Changing Health Claims & Appeals Rules Create Challenges For Plan Members, Sponsors, Fiduciaries, Administrators & Insurers

Catch Up On The Latest Developments At RPTE 22nd Annual Spring Symposia

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New rules mandating that many health plans and health insurers comply with the "effective internal claims and appeals processes" ("ACA Rules") enacted under the Patient Protection and Affordable Care Act ("ACA") are the latest in a series of recent changes impacting federal requirements for handling health benefit claims and appeals. As these ACA Rules become applicable to some, but not health plans, they are adding additional complexity to an already complicated and evolving maze of laws, regulations and legal precedent governing the health benefit claims processing and payment.

Understanding and using these rules often plays a key role in determining the outcome of litigation and other challenges to health benefit claims and appeals denials. Changes in the governing regulations and precedent often makes maintaining the understanding needed to master and effectively use these rules confusing and challenging for employee benefit plan sponsors, their insurers and administrators, patients, health care providers and other parties, and the attorneys working to guide these clients through the health coverage maze.

The opportunity to bone up on these evolving health claims rules is one of the many options attorneys that attend the ABA RPTE 22nd Annual Spring Symposia on April 28-29, 2011 in Washington, DC., will enjoy.

Evolving Regulations & Precedent Reshaping Rules For Handling Employment-Based Health Claims & Appeals

While economic, health care cost and other pressures have lead to a decline in the number of Americans covered by private insurance in recent years,[i] employment-based coverage overwhelmingly remains the leading source of coverage for most privately covered Americans.[ii]

For more than 25 years, the reasonable claims and appeals requirements of the Employee Retirement Income Security Act of 1974 (ERISA) primarily have governed the processing and payment of employment-based health and other employee benefit claims.

Under the sweeping preemptive provisions of ERISA § 514, ERISA generally preempts historical state regulation and precedent governing the payment and processing of employment-based[iii] health plan claims and appeals other than state regulations governing the business of insurance deemed consistent with ERISA's regulatory scheme and purposes.[iv] While ERISA § 514 remains one of the most frequently litigated provisions of ERISA and has been held not to reach to certain state regulation of self-insured health plan service providers and third party collection actions brought by providers,[v] the courts continue to give its provisions sweeping and broad reach. While courts may enforce additional state regulations applicable to insurers under limited situations when deciding claims involving health benefits provided by state regulated insured health plans, insurers also remain subject to the obligation also to comply with

ERISA. Accordingly, ERISA's reasonable claims and appeals requirements continue to define the core standards for employment-based health coverage claims and appeals.

ERISA generally requires that ERISA 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.[vi]

Although Labor Department regulations implementing ERISA § 503 applied the same standards to health and disability plans as other ERISA-regulated plans, the Labor Department updated its Labor Regulation § 2560.503-1 ("2000 Claims Regulation") in 2000 to include detailed requirements for health and disability plans. All ERISA-covered health plans generally must administer any "adverse benefit determination" in conformity with the requirements of the 2000 Claims Regulation.

The 2000 Claims Regulation defines an adverse benefit determination to include virtually any denial, reduction, termination of, or a failure to provide payment (in whole or in part). Under the 2000 Claims Regulation, an adverse benefit determination generally must be made and communicated in accordance with specific and detailed requirements. These rules require claims and appeals be administered within specific timelines and comply with detailed notification, disclosure, conflict of interest and other requirements. The 2000 Claims Regulations apply to both health plans covered by ACA and those grandfathered from ACA coverage. Consequently, while the ACA Rules also may require that plans not grandfathered under ACA also comply with the additional requirements of the ACA Rules, the 2000 Claims Regulation continue to define the foundational federal rules governing the handling of all ERISA-covered health claims and appeals.

ACA Bringing Changes To Health Plan Claims & Appeals

While ACA does not replace the ERISA reasonable claims and appeals requirements, it does impose added requirements for the handling of claims and appeals by ERISA-covered health plans and certain other health plans and insurance arrangements that do not qualify as "grandfathered plans" under ACA. When a health plan or health insurance policy is covered by ACA, the ACA's requirements apply both to ERISA-covered arrangements and those exempted from ERISA coverage under ERISA § 4(b).

Beginning with the first plan year that begins after September 22, 2010, ACA Section 2719 generally requires that non-grandfathered health plans and health insurers claims and appeals must administer adverse benefit determinations including rescissions 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 in addition to complying with the 2000 Claims Regulations. Interim final implementing regulations ("2010 ACA Rules") implementing these new ACA Rules were published jointly by the Departments of Labor, Health & Human Services, and Treasury on July 23, 2010.[vii]

The 2010 ACA Rules require that ACA covered health plans and policies:

- Comply with the 2000 Claims Rules;
- Comply with specific and highly detailed 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;
- Continue to provide 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.

