



New Claim Review Regulations Ease Compliance Burdens For Group Health Plans

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This compliance exclusive discusses how the Final Regulations provide significant relief from a number of the requirements that were originally included in the Claims Review Rules.

COMPLIANCE EXCLUSIVE

A Newsletter from SHPS HR Solutions

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On June 24, 2011, the U.S. Departments of Treasury, Labor and Health and Human Services (collectively, the “Agencies”) jointly issued new interim final regulations and related guidance¹ regarding the internal appeals and external claim review procedures (“Claims Review Rules”) for fully insured and self-funded group health plans and insurance policies issued in the individual market. These new requirements were added by the Affordable Care Act (ACA). The Claims Review Rules apply only to non-grandfathered group health plans otherwise subject to the health insurance reforms added by ACA.

This compliance exclusive discusses how the Final Regulations provide significant relief from a number of the requirements that were originally included in the Claims Review Rules.

Requirements Relating to Internal Claims and Appeals

Up to 72 hours now allowed for benefit determinations relating to urgent care

The Final Regulations generally return to the pre-ACA rule in the ERISA claims regulations that determinations relating to urgent care must be made within 72 hours. However, the plan or insurer must defer to the provider's determination as to whether a claim involves urgent care. In the preamble to the revised regulations, the Agencies emphasize that 72 hours is an outside limit and that medical exigencies may require a more rapid determination.

Diagnosis and treatment codes now only required upon request

The Final Regulations eliminate the requirement that notices of adverse benefit determinations (ABDs) automatically include diagnosis and treatment codes and their meanings. Instead, plans and insurers must provide such codes and their meanings as soon as practical following a request from a plan participant or beneficiary. The notice of an ABD must inform participants and beneficiaries of their right to obtain such codes.

¹ The guidance includes the Final Regulations, Technical Release 2011-22 (Guidance on External Review for Group Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage, and Guidance for States on State External Review Processes), and model notices of adverse benefit determinations, all of which are available on the DOL EBSA website at <http://www.dol.gov/ebsa/healthreform/>.

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Requirement that notices be provided in a culturally and linguistically appropriate manner (“CLA requirements”)

In one of the most significant changes to the original Claims Review Rules, the CLA requirements (e.g., to provide notices in non-English languages) are completely replaced by a far simpler approach. The original plan by plan determination of whether the CLA requirements apply is replaced by a single standard based on the county to which the notice is sent. The threshold is that at least 10 percent of the population in the claimant’s county are literate only in a particular non-English language. Under the Final Regulations, Plans are not responsible for making this determination; rather, the list of counties to which the CLA requirements apply and the relevant languages are to be published by the Agencies. The preamble to the Final Regulations contains a current list of relevant counties and languages. There are 255 counties (78 of which are in Puerto Rico) that meet the threshold. In the vast majority of cases, Spanish is the relevant non-English language; however, Chinese, Tagalog, and Navajo are present in a few counties affecting just five states, Alaska, Arizona, California, New Mexico, and Utah.

The Final Regulations also eliminate the “tagging and tracking” requirement under which, once a claimant requested a notice in an applicable non-English language, all subsequent notices had to be in that language. This requirement was challenging for many current systems. In lieu of this requirement, the Final Regulations require that the English versions of all notices include a prominently displayed statement in any applicable non-English language describing how to access the language services provided by the plan. Targeted notices are not required, i.e., the statements may be included in all notices. The Agencies have published model notices that contain sample statements in each of the relevant languages.² The plan or issuer must provide oral language services (such as a telephone customer assistance hotline) in any applicable non-English language and, upon request, must provide a written translation of any notice in any applicable non-English language.

The Final Regulations constrict the “strict adherence” standard for exhaustion of remedies

The original Claims Review Rules allow claimants to by-pass the internal appeals process if all of the procedural requirements are not strictly adhered to. The Final Regulations provide an exception to this strict adherence requirement for errors that are minor and meet certain other requirements. In particular, claimants may be required to exhaust internal administrative

remedies despite a failure of a plan or insurer to strictly comply with the applicable rules if the failure was: de minimis; non-prejudicial to the claimant; attributable to good cause or matters beyond the control of the plan or insurer; in the context of an ongoing good-faith exchange of information; and not reflective of a pattern or practice of noncompliance.

Effective date of changes

These changes to the internal claims process will take effect for plan years beginning on or after January 1, 2012.

Requirements Relating to External Reviews – In General

Plans and issuers must follow either a federal external review process or a state external review process. Ultimately, both the federal and state processes are to include at a minimum the consumer protection provisions of the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners (the “NAIC Model Act”). The process that applies depends on whether the plan is fully insured or self-insured.

Requirements Relating to External Reviews – Self-Insured Plans Subject to ERISA or the Code

Self-insured plans subject to ERISA and/or the Code are generally required to comply with a federal external review process that uses independent reviewing organizations or IROs (the “private IRO process”).³ DOL Technical Release 2010-01⁴ sets forth a safe harbor process for complying with the federal external review requirements. The Final Regulations make several key changes with respect to the federal external review process.

