HONIGMAN ALERT

Health Care Reform

April 21, 2011

Extended Enforcement Grace Period for Certain Claims and Appeals Requirements

Among the many changes brought about under the Affordable Care Act (ACA) are changes to the internal claims and appeal procedures for group health plans and health insurers, and the creation of new federal external review procedures that apply to health insurers and group health plans, even to group health plans that are self-funded.

These new requirements are complex, so much so that the Departments of Labor (DOL), Treasury and Health and Human Services (HHS) (collectively, the Agencies) have extended, for a second time, the grace period for enforcing these new rules. Unfortunately, the extensions are not across the board, so employers, plan administrators and third party administrators (TPAs) must understand what is required and when each requirement will become effective.

Background: Brief Overview of the New Claim Procedure Requirements

We have issued previous Health Care Reform Alerts that explain these new requirements – "New Claim and Appeal Procedures," "Interim Procedures for Federal External Claims Review" and "Grace Period for Some Internal Appeal Changes; Clarification On Grandfathered Plan." Below is a summary of the most salient points from the prior alerts:

- *Not Applicable to Grandfathered Plans* - These new requirements do not apply to grandfathered plans.
- *Changes to Current DOL Internal Claims Procedures* - The ACA made certain revisions to the current DOL internal claims procedure requirements and made them directly applicable to health insurers. These changes are:
  - An "adverse benefit determination" includes a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit
  - Urgent care claims must be determined within 24 hours, not 72
  - Claimants must be provided (free of charge) any new or additional evidence that was considered, relied upon or generated in connection with the claim, or any new or additional rationales for the denial on appeal, and claimants must be given a reasonable opportunity to respond to the new evidence and/or rationales
  - To prevent conflicts of interest, employment and promotion decisions with respect to claims adjudicators or medical consultants cannot be based on their willingness to support claim denials
  - Notices must be provided in a culturally and linguistically appropriate manner
  - Notices denying claims must include:
    - information sufficient to identify the claim;

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        - diagnosis and treatment codes and their meanings;
        - a description of the plan's internal and external review procedures; and
        - contact information for the state's office of health insurance consumer assistance or ombudsman.
    - Failure of the claims administrator to adhere to all internal claims and appeals requirements, no matter how minor, allows the claimant to be deemed to have exhausted his or her administrative remedies and go directly to court.
    - Plans must provide continued coverage pending the outcome of the internal appeal, and cannot reduce or terminate an ongoing course of treatment without advance notice and an opportunity for review prior to implementing the change. Individuals undergoing urgent care treatment or an ongoing course of treatment are entitled to an expedited external review.
- *External Review Procedures* - All plans — both insured and self-funded — will now be required to provide an external review of certain claims. All but six states currently have external review procedures that apply to health insurers, but not all of them, as is required under the ACA, include the consumer protections provided in the Uniform Health Carrier External Review Model Act issued by the National Association of Health Insurance Commissioners (NAIC).

  The Agencies, therefore, created a safe harbor for compliance with these new external review requirements until more extensive guidance is issued.

  1. States will have until July 1, 2011 to incorporate the consumer protections found in the NAIC's model act into their statutory external review procedures. Both insured and self-funded plans that comply with these upgraded state statutory requirements will be deemed to be in compliance with the federal external review requirements.
  2. Non-grandfathered self-funded plans and insured plans in states that either do not have a state external review statute or have not timely upgraded their statutes to include the NAIC model act's consumer protections must follow the federal external review procedures. These new federal external review procedures are explained in detail in our prior Health Care Reform Alert, entitled "Interim Procedures for Federal External Claims Review."

Regulatory Grace Periods and Enforcement Deadlines

As provided in the ACA, all of these new requirements would have been effective, and subject to enforcement, as of the first day of the plan year beginning on or after September 23, 2010 (for calendar year plans, January 1, 2011).

In Technical Release 2010-02 (9/20/2010), the DOL, on behalf of the Agencies, allowed for an enforcement grace period until July 1, 2011, but only with respect to some of the new internal claims procedure requirements. Requirements subject to this enforcement grace period are:

- the timeframe for making urgent care claim determinations;
- the provision of notices in a culturally and linguistically appropriate manner;
- the requirement for greater specificity in the adverse benefit determination notices; and
- the deemed exhaustion of administrative remedies rule for failure to substantially comply with these new rules.

