

# Legislative Brief

## Health Care Reform: Guidance on External Review Processes for Insurers



### **EXECUTIVE SUMMARY**

The Patient Protection and Affordable Care Act (PPACA) requires non-grandfathered group health plans and health insurance coverage to adopt an improved internal claims and appeal process and to follow minimum requirements for external review.

The Department of Health and Human Services' (HHS) Office of Consumer Information and Insurance Oversight (OCIIO) has issued Technical Guidance regarding the external review requirements for health insurance issuers in the group and individual markets. The Technical Guidance explains the interim procedures that health insurance issuers will have to follow if their state does not have an external review law. The final guidance is expected to be released by **July 1, 2011**.

This The Barnett Group Legislative Brief summarizes the Technical Guidance. Please read below for more detailed information. The Technical Guidance is available at [www.hhs.gov/ociio/regulations/interim\\_appeals\\_guidance .pdf](http://www.hhs.gov/ociio/regulations/interim_appeals_guidance.pdf).

### **TECHNICAL GUIDANCE FOR HEALTH INSURANCE ISSUERS**

#### **Background**

PPACA, in Section 2719 of the Public Health Service Act (PHSA), requires health insurance issuers to comply with the external review process in their state, if it meets certain minimum requirements. At a minimum, the process must include the consumer protections set forth in the Uniform External Review Model Act issued by the National Association of Insurance Commissioners (NAIC Uniform Model Act). If the state process does not meet that standard, Section 2719 requires health insurance issuers to implement an effective external review process that meets certain standards issued by HHS.

HHS, along with the Departments of Labor and Treasury (the Departments), released interim final regulations implementing Section 2719 on July 23, 2010. The regulations include a **transition period prior to July 1, 2011**. During the transition period, HHS will work with states to assist them in making any necessary changes so that the state process provides the consumer protections in the NAIC Uniform Model Act. The Technical Guidance establishes the interim external review processes that apply during the transition period.

The interim process will vary, depending on the category into which a state falls. During the transition period, HHS will not take any enforcement action against a health insurance issuer that complies with the Technical Guidance.

- In states **with external review laws in effect on March 23, 2010**, for plan or policy years beginning prior to July 1, 2011, a health insurance issuer must follow that state's external review process to the extent applicable during this transition period. HHS encourages states with external review laws that do not currently apply to all of its fully insured market to extend the protections of the law to the entire fully insured market in its state.
- In states **that have passed external review laws between March 23, 2010 and September 23, 2010**, under this guidance, the process provided for under those laws will apply in that state.
- In states **that have not passed an external review law that is in effect on September 23, 2010**, a health insurance issuer must follow the interim external review process that is set forth in this Technical Guidance. This process will be administered by the Office of Personnel Management (OPM).

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Prior to July 1, 2011, HHS will issue further guidance as to which state external review laws have been determined to satisfy the minimum standards of the NAIC Uniform Model Act and which states, following consultation, will be subject to the federal external review process. The Departments will also issue guidance on the standards for the federal external review process that will replace this interim process.

### **Interim Federal External Review Process for Health Insurance Issuers in the Group and Individual Markets**

External review is available for both individuals who purchase a health insurance policy and participants and beneficiaries in group health plans who purchase a health insurance policy from the health insurance issuer. External review is available for adverse benefit determinations and final internal adverse benefit determinations, which include denials of claims, adverse coverage determinations and rescissions. However, external review is not available for participants and beneficiaries in group health plans to resolve disputes about eligibility to participate in an employer-sponsored group health plan other than those disputes that are related to rescissions.

