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# **PPACA Regulations: Internal & External Appeals**

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**American Benefits Council Call**

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# Regulations

- Published July 23, 2010.
- Comments due September 21, 2010.
- Applies to non-grandfathered plans (n/a to grandfathered plans).
- Applies to individual and group coverage (insured & self-funded).

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# New Internal Claims & Appeals Rule

- Six Changes (according to agencies)
  - Definition of “adverse benefit determination”
  - Urgent Care Timeframe
  - Appeals Procedure (Documents to Review)
  - Conflicts of Interest
  - Denial Notice Content
  - Strict Adherence
  - Plus: Continued Coverage Upon Appeal

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# Builds on Existing DOL Claims Procedure Rules

- Extends DOL rules to non-ERISA & individual plans.
- Preamble says DOL expects to issue future regulations with “additional, more comprehensive updates” to existing regulations.
- New rules apply in addition to DOL rules, but only to group health plans. (So other plans, such as pension, life, disability still only subject to original DOL rules.)

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# Refresher:

## DOL Claims Regulations

### Initial Claims Deadlines

- Urgent – as soon as possible taking into account medical exigencies, but no later than 72 hours.
- Pre-Service – reasonable time appropriate to medical circumstances, but no later than 15 days (plus 15-day extension).
- Post-Service – reasonable time, but no later than 30 days (plus 15-day extension).
- Concurrent – if approved ongoing course of treatment, any reduction to be sufficiently in advance to allow claimant to appeal before benefit reduced. Request to extend treatment within 24 hours (for urgent) or regular post-service period (non-urgent).

### Appeals Deadlines

- Only two levels allowed, no extensions.
- Urgent – as soon as possible taking into account medical exigencies, but no later than 72 hours.
- Pre-Service – reasonable time appropriate to medical circumstances, but no later than 30 days (15 days each if two levels).
- Post-Service – reasonable time, but no later than 60 days (30 days each if two levels).

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## Refresher:

# DOL Claims Regulations - Appeals

- 180 days to file appeal (for group health plans).
- Claimant may provide written comments, documents, or other information.
- Claimant may request “relevant” documents from plan.
- Review must be de novo (no deference to initial claim) and conducted by individual not involved in initial claim.
- If medical judgment involved, must consult health care professional with appropriate experience who was not involved in initial claim.

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## Refresher:

# DOL Claims Regulations – Notices

- Reason for denial with reference to specific plan provision.
- Additional information necessary to perfect claim and why information necessary.
- Description of appeal procedures and time limits.
- Right to bring civil action under ERISA.
- If internal rule, guideline, or procedure relied upon, either rule or statement that available upon request.
- If based on medical necessity or experimental treatment exclusion, either explanation or statement that available upon request.
- Statement of right to request relevant documents (appeal denial notice).
- Description of any voluntary appeal procedure (appeal denial notice).

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# New Internal Appeals Rule

## Change #1 - Scope

- Defines “adverse benefit determination” same as DOL rules.
  - DOL regulations apply to “claims for benefits,” not just inquiries or claims involving eligibility.
- Also applies to rescissions.
- For individual coverage, applies to initial eligibility claims, too.



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# New Internal Appeals Rule

## Change #2 – Urgent Claims

- Timeframe for urgent care claims reduced from 72 hours to 24 hours.
- Regulations references “claim” section, not appeal, so uncertain whether new rule applies to both?

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# New Internal Appeals Rule

## Change #3 – Review Procedure

- Plan must provide, free of charge, any new or additional evidence considered, relied upon, or generated in connection with claim.
- Must be provided as soon as possible and sufficiently in advance of appeal decision deadline to give claimant opportunity to respond prior to deadline.
- Before plan can base decision on new or additional rationale, must provide claimant with rationale sufficiently in advance of deadline to allow opportunity respond.
- Appears to be automatic (not just upon request).

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# New Internal Appeals Rule

## Change #4 – Conflicts

- Plan must ensure claims and appeals adjudicated in manner with independence and impartiality of persons involved.
- Decisions involving hiring, compensation, and promotion must not be based on likelihood individual will support denial.
- Example: Plan cannot pay bonus based on number of denials or contract with medical expert based on reputation for outcomes.

