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DOL Grants Certain Group Health Plans Relief by Extending Non-Enforcement Period for Internal Claims and Appeals Requirements

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The Department of Labor extended its non-enforcement period, until plan years beginning after December 31, 2011, for certain internal claims and appeals requirements under the Patient Protection and Affordable Care Act (PPACA) that apply to non-grandfathered group health plans.[1] The internal claims and appeals requirements are among PPACA's most significant and controversial changes. If a non-grandfathered plan fails to comply with these requirements in any respect – no matter how insignificant – claimants will be deemed to have exhausted their administrative remedies and may go directly to court. The extension of the non-enforcement period for some of these requirements is welcome news for employers; however, because this extension is likely the final delay, employers should be working diligently to comply with them.

The remainder of this Client Alert discusses PPACA's internal claims and appeals requirements and the new non-enforcement period.

PPACA's Internal Claims and Appeals Requirements

PPACA requires non-grandfathered group health plans to have an effective internal claims and appeals process. On July 23, 2010, the DOL issued interim final regulations,[2] applicable to plan years beginning after September 22, 2010, that require the following changes[3] to internal group claims and appeal procedures for non-grandfathered group health plans:

1. *Coverage Rescissions*. A coverage rescission must be included in the scope of adverse benefit determinations eligible for internal claims and appeals, even if the coverage rescission does not have an adverse impact on any particular benefit.[4]

2. *Urgent Care Determinations*. Urgent care claim benefit determinations (whether or not adverse) must be made within 24 hours of claim receipt (rather than the 72 hours permitted under existing ERISA regulations).

3. *Full and Fair Review.* The plan must permit claimants to review the claim file and present evidence and testimony as part of the internal claims and appeals process (although it is unclear whether in-person testimony is required). In addition, the plan must provide claimants with any new or additional evidence considered, relied upon or generated by or at the direction of the plan; such evidence must be provided to the claimant as soon as

possible and sufficiently before the due date for the benefit determination to give the claimant a reasonable opportunity to respond before that date. Before the plan issues a final adverse benefit determination based on a new or additional rationale, the plan must provide the new or additional rationale to the claimant as soon as possible and sufficiently before the due date for the final benefit determination[5] to give the claimant a reasonable opportunity to respond before that date.

4. *Conflicts of Interest*. The plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the impartiality and independence of the persons involved in decision making. Decisions regarding hiring, compensation, termination, promotion and similar matters for any such persons must not be based on the likelihood that the individual will support benefit denials.

5. *Notices.* Notices of adverse benefit determinations must be provided in a "culturally and linguistically appropriate manner" and must contain: (a) information sufficient to identify the claim involved, including date of service, health care provider, claim amount, diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning; (b) the denial code and its corresponding meaning and the plan's standard, if any, that was used in denying the claim; (c) a description of internal and external review processes, including how to initiate an appeal; and (d) contact information for any applicable state office of consumer health assistance or ombudsman established under the PPACA to assist individuals with internal claims and appeals and external review processes.[6]

6. *Noncompliance*. If a plan fails to comply with any of the above requirements, the claimant is deemed to have exhausted his or her administrative remedies and may file an ERISA lawsuit, calling into question whether benefit claims will be adjudicated under the standard abuse of discretion standard of review.[7]

Non-Enforcement Period

These interim final regulations are very controversial and were heavily criticized by employers and health insurance issuers. One of the strongest criticisms was that the effective date of the regulations did not provide plans, employers and insurers enough time to adjust their claims procedures and policies to conform to the regulations.

On September 20, 2010, the DOL issued Technical Release 2010-02 to give employers and insurers more time to comply with these requirements. Specifically, the release indicated that prior to July 1, 2011, neither the DOL nor the Treasury Department[8] would take enforcement action against a plan for failing to comply with the shorted time frame to respond to urgent care claims described in 2 above, the notice requirements described in 5 above or the non-compliance consequences described in 6 above, provided the plan was working in good faith to implement the new requirements.

