

Health Care Reform's Claims and Appeals Rules Amended

Section 2719 of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act ("PPACA"), requires non-grandfathered insured and self-insured group health plans (and insurers) to amend their claims and appeals procedures. The procedures mandated by PPACA incorporate existing claims procedure rules under the Employee Retirement Income Security Act and require plans to conform to agency standards. In July 2010, the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and Treasury ("IRS") (collectively, the "Departments") issued interim final regulations providing such standards. The July 2010 interim final regulations were significantly amended in June 2011. The DOL has also issued several related technical releases. Plans should welcome the latest guidance, as it generally delays compliance deadlines and relaxes and clarifies the July 2010 regulations.

Amendments to Internal Claims and Appeals Requirements

The guidance amended the internal claims and appeals requirements regarding: (1) urgent care claims, (2) adverse benefit determination notices, (3) culturally and linguistically appropriate notices, and (4) deemed exhaustion of internal claims and appeals. Under a March 2011 DOL technical release, the compliance deadline for PPACA's claims and appeals standards has been delayed until plan years beginning on or after January 1, 2012. The March 2011 release modified a September 2010 release by extending the compliance deadline from June 2011 to January 1, 2012 and by removing the requirement that plans make a good faith effort to implement the internal claims and appeals amendments during the grace period.

Urgent Care Claims

Under the new standards, plans must notify claimants of urgent care benefit determinations, regardless of whether they are adverse, as soon as possible (accounting for the medical exigencies), but no later than 72 hours after receiving the claim. Plans must defer to healthcare providers regarding whether the claims are for "urgent care." The latest guidance amends the July 2010 interim final regulation by lengthening the notice deadline from 24 hours to 72 hours and by adding the healthcare provider deference requirement.

Adverse Benefit Determination Notices

The new standards require that plans state in notices of adverse benefit determination that diagnosis and treatment codes and their meanings are available upon request. The Departments released model notices with language plans may use to satisfy this requirement. The latest guidance also clarifies that requests for diagnosis and treatment codes do not alone trigger an internal appeal or external review. The guidance significantly relaxes the rules under the July 2010 interim final regulations, which required diagnosis and treatment codes and their meanings be provided automatically in adverse benefit determination notices.

Culturally and Linguistically Appropriate Notices

Section 2719 of PPACA requires plans to provide notice of available internal and external appeal procedures to participants in a culturally and linguistically appropriate manner. The latest guidance limits such notice to participants in counties where 10% or more of the population is only literate in the same non-English language based on U.S. census data. A list of counties meeting this non-English threshold will be updated annually on the Departments' web sites. Currently, the non-English threshold is met in 255 counties. In New York, the threshold is met for Spanish in Bronx, New York, and Queens counties. If the non-English threshold is satisfied, every English notice a group health plan sends to participants in those counties must prominently display a one-sentence statement in the non-English language offering agency-provided language-assistance services. The Departments' model adverse benefit determination notices offer example sentences that satisfy this requirement in Spanish, Tagalog, Chinese, and Navajo. Plans must also provide written notices in the non-English language upon request, and must have a customer assistance process (e.g., a telephone hotline) providing language services in the non-English language to answer questions and assist with filing claims and appeals. The most significant amendment to the July 2010 interim final regulations was to standardize the percentage threshold for triggering the non-English notice requirements. The July 2010 rules had required each plan to individually test whether its participant pool met a certain non-English percentage threshold.

Deemed Exhaustion of Internal Claims and Appeals

The latest guidance provides that internal claims and appeals procedures are deemed exhausted, and claimants may immediately seek de novo external review, if the plan fails to satisfy all of the internal claims and appeals process standards, except where the violation is (1) de minimis, (2) non-prejudicial, (3) attributable to good cause or beyond the plan's control, (4) in the context of an ongoing, good faith information exchange, and (5) not reflecting a pattern or practice of noncompliance. Claimants are entitled to an explanation from the plan addressing why it meets these requirements upon written request. The plan then has 10 days to provide the explanation. If the external reviewer or court rejects a request for immediate review because the plan satisfies these requirements, then the plan must provide claimants notice that they can re-file and pursue the internal appeal. Claimants have 10 days from receipt of the notice to re-file. The latest guidance drastically eases the burden of the July 2010 interim final regulations, which stated that claimants could seek de novo external review whenever the plan failed to "strictly adhere" to the internal claims and appeals rules, without exception.

