

To: Our Clients and Friends

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## Regulations Issued Under Health Care Reform on Preventive Services and Internal Claims and Appeals, and External Review Procedures

The Departments of Treasury, Labor and Health & Human Services (the "Departments") recently issued two more batches of interim final regulations under the Patient Protection and Affordable Care Act, as amended (the "Act"). This new guidance addresses (i) the preventive services coverage mandate, and (ii) the new internal claims and appeals and external review processes. Both sets of interim final regulations are effective for plan years beginning on or after September 23, 2010. Neither requirement applies to [grandfathered group health plans](#).

### Coverage of Preventive Services

The Act precludes non-grandfathered group health plans from imposing any cost-sharing requirements (e.g., co-pay, co-insurance, or deductible) on certain in-network preventive health services that fall into the following categories:

- Services that have in effect a rating of A or B as recommended by the U.S. Preventive Services Task Force;
- Immunizations for children, adolescents and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Evidence-informed preventive care and screenings for infants, children, adolescents and women supported by the Health Resources and Services Administration.

A list of the preventive services currently falling within one of these categories is available at <http://www.healthcare.gov/law/about/provisions/services/lists.html>. Plans must comply with the existing requirements effective for plan years beginning on or after September 23, 2010. Any additional recommendations provided in the future must be covered as of the first plan year beginning on or after the first anniversary of the when the recommendations are updated. Once an item or service has ceased to be a recommended preventive service pursuant to the above, a plan is no longer required to waive cost-sharing requirements with respect to that item or service. The regulations make clear that a

plan is not required to cover out-of-network preventive services described above, and may impose cost-sharing requirements on such services.

The regulations also clarify cost-sharing requirements applicable where the preventive services are provided as part of an office visit, as follows:

- If a recommended preventive service is billed separately from an office visit, the plan may impose cost-sharing requirements with respect to the office visit.
- If a recommended preventive service is not billed separately from an office visit and the primary purpose of the visit is delivery of the preventive service, cost-sharing requirements may not be imposed.
- If a recommended preventive service is not billed separately from an office visit and the primary purpose of the visit is not the delivery of such preventive services, cost-sharing requirements may be imposed.

### **Internal Claims and Appeals, and External Review Procedures**

Less than a week after the preventive service regulations were issued, the Departments issued another batch of interim final regulations, which address internal claims and appeals and external review procedures. The regulations set forth a number of clarifications and mandates to go along with and supplement existing Department of Labor regulations governing claims and appeals procedures for employee benefit plans.

The interim final regulations provide the following rules and clarifications:

- A [rescission of coverage](#) shall be treated as an “adverse benefit determination” subject to the rules regarding denied claims.
- The maximum time frame within which a plan must notify a claimant of a benefit determination with respect to an urgent care claim is reduced from 72 hours to 24 hours.
- To provide a full and fair review of an adverse benefit determination, a plan must now also provide the claimant, free of charge, any new or additional evidence considered or generated in connection with the claim, as well as an explanation of the rationale underlying the determination before providing notice of the final adverse benefit determination. This new evidence and rationale must be provided to the claimant sufficiently in advance of the final determination to give the claimant a reasonable opportunity to respond.
- The plan must ensure that all claims determinations and appeals are designed to ensure impartiality and independence with respect to the persons making the decisions. For example, decisions regarding hiring, compensation, termination, promotion or other similar matters of a claims adjudicator or medical expert cannot be made based on the likelihood that the individual will support the denial of benefits.
- A plan must now provide notice of an adverse claims determination (in a culturally and linguistically appropriate way) that includes information necessary to identify the claim involved and the reason(s) for the adverse determination.

- If a plan fails to strictly comply with the new requirements regarding internal claims procedures or any previously existing claims and appeals procedure rules, the claimant will be deemed to have exhausted all administrative remedies available under the plan, and may pursue judicial review following the noncompliance.

In addition, if a claimant's appeal of an adverse benefit determination is denied, he or she is entitled to an external review of that determination through an external review process. The Regulations set forth rules determining whether a state or federal external review applies. In the case of a fully-insured plan where a state's external review process provides equivalent consumer protections as those included in the "NAIC Uniform Model Act" (the "Model Act"), the state's external review process will apply. In such a case, it would be the issuer of the insurance policy—not the plan—that would be required to comply with the state or federal external review process, as applicable. At a minimum, the regulations require the state external review process to, among other things:

- review an issuer's decision based on medical necessity, appropriateness, level of care or effectiveness of a covered benefit;
- require issuers to provide claimants notice of their right to a written external review of an adverse benefit determination;
- allow for exceptions to requirement for exhaustion of internal claims and appeals process;
- provide that an issuer pay the cost of the external review;
- not impose a minimum dollar limit on claims eligible for external review;
- allow at least four months to file a request for external review;
- provide that reviews will be randomly assigned to ensure impartiality and independence of the reviewer;
- provide that the decision of the reviewer is binding on the issuer and the claimant and shall be made within 45 days from receipt of the request for external review; and
- provide for expedited review if the adverse determination concerns an admission, availability of care, continued stay, care following emergency services, or concerns a condition for which the standard time frame would jeopardize the life or health of the claimant.

Self-insured group health plans generally are not be subject to state external review processes and mostly will be required to comply with the federal external review process. Where a state has not adopted an external review process that meets the minimum requirements of the Model Act, or has not adopted an external review process at all, the federal review process shall apply to fully-insured plans as well. Although subsequent regulations will frame the federal external review process, it is expected to be similar to the state review processes that satisfy the Model Act and will be operated in accordance with rules similar to those above.

The regulations make clear that the Federal external review process will not apply to determinations of whether or not someone is eligible for benefits under a group health plan. Therefore, if benefits are denied on the basis that the employee or spouse is not eligible for coverage, that denial would not be subject to the Federal external review process. Whether a denial is subject to a state external review process for fully-insured plans will depend on the terms of the state external review process. It is not

clear how this rule will apply to a rescission due to, for example, a misrepresentation as to eligibility. Under such a scenario, the denial of coverage is based on a lack of eligibility, but if it is denied retroactively, it would constitute a rescission, which is treated as an “adverse benefit determination” pursuant to these regulations. Hopefully, this will be clarified by the final regulations.

The attorneys of the Employee Benefits and Executive Compensation group of Bryan Cave LLP are available to answer your questions.

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