

July 28, 2010

## MEMORANDUM TO CLIENTS

**RE: PPACA Appeal Process Changes – Interim Final Rule**

The Patient Protection and Affordable Care Act ("PPACA") requires non-grandfathered plans to make two potentially significant changes to their appeal process, imposing a new requirement for an external review and making changes to the internal appeal provisions that plans already have in place. On July 22, 2010, the Departments of Treasury, Labor, and Health and Human Services jointly released Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes ("IFR" or "Rule") under PPACA. 75 Fed. Reg. 43,330 (July 23, 2010). The IFR applies to group health plans, insurance issuers offering group health insurance coverage, and insurance issuers offering individual policies, but does not apply to grandfathered plans. (The IFR will be codified in 26 C.F.R. Parts 54 and 602, 29 C.F.R. Part 2590, and 45 C.F.R. Part 147.)

The Rule provides guidance on the new, mandatory external review process required under the PPACA and makes certain changes to the existing standards for internal claims and appeals. These changes generally will apply to plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans). Comments are due by September 21, 2010.

**I. External Review Standards**

Some insured plans already are subject to State external review programs, but those that are not, and those that are subject to State external review requirements that do not meet certain standards, will be required to comply with Federal external review requirements. The Rule provides a basis for determining when plans and issuers must comply with an applicable State external review process and when they must comply with the Federal external review process. Significantly, the Rule does not establish specific guidance for Federal external review. The Rule's preamble states that more specific guidance will be issued in the "near future."

**A. State Standards for External Review**

Insured (individual and group coverage) and non-ERISA self-funded plans (such as state and local governmental plans and church plans) that are subject to a state external review program that meets that NAIC Uniform Model Act must comply with the State external review and not the Federal external review process. Under the Rule, consistent with the consumer protections in the NAIC Uniform Model Act, the State external review must:

- Apply to decisions involving medical necessity, health care setting, level of care and effectiveness of a covered benefit;
- Allow exceptions to any exhaustion requirement consistent with the appeals rules;
- Provide for the issuer to pay the cost of an independent review organization to conduct the external review (subject to nominal filing fee for an individual);
- Not impose a minimum dollar amount on the claim;

- Allow four months for filing the external appeal;
- Establish rules that apply to the assignment and independence of the independent reviewer;
- Be binding on the issuer or, if applicable, the plan; and
- Provide for expedited review of certain claims.

**B. Federal Standards for External Review**

Insured and self-funded ERISA plans that are not subject to a State external review process, or are subject to a State external review process that does not meet the consumer protection standards in the NAIC Uniform Model Act, must comply with the Federal external review process. The Rule states that the standards for the Federal external review process will be similar to the NAIC Uniform Model Act process, and will provide –

- A description of how a claimant may initiate an external review;
- Procedures for preliminary review to determine whether a claim is subject to external review, minimum qualifications for the Independent Review Organization or "IRO";
- A process for approving IROs to conduct external reviews, and a process for random assignment of external review to approved IROs;
- Standards for IRO decisionmaking;
- Rules for providing notice of final decisions;
- Expedited review requirements to protect the health of the claimant;
- Consumer protections to ensure that adequate clinical and scientific experience and protocols are considered for claims involving experimental or investigational treatments;
- Additional notice requirements describing the Federal external review procedures; and
- Requirements to give claimants information relevant to the processing of the external review, including the information considered and relied upon in making the adverse benefit determination of final internal adverse benefit determination.

The Federal external review standards also will provide that the external review decision is binding on the plan or insurer and the claimant, subject to judicial review, and may establish external review reporting requirements for IROs.

The agencies indicated they will issue more guidance in the near future on the Federal process. In particular, the agencies will address how non-grandfathered, self-insured group health plans that currently maintain an internal appeals process that otherwise meets the Federal external review standards may comply or be brought into compliance with the requirements of

the new Federal external review process. The agencies may deem an external review process of a group health plan or health insurance issuer, in operation as of March 23, 2010, to be compliant with the rules.

## **II. Internal Claims and Appeals**

Section 2719 of the Public Health Service Act ("PHSA"), as added by the PPACA generally requires health plans and insurers offering group or individual health insurance to implement an effective appeals process for appeals of coverage determinations and claims. In addition to the Department of Labor ("DOL") claims regulation requirements that already are applicable to group health plans, the IFR provides that plans and insurers must:

- Have in effect an internal claims appeals process;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes and the availability of any applicable office of health insurance consumer assistance or ombudsman established to assist with the appeals processes;
- Allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process; and
- Provide an external review process for such plans and issuers that, at a minimum, includes the consumer protections provided in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners.

Group health plans and health insurance issuers offering group health insurance coverage must comply with all the requirements applicable to group health plans under the current DOL claims regulation, in addition to several new requirements discussed below. The DOL claims regulations, which currently applies only to ERISA plans, will also apply directly to issuers (including with respect to individual coverage), as well as governmental and church plans.

