BULLETIN

THE SEGAL COMPANY

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ERISA CLAIMS AND APPEALS REGULATIONS FINALIZED

The Department of Labor (DOL) recently published a long-awaited final rule governing claims and appeals procedures for ERISA-governed health and disability plans.[1] The final rule establishes a complicated structure for health and disability benefit claims and appeals that will require significant revisions to plan documents, procedures and operations.[2] The new rule is applicable for claims filed under a plan on or after January 1, 2002. (There is no delayed effective date for collectively bargained plans or Taft-Hartley plans.) Highlights of the new rule include the following:

- **Claims procedures differ by claim type.** For health plans, the rule sets forth different procedures and timeframes for decision-making depending on whether a claim is an "urgent care claim" (72 hours), a "pre-service claim" (15 days) or a "post-service claim" (30 days). Brief extensions of time are permitted for pre-service and post-service claims, but not for urgent claims. Claims for disability benefits must be decided within 45 days and plans may extend the time period twice up to a maximum of 105 days total. This rule applies even if the disability benefit is being paid from a pension plan.

- **The time periods for deciding claims begin to run at the time the claim is filed, regardless of whether the claim is complete.** If the time period for deciding pre-service, post-service or disability claims is extended due to a claimant's failure to submit necessary information, the plan's deadline is delayed from the date on which notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

- **New participant communications are required**. Group health plans must give a claimant (or his or her authorized representative) notice if he or she has failed to follow the plan's procedures for filing a pre-service claim. Notice must be provided as soon as possible, but not later than 5 days for non-urgent pre-service claims and 24 hours for urgent pre-service claims. Moreover, in addition to information required currently, the explanation of benefits (EOB) provided to the participant or beneficiary when a health or disability benefit is denied must include a copy of any internal rule, guideline, protocol or other similar criterion relied upon in making the decision or a statement that the criterion was relied upon and a copy is available free or charge upon request. If the adverse benefit determination is based on medical necessity or experimental treatment exclusions, the EOB must contain either an explanation of the scientific or clinical judgment or a statement that such explanation will be provided free of charge upon request.

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[1] The Final Regulations were published in the *Federal Register*, Vol. 65, No. 225 (November 21, 2000). The DOL also published a final rule governing the content of summary plan descriptions.

[2] The Segal Company is preparing a more complete discussion of the rules in an issue of our publication *In Depth*. To request the January 2001 *In Depth*, "DOL's Final Rule on Claims and Appeals Establishes a Complicated Structure for Health and Disability Plans," contact your Segal Company consultant.

- **There are new requirements for claims procedures.** The regulation requires that a plan's claims procedures include administrative safeguards and processes designed to ensure and verify that benefit claims determinations are made in accordance with governing plan documents and are applied consistently with respect to similarly situated claimants.

- **State laws governing claims reviews are not preempted under the rule unless the state law prevents the application of the rule.** In addition, the DOL states that a state "external review" law would not be preempted so long as the external review is conducted by parties other than the insurer, the plan, its fiduciaries, the employer or any agent of the above.

- **If a participant or beneficiary is receiving approved treatment, the plan's "concurrent review" program must provide notice and an opportunity to appeal before approved benefits are terminated**. Requests for an extension of approved benefits for urgent care must be decided within 24 hours.

- **For group health plans, claimants must have at least 180 days to file an appeal.** Urgent appeals require an expedited review process and must be decided within 72 hours. If a plan has one level of appeal, pre-service claim appeals must be decided within 30 days, and post-service claims within 60 days. If the plan has two levels of appeal, the first notification of determination must be provided within 15 days for pre-service claims and 30 days for post-service claims.

- **Rules outline who will conduct appeals and how they should be conducted.** The rule permits plans to continue to have two mandatory levels of appeal, rather than one. This allows one appeal to be decided by an insurer or administrator, and a second appeal to be decided by the plan sponsor For group health plans, appeals must be conducted without giving deference to the initial adverse decision ("*de novo*"), and must be decided by a fiduciary who did not make the initial adverse decision (and is not a subordinate of the person who made the decision). For Taft-Hartley plans, the final rule permits decisions on appeal to be made by the Board of Trustees at a quarterly meeting, except in the case of "urgent care" and "pre-service" appeals. For all plans, the rule permits mandatory arbitration of benefit claims under certain circumstances.

- **When an appeal involves a medical judgment, the appropriate named fiduciary must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.** The health care professional does not need to be independent, but must not have been consulted regarding the initial adverse determination, or be a subordinate of the person whose judgment is being reviewed.

- **For all plans, the appeals procedure must provide the claimant access to all relevant information**. "Relevant" information includes information relied upon, submitted, considered or generated in the appeals process, or information that demonstrates compliance with the appeals administrative process and safeguards. For group health plans, relevant information includes statements of policy or guidance concerning the treatment option or benefit (whether or not relied upon in the appeal).

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As with all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their attorneys for authoritative advice on the interpretation and application of these rules. The Segal Company can be retained to work with plan sponsors and their attorneys to review their current claims and appeals procedures or to introduce new claims and appeals procedures.

THE SEGAL COMPANY							www.segalco.com
ATLANTA	(678) 306-3100	HARTFORD	(860) 678-3000	NEW ORLEANS	(504) 483-0744	SAN FRANCISCO	(415) 263-8200
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