

# HEALTH REFORM IMPACT

## What you need to know NOW

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

### Health Reform's New Claims Appeals Rules

August 4, 2010

Recently issued interim final regulations will expand the Department of Labor's ("DOL") current internal claims procedures regulation and apply new "external" appeals rules to claims denied at the internal level. The rules are effective for plan years beginning after September 22, 2010, and will affect all group health plans, including those not previously subject to ERISA's claims procedure requirements (e.g., church plans, state and local government plans). The rules also apply regardless of whether a plan provides benefits on an insured or self-insured basis. Plans that enjoy "grandfathered" status under the health reform law are exempt from the new regulations as long as they maintain that status.

#### *New Internal Appeals Rules*

The DOL rules applicable to internal claims procedures have been revised to include more participant rights and disclosures. Specifically, the regulations add six new requirements to the current DOL regulation governing internal claims procedures:

- Pending the final resolution of any internal appeal of an "adverse benefit determination," plans must continue to provide coverage. This treatment applies to ongoing courses of treatment as well as (for the first time) rescissions of past coverage. A rescission includes any cancellation or discontinuance of coverage that has a retroactive (as opposed to prospective) effect.
- Plans must notify participants of a benefit determination regarding urgent care no more than 24 hours after receipt of the claim, unless the participant fails to provide information needed to determine whether benefits are payable. This is a change to the requirements of the current DOL claims procedure regulations, which require notification of urgent care determinations no more than 72 hours after receipt of the claim. Individuals in urgent care situations or receiving an ongoing course of treatment may be allowed to proceed with expedited external review at the same time the internal appeals process is in progress.
- Claimants must be provided, free of charge, (i) any "new or additional evidence" used in making an adverse benefit determination, and (ii) any "new or additional rationale" used

in upholding a previous adverse benefit determination. This information must be provided as soon as possible and sufficiently *in advance* of the due date for a plan's benefit determination so that the recipient has a reasonable opportunity to respond.

- Plans must ensure that all claims are adjudicated in a manner that ensures impartiality of the decision-makers. Thus, decisions regarding the hiring, compensation (including bonuses), termination, or promotion of persons adjudicating claims must be made without regard to the person's support of benefit denials or any other factor that might affect the person's objectivity.
- Certain additional information must be reflected in notices of benefit determination, including treatment codes, diagnosis codes, reasons for any denial (and a corresponding denial code) and a description of the standard used in denying a claim. The notice must also describe information on how to initiate an appeal, including contact information for available offices of consumer assistance (the reform legislation funds the creation of such offices). The Department of Health and Human Services ("HHS") and DOL intend to issue new model notices for this purpose in the near future.
- If a plan fails to comply "strictly" with the revised internal claims processes, claimants are deemed to have exhausted the internal process and may immediately initiate an external review or pursue any other recourse available under law (e.g., filing court suit). The regulations emphasize that there is no "de minimis" exception to this rule. The Departments will indicate in future guidance the applicable standard for external review (e.g., whether the abuse of discretion standard will still be available).

### *External Appeals*

Group health plans must institute external appeals procedures for review of internal adverse benefits determinations by "independent review organizations" (IRO). This requirement will be completely new for many plans, including self-insured plans that are subject to ERISA rather than state laws. Plans that are subject to state external review procedures (e.g., insured plans) must continue to comply with those standards, provided the procedures incorporate certain minimum consumer protections set forth in the Uniform Health Carrier External Review Model Act ("NAIC Uniform Model Act"). For plan years beginning before July 1, 2011 (and after September 22, 2010), state laws will be deemed sufficient for this purpose. For plan years beginning on or after July 1, 2011, HHS will review each state's external appeal laws and determine whether the law incorporates the required consumer protections, including payment of costs by the plan, written notice of external appeals rights, and adjudication periods for review. If the state law is deemed sufficient, the plan may continue to operate under those rules. If the state law is not sufficient, the plan will be subject to new federal external review procedures to be established by HHS and DOL.

The new federal external review process will incorporate the requirements of the NAIC Uniform Model Act, as supplemented by HHS and DOL in future guidance. However, the scope of "adverse benefit determinations" subject to the new federal external review rules will not include determinations relating to a claimant's satisfaction of basic threshold requirements for plan eligibility (e.g., worker classification issues). Thus, plans subject to the federal external review process will retain authority for making "eligibility" determinations as they do under current law, while "benefit" decisions will be subject to the new appeal rules. The federal

external review standards will also describe how claimants may initiate reviews, the minimum qualifications for IROs, a process for random assignment of external review cases to IROs (and procedures for adjudication of those cases), and required notices following external review. Expedited external reviews will be available in cases of emergency, urgent care or other situations where applying standard review timeframes would jeopardize the claimant's health. The external review rules will describe how plans should notify participants of their new review rights (including alternate language requirements if a certain percentage of the plan's participants do not speak English).

External review decisions will be binding on plans and claimants, although claimants will retain the right to pursue other remedies available under law (e.g., initiation of court case under ERISA 502).

If you have questions regarding the information in this alert, or with respect to other provisions of the health reform legislation as it relates to your employee benefits plans, please contact any of the attorneys in our Employee Benefits Practice Group listed below.

Also, please [click here](#) to visit our special Web page for Health Reform IMPACT.

**Bass, Berry & Sims Employee Benefits Attorneys**

**Fritz Richter**  
(615) 742-6256  
[frichter@bassberry.com](mailto:frichter@bassberry.com)

**David Thornton**  
(901) 543-5922  
[dthornton@bassberry.com](mailto:dthornton@bassberry.com)

**Richard Barry**  
(615) 742-6230  
[rbarry@bassberry.com](mailto:rbarry@bassberry.com)

**Curtis Fisher**  
(615) 742-7892  
[cfisher@bassberry.com](mailto:cfisher@bassberry.com)

**John Kirk**  
(615) 742-7808  
[jkirk@bassberry.com](mailto:jkirk@bassberry.com)

**Michael Moore**  
(901) 543-5916  
[mtmoore@bassberry.com](mailto:mtmoore@bassberry.com)

*The materials contained herein have been abridged from the statutory sources and should not be construed or relied upon for legal advice. Readers are urged to consult legal counsel concerning particular situations and specific legal questions.*

*To ensure compliance with requirements imposed by the IRS, we inform you that this message is not intended to be used, and cannot be used, by the addressee or any other person for the purpose of avoiding penalties that may be imposed under the Internal Revenue Code.*