

## AMENDMENTS TO GUIDANCE ON CLAIMS PROCEDURES AND EXTERNAL REVIEW PROCESSES

The Departments of Treasury, Labor, and Health and Human Services (the “Departments”) have published amendments to the interim final regulations issued last year implementing PPACA’s new standards for internal claims procedures and external review processes (the “Amendments”). The new standards apply to non-grandfathered health plans, and generally apply to calendar year plans beginning January 1, 2012.

In addition, the Labor Department has issued Technical Release 2011-02 which (1) modifies guidance issued in August 2010 establishing interim safe harbor external review processes and (2) includes revised model notices for both internal and external claims decisions.

Links to the amendments and other related guidance described in this Advisory are included at the end of this Advisory.

### AMENDMENTS CHANGE REQUIREMENTS FOR INTERNAL CLAIMS AND APPEALS PROCEDURES

The Amendments make the changes described below to the standards set forth in the interim final regulations for internal claims and appeals processes that calendar-year plans and issuers are required to implement by January 1, 2012.

#### Reinstate 72-Hour Deadline for Deciding Urgent Care Claims

The interim final regulations would have required non-grandfathered health plans to decide a claim for urgent care within 24 hours after receiving the claim. The existing Labor Department regulations require plans to decide a claim for urgent care within 72 hours after receiving the claim. The Amendments reinstate the existing 72-hour rule, provided that the plan accepts the attending provider’s classification of an ur-

### HIGHLIGHTS

- The amendments to the interim final regulations make the following changes:
  - Eliminate the 24-hour and reinstate the 72-hour deadline for deciding urgent care claims,
  - Relax requirements to include diagnosis and treatment codes in notices of claim denials,
  - Relax the strict compliance standard,
  - Revise requirements for non-English claim denial notices,
  - Update the list of consumer assistance programs,
  - Temporarily narrow the scope of claims eligible for external review,
  - Clarify the effect of an external reviewer’s decision, and
  - Extend the transition period for state external review procedures until December 31, 2011.
- Technical Release 2011-02 makes the following changes:
  - Reinstates the requirement to contract with at least three IROs, and
  - Establishes temporary consumer protection standards for state external review processes.

gent care claim; otherwise, the 24-hour rule will apply.

### Relax Requirements to Include Diagnosis and Treatment Codes (and Their Corresponding Meanings) in Notices of Claim Denials

The interim final regulations would have required notices of claim denials to include diagnosis and treatment codes and their corresponding meanings. The Amendments eliminate the requirement to provide diagnosis and treatment codes (and their corresponding meanings) in notices of claim denials. In lieu of this requirement, the Amendments require claim denial notices to provide a statement that diagnosis and treatment codes (and their meanings) associated with a claim will be provided upon request. The Amendments prohibit the plan from considering a request for such information, alone, to be a request for an internal appeal or external review of the claim.

### Relax the Strict Compliance Standard

The interim final regulations would have provided that a claimant would be deemed to have exhausted the claims procedures if a plan fails to follow the claims procedures strictly, regardless of whether the error was de minimis or whether the plan substantially complied with claims procedures. As a result, the claimant would be allowed to pursue the claim in court and the judge might not have to defer to the plan administrator's decision.

The Amendments revise this rule to provide that a claimant will *not* be deemed to have exhausted the claims procedures if all of the following are true for the violation:

- it is de minimis,
- it is not likely to be prejudicial to the claimant,
- it is attributable to good cause or matters beyond the plan's control,
- it occurs in the context of an ongoing good-faith exchange of information between the plan and the claimant, and
- it is not reflective of a pattern or practice of non-compliance.

A claimant may request an explanation of a violation and the plan must provide the explanation,

including a description of its reasons, if any, for asserting that the violation does not cause the claims process to be exhausted. The explanation must be provided within ten days after the claimant's request.

