Questions and Answers About Health Reform

November 2010

Appeals and external review

Overview

**Appeals:** Plans are required to have an internal appeals process (compliant with existing DOL requirements) that allows 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. Notice of the appeals process is required to be provided to enrollees in a culturally and linguistically appropriate manner.

**External review:** Plans must also have an external review process. The requirements of the external review process are dependent upon whether a plan is subject to the “state standard” or the “federal standard” under the interim final regulations.

Questions and answers:

**Do the PPACA requirements for appeals and external reviews apply to grandfathered plans?**

No. Aetna will apply PPACA-required claims/appeals policies and procedures to grandfathered and non-grandfathered plans, except that Aetna will support an alternative external review process for grandfathered plans.

**Do the PPACA requirements for appeals and external reviews apply to self-insured and insured plans?**

Yes, the requirements apply to plans that are not grandfathered, regardless of funding arrangements.

**When are the changes effective?**

The requirements went into effect for non-grandfathered plan years on or after September 23, 2010. In guidance issued September 20, 2010, HHS granted a good faith enforcement grace period through July 1, 2011 for the implementation of certain changes, including the turnaround timeframe for initial urgent care claim determinations, requirements for additional content in adverse determination notices and language requirements related to adverse determinations. Those changes require system and process modifications which were not possible by the September 23, 2010 effective date.

**How will Aetna comply with the new appeals/external review requirements?**

While PPACA does add some significant new requirements, the claims/appeals procedures and external review requirements of PPACA closely track many of our existing policies and procedures. In response to the new requirements, we have updated our standard claims/appeals policies and procedures to be compliant with PPACA. Where Aetna administers the appeal, Aetna will apply these changes regardless of the grandfathered status of a plan. Aetna will, however, support both pre-PPACA external review processes and post-PPACA external review processes for grandfathered plans.

**What changes were made by the PPACA interim final regulations with respect to urgent care initial claim determinations?**

The regulations have reduced the timeframe for initial urgent care claim determinations from a 72-hour turnaround time to a 24-hour turnaround time after receipt of claim; however, the regulations still allow a 48-hour turnaround in situations where the enrollee has failed to provide sufficient information, upon receipt of additional information. All other timeframes that apply under the DOL rules continue to apply.

This requirement is subject to the enforcement grace period through 7/1/11.

**What adverse determinations are subject to the appeals requirements?**

“Adverse determinations” under PPACA mirror the DOL definition, and also applies to rescissions. It is also important to note that for individual coverage, the scope includes initial eligibility claims as well.

**PPACA allows enrollees to review their files, to present evidence and testimony as part of the appeals process. What does that mean?**

The interim final regulations state that this means a plan must provide, free of charge, any new or additional evidence considered, relied upon, or generated in connection with a claim sufficiently in advance of a final internal adverse benefit determination to give enrollee opportunity to respond prior to the deadline.
In addition, before a plan can base a final internal adverse benefit determination on new or additional rationale, it must provide the enrollee with such rationale sufficiently in advance of deadline to allow an opportunity to respond.

**What are the new requirements for the actual denial notices (such as EOBs, appeal notices)?**

In addition to requiring that notices be provided in a “culturally and linguistically appropriate manner,” the following new elements must also be included in the notices:

- Date of service
- Health care provider
- Claim amount (if applicable)
- Diagnosis code (such as ICD-9, ICD-10, or DSM-IV) and corresponding meaning
- Treatment code (such as CPT code) and corresponding meaning
- Denial code (such as CARC and RARC) and corresponding meaning
- Description of plan’s standard for denying the claim, and discussion of decision (if it is a final internal adverse benefit determination notice)
- Description of available internal appeals and external review processes
- Contact information for any applicable health insurance consumer assistance or ombudsman

Model notices are available at: [www.dol.gov/ebsa](http://www.dol.gov/ebsa) and [www.hhs.gov/ociio](http://www.hhs.gov/ociio).

These requirements are also subject to the enforcement grace period through 7/1/11.