On March 18, 2011, the DOL issued Technical Release 2011-01, which extends until plan years beginning after December 31, 2011, the non-enforcement period for failing to comply with the shortened time frame to respond to urgent care claims described in 2 above, the non-compliance consequences described in 6 above, and the requirements described in 5 above to provide notices in a culturally and linguistically appropriate manner and to automatically disclose diagnosis and treatment information. The non-enforcement period for the other requirements described in 5 was extended until plan years beginning after June 30, 2011.

Practice Pointer: *Because the compliance extension does not apply to private litigants, most plan sponsors will want to implement the new requirements as soon as possible in order to maximize the chances of having a court determine benefit claims under an abuse of discretion standard of review.*[9]

NOTE: The interim final regulations also require non-grandfathered health plans to provide an effective external review process, including self-insured plans that historically have been exempt from such requirements traditionally imposed by state laws. Technical Release 2010-01 sets forth an interim safe harbor compliance method for non-grandfathered group health plans that are not subject to a state external review process that is applicable for plan years beginning after September 22, 2010 until superseded by future guidance.[10] *The non-enforcement periods of Technical Releases 2010-02 and 2011-1 do not apply to the external review requirement.*

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[1] These rules do not apply to grandfathered plans. *See* Section 1251 of the Patient Protection and Affordable Care Act, Public Law 111–148, and Section 2301 of the Health Care and Education Reconciliation Act, Public Law 111–152.

[2] 29 C.F.R. § 2590.715-2719.

[3] Group health plans subject to ERISA have been long been required to maintain internal claims and appeals procedures that satisfy various requirements. *See* ERISA §§ 503; 29 C.F.R. § 2560.503-1*, et seq*.

[4] For example, an employee misrepresents the number of hours she works for the months of January and February and obtains coverage in error during that time, but does not incur any claims. Beginning in March, the number of hours the employee works reaches the threshold for plan eligibility. If the employer rescinds coverage for January and February (when no claims were incurred) and reinstates coverage beginning in March, such a rescission is considered an adverse benefit determination and may be challenged by the employee even though no actual adverse impact will result.

[5] An important outgrowth of this new requirement, which allows a claimant to respond to a new reason for denying a claim in the final level of appeal, may be that compliance precludes application of the Ninth Circuit's en banc decision in *Abatie v. Alta Health & Life Ins. Co*., 458 F.3d 955 (9th Cir. 2006) (holding that "an administrator that adds, in its final decision, a new reason for denial, a maneuver that has the effect of insulating the rationale from review, contravenes the purpose of ERISA. This procedural violation must be weighed by the district court in deciding whether Alta abused its discretion.").

[6] The DOL has published model notices of adverse benefit determination in English and Spanish, which are available at www.dol.gov/ebsa/IABDModelNotice2.doc. In addition, Technical Release 2011-01 includes an Appendix listing states with consumer health assistance offices or ombudsmen established under the PPACA.

[7] DOL Reg. § 2590.715-2719(b)(2)(ii)(F). The regulation states that if a claimant decides to pursue remedies under ERISA 502(a), then the claim or appeal is "deemed denied." Prior DOL claims regulations from 1977 included such language and courts concluded that because a deemed denial did not involve the exercise of discretion, the claim was subject to a de novo standard of review. DOL Reg. § 2560.503-1 (1977). It is unclear whether the DOL intends to reinstate this approach.

[8] Section 9815 of the Internal Revenue Code of 1986 as amended (the "Code") requires group health plans to comply with PPACA's market reforms, including the internal claims and appeals requirements, unless they are grandfathered plans. Code Section 4980D imposes excise taxes for violations of this requirement, and the tax generally is assessed on the employer maintaining the plan. These taxes are self-reported and paid on IRS Form 8928.

[9] The DOL states in a footnote that the non-enforcement period is not binding on private litigants.

[10] The safe harbor generally provides that a plan will comply with these requirements as long as it meets one of two methods of compliance. The first is to adopt the procedures provided in Technical Release 2010-1, which are based on the external review standards under the NAIC Uniform Model Act in place on July 23, 2010. The second method is to voluntarily comply with a state external review process for a state that has expanded it to include self-insured plans.