APPEALS

What does PPACA say about appeals?

Health care reform says that the appeals process must include an external appeal. The review must follow a state's external review law. If there is no state external review law, health insurance carriers must have independent organizations that meet federal rules review their appeals.

July 22, 2010 – HHS Releases Final Interim Guidance

On July 22, the Departments of Treasury, Labor and Health and Human Services jointly released Interim Final Rules enhancing a plan's claims and appeals process.

Back in 2000, the Department of Labor issued regulations - for all ERISA health plans - with the intent to ensure timely decisions regarding urgent and non-urgent care, as well as to ensure appropriate notification to plan participants of their appeal rights. **The regulations issued on July 22, 2010, generally add six new requirements to those already in the existing internal claims procedures regulation.**

These are interim final rules (IFRs), which means final rules may eventually differ, but these rules are final in the interim.

General highlights of new regulations:

- The regulations generally require compliance with the existing ERISA Department of Labor (DOL) regulations governing claims and appeals. All group and individual plans must comply with the existing ERISA DOL regulations, even if the plan is not subject to ERISA.
- The rules under the newly released interim final regulations apply to group health plans, insurance issuers offering group health insurance coverage and individual policies.
- Grandfathered plans are exempt for as long as they remain grandfathered.
- Plans must adopt the regulations on the first plan anniversary on or after September 23, 2010
- Coverage Pending Outcome of Appeal - Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. This is consistent with existing DOL regulations.
- Linguistically and Culturally Appropriate - Group plan relevant notices must be provided in a foreign language upon request if the employer's employee population meets certain threshold requirements of non-English speaking employees. And a foreign language statement - offering the non-English version - must be included in all English language notices. Once a person has requested a non-English notice, all future notices to that person must be in the non-English language.

- Individual Plans - Notices must be provided in a foreign language upon request if a certain percentage of the population residing the individual's county are literate only in the same non-English language. HHS will provide further guidance on this requirement.

External Review
(Requirements vary)

- State Laws - Plans must comply with state external review requirements as applicable. States have a transition period until July 1, 2011 to amend their laws to satisfy federal requirements; in the interim the state law continues to apply.
- Federal Law - Where a state law does not exist or is not applicable, plans must comply with a federal external review process - this is not detailed in the regulations. However the regulations state that the federal requirements will be similar to those in the NAIC Uniform Model Act. Additional guidance is forthcoming.
  The agencies may deem the external review processes that were in operation on 3/23/10 are in compliance with the Affordable Care Act requirements, either permanently or temporarily.

Claims and Appeals Process
The regulations establish six new requirements in addition to the existing DOL regulations:

1. The definition of "adverse benefit determination" was revised to include rescission of coverage.
2. The notification of determination (approval or denial) for a claim involving urgent care must be made within 24 hours after receipt (as opposed to 72 hours under the existing regulations), if all necessary information has been received.
3. The requirements clarify existing requirements that the plan or issuer must provide to the claimant, free of charge, any new or additional evidence considered, relied upon, or generated in connection with the claim prior to a decision.
4. All claims and appeals must be judged in a manner designed to ensure the independence and impartiality of the person making the decision.
5. A notice of denial must include information sufficient to identify:
   - The claim involved
   - Reasons for denial
   - Documentation of the appeal and review processes
   - Contact information for any applicable office of health insurance consumer assistance or ombudsman.

Regulators will issue model notices that can be used to satisfy all the notice requirements under the regulations in the very near future.

6. If the plan does not strictly adhere to all internal claim and appeals processes, the claimant is deemed to have exhausted the process and can proceed to external review and pursue other remedies under the law.

<u>Additional Requirement for Individual Plans</u>

In addition to the above requirements, there are three additional requirements for individual policies only:

1. The existing DOL claim and appeal regulations also apply to "initial eligibility determinations." Note: The existing ERISA regulations specifically do not apply to eligibility determinations.
2. Individual plans are only permitted to have one level of internal appeals, after which the individual can proceed to an external review.
3. Records of all claims and notices associated with the internal claim and appeal process must be maintained for at least 6 years.

June 24, 2011 – Internal and External Claims and Appeals Amendment

On June 22, 2011, the Departments of Health and Human Services (HHS), Labor, and the Treasury released amendments to the Interim Final Regulations for internal claims and appeals and external review processes under the Patient Protection and Affordable Care Act (PPACA). The amendments apply to non-grandfathered individual insurance policies as well as non-grandfathered insured and self-insured group health plans. At the same time, the Department of Labor published Technical Release 2011-02 providing further guidance on external review.

Below is a summary of the relevant changes:

- Diagnosis and procedure codes are no longer required on all denial notices. Instead, denial notices must identify the opportunity to request this information and it must be provided if requested by the claimant.
- Language thresholds will be determined based upon the claimant's county of residence rather than by employer. If a county meets the established threshold for a given language, a statement in the relevant non-English language(s) about the availability of language services must be included in denial notices. The requirement to translate notices into languages other than English is met if language assistance services are provided to enrollees. Some notices must still be translated, but only if requested by the claimant.
- The timeframe for benefit determinations on an urgent care claim has been changed back to 72 hours instead of 24 hours.
- Claimants cannot proceed directly to external review for violation of any of the internal review process requirements if the violation is "de minimis," (i.e., did not cause and is not likely to cause prejudice or harm to the claimant's right to external review). This is provided that the plan or insurer demonstrates the violation was for good cause or due to matters beyond its control and occurred in the context of an ongoing and good faith exchange with the claimant.
- The model notices for initial and final internal adverse benefit determinations and external adverse benefit determinations have been revised.
- For external reviews initiated on and after September 20, 2011, the scope of claims eligible for the Federal External Review process is narrowed (at least temporarily) to those involving medical judgment and rescission of coverage. Those involving only contractual or legal interpretation are excluded.
- By July 31, 2011, HHS intends to issue determinations regarding each state's compliance with either (i) "NAIC-parallel" external review process standards (i.e., standards meeting all the consumer protections in the NAIC Uniform Model Act), or (ii) temporary "NAIC-similar" process standards established by the Departments. Existing state external review processes are deemed compliant until December 31, 2011. By January 1, 2012, non-federal government self-insured plans and insurers must have implemented for each state an external review process that complies with:

1. the state's "NAIC-parallel" process standards;
2. the state's temporary "NAIC-similar" process standards, or
3. a federally administered external review process if HHS has determined that the state's process complies with neither the "NAIC-parallel" nor "NAIC-similar" standards.

If a state's external review process does not meet "NAIC-parallel" standards by January 1, 2014, the federally administered external review process must be used for that state.