Scope of the federal external review process

The breadth of claims with respect to which the federal external review processes applied was the subject of great concern to many employers. Under the Claims Review Rules, all benefit denials, other than questions of eligibility could be subject to external review. In contrast, the NAIC Model Act is limited to claims relating to medical necessity, appropriateness, healthcare setting, level of care or effectiveness of a covered benefit.

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³ Plans may also voluntarily comply with a state process if state makes the process available to self-insured plans.

⁴ The release may be found at <http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf>

The Final Regulations move the scope of the federal review closer to the NAIC Model Act, although it is not identical. Under the Final Regulations, the scope of the federal review includes matters that involve “medical judgment.” Medical judgment includes, but is not limited to, those factors listed in the NAIC Model Act. The actual extent of the difference as a practical matter may depend on how each plan implements its own review program.

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The preamble lists a number of other examples of situations that involve medical judgment, including (to list a few) whether a participant is entitled to a reasonable alternative standard for a reward under a wellness program; the frequency, method, treatment or setting for a required preventive service where none is specified in the recommendations; and whether a plan is complying with the non-quantitative treatment limitations under the Mental Health Parity Act. The external review process continues to apply to rescissions.

The narrowing of the scope of the federal external review is temporary, and will be revisited by the Agencies by January 1, 2014, when the remainder of the health reforms become effective. If the Agencies revert to a broader scope of review, they will provide some time for plans and issuers to adjust.

Effective date of change

The change in the scope of the federal external review is effective with respect to claims for external review initiated on or after September 20, 2011.

IRO assignment process

The original DOL safe harbor guidance on the external review process provided that, to be eligible for the safe harbor, the plan (or the plan’s TPA) must contract with at least three IROs. The purpose of this requirement was to ensure an independent and impartial review process. In subsequent Frequently Asked Questions, the Agencies clarified that failure to contract with at least three IROs would not be a per se violation of the Claims Review Rules and that, instead, the plan could demonstrate other steps taken to ensure that its external review process was independent and without bias.

Under revised DOL guidance, a plan must contract with at least two IROs by January 1, 2012 and rotate assignments among them. As this is a safe harbor, a plan may use an alternative process to demonstrate that reviews are independent and unbiased. However, DOL and the Treasury Department will “look closely” at any alternative means. At a minimum, these agencies expect plans to document how any alternative process constitutes random assignment, as well as how it ensures that the process is not subject to undue influence by the plan and without bias.⁵

Requirements Relating to External Reviews – Fully Insured Plans

In general, in the case of a fully insured plan, the issuer is responsible for complying with the external review requirements. If the state has a compliant external review process, then the issuer must comply with that process.⁶ If the state does not have a compliant process, then a federal external review process applies. The original regulations provided a transition period to allow states to bring their laws into compliance with the NAIC Model Act. The Final Regulations end the transition rule for existing state processes on December 31, 2011, regardless of the plan year. A further transition period is provided until January 1, 2014 for state processes that are similar to the NAIC Model Act process. Beginning January 1, 2014 state processes must comply with the NAIC Model Act. In states without a qualifying state process, the insurer may elect either to follow an HHS process administered through the federal Office of Personnel Management or the IRO process that applies to self-funded plans.

⁵ DOL Technical Release 2011-02 may be found at <http://www.dol.gov/ebsa/newsroom/tr11-02.html>.

⁶ Note that plans that are exempt from ERISA, such as nonfederal governmental plans, may be subject to state law because ERISA preemption does not apply.

About the Authors



John Hickman is head of Alston & Bird's Health Benefits Practice where he leads five attorneys devoted exclusively to HIPAA privacy, flexible benefits, and other health and welfare benefit issues. He has been a pioneer in the consumer-directed healthcare arena and has worked closely with health plans, financial institutions and employers as well as the Internal Revenue Service, Treasury, and Department of Labor in developing guidance for tax-favored health reimbursement arrangements and health savings accounts. John has lectured widely and published articles on HIPAA, ERISA litigation and cafeteria and health plan issues. He is co-author of the *Cafeteria Plans Manual*, *HIPAA Portability and Privacy*, and *Consumer-Driven Health Care* (published by the Employee Benefits Institute of America). John is also an adjunct professor of law at Emory University School of Law.



Carolyn Smith, counsel at Alston & Bird, handles a full range of executive compensation and employee benefits issues as well as a variety of federal tax regulatory and legislative matters. Prior to joining Alston & Bird, Carolyn was Associate Deputy Chief of staff of the Joint Committee on Taxation, U.S. Congress. During her 20+ years on the Joint Committee staff, she was responsible for major pension, health, and tax legislation from the Tax Reform Act of 1986 through the Pension Protection Act of 2006. Recent provisions for which she had primary responsibility include the PPA funding and cash balance provisions, Code Section 409A, HIPAA rules, and Health Savings Accounts.

About SHPS

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