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# New Internal Appeals Rule

## Change #5 – Denial Notices

- Must be provided in culturally and linguistically appropriate manner.
- New Content
  - Date of service, provider, & claim amount.
  - Diagnosis code, treatment code, & denial code (& meanings).
  - Standard used in denying claim (for example, if medical necessity, must include description of standard).
  - Description of internal and external appeals.
  - Contact information for office of health insurance consumer assistance or ombudsman.
- Agencies to issue model.

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# New Internal Appeals Rule

## Change #6 – Strict Adherence

- If plan fails to “strictly adhere” to all requirements, claimant is deemed to have exhausted internal claims and appeals process.
- May initiate external review or go to court.
- Applies regardless of whether plan “substantially complied” or whether error was “de minimis.”

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# New Internal Appeals Rule

## Continued Coverage

- Plan must provide continued coverage pending outcome of internal appeal.
- Regulation says plans must comply with DOL regulations related to concurrent care.
- Somewhat unclear what this means or whether this rule only applies to concurrent care claims.

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# New Internal Appeals Rule

## Linguistically Appropriate Notices

- Fewer than 100 participants – Must provide non-English notice upon request if at least 25% of plan participants are literate only in same non-English language.
- 100 or more participants - Must provide non-English notice upon request if lesser of at least (1) 500 participants or (2) 10% of plan participants are literate only in same non-English language.
- For individual coverage – applies if at least 10% of population in claimant's county are literate only in same non-English language.
- Also must include prominent statement in English version (in non-English language) offering notice upon request and provide future notices to that claimant in non-English language. If maintain customer assistance, must maintain in non-English language, too.

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# External Review - Overview

- Plans must comply with either a State external review process (if applicable) or a new Federal external review process
  - IFR provides set of rules for determining when plans and issuers must comply with applicable state external review process or new Federal external review process
  - Provides minimum requirements for qualifying state external review processes with transitional rule
  - Leaves unanswered specifics on new Federal process, but indicates it will look very similar to rules for qualifying state processes
  - Gives HHS Secretary authority to deem external review processes in effect as of March 23, 2010 as compliant
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# External Review – Applicable Process

- IFR provides set of rules for determining when plans and issuers must comply with applicable state external review process or new Federal external review process
  - For self-insured group health plans –
    - If ERISA-governed, then will need to apply Federal external review process
    - If not ERISA-governed (such as church and governmental plans), then likely subject to existing or future state external review process; if none applies, then look to new Federal process

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# External Review – Applicable Process

- IFR provides set of rules for determining when plans and issuers must comply with applicable state external review process or new Federal external review process
  - For insured group health plans and individual insurance policies –
    - Need to apply existing or future qualifying state external review process; if none applies, then need to look to new Federal process
    - IFR makes clear that, with respect to an insured group health plan, the obligations contained in the IFR generally fall on the issuer, not the plan

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# External Review – State Process

- A qualifying state external review process is one that is “binding” on an issuer AND, at a minimum, includes the specific consumer protections in the NAIC Uniform Model Act as set forth in the IFR
  - Note: Although generally only applies to insured arrangements, likely to be framework for future Federal process
    - PHSA section 2719(b)(2) requires the Departments to establish standards for the Federal process that are “similar to the external appeals process that meets the standards in these regulations”
  - IFR “encourages” states to establish qualifying external review processes
    - “The Departments prefer having States take the lead role in regulating health insurance issuers, with Federal enforcement only as a fallback measure”

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# External Review – State Process

- **To be a qualifying state external review process, the following from the NAIC Uniform Model Act must be included –**
  - Provide for external review of “adverse benefit determinations” based on medical necessity, appropriateness, setting, level of care, or effectiveness
  - Require issuers to provide effective written notice to claimants of external review rights
  - Make exhaustion of internal claims and appeals process unnecessary where (i) issuer waived exhaustion requirement, (ii) claimant has exhausted under applicable law, or (iii) claimant has applied for expedited external review process at time of expedited internal appeal

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# External Review – State Process

- **To be a qualifying state external review process, the following from the NAIC Uniform Model Act must be included – (cont'd)**
  - Prohibit the establishment of a minimum dollar threshold for a given claim to be eligible for external review
    - For example, a \$500 minimum claims threshold cannot be permitted
  - Require that claimants be provided at least four months from notice of adverse benefit determination to request external review
  - Require issuers to include a description of the external review process in the SPD “or” other evidence of coverage that it provides to claimants
    - Must be substantially similar to that as set forth in section 17 of the Uniform Model Act

