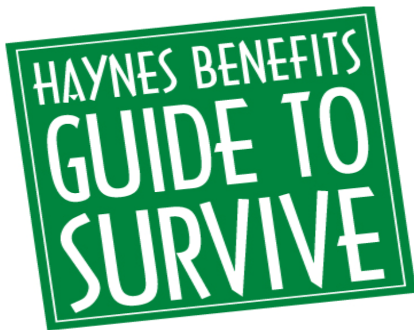

. . . Health Care Reform 2010

Enforcement Grace Period for Claims and Appeal Procedures

On September 20, 2010, HHS, DOL and Treasury announced an enforcement grace period until July 1, 2011 with respect to the new internal claims and external appeal requirements. These new internal claims and external appeal requirements apply to health insurance issuers and non-grandfathered group health plans, effective as of the policy year or plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans).

This alert will briefly describe these new internal claims review and external appeal procedures and the significance of the enforcement grace period until July 1, 2011. In addition, we will discuss the relevance of these regulations in determining whether to retain grandfathered plan status.

Our comments are in italics.

Enforcement grace period until July 1, 2011. The enforcement grace period until July 1, 2011 means that HHS and DOL will not initiate enforcement actions and the IRS will not assess excise taxes against health insurance issuers or plans who are working in good faith to implement the new internal claims review and external appeal standards, but do not have them in place because of the time required to modify plan or policy procedures and computer systems in order to fully comply with the new internal claims review and external appeal requirements.

In other words, until July 1, 2011, HHS, DOL and IRS investigators or examination specialists will be in a "we are here to help mode," not an "enforcement mode," provided a plan sponsor's or insurance issuer's good faith efforts to comply with these internal claims review and external appeal regulations are a work in progress.

What are the claims and appeals procedures in a nutshell?

ERISA claims procedures continue to apply to employer sponsored group health plans. The new internal review and external appeal procedures either modify or add to the ERISA section 503 claims procedures.

Rescission of coverage is an adverse benefit determination which is eligible for an internal claim review and an external appeal, even if the rescission does not affect a policy or plan benefit.

This is broader than the current definition of an "adverse benefit determination" in the DOL claims procedures for group health plans under ERISA.

Prompt response to urgent care claims. Notification of the determination of an urgent care claim must be made as soon as possible, but not later than 24 hours (rather than 72 hours), after receipt of the claim, unless the claimant does not provide sufficient information for a determination of whether the claim is covered or payable.

> *Grandfathered plans may adopt the 24-hour urgent claim response standard (even though they are not required to do so) because insurers and TPAs may apply this new response time standard to all urgent care claims, regardless of whether the policy or plan is grandfathered.*

Full and fair review. Plans must allow claimants to present evidence and testimony. In addition, plans must provide the claimant (free of charge) with any new or additional evidence or rationale relied upon by the plan in the claims process and provide the claimant with a reasonable period of time to respond to the new evidence or rationale.

Conflicts of interest. Decisions such as the hiring or compensation of claims adjudicators cannot be based on the likelihood that the individual or independent review organization ("IRO") will likely support the denial of benefits. For example, plans must, generally, contract with three IROs, each of whom must be accredited by the Utilization Review Accreditation Committee ("URAC") or a similar accrediting organization, and establish an independent, unbiased method of selecting the IRO for each claim.

> *The DOL in recently issued FAQ and a technical release, indicated that a group health plan's TPA may enter into contracts with IROs on behalf of the plan sponsor. Furthermore, the terms of the contract with an IRO is prescribed in the regulations. This is welcome news. There was concern that each group health plan would be required to individually contract with at least three IROs.*

Notices required by the regulations must be provided in a culturally and linguistically appropriate manner. This is required by the statute and explained in further detail in other recent regulations.

Claims adjudication notice content requirements are prescribed in the regulations and must include:

- Information sufficient to identify the claim, along with diagnosis and treatment codes and explanations;
- Reasons for claim denials with denial codes, a description of the plan or insurer's standards in denying the claim and in a final adverse benefit determination, a discussion of the decision;
- Descriptions of the internal review and external appeal process, including how to initiate an appeal; and
- Contact information with respect to the availability of assistance from the applicable office of health insurance consumer assistance or ombudsman.

Strict adherence standard. If a plan or issuer fails to strictly adhere to the requirements of the regulations, the claimant will be deemed to have exhausted the internal claims review process and may either initiate the applicable state or federal external appeal process or other remedies, including judicial review in state or federal court.

This strict adherence requirement can increase litigation risks for non-grandfathered health plans.

Continued coverage. Plans must provide continued coverage pending the outcome of an appeal. An ongoing course of treatment cannot be reduced or terminated without advance notice and review.

Standards for external review. If state standards meet the requirements of the NAIC Uniform Model Act, then an insurer must comply with that standard. The same holds true for a self-funded insured plan subject to that process, such as when the process is not preempted by ERISA. Other plans must comply with a separate federal external review process described in the regulations. The regulations set forth very detailed and stringent minimum standards for both the federal and state external review processes.

Both the minimum standards for state external review process and the federal external review process are quite stringent. Plans should study the process carefully before making a final determination whether to retain grandfathered plan status in order to be exempt from these new internal claims and external appeal requirements.

Model DOL Notice. The Labor Department has also issued a model form for the notice of an adverse benefits determination.

October 4, 2010