U.S. Department of Health and Human Services

Office of Consumer Information and Insurance Oversight
Washington, D.C. 20201

DATE: SEPTEMBER 20, 2010

SUBJECT: INTERIM PROCEDURES FOR INTERNAL CLAIMS AND APPEALS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

BACKGROUND:

The Patient Protection and Affordable Care Act (the Affordable Care Act), Public Law 111-148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (the Reconciliation Act), Public Law 111-152, was enacted on March 30, 2010. The Affordable Care Act and the Reconciliation Act reorganize, amend, and add to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans.

The Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments) have been issuing regulations in several phases to implement the revised PHS Act sections 2701 through 2719A and related provisions of the Affordable Care Act. Section 2719 of the PHS Act applies to group health plans and health insurance coverage that are not grandfathered health plans within the meaning of section 1251 of the Affordable Care Act.[1] It sets forth standards for plans and issuers regarding both internal claims and appeals and external review. The Departments published interim final regulations implementing PHS Act section 2719 on July 23, 2010, at 75 FR 43330 (the interim final regulations).

On September 1, 2010, HHS issued "Technical Guidance for Interim Procedures for Federal External Review Relating to Internal Claims and Appeals and External Review For Health Insurance Issuers in the Group and Individual Markets under the Patient Protection and Affordable Care Act." This document, "Interim Procedures for Internal Claims and Appeals under the Patient Protection and Affordable Care Act" sets forth an enforcement grace period for compliance with certain new provisions with respect to internal claims and appeals.

[1] The Departments published interim final regulations implementing section 1251 of the Affordable Care Act on June 17, 2010, at 75 FR 34538.

DISCUSSION:

Section 2719 of the PHS Act generally requires that group health plans and health insurance issuers have an effective internal claims and appeals process. The statutory language provides further that plans and health insurance issuers in the group market shall provide an internal claims and appeals process that initially incorporates the procedures of 29 CFR 2560.503-1 (the DOL claims procedure regulation) and shall update such procedures in accordance with any standards established by the Secretary of Labor for such plans and issuers.

The interim final regulations, unlike the DOL claims procedure regulation, apply to health insurance issuers, in addition to group health plans. Moreover, the interim final regulations provide the following additional standards for internal claims and appeals processes:

1. The scope of adverse benefit determination eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).[2]

2. Notwithstanding the rule in the DOL claims procedure regulation that provides for notification in the case of urgent care claims[3] not later than 72 hours after the receipt of the claim, a plan or issuer must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim by the plan or issuer.[4]

3. Clarifications with respect to full and fair review, such that plans and issuers are clearly required to provide the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale.

4. Clarifications regarding conflicts of interest, such that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual such as a claims adjudicator or medical expert must not be based upon the likelihood that the individual will support the denial of benefits.

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[2] This definition is broader than the definition in the DOL claims procedure regulation, which already provides that a denial, reduction, or termination of, or a failure to provide payment (in whole or in part) for a benefit is an adverse benefit determination eligible for internal claims and appeals processes.

[3] A claim involving urgent care is generally a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or, in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

[4] Note, under the interim final regulations, there is a special exception if the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan.

5. Notices must be provided in a culturally and linguistically appropriate manner, as required by the statute, and as set forth in paragraph (e) of the interim final regulations.

6. Notices to claimants must provide additional content. Specifically:

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

   - The plan or issuer must ensure that the reason or reasons for an adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision.

   - The plan or issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

   - The plan or issuer must disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

7. If a plan or issuer fails to strictly adhere to all the requirements of the interim final regulations, the claimant is deemed to have exhausted the plan's or issuer's internal claims and appeals process, regardless of whether the plan or issuer asserts that it has substantially complied, and the claimant may initiate any available external review process or remedies available under ERISA or under State law.

Since publication of the interim final regulations, some plans and issuers have stated that they did not anticipate some or all of the additional standards and more time is needed to change plan or policy procedures and to modify computer systems in order to come into compliance.

CONCLUSION:

This document sets forth an enforcement grace period until July 1, 2011 with respect to some of the additional standards set forth in the interim regulations in order to give plans and issuers more time to implement procedures and make changes to computer systems in order to comply fully. Specifically, with respect to standards #2 (regarding the timeframe for making urgent care claims decisions), #5 (regarding providing notices in a culturally and linguistically appropriate manner), #6 (requiring broader content and specificity in notices), and #7 (regarding substantial compliance), HHS will not take any

enforcement action, during the grace period, against a self-funded nonfederal governmental health plan, that is working in good faith to implement such additional standards but does not yet have them in place. Similarly, HHS is encouraging States to provide similar grace periods with respect to issuers and HHS will not cite a State for failing to substantially enforce the provisions of part A of title XXVII of the PHS Act in these situations.

Questions concerning the information contained in this document may be directed to Ellen Kuhn at 301-492-4100.