SOLUTIONS LAW PRESS

HR & BENEFITS UPDATE

Tighten & Update of Health & Other Plan Claims & Appeals Procedures & Documentation In Response To New Regulations, Tightening Court Review

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August 8, 2010

Employer and other health plan sponsors, insurers, fiduciaries and administrators should move quickly to review, update and tighten their plan documents, administrative procedures and agreements, decisional criteria, investigation and decision-making documentation, and claims and appeals-related notification and other communications in response to new requirements and guidance in recently proposed Labor Department Regulations and the increased willingness of Federal courts to scrutinize and overturn benefit denials.

New regulations (ACA Appeals Rules) implementing tighter health plan claims and appeals rules enacted under the Patient Protection & Affordable Care Act (Affordable Care Act) are the latest in a wave of new Affordable Care Act and other federal regulations that require quick updates to employment-based health plans.

The new ACA Appeals rules published July 23, 2010 primarily focus on additional claims and appeals standards that group health plans not "grandfathered" under the Affordable Care Act must meet by the first plan year beginning after September 22, 2010. However, clarifications of the Labor Department's interpretation of existing claims and appeals rules for employment-based group health plans shared with the ACA Appeals Rules make clear grandfathered plans also have work to do. 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 ACA Appeals Rules.

Beyond responding to the Labor Department's ACA Appeals 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.

All Group Health Plans Should Review, Tighten Claims & Appeals Processes

Currently, all group health plans covered by the Employee Retirement Income Security Act (ERISA) must administer claims and appeals prudently using reasonable claims and appeals procedures that comply with detailed Labor Department regulations and other ERISA standards. Group health plan sponsors, insurers and administrators should view recent Federal court decisions like the August 4, 2010 decision of the 7th Circuit in *Holmstrom v. Metropolitan Life Insurance Company* as strong signals that tighter claims and appeals documentation and practices already are needed 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 without regard to whether the group health plan

qualifies as grandfathered or non-grandfathered for purposes of the Affordable Care Act, timely review and strengthening of claims and appeals processes is important for all group health plans.

Labor Department commentary included in the ACA Appeals Rules Preamble and a string of recent court decisions send a strong message that the adequacy of all ERISA-covered group health plans – whether or not grandfathered under ACA- should be evaluated and tightened. The Preamble discussion makes clear that the Labor Department views existing ERISA claims and appeals regulations and imposing on insurers, plan administrators and fiduciaries much broader and more detailed responsibilities than generally understood or followed by most 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.

This Labor Department guidance and Labor Department briefs filed in various pending litigation echoes similar messages that federal courts increasingly are sending when deciding – and reversing – claims denials. Together, these developments create a strong justification for health and other employee benefit plan sponsors, insurers and administrators to quickly review, clean up and strengthen claims and appeals decision-making, documentation and notifications to protect the defensibility of denials.

The August 4, 2010 decision of the 7th Circuit in *Holmstrom v. Metropolitan Life Insurance Company*, is illustrative of the growing judicial willingness of Federal courts to scrutinize and reverse benefit denials under ERISA-covered plans. As *Holmstrom* demonstrates, this heightened scrutiny extends to even those employee benefit plans qualifying for "deferential review" under ERISA.

In *Holmstrom*, the 7th Circuit overruled a Metropolitan Life Insurance Company (MetLife) decision to terminate disability benefits under an ERISA-covered plan because it said inadequacies in the claims and appeals determination processes and notifications made the determination arbitrary and capricious. This action is particularly notable as the court specifically found that the plan in question qualified for "deferential review" based on grants of discretionary authority included in the governing plan document.

As justification for its finding, the 7th Circuit, among other things found MetLife acted arbitrarily by failing to notify Holmstrom what evidence the plan required to prove she remained disabled and the grounds for the denial of her claim with sufficient specificity to afford her a full and fair review. According to the 7th Circuit:

> When an administrator asks for additional information in broad terms, it is too easy to find later a reason to deem what it was given to be insufficient. If the administrator believes that a procedure must have certain characteristics, or that it must be performed by a certain kind of professional, it must provide at least some level of guidance, unless

the test sought is so well-known that a claimant or her attorney or other representative can reasonably be expected to know what the administrator expects.