If (1) a claimant seeks immediate external or judicial review of a claim on the grounds that there has been a failure to follow the claims procedures strictly and (2) the external reviewer or court rejects review of the claim on the basis that the failure did not result in a deemed exhaustion of the claims procedures, the plan must provide the claimant with notice of an opportunity to re-submit and pursue an internal appeal of the claim. The time periods for resubmitting the claim must begin to run upon the claimant's receipt of the notice.

### Revise Requirements for Providing Non-English Claim Denial Notices

The interim final regulations would have required notices of claim denials to be provided in a non-English language if a threshold number (generally, at least ten percent) of participants were literate only in that non-English language. The Amendments revise the test so that it is no longer applied to a plan's participant population. Instead, the test is based on whether ten percent or more of the population residing in a claimant's county is literate in only the same non-English language; this determination is based on a survey published by the United States Census Bureau. Currently, 255 U.S. counties in 22 states meet this threshold with respect to at least one of the following languages: Spanish, Chinese, Tagalog, and Navajo. The current list of counties meeting the threshold test is included in the Amendments.

The interim final regulations would have required plans with numbers of non-English participants that met or exceeded the threshold:

- to include in a claim denial notice a statement in the non-English language offering to provide the notice in the non-English language,
- to provide all subsequent notices in the non-English language if a participant requested a prior notice to be translated, and

- to provide oral language assistance in the non-English language if the plan maintains a customer assistance process (such as a telephone hotline).

The Amendments replace these requirements with the following requirements with respect to a claimant who resides in one of the counties that meets the threshold:

- The plan must provide oral language services (such as a telephone customer assistance hotline) to answer questions in any applicable non-English language and to provide assistance with filing claims, appeals, and requests for external review.
- The plan must include in any claim denial notice sent to the claimant a one-sentence statement in the relevant non-English language about the availability of, and instructions for getting access to, language services. The Departments have provided sample sentences in revised versions of their model claim denial notices included as an Appendix to Technical Release 2011-02.
- The plan must provide the claimant a claim denial notice in the non-English language upon request. Non-English notices are not required unless requested, even if the claimant requested translations for prior notices.

The Departments requested comments regarding the amendments to the requirements for providing non-English claim denial notices. In particular, the Departments have asked whether employers would like health insurers to be required to provide notices in non-English languages to persons who do not reside in counties that meet the threshold test but to whom the employer nevertheless would like the insurer to provide non-English notices.

#### **Update the List of Relevant Consumer Assistance Programs**

Plans must include in claim denial notices information regarding the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsmen. The Departments published a list of state consumer assistance programs or ombudsmen on March 18, 2011. The Departments is-

sued an updated list on June 22, 2011.

#### **AMENDMENTS AND NEW GUIDANCE CHANGE REQUIREMENTS FOR EXTERNAL REVIEW PROCESSES**

The Amendments and Technical Release 2011-02 make the changes described below to the standards set forth in the interim final regulations and other guidance for external review processes that calendar-year plans were required to begin providing after December 31, 2010.

#### **Temporarily Change the Scope Of Claims Eligible for External Review**

The federal external review process applies to non-grandfathered self-insured plans that are subject to ERISA or are otherwise not subject to a state external review process. Effective for plan years beginning on or after September 23, 2010, the interim final regulations required plans to provide an external review process for any claim denial except denials based on eligibility determinations. The Amendments provide that claims will not be eligible for external review unless they involve (1) medical judgment, as determined by the external review, or (2) a rescission of coverage. This change applies to claims submitted for external review on or after September 20, 2011. Thus, claims regarding legal and contract issues submitted after this date will not be eligible for external review.

The regulations give several examples of claims involving medical judgment, including those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The more atypical examples of medical judgment include:

- determinations regarding whether an individual is entitled to a reasonable alternative standard for a reward under a wellness program,
- review of the frequency, method, treatment, or setting for a recommended preventive service, and
- whether a plan is complying with nonquanti-

tative treatment limitations of the Mental Health Parity and Addiction Equity Act, such as restrictions based on medical management techniques and exclusions based on fail-first or step therapy protocols or failures to complete required courses of treatment.

