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A Closer Look At the Amended Claims and Appeals Regulations Applicable to NON-Grandfathered Health Plans

In *Benefit News Briefs 2011-42*, we reported on the release of amended regulations concerning claims and appeals **for NON-GRANDFATHERED plans.** The amended regulations amend the prior regulation issued July 2010. The July 2010 regulations were discussed in *Benefit News Briefs 2010-59; 2010-63;* and *2010-68* and *Special Bulletin 2011-17.*

The changes in the regulations were broken down into six areas which we discuss in more detail below. The discussion is drawn from the *Preamble* to the amended regulations. The rules are available at: *http://www.gpo.gov/fdsys/pkg/FR-2011-06-24/pdf/2011-15890.pdf* or by "*clicking here*."

Especially notable changes made by the amended regulations include:

- eliminates the "24 hour" rule which required health plans to notify a claimant of a benefit determination with respect to a claim involving urgent care not later than 24 hours after the claim, even if the decision was not a denial. The prior 72-hour maximum DOL rule is effective again.
- eliminates the requirement to *automatically provide the diagnosis and treatment codes* as part of a claim denial or denial on appeal and instead substitutes a requirement that the plan must provide *notification of the opportunity to request the diagnosis and treatment codes.*
- changes the threshold for requiring the inclusion on claims and appeals denials of a sentence in a relevant non-English language about the availability of assistance for non-English speakers. This additional sentence must be used in <u>any county</u> where the claimant resides if 10% or more of the county is listed by the Census Bureau as speaking the same non-English language. Most instances involve Spanish. Sample sentences are included.
- narrows the external review scope of any claim denial to only claims that involve: (1) medical judgment or (2) a rescission of coverage.

Prepared by Mike Ewing, J.D.
Director of Research
United Actuarial Services, Inc.
(317) 580-8659 • Fax (317) 580-8651
email: mewing@unitedactuarial.com

- requires self-insured plans to contract with at least two IROs by January 1, 2012 and with at least three IROs by July 1, 2012 and to rotate assignments among them in order to be eligible for a safe harbor from enforcement from the Department of Labor and the IRS. Originally, such plans had to contract with three IROs by the earlier date.

1. Expedited Notification Of Benefit Determinations Involving Urgent Care

This amendment permits plans to follow the original rule in the DOL claims procedure regulation (requiring decision-making in the context of pre-service urgent care claims as soon as possible consistent with the medical exigencies involved but in no event later than 72 hours), *provided* that the plan defers to the attending provider with respect to the decision as to whether a claim constitutes ''urgent care.'' Prior to this change, the new regulations provided that a plan must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care (as defined in the DOL claims procedure regulation) as soon as possible, taking into account the medical exigencies, but not later than **24 hours** after the receipt of the claim by the plan or issuer, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance coverage.

2. Additional Notice Requirements With Respect To Notice Of Adverse Benefit Determinations Or Final Internal Adverse Benefit Determination

The amended regulation **eliminates** the requirement to *automatically provide the diagnosis and treatment codes* as part of a notice of adverse benefit determination (or final internal adverse benefit determination) and instead **substitutes a requirement** that the plan must provide *notification of the opportunity to request the diagnosis and treatment codes* (and their meanings) in all notices of adverse benefit determination (and notices of final internal adverse benefit determination), and a requirement to provide this information upon request. This amendment also clarifies that, in any case, a plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for (and therefore trigger the start of) an internal appeal or external review.

3. Deemed Exhaustion Of Internal Claims And Appeals Processes

The amended regulation also provides an exception to the strict compliance standard for claims processing errors that are minor and meet certain other specified conditions. Under the amended approach, any violation of the procedural rules of the July 2010 regulations pertaining to internal claims and appeals would permit a claimant to seek immediate external review or court action, as applicable, unless the violation was:

(1) De minimis;
(2) Non-prejudicial;
(3) Attributable to good cause or matters beyond the plan's or issuer's control;
(4) In the context of an ongoing good-faith exchange of information; and
(5) Not reflective of a pattern or practice of non-compliance.

In addition, the claimant would be entitled, upon written request, to an explanation of the plan's basis for asserting that it meets this standard, so that the claimant could make an informed judgment about whether to seek immediate review. Finally, if the external reviewer or court rejects the claimant's request for immediate review on the basis that the plan met this standard, this amendment allows the claimant to resubmit and pursue the internal appeal of the claim.

4. Providing Notices In A Culturally And Linguistically Appropriate Manner

This amendment establishes that if 10% or more of the total population residing in the claimant's county are literate only in the same non-English language, then health plans are required to provide a one-sentence statement in the relevant non-English language about the availability of non-English language services.
At the time of publication of this amendment, 255 U.S. counties (78 of which are in Puerto Rico) meet or exceed this 10% threshold. The overwhelming majority of these non-English language speakers speak Spanish; however, Chinese, Tagalog, and Navajo are present in a few counties in five states (specifically, Alaska, Arizona, California, New Mexico, and Utah). A full list of the affected U.S. counties in 2011 is included in Table 2 later in the *Preamble*, under the heading, ''IV. Economic Impact and Paperwork Burden'' or is available by "*clicking here*."