Amendments to External Review Requirements

The latest guidance amends the State and federal external review standards. The external review procedures are for claimants that have exhausted the internal review procedures. Generally, State external review applies to all insured plans (grandfathered and non-grandfathered), while federal external review applies to non-grandfathered self-insured plans.

State External Review Amendments

The latest guidance provides that insured plans may comply with any existing State external review process until December 31, 2011. If the State does not have an external review process, then plans must comply with an HHS-administered federal external review process. The latest guidance extended the July 2010 interim final regulation's compliance deadline of July 1, 2011 to December 31, 2011. After December 31, 2011, insured plans only must comply with a State's external review process if (1) the State process meets 16 minimum consumer protections based on the Uniform External Review Model Act of the National Association of Insurance Commissioners ("NAIC"), or (2) the State process operates under federal standards similar to the NAIC model. The latest guidance stipulates that the second option is only available until January 1, 2014. If the State's procedures do not meet either of these standards, then insurers are subject to a federal external review process similar to the NAIC model, which could be either (a) an HHS-administered process, or (b) the private-accredited independent review organization ("IRO") process available to self-insured plans.

New York State currently has an external review process that meets the NAIC's 16 consumer protections. Therefore, New York employers should not see any significant changes to their insured plan's external appeal procedures.

Federal External Review Amendments

The federal external review process is generally a DOL and IRS supervised process under which non-grandfathered self-insured plans must contract with IROs to perform reviews. A DOL technical release issued in August 2010 announced an interim safe harbor for the external review process. The latest guidance provides that, to be eligible for this safe harbor, self-insured plans must contract with at least 2 IROs by January 1, 2012 and at least 3 IROs by July 1, 2012, and generally rotate assignments among them. The latest guidance gives plans more time to contract with IROs than in the August 2010 DOL release, which required plans to contract with at least 3 IROs by July 1, 2011. Self-insured plans must still comply with a list of standards in the August 2010 DOL release to satisfy the interim safe harbor. As an alternative to the safe harbor, the August 2010 DOL release provides that plans can comply with a State external review process.

The latest guidance also limits federal external review to claims regarding medical judgment (excluding claims involving contractual or legal interpretation) and rescissions of coverage. The external reviewer (i.e., the IRO) determines whether a claim involves medical judgment. The latest guidance significantly narrows the scope of eligible claims, as the July 2010 interim final regulations had provided that federal external review applies to every adverse benefit determination, unless related to the plan's eligibility requirements. The latest guidance, however, only applies to external review proceedings initiated on or after September 20, 2011. Further, it only temporarily suspends the July 2010 interim final regulation's rule, probably until January 1, 2014, to solicit comments and give self-insured plans time to adjust.

External Review Clarification

Under the July 2010 interim final regulations, an external review decision is binding on the parties, except where other remedies are available under State or federal law. The latest guidance clarifies that plans must provide benefits awarded under a final external review decision without delay and must continue to provide such benefits unless or until a judicial decision otherwise.

Recommended Action

Sponsors of non-grandfathered group health plans should begin preparing for the new internal claims and appeals and external review requirements by, among other things, reviewing and updating claims procedures in Summary Plan Descriptions and other affected plan documents, updating claim denial notices, and beginning to coordinate with IROs. Due to the breadth and complexity of the claims procedures, plan sponsors should start developing compliant procedures as soon as possible to ensure they satisfy the Departments' standards by the rapidly approaching deadlines.

If you have any questions about this memorandum, please contact Mark Burgreen in our Syracuse office (315.218.8279, mgburgreen@bsk.com) or any of the other members of our Employee Benefits and Executive Compensation Practice Group listed below.

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