**What happens if all of the requirements are not met?**

The interim final regulations adopt a new standard for plans/issuers — if plan fails to “strictly adhere” to all of the requirements, the enrollee is deemed to have exhausted the internal claims and appeals process and can proceed to external review or to court.

This requirement is also subject to the enforcement grace period through 7/1/11.

**PPACA requires plans to continue coverage pending the outcome of the appeals process. Did the interim final regulations provide more information around this requirement?**

Yes. The interim final regulations require plans/issuers to comply with the requirements of the DOL claims regulation, which generally prohibits plan/issuer from reducing or terminating a previously approved ongoing course of treatment or approved number of visits without providing advance notice and opportunity for advance review.

**PPACA requires that notice of the available appeals process be provided to enrollees in a “culturally and linguistically appropriate manner.” What does that mean?**

The interim final regulations related to internal claims and appeals and external review processes addressed this requirement. The regulations state that a plan has met the requirement if relevant notices are provided in a non-English language based on thresholds of number of people who are literate only in the same non-English language.

The thresholds vary by market segment as follows:

- **Groups <100 plan participants:** 25 percent of all plan participants literate only in same non-English language
- **Groups with 100 or more plan participants:** lesser of 500 participants, or 10 percent of plan participants literate only in same non-English language
- **Individual:** 10 percent of population residing in the county literate only in the same non-English language.

If the threshold is met, plan/issuer:

- Must provide notice upon request in non-English threshold language
- Must include a statement in the English versions of all notices, prominently displayed in the non-English threshold language, offering the provision of such notices in the non-English threshold language
- Once request is made, must provide all subsequent notices to enrollee in the non-English language
- Must provide interpretation services in threshold non-English language(s) through customer service

These requirements are also subject to the enforcement grace period through 7/1/11.
What plans are subject to external review process under PPACA?

Plans that are subject to PPACA and not grandfathered (self-funded/ fully insured, group/individual) are subject to some form of external review process. The interim final regulations provide both a state and federal standard of external review.

What is the state standard for external review, and what plans are subject to this standard?

State Standard: Insured plans that are subject to state external review requirements that meet the consumer protections in the NAIC Uniform Model Act as specified under the regulations will satisfy the “state standard” for external review under PPACA. A transition period is granted in states with an existing state external review process.

For plan years beginning before July 1, 2011, applicable state external review processes are deemed compliant. After July 1, 2011, HHS will determine whether or not state law meets the “state standard.”

For states that do not have an external review law in effect as of September 23, 2010 (AL, MS, NV and the U.S. Territories) for insured plans, the carrier must follow the federal external review process administered by the Office of Personnel Management.

What is the federal standard for external review, and what plans are subject to this standard?

Federal Standard: Self-funded plans are subject to the Federal external review process, which substantially follows the NAIC Uniform Model Act and was outlined in technical guidance released on 9/23/10. Importantly, the Federal external review process includes a zero dollar threshold for external reviews, and has a broad scope which includes coverage determinations and rescissions. In addition, it requires the plan to contract with three independent review organizations (IROs).

Insured plans will also be subject to this standard once the transition period ends (after 7/1/11) if HHS determines that the state external review process does not meet the “state standard”.

If state voluntarily chooses to expand its external review process to self-funded plans, such plans may comply with the state process. Aetna, however, will not be able to administer this option for self-funded plans.

HHS also has authority to deem external review processes in operation on 3/23/10 to be in compliance with PPACA requirements either permanently or temporarily.

Can the third-party administrator contract with the IROs on behalf of a self-funded plan?

Yes, an FAQ was issued which clarified that a plan is not required to contract directly with any IRO. The plan’s TPA may contract with the IROs in accordance with the requirements in the technical guidance.

Aetna has contracted with three URAC accredited IROs in accordance with the requirements.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

This summary is provided for informational purposes only. This summary should not be construed as, or relied upon, as legal or any other advice. Employers should consult with their own legal counsel for a comprehensive explanation of the rules and the proper application of these rules to their particular situation.