The 7th Circuit additionally took exception to the use by MetLife of a 'moving target' of proof throughout the course of the appeal According to the 7th Circuit, MetLife acted arbitrarily by continuously inviting Holmstrom to submit additional evidence to establish her disability, then when Holmstrom provided it, repeatedly finding the new evidence insufficient under new standards or expectations not previously communicated to Holmstrom. The 7th Circuit found "[s]uch conduct frustrates fair claim resolution and is evidence of arbitrary and capricious behavior."

Beyond these two broad procedural deficiencies in the handling of Holmstrom's claim, other arbitrary actions by MetLife that the 7th Circuit found justified reversal included:

- Improperly making selective use of evidence;
- Improperly giving undue weight to certain medical standards not warranted by the medical literature; and
- Requiring the claimant to provide definitive proof of the condition when no accepted definitive test exists in the medical literature and subjective evidence in the medical record met generally accepted clinical standards to support the diagnosis.

Like an increasing number of other Federal court decisions, the 7th Circuit's decision makes clear that many Federal courts afford little deference to the benefit determinations made by ERISA plan administrators and fiduciaries unless the plan decision-making is supported by strong processes, documentation, and notifications.

ACA Appeals Rules Require Non-Grandfathered Plans Make Additional Updates Quickly

In addition to complying with existing claims and appeals requirements, the new ACA Appeals Rules also will require that non-grandfathered health plans modify existing claims and appeals procedures to comply with new federal appeals protections mandated under the Affordable Care Act. The ACA Appeals Rules requirements for internal claims and appeals processes generally will apply to any denial, reduction, or termination of, or failure to provide or make a payment (in whole or in part) for a benefit, including any:

- Rescission of coverage as defined in the regulations restricting rescissions;
- Determination of an individual's eligibility to participate in a plan or health insurance coverage;
- Determination that a benefit is not a covered benefit;
- Imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits;
- Determination that a benefit is experimental, investigational, or not medically necessary or appropriate;
- Other denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit can include both pre-service claims (for example, a claim resulting from the application of any utilization review), as well as post-service claims; and
- Any other instance where a plan pays less than the total amount of expenses submitted with regard to a claim, including a denial of part of the claim due to the terms of a plan or

health insurance coverage regarding co-payments, deductibles, or other cost-sharing requirements.

When applicable, the new ACA Appeals 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;
- Provide continued coverage pending the outcome of an internal appeal; and
- Comply with the ACA Appeals 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;
- Comply with the ACA Appeals Rules' requirements for ensuring that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision; and
- Provide more detailed notification about appeals and other rights as required by the ACA Appeals Rules.

The ACA Appeals Rules also state that if a plan or issuer that fails to strictly adhere to all of its requirements with respect to a claim, the claimant may initiate an external review and pursue judicial review and other remedies regardless of whether the plan or issuer asserts that it substantially complied with these requirements or that any error it committed was de minimis.

Many Other Changing Federal Rules Require Other Plan Updates

Changing claims and appeals standards are only a small part of the sweeping range of developments that employer and other plan sponsors, administrators, and fiduciaries of group health plans must deal with as the struggle to design and administer legally defensible plans this year.

The new ACA Appeals Rules are the latest in a wave of new Affordable Care Act and other federal regulations that require quick action by employment based health plans, their employer and other sponsors, fiduciaries, administrators and insurers. Regulations issued in previous weeks define when health plans and health insurance policies qualify as "grandfathered" under the Affordable Care Act and interpret and implement many other federal health plan rule changes enacted by the Affordable Care Act.

