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LEGAL ALERT

June 29, 2011

Changes to PPACA Claims and External Review Rules Include More Transition Relief

On June 24, 2011, the tri-agency task force[1] drafting regulations under the Patient Protection and Affordable Care Act (PPACA) published interim final regulations amending the regulations regarding internal claims and appeals and external review processes for group and individual health care coverage issued in July 2010. In addition, the task force issued Technical Releases supplementing the regulations, as well as revised model notices. The PPACA claims and appeals rules do not apply to grandfathered group or individual health plans but do apply to non-grandfathered plans and policies, whether or not subject to ERISA.

The July 2010 regulations provided rules for plan years beginning on or after September 23, 2010. Two subsequent releases delayed the effective date for certain of the rules. Some of the delayed rules become effective for plan years beginning on or after July 1, 2011, while other rules were delayed until plan years beginning on or after January 1, 2012. The 2011 amendments to the regulations and the new releases provide additional transition relief and ease or clarify a number of the rules in the July 2010 regulations. This Legal Alert focuses primarily on changes applicable to group health plans subject to ERISA.

Internal Claims and Appeals Procedures: Background

Historically, group health plans subject to ERISA have been required to comply with the Department of Labor (DOL) claims procedure regulations.[2] Among other requirements, those regulations require plans to provide claimants receiving an adverse benefit determination with: (1) a notice that includes the reasons for the determination and a reference to the relevant plan provisions on which the denial is based; (2) a description of any additional information necessary to perfect the claim; and (3) a description of the procedure for appealing the denial.

In addition, section 2719 of the Public Health Services Act , as added by PPACA, requires non-grandfathered group health plans to implement an internal appeals process and an external review process that meet minimum State or Federal standards and to provide enrollees with information on appeals and State health insurance consumer assistance in a "culturally and linguistically appropriate manner." The July 2010 interim final regulations interpreting section 2719:

- Expand the definition of adverse benefit determinations made subject to claims review;
- Reduce the maximum response time for urgent care decisions from 72 to 24 hours;
- Require the inclusion of additional information regarding claims (such as diagnosis and treatment codes) in notices of claims denials;

[1] The tri-agency task force consists of the Internal Revenue Service, the Department of the Treasury, the Employee Benefits Security Administration of the Department of Labor, and the Department of Health and Human Services.

[2] The claims procedure regulations can be found at 29 C.F.R. § 2560.503-1.

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- Require plans (in certain circumstances) to provide benefit determinations in languages other than English; and
- Provide for a "strict adherence" standard under which a failure to comply with every aspect of the appeals process to the letter triggers deemed exhaustion of the appeals process and permits the claimant to seek de novo external review of the plan's decision or to sue under section 502 of ERISA.

Amendments to Internal Claims and Appeals Procedures

In response to comments regarding the July 2010 regulations and the related releases, the latest guidance amends certain key aspects of the rule as applied to non-grandfathered group health plans. Specifically, the amendments:

- Return to a 72-hour maximum response time frame for urgent care claims, provided the plan or issuer defers to the attending provider as to whether the claim is for "urgent care."
- Eliminate the requirement to provide diagnostic and treatment codes in the initial or final notice of claims denial; though the notice must inform the claimant that he or she may request the codes and their meanings, and that information must be provided upon request.
- Retain the "strict adherence" compliance standard that results in deemed exhaustion of the appeals process, but provide an exception for minor compliance errors that are: (1) de minimis, (2) non-prejudicial, (3) attributable to good cause or matters beyond the plan's or issuer's control, (4) made in the context of an ongoing, good-faith exchange of information, and (5) not reflective of a pattern or practice of noncompliance. If a plan asserts that a compliance error is minor, the plan must disclose the basis for its determination. Also, if an external reviewer or a court rejects a claimant's request for immediate review on the basis of this standard, the claimant must have the opportunity to resubmit the claim to the plan for completion of the internal appeals process.

In addition, the 2011 amendments modify the standard for determining compliance with the "culturally and linguistically appropriate" notice requirement. The July 2010 regulations required certain plans, upon request, to provide claims denial notices in a non-English language based on two factors: (1) the number of participants in the plan, and (2) the number of participants literate only in the same non-English language. In an effort to simplify this standard, the amendments provide that a plan must comply with the notice requirement if 10% or more of the population in the claimant's county (as determined by Federal census data) are literate only in the same non-English language, and denial notices are provided in that language upon request. The affected counties are listed in the preamble to the 2011 regulations, and the preamble notes the list will be updated periodically on agency websites.

The English version of claims denial notices to claimants in those counties must also include a statement regarding the availability of language services and State consumer insurance assistance in the same non-English language. The revised model notices of initial and final determinations that were released with the 2011 regulations include sample statements in the four relevant languages. Finally, the amendments require a plan or issuer to provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language to answer questions and assist with filing claims, appeals and requests for external review.