### **A. Continued Coverage**

Under the IFR, a plan or issuer must provide continued coverage pending the outcome of an internal appeal. For this purpose, the plan and issuer must comply with the current ERISA claims procedure regulations, which generally provide that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. (It is not clear whether this rule applies only to concurrent care claims or whether plans could suspend payment until the claim is processed.) Certain individuals will be permitted to proceed with an expedited external review at the same time as the internal appeals process.

### **B. Adverse Benefit Determination**

The Rule broadens the definition of adverse benefit determination to include any rescission in coverage, which generally means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent that it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. The Rule does not appear to extend to

claims for eligibility alone (that are not tied to a claim for benefits), except with respect to individual coverage, the rule expressly covers eligibility determinations as well.

**C. Expedited Notice for Urgent Claims**

The Rule reduces the 72-hour notification period for urgent claims under the current DOL claims regulation to 24 hours. Specifically, the Rule requires notice of benefit determinations (whether adverse or not) for urgent care claims as soon as possible, but no later than 24 hours after the receipt of the claim, unless the claims fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance coverage.

**D. Additional Claimant Rights**

The Rule provides that a plan or issuer must allow a claimant to review his or her claim file and to present evidence and testimony as part of the internal claims and appeal process. The plan or issuer must give the claimant (it appears automatically and not just upon request) free of charge, any new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim. This information must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to give the claimant a reasonable opportunity to respond prior to that date. Similarly, before the plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free or charge, with the new or additional rationale. This must occur as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to give the claimant a reasonable opportunity to respond prior to that date. (So, it appears that plans must provide this material during the ongoing appeals process.)

**E. Conflicts of Interest**

Under the Rule, claims and appeals must be adjudicated in a manner designed to ensure the independence and impartiality of the person involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will deny benefits.

**F. Notice Requirements**

The Rule imposes new notice requirements and requires such notices to be provided in a culturally and linguistically appropriate manner. Notices will be considered to be provided in a culturally and linguistically appropriate manner if they are provided in a non-English language in accordance with certain thresholds based on the number of people literate in the same non-English language. The thresholds are based on the number of participants in a plan for group health plans and on the number of residents in the county for the individual market.

Additionally, any notice of adverse benefit determination or final internal adverse benefit determination must include: (1) the date of service, (2) the health care provider, (3) the claim amount (if applicable), (4) the diagnosis code (such as an ICD code or DSM-IV code), (5) the treatment code (such as a CPT code), and (6) the corresponding meaning of such codes. The denial codes (such as a CARC and RARC) must also be included, along with a description of the

plan's or issuer's standard, if any, used in denying the claim. The above information must be provided in addition to the content already required to be included in a denial notice in the existing DOL claims regulation.

Notices of final internal adverse benefit determinations must also include a discussion of the decision, plus a description of available internal appeals and external review processes, including information regarding how to file an appeal and information regarding any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes. Model notices will be issued by the agencies.

**G. Individual Coverage**

Health insurance issuers offering individual health insurance coverage must comply with all of the requirements for the internal claims and appeals process that apply to group health coverage discussed above. In addition, under the Rule, (1) initial eligibility determination for individual health insurance coverage are included in the scope of the initial claims and appeals process, (2) individual policies may have only one level of internal appeals (unlike group health plans which may have second level), and (3) issuers of individual policies must maintain records of all claims and notice associated with their internal claims and appeals process for at least six years.

**H. Non-Compliance**

The Rule also provides that where a plan or issuer does not "strictly adhere" to these requirements, the claimant will be deemed to have exhausted the internal claims and appeals process and may immediately initiate an external review or pursue any available remedies, such as judicial review. The Rule states that this "strict adherence" rule applies even where a plan or issuer has "substantially complied" or where an error was *de minimis*. This new standard is a departure from the existing DOL claims regulation, where the regulators had looked to substantial compliance (and appears to establish a different standard for health and non-health plans).

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Authors: Lonie A. Hassel, Cheryl Risley Hughes, Christy A. Tinnes and Will E. Wilder

If you have any questions, please contact your regular Groom contact or any of the attorneys listed below:

Jon W. Breyfogle	jbreyfogle@groom.com	(202) 861-6641
Jenifer A. Cromwell	jcromwell@groom.com	(202) 861-6329
Elizabeth T. Dold	edold@groom.com	(202) 861-5406
Thomas F. Fitzgerald	tfitzgerald@groom.com	(202) 861-6617
Lonnie A. Hassel	lhassel@groom.com	(202) 861-6634
Cheryl Risley Hughes	chughes@groom.com	(202) 861-0167
Christine L. Keller	ckeller@groom.com	(202) 861-9371
Tamara S. Killion	tkillion@groom.com	(202) 861-6328
Mark C. Nielsen	mnielsen@groom.com	(202) 861-5429
William F. Sweetnam, Jr.	bsweetnam@groom.com	(202) 861-5427
Christy A. Tinnes	ctinnes@groom.com	(202) 861-6603

Kevin L. Walsh  
Will E. Wilder  
Brigen L. Winters

kwalsh@groom.com  
wwilder@groom.com  
bwinters@groom.com

(202) 861-5433  
(202) 861-6640  
(202) 861-6618