All employer and other group health plan sponsors, fiduciaries, insurers and administrators should be prepared to act quickly to update their health plan documents, communications, insurance and vendor agreements and other practices to comply with new federal requirements that become effective under the Affordable Care Act on the first day of the plan year beginning

after September 22, 2010 and various other changes in federal health plan rules effective or scheduled to take effect during 2010 or 2011 plan years. Many plan sponsors also may need to act quickly to cancel or revise certain design or vendor changes planned or already implemented since March 23, 2010 to position their health plan to qualify for grandfather status. Quick action also may be needed to preserve options to claim small employer tax credits, retiree medical subsidies or other opportunities.

In addition to responding to these Affordable Care Act changes, most group health plans also will require updates in response to other federal health plan rule changes beyond those enacted under the Affordable Care Act. These Affordable Care Act and other impending federal health plan changes will require employment-based group health plans, their employer and other plan sponsors, plan fiduciaries, plan administrators and other service providers and insurers to make quick decisions and to act quickly to meet impending federal compliance deadlines while preserving flexibility and managing costs.

August 24 "2010 Health Plan Update" Internet Workshop Provides Key Information

Solutions Law Press invites you to catch up on the latest guidance about the new group health plan Affordable Care Act and other federal health plan regulations by participating in a live **"2010 Health Plan Update"** internet broadcast briefing on Tuesday, August 24 2010. The briefing will be conducted via live video broadcast from 11:00 A.M.-1:30 P.M. Central Time. **Register & Get More Details.**

Learn the tests that will decide if your group health plan will qualify as "grandfathered" from key Affordable Care Act requirements and assess what updates you should consider making to meet critical 2010/2011 Affordable Care Act & other federal health plan compliance deadlines.

The August 24, 2010 "2010 Health Plan Update" briefing will cover the latest guidance on Affordable Care Act and other federal health plan regulatory changes impacting employment-based group health plans and their sponsors for plan years beginning between September 23, 2010 and September 22, 2011 and other key information to help employers, group health plans, insurers, plan administrators, fiduciaries, broker and others working with these plans to understand and respond to these new requirements including**:**

- How to qualify your health plan as a grandfathered plan under Affordable Care act
- How to decide if maintaining grandfathered plan status is worthwhile
- Claims & appeals requirements for grandfathered & non-grandfathered plans
- Preventive care coverage mandates & wellness program requirements & rules under Affordable Care Act & other federal regulations
- Updated dependent child eligibility, pre-existing condition & other requirements for grandfathered & non-grandfathered plans
- Special enrollment, preexisting condition & other eligibility mandates for grandfathered & non-grandfathered plans under new Affordable Care Act, new FMLA, COBRA, Michelle's Law, HIPAA & other federal regulations
- Mental health & substance abuse, provider choice & other benefit mandates under Affordable Care Act, Mental Health Parity & other federal rules
- Update on other recent & pending Affordable Care Act group health plan rule guidance
- Tips to review & update your plans, vendor agreements & processes to meet Affordable Care Act & other federal group health plan dictates

- Expected future Affordable Care Act & other federal rule changes & tips for preparing
- Practical strategies for responding to new requirements & changing rules
- Participant questions

To register or get additional information, see **here**.

For Assistance or More Information

If your organization needs assistance updating your heath care program documentation, policies or procedures in response to these or other requirements or with other employee benefit, insurance or human resources matters, please contact the author of this update, Board Certified Labor & Employment attorney Cynthia Marcotte Stamer at (469) 767-8872 or via e-mail **here**.

