Blue Cross Blue Shield Association
Compliance & Ethics Teleconference

Claims and Appeals Procedures Under the Affordable Care Act

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Topics

- Overview
- DOL Requirements
- Affordable Care Act Requirements
- Compliance Dates
- External Review

Overview

Pre-Affordable Care Act

State claims & appeals requirements applied to:

- Insured plans
- Non-ERISA self-funded plans (?)

Department of Labor Claims Procedure Rule applied to:

- ERISA group health plans
- Insurers (as fiduciary of ERISA group plan)

Under Affordable Care Act

State requirements:

- Insured plans
- Non-ERISA self-funded plans (?)

Dept of Labor Claims Procedure Rule:

- Insured coverage—group and individual (applies directly)
- Self-funded group health plans (ERISA and non-ERISA)

Affordable Care Act Requirements:

- Insured coverage—group and individual
- Self-funded group health plans (ERISA and non-ERISA)

Grandfathered Plans

Insured individual coverage

- Neither DOL nor Affordable Care Act applies
- State requirements still apply

Insured group coverage

- Affordable Care Act does *not* apply
- DOL applies to insurer as fiduciary:
  - For ERISA groups, but
  - *Not* for non-ERISA groups
- State requirements still apply

Grandfathered Plans

Self-funded ERISA plans

- DOL applies
- Affordable Care Act does *not* apply
- State requirements do *not* apply

Self-funded non-ERISA plans

- Neither DOL nor Affordable Care Act apply
- State requirements may apply

Broad Application

Claim administrators

- PBMs
- Mental health benefit managers

Plans

- FSAs/HRAs
- But *not* excepted benefits

DOL Requirements

DOL Claims Procedure Rule

Reasonable claims procedures

- Notice for failure to use proper process
- Authorized representatives
- Adherence to plan documents
- Consistent application
- Timelines (72 hours/15 days/30 days)
- Limit of two appeals

DOL Claims Procedure Rule

Reasonable appeals procedures

- 180 days to file appeal
- Opportunity to submit written material
- Claimant access to relevant information
- Consider claimant's input
- Review decision without deference
- Consult health professional
- Timelines (72 hours/30 days/60 days)
- Identify experts

Affordable Care Act Requirements

Affordable Care Act

Rescissions as benefit determinations

- Cancellation with retroactive effect, but not
  - Monthly reconciliation with plan
  - Failure to pay premium
- Exception for fraud or material misrepresentation
- Initial eligibility determinations

(individual market only)

Affordable Care Act

Urgent care determinations

- ASAP, given medical exigencies
- Not more than 72 hours
- Deference to attending provider
  - Physician with knowledge standard

Affordable Care Act

Full and fair review

- Claimant may:
  - Review claim file
  - Present evidence & “testimony”
- New or additional evidence
- New or additional rationale
- One internal appeal (individual market only)

Affordable Care Act

Avoiding conflicts of interest

- Ensure independence & impartiality
- Prohibit “likelihood of denying benefits” as criteria for:
  - Hiring
  - Compensation
  - Termination
  - Promotion, etc.

Affordable Care Act

Additional notice content

- Sufficient to identify the claim
  - Date of service
  - Health care provider
  - Claim amount (if applicable)
  - Availability of diagnosis & treatment codes
- Denial codes & meanings
- Description of any standard used

(with discussion in final notice)

Affordable Care Act

Additional notice content (con't)

- Internal & External Review processes
- Ombudsman office (if available)

See handout for combined list

Must provide diagnosis & treatment codes with meanings

Affordable Care Act

Culturally & linguistically appropriate notice

Required in languages & counties identified by HHS

- Prominent statement of availability in English version
- Notice upon request
- Oral customer assistance

Affordable Care Act

Culturally & linguistically appropriate notice

- 255 total counties
- 250 Spanish (78 in Puerto Rico)
- 3 counties Navajo (AZ, NM, VA)
- 2 counties Tagalog (Alaska)
- 1 county Chinese (San Francisco)
- For full list, click here—see pages 37221-24)

