Davis Wright Tremaine LLP

# Health Care Reform: Summary of Amended Regulations on Claims and Appeal Procedures for Group Health Plans

By Dipa N. Sudra and Jeff Belfiglio

July 14, 2011

Health care reform requires *nongrandfathered* group health plans, both insured and self-insured, to change their internal claims procedures and external review procedures. Even as plans work to implement these rules, the Internal Revenue Service, the Department of Labor, and the Department of Health and Human Services have jointly released amended interim final regulations in response to comments on the interim final regulations issued last July (discussed in a previous advisory). The agencies also issued technical guidance[1] and revised model notices.[2]

In this advisory we compare the amended provisions of the interim final regulations with those proposed last July that are applicable to group health plans. Although the amendments are effective July 22, 2011, previously announced grace periods continue to apply.

| Provision Relating to Internal Claims Procedures | 2010 Interim Final Regulations | 2011 Amendment |
|---|---|---|
| *Urgent care benefit determination* | Plan to notify claimant of urgent care benefit determination as soon as possible, but not later than 24 hours after receipt. | Plan to notify claimant of urgent care benefit determination as soon as possible consistent with the medical exigencies, but no later than *72 hours* after receipt of claim. Plan must defer to attending provider as to whether a claim is for urgent care. |
| *Provision of diagnosis and treatment codes in notice of adverse benefit determination* | Any notice of adverse benefit determination must automatically include diagnosis and treatment codes and corresponding meaning, plan's standard, and discussion of decision (if final). | Eliminates requirement to automatically provide diagnosis and treatment codes, but plan must describe availability, upon request, of such codes and their meanings, and provide such information if requested. Such request not to be treated, by itself, as the start of an internal appeal or external review. |
| *Deemed exhaustion of internal claims and appeals processes* | Claimant may immediately seek *de novo* review if plan fails to strictly adhere to all requirements of 2010 regulations for internal claims and appeals processes. | Same approach, but exception added for de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant. Plan must show violation was for good cause or due to matters beyond its control, and that violation occurred in context of an ongoing, good faith exchange of information. Violation must not be reflective of a pattern or practice of noncompliance. Claimant may request written explanation of violation, which must be provided within 10 days. If external reviewer rejects request for immediate review, within a reasonable time thereafter (not exceeding 10 days) plan must give claimant notice of opportunity to resubmit internal appeal. |
| *Culturally and linguistically appropriate notice*[3] | Plan to provide relevant notices in a culturally and linguistically appropriate manner:<br>A plan covering fewer than 100 participants required to provide non-English language notice if 25% of all participants are literate only in the same non-English language.<br>Plan covering 100 or more participants required to provide non-English language notice if the lesser of 500 participants or 10% of all participants are literate only in the same non-English language. | If 10% or more (determined per census data) of the population residing in the claimant's county is literate only in the same non-English language:<br>Each English version notice sent to an address in such county must include a sentence in the relevant non-English language regarding language services.<br>Plan to provide oral non-English language services (e.g., hotline), to answer questions and assist with filing claims and appeals.<br>Plan to provide written notices in non-English language on request.<br>No tagging and tracking required. |

| Provision Relating to External Review Requirements | 2010 Interim Final Regulations | 2011 Amendment |
|---|---|---|
| *Insured and non-ERISA coverage: Duration of transition period for state external review processes* | If state laws do not meet minimum consumer protections of NAIC Uniform Model Act, insured coverage subject to federal external review process. Transitional rule permits plans to use existing state external review process for plan years beginning before July 1, 2011. | Transition period ends on Dec. 31, 2011. Prior to Jan. 1, 2012, state external review process applies in lieu of the federal external review process. For adverse benefit determinations provided on or after Jan. 1, 2012, federal external review process applies unless DHHS determines that a state law meets the regulation's requirements. |
| *Scope of federal external review process for self-funded plans* | Federal external review process applies to any adverse benefit determination unless it related to participant's failure to meet plan's eligibility requirements. | Temporary suspension of rule in 2010 regulations (probably until Jan. 1, 2014). Federal external review process applies only to claims involving *medical judgment* or *rescission of coverage*, and for which external review has not been initiated before Sept. 20, 2011. |
| *External review decision binding* | External review decision by independent review organization binding on parties, except to extent other remedies available under state or federal law. | Clarifies that plan must provide benefits pursuant to the final external review without delay, regardless of whether the plan intends to seek judicial review and unless or until there is a judicial decision otherwise. |

**FOOTNOTES**

1 Technical Release 2011-02 addresses state and federally administered external review processes, and Technical Guidance addresses the use of a federal external review process by insurers and self funded nonfederal governmental plans.

2 (1) Adverse Benefit Determination; (2) Final Internal Adverse Benefit Determination; and (3) Final External Review Decision.

3 See also Technical Guidance regarding implementation of the cultural and linguistically appropriate notice requirements.