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HEALTH LAW ALERT
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Federal Agencies Ease Requirements for Appeals Procedures
Drop 24-Hour Urgent Care and Diagnosis Code Provisions
Foreign Language Notice Requirements Also Eased

On Friday, the Centers for Medicare and Medicaid Services ("CMS"), the Internal Revenue Service, and the Employee Benefits Security Administration (the "Agencies") jointly issued an amendment to the interim final rules concerning internal claims and appeals and external review processes under the Affordable Care Act (the "Amendment"). The Amendment eliminates controversial requirements obligating health insurance issuers (and other health plans) to process urgent care claims within 24 hours and to include in explanations of benefits ("EOBs") or other notices of adverse benefit determinations diagnosis codes and their corresponding meanings. The Agencies also will eliminate the requirement that a separate determination be made for each group health plan with respect to whether notices be provided in a non-English language. This Amendment applies to self-funded group health plans and group insurance coverage; it is not entirely clear whether it applies to individual insurance coverage (see box, next page).

Together with contemporaneously issued technical guidance, the Amendment also provides insurers greater flexibility in establishing external review procedures and provides some relief from the interim final rule's "strict adherence" requirement, which would have permitted claimants to qualify for external review or sue a health plan prior to exhausting the plan's internal appeals process as a result of any error in the process, no matter how small.

The Amendment goes into effect on July 22 and is published at 76 *Federal Register* 37208 (click here). Comments on the Amendment are due on or before July 25, 2011. Click here to see the CMS version of the Amendment incorporated into my compilation of Selected Federal Health Insurance Provisions (*see* first line under "Compiled Rules") (or see the "Resources" page at tbixbylaw.com). The Amendment and the original interim final rule apply **only** to **non-Grandfathered plans**.

Urgent Care Claims

Under the original interim final rule, insurers (and other health plans) would have been required to furnish notice of a benefit determination for an urgent care claim within 24 hours of receiving the claim. The Department of Labor's Claims Procedure Rule, which is the basis for these Affordable Care Act requirements, had previously required notice be provided "as soon as possible, taking into account the medical exigencies, but not later than

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72 hours after receipt of the claim." Under the Amendment, the Agencies fall back to this original Department of Labor standard—with "the 72-hour timeframe remain[ing] only an outside limit." The Amendment reiterates a requirement in the Claims Procedure Rule that a health insurance issuer (or other health plan) defer to the attending provider's decision in determining that a claim qualifies as an urgent care claim.

Diagnosis Codes

The interim final rule required insurers and health plans to include "the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning" in any notice of adverse benefit determination, such as an EOB. Under the Amendment, health plans are not required to "automatically provide" the codes, but must provide claimants the diagnosis and treatment codes upon request. The EOB (or other notice of adverse benefit determination) must provide claimants notice of this right.

The Agencies acknowledged that the diagnosis code requirement raised HIPAA Privacy Rule concerns because EOBs are often sent to the primary subscriber and may contain sensitive information about an adult dependent. Neither the Amendment nor the Agencies' discussion of the Amendment addresses how this privacy concern may be resolved when a claimant does request the diagnosis and treatment codes for an adult dependent.

Note that, under the original interim final rule, EOBs (and other notices of adverse benefit determination) must include a **denial code** and its corresponding meaning. This requirement was **not** changed by the Amendment and therefore remains in effect.

Non-English Language Notices

The original interim final rule required each group health plan (and a group health insurance issuer with respect to each group

Application to Individual Insurance Coverage

Although nothing in the preamble to the Amendment or in guidance published by the Agencies indicates health insurance issuers should treat individual health insurance coverage differently than group coverage, some key provisions in the Amendment itself apply only to group coverage.

The claims and appeals procedure rule that applies to health insurance issuers establishes requirements for **group** health insurance issuers in one subsection (45 C.F.R. § 147.136(b)(**2**)) and for **individual** health insurance issuers in another (45 C.F.R. § 147.136(b)(**3**)). While these provisions were very similar in the original interim final rule, the Amendment published on Friday affects only the **group** provisions—45 C.F.R. § 147.136(b)(**2**). Specifically, the following amended provisions apply only to group health insurance:

- Elimination of the 24-hour urgent care requirement;
- Elimination of the requirement to provide diagnosis code and corresponding meaning;
- Easing requirements for deemed exhaustion of plans' appeal processes.

This is probably an oversight by the Agencies. In any event, plans should keep an eye out for clarification from the Agencies on the subject.

health plan it covered) to determine whether a sufficient number of plan members were "literate only in the same non-English language" to trigger a requirement that non-English language notices be available for members of that plan. Moreover, once a member of one of these plans requested notice in a non-English language, all subsequent notices would have to be provided to that member in the relevant non-English language—a requirement the Agencies refer to as "tagging and tracking."

Under the Amendment, the Department of Health and Human Services (HHS) will identify counties in which 10% or more of the population is literate only in a non-English language. When sending a notice to any address in these counties, health plans (insured and self-funded groups and insured individual plans) will be required to provide (in the applicable non-English language) notice that the plan will make information resources available in the non-English language. Health plans must provide (and their notice must describe) (a) oral language services, including services to answer questions and provide help in filing claims and appeals, in the applicable non-English language, and (b) a translation of the notice into the applicable non-English language, upon request. The "tagging and tracking" requirement is eliminated, however. Accordingly, a health plan is not required to track which members are to receive non-English notices; rather, the health plan is required to provide a notice (such as an EOB) in a non-English language only when requested to do so for a specific notice.

