MAZURSKY CONSTANTINE LLC
VCG CONSULTANTS LLC

theHRBenefitsAuthority

Employee Benefits
Executive Compensation
ERISA Litigation
Human Resources Law

September 6, 2011

Health Care Reform Act
External Review and Internal Claims and Appeals Requirements Relaxed

In July of 2010, the U.S. Departments of Treasury, Labor, and Health and Human Services issued interim final rules for the external review and internal claims and appeals requirements applicable to non-grandfathered group health plans under the Health Care Reform Act. These rules have been amended to relax some of their more onerous requirements.

External Review Process Changes.

- **Scope of Federal External Review Process Narrowed.** The Federal external review process applies to all non-grandfathered, self-funded group health plans covered by ERISA. Prior to the amendment, any adverse benefit determination could be reviewed under the Federal external review process, unless it related to a participant's or beneficiary's failure to meet the requirements for eligibility under the plan. The amendment significantly narrows the scope of appeals that qualify for the Federal external review process to only include claims that involve:

  - Medical judgment, as determined by the external reviewer (*e.g.*, medical necessity determinations or experimental and investigation determinations); or
  - A rescission of coverage.

  The amendment further clarifies that:

  - Medical judgment claims would not include those that involve only contractual or legal interpretation without any use of medical judgment; and
  - Whether a participant or beneficiary is entitled to a reasonable alternative to attain a reward in a wellness program ***is*** a medical necessity determination and subject to external review.

  This amendment is effective for claims for which external review is initiated on or after September 20, 2011, and will expire on or before January 1, 2014.

- **IRO Contracting Requirements.** Group health plans that are subject to the Federal external review process must contract with at least two Independent Review Organizations (IROs) by January 1, 2012, and with at least three by July 1, 2012.

Internal Claims and Appeals Changes. The following changes made to the internal claims and appeals procedures are generally effective for plan years beginning on or after September 23, 2010 (*i.e.,* on January 1, 2011, for calendar year plans). However, as noted below, several of these requirements will not be effective until 2012.

- **Notification Period for Urgent Care Claims Increased from 24 Hours Back to 72 Hours.** The amendment reinstates the prior rule under the ERISA claims regulations that urgent care claims must be decided as soon as possible taking into account medical exigencies involved but no later than 72 hours after receipt of the claim. Plans must also defer to the attending provider as to whether a claim constitutes "urgent care."

- **Diagnosis and Treatment Codes No Longer Provided Automatically.** The amendment removes the requirement to ***automatically*** provide the diagnosis and treatment codes in notices of adverse benefit determinations. Group health plans will need to provide claimants with a notice of the opportunity to request the diagnosis and treatment codes (and their respective meanings). This applies to all notices of adverse benefit determinations for plan years beginning on or after January 1, 2012.

- **Non-English Language Notices Modified.** Group health plans are required to provide notices of adverse benefit determination in a culturally and linguistically appropriate manner for plan years beginning on or after January 1, 2012. The amendment provides that if the address to which a notice is sent is in a United States county in which 10% or more of the residents are literate only in the same non-English language, the plan will need to:

  - Include, in the English versions of all notices, a statement prominently displayed in the applicable non-English language clearly indicating how to access the services provided by the plan;
  - Provide, upon request, the notice in the applicable non-English language; and
  - Provide oral language services (such as a telephone customer assistance hotline) that include answering questions in the applicable non-English language, as well as providing assistance with filing claims and appeals in the applicable non-English language.

  The 10% or more standard for a county is determined based on the American Community Survey data published by the United States Census Bureau and will be made available at http://www.dol.gov/ebsa/healthreform along with sample notices.

  The amendment removes the requirement that any individual who requested a notice in a non-English language be "tagged and tracked" so that any future notices would be provided automatically in that non-English language.

- **Exception to "Strict Adherence" Rule.** The amendment adds an exception to the rule that a claimant is deemed to have exhausted the internal claims and appeals procedures when a plan fails to strictly adhere to its own procedures. Under this exception, the internal claims and appeals procedures

are ***not*** deemed exhausted if the failure was:

- De minimis;
- Non-prejudicial;
- Attributable to good cause or matters beyond the plan's or issuer's control;
- In the context of an ongoing good-faith exchange of information; and
- Not reflective of a pattern or practice of non-compliance.

The strict adherence rule is effective for plan years beginning on or after January 1, 2012.

Next Steps. This amendment is good news for plan sponsors of non-grandfathered self-funded group health plans. These plans should continue working with third-party administrators to ensure compliance with the new claim procedures by the applicable effective dates, including updating notices, determining whether any non-English language requirements are applicable, and implementing procedures to ensure requests for external review are appropriately determined.

Contact Information. For additional information, please contact Nicole Bogard (404.888.8830), Leslie Schneider (770.863.3617), Amy Heppner (404.888.8825), Kelly Scott (404.888.8838) or Will Cantrell (404.888.8839).

IRS Circular 230 Notice: To ensure compliance with requirements of U.S. Treasury regulations, we inform you that any tax advice contained in this newsletter is not intended to be used, and cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code or promoting, marketing, or recommending to another party any transaction or matter addressed herein.