

KELLY, HANNAFORD & BATTLES P.A.

ANTHONY R. BATTLES
JULE M. HANNAFORD IV
A. DAVID KELLY
THEODORE K. RICE
SONJA LEMMER MARTENS
HOLLY A. FISTLER

MARK D. MEYER
JEAN L. FINDORFF
OF COUNSEL

ATTORNEYS AT LAW
900 BAKER BUILDING
706 SECOND AVENUE SOUTH
MINNEAPOLIS, MINNESOTA 55402
TELEPHONE (612) 341-0881
FACSIMILE (612) 341-1041
KHBLAW.COM

WRITER'S DIRECT DIAL:
612/455-6084
TRice@KHBlaw.com

WRITER'S DIRECT DIAL:
612/341-3398
HFistler@KHBlaw.com

March 29, 2011

Re: Grace Period Extension and (Some) Relief for Self-Insured Health Plan Sponsors Implementing New Claims, Appeals and External Review Processes

Dear Clients and Other Friends:

On March 18, 2011, the DOL issued Technical Release 2011-01 which extended the regulatory enforcement grace period for some, but not all, of the health care reform law's new claims, appeals and external review requirements. This Technical Release also provides relief to plan sponsors by eliminating the requirement to implement good faith procedures for requirements subject to the grace periods. This letter reviews the new requirements for claims, appeals and external review processes, and includes an explanation of the new deadlines (see table below) as applicable to non-grandfathered self-insured group health plans.¹ Although Technical Release 2011-01 extended some enforcement grace periods, non-grandfathered self-insured group health plan sponsors should review the new requirements and begin implementing an external review process.

Background

Under the Patient Protection and Affordable Care Act ("PPACA"), non-grandfathered self-insured health plan sponsors are required to implement changes to their internal claims, appeals and external review processes. Interim final regulations jointly issued by the IRS, HHS and DOL on July 23, 2010 provided initial guidance effective for plan years beginning after September 23, 2010.² Subsequently, the DOL issued a series of technical releases that assists plan sponsors to implement these new requirements and provides relief in the form of regulatory enforcement grace periods.³

¹ This is the focus of this letter. However, fully-insured plans are subject to similar rules and fully-insured plan sponsors should consult with their insurers regarding the implementation of the new requirements.

² Interim Final Rules for Group Health Insurance Plans and Health Insurers Relating To Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act (available at: <http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=24056>)

³ These include the following documents:

DOL Tech. Rel. 2010-01 (available at: <http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf>);

DOL Tech. Rel. 2010-02 (available at: <http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-02.pdf>);

DOL Tech. Rel. 2011-01 (available at: <http://www.dol.gov/ebsa/pdf/tr11-01.pdf>); and

HHS

PPACA Changes Existing Internal Claims and Appeals Procedures

Generally, the new internal claims and appeals rules apply to non-grandfathered group health plans. (Grandfathered plans will continue to follow existing DOL rules until January 1, 2014.) The interim final regulations added the following standards to the existing DOL claims procedures for non-grandfathered plans:

1. A rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time) is now included as an “adverse benefit determination”.
2. The plan must notify a claimant of a benefit determination (whether adverse or not) with respect to an urgent care claim as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim.
3. As part of the requirement to conduct a full and fair review, plans are required to provide the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by the plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale.
4. To address conflicts of interest, decisions such as hiring, compensation, termination, promotion or other similar matters with respect to an individual such as a claims adjuster or medical expert must not be based on the likelihood that the individual will support denial of benefits.
5. Notices must be provided in a culturally and linguistically appropriate manner.
6. Additional content for the notices is specified, including: information sufficient to identify the claim; diagnosis and treatment codes and their meanings; the availability of appeal and external review procedures; and the contact information for the state’s office of health insurance consumer assistance or ombudsman.⁴
7. If a plan fails to “strictly adhere” to all the internal claims and appeals requirements, then the claimant is deemed to have exhausted the internal claims and appeals procedures. Under this rule, even minor failures to strictly adhere to procedures could result in external reviews and/or court actions by claimants. Plans that fail to comply may be liable for excise taxes under the Internal Revenue Code of \$100 for each day of noncompliance with respect to each individual to whom such failure relates.
8. A plan must provide continued coverage pending the outcome of an internal appeal. Plans are prohibited from reducing or terminating an ongoing course of treatment without providing advance notice and an opportunity for advance review. Additionally, individuals receiving urgent care and individuals receiving an ongoing course of treatment may be allowed to proceed with expedited external review at the same time as the internal appeals process, under either a State external review process or the Federal external review process.

⁴ As of the date of this letter, it is unclear whether there is such a contact for Minnesota, as the State of Minnesota was the only state omitted from the table in the Appendix to DOL Tech. Rel. 2011-01.

External Review Process is New for Self-Insured Plans

Generally, the new claims, appeals and external review rules apply to non-grandfathered group health plans. The mandated external review process, in particular, is a new process for non-grandfathered self-insured plans. The new rules allow plans to follow state external review processes. If a state either does not provide an external review program or does not allow self-insured plans to participate in the state program, then the PPACA-established federal external review process must be followed. The interim final regulations provide both an explanation of the federal process and a safe-harbor for self-insured plans.

