Health Care Reform – Significant New Changes to Claims and Appeals Requirements

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As summarized in a previous FR Alert, non-grandfathered group health plans are subject to new claims and appeals requirements under the Patient Protection and Affordable Care Act, as modified by the Health Care and Education Reconciliation Act of 2010. In July and August of 2010, the Departments of Treasury, Labor, and Health and Human Services (the "Agencies") issued interim final regulations and other guidance regarding these new requirements. On June 24, 2011, the Agencies released an amendment that significantly changes many of the original requirements in the interim final rules.

The following is a summary of the significant changes made to the interim final rules:

Deadline for Notification of Urgent Care Determinations Lengthened to 72 Hours

The interim final rules shortened the deadline for providing determinations of urgent care claims from 72 hours to 24 hours. The amendment eliminates this change, and retains the current requirement that urgent care claims must be decided as soon as possible but not later than 72 hours. The preamble to the amendment does, however, say that the 72-hour deadline is an outside limit and some claims may have a shorter deadline based on the medical exigencies involved.

Revisions to Additional Content Requirement for Benefit Denial Notice

The interim final rules required that benefit denial notices contain diagnosis, treatment and denial codes. The amendment eliminates this requirement, and instead requires that benefit denial notices must notify participants that these codes will be provided upon request. The Agencies have issued new model notices that incorporate this change.

Standardization of Foreign Language Requirement

The interim final rules required non-grandfathered plans with a certain threshold of participants who are literate only in a common non-English language to provide benefit denial notices in that non-English language. The amendment standardizes this requirement by stating that a plan meets the foreign language threshold if 10 percent or more of the population residing in the claimant's county are literate only in a common non-English language. This determination must be based on the most recent data published by the U.S. Census Bureau. There are currently 255 counties that meet the 10% threshold. Non-grandfathered plans that have claimants who reside in these counties must include a one-sentence statement (in the appropriate foreign language) on all claim and appeal notices to such claimants. The Agencies' new model notices include language (in English) that can be used to satisfy this requirement.

Deemed Exhaustion of Internal Review Process for Less than Strict Compliance

The interim final rules provided that a non-grandfathered plan's failure to strictly follow all of the claims and appeals requirements with regard to any particular claim would result in that claim being deemed denied for all relevant purposes. This would have resulted in claimants being able to sue the plan or initiate an external appeal following any failure by the plan to strictly comply with the claims and appeals requirements, however minor or non-prejudicial the failure might be. Even more importantly, the interim final rules provided that if a claimant sued in court under these circumstances, the claim or appeal would be considered to have been denied by the plan without the exercise of fiduciary discretion, meaning the court would have reviewed the claim or appeal *de novo* (without deference to the claims administrator's decision).

Thankfully for plan sponsors and administrators, the amendment significantly modifies this rule. The amendment provides that a non-grandfathered plan's failure to comply with the claims and appeals requirements will not result in a "deemed denial" as described above if the failure was: *de minimis*; non-prejudicial; attributable to good cause or matters beyond the plan's control; in the context of an ongoing, good-faith exchange of information between the claimant and the plan; *and* not reflective of a pattern or practice of non-compliance by the plan.

Effective Dates

All of the amended requirements discussed above are effective for plan years beginning on or after January 1, 2012. The other claims and appeals requirements in the interim final rules, which are unchanged, are generally effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans).

External Review Process—Change to Eligible Claims

For non-grandfathered self-insured plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA") (generally, employer plans other than church or governmental plans), the interim final rules provide for a new external review process for claimants who had exhausted the internal review procedures. Under the interim final rules, this external review process was required for any adverse benefit determination other than a determination involving eligibility. The amendment narrows this requirement, stating that the external review process is now only required for claims involving medical judgment and rescissions of coverage. The amendment provides some additional guidance on the definition of "medical judgment," which is fairly broad and intended to cover a wide variety of claims. In general, the external review process must still meet the requirements outlined in the interim final rules and other guidance already issued by the Department of Labor.

External Review Process—Enforcement Safe Harbor

In conjunction with the amendment, the Department of Labor also released additional guidance (Technical Release 2011-02) regarding an enforcement "safe harbor" for the external review process. This safe harbor was initially made available in 2010 following the issuance of the interim final rules. Technical Release 2011-02 clarifies that, in order to qualify for the safe harbor, non-grandfathered self-insured ERISA plans must have contracts in place with at least 2 independent review organizations ("IROs") by January 1, 2012, and at least 1 additional IRO (for a total of 3) by July 1, 2012. There are additional requirements for these IRO contracts, so plan sponsors should strongly consider working with counsel in attempting to qualify for the safe harbor.

The text of the amendment to the interim final rules may be found here.

More Information

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