Claims, Appeals and External Review Rules Liberalized

For more information regarding this or any other employment-related issue, please contact your Vorys attorney or a member of the Vorys Labor and Employment Group by calling 614.464.6400.

The Patient Protection and Affordable Care Act (PPACA) imposed new rules for claims, appeals and external review on non-grandfathered group health plans. Those rules, as originally issued on July 23, 2010, were surprisingly complex and burdensome. After a series of modest modifications, the IRS, DOL and HHS came out with some more significant changes on June 24, 2011.

Deadline for decisions on urgent care claims

- Old: The claims administrator would have had to decide urgent care claims as soon as possible and not later than *24 hours* after the claim is filed.

- New: The claims administrator must decide urgent care claims as soon as possible and not later than *72 hours* after the claim is filed (as per the pre-PPACA rule).

Inclusion of diagnosis and treatment codes on explanations of benefits (EOBs)

- Old: EOBs would have had to include diagnosis and treatment codes and their meanings.

- New: The EOB must include a notice that the claimant can request the diagnosis and treatment codes and their meanings.

Claimant's obligation to complete appeals process before bringing suit

- Old: A claimant would have had the right to immediately bring suit (and not complete the internal claims and appeals process) if the internal claims and appeals process was defective in any way (no matter how minor).

- New: A claimant does not have a right to bring suit before completing the internal claims and appeals process if errors in the process were: (a) minor; (b) not prejudicial; (c) attributable to good cause or matters beyond the plan's control; (d) in the context of an ongoing good-faith exchange of information; and (e) not reflective of a pattern or practice of non-compliance. However, a claimant can request an explanation of the plan's basis for asserting that it meets this standard.

Foreign language notices and assistance

- Old: The plan would have had to offer foreign language notices and assistance based on the percentage of plan participants who are literate only in the same non-English language. Further, participants who requested foreign language notices would have had to been tagged and tracked so as to provide subsequent notices in the foreign language.

- New: The plan must offer foreign language notices and assistance based on whether a participant resides in a county in which 10% or more of the population is literate only in the same non-English language. The regulations include a table listing the counties where this is the case and the relevant languages (Spanish, Chinese, Tagalog and Navajo). The table will be updated annually. The new rules also eliminate the requirement to tag and track participants.

Contracting with Independent Review Organizations (IROs)

- Old: To qualify for a safe harbor standard for external review, plans (or their claims administrators) were supposed to have contracted with three IROs.

- New: To qualify for a safe harbor standard for external review, plans (or their claims administrators) are supposed to contract with two IROs by January 1, 2012 and three IROs by July 1, 2012.

Claims subject to external review

- Old: Claimants could request external review of all claims that were denied on appeal unless the denial was based on the claimant's ineligibility for coverage.

- New: Pending further guidance, claimants can request external review of claims that were denied on appeal only if the claim involves medical judgment or a rescission of coverage. The new rules apply with respect to claims for which external review has not been initiated before September 20, 2011.

  "Medical judgment" is interpreted broadly to include such issues as medical necessity, health care setting, level of care, whether a condition is pre-existing, or whether a treatment is experimental or investigational – and a claimant has the right to have an IRO decide whether his or her claim involves "medical judgment. " It is not clear whether a rescission based on a claimant's ineligibility for coverage is or is not subject to external review.

Take-aways

- Clients with non-grandfathered medical plans: Your claims administrators will welcome the recent changes.

- Clients with grandfathered medical plans: The PPACA rules for claims, appeals and external review do not apply to your plan. However, these changes make the new claims process more manageable, which may make the loss of grandfathered status more palatable.

Other developments

- Medicare Part D: One of the notices typically distributed with annual enrollment materials is a Creditable (or Non-Creditable) Coverage Disclosure Notice addressing how your prescription drug coverage relates to Medicare Part D prescription drug coverage. These notices are supposed to be distributed annually, before the start of the annual Medicare Part D enrollment period. In the past, the Medicare Part D enrollment period was November 15 through December 31 of each year. The PPACA moved the Medicare Part D enrollment period to October 15 through December 7, starting in 2011. That changes the due date for the annual distribution of the Notices from November 1 to October 15. If you are claiming the retiree drug subsidy, the new deadline is particularly important because the retiree drug subsidy is contingent on providing compliant Notices. In contrast, if you are not claiming the retiree drug subsidy, you are required to provide the Notice but there is no specific penalty if the notice is provided late.

  Check the CMS website (http://www.cms.gov/CreditableCoverage) for updated model notices reflecting the new annual enrollment period.

- Standardized electronic transactions for health plan eligibility and claims status: In an attempt to increase uniformity in how providers and claims administrators exchange information, the Department of Health and Human Services recently published regulations standardizing the information to be exchanged with respect to participants' eligibility and claims status.

- Federal rules for state insurance exchanges: The Department of Health and Human Services recently published proposed regulations on the state health insurance exchanges that are supposed to be up and running in 2014.

Please let us know if you want further information about these or other aspects of the impact on health care reform on employment-based health benefits.
