PARKER BROWN & MACAULAY, P.C.
4 FANEUIL HALL MARKETPLACE
BOSTON, MA 02109

INTERIM FINAL RULES FOR INTERNAL CLAIMS/APPEALS AND EXTERNAL REVIEW PROCESSES (July 23, 2010)

Interim final rules for Internal Claims/Appeals and External Review Processes have been released jointly by the IRS, the DOL's Benefits Security Administration, and HHS's Office of Consumer Information and Insurance Oversight. (75 Fed. Reg. 43330)

These rules implement section 2719 of the Public Health Services Act, as created by PPACA, and are effective for plan years beginning on or after September 23, 2010. They generally apply to both insured and self-insured health plans. The rules will not apply to plans in place on March 23, 2010 unless and until such plans lose their grandfathered health plan status.

However, as a practical matter, please note that employers with grandfathered GHPs that are fully insured may end up complying with these rules despite their grandfathered status to the extent the fully insured group product purchased by such employers already complies (or is updated by the insurer to comply) with these interim rules.

Here are the highlights from the new rules:

Internal Claims/Appeals (The claims adjudication/appeal process under ERISA you may be familiar with)

- With respect to internal claims and appeals processes for group health coverage, plans and issuers must initially incorporate the internal claims and appeals processes set forth in the DOL claims procedure regulation (29 CFR 2560.503-1) and update such processes in accordance with standards established by the Secretary of Labor.

- These interim final regulations add six new requirements to the DOL claims procedure regulation (and additional requirements may be added by DOL in the future):

    - Broadens the definition of adverse benefit determination in the DOL claims procedure regulation to include any rescission of coverage whether or not there is an adverse effect on any particular benefit at that time.

    - Shortens the timeframe that a plan or issuer must notify a claimant of a benefit determination (whether adverse or not) with respect to an urgent care claim from not later than 72 hours, to as soon as possible but not later than 24 hours after the receipt of the claim by the plan or issuer.

    - Requires the plan or issuer to provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with the claim, or any new or additional rationale for an adverse benefit determination. The evidence or rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

- Avoids conflicts of interest by prohibiting plans and insurers from rewarding employees based on claims denials or from hiring experts to review claims based upon the likelihood that the individual will support the denial of benefits.

- Creates additional content to be included in any adverse benefit determination notices sent to claimants including diagnosis, treatment and denial codes and a discussion of their meanings; a discussion of the decision; notice of the internal/external review processes; and availability of and contact information for state consumer assistance/ombudsman. Model notices are promised in the near future.

- Deems a claimant to have exhausted the internal process and permits the claimant to initiate an external review and pursue any available remedies under applicable law, such as judicial review if a plan or issuer fails to strictly adhere to all the requirements of the internal claims and appeals process (notwithstanding an assertion by plan or issuer that it substantially complied or that any error it committed was de minimis.

➢ In addition to these six new requirements, the statute and these interim final regulations require a plan and issuer to provide continued coverage pending the outcome of an internal appeal. Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advanced review.

External Review Processes (Review of final internal benefit denials by independent review organization)

➢ With respect to external review, the interim rules provide a system for applicability of either a State external review process or a Federal external review process. These regulations provide rules for determining which process applies, as well as guidance regarding each process.

➢ According to a related government fact sheet, 44 states now have some sort of external appeals mechanism. States will not be required to create or change their external review process. However, the federal government is urging states to create or upgrade their external review process by adopting standards established by the National Association of Insurance Commissioners. For plan years beginning before July 1, 2011, State external review processes applicable to health insurers or group health plans will be deemed to meet the interim rules.

➢ For plans and issuers not subject to an existing State external review process, (including non-grandfathered self-insured plans), a Federal external review process will apply for plan years beginning on or after September 23, 2010. The Departments will be issuing more guidance in the near future on the Federal external review process.

Notices

➢ The interim final regulations also set forth rules related to the form (including new content) and manner of providing notices in connection with internal claims and appeals and external review processes, including a requirement that the notices be provided in a culturally and linguistically appropriate manner.

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- Providing relevant notices in a culturally and linguistically appropriate manner means providing required notices in a non-English language IF the number of participants who are literate in the same non-English language exceed the following threshold numbers:
    - For plans with LESS than 100 participants: 25% or more participants are literate only in the same non-English language; or
    - For plans with 100 OR MORE participants: the lesser of 10%, or 500 or more participants are literate only in the same non-English language.
- In addition, once the applicable threshold is met:
    - Notice must be provided upon request in the non- English language for which the threshold is met.
    - The plan or issuer must also include a statement in the English versions of all notices, prominently displayed in the non- English language, offering the provision of such notices in the non-English language.
    - Once a request has been made by a claimant, the plan or issuer must provide all subsequent notices to that claimant in the non-English language.
    - In addition, to the extent the plan or issuer maintains a customer assistance process (such as a telephone hotline) that answers questions or provides assistance with filing claims and appeals, the plan or issuer must provide such assistance in the non-English language.

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Please contact me if you have any questions or comments.

Richard A. Szczebak
Of Counsel
PARKER BROWN & MACAULAY, P.C.
4 Faneuil Hall Marketplace
Boston, MA 02109
Phone: 617-399-0441 (direct)
Email: rszczebak@parkerbrown.com
www.parkerbrown.com

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