To facilitate the external review process, all health insurance issuers in the individual, small and large group markets operating in the states with no external review law in effect on September 23, 2010, must provide the following information electronically by September 23, 2010 to **externalappeals@hhs.gov**:

- Indicate whether or not Section 2719 is applicable to them (i.e. they participate in the health insurance market) and, if so, the products to which it does or does not apply. For each product to which it does not apply, please specify the reason(s) (i.e., if a product is grandfathered).
- If Section 2719 is applicable, contact information for designated personnel in their appeals department, including name(s), mailing address(es), telephone number(s), facsimile number(s) and electronic mail address(es). In addition, contact information for a designated individual who will be available to address urgent care cases outside of normal business hours (including weekends and holidays). This information should be provided by September 23, 2010 and electronically copied to **disputedclaim@opm.gov**. This contact information will be used by OPM to contact the health insurance issuer after a claimant initiates an external review.

### **A. Procedures for Providing Standard External Review**

The Technical Guidance includes procedures for providing standard external review under the interim process. Standard external review is used for adverse benefit determinations and final internal adverse benefit determinations that do not meet the criteria for expedited review.

1. Request for external review. A claimant or authorized representative may file a written request for an external review with the external review examiner ("examiner") within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

2. Notice to claimants. An adverse benefit determination or a final internal adverse benefit determination must contain a notice to the claimant that the claimant can request an external review. The notice must meet all of the requirements contained in the interim final regulations. The notice must also inform the claimant that the claimant can request an external review in writing by sending it electronically to **disputedclaim@opm.gov**; by faxing it to 202-606-0036, or by sending it by mail to: P.O. Box 791 Washington, DC 20044.

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In addition, the notice must inform the claimant of the following: that if the claimant has any questions or concerns during the external review process, the claimant can call the toll-free number 877-549-8152; and that the claimant can submit additional written comments to the external reviewer at the mailing address above. The claimant should also be notified that if any additional information is submitted, it will be shared with the health insurance issuer in order to give the health insurance issuer an opportunity to reconsider the denial. Lastly, health insurance issuers must provide claimants with the Privacy Act Statement. This Statement can be downloaded at [www.hhs.gov/ocio/regulations/consumerappeals/index.html](http://www.hhs.gov/ocio/regulations/consumerappeals/index.html).

Health insurance issuers must electronically provide to HHS samples of each of their notices that contain this appeals information. This information should be provided at **externalappeals@hhs.gov**. If these notices are changed during the plan or policy year, updated copies must be electronically sent to HHS at **externalappeals@hhs.gov**.

3. Independent reviewer qualifications. Review must be conducted by an independent third party with clinical and legal expertise and with no financial or personal conflicts with the health insurance issuer.
4. Procedure for preliminary review. When the examiner receives an external review request, the examiner will contact the health insurance issuer.
  - a. Within five business days of receipt of request by the examiner, the health insurance issuer must provide to the examiner all of the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination including:
    - i. Claimant's certificate of coverage or benefit;
    - ii. A copy of the adverse benefit determination;
    - iii. A copy of the final internal adverse benefit determination;
    - iv. A summary of the claim;
    - v. An explanation of the health insurance issuer's adverse benefit determination and final internal adverse benefit determination; and
    - vi. All documents and information considered in making the adverse benefit determination or final internal adverse benefit determination including any additional information that may have been provided to the health insurance issuer or relied upon by the health insurance issuer during the internal appeals process.

This information can be provided electronically at **disputedclaim@opm.gov**, by fax at 202-606-0036 or by priority mail at the mailing address listed in (A)(2).

- b. The examiner will review the information from the health insurance issuer and may request additional information that it deems necessary to the external review. If the examiner requests additional information, the health insurance issuer shall supply the information as expeditiously as possible and within five business days.
- c. If the examiner determines that the claimant is not eligible for external appeal, the examiner will notify the claimant and the health insurance issuer in writing.

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### 5. Review Process.

