



**INFORMATIONAL MEMORANDUM
OIR-10-6M
ISSUED
SEPTEMBER 24, 2010**

Florida Office of Insurance Regulation
Kevin M. McCarty, Commissioner

ALL HEALTH INSURERS AND HMOs

The purpose of this memorandum is to notify health insurers and health maintenance organizations (HMOs) of the federal interim final rule relating to Internal Claims and Appeals and External Review Processes as required in the Patient Protection and Affordable Care Act (PPACA). The rule may be viewed in its entirety in Vol. 75 Federal Register, 43,330 (July 23, 2010). This Informational Memorandum is not intended to be a comprehensive summary of the provisions of the interim final rule, but is a courtesy to inform you of new federal requirements.

The Rule is effective September 21, 2010, and is applicable to group health plans (including self-insured groups, governmental and church plans) and health insurance issuers offering group or individual health coverage which are issued on or after September 23, 2010. These requirements do not apply to grandfathered health plans.

Internal claims and appeals processes

The regulations set forth separate rules for group health coverage and individual health insurance coverage. Section 2719 of the Public Health Service Act (PHSA), as added by the PPACA, provides that **Group** health coverage must initially incorporate the internal claims and appeals processes set forth in 29 CFR 2560.503-1 and update such processes in accordance with standards established by the Secretary of Labor. Similarly, with respect to internal claims and appeals processes for **Individual** health insurance coverage, issuers must initially incorporate the internal claims and appeals processes set forth in applicable State law and update such processes in accordance with standards established by the Secretary of Health and Human Services.

Group

In addition to **Group** health plans and health insurance issuers offering group health insurance coverage being subject to the Department of Labor (DOL) claims procedure regulation; six new requirements have been added:

1. Adverse Benefit Determination: Broadens the definition of adverse benefit determination to include any rescission in coverage, which generally means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent that it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

2. Expedited Notice for Urgent Claims: Reduces the 72-hour notification period for urgent claims under the current DOL claims regulation to 24 hours. Requires notice of benefit determinations (whether adverse or not) for urgent care claims as soon as possible, but no later than 24 hours after the receipt of the claim, unless the claims fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health coverage.
3. Additional Claimant Rights: Provides that a claimant must be allowed to review his or her claim file and present evidence and testimony during the claims review process. All new or additional evidence being considered, relied upon or generated by the plan or issuer in connection with the claim must also be provided to the claimant at no charge as soon as possible in advance of the date of the final internal adverse benefit determination.
4. Conflicts of Interest: Claims and appeals must be adjudicated in a manner designed to ensure independence and impartiality of the person involved in the making of the decision.
5. Notice Requirements: Notice to enrollees must be provided in a culturally and linguistically appropriate non-English manner based on the number of participants in a plan and the number of residents in the county. Adverse benefit determinations must include additional information: date of service, health care provider, claim amount (if applicable), diagnosis code, treatment code and corresponding meaning of such codes. Denial codes must also be included along with a description of the standard used in denying the claim. Denial notices must also include a discussion of the decision, plus a description of the available internal appeals and external review processes.
6. Non-Compliance: Provides that if a plan or issuer does not “strictly adhere” to these requirements, the claimant will be deemed to have exhausted the internal claims and appeals processes and may immediately initiate an external review or pursue any available remedies, such as a judicial review.

In addition to the six (6) new requirements, a plan and issuer is required to provide continued coverage pending the outcome of an internal appeal.

Individual

Health insurers offering Individual health coverage must comply with all of the requirements that apply to group health coverage discussed above. In addition, under the rule:

1. Initial eligibility determination for individual health insurance coverage is included in the scope of the initial claims and appeals process;
2. Individual policies may have only one level of internal appeals (unlike group health which may have a second level); and

3. Issuers of individual policies must maintain records of all claims and notices associated with their internal claims and appeals process for at least six (6) years.

External Review

The Rule provides that plans and issuers must comply with either a State external review process or the Federal external review process. At this time, Florida does not have an external review process for plans and issuers with the exception of the Subscriber Assistance Panel (SAP) for managed care entities. The Rule provides that a State external review process must include, at a minimum, the consumer protections of the NAIC Uniform Model Act. The Department of Health and Human Services (HHS) will determine whether a State external review process meets these requirements. In order to allow States time to amend their laws to meet the minimum standards, the Departments are using their authority under PHS Act section 2719(c) to treat existing State external review processes as meeting the minimum standards during a transition period for plan years (in the Individual market, policy years) beginning before July 1, 2011. Managed care entities will continue to adhere to the Florida statutory provisions until July 1, 2011.

The Office of Insurance Regulation (“the Office”) will propose to the Florida Legislature that it establish legislatively an external review process that meets the minimum protections of the NAIC Uniform Model Act (Act), which may be viewed at <http://www.dol.gov/egsa> and <http://www.hhs.gov/ociio/>. During the transition period, guidance from the Office of Consumer Information and Insurance Oversight (OCIIO), Office of Personnel Management (OPM) located on the Department of Health and Human Services (HHS) website, http://www.hhs.gov/ociio/regulations/consumerappeals/interim_appeals_guidance.pdf states that a health insurance issuer is deemed to comply with federal requirements if it follows that state’s external review process to the extent applicable during this transition period. Therefore, the Office has been told by OCIIO that the federal external review process through OPM is not available to health insurance issuers in Florida.

The Office strongly encourages health insurance issuers that are not HMOs to adopt voluntarily the interim procedures for self-funded plans outlined in Technical Release 2010-01 issued by the U.S. Department of Labor (DOL) on August 23, 2010 at <http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf>, and provide an external review process to its insureds during the interim period.

If you have questions regarding the content of this Memorandum, please contact Eric Lingswiler, Director of Life and Health Product Review, Florida Office of Insurance Regulation at eric.lingswiler@flor.com or (850) 413-5110.