The Agencies identify approximately 175 United States counties in which the non-English language requirement will apply and identify four non-English languages. Three counties meet the threshold for Navajo, two for Tagalog (in the Aleutian Islands), and one for Chinese (San Francisco). The remaining counties on the list (approximately 170) meet the threshold for Spanish.[1] HHS will update this information annually on its website. A list of the counties (organized by State) is available in the preamble to the Amendments (click here—see pages 37221-24).

External Review

Under the Amendment and other guidance issued at the same time as the Amendment, the Agencies provide States and health insurance issuers greater flexibility in coming into compliance with the Affordable Care Act's external review procedure requirements. The Affordable Care Act requires health insurers in the group and individual market (and, when applicable, group health plans[2]) to comply with the requirements of the State process in States that have an external review requirement that meets the standards of the National Association of Insurance Commissioners' (NAIC's) Uniform External Review

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[1] In addition, the Agencies identify all 78 Puerto Rico "municipos"—the equivalent of counties—as counties in which more than 10% of the population is literate only in Spanish.

[2] Group health plans subject to ERISA are not required to comply with State external review laws. Non-federal governmental plans, however, do not benefit from ERISA's preemption of State law and may, depending on the specifics of the applicable State law, be subject to a State's external review requirements.

Model Act. In States that do not have a process meeting the NAIC standards, health insurers and group health plans must implement "an effective external review process that meets minimum standards established by [HHS]."

State External Review Processes. Recognizing that "enacting State legislation and regulations can often be a complex and time-consuming process," the Agencies will extend until January 1, 2012 a grace period for States to establish a process that meets the NAIC standards (referred to in Agency guidance as an "NAIC Parallel process"). Thus, for the remaining 6 months of the grace period, health insurers (and, when bound by State law, group health plans) must comply with any State process in effect. Health insurers (and, when applicable, group health plans) must continue to comply with the State process in States deemed to have an NAIC Parallel process after the grace period ends.

In States that have external review processes that are close to meeting the NAIC standards—referred to in Agency guidance as "NAIC Similar processes" (see box, below)—health insurers (and, when applicable, group health plans) will be required to comply with the State process until January 1, 2014. Unless these States revise their processes to fully meet the NAIC standards by 2014, health insurers and group health plans in those States will thereafter be required to use a "federally administered" external review process.

HHS is to identify the State processes that fully meet the NAIC standards (that is, States that have NAIC Parallel processes) and State processes that come close to meeting the

"NAIC Parallel" and "NAIC Similar" Processes

A State external review process that will permanently meet the requirements of the Affordable Care Act (an NAIC Parallel process), must meet sixteen standards set out in the original interim final claims and appeals process rule. An "NAIC Similar process" must meet less-stringent (though "similar") requirements. An NAIC Similar process will only qualify to meet the Affordable Care Act's external review requirements through January 1, 2014. States must amend their processes to fully comply with the NAIC standards by that date or health insurers (and, when applicable, group health plans) will become subject to a Federal external review process. Some of the significant differences between the processes are listed below:

An NAIC Parallel process must:

- Provide response in 45 days
- Provide urgent care response in 72 hours
- Limit fee to $25/claim, $75/year
- Waive fee for financial hardship
- Refund fee if claimant wins

An NAIC Similar process must:

- Provide response in 60 days
- Provide urgent care response in 4 days
- Limit fee to $25/claim

Click here to review the technical guidance describing an NAIC Similar process (see list beginning on page 5).

NAIC standards (that is, NAIC Similar processes) by July 31 in order to give States and affected health insurers (and affected group health plans) sufficient time to implement applicable external review procedures.

Federal External Review Processes. Under previous guidance, group and individual health insurers subject to the Federal external review process were required to submit to a process administered by the Office of Personnel Management. ERISA plans, on the other hand, could establish their own external review processes, either meeting the requirements of a Department of Labor safe harbor or meeting standards established by the Department of Labor (a "private accredited IRO process"). Group and individual health insurers (as well as non-Federal governmental self-funded group health plans) that are required to comply with the Federal external review process (because no State process qualifies under standards discussed above) now may elect to either (a) establish a private accredited IRO process under the Department of Labor safe harbor (or standards) or (b) work through the Office of Personnel Management process. Click here to see technical guidance concerning election of a Federal External Review Process.

Exhaustion of Plan's Appeal Process

The original interim final rule provided that a claimant would be deemed to have exhausted a health plan's internal claims and appeals process, and so could immediately pursue external review or available remedies under ERISA or applicable State law, if the health plan "fail[ed] to strictly adhere to all of the requirements" of the original interim final rule, including strict compliance with the Department of Labor's Claims Procedure Rule. Under this provision, any error in the process, even if the error did not prejudice the claimant, would give the claimant cause to abandon a plan's internal claims and appeals process. The Amendment revises this provision, but nevertheless permits claimants to claim exhaustion for minor defects a plan's process.

Under the Amendment, a claimant is deemed to have exhausted a plan's internal claims and appeals process if the plan "fails to adhere to all of the requirements" of the amended final rule, including strict compliance with the Department of Labor's Claims Procedure Rule, unless:

- The violation is *de minimus*,
- The violation does not cause (and is not likely to cause) prejudice or harm to the claimant; and
- The health plan demonstrates that the violation:
    - Was for good cause or due to matters beyond the plan's control;
    - Occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant; and

- Was not part of a pattern or practice of violations by the plan.

If the plan believes a violation does not give the claimant cause to deem the internal process to be exhausted, the plan must provide the claimant a written explanation of the violation and a "specific description" of why it meets the above criteria, upon request.

Model Notices

Due to the Amendment and accompanying technical guidance, the Agencies revised various model notices they had published last year, including a model notice of adverse benefit determination. The model notices are posted in an appendix to technical guidance. Click here for the technical guidance (see pages 11-16).

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