Agencies Release PPACA Claims/Appeals Regulations

This is the eleventh issue in our series of alerts for employers on selected topics in health care reform. (Click here to access our general summary of health care reform and other issues in this series). This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

Interim final regulations were recently issued implementing the claims/appeals requirements of the Patient Protection and Affordable Care Act (PPACA). The regulations apply to group health plans as well as to group and individual health insurance issuers for plan or policy years beginning after September 23, 2010. The new regulations do not apply to grandfathered plans; however, the Department of Labor is considering further updates to existing claims/appeals procedures and the revised procedures may apply to grandfathered plans.

The regulations explain the requirements of a two-step process which includes an internal claims/appeals process as well as an external review process.

Internal Claims/Appeals Process

Group health plans that are subject to ERISA have long been familiar with the claims/appeal process provided in regulations issued by the Department of Labor (DOL). The new health reform regulations expand on the DOL regulations, add several new requirements and extend application of the requirements to non-ERISA group plans and to issuers of individual health insurance.

The regulations add the following new requirements:

- “Adverse Benefit Determination” Expanded to Include Rescission. The definition of “adverse benefit determination” is expanded to include rescission of coverage. As defined in other health reform regulations, a rescission is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent that it results from a failure to timely pay required premiums or contribution towards the cost of coverage.

- Urgent Care Claims Response Time Shortened. The interim regulations shorten the time period for responding to a claim involving urgent care from 72 hours to 24 hours.
• Providing Claimants With Information On New Evidence or Rationale. Plans will be required to automatically provide a claimant, free of charge, with any new or additional evidence considered, relied on or generated by the plan in connection with the claim. This evidence must be provided as soon as possible and sufficiently in advance of the date the plan must provide notice of its decision on the appeal. In addition, before the plan can issue an adverse benefit determination on review based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date the plan must provide notice of its decision on appeal. Presumably this will allow the claimant time to respond to the new evidence or rationale before a decision is made on the claim/appeal.

• Avoiding Conflicts of Interest. To ensure the integrity of decisions and avoid conflicts of interest, decisions on hiring, compensation, termination, promotion, etc. cannot be based on the likelihood that the individual (e.g., a claims adjudicator or medical expert) will support a claim denial. For example, a plan cannot provide bonuses based on how many denials are made by a claims adjudicator.

• Denial Notice Requirements. The new regulations require plans to provide notices to enrollees in a “culturally and linguistically appropriate” manner. This means that plans covering fewer than 100 participants must provide notices on request in a non-English language if 25% or more of the plan participants are literate only in that same non-English language. For plans that cover 100 or more participants, the threshold is the lesser of 500 or 10% of plan participants. Plans to which these thresholds apply must also include a statement in the English versions of all notices offering to provide the notice in the non-English language. Once a request has been made by a claimant to receive notice in the non-English language, all subsequent notices provided to that claimant must be provided in that language. If the plan maintains a customer assistance service (such as a hotline) that answers questions about or assists with claims and appeals, the plan must provide assistance in the non-English language.

Denial notices must also comply with the following:

• Any notice of an adverse benefit determination must include information sufficient to identify the claim involved, including the date of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

• The notice of adverse benefit determination not only must include the reason for the adverse determination, but must include the denial code and its corresponding meaning, as well as a description of the plan’s standard, if any, used in denying the claim. The notice of denial on a final appeal must include a discussion of the decision.

• The plan must provide a description of available internal appeals and external review processes, including information on how to initiate an appeal.

• The plan must provide information on how to contact any applicable consumer assistance established under the Public Service Health Act to assist individuals with the claims process.

Model notices will be issued soon that can be used to satisfy the notice requirements.

• Deemed Exhaustion of Internal Claims/Appeals Process. Under the new regulations, if a plan fails to strictly adhere to all of the requirements of the internal claims/appeals process, the claimant will be deemed to have exhausted
the internal claims/appeals process, regardless of whether the plan asserts that it substantially complied with the requirements or that any error committed was de minimis. In this case, the claimant can initiate an external review or pursue judicial review and the claim or appeal will be deemed denied on review without the exercise of discretion by a plan fiduciary. This will permit a court to review the claim on a de novo basis without deference to any decision previously made by a plan fiduciary.

The Department of Labor expects to issue future regulations that will propose additional, more comprehensive updates to the standards that apply to the internal claims/appeals process. It is possible that these new regulations will also apply to grandfathered plans.

As noted above, the new internal claims/appeals requirements apply for plan years beginning on or after September 23, 2010, but it is unclear from the guidance whether these requirements will apply to pending claims for which no final determination has been made when the new requirements take effect.

External Review

The interim regulations require a system that will provide claimants with either a state or federal external review process for plan years beginning on or after September 23, 2010. The state review process will apply to insured plans and all group health plans not subject to ERISA. The federal process will apply to self-insured employer-sponsored plans that are subject to ERISA and to all insured and non-ERISA plans in situations where no state process is in place or where the state process does not meet applicable guidelines.

The external review process will be built on standards established by the National Association of Insurance Commissioners (NAIC) and contained in the NAIC’s Uniform Health Carrier External Review Model Act (NAIC Model Act). Many states already have some type of external review process in place. States that have not already adopted an external review process that includes the protections provided in the NAIC Model Act are encouraged to take action before July 1, 2011.

The state process will be required to include the following:

- Written notice by plans or issuers to claimants concerning their rights to an external review
- Requirements related to the exhaustion of an internal claims/appeal process
- Payment by the issuer or plan of the cost charged by the independent review organization for conducting the review, but a nominal filing fee of up to $25 may be charged to the claimant
- No restrictions on the minimum dollar amount for a claim to be eligible for external review
- A period of at least four months for the claimant to file a request for an external review
- Impartial independent review organizations without conflicts of interest and that are assigned on a random basis or another method that assures the independence and impartiality of the assignment process
- Maintenance of a list of approved independent review organizations based on the nature of the health care service that is the subject of the review
- A requirement that the decision of the independent review organization be binding on the issuer or plan and the claimant, except to the extent other remedies are available under state or federal law
• Expedited review of claims within 72 hours where the standard review time frame would jeopardize the life or health of the claimant

• A requirement that a description of the review process be provided in or attached to the summary plan description, policy, membership booklet or other evidence of coverage

A plan that is not subject to a state external review process will be required to provide a federal external review process related to adverse benefit determinations. The federal external review process will not apply, however, to determinations related to failure to satisfy a plan’s eligibility requirements for participation. Although the new regulations provide a framework for the federal external review process, additional guidance will be forthcoming.

The federal process will be built on the NAIC Model Act and will describe how a claimant may initiate a review, who is eligible for the review process, and the standards that will apply to the independent review organization that will conduct the reviews. The federal process will also set notice requirements for plans describing the federal review process, such as inclusion of information about the process in summary plan descriptions.

**Employer Action Plan for Non-Grandfathered Plans**

• Revise claims/appeals procedures to include the new 24-hour timeframe for responding to urgent care claims.

• Contact your claims administrators to make sure that they are ready to comply with the new requirements.

• Watch for additional guidance related to the applicable state or federal external review process.

*For further details, or if you have any questions regarding the new claims/appeals requirements, contact your Seyfarth Shaw LLP attorney or any Employee Benefit attorney listed on the website at [www.seyfarth.com/employeebenefits](http://www.seyfarth.com/employeebenefits), or send your questions to HealthReform@seyfarth.com.*