To meet the fair review requirements, the 2010 ACA Rules among other things require that covered health plans and policies:

- Timely allow a claimant to review the claim file and a reasonable opportunity to present evidence and respond in the course of the internal claims and external appeals process;
- Before issuing a final internal adverse benefit determination based on a new or additional rationale, timely provide the claimant free of charge, with the rationale and a reasonable opportunity to respond;
- Comply with new conflict of interest rules for the hiring, compensation, termination, promotion, or other arrangements with a claims adjudicator or medical expert;
- Provide expanded information and other disclosures in summary plan descriptions, claims and appeal denial notifications;
- Give notices in a culturally and linguistically appropriate manner; and
- Deem claimants as having exhausted the plan's required administrative procedures when the plan or insurer fails to strictly fulfill any applicable claims and appeals procedural requirements regardless if the defect materially impacted the outcome of the claims or appeals decision.

Since issuing the 2010 ACA Rules, the Labor Department, IRS and HHS subsequently have announced a Grace Period ("Grace Period") during which these agencies have said they will not act to penalize a health plan or insurer covered by ACA for failing to fully comply with certain requirements of the 2010 ACA Rules before the first plan year beginning after December 31, 2011, as long as the applicable plan or insurer makes good faith efforts to comply with the requirements during the Grace Period.[viii]

The agencies intend for the Grace Period to allow sponsors, issuers and administrators of ACA covered plans some leeway in complying with the requirements covered by the Grace Period Guidance until the agencies have an opportunity to clarify their interpretation of certain aspects of the 2010 ACA Rules. Because the Grace Period Guidance only delays enforcement by the agencies, and not participants and beneficiaries, however, health plan administrators and health insurers may still face the risk that plan participants, health care providers with benefit assignments or other plan beneficiaries may challenge plan claims or appeals determinations based on alleged noncompliance with ACA during the Grace Period.

Furthermore, the Grace Period Guidance does not give ACA covered health plans and health insurers a free walk from compliance with the 2010 ACA Rules during the Grace Period. The Grace Period Guidance only grants enforcement relief from some – not all – of the requirements of the 2010 ACA Rules and only applies this relief to plans and insurers that make "good faith" efforts to comply with the requirements during the Grace Period. In particular, the Grace Period Guidance only applies to agency enforcement of the 2010 ACA Rules shortening the time allowed for plans to make urgent care claims decisions, requirements to provide certain additional information in notices about claims and appeals, requirements that claims and appeals related communications be culturally and linguistically appropriate and the rule deeming a participant or beneficiary automatically to have fulfilled applicable administrative procedures if the plan fails to meet any requirement of the 2010 ACA Rules. ACA covered plans otherwise remain accountable to the Labor Department and other agencies for prudently administering

claims and appeals in accordance with all other requirements of the 2010 ACA Rules and the 2000 Claims Regulations.

Recent Court Decisions & ACA Guidance Signals Health Plan Administrators & Insurers Can Expect Tighter Scrutiny of Claims & Appeals Decisions

While the agencies continue to refine their interpretation of the ACA Rules, emerging agency and judicial guidance signal that regulators and the courts already are tightening their scrutiny of claims and appeals decisions made by health plan administrators and insurers.

In its official commentary in the preamble to the 2010 ACA Rules, the Labor Department[ix] shared its perception that many existing health plans and insurers fail to appreciate fully the requirements of the 2000 Claims Regulations and signaled it is likely to revise the 2000 Claims Regulations alongside its implementation of the ACA Claims Rules.

Whether or not the Labor Department tightens the 2000 Claims Rules, courts often are finding defects in the handling of claims and appeals in light of the 2000 Claims Rules that justify reversal of plan or insurer health and disability claims decisions.[x] Over the past decade, federal courts increasingly, expressly or implicitly, have cited 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,[xi] imposing civil penalties and other remedies against plan administrators and other fiduciaries under ERISA Section 502(c)[xii] or even in some cases, holding a plan administrator or other fiduciary liable for breach of fiduciary duties.[xiii]

The Labor Department commentary and this emerging precedent demonstrate that the ability of a participant, beneficiary or the Labor Department to introduce evidence that a plan or insurer failed to comply with the 2000 Claims Regulations or other procedural irregularities occurred in the handling of claims or appeals significantly increases the likelihood that a court will reverse the plan or insurer's decision. A review of this guidance shows that both the Labor Department and federal courts will be significantly influenced by:

- The documentation of the evidence and other analysis considered in reviewing and deciding claims and appeals and the notification about this to claimants;
- The documented compliance or lack of compliance by the plan administrator or insurer with the 2000 Claims Rules and other relevant standards governing the handling of claims and appeals;
- Evidence that judgments may have been inappropriately compromised by conflicts of interest;
- The adequacy and completeness of notifications and provision of access to information and appeals rights impacting on the ability of a claimant to timely understand and appeal a claim; and
- Other procedural or operational irregularities indicating that plan fiduciaries have failed to prudently administer the claim or appeal appropriately.

