



MONDAY, AUGUST 2, 2010

HEALTH CARE REFORM UPDATE

RULES ISSUED FOR INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW PROCESS

On July 23rd, the United States (U.S.) Department of Health and Human Services, and the U.S. Department of the Treasury (combined “The Departments”) issued interim final regulations” (IFR) for internal claims and appeals and external review processes under the Patient Protections and Affordability Care Act (PPACA). These rules apply to those employers who offer non-grandfathered group health plans as well as issuers of individual coverage. It’s important to note that the IFR do not apply to grandfathered plans. (A memo explaining the difference between grandfathered and non-grandfathered plans, and the recent interim final rules on grandfathered plan is available on our website here: http://www.trion.com/healthreform/documents/2010.06.14.Grandfathering_InterimFinalRules_Analysis.pdf)

In the simplest terms, these IFR also add to the claims and appeals procedures that already exist U.S. Department of Labor (DOL) regulations and, in fact, The Departments are characterizing the procedures in these new IFR as “clarifications” of the DOL’s existing regulations. With regard to the external review process, the IFR gives rules for determining which review process applies and the appropriate guidance.

Our partners at the Washington, D.C.-based law firm Steptoe and Johnson have prepared a detailed memo with full analysis to help you make sense of these new IFR and the steps you need to apply them to the plans in your organization. You can access this memo by going to http://www.trion.com/healthreform/2010.07.28.Internal_and_External_Claims_Appeals_and_Review.pdf . While we do recommend reviewing the full memo linked above, we have also included a few key highlights of the IFR below for your immediate reference.

Finally, as your partner, we remain committed to working closely with you to understand how your plan designs and costs may be impacted, and what steps you are required to take to comply with this legislation. We hope you continue to find our updates helpful and invite you to review past issues at <http://www.trion.com/healthreform>. Please continue to share your questions and comments by emailing them to us at health.reform@trion.com or calling **610.945.1198**. Thank you.

Internal Claims and Appeals Processes

The IFR add six new requirements to the existing DOL regulations. They:

1. Broaden the definition of “adverse benefit determination” in that it now also includes a rescission of coverage.
2. Provide that a plan or issuer must notify a claimant of a benefit determination (whether adverse or not) if it involves “urgent care” no more than 24 hours after the plan or insurer receives it—unless, that is, the claimant fails to provide sufficient information to determine whether (or to what extent) benefits are covered or payable.
3. Give additional criteria to ensure claimants receive “full and fair” review. This requires the plan or issuer to give claimants a) any new or additional evidence considered in connection with a claim and b) a rationale for a plan’s adverse benefit determination before it’s issued.
4. Offer new criteria with respect to avoiding conflicts of interest. The plan or issuer must ensure that all claims and appeals are adjudicated in a way that ensures the independence and impartiality of those involved in making decisions. Those regarding hiring, compensation, termination, promotion, or similar matters with respect to any individual may not be made based upon the likelihood that the individual will support a denial of benefits.

5. Provide new standards regarding notice to enrollees. The plan or issuer must provide notice to enrollees in a way that is culturally and linguistically appropriate—and that includes sufficient information around an adverse benefits determination and the associated claim. (This will require notice to be provided in a non-English as well as English in some circumstances.)
6. Offer protections to claimants in the case of a plan or issuer that fails to strictly adhere to all of the requirements of the internal claims and appeals process. In this scenario, a claimant may initiate external review (such as judicial review), whether or not he or she has exhausted the internal claims and appeals process.

In addition to these six new requirements, the statute and IFR require a plan or issuer to continue coverage pending the outcome of an internal appeal. Individuals in both an urgent care situation and/or receiving an ongoing course of treatment may also be permitted to proceed with expedited external review at the same time as the internal appeals process.

External Review Process

In addition to providing for the internal claims and appeals process, the new IFR address a system for either a State or Federal external review process.—and rules for determining which process applies and how.

For issuers in states with a mandated external review process: They'll have to comply with this process if it applies to and is binding upon that issuer, and if it includes consumer protections set forth in the National Association of Insurance Commissioners (NAIC) Uniform Model Act. And then, HHS will decide whether state external laws satisfy these minimum consumer protections.

Until then, the Departments will determine how existing state-sanctioned processes satisfy the IFR requirements until July 1, 2011; issuers who are subject to these processes will then have to comply with those requirements for plan years beginning before July 1, 2011. It is anticipated that issuers will have additional guidance from HHS for plans years starting after July 1, 2011.

In any event, if an employer's health benefits are provided through health insurance coverage, it will be the responsibility of the issuer, not the plan sponsor to satisfy the external review obligation.

For issuers not subject to a state external review process: They must comply with a federal external review process, which the HHS is yet to establish. Once done, the federal process will apply similar NAIC standards to the process..

Finally, the Departments have noted that they will provide additional guidance on how non-grandfathered self-insured plans that currently maintain an internal review and appeals process which is capable of meeting the federal external review process requirements can be deemed in compliance with the federal requirements. This will help to ease compliance burdens for these plans.