McGraw Wentworth

REFORM Update

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The Departments of Labor, Health and Human Services, and the Treasury (the Departments) recently issued Technical Release No. 2011-01. This guidance addresses a delay in the enforcement of specific requirements dealing with internal claim reviews and appeals.

The health care reform legislation revised the claim appeal process in order to guarantee that every claimant receives a full and fair review of all claims and subsequent appeals for denied claims. These changes impact the internal claim review and appeal process.

Guidance has already been released to provide more details on the internal and external claim review appeal requirements. Several *Reform Updates* were issued in response:

- ***Reform Update 13*** (http://www.mcwent.com/Reform_Update/Reform_Update_13.pdf) – Offers a broad overview of the internal and external claim review and appeals requirements of health care reform.
- ***Reform Update 15*** (http://www.mcwent.com/Reform_Update/Reform_Update_15.pdf) – Provides model notice language for claim appeals and reviews, as well as alternatives for meeting the external review requirements until the federal review process is established.
- ***Reform Update 18*** (http://www.mcwent.com/Reform_Update/Reform_Update_18.pdf) – Discusses the delay in enforcing certain aspects of the internal review process.

This latest guidance further extends the enforcement grace period for various aspects of the internal claim review and appeal rules. The guidance also provides a resource for assistance in communicating state options for external review programs. According to the health care reform statutes, these internal and external review requirements were to impact plans as of the first day of the first plan year following September 23, 2010. (A delay in the effective date was permitted for grandfathered plans.)

The effective date for certain aspects of the internal claim review and appeal requirements was delayed last September, by Technical Release 2010-02, until July 1, 2011. However, following feedback from stakeholders involved in the claim review process, the Departments determined that group health plans would need even more time to comply with a number of the new requirements. The Departments have now further delayed the effective date, in order to strike a workable balance for plans and participants.

Per Technical Release 2011-02, the effective date for the following additions to the internal claim and review process are delayed until the first day of the first plan year beginning on or after January 1, 2012:

- The time frame for claim determinations on urgent care claims is shortened to no more than 24 hours after the receipt of the claims. (Current ERISA claim procedures require urgent care claims to be determined and communicated to a claimant no later than 72 hours after the receipt of the claim.)
- Benefit determinations and appeal notices must be provided in a culturally and linguistically appropriate manner.

- A claimant may initiate any external review process, or other remedies available under ERISA or state law, if a plan or insurer fails to strictly adhere to all the requirements of the 2010 interim final regulations. At that point, the claimant will be deemed to have exhausted the plan's or insurer's internal claim review and appeal process.

In addition, this latest delay applies to only one aspect of an additional requirement of the claim review process that was included in the first delay of the effective date. This particular requirement addresses information that must be included in a notice of an adverse benefit determination or a final notice of an adverse benefit determination:

1. Sufficient information to identify the claim, such as the date of service, health care provider, the amount of the claim, the diagnosis and treatment codes and their corresponding meanings.
2. The denial code and its associated meaning, as well as a description of the plan standard, if any, used to deny the claim.
3. The available internal appeals and external review processes, including information on how to initiate an appeal.
4. Contact information for any applicable office of health insurance consumer assistance or ombudsman, established under the Public Health Service Act, to assist individuals with internal claims and appeals, as well as the external review process.

With respect to these responsibilities, the extended grace period (ending on the first day of the first plan year beginning on or after January 1, 2012) applies solely to the requirement to disclose diagnosis and treatment codes and their corresponding meanings.

This Technical Release changed the effective date for the other additional requirements noted above to the first day of the first plan year beginning on or after July 1, 2011. This will give plans more time to comply with the additional information required in adverse benefit determinations or final notices of adverse benefit determinations.

The Technical Release highlights a number of resources that health plans and insurers can use to comply with the internal and external claim requirements:

1. A current list of relevant consumer assistance programs and ombudsmen available in various states. Plans may rely on this list when developing their notices of adverse benefit determinations and final adverse benefit determinations. The Departments will continually update this list, which can be found at www.dol.gov/ebsa/newsroom/tr11-01.html. However, health plans and insurers are not required to update this information on their adverse benefit determinations more than once annually, before the beginning of each plan year.
2. An interim process that self-funded plans can adopt to meet the requirements for an external review before the federal process has been established. Details can be found at www.dol.gov/ebsa/healthreform.
3. Model notices for disclosures regarding external reviews. These model notices can also be found at www.dol.gov/ebsa/healthreform.

In many cases, your third party administrator or insurance carrier will handle internal claim reviews and appeals. However, your organization should check with your administrator or insurance carrier to confirm that they are handling claim reviews as required by health care reform.

In addition, you should check with your vendor on the external review process. Many states already manage an external review process for fully insured plans. For self-funded plans, many third party administrators are offering to coordinate the external review process until the federal review process is established. In some cases, the third party administrator may charge an additional fee for this service.

It is important to understand that the delayed effective date applies only to the changes noted. Plans must address the following required changes, which were not afforded a delay in effective date, and will take effect on the first day of the first plan year following September 23, 2010:

1. Plan must view coverage rescissions as an adverse benefit determination.
2. If new evidence is considered or relied upon in a claim determination or appeal, or if the carrier or administrator relies on any new or additional rationale in denying a claim, then the claimant must be provided with an opportunity to respond to the new evidence or the new rationale.
3. Plans must closely monitor potential conflicts of interest. A plan cannot allow hiring, compensation, promotion or other employment incentives to influence a claims adjudicator or medical expert in supporting a claim denial.

It is clear that the Departments intend to issue additional guidance in the future to assist health plans and insurance carriers in complying with the new claims review and appeals requirements.

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