Current Chair of the American Bar Association (ABA) RPTE Employee Benefit & Other Compensation Group, a Council Member of the ABA Joint Committee on Employee Benefits and Past Chair of the ABA Health Law Section Managed Care & Insurance Interest Group, Ms. Stamer continuously advises employers, health and other employee benefit plans, plan sponsors, fiduciaries, plan administrators, plan vendors, insurers and others about health program related legal, operational, documentation, public policy, enforcement, privacy, technology, litigation and risk management and other concerns. Ms. Stamer also publishes, conducts client and other training, speaks and consults extensively on these and other health and managed care program concerns and practices. She regularly speaks and conducts training for the ABA, American Health Lawyers Association, Institute of Internal Auditors, Society for Professional Benefits Administrators, Southwest Benefits Association and many other organizations. Her insights on these and related topics have appeared in Atlantic Information Service, Bureau of National Affairs, World At Work, The Wall Street Journal, Business Insurance, Managed Healthcare, Health Leaders, various ABA publications and a many other national and local publications. To contact Ms. Stamer or for additional information about Ms. Stamer, her experience, involvements, programs or Publishers of her many highly regarded writings on health industry and human resources matters include the Bureau of National Affairs, Aspen Publishers, ABA, AHLA, Aspen Publishers, Schneider Publications, Spencer Publications, World At Work, SHRM, HCCA, State Bar of Texas, Business Insurance, James Publishing and many others. You can review other highlights of Ms. Stamer's experience **here**.

Other Resources

If you found this information of interest, you also may be interested in reviewing other recent Solutions Law Press updates including:

- ✓ **Small Employers Sponsoring Health Coverage May Qualify For New Tax Credit, Must Act Quickly To Comply With Other New Federal Health Plan Mandates Under Affordable Care Act & Other Laws**
- ✓ **Rite Aid Pays $1 Million HIPAA Privacy Settlement As OCR Tightens HIPAA Regulations**
- ✓ **New Affordable Care Act Mandated High Risk Pre-Existing Condition Insurance Pool Program Regulations Prohibit Plan Dumping of High Risk Members, Set Other Rules**
- ✓ **Register Now For 8/24 2010 Health Plan Update Briefing**
- ✓ **Congress & Labor Department Considering Tightening of Retirement Plan Regulations**
- ✓ **Testimony Highlights Growing Exposure of Businesses Misclassifying Workers; Businesses Should Act to Minimize Risks**
- ✓ **Businesses Employing Children Should Review & Tighten Practices In Light of Tightened Rules & Increased Penalties**

- ✓ New Affordable Care Act Health Plan Appeals Regulations Require Health Plan Updates
- ✓ Blockbuster & Health Delivery Disability Discrimination Settlements Highlight Need For Tightened Disability Discrimination Risk Management
- ✓ Agencies Release Regulations Implementing Affordable Care Act Health Plan Preventative Care Mandates
- ✓ New Retirement Plan Resource To Help Spanish-Speaking Participants With Retirement Planning
- ✓ Office of Civil Rights Proposes Changes To HIPAA Privacy, Security & Civil Sanctions Rules
- ✓ St. Louis Employer's OSHA Violations Trigger Contempt Order and Penalties
- ✓ Review & Strengthen Defensibility of Existing Worker Classification Practices In Light of Rising Congressional & Regulatory Scrutiny
- ✓ Key Affordable Care Act Health Plan Coverage Mandates Guidance Issued June 28; Apply ASAP For Early Retirement Reinsurance Program
- ✓ HHS, DOL & IRS Rules Define "Grandfathered" Group Health Plans & Health Insurance Coverage under the Patient Protection and Affordable Care Act
- ✓ New Rule Requires Federal Government Contractors To Post New "Employee Rights Under The National Labor" Poster
- ✓ Defined Contribution Plans Investing In Publically Traded Employer Securities Face New Requirements
- ✓ CBO Raises Estimated Cost of Health Care Reforms As Employers, Health Plans Brace Costs Of Newly Effective & Impending Mandates
- ✓ Certain Workforce Reductions Trigger Plant Closing Notice & Other Obligations
- ✓ Mishandling Employee Benefit Obligations Creates Big Liabilities For Distressed Businesses & Their Business Leaders
- ✓ DOL Plans To Tighten Employment Protections For Disabled Veterans & Other Disabled Employees Signals Need For Businesses To Tighten Defenses
- ✓ COBRA, HIPAA, GINA, Mental Health Parity or Other Group Health Plan Rule Violations Trigger New Excise Tax Self-Assessment & Reporting Obligations

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