Employee Benefits & Executive Compensation Alert

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Enforcement Dates Extended for PPACA Internal Appeals Procedures

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The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively and commonly known as PPACA), requires group health plans (other than "grandfathered"[1] plans) and insurers offering group and individual health insurance coverage to implement internal claims and appeals procedures and external review procedures for claims adjudications and coverage determinations.[2]

Background

Interim final regulations issued July 23, 2010[3], which take as their starting point existing claims procedure rules promulgated in 2000 (the 2000 DOL claims procedures) provide several new standards for internal claims and appeals processes. Although the new standards set forth in the regulations are technically effective for plan years beginning on or after September 23, 2010, the departments of Health and Human Services (HHS), Labor (the DOL), and the Treasury (collectively, the Agencies) have provided enforcement grace periods for some (but not all) of the new standards.[4] These grace periods are meant to give plans and issuers time to make the systems changes necessary to comply with the new requirements. During the grace periods, the DOL and the Internal Revenue Service (IRS) will not take any enforcement action against a group health plan and HHS will not take any enforcement action against a self-funded nonfederal nongovernmental health plan, provided that such plans are working in good faith to implement the standards.[5]

Standards and Grace Periods

The following chart lists these new internal claims and appeals standards as well as the dates compliance is required.

Standard Number	Standard	Grace Period Ends/Compliance Required by
1.	The scope of adverse benefit determinations 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).	Plan Years beginning on or after September 23, 2010

2.	Despite the rule in the 2000 DOL claims procedure regulation that provides for notification in the case of urgent care claims 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.	Plan Years beginning on or after January 1, 2012
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.	Plan Years beginning on or after September 23, 2010
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.	Plan Years beginning on or after September 23, 2010
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 2010 interim final regulations.	Plan Years beginning on or after January 1, 2012
6.	Notice Form and Content	
6.a.	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.	Plan Years beginning on or after January 1, 2012
6.b.	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.	Plan Years beginning on or after July 1, 2011
6.c.	The plan or issuer must provide a description of available internal appeals and external review processes, including information regarding how to	Plan Years beginning on or after July 1, 2011

	initiate an appeal.	
6.d.	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.	Plan Years beginning on or after July 1, 2011
7.	If a plan or issuer fails to strictly adhere to all the requirements of the 2010 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.	Plan Years beginning on or after January 1, 2012

Impact

These new requirements create several challenges for plans, plan sponsors, and issuers. Notably, it will be difficult to automate claims procedures under the new rules; rather, a customized denial notice is likely to be required for each claims denial, including a host of detail about the claim. In some cases, the notices will need to be translated into a language other than English. Further, plans, plan sponsors, and issuers must make sure that adequate systems and personnel are in place to meet the new 24-hour notification requirement for urgent care claims.

Action Steps

Plans, plan sponsors, and issuers should begin an immediate review of their health plan claims procedures to determine what changes will need to be made to processes, personnel, denial notices, and plan documents, and consult counsel for assistance.

If you have any questions about this alert, please contact your Mintz Levin attorney or one of our Employee Benefits attorneys.

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Endnotes

1 Plans lose "grandfathered" status if certain changes are made to benefits and costs. Grandfathering is discussed in more detail in our *Health Care Reform Advisory*, June 16, 2010.

2 See Sections 1101, 1004(a), and 10101 of PPACA, which add Public Health Service Act Section 2716.

3 See 75 FR 43330.

4 See Technical Releases 2010–02 and 2011–01.

5 Technical Release 2010–02 also stated that the HHS was encouraging states to provide similar grace periods with respect to issuers, and that HHS would not cite a state for failing to substantially enforce the provisions of Part A of title XXVII of the Public Health Service Act in these cases.

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