This guidance will be updated annually if there are changes to the list of the counties determined to meet this 10% percent threshold that are literate only in the same non-English language The annual updates can be found at: *http://www.dol.gov/ebsa/healthreform* and *http://cciio.cms.gov/*.

This amendment requires that **each notice sent by a plan *to an address in a county* that meets this threshold *include a one-sentence statement in the relevant non-English language*** about the availability of non-English language services. Plans may wish to flag the counties meeting the threshold where they send claims notices and make sure such notices have the non-English one-sentence sample notice. Plans are thus required to send such notices even if the plan knows the recipient does not speak the non-English language.

Sample sentences were contained in the relevant languages in the model notices contained in *Benefit News Briefs 2011-42*. The sample sentences are reproduced below:

SPANISH (Español): Para obtener asistencia en Español, llame al [insert telephone number].

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].

CHINESE (中文): 如果需要中文的帮助，**请拨打这个号码** [insert telephone number].

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].

The *Preamble* to these amended regulations states that for ease of administration, some plans may choose to use a one sentence statement for all notices within an entire State (or for a particular service area) that reflects the threshold language or languages in any county within the State or service area. For example, statewide notices in California could include the relevant one-sentence statement in Spanish and Chinese because Spanish meets the 10% threshold in Los Angeles County and 22 other counties and Chinese meets the 10% threshold in San Francisco County.

Some states with subscribers to Research Department publications meeting the 10% threshold necessitating use of the one-sentence non-English notice include:

State	County	% Spanish speakers
IA	Buena Vista County	12%
ID	Clark County	22%
ID	Minidoka County	11%
ID	Owyhee County	12%
ID	Power County	13%
IL	Kane County	15%
KS	Finney County	16%
KS	Ford County	23%
KS	Grant County	16%
KS	Hamilton County	11%
KS	Seward County .	26%
KS	Stanton County	19%
KS	Stevens County	11%
KS	Wichita County	12%
KS	Wyandotte County	10%
NY	Bronx County	20%
NY	New York County	10%
NY	Queens County	12%
NE	Colfax County	23%
NE	Dakota County	14%
NE	Dawson County	15%
NJ	Hudson County	18%
NJ	Passaic County	16%

In addition to including a statement in all notices in the relevant non-English language, this amendment requires a plan to provide a customer assistance process

(such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request.

For this purpose, plans are permitted to direct claimants to the same customer service telephone number where representatives can first attempt to address the consumer's questions with an oral discussion, but also provide a written translation upon request in the threshold non-English language.

Finally, this amendment removes any ''tagging and tracking'' requirement that would have otherwise applied under the July 2010 regulations. The ''tagging and tracking'' requirement would have required "tagging" anyone who requested a notice in another language and "tracked" them so any future notices were sent in that language.

5. Scope of the Federal External Review Process

The amendment suspends the original rule in the July 2010 regulations regarding the scope of claims eligible for external review for plans using a Federal external review process and **narrows the scope to claims** that involve **(1) medical judgment** (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or **(2) a rescission of coverage**.

The amended regulation provides numerous examples of situations in which a claim is considered to involve medical judgment. These include:

- The appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home health care versus rehabilitation facility);
- Whether treatment by a specialist is medically necessary or appropriate (pursuant to the plan's standard for medical necessity or appropriateness);
- Whether treatment involved ''emergency care'' or ''urgent care'', affecting coverage or the level of coinsurance;
- A determination that a medical condition is a preexisting condition;
- A plan's general exclusion of an item or service (such as speech therapy), if the plan covers the item or service in certain circumstances based on a medical condition (such as, to aid in the restoration of speech loss or impairment of speech resulting from a medical condition);
- Whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the plan's wellness program
- The frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline of the U.S. Preventive Services Task Force, the Advisory

Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in PHS Act Section 2713 and its implementing regulations); and

- Whether a plan is complying with the non-quantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.

6. Clarification Regarding Requirement That External Review Decision Be Binding

This amended regulation clarifies that, for purposes of the "**binding provision**" of external review decisions, the plan must provide benefits (including making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Technical Release 2011-02

Benefit News Briefs 2011-42 also mentioned *Technical Release 2011-02.* This Technical release changed the interim enforcement safe harbor regarding external review for self-insured plans subject to ERISA and/or the Internal Revenue Code to contracting with at least two accredited IROs and rotate assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection).

Specifically, to be eligible for a safe harbor from enforcement from the Department of Labor and the IRS, self-insured plans will be required to contract with at least **two IROs** by January 1, 2012 and with at least three IROs by July 1, 2012 and to rotate assignments among them.

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