PUBLICATION

Interim Final Rules Issued on Claims Appeals under PPACA

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The U.S. Department of Health and Human Services (DHHS), the Department of Labor (DOL) and the Treasury (IRS) (collectively "the Departments") have issued separate but complementary rules on internal claims and appeals and external appeals for group health plans and health insurance issuers under PPACA.

The purpose of Public Health Service Act Section 2719 and these rules is to "ensure that plans and issuers implemented more uniform internal and external claims and appeals processes and to set a minimum standard of consumer protections that are available to participants, beneficiaries, and enrollees."

Currently, internal claims review and appeals applicable to ERISA plans are set forth in 29 CFR 2560.503-1. PHS Act section 2719 requires plans and issuers providing group health coverage to initially incorporate these DOL processes and update the processes with standards established by the DOL. Issuers of individual health insurance coverage must implement the processes established by state law but will then be required to update the processes with those established under these rules by DHHS.

PHS Act Section 2719 also calls for a system for application of either a state external review process or a federal external review process. These interim final rules address a system of applicable minimum standards for a state external review process. Until July 1, 2011, a transition period will apply for applicable plans and issuers subject to an existing state process. During the transition period, DHHS will work with the states to assist them in incorporating additional consumer protections which will continue to apply after the transition period. Once the transition period ends, states must either comply with those provisions or group health plans and health insurance issuers will be subject to the federal external appeals process.

Plans and issuers (including self insured plans) which are not subject to an existing state external review process will be subject to the new federal external review process effective for plan years beginning on or after September 23, 2010. The interim final rules set forth the scope of claims eligible for review under the federal external review process and will establish the standards "through guidance" for that process. It is expected to be similar to the state external review process set forth in these interim final rules. These rules outline some of the elements of the federal process. The rules also set forth the notice requirements for both the internal claims and appeals and external review process which will be required to be communicated in a "linguistically and culturally appropriate manner."

DHHS also reiterates and preserves the Departments' authority to deem external review processes in operation on March 23, 2010 to be in compliance with the requirements of PHS Act section 2719 either permanently or temporarily (the grandfathered status). These interim final rules will not apply to grandfathered health plans – certain plans and issuers offering group and individual health insurance coverage which meet the grandfather health plan definition under PPACA.

Internal Claims and Appeals Process

First, the interim final rules provide that both group health plans and health insurance issuers are subject to the DOL internal claims and appeals procedure regulation. ERISA plans already must comply with these standards. In addition, the interim final rules set forth six additional requirements which include:

1. a broader definition of "an adverse benefit determination" to include a rescission of coverage;
2. the notice requirement for an urgent care claim benefit determination not later than 24 hours after the receipt of the claim;
3. additional requirements to assure "full and fair review;"
4. new criteria to avoid "conflicts of interest;"
5. new standards regarding notice to enrollees regarding adverse benefit determinations to include the reasons for the denial, identification of the specific claim in issue, dates of service, health care provider, claim amount and diagnosis code, treatment code and its meaning, the appeals processes (both internal and external) and contact information for consumer assistance or the ombudsman; and
6. the claimant's right to claim exhaustion of the internal claims and appeal process when the plan or issuer fails to adhere to the requirements contained in the DOL rules as updated.

Second, in addition to the new requirements, a plan and issuer will be required to continue coverage pending the outcome of an internal review and appeal. This includes allowing for advance notice and an opportunity for advance review before benefits can be terminated. For urgent care claims, where the individual is undergoing ongoing treatment, an expedited review process must be provided at the same time as the internal appeals process under either a state external review process or a federal external review process.

These processes will also generally apply to the individual market as well. There are certain distinctions for those health insurance issuers who are not involved in the group market but only offer individual health insurance coverage. These issuers of individual coverage will have to comply with three additional requirements:

7. The issuer must apply the internal and appeals processes to cover initial eligibility determinations for health insurance coverage. With the prohibition against preexisting condition exclusions going into effect for policy years on or after September 23, 2010, for children under 19 and for all others for policy years on or after January 1, 2014, this is an important requirement.
8. Only one level of appeal is allowed so that claimants can quickly move to the external review process or judicial appeal; and,
9. Issuers must maintain records of all claims and notices with the internal claims and appeals processes for at least 6 years and make them available for examination upon request. A claimant or state or federal agency official may request and receive the documents free of charge. HIPAA and other privacy rules will apply to any request.

External Review Processes

The interim final rules set forth the minimum consumer protections, taken from the NAIC Uniform Model Act, that must apply for a plan or issuer to be subject to a state external review process. There are 16 consumer protection standards set forth in the rules for an external review process and these are minimum standards.

The interim final rules also set forth the basis for determining when the state versus the Federal external review process applies. The federal external review process applies to ERISA plans.

Further, any plan or issuer not subject to a state external review process must comply with the federal external review process. However, if an issuer provides health insurance coverage that is subject to an applicable state external review process that provides minimum consumer protections in the NAIC Uniform Model Act, then it will not have to comply with the federal external review process. The regulations clarify when the issuer, as opposed to the plan, must satisfy the external process obligations. When the issuer provides the health insurance coverage, the issuer has the obligation to provide the external review process.

DHHS will determine if the state process meets the minimum necessary consumer protection standards but during a transition period the state process may be treated as satisfying the requirements. DHHS has already determined certain state processes that don't meet the criteria. The PPACA also provides a mechanism for the Departments to consider the process "as determined appropriate." For those that don't fall in that category, the states will have an opportunity to amend their existing laws and be treated as meeting at least the minimum standards, at least until July 1, 2011. Thus for policy plan years beginning before July 1, 2011, a health insurance issuer subject to an existing state external process must comply with the state and not the federal process. After July 1, 2011 the process that applies will depend on the type of coverage and whether the state process is determined to meet the minimum consumer protection standards. The date of the final internal adverse benefit determination will determine what process will apply.

The interim final rules permit application of the state external review process on a self insured group health plan when ERISA preemption does not preclude a state external review process from applying, such as in the case of a nonfederal governmental plan and church plans not covered by ERISA preemption or a multiple employer welfare arrangement which can be subject to both ERISA and state insurance laws.

An additional NAIC Uniform Model Act provision not addressed in the regulations is the required scope of an applicable state external review process. Some states do not apply their existing external review process to all types of health care coverage. The Departments are encouraging states to amend their existing laws to apply to all types of coverage. In the absence of that change the federal review process will apply as a "fallback measure." However, the Departments are seeking comments on or before September 21, 2010 on whether the federal external review process should apply to all plans and issuers in states that do not adopt a universal state external review process for all issuers that are not ERISA preempted.

For additional information about the interim rules or for assistance in submitting comments, contact your Baker Donelson attorney or any of the attorneys or advisors in our Health Reform group.