Employee Benefits Advisory

August 26, 2010

Guidance Issued Regarding Internal Claims, Appeals, and External Review Processes

This is the sixth in a series of alerts intended to help guide employers and plan sponsors through their new obligations under the recently-enacted health care reform laws and related guidance.

Interim final rules issued by the Departments of Treasury, Labor (DOL) and Health and Human Services (HHS) expand upon the DOL's existing requirements for group health plan claims procedures to impose new claims and appeal procedures, to require an external appeal process for denied claims, and to require that benefits continue while an appeal is pending. The rules, which are effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans) apply to non-grandfathered group health plans and insurers, including those plans that were not previously subject to the claims procedures, such as non-ERISA plans (e.g., church plans and government plans) and issuers of individual health insurance.

The rules add the following seven substantive requirements to the internal claims and appeals process:

(1) **Expanded Definition of Adverse Benefit Determination.** Whereas the DOL's claims and appeals procedures previously applied to claim denials only, the interim rules expand the determinations covered to include a rescission of coverage. Generally, a rescission of coverage means that a participant's coverage is retroactively cancelled or discontinued.

(2) **Reduced Response Time for Urgent Care Claims.** Urgent care claims must be decided as soon as possible, but no later than 24 hours after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, and to what extent, benefits are covered or payable. The prior rule generally required determinations

CONTACTS

If you have questions or need assistance complying with these requirements, please contact any of the McKenna Long & Aldridge LLP attorneys or public policy advisors with whom you regularly work. You may also contact:

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to be made within 72 hours after receipt of an urgent care claim.

(3) **Additional Information Available to Claimant.** Plans and insurers must allow claimants to review their claim file and present evidence and testimony. Claimants must also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by or for the plan or insurer in connection with the claim. Finally, the claimant must receive notice of any new or additional rationale *before* a plan or insurer issues an adverse appeal decision based on the new or additional rationale. The stated purpose of this advance notice requirement is to provide the claimant with a reasonable opportunity to respond before the final decision is made.

(4) **Conflicts of Interest.** Plans and insurers must ensure that all claims and appeals are handled in a manner to prevent conflicts of interest. Thus, decisions regarding hiring, compensation, termination or promotion of claims adjudicators or medical experts must be made without regard to the likelihood that the individual would agree with the denial of benefits.

(5) **Notice Requirements.** Plans and insurers must provide notice in a "culturally and linguistically appropriate" manner. This may require providing claimants with notices in a non-English language, if a minimum percentage of participants are literate only in that language. These notices must contain certain additional information. Model notices are expected to be issued soon.

(6) **Strict Compliance Required.** Failure to *strictly* adhere to the new internal claims and appeals requirements results in a claimant being deemed to have exhausted the internal claims and appeals process. This means the claimant will be eligible to initiate an external review or file a lawsuit. If this happens, the court will not be required to give deference to any decisions previously made.

(7) **Provide Benefits During Appeal.** A plan or insurer must continue to cover the claimant pending the outcome of any internal appeal.

External Review

In addition to imposing additional requirements on the internal claims and appeals process, the regulations also require that plans and insurers provide claimants with an opportunity for an external review once the internal process is exhausted. The external review process must satisfy applicable state or federal requirements, depending upon whether the group health plan is fully-insured or self-insured and whether the state process meets certain guidelines.

Additional Guidance

Note that the DOL has indicated that it plans to issue regulations that will propose more comprehensive updates to the internal claims and appeals process in the future. These regulations may apply to grandfathered plans as well. We will notify you when these regulations are issued.

Recommended Actions

In order to timely comply with these new requirements, employers and plan sponsors should:
(1) before December 31, 2010, amend existing claims and appeals procedures, whether in the plan, SPD, or separate document, to comply with the new guidelines;
(2) make sure that claims administrators are aware of these changes and have updated processes accordingly;
(3) provide written notice of changes to participants by 11/1/10; and
(4) review any forms and plan materials to be distributed to participants and revise as necessary.

To view previous alerts from this series, please click on the following links:

Health Care Reform - What Does it Mean to Employers?

Health Care Reform: Can You Continue to Limit Coverage for Pre-Existing Conditions?

Guidance Issued For "Grandfathered Plan Status" Under The Health Care Reform Act

Reimbursement Application Released For Early Retiree Reinsurance Program

Guidance Issued Regarding Coverage of Preventative Services Under Health Care Reform

With a team of attorneys who are highly experienced in the employee benefits field, MLA can provide answers to questions and assistance in complying with these requirements.

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