VENABLE LLP

employee benefits &
executive compensation alert

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**Our Employee Benefits and Executive Compensation attorneys have a diversified national practice. We assist clients of all shapes and sizes—businesses in virtually every industry sector, 501 (c)(3)s and other tax-exempt organizations, and governmental entities under 414(d)—on compensation and benefit-related issues.**

# Health Care Reform: More Changes to the Claims and Appeals Process

The Internal Revenue Service (IRS), Department of Labor (DOL), and Department of Health and Human Services (HHS) modified the review process for claims for benefits under non-grandfathered health plans once again.[1] The changes offer plan sponsors relief from some of the more onerous provisions of previous guidance, but also further complicate the review process.

Here are the top ten things you need to know about the recent modifications.

1. **Timing.** Except as noted below, the changes apply to calendar year plans beginning January 1, 2012.
2. **Urgent care claims.** The time frame for notifying claimants of urgent care benefit determinations is, once again, not later than 72 hours (rather than 24 hours) – but only if the plan defers to the attending provider's determination that a claim is for urgent care.
3. **Diagnosis and treatment codes.** Diagnosis and treatment codes and their meanings no longer have to be provided automatically in a notice of adverse benefit determination or final internal adverse benefit determination. Instead, these notices must include a statement that claimants can request this information – and plans must provide it upon request.
4. **Deemed exhaustion and strict compliance.** Certain *de minimis* variations from required internal review procedures will no longer result in the internal review process being deemed exhausted. (Deemed exhaustion allows the claimant to proceed beyond the internal review process.) Upon request, the plan must provide a claimant with a written explanation of why it meets the *de minimis* exception. If a claimant's request for immediate outside review is rejected because the plan met the *de minimis* exception, the plan must notify the claimant that he or she may resubmit the claim and complete the internal review process.
5. **Culturally and linguistically appropriate notices.** If 10% or more of the population residing in a claimant's county speaks only the same non-English language, all notices must include a statement, in the relevant non-English language, that customer assistance and written notices are available in the applicable non-English language upon request. Tracking which individual claimants require non-English notices or other accommodations is no longer necessary.
6. **Scope of claims subject to federal external review.** Claims that are initiated after September 19, 2011, are eligible for external review by an independent review organization (IRO) only if the claims involve medical judgment or a rescission of coverage.
7. **Binding IRO determinations.** Once a final decision has been rendered by an IRO, a plan must provide benefits to the claimant in accordance with the decision, regardless of whether the plan seeks judicial review of the decision, and the plan must continue to provide the benefits until a judicial decision overturns the IRO's determination. This "clarification" appears to be retroactively effective to the fall of 2010.
8. **IRO changes applicable to ERISA plans.** Plans are not immediately required to contract with at least three IROs to meet the external review safe harbor. Self-insured ERISA plans can meet the safe harbor by contracting with at least two IROs by January 1, 2012 and at least three IROs by July 1, 2012.
9. **State external process changes.** There is a transition period until January 1, 2012, for implementation of state external review processes meeting the requirements of previous guidance. In addition, states may operate external review processes under standards similar to the process contained in the NAIC Uniform Model Act until January 1, 2014.
10. **Three new models.** The model notices of adverse benefit determination, final internal adverse benefit determination, and final external review decision have been updated as of June 22, 2011, consistent with these newest changes.

We would be happy to answer any questions that you may have about what the new amendments mean for your non-grandfathered health plan, health care reform in general, or any other employee benefits matters. Please contact any member of our **Employee Benefits & Executive Compensation** team to discuss these issues.

[1] On June 22, 2011, amendments to prior interim final regulations on the claims and appeals process for non-grandfathered health plans were issued. The amendments can be accessed by clicking here. Issued with the amendments to the interim final regulations were DOL and HHS Technical Release 2011-02 (Guidance on External Review for Group Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage, and Guidance for States on State External Review Processes), HHS Technical Guidance (Instructions for Self-Insured Nonfederal Governmental Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage on How To Elect a Federal External Review Process), and HHS Technical Guidance (Updated Instructions for Calculating County Level Estimates Pertaining to the Culturally and Linguistically Appropriate Standards Set Forth in the Internal Claims and Appeals and External Review Processes under the Affordable Care Act).

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