Quarles & Brady LLP Client Alert

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Final Claims and Appeal Rules: Important Changes for Employers, Insurers and TPAs

Last week new -- and final -- claims and appeal regulations were released. These regulations relax several of the requirements that were first proposed in 2010. Despite these changes, the new regulations leave in place several challenging provisions for employers (especially those with self-funded health plans), insurers and third party administrators ("TPAs").

Previous Guidance. Last year's health care reform law (known as the Affordable Care Act or "ACA") requires many "non-grandfathered" health plans to comply with claim and review procedures. ("Grandfathered" health plans avoid the new rules but may still need to comply with ERISA's claims and appeal rules.) In 2010 and early 2011 the U.S. Department of Health and Human Services ("HHS"), Department of Labor ("DOL") and the Internal Revenue Services ("IRS") issued several notices and technical releases to implement these new claims and appeal rules. Some of the guidance was controversial and raised many practical concerns about how employers, insurers and TPAs would administer the rules.

New Guidance, New Administrative Procedures. Much of the new guidance from last week provides welcome clarifications or relief. However, other pieces remain unchanged -- or changed in a relatively minor way. Thus, employers, insurers and TPAs must review the guidance to identify and respond to the new guidance.

Prior Rule	New Rule	Comments
1. <u>Diagnosis and Treatment Codes</u>. Diagnosis and treatment codes provided automatically in adverse benefit determinations (such as an explanation of benefits ("EOB")), along with meaning of code.	No longer automatic. Plan must provide notification of opportunity to request codes and meanings. Plan must provide code "as soon as practicable" upon request.	A welcome change for insurers and TPAs. Not a complete elimination of the rule so employers (if self-administered), insurers and TPAs must still create administrative processes to comply with the rule, which can raise practical questions (e.g., how quickly is "as soon as practicable"?).
2. <u>Claims Eligible for External Review</u>. Wide variety of claims eligible for external review (including those not based on medical standard).	Until approximately 2014, for many plans scope is reduced to those that involve rescission or "medical judgment." "Medical judgment " includes: (a) appropriate health care setting; (b) whether specialist treatment is medically necessary or appropriate; (c) whether	Broad definition of "medical judgment" could create unexpected results. For example, suppose Employer A excludes Provider X (a specialty hospital or clinic) because X charges high amounts (the main reason) and because of concerns about whether it is an appropriate health care setting

	treatment involved "emergency care" or "urgent care"; (d) whether condition is a "preexisting condition"; (e) whether participant is entitled to a reasonable alternative standard for a reward under a wellness plan; (f) excluding an item or service, if plan covers in certain circumstances based on a medical condition; and (g) certain other situations.	(a secondary, less important reason). Will IRO be able to force plan to cover Provider X (even if it violates the plan terms), because Employer A's decision "involves" medical judgment to some extent?
3. <u>Review of Urgent Care Claims</u>. Twenty-four (24) hour review of claims involving "urgent care".	Plans can use longer time period of up to 72 hours, but plans doing so must "defer" to physician's (not plan's) interpretation of "urgent care".	It is unclear what happens if the physician is clearly wrong -- would deference be required if the physician's determination violated the plan's terms? Plan amendment may be required to incorporate "deference" standard.
4. <u>Strict Compliance</u>. Strict compliance required for claims and appeal rules. Failure to strictly comply can lead to de novo (non-deferential) review by a court.	Some minor errors do not permit immediate external review or court action.	Employers, insurers and TPAs will likely appreciate that there was some relief -- but may have been hoping for more. Relief seems limited and difficult to satisfy. Relief applies if violation was: (a) de minimis; (b) non-prejudicial; (c) due to good cause or matters beyond control of plan; (d) in the context of an ongoing good faith exchange of information; and (e) not reflective of a pattern or practice of non-compliance. Plan must explain, upon request and within 10 days, why it satisfies this exception. Some elements not well-defined and may be difficult for employer / insurer / TPA to prove (such as whether there was an "ongoing good faith exchange of information").
5. <u>Non-English Language Assistance</u>. Some plan materials must be provided in a non-English language, depending on	Standard no longer based on plan participants. Rather, standard based on 10% of all people literate in same non-	Plans and insurers still must provide "oral language services" (e.g., telephone customer assistance) in non-English

whether a certain percentage of plan participants are literate in only that language.	English language of population of claimant's county. List of counties to be provided and updated by federal agencies. Requirement to track preferred language on enrollee-by-enrollee basis arguably eliminated. One-sentence sample language provided in Spanish, Chinese, Navajo and Tagalog.	language in some situations, which could be costly. Many plans will need to track enrollees based on county where they live. May be difficult to track and raises host of practical questions -- e.g., how often must 10% be identified? Once at beginning of year? Every quarter? Once per month?
6. <u>Binding Effect of IRO Decision</u>. External review decision from IRO is binding on plan.	Clarifies that plan must pay benefits "without delay", even if it intends to seek a judicial review of the adverse IRO decision.	Standard of payment "without delay" is unclear. Will time periods track typical ERISA time periods?
7. <u>Updated Model Notices</u>. Model notices provided (notice of adverse benefit determination; notice of final internal adverse benefit determination; notice of final external review decision).	Models updated.	Revised notices should be used.
8. <u>State External Review</u>. States are to implement external review process.	States receive extra time (until January 1, 2012) to implement process.	
9. <u>External Review Process</u>. Insurers and self-insured nonfederal governmental plans subject to external review process.	Some changes to process (e.g., must allow for external review based on medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit).	
10. <u>IRO Contracts</u>. Self-funded plans must contract with IROs to provide external review. Contract must provide various safeguards (e.g., random selection of IRO for each claim). Some flexibility in enforcement (e.g., if do not strictly comply with guidance, can demonstrate compliance on case-by-case basis).	More stringent enforcement with respect to IROs. Many self-insured plans must contract with at least two IROs by January 1, 2012 and with three IROs by July 1, 2012. Must rotate assignments among IROs. Any variance will cause agencies to "look closely". Plans must document how any alternative process constitutes random assignment. Plans must ensure	Employers may satisfy rule through their TPA's contract with IROs. However, employers should verify that terms of TPA - IRO contract satisfy requirements. TPAs should prepare for such questions from their clients.

	that process is independent and without bias.	

Link to Guidance. The new guidance and model notices can be found at the DOL web site: http://www.dol.gov/ebsa/.

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