Affordable Care Act

Deemed exhaustion of process

- Deemed exhaustion if fail to adhere to *all* requirements
- Immediate external review or other remedies
- ERISA plans may lose deferential review standards
  - Arbitrary & capricious vs. de novo
  - Record vs. additional information

Affordable Care Act

Exception to deemed exhaustion

- De minimus violation
- No prejudice or harm
- Due to good cause or beyond plan control
- Ongoing, good faith exchange of information
- Not part of pattern or practice
- Written explanation w/i 10 days

Compliance Dates Under Grace Periods and Amended Rule

(See handout)

Compliance Dates

Plan year basis

Three compliance dates

- 9/23/2010
- 7/1/2011
- 1/1/2012

External review

External Review

Application

State process applies to:

- Plans subject to State law, if:
  - State has NAIC “Parallel process”—permanently
  - State has NAIC “Similar process”—until 1/1/2014

Federal processes apply:

- To every other plan

Application

NAIC Parallel Process (23 States)

- Provide response in 45 days
- Urgent care response in 72 hours
- Limit fee to $25/claim, $75/year
- Waive fee for financial hardship
- Refund fee if claimant wins

NAIC Similar Process (10 States)

- Provide response in 60 days
- Urgent care response in 4 days
- Limit fee to $25/claim

"Similar" Process for Insurers in:

- Arizona
- Delaware
- Indiana
- Kansas
- Michigan
- Minnesota
- New Mexico
- North Carolina
- Tennessee
- Wyoming

➢ **Must use State process until 1/1/2014**

➢ **Use Federal process thereafter (unless State process "upgraded" to NAIC Parallel process)**

"Parallel" Process for Insurers in:

- Arkansas
- California
- Colorado
- Connecticut
- Hawaii
- Idaho
- Illinois
- Iowa
- Kentucky
- Maine
- Maryland
- Nevada
- New Jersey
- New York
- Oklahoma
- Oregon
- Rhode Island
- So. Carolina
- So. Dakota
- Utah
- Vermont
- Virginia
- Washington

➢ **Must use State process (permanent)**

Federal Process for Insurers in:

- Alabama
- Alaska
- Dist. Columbia
- Florida
- Georgia
- Louisiana
- Massachusetts
- Mississippi
- Missouri
- Montana
- Nebraska
- New Hampshire
- North Dakota
- Ohio
- Pennsylvania
- Texas
- West Virginia
- Wisconsin
- Territories

Issues Eligible for Review

NAIC process: medical judgment

- Medical necessity
- Appropriateness
- Health care setting
- Level of care and
- Effectiveness

Federal processes:

- Same scope + rescissions (suspension)
- All adverse benefit determinations

Federal Processes

Insured plans elect:

- Office of Personnel Management process *or*
- Private accredited IRO process
- Must e-mail election to externalappeals@cms.hhs.gov

ERISA self-funded plans:

- Private accredited IRO process

OPM Process (Insurers)

Control of process

- Include contact information in ABD notices
- Request goes directly to OPM (4 months)
- OPM assigns examiner (clinical & legal expertise)
- Examiner notifies plan & requests information
- All documentation due in 5 days (immediate)
- Examiner conducts preliminary review
- Examiner de novo review
- Notice within 45 days (72 hours)

Private IRO Safe Harbor

Request for external review

- Up to 4 months after final determination

Plan's preliminary review

- Within 5 business days (immediate)
- Determine whether:
  - Claimant was covered under plan
  - Decision based on eligibility for group health plan
  - Internal processes exhausted
  - All information provided

Private IRO Safe Harbor

Issue notice within 1 business day

- If request is complete but ineligible:
  - Explain reasons for ineligibility
  - Provide EBSA toll-free number
- If request is incomplete:
  - Information to perfect request
  - 4 months/48-hour deadline

Refer to Accredited IRO

- Contract with and rotate between:
  - At least 2 by 1/1/2012
  - At least 3 by 7/1/2012

Private IRO Safe Harbor

Contract with each IRO must

- Have no financial incentives for denial
- Require IRO to:
  - Use legal expertise as necessary
  - Notify claimant of acceptance
  - Forward information from claimant to Plan
  - Review the claims de novo
  - Written notice in 45 days (72 hours)
  - Maintain records for 6 years

QUESTIONS

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