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More Guidance on Claims and Appeals Requirements for 2011

One of the many consequences of the Patient Protection and Affordable Care Act (as amended by the Health Care and Education Reconciliation Act of 2010) (together, the "Act") is that group health plans and health insurers have new internal claims review requirements, and also are now required to have an external review process. In our July 29, 2010 Alert, we summarized interim final regulations the agencies issued regarding these new claims and appeals requirements.

As we noted, the July regulations primarily affect insured group health plans by making them comply with state external review processes (and mandating certain minimum elements of such state processes). However, self-insured plans are not subject to state insurance laws, and so the guidance issued with the

July regulations stated that future guidance would be forthcoming on what the federal requirements would be for self-insured plans. Last week, the agencies implementing the Act issued guidelines and model notices establishing these federal claims and appeals procedures.

Self-insured group health plans will want to carefully review the guidance and perhaps customize the model notices to conform to their operations. Plan sponsors should consult with their legal advisors and third party administrators to ensure careful compliance. In general, however, self-funded plans should know:

- Self-insured group health plans have been granted an interim enforcement safe harbor until further notice.
- In order to avoid penalty during the enforcement safe harbor, a self-insured group health plan must either (a) comply with the standard and expedited external review procedures detailed in the guidance (which are based on the new state minimum procedures), or (b) voluntarily comply with a state process (assuming that the state is willing to allow access to its external review process).
- The agencies intend to issue additional guidance in the future with model language for the plan's SPD, describing the plan's new internal claims and appeals and external review procedures.

These new requirements will almost certainly require a group health plan to amend its claims and appeals language, modify its administrative forms, educate its fiduciary appeals committee, and probably modify its services agreements.

This is one of the areas of healthcare reform where it will be important for a plan to decide whether it wants to keep its "grandfathered status" -- grandfathered plans are exempt from the new claims and appeals procedures. If not grandfathered, a group health plan operated on a calendar-year basis will need to be in compliance on January 1, 2011.

For assistance, or if you have questions about any other employee benefit matters, please contact a member of our Benefits Law Group.

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