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## LIMITED RELIEF ON NEW CLAIMS AND APPEALS PROCEDURES

Responding to questions and comments from health plan sponsors and insurers, the agencies charged with enforcing the Affordable Care Act (the "Act") have answered several frequently asked questions concerning the Act's implementation. The bulk of these FAQs involve the Act's more stringent claims and appeals procedures for non-grandfathered health plans. Collectively, these FAQs provide welcome -- though still limited -- relief to plan sponsors who are scrambling to comply with these new claims and appeals requirements within the next few months.

As explained in our [September 2010 article](#), the Department of Labor ("DOL") published detailed guidelines on these requirements in its Technical Release 2010-01. In Question 8 of the recent FAQs, the DOL notes that those guidelines were intended to provide a "safe harbor" from enforcement by the federal agencies. Plans that do not satisfy all of those standards may still be found to comply with the statutory requirements, under a "facts and circumstances analysis" to be conducted on a case-by-case basis.

The example given in the FAQs involves a plan that does not contract with three independent review organizations ("IROs") and then rotate external appeal assignments among those IROs on a random basis. So long as such a plan is able to demonstrate that other steps were taken to ensure that its external review process is independent and without bias, the failure to comply with these specific requirements would not be in violation of the Act.

The FAQs also note (in Question 9) that a plan need not contract directly with three different IROs. Instead, a plan may contract with a third-party administrator that then contracts with three IROs. This is likely to be the more common pattern for self-funded plans, at least for those that do not have an in-house claims paying capability.

The FAQs do caution, however, that this approach does not relieve a plan from responsibility if there is a failure to provide an individual with an appropriate external review. Moreover, fiduciaries of ERISA plans have an ongoing duty to monitor the services provided by IROs.

In connection with the issuance of Technical Release 2010-01, the agencies announced that self-funded plans could voluntarily comply with a state's external review procedures for fully insured plans.

Because some states do not mandate such external reviews, however, some plans have found it difficult to locate IROs within their state. In Question 10 of the recent FAQs, the DOL makes clear that plans are free to contract with IROs located *outside* of their state.

Another ambiguity arising from Technical Release 2010-01 involved the deadline for responding to an appeal following the denial of an "urgent care" claim. Although the Release made clear that the deadline for ruling on an urgent care *claim* was being shortened from 72 hours to 24 hours, it did not specifically address the prior, 72-hour deadline for responding to an *appeal* of such a claim. Question 11 of the recent FAQs notes that the 72-hour deadline remains in place for urgent care appeals.

The DOL has also revised its "Model Notice of Adverse Benefit Determination" to clarify the 24- and 72-hour deadlines that will now apply to urgent care claims and appeals. This [revised notice](#) carries a revision date of September 20, 2010.

Finally, the DOL has recognized that many plans and insurers simply cannot meet the tight deadline for complying with several of the standards set forth in Technical Release 2010-01. As a part of the recent FAQs (Question 12), the DOL has announced an enforcement grace period for certain of those standards. This grace period is outlined in an additional Technical Release (No. 2010-02).

Technical Release 2010-02 explains that, until July 1, 2011, the agencies charged with enforcing the Act's more stringent claims and appeals procedures will not require full compliance with the following four standards, as announced in Technical Release 2010-01 -- so long as a plan or insurer is working in good faith to implement those standards:

- Standard # 2 (imposing the 24-hour deadline for ruling on urgent care claims),
- Standard # 5 (requiring that notices be provided in any foreign language that is used by a significant percentage of plan participants),
- Standard # 6 (requiring broader and more specific content in denial notices), and
- Standard # 7 (requiring strict compliance with all of the regulatory requirements)

The DOL emphasizes that this latest relief is not a license for plan sponsors or insurers to cease their efforts to comply with the new claims and appeals procedures. Accordingly, sponsors and insurers of non-grandfathered plans will want to continue their efforts to come into compliance.

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