



IRS, DOL & HHS Issue Amendments to Internal Claims and Appeals and External Review Processes for Group Health Plans and Issuers

LEGISLATIVE BRIEF

June 29, 2011

The IRS, DOL & HHS (the Departments) jointly issued Amendments to the Interim Rules on Internal Claims and Appeals and External Review Processes for Group Health Plans and Health Insurance Issuers. (June 23, 2011) The Departments also issued revised Model Notices on Final Internal Adverse Benefit Determination, Adverse Benefit Determination, and Notice of Final External Review Decision (June 22, 2011).

These rules apply to **non**-grandfathered insured and self-funded group health plans of all sizes, and to health insurance issuers in both the group and individual markets. These Amendments will be effective July 23, 2011 (30 days after publication date), but the changes made do not apply to calendar year plans until January 1, 2012.

Background

The HCR law and Interim Final Regulations (published June 23, 2010) required non-grandfathered health plans to implement additional claims and appeals and external review procedures by January 1, 2011 for calendar-year plans (specifically, the first day of the first plan year beginning on or after September 23, 2010). In September 2010 the DOL extended the deadline to July 1, 2011 (Technical Release 2010-02, issued September 20, 2010). Then, on March 18, 2011 (Technical Release 2011-01) the DOL modified and further extended the enforcement grace period for internal claims and appeal from July 1, 2011 to January 1, 2012 for calendar year plans. (An earlier effective date applies for certain provisions for non-calendar year plans.) The Departments stated in the March 18th Tech. Rel. that one reason they were further extending the deadline was that they would soon issue Amendments, which they now have.

Short Summary of the June 2011 Amendments

The June 24th Amendments make four changes to the Internal claims and appeals procedures and three changes to the External review procedures. A short summary of the changes are:

Internal claims and appeals procedures

1. For benefit determinations of "**urgent care**" **claims**, the Amendments **revert back to the 72 hour timeframe** under the existing DOL/ERISA claims procedures. The July 2010 Interim regulations had shortened this timeframe to 24 hours.

2. In claim denials, a plan or issuer must provide notification of the **opportunity to request** the diagnosis and treatment codes (and their meanings) in all claims and appeals notices provided to claimants, and must provide this information upon request. The July 2010 Interim regulations had required that plans or issuers provide the *actual* diagnosis and treatment codes in all such notices.
3. Claimants can seek **immediate external review or court action** if the plan or issuer does not "strictly comply" with its internal review procedures **only if the non-compliance is not "de minimis"** and comes within the categories listed in the Amendment.
4. Plans and issuers must provide denial notices in the same non-English language (or a one-sentence statement about the availability of non-English language services) if **10% or more of the population residing in the claimant's county are literate only in that non-English language**. Previously, the threshold was applied to the employer's plan. The Departments provide a lengthy table of 225 U.S. counties in which the threshold applies as of June 2011. In the overwhelming majority of these 225 counties, the non-English language is Spanish.

External review procedures

1. Before January 1, 2012, applicable **State external processes will apply** in lieu of the requirements of the Federal external review process.
2. The Amendments narrow the scope of **claims eligible for the Federal external review process** (for external reviews initiated on and after September 20, 2011) to those involving medical judgment or rescission of coverage, and excluding claims involving only legal or contractual interpretations.
3. The Amendments clarify the requirement that external review decisions are binding by specifying that the health plan or issuer must provide benefits without delay (including by making payment on the claim) as required by the final external review decision, **even if the plan or issuer intends to seek judicial review** of the external review decision and unless or until there is a judicial decision otherwise.

Next Steps for Employers

Check with your insurers and TPAs to make sure they have or will incorporate the above changes into their claims denial notices and claims and review procedures.

- Make sure your summary plan descriptions (SPDs) for the 2012 plan year include the above changes, and issue summaries of material modifications (SMMs) next year if necessary.
- No immediate changes are necessary for calendar year plans because the changes made by the Amendments (and the previously-issued Technical Releases) do not apply until January 1, 2012.

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