This narrowing of the scope of claims eligible for external review is temporary, however. The Departments expect that the restriction will be lifted by January 1, 2014, unless the Departments are persuaded, through public comments, to make this change permanent. The Departments will give advance notice to enable plans sufficient time to comply with any decision to lift the suspension or otherwise modify the rule.

The Departments have requested comments and data regarding external review claims that have been processed by private independent reviewers, including the number of claims reviewed, type of review, and costs associated with the review.

### **Clarify the Effect of an External Reviewer's Decision**

The interim final regulations provide that external review decisions are binding on the plan, issuer, and claimant, except to the extent that other remedies are available under state or federal law. The Amendments clarify that if an external review decision overturns a claim denial or otherwise requires payment on a claim, the plan or issuer must provide the benefits without delay, regardless of whether the plan or issuer intends to seek judicial review.

### **Reinstate (on a Phased-In Basis) The Requirement to Contract With at Least Three IROs**

In August 2010, the Department of Labor issued Technical Release 2010-01 setting forth an interim safe harbor external review process for self-insured plans. The guidance required plans to contract with at least three accredited independent review organizations ("IROs") and to rotate assignments among them in order to satisfy the safe harbor. Shortly thereafter, the Departments issued guidance providing that the failure to contract with three IROs would not be a *per se* violation of the external review requirements if the plan could demonstrate that its

external review process was independent and without bias. Technical Release 2011-02 reinstates the requirement to contract with three IROs in order to be eligible for the safe harbor. Plans must contract with at least two IROs by January 1, 2012 and with at least three IROs by July 1, 2012. Plans may use alternative processes to satisfy the interim final regulations' requirement for random assignment of claims among external reviewers; however, the plan must document how the alternative process is independent (*i.e.*, not subject to undue influence by the plan) and without bias.

### **Extend the Transition Period for State External Review Procedures**

State external review processes generally apply to issuers of health insurance coverage that are subject to state insurance laws, self-insured plans that are not subject to ERISA (such as state or local governmental plans and church plans), and multiple employer welfare arrangements. The interim final regulations require state external review processes to include several consumer protection provisions. For plan years beginning before July 1, 2011, existing state external review procedures will be deemed to meet these minimum consumer protection requirements. If a state external review process does not satisfy the minimum standards after this transition period, the plan or issuer must apply the federal external review process.

The Amendments extend the transition period to December 31, 2011. In addition, before January 1, 2014, a state's external review process will be certified by the Departments if it meets temporary consumer protection standards set forth in Technical Release 2011-02 (also released on June 22, 2011). If a state process that is certified on the basis of meeting the temporary standards does not satisfy all of the minimum consumer protection requirements after December 31, 2013, plans or issuers will be required to use the federal external review process in that state. For nonfederal governmental health plans that use a federal external review process, the Department of Health and Human Services has issued guidance on how the plans may choose between the process managed by HHS or the federal external review process available to other self-insured

plans which employs private IROs.

## DEADLINE FOR COMMENTS

Comments on the Amendments are due July 25, 2011.

## LINKS TO GUIDANCE

- [Amendments to Interim Final Regulations](#)
- [Technical Release 2011-02](#)
- [Revised Model Notices](#)
  - [Initial Internal Adverse Benefit Determination](#)

- [Final Adverse Benefit Determination](#)
- [Final External Review Decision](#)

- [Updated List of Consumer Assistance Programs](#)
- [Updated Health and Human Services Technical Guidance with Instructions for Issuers to Determine Who Should Receive Non-English Notices](#)
- [Health and Human Services Technical Release with Instructions for Nonfederal Governmental Self-Insured Health Plans to Elect Federal External Review Process](#)

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