CONNER STRONG

Legislative Update

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Regulations Released on Internal Appeals and External Review Processes Related to Health Insurance Reform

The various rules related to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (national health insurance reform) continue to be issued by the various federal regulators almost on a daily basis. This will likely continue for the foreseeable future due to the enormity of the new Reform Act. One of the latest set of rules issued is related to the appeal process for non-grandfathered plans (click here to review grandfather plan definition and rules). The intent of these latest interim final rules set the parameters and requirements for non-grandfathered group health plans and health issuers related to uniform internal appeals and the new external review processes. Under the new rules, insured plan sponsors may generally rely on their insurance companies for compliance. That is, for insured plans the insurance companies will have to ensure their appeal processes are compliant with the new law.

While self-insured plans can now start to evaluate and implement the new rules for internal claims and appeals, they must wait for guidance on the federal external review standards. The rules generally apply to group health plans and group health insurance issuers for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans), but **do not** apply to grandfathered plans.

In addition to ERISA's claims and appeal rules, non-grandfathered plans must make the following required changes and notify plan participants of them before the rules take effect the first plan year beginning on or after September 23, 2010:

· **Faster Determinations for Urgent Care** - All plans must notify claimants of benefit determinations for "urgent care" within 24 hours of receipt of claims, unless claims have insufficient information.

· **Greater, More Timely Disclosures for Adverse Determinations** -If during the course of reviews, reviewers (the insurer or for self funded plans, the claims administrator) produce or obtain new or additional evidence for the claims, they must provide it to claimants as soon as possible but well in advance of adverse benefit determinations so that claimants have the opportunity to respond before the deadline. Reviewers must do the same if they will be basing their decisions on new or additional rationales to give claimants sufficient opportunity to respond. Reviewers may not charge claimants fees to provide the information.

· **New Notice Requirements** - Plans must provide notices to claimants in culturally and linguistically appropriate language, defined using Department of Labor (DOL) standards for summary plan descriptions. The DOL requires notices in a non-English language when the lesser of 500 people or 10% of plan participants do not speak English and they only speak that language. In addition, plans must include certain additional information in notices. The federal agencies will soon issue model notices that will satisfy the notice requirements under these interim final regulations.

· **Federal External Review Process for Self-Funded Plans** - The current regulation did not include specific requirements in this area. Guidance on the federal external review process requirements for **non-grandfathered,** self-insured plans is expected in the near future.

· **External Review Process for Insured Plans (and Self-Funded Multiple Employer Welfare Plans (MEWAs), State and Local Government, and Church Plans)** - These provisions apply to plans currently subject to state external review requirements (not preempted by ERISA). The provisions include a transition period that will end on July 1, 2011. During the transition, current state requirements apply and the federal government will work with states individually to assure uniform state requirements for external review beginning July 1, 2011. However, plans must comply with federal external review requirements if state external review results are not binding on plans or state requirements do not meet minimum National Association of Insurance Commissioners (NAIC) standards for external review.

You can also review the White House official fact sheet on the new rules for more information.

Employers and plan sponsors will need to carefully review all of their plan materials to ensure compliance with these new requirements.

As more information becomes available, we shall distribute it to our customers. As always, if you have any questions regarding the latest on national health insurance reform, visit the health reform section on our website or **contact your Conner Strong account representative at 1-877-861-3220.**

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