Though intending to amend the Interim Final Regulations (IFRs) (7/23/2010 and 8/26/2010), that set forth these new claims procedures, the Agencies have not yet done so. Given this delay, they decided to provide additional compliance relief as they did not want to begin enforcing standards that would likely be modified in the near future.

The DOL issued Technical Release 2011-01 (3/18/2011), to act as a bridge until the 2010 IFRs can be amended. This new guidance extended the enforcement grace period for items in the first, second and fourth bullet points, above, to the first day of the plan year beginning on or after January 1, 2012.

With respect to the third bullet point, the enforcement period for requiring notices to include diagnostic and treatment codes and their meanings, is extended to January 1, 2012. The other requirements for broader content and specificity in the notices of adverse benefit determinations (*i.e.*, (i) disclosure of information sufficient to identify a claim, (ii) the reasons for the adverse decision, (iii) the description of available internal and external review procedures, and (iv) the contact information for the state office of health consumer assistance or ombudsman) will be extended only from July 1, 2011 to the first day of the first plan year beginning on or after July 1, 2011 (which is January 1, 2012 for calendar year plans).

The following chart clarifies the enforcement dates.

ACA Requirement	Initial Enforcement Grace Period	Extended Enforcement Grace Period
Internal Claims and Appeal Procedures		
Rescission of coverage is an adverse benefit determination	No extension – original effective date applies	No extension – original effective date applies
24-hour period for urgent care claims	DOL Tech. Release 2010-02 Grace period until July 1, 2011	DOL Tech. Release 2011-01 Grace period until first day of Plan Year on or after January 1, 2012
Provision of new evidence and rationales in Notice of Adverse Benefit Determination	No extension – original effective date applies	No extension – original effective date applies
Preventing conflicts of interest	No extension – original effective date applies	No extension – original effective date applies
Notices provided in culturally and linguistically appropriate manner	DOL Tech. Release 2010-02 Grace period until July 1, 2011	DOL Tech. Release 2011-01 Grace period until first day of Plan Year on or after January 1, 2012
Enhanced notice requirements	DOL Tech. Release 2010-02 Grace period until July 1, 2011	DOL Tech. Release 2011-01 Grace period extended to plan years beginning on or after January 1, 2012, but only for diagnosis and treatment codes and their meanings Grace period extended for all other notice information requirements only until plan years beginning on or after July 1, 2011

ACA Requirement	Initial Enforcement Grace Period	Extended Enforcement Grace Period
Strict adherence to these requirements or administrative remedies deemed exhausted	DOL Tech. Release 2010-02 Grace period until July 1, 2011	DOL Tech. Release 2011-01 Grace period until first day of Plan Year on or after January 1, 2012
Continued coverage pending appeal	No extension – original effective date applies	No extension – original effective date applies
External Review Procedures		
Implementation of external review procedures	No extension – original effective date applies Safe harbor compliance set forth in Tech. Rel 2010-01	DOL Tech. Release 2011-01 Safe harbor compliance continues until new guidance issued

Action Steps

Plan sponsors, TPAs and health insurers should familiarize themselves with both the new internal claims procedures and external review procedures, and determine how and when these will apply. If the plan or arrangement is grandfathered, these will not apply, but if the plan loses grandfathered status, they will.

It is necessary to review and revise (i) all plan documentation to reflect the applicable new requirements, and (ii) all notices used to communicate both initial claim determinations and determinations on review. Sponsors of self-funded plans will have to determine whether their state's statutory external review procedures are available to them, and if not, understand what the federal external review procedures will require. At a minimum, this will entail establishing contracts with at least three accredited Independent Review Organizations (IROs), either directly or through their plan's TPA. Plan sponsors should also review all administrative service agreements and insurance contracts to ensure that those who are contracted to perform clams adjudication services for their plans are in compliance with these new procedures, or will be when any applicable enforcement grace period ends.

If you have any questions about the content or timing of these new claims procedures, or any other aspect of ACA compliance or if you have any other employee benefit concerns, please contact one of the Honigman attorneys listed in this Alert.

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