- a. The examiner will review all of the information and documents timely received. In reaching a decision, the examiner will review the claim de novo and not be bound by any decisions or conclusions reached during the health insurance issuer's internal claims and appeals process.
- b. The examiner will forward all documents submitted directly to the examiner by the claimant. Upon receipt of any information submitted by the claimant, the examiner must within one business day forward the information to the health insurance issuer. Upon receipt of any such information, the health insurance issuer may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the health insurance issuer must not delay the external review. The external review may be terminated as a result of the reconsideration only if the health insurance issuer decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making a decision to reverse, the health insurance issuer must provide written notice of its decision to the claimant and the examiner. The examiner must terminate the external review upon receipt of the notice from the health insurance issuer.
- c. The examiner must provide written notice of the final external review decision as expeditiously as possible and within 45 days after the examiner receives the request for the external review. The examiner must deliver the notice of final external review decision to the claimant and the health insurance issuer.
- d. The examiner's final external review decision notice will contain:
  - i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial, including denial codes);
  - ii. The date the examiner received the assignment to conduct the external review and the date of the examiner's decision;
  - iii. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
  - iv. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
  - v. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the health insurance issuer or to the claimant;
  - vi. A statement that judicial review may be available to the claimant; and
  - vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.
- e. After a final external review decision, the examiner must maintain records of all claims and notices associated with the external review process for six years. The examiner must make such records available for examination by the claimant or health insurance issuer upon request.

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6. Reversal of health insurance issuer's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the health insurance issuer immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

### **B. Expedited External Review**

1. Request for expedited external review. A claimant may make a written or oral request for an expedited external review with the examiner at the time the claimant receives:
  - a. An adverse benefit determination, if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal, or an adverse benefit determination if the adverse benefit determination concerns an admission, availability of care, continued stay or health care item or service for which the claimant received services, but has not been discharged from a facility, and the claimant has filed a request for an expedited internal appeal; or
  - b. A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay or health care item or service for which the claimant received services, but has not been discharged from a facility.
2. Notice to claimants. An adverse benefit determination or a final internal adverse benefit determination must contain a notice to the claimant as set forth in paragraph (A)(2). In addition, claimants must be notified that in urgent care situations, their requests for expedited review can be initiated by calling the toll free number 877-549-8152.
3. Independent reviewer qualifications. Review will be conducted by an independent third party that meets the requirements in paragraph (A)(3).
4. Procedure for preliminary review. When the examiner receives an external review request, the examiner will contact the health insurance issuer.
  - a. Immediately upon receipt of request by the examiner, the health insurance issuer must provide to the examiner all documents and information required under (A)(4).
  - b. The examiner will review the information from the health insurance issuer and may request additional information that it deems necessary to the external review.
  - c. If the examiner determines that the claimant is not eligible for expedited external appeal, the examiner will notify the claimant and the health insurance issuer as expeditiously as possible.
5. Review Process.
  - a. The examiner must comply with the requirements set forth in (A)(5)(a).

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- b. The examiner will forward all documents submitted directly to the examiner by the claimant. Upon receipt of any information submitted by the claimant, the examiner must immediately forward the information to the health insurance issuer. Upon receipt of any such information, the health insurance issuer may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the health insurance issuer must not delay the external review. The external review may be terminated as a result of the reconsideration only if the health insurance issuer decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Immediately after reversing the decision, the health insurance issuer must provide notice of its decision to the claimant and the assigned examiner. This notice can be provided orally but must be followed up with written notice within 48 hours. The examiner must terminate the external review upon receipt of the initial notice from the health insurance issuer.
  - c. The examiner must provide notice of the final external review decision as expeditiously as the medical circumstances require and within 72 hours or less (depending on the medical circumstances of the case) once the examiner receives the request for the external review. The examiner must deliver the notice of final external review decision to the claimant and the health insurance issuer. This notice can be initially provided orally but must be followed up in writing within 48 hours.
  - d. The examiner's final external review decision notice must comply with the requirements set forth in (A)(5)(d).
  - e. After a final external review decision, the examiner must maintain records as required in (A)(5)(e).
6. Reversal of health insurance issuer's decision. The health insurance issuer must comply with the requirements established in (A)(6).

*Source: Department of Health and Human Services' Office of Consumer Information and Insurance Oversight*

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