Client Alert

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Health Care Reform Update: New Claims Procedure Rules Go Into Effect

by Mark C. Jones

Over the last two months, the Departments of Labor, Treasury and Health and Human Services have issued a series of interim final rules implementing the provisions of the Patient Protection and Affordable Care Act ("PPACA") that first become effective. (For information on PPACA, see our client alerts dated March 30 and May 13 and September 8 and our white paper dated July 12, 2010.) Among the most significant changes in this series are the new procedures that employers with non-grandfathered group health plans must put into place this year for the review of benefits claims.

Internal Claims and Appeals Processes

Insured group health plans and self-insured plans (other than grandfathered plans) must put into place new, written internal claims and appeals processes, effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans). These procedures, which supplement the current claims procedure regulations under ERISA, are intended to safeguard the impartiality of the claims review process, offer participants greater access to their records, and give them a greater opportunity to present their case on appeal. To the extent that these requirements are satisfied by a health insurance issuer in connection with a group health plan, the requirements are also deemed to be satisfied by the plan.

Change to Existing Requirements Under ERISA. Interim final rules published on July 23, 2010 extend the application of the ERISA claims procedures to rescissions of coverage, whether or not there is an adverse effect on benefits, and accelerate the maximum notice period for benefit determinations for urgent care from 72 hours after receipt of the claim to 24 hours, taking into account the medical exigencies. An exception to this timing applies if the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan.

New Requirements. The new regulations also add a number of new requirements. A plan must affirmatively provide a claimant with any new evidence that is considered or generated by the plan in connection with the claim and, on appeal, any new or additional rationale for the plan's decision, in each case as soon

as possible and sufficiently in advance of the date on which the notice of determination is required so that the individual has a reasonable opportunity to respond prior to that date. The obligation to provide this information is not dependent on the claimant's request, as it is under current regulations. The plan must also ensure 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. For example, decisions regarding the hiring or compensation of a claims adjudicator or medical expert may not be based upon the likelihood that the individual will support a denial of benefits.

Notices of adverse benefit determination must include several new pieces of information, including the diagnosis, treatment and denial codes and their corresponding meanings, a discussion of any plan standard used in denying the claim (including a discussion of the decision, in the case of a decision on appeal), a description of available internal appeals and external review processes, and contact information for any applicable state office of health insurance consumer assistance or ombudsman to assist participants with internal claims and appeals and external review processes.

Finally, the regulations provide that the claimant is deemed to have exhausted his or her internal appeals if the plan fails to strictly adhere to all of the regulatory requirements for processing a claim, even if any error it committed was de minimis. This standard is significantly higher for employers that sponsor health plans than the "substantial compliance" standard currently applied in many decisions at law. As a result, the new standard is expected to lead to an increase in benefit claims brought in court, a factor employers should take into account in determining whether to maintain their plans as grandfathered plans.

Notices to Claimants. PPACA requires notices of available internal claims and appeals and external review processes to be provided in a culturally and linguistically appropriate manner. The interim final rules provide that this requirement is satisfied by providing notices, upon request, in a non-English language, if the plan that covers fewer than 100 participants of whom at least 25 percent are literate only in the same non-English language. If the plan covers 100 or more participants, this requirement is satisfied by providing notices, upon request, in a non-English language, if at least 10 percent (or, if less, 500 participants) are literate only in the same non-English language. If either of these thresholds is met, the plan must include a statement in the English version of all notices, prominently displayed in the non-English language, offering the provision of the notice in the non-English language. Once a claimant requests a notice in the non-English language, the plan must provide all future notices to the claimant in the same language. If the plan maintains a hotline or other customer assistance process that answers questions or provides assistance with filing claims and appeals, the plan must also provide such assistance in the same non-English language.

What Plan Sponsors Need to Do. Employers that have implemented new plans since March 23, 2010 or have older plans that will not be operated as grandfathered plans must notify participants and enrollees of the availability of these internal claims processes no later than the first day of the first plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans). In addition, employers should revise their claims procedures and model determination notices by this date to ensure that their documentation is in place for the new plan year. (Model notices of adverse benefit determination and final internal adverse determination have been posted at www.dol.gov/ebsa.)

Employers should also determine whether their services agreements need to be revised to clarify which party has the authority for monitoring compliance with these rules and liability in the event of any compliance failure. In order to comply with the language requirements, employers should coordinate with their administrators to track the primary language of the plan participants and to keep a record of any requests for non-English language notices so that future notices will be provided in the same language.

External Reviews

PPACA provides that insured group health plans and self-insured plans (other than grandfathered plans) must comply with a state or federal external review process. Interim final rules published on July 23, 2010 provide that a fully insured health plan will be deemed to comply with this requirement if the plan's insurance provider is subject to a state external review process that complies with minimum consumer protections set forth in the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act (the "NAIC Uniform Act"). These protections include waiving any exhaustion requirement where the claimant has applied for expedited external review and an expedited internal appeal, allowing the claimant at least four months to file a request for external review, permitting the claimant to submit additional information to the applicable independent review organization ("IRO"), and requiring written notice of the decision on review to be provided to the claimant within 45 days or, in the event of an expedited external review, within 72 hours. To give states time to incorporate these protections, the interim final rules provide that state external review processes will be considered to meet these standards for plan years beginning before July 1, 2011 (that is, through December 31, 2011 for calendar-year plans).

Federal External Review Process. If a state does not have an external review process or ERISA preempts the application of the state review process (as it does for most nongovernmental self-insured plans), the interim final rules provide that the plan must instead comply with the federal external review process. The interim final rules did not set out the federal external review standards specifically, but indicated that it is to be similar to state external review processes incorporating the consumer protections of the NAIC Uniform Act, but will not extend to eligibility determinations.

Safe Harbor. On August 23, 2011, the Department of Labor issued a Technical Release providing an interim safe harbor pursuant to which no enforcement action will be taken against a self-insured group health plan that either voluntarily complies with an applicable state external review process or complies with procedures, based on the NAIC Uniform Act, set out in the release. In general, the release includes specific procedures for initiating an external review, determining whether a claim is eligible for external review, assigning an IRO to conduct the review, and providing notice of the final external review decision. The Technical Release also provides an expedited external review process if the time for completing an expedited internal appeal or standard external review would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function or if the claimant is currently an in-patient and the benefit determination concerns emergency services. This safe harbor is effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans), until future guidance on the federal external review process is issued.

What Plan Sponsors Need to Do. Employers that have implemented new plans since March 23, 2010 or have older plans that will not be operated as grandfathered plans must notify participants and enrollees of the availability of these external claims processes no later than the first day of the first plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans). In addition, employers should revise their claims procedures and model determination notices to ensure that their documentation is in place for the new plan year. (A model notice of final external adverse determination has been posted at www.dol.gov/ebsa.) Employers should also determine whether their services agreements need to be revised to clarify which party has the authority for determining the eligibility of requests for external review and monitoring compliance with the regulatory requirements. The same requirements for providing communications in a non-English language that apply to internal benefit determinations also apply to external benefit determinations.

If you have any questions about the interim final rules and their application to your company's health care arrangements, please contact the Pillsbury attorney with whom you usually work or one of the following members of our Compensation & Benefits practice section:

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