The external review safe harbor guidance for non-grandfathered self-insured plans was issued in DOL Technical Release 2010-01 on August 23, 2010.⁵ This safe harbor is effective until superseded by future guidance on the federal external review process. Compliance with this safe harbor is to be determined on a case-by-case basis. Generally to meet the safe harbor, a plan must comply with one of the following two approaches:

- Comply with the interim federal external review process. The interim process outlined in the Technical Release includes two types of review – standard and expedited – which generally are based on the Uniform Health Carrier External Review Model Act issued by the National Association of Insurance Commissioners (“NAIC”) procedures. An important element of this process is to designate three independent review organizations (“IROs”), which will alternate in handling external reviews. Plans may instead contract with TPAs that, in turn, contract with IROs as required under PPACA. In this case, plan sponsors must monitor the review process to confirm compliance.
- Comply with a state’s external review process. Non-grandfathered self-insured plans may comply with a state’s external review process if the state’s process meets minimum standards of the NAIC Model Act and is made available to self-insured plans. In Minnesota, however, non-grandfathered self-insured group health plans are not yet permitted to participate in the state external review program. Currently, the Minnesota Department of Health only offers the state process to fully-insured plans and certain governmental plans. This means that non-grandfathered self-insured group health plans located in Minnesota must follow the interim federal external review procedures set forth in DOL Technical Release 2010-01 for the time being.

New Regulatory Enforcement Grace Periods and Differing Deadlines

Technical Release 2011-01 extends the regulatory enforcement grace period for certain internal claims and appeals processes until the first plan year starting on or after January 1, 2012. Moreover, this Technical Release provided additional enforcement relief. As the IRS, DOL and HHS need more time to publish amended regulations, the DOL eliminated the requirement that plan sponsors implement in good faith the standards to which any grace period applies (initial and extended). However, for standards without grace periods – such as including rescissions as an adverse benefit decision and continued coverage pending claims and appeals – the relief does not apply (see table below).

⁵ DOL Tech. Rel. 2010-01 (available at: <http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf>)

Originally under the interim final regulations, non-grandfathered group health plans were required to be fully compliant with the internal claims, appeals and external review procedures for plan years beginning on or after September 23, 2010. For calendar year plans, the initial effective date was January 1, 2011. However, as a result of the series of grace periods and extensions, different requirements have different enforcement dates as demonstrated below:

PPACA Provision	Initial Enforcement Grace Period	Extension of Grace Period?
Internal Claims and Appeals Procedures		
1. Rescission of coverage = adverse benefit decision	None - initial effective date applies	None - initial effective date applies
2. 24-hour notice period for urgent care claims	DOL Tech. Rel. 2010-02 Grace period until July 1, 2011	DOL Tech. Rel. 2011-01 Extended to plan yrs. beginning on or after Jan. 1, 2012
3. Full and fair review of evidence and rationales	None - initial effective date applies	None - initial effective date applies
4. Preventing conflicts of interest	None - initial effective date applies	None - initial effective date applies
5. Notices to claimants written in a culturally and linguistically appropriate manner	DOL Tech. Rel. 2010-02 Grace period until July 1, 2011	DOL Tech. Rel. 2011-01 Extended to plan yrs. beginning on or after Jan. 1, 2012
6. Enhanced notices requirements	DOL Tech. Rel. 2010-02 Grace period until July 1, 2011	DOL Tech. Rel. 2011-01 Full extension only for diagnosis and treatment codes and meanings to plan yrs. beginning on or after Jan. 1, 2012 Partial extension for everything else until plan yrs. beginning on or after July 1, 2011 (For calendar year plans, this is effectively the same deadline)
7. "Strict Adherence" standard	DOL Tech. Rel. 2010-02 Grace period until July 1, 2011	DOL Tech. Rel. 2011-01 Extended to plan yrs. beginning on or after Jan. 1, 2012
8. Continued coverage pending claim/appeal	None - initial effective date applies	None - initial effective date applies
External Review Procedures		
Implementation of safe harbor external review procedures (federal or state program, if any)	None - initial effective date applies External review safe harbor process available	DOL Tech. Rel. 2010-01 safe harbor continues until new guidance issued

Action Steps for Non-Grandfathered Self-Insured Group Health Plans:

Although grace periods have been issued and extended, non-grandfathered self-insured plans should take steps now to ensure that the new claims, appeals and external review processes are being implemented as required by PPACA. Plan sponsors must ensure that their TPAs are contractually obligated to address these new requirements. This is very important, as plan

sponsors are responsible for assuring that the internal claims, appeals and external review processes are PPACA-compliant.

As non-grandfathered self-insured group health plan sponsors review current processes and implement new requirements, they should consider the following action steps:

Action Steps!

- Review the new internal claims, appeals and external review rules:
 - Determine applicability of state or federal external review process.
 - Determine, from a cost/benefit standpoint, whether to apply a different process for internal/external appeals to any excepted benefits.
 - Confirm whether interim safe harbor of DOL Tech. Rel. 2010-01 will be in effect if the plan does not have a State external review process available:
 - If state external review process is not available, then establish process ASAP, including contracting with at least three independent review organizations (“IROs”) or confirm that the TPA is doing so; and
 - Note: Minnesota does not yet make its state external review process available to self-insured group health plans (as of this date).
 - Document internal claims, appeals and external review process.
- Review/revise plan documents.
- Review/revise Summary Plan Descriptions; issue Summary of Material Modifications as necessary.
- Review/revise any forms and notices used to communicate benefit determinations:
 - Model notices are available from the DOL to assist plan sponsors and TPAs meet new content requirements (see www.dol.gov/ebsa/healthreform).
- Review/revise applicable service agreements – especially with TPAs if they are responsible for conducting the internal claims and appeals process and/or managing the external review process.

PPACA Is Complex, We Can Help

Kelly, Hannaford & Battles P.A. helps employers and TPAs address the many changes brought about by health reform, including the new claims, appeals and external review requirements. Please contact us if you would like assistance with addressing health reform matters. If you would like a copy of our easy-to-reference outline of the timelines for claims, appeals and external review procedures, please contact us to request that outline.

Sincerely,

Theodore K. Rice

Holly A. Fistler