These and other developments strongly suggest that victory in disputes over health benefit claims and appeals decisions increasingly will go to the party that best understands and uses these and other claims and appeals standards to its benefit and against a party that fails to understand and comply with these requirements. Consequently, health plans and their insurers, participants and beneficiaries challenging

health claim determinations, and the attorneys representing these parties should look for guidance from the 2000 Claims Rules, the 2010 ACA Rules, where applicable and the emerging precedent.

Spring Symposia Offers Opportunities To Catch Up On Health & Other Employee Benefit Plan Developments

The RPTE 22nd Annual Spring Symposia on April 28-29, 2011 in Washington, DC offers participants the opportunity to strengthen their understanding and skills for advising and representing clients in disputes over health and disability benefit claims, as well as strengthen their knowledge and skills for dealing with these and other employee benefit concerns.

Attorneys interested in broadening or updating their health or other employee benefit knowledge and skills may participate in continuing education programs on:

- *"River Deep Mountain High" - Counseling Closely Held Business Owners About Compensation Planning* on Thursday, April 28 from 8:15 – 9:45 a.m. co-hosted by the Business Planning Group and the Employee Benefit Plans and Other Compensation Arrangements Group;
- *"Lean On Me" - Group Health and Disability Claims and Appeals: The Brave New World for Making, Administering, and Paying Claims* on Thursday, April 28 from 10:00 – 11:30 a.m. co-hosted by the Employee Benefits and Other Compensation Group and the Elder Law, Disability Planning and Bioethics Group; and
- *"Welcome to the Jungle" - Health Care Reform Bootcamp* on Friday, April 29 from 1:15 – 2:30 p.m. co-hosted by the Employee Benefits and Other Compensation Group and the Elder Law, Disability Planning and Bioethics Group.

Symposia participants also can learn about opportunities to expand their involvement in the employee benefit related activities of the Section and the ABA and build their relationships with other employee benefit practitioners by attending the Employee Benefits & Other Compensation Arrangement Group meeting at the Section of Real Property Trust and Estate Law - Groups and Committees Luncheon (ticket required); networking with members of the Group and others at the Sponsor Reception (complimentary) on Thursday night, joining with other Group members and friends attending the Symposia Reception at the Library of Congress following the Sponsor Reception Thursday evening (ticket required); and visiting with Group Chair Cynthia Stamer, Group Vice-Chair Robert Miller or other Group Committee Chairs and members at the meeting.

In addition to these opportunities at the Symposia, RPTE members interested in employee benefit matters also have many other opportunities throughout the year to expand or maintain their employee benefits knowledge and involvement with the Employee Benefits & Other Compensation Arrangements Group.

Through its membership in the Joint Committee on Employee Benefits (JCEB), Group members can participate at preferred rates in a broad range of employee benefit related continuing education teleconferences and other programs on employee benefits. Group members often also are selected to help plan or speak on these programs or participate in other JCEB activities.

In addition, the Group hosts bi-monthly "Study Group" teleconference calls on the first Monday of every other month and at other selected times throughout the year during which participants are briefed on and discuss new developments and other issues affecting employee benefits.

The Group also is actively working on a number of projects, in which interested members have the opportunity to participate.

RPTE members interested in expanded involvement in the Group or more information are encouraged to contact Group Chair Cynthia Stamer **here**, Group Vice Chair Robert Miller **here** or the Chair or Vice Chair of the Group Committee of interest to the member.

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[i] See "Census Bureau: Recession Fuels Record Number Of Uninsured Americans," Kaiser Health News (September 17, 2010) **here**.

[ii] See "Health Insurance and State: NCSL Overview, 2011" National Conference of State Legislatures, February 2011 **here**.

[iii] ERISA generally does not apply to plans or arrangements exempt from ERISA coverage under ERISA § 4(b).

[iv] See ERISA § 514.

[v] See, e.g., *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004); *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, (2003); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, (2002); *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, (1999); *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, (1997); *NY State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*., 514 U.S.645 (1995); Pilot Life Ins. Co. v.Dedeaux, 481 U.S. 41 (1987); Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, (1985); FMC *FMC Corp. v. Holliday*, 498 U.S. 52, (1990); *Massachusetts v. Morash*, 490 U.S. 107 (1989); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *Shaw v. Delta Air Lines, Inc*., 463 U.S. 85, (1983).

[vi] See ERISA § 503.

[vii] See 75 Fed. Reg. 43330**.**

[viii] See Technical Release 2010-02, T.R. 2010-02 (September 20, 2010) as modified and extended by Technical Release 2011-01, T.R. 2011-01 (March 18, 2011) (the "Grace Period Guidance").

[ix] 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**.**

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

[xi] 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).

[xii] *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).

[xiii] 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).