SITZMANN ▪ MORRIS ▪ LAVIS

Employee Benefits | Life Insurance | Retirement Planning

TO: Clients of Sitzmann Morris & Lavis Inc.

RE: Interim Final Rules – Internal Claims and Appeals and External Review

On July 23rd the Departments of the Treasury, Labor (DOL) and Health and Human Services (HHS) published interim final rules. These interim final regulations were published to implement the Public Health Service Act (PHS Act) section 2719, relating to internal claims and appeals and external review processes for group health plans. These requirements do not apply to grandfathered health plans.

Effective Dates: These interim final regulations are effective September 21, 2010, 60 days after publication in the federal register.

Key Provisions:

Internal Claims and Appeals Process

The regulations set forth six new requirements in addition to those currently in the DOL claims procedure regulation.

1) Definition of an adverse benefit determination is broadened to include a rescission of coverage, even if there is no immediate effect on a particular benefit at the time of the rescission. Adverse benefit determinations include a denial, reduction or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit. These include determinations based on:
    a. Eligibility to participate in the plan,
    b. A benefit not covered
    c. A benefit being experimental, investigational or not medically necessary or appropriate, or
    d. The imposition of a pre-existing condition exclusion, source of injury exclusion, network exclusion or other limitation on a covered benefit.

2) A plan or issuer must notify a claimant of a benefit determination with respect to a claim involving urgent care as soon as possible, but not later than 24 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to make a determination. This is a change from the previous 72 hour requirement.
3) The plan or issuer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim. It must be provided enough in advance of the date the notice of a determination is required for the claimant to respond. Prior to a final adverse decision is made, the claimant must also be provided with the rationale for the decision.
4) There are new criteria with respect to avoiding conflicts of interest. Claims and appeals must be adjudicated in a manner that ensures the independence and impartiality of the individuals making the decision.
5) New standards regarding notice to enrollees of an adverse decision. It must include:
    a. Date of service
    b. Health care provider
    c. Claim amount
    d. Diagnosis code
    e. Treatment code
    f. Meanings of the codes
    g. Discussion of the claim and appeals procedures
    h. Contact information for applicable consumer assistance office established under PHSA Section 2793.

    Model notices will be issued in the near future.
6) In the case of a plan or issuer who fails to *strictly* adhere to all the requirements, the claimant is deemed to have exhausted the internal claims and appeals process and the claimant can initiate an external review and pursue available remedies.

Coverage must be continued pending appeal. The plan is required to follow the ongoing course of treatment provisions in the DOL claims procedures.

Notices in Languages Other than English

Notices must be provided in a "culturally and linguistically appropriate manner." Plans and issuers can meet this requirement by providing notices in a non-English language based on the following:

- For plans that cover fewer than 100 participants at the beginning of the plan year, the threshold is 25% being literate only in the same non-English language. For plans with 100 or more participants at the beginning of a plan year, the threshold is the lesser of 500 participants or 10% of all participants being literate in only the same non-English language.
- If this threshold is met, (1) notice must be provided upon request in that non-English language, and (2) the English version of the notice must include a prominent statement in the non-English language offering the additional notice in that other language. Once a participant requests a notice in that language, all future notices must be provided to that individual in the other language.
- If a plan or issuer maintains customer assistance, such as a telephone hotline, regarding claims and appeals, it must also be provided in that other language.

State Standards for External Review

If benefits under a group health plan are provided through insurance coverage, only the issuer, and not the plan, is required to comply with the review process.

PHS Act section 2719 allows plans and issuers to comply with either a State or Federal external review process. If a state external review process includes, at a minimum, the consumer protections in the NAIC Uniform Model Act, then the issuer must continue to comply with that state's external review process. Following are some of the protections included:

- External review must apply to adverse benefit determinations that are based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- Issuers must provide effective written notice to claimants of their rights regarding external review.

- Issuers must pay the cost of an independent review organization ("IRO") for conducting the external review, however the state can choose to pay this cost.
- The claimant's filing fee for an external review cannot exceed $25.
- The decision must be binding on the plan or insurer as well as the claimant, except to the extent that there are other remedies under state or federal law.
- The IRO must provide written notice of its decision no more than 45 days after receipt of the request for external review by the IRO.
- In the case of the request for an expedited external review by the IRO, a decision must be made within 72 hours and notify the claimant and the issuer or plan of the determination.

For plans subject to existing State processes, the regulations include a transition period until July 1, 2011. During this period the State process applies. There are some states that only apply the external appeals process to HMOs. Guidance is expected on the issue of how to handle insurers with non-HMO policies in such states.

Federal External Review Process

For plans not subject to existing State processes, a Federal process will apply for plan years beginning on or after September 23, 2010. Self-insured plans must comply with the Federal process.

The Departments will address in sub-regulatory guidance how non-grandfathered self-insured group health plans that currently maintain an internal appeals process that otherwise meets the Federal external review standards may comply or be brought into compliance with the requirements of the new Federal external review process.

The rules describe the scope of claims eligible for the process but not the process itself. The Departments will be issuing more guidance in the near future on the Federal external review process.

The rules note that an adverse benefit determination or final internal adverse benefit determination that relates to a participant’s or beneficiary’s failure to meet the requirements for eligibility under the terms of a group health plan (i.e., worker classification and similar issues) is not within the scope of the Federal external review process.

What's Next:

The DOL is considering additional updates to the code and expects to issue future regulations that will propose additional, more comprehensive updates to the standards for plan internal claims and appeals processes. As mentioned above, the Departments will be issuing more guidance in the near future on the Federal external review process.

Contact your SML Account team if you have any questions.