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Additional Clarifications Issued for Non-Grandfathered Plans

Recent guidance contains important clarifications on the internal appeals and external review processes applicable to group health plans that are not grandfathered under the Patient Protection and Affordable Care Act (PPACA). The guidance also addresses plan coverage of out-of-network emergency services.

Background

On July 23, 2010, the three agencies responsible for health care reform issued interim final regulations on the internal claims and appeals and external review requirements applicable to non-grandfathered group health plans. (See our August 11, 2010 *For Your Information*.) The agencies subsequently announced the availability of guidance detailing interim procedures for the federal external review process, and model notices for internal claims and appeals and for external review processes under PPACA. In conjunction with this guidance, the DOL issued Technical Release 2010-01, which sets out the details of an interim enforcement safe harbor applicable to non-grandfathered self-funded plans.

Last week, the agencies released additional guidance in the form of a series of Frequently Asked Questions (FAQs). Along with the FAQs, the DOL issued Technical Release 2010-02, which addresses certain issues related to internal claims and appeals.

The FAQs that address the "age 26" rule and the maintenance of grandfather status were the subject of our September 22, 2010 *For Your Information*.

Guidance on the Internal Appeals Process

Technical Release 2010-02 sets out an enforcement grace period until July 1, 2011 for compliance with some of the internal claims and appeals standards contained in the interim final regulations. The grace period, which is intended to give plans and issuers more time to implement procedures and make necessary changes to computer systems, applies to –

- shortening the timeframe for making the initial benefit determination involving an urgent care claim from 72 hours to 24 hours
- providing notices in a culturally and linguistically appropriate manner

- expanding the content requirements for adverse benefit determination or final internal adverse benefit determination notices
- applying the strict adherence standard to all the requirements of the interim final regulations.

BUCK COMMENT. *The FAQs clarify that the shortened timeframe for urgent care claims only applies to the initial benefit determination and that the timeframe for making internal appeals decisions involving these claims remains unchanged. The model notice of adverse benefit determination previously posted has been revised as of September 20, 2010.*

During the enforcement grace period, the DOL, IRS and HHS will not take any enforcement action against a plan that is working in good faith to implement the additional standards but does not yet have them in place. The technical release also notes that, if a plan takes good faith steps towards compliance, it would not have to report excise tax liability on IRS Form 8928 with respect to a failure to meet any of these particular standards.

Technical Release 2010-02 makes it clear that the enforcement grace period only applies to the new content requirements imposed by the interim final claims and appeals regulations and that plans subject to ERISA must continue to comply with the content requirements for claims notices prescribed in the current ERISA claims regulations. The FAQs also clarify that, under existing regulations, claimants may obtain upon request coding and other information relevant to the claimant's claim for benefits free of charge.

Guidance on the External Review Process

In addition to an enforcement safe harbor, Technical Release 2010-01 sets out interim procedures for self-funded plans with respect to the external review process. The FAQs provide a number of important clarifications regarding the review process including –

Insured Plans. Under the transitional relief provided in the interim final regulations, insured plans can use existing state external processes, in one of the states in which they operate, to comply with the new federal requirements. The FAQs note that this transitional relief is available both to plans in existence on March 23, 2010 and to new plans.

Enforcement Safe Harbor for Self-Funded Plans. The FAQs make clear that the enforcement safe harbor set out in Technical Release 2010-01 is simply a "safe harbor," and that plans whose external review processes fail to satisfy all of its standards will not necessarily be considered to be out of compliance. Rather, compliance will be determined on a case-by-case basis under a facts and circumstances analysis. As an example, the FAQs note that a plan that fails to contract with at least three independent review organizations (one of the enforcement safe harbor requirements) will not automatically violate the law as long as it can demonstrate that it took other steps to ensure it has an independent and unbiased external review process.

Contracting with Independent Review Organizations (IROs). Although Technical Release 2010-01 stated that a plan must contract with an IRO, the FAQs clarify that a plan may satisfy that requirement by contracting with a third-party administrator that, in turn, contracts with an IRO. In such circumstances, the contractual relationship does not automatically relieve the plan from responsibility if there is a failure to provide an individual with external review or relieve fiduciaries of ERISA plans of their duty to monitor plan service providers. The FAQs also note that plans may contract with an IRO even if it is located in a different state.

BUCK COMMENT. *Plan sponsors will need to confirm that the contract between their TPAs and the IROs contain the provisions required by Technical Release 2010-01. In particular, the plan sponsor should confirm that there is a mechanism to prevent an IRO that dealt with the claim previously from performing the external review. The sponsor should also consider adopting processes for routine monitoring of the review process.*

Guidance on Out-of-Network Emergency Service

Section 2719A of the Public Health Service Act prohibits non-grandfathered plans that provide benefits for emergency services from imposing out-of-network copayments or coinsurance requirements that exceed in-network levels. However, the law does not require plans to cover amounts that out-of-network providers may "balance bill" the patient. Interim final regulations issued in June, 2010 set minimum payment standards to ensure that a plan will not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply balance bill. (See our July 2, 2010 *For Your Information*.)

The FAQs clarify that a plan is not required to satisfy these payment minimums if state law prohibits balance billing or if the plan is contractually responsible for any amounts balance billed by an out-of-network emergency services provider. In both circumstances, the plan must provide individuals with adequate and prominent notice of their lack of financial responsibility for such amounts, to prevent inadvertent payment by the patient.

BUCK COMMENT. *The agencies have not issued model language for this notice requirement.*

Conclusion

While this new guidance provides some needed clarification, there are still many aspects of the health care reform which remain uncertain. Buck's consultants are available to work with you as you adapt your open enrollment communications and plan procedures to come into compliance with the new rules.