The amended regulations will be enforced for plan years beginning on or after January 1, 2012. As a reminder, however, most provisions of the July 2010 regulations that were not amended are currently

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effective, except that the rules requiring additional content in notices of claims denials, other than diagnostic and treatment codes, are effective for plan years beginning on or after July 1, 2011.

External Review Process: Background

PPACA requires all non-grandfathered plans, whether fully insured or self-insured, to make available a State or Federal external review process for claims denials. The external review process involves a review of an adverse benefit determination by an independent third party, who then makes a binding decision to uphold or reverse the claims denial. The applicable external review process for any particular claim is based on the process (Federal or State) applicable to the plan at the time of a final internal adverse benefit determination.

The July 2010 regulations require issuers of fully insured group health plans[3] to comply with a State's external review process to the extent the process includes, at a minimum, 16 consumer protections found in the National Association of Insurance Commissioners (NAIC) Uniform Model Act. If a State's external review process does not meet the minimum standards, the 2010 regulations require issuers in that State to comply with similar Federal external review standards issued by the Secretary of the Department of Health and Human Services (HHS), utilizing private reviewers. However, a transition rule in the July 2010 regulations permits issuers to utilize any existing State external review process for plan years or policy years beginning before July 1, 2011. If no State process is available to an issuer, the issuer generally must use an HHS-supervised review process. Self-insured plans subject to ERISA are to use the Federal external review process.

Amendments to State Minimum External Review Standards

The 2011 amendments to the July 2010 regulations make certain changes to the 16 NAIC minimum consumer protections that must be part of the State external review process. In addition, Technical Release 2011-02, issued concurrently with the amendments, provides for a new transition period until December 31, 2011, for States to comply with the minimum standards. The amendments also establish a set of "NAIC-similar" temporary standards that will apply to plans and issuers in States without an external review process that will be considered to meet the minimum standards until January 1, 2014. If HHS determines that a State has neither implemented the 16-factor minimum consumer protections required under the July 2010 regulations, nor an NAIC-similar process, issuers in the State will have the choice of participating in either the HHS-administered process or the Federal external review process.

For plan years beginning after January 1, 2014, if an applicable State external review process does not meet the NAIC minimum consumer protections, the plan or issuer must submit to a Federal external claims process, such as the process currently administered by HHS or the temporary standards described above. Separate guidance issued by HHS contemporaneously with Technical Release 2011-02 describes the process for electing between the two Federal processes available to plans subject to State external review.

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[3] Some non-grandfathered self-insured plans, such as nonfederal governmental plans and church plans not covered by ERISA preemption, are also subject to the State external claims process, and, in some cases, Multiple Employer Welfare Arrangements (MEWAs) may be as well.

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Amendments to Federal External Review Standards

As described above, generally self-insured group health plans and issuers of fully insured plans in States without an external review process that meets minimum requirements must submit to a Federal external review process that is similar to the NAIC Uniform Model Act process. In this case, for an insured plan, compliance with the Federal external review process may be handled by either the plan or the issuer.

Scope of Federal External Review

Under the July 2010 regulations, any adverse benefit determination was subject to review under the Federal external review process, except an eligibility decision. The 2011 amendments to the regulations suspend this rule for claims for which an external review has not been initiated before September 20, 2011, in favor of a narrower, temporary rule. The temporary rule limits Federal external review to (1) claims involving medical judgment as determined by the external reviewer, such as medical necessity or effectiveness of in-network services, and (2) rescission of coverage claims. The temporary rule is expected to remain in place until January 1, 2014. The agencies will provide advance notice if there is a return to the old rule or a modification of the temporary standard. Thus, under the temporary rule, a denial of a claim that involves only a contractual or legal interpretation is not subject to external review.

Modification of Enforcement Safe Harbor

Technical Release 2011-02 also modifies the safe harbor for the Federal external review process outlined in Technical Release No. 2010-01. The safe harbor originally provided for an interim enforcement safe harbor which, among other things, required plans to contract with at least three independent review organizations (IROs) and rotate assignments between them. However, this enforcement policy was modified in September 2010 as a result of difficulties plans and issuers encountered in contracting with IROs. Technical Release 2011-02 extends the enforcement safe harbor for plans that contract with at least two IROs by January 1, 2012, and at least three IROs by July 1, 2012, or use an alternative process subject to review by the agencies.

Clarification Regarding Binding Decision Requirement

Finally, the 2011 amendments to the July 2010 regulations clarify the rule that both the claimant and the plan or issuer are bound by the final decision of the IRO, except to the extent that other remedies are available under State or Federal law. The amendment clarifies that the plan or issuer must provide benefits pursuant to the final decision of the external reviewer without delay, regardless of whether the plan or issuer intends to seek judicial review of the decision. However, a plan or issuer may choose to pay a claim voluntarily at any time during or after the external review process.

If you have any questions about this Legal Alert, please feel free to contact any of the attorneys listed below or the Sutherland attorney with whom you regularly work.

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