2010-02 available at http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-02.pdf and 2011 available at http://www.dol.gov/ebsa/newsroom/tr11-01.html.

[ii] See 75 Fed. Reg. 43330.

[iii] See e.g., *Wills v. Regence Blue Cross Blueshield of Utah*, 2011 WL 887671 (D.Utah, March 14, 2011)

[iv] See, e.g. *Smith v. Medical Benefit Administrators Group, Inc.*, 2011 WL 913085 (7th Cir, March 15, 2011)(recognizing health plan administrator's noncompliance with preauthorization procedures required by 2000 Claims Regulations could justify reversal of claims denial); *Hughes v. Cuna Mutual Long Term Disability Ins.*, 2011

WL 902026 (S.D. Ind., March 14, 2011); *Holmstrom v. Metropolitan Life Ins. Co.*, 615 F.3d 758, 766 (7th Cir.2010)(reversing disability claim as arbitrary and capricious where medical judgment based determinations not made in accordance with procedures required under 2000 Claims Rules); *Lewis v. Aetna Ins. Agency, Inc.*, 2010 WL 4386484 (S.D.Ill., October 29, 2010)(excusing claimant from exhausting administrative procedures based on administrator's noncompliance with ERISA claims procedures); *ODS Health Plan, Inc. v. Trustee of the Richard Bielenberg, Beneficiary, Client Lawyer Trust Account*, 2010 WL 4008362 (D.Ore., Oct. 12, 2010).

[v] See, e.g., *North Cypress Medical Center Operating Co*. v. CIGNA Healthcare, 2011 WL 819490 (S.D.Tx.March 2, 2011)(claim for penalties and attorney fees under ERISA § 501(c) for failing to provide required information); Olsen v. Trustees of Duluth Building Trades Welfare Fund, 709 F.Supp2d 699 (D.Minn. 2010)(injunctive relief, penalties and other remedies for failing to provide required notifications and information).

[vi] See, e.g. *North Cypress Medical Center Operating Co*. v. CIGNA Healthcare, 2011 WL 819490 (S.D.Tx, March 2, 2011) (Allegation that a fiduciary refused to provide UCR information in response to a specific inquiry by a plan beneficiary is sufficient to state a claim under ERISA § 404); *Smith v. Medical Benefit Administrators Group, Inc.*, 2011 WL 913085 (7th Cir, March 15, 2011)(holding health plan administrator that routinely delays preauthorization decisions or pre-authorizes proposed medical treatments without considering whether the health plan cover the pre-authorized treatment or condition breaches of the fiduciary obligations owed to plan participants).

Lean on Me: Group Health & Disability Claims & Appeals
Internal Claims and External Review After Health Care Reform
Fact Pattern

Helmer Johnson and his wife, Gunhild Johnson live in Roseau, Minnesota where Helmer is employed with Marvin Windows, a window manufacturer with 100 employees in nearby Warrod, Minnesota where employees are covered under a self-funded plan. His wife, Gunhild, is employed in Roseau as a seasonal employee for Polaris Industries, with 66 employees, Polaris is the manufacturer of snowmobiles where she works from late summer through Christmas and is covered under a fully-insured plan. They have children, Kinut, 14 and Solveig, age 26. Helmer's primary language is Norweigan. Gunhild speaks Norwegian fluently and has limited English proficiency as do some of the older residents of Roseau, Minn.

Roseau, a town of under 500 residents does not have a hospital. Gunhild would like to take her daughter, Solveig, to nearby Warrod General Hospital for evaluation and treatment for "teenage problems". One Tuesday, grasping her husband's employer's SPD in her hand, Mrs. Johnson headed to Warrod with Solveig in tow. She met with Dr. Hanson, a general practitioner that travels to Warrod General to see patients every other Tuesday and Wednesday. Solveig admitted to Dr. Hanson that during the long cold winters, she "sniffs" some bath salts for fun. After examining Solveig, he determined that she had some form of substance abuse and recommended further evaluation. Solveig was admitted to Knorr Treatment Facility in Warrod for an undetermined period. At that time, Gunhild was handed a bill for $1500.00, the co-payment for the service.

Gunhild received the EOB from Polaris denying treatment from Knorr Treatment Facility saying it was not a "covered treatment facility" and exclaimed "Uff da!" On the next day, she received an EOB from Marvin Windows saying that Solveig was no longer a dependent under the plan and that the plan had been amended to exclude substance abuse treatment, to which she said "Uff da, Uff da! What are we to do now?"

At that time Gunhild immediately placed a phone call to Marvin Windows' Human Relations department where she spoke to Arlette. In a heavy Norwegian accent, Gunhild wanted to know, " I can't read this paper. I thought we were covered for this?" Gunhild also placed a call to her employer, Polaris, where she asked Herdice, the plant manager, for a copy of the employer's plan document. Gunhild was so upset that the cost of the Marvin Window's plan's co-payment was too high and that they said Dr. Hansen, was not an in-network health care provider and they won't give him a copy of the medical necessity determinations. Now they are saying that Knorr Treatment Facility is not a recognized a treatment facility under the plan. She wants to file an appeal.

Helmer says "You betta call Olaf". Gunhild cries "Ya, ya you betcha" and places a call to you, Olaf, her trusted attorney, to help her get the treatment coverage mess cleared up. Gunhild asks, 'doesn't health care reform require our claims and appeals notices to be provided in a language I can understand? What exactly does that mean?" She also asks, "Now they won't cover my daughter's doctor because he is not "in-network" what is that?" What can you tell Gunhild and Helmer?