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# External Review – State Process

- **To be a qualifying state external review process, the following from the NAIC Uniform Model Act must be included – (cont'd)**
  - A state must be required to maintain a list of approved IROs
    - State process must only allow for approval of IROs that are accredited by a nationally recognized private accrediting organization
  - IROs must be assigned on random basis or “another method ... that assures the independence and impartiality of the assignment process”
    - Example: rotational assignment
    - In no event may issuer, plan or claimant choose the IRO

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# External Review – State Process

- **To be a qualifying state external review process, the following from the NAIC Uniform Model Act must be included – (cont'd)**
  - Issuer or state must pay for the cost to conduct the external review
    - Cannot require claimant to pay
    - State may impose nominal filing fee of \$25 per claim unless it would result in undue financial hardship; but not to exceed \$75 annually
  - Require the IRO to allow the claimant to submit additional information in writing and require such IRO to consider that information as part of the external review process
    - Must require that claimants be noticed of this right
    - Must require information submitted to be forwarded to the issuer

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# External Review – State Process

- **To be a qualifying state external review process, the following from the NAIC Uniform Model Act must be included – (cont'd)**
  - Require that IROs have no conflicts of interest that will influence its independence
    - IRO may not own or control, or be owned or controlled by a health insurance issuer; group health plan, plan sponsor; trade association of plans, issuers, or health care providers generally (*i.e.*, NOT claim specific)
    - The selected IRO and clinical reviewer may not have a “material professional, familial, or financial conflict of interest” with respect to the various stakeholders (*i.e.*, claim specific)
  - Make the decision of the IRO “binding” on the plan or issuer, as well as the claimant (except to extent of other remedies)
    - Does this mean cannot extend coverage if later decide to do so?



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# External Review – State Process

- **To be a qualifying state external review process, the following from the NAIC Uniform Model Act must be included – (cont'd)**
  - Require IROs to maintain written records and make them available upon request to the State
    - Similar to section 15 of NAIC Model Uniform Act
  - Require that procedures be followed for external review of adverse benefit determinations involving (i) experimental, or (ii) investigational treatment, “substantially similar” to that set forth in section 10 of the NAIC Uniform Model Act

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# External Review – State Process

- **To be a qualifying state external review process, the following from the NAIC Uniform Model Act must be included – (cont'd)**
  - Regarding standard external review –
    - IRO must provide written notice within no more than 45 days after receipt of request for external review
    - IRO must provide written notice to issuer and claimant of decision
  - Regarding expedited external review –
    - Must provide for expedited review in (i) certain situations where the claimant has received emergency services, but has not yet been discharged, or (ii) where standard review process would “seriously jeopardize the life or health of the claimant” or his or her ability to regain “maximum function”
    - IRO must make decision “as expeditiously as possible”, but within 72 hours, and must notify claimant and issuer of determination

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# External Review – Transition

- Provides transitional rule for state external review processes
  - For plan years beginning before July 1, 2011, an applicable state external review process is considered to be compliant
  - The state external review process is “considered binding” on applicable plans and issuers (such as non-ERISA plans and insured plans and issuers), in lieu of Federal process
    - If no applicable state review process, then will need to comply with Federal process
  - For adverse benefit determinations provided after the first day of the first plan year beginning on or after July 1, 2011, the Federal process applies unless state program is determined to be compliant by HHS

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# External Review – Federal Process

- New Federal review process
  - Contours unknown; guidance expected in “near future”
  - It “will be very similar” to the process set forth in the NAIC Uniform Model Act and will meet the standards issued by the [HHS] Secretary”
    - IFR expressly states that standards will include all of the criteria that apply to compliant state external review processes, including requirement that decisions of IRO be “binding”
    - May require external review reporting requirements for IROs
    - Will establish additional notice requirements regarding new process
  - Will apply to any “adverse benefit determinations”, except with respect to claims based on the claimant’s eligibility for participation under the terms of a group health plan

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# External Review – HHS Certification

- HHS Secretary may certify existing external review processes as compliant
  - Applies to processes with respect to both group health plans (both insured and self-insured) and individual insurance
  - Appears to only apply to processes “in operation” as of March 23, 2010
  - How to apply? When? What is required?
    - Many questions, few answers in the IFR
    - IFR does indicate the process must “substantially meet[]” the requirements applicable to compliant state external review processes or the TBD Federal review process

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# Questions?