

# Appeals standards

October 2010

***UnitedHealthcare is committed to supporting and complying with the new health care reform provisions. We are working to help our customers make changes that better manage costs and enhance the health and well being of plan participants.***

## Summary

According to the Patient Protection and Affordable Care Act (PPACA), group health plans and health insurance issuers offering group or individual health insurance coverage must have an effective appeals process for appeals of coverage determinations and claims. This includes notices to enrollees of available appeals processes, along with an opportunity to review their file and present evidence. UnitedHealthcare has traditionally provided the enrollee the right to submit information and review their file.

Enrollees must also be offered an external appeals process, and this shall include the consumer protections in the NAIC Uniform Review Model Act and the minimum standards established by the US Department of Health and Human Services.

The appeals provision is effective for plan years beginning on or after September 23, 2010, but allows for grandfathered plans to continue with existing appeal processes.


## Claims procedures

Interim Final Regulations for the US Department of Health and Human Services (HHS) also sets forth six new requirements, raising the federal floor of protection established in the Department of Labor claims procedure regulation (DOL claims regulation) impacting group health plans. The six component requirements are highlighted as follows:

1. The definition of an “adverse benefit determination” is now broader, in that an adverse benefit determination for purposes of this IFR also includes a rescission of coverage.

An adverse benefit determination eligible for “internal” claims and appeals processes under the IFR also includes a “denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment” that is based on, among other things:

- A determination of an individual’s eligibility for coverage (e.g., rescission), or
- The imposition of a preexisting condition exclusion, or
- A denial of part of the claim due to the terms of a coverage document regarding co-pays, deductibles, or other cost sharing requirements.

- 
2. 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. This provision applies only to initial determinations, not to appeals.
  3. Additional criteria to ensure that a claimant receives a full and fair review. Specifically, the claimant must be provided, free of charge, with any “new or additional evidence considered, relied upon, or generated” in connection with the claim. Such evidence must be provided in advance of the review date. This gives the claimant a reasonable opportunity to respond prior to that date (e.g., for urgent claims within the 24 hour window).
  4. New criteria with respect to avoiding conflicts of interest when adjudicating claims to ensure the independence and impartiality of the persons involved in making the decision. For example:
    - A plan or issuer cannot provide bonuses based on the number of denials made by a medical expert (e.g., defined as a “claims adjudicator” in the IFR).
    - A plan or issuer cannot contract with a medical expert based on the expert’s reputation for outcomes in contested cases.
  5. New standards relating to notices to enrollees in addition to existing DOL requirements
    - Date of service
    - Provider name
    - Claim amount, if applicable
    - Diagnosis code
    - Treatment code
    - Denial code (must include explanations of the meanings of the codes)
    - Explanation of the standard used in making the decision, e.g. medical necessity
    - Appeal rights available
    - Availability of any ombudsman/assistance services
  6. If a plan or issuer fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process. The claimant may subsequently initiate an external review and pursue any available remedies under applicable law, such as judicial review.

### **Continuation of Coverage**

Under the new law, a plan and issuer must provide continued coverage pending the outcome of an internal appeal. Plans must comply with the requirements of the DOL claims regulations, which generally prohibit a plan or issuer from reducing or terminating an ongoing course of treatment without providing advance notice and an opportunity for advance review.



## Urgent care claims

A claimant must be notified 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 demands, but not later than 24 hours after the receipt of the claim, unless the claimant fails to provide sufficient information to make the determination. This is a change from the previous 72 hour notification requirement on urgent care claims.

## External Review Program

Non-grandfathered plans must comply with either a state external review process or a new Federal external review process for clinical appeals that is based upon the NAIC Model External Review Act. Most fully-insured plans are already subject to state external review processes that will remain in place. Plans not subject to State law (self funded ERISA plans governed by the Federal requirements) are subject to the Federal external review program.

UnitedHealthcare intends to continue to offer to its non-grandfathered self-funded customers an External Review Program (formerly referred to as the Voluntary External Review Program) to support our customers' needs to implement external review processes under the new regulations. UnitedHealthcare has contracted with four accredited/licensed vendors who act as the Independent Review Organization (IRO) for the External Review Program (more than the three required by the PPACA).

Options for UnitedHealthcare customers regarding the new external review provisions include:

- Self-funded customers using UnitedHealthcare's previous Voluntary External Review Program need to do nothing additional to receive the new External Review Program and comply with the new federal standards;
- Self-funded customers choosing not to utilize UnitedHealthcare's External Review Program can voluntarily comply with an existing state program, or may comply with a new program being established through the federal Office of Personnel Management (OPM);
- Fully-insured customers remain subject to existing state external review processes, as long as those processes meet the minimum federal standard. UnitedHealthcare anticipates those state processes to remain in place, with no change for the customer.

**No cost for new External Review Program:** Customers who used UnitedHealthcare's Voluntary External Review Program in the past will no longer be billed for the new External Review Program services. Customers who contracted directly with external review vendors in the past are encouraged to use our External Review Program at no cost. Customers who have not had IRO services in the past are encouraged to utilize our External Review Program with no pricing impact.

There will be no price differential for grandfathered plans that "opt out" of this provision.

## Effective date and transition period

New and non-grandfathered plans must comply with these claims and appeals provisions beginning on the first plan year following the sixth month anniversary of the law (9/23/2010). **The rules do not apply to grandfathered plans.**

On September 20, 2010, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (the Departments) issued a Technical Release 20-2010 setting forth an enforcement grace period until July 1, 2011 for compliance with certain new interim final regulation (IFR) provisions with respect to internal claims and appeals. The grace period is established in order to give plans and issuers more time to implement procedures and to modify computer systems in order to come into compliance.

Specifically, the grace period applies to the following four areas:

- **Urgent Care Review Timing:** 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;
- **Cultural/Linguistic Notices:** Providing notices in a culturally and linguistically appropriate manner;
- **Notices:** Requiring broader content and specificity in notices such as the diagnosis code and its corresponding meaning on EOBs and health statements, and the contact information for the office of health insurance consumer assistance or ombudsman; and

During the grace period, no enforcement action will be taken by the Department of Labor and the Internal Revenue Service against a group health plan, and HHS will not take any enforcement action against a self-funded non-federal governmental health plan, that is working in good faith to implement such additional standards but does not yet have them in place.

For the plans subject to the State processes the IFR includes a transition period until July 1, 2011 to allow States to implement necessary changes. Until that time the State programs are entitled to still function as they do today. 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 applicable provisions.

***For questions, contact your UnitedHealthcare representative.***

