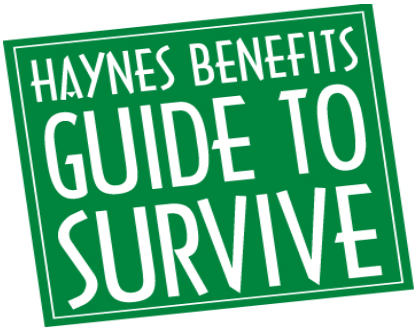

. . . Health Care Reform 2011

Amendments to the Internal Claims, Appeal and External Review Regulations

On June 22, 2011, the U.S. Departments of Health and Human Services, Labor and Treasury amended the interim final regulations relating to the internal claims, appeals and external review regulations under the Patient Protection and Affordable Care Act of 2010.

The regulations only apply to ***non-grandfathered*** insured and self-insured health plans.

The following changes, which are generally effective as of January 1, 2012, are intended to make these regulations more workable:

Urgent Care:

- Benefit determinations with respect to urgent care claims has been extended from 24 hours to 72 hours. Plans and issuers must defer to the attending provider's determination of whether a claim is for urgent care.

Diagnostic and Treatment Codes:

- Adverse benefit determinations will not need to include diagnostic and treatment codes and explanations of the meanings of these codes, but plans and issuers must disclose in writing that this information is available, upon request.

Scope of Federal External Review:

- The scope of the federal external review process for self-insured plans has been amended to clarify that external review does not apply to "eligibility for coverage" claim denials, but rather is limited to adverse benefit determinations that involve either medical judgment or rescission of coverage.

Federal External Review—Independent Review Organizations:

- Under the federal external review process, self-insured plans must contract with two independent review organizations ("IROs") by January 1, 2012, and three IROs by July 1, 2012, and randomly rotate among them in order to be eligible for a safe harbor. An

alternative method of the assignment of external review to IROs is permitted, provided the method is without bias and not subject to undue influence by the plan or issuer.

State External Review—Transition Rules:

- Under the state external review process, insured plans must satisfy certain transition rules to January 1, 2012 and from January 1, 2012 to January 1, 2014 comply with 13 temporary National Association of Insurance Commissioner standards. These standards include external review by one or more IROs.

Strict Adherence Rule; De Minimis Exception:

- The strict adherence rule, which permits a claim to be moved to external appeal for any violation of the internal claim rules, is relaxed to provide a de minimis exception.

Benefit Claims Payments After External Review:

- Benefit claims payments must be made after an external review allowing a claim, even if the plan or issuer intends to appeal for judicial review, unless a court orders otherwise.

Non-English Language Notices:

- Certain notices must be provided in a culturally and linguistically appropriate manner (i.e., in a non-English language) under certain circumstances. Under the amended regulations, non-English language notices only need to be provided to claimants in counties where ten percent or more of the population is literate in the same non-English language. HHS has provided a list of these 255 counties (9 of which are in Kansas and none of which are in Missouri). This list will be updated by HHS annually. If this requirement applies, oral language services need to be provided to claimants in these counties who are not literate in English, and the English version of all claims notices to claimants in these counties must include a statement in the non-English language describing how to access non-English language services.

While these changes may make compliance with these new claims procedures more workable, not being subject to these complex regulations is a significant advantage of maintaining grandfathered plan status.

Written by Thomas C. Graves
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