

Overview of PPACA Internal and External Review and Employee Protections

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This paper provides an overview of the benefits claims and whistleblower provisions of the Patient Protection and Affordable Care Act and regulations.

I. Internal Claims and Appeals.

A. Does not apply to grandfathered health plans. 29 C.F.R. § 2590.715-2719(a)(1).

B. “Adverse benefit determination” is defined as in the DOL regulations under ERISA § 503, 29 U.S.C. § 1133. *See* 29 C.F.R. § 2590.715(a)(2)(i). Thus, an adverse benefit determination is “a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit.” 29 C.F.R. § 2560.503-1(m)(4). Under the § 503 regulation, an adverse benefit determination includes:

1. A determination that is based on a participant’s or beneficiary’s eligibility to participate in a plan.
2. With respect to group health plans, determination that results from application of utilization review.
3. With respect to group health plans, a failure to cover an item or service for which benefits are otherwise provided, on the basis that the item or service is experimental, investigational, or not medically necessary or appropriate.

C. The EBSA regulations add to the definition of “adverse benefit determination” any rescission of coverage as defined in 29 C.F.R. § 2590.715-2712(a)(2). A rescission is an adverse benefit determination “whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time.” 29 C.F.R. § 2590.715-2719(a)(2)(i).

- D. The internal claims and appeals process must be provided by either the group health plan or the issuer of health insurance coverage. 29 C.F.R. § 2590.715-2719(b)(2).
- E. The internal claims and appeals process must comply with all the requirements applicable to group health plans under the regulations under ERISA § 503, 29 C.F.R. § 2560.503-1, with the following modifications:
1. The addition of rescissions to the definition of “adverse benefit determination,” as noted above.
 2. The plan or issuer shall defer to the determination of the attending provider as to whether a claim is one involving “urgent care” as defined in 29 C.F.R. § 2560.503-1(m)(1). 29 C.F.R. § 2590.715-2719(b)(2)(ii)(B). Compare 29 C.F.R. § 2560.503-1(m)(1), under which a “claim involving urgent care” is one as to which application of the time periods for making non-urgent care determinations either:
 - a. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
 - b. In the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
 3. The 72-hour notification period of 29 C.F.R. § 2560.503-1(f)(2)(i) continues to apply to benefit determinations involving urgent care. Earlier efforts to reduce the period to 24 hours were abandoned.
 4. Plans must continue to comply with the requirements of 29 C.F.R. § 2560.503-1(h)(2), which sets forth time limits for the claim and appeal process for urgent care claims, pre-service claims, and post-service claims. See 29 C.F.R. § 2590.715-

2719(b)(2)(ii)(C). In addition, to provide a full and fair review, the plan or issuer must:

- a. Allow a claimant to review the claim file and to present evidence *and testimony* as part of the internal claim and appeal process. 29 C.F.R. § 259.715-2719(b)(2)(ii)(C).
- b. **New evidence.** Provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer, or at the direction of the plan or issuer, in connection with the claim, *as soon as possible and sufficiently in advance of the deadline* for notice of final internal adverse benefit determination *to give the claimant a reasonable opportunity to respond*. 29 C.F.R. § 2590.715-2719(b)(2)(ii)(C)(1).
- c. **New or additional rationale.** As with new evidence, claimants must be given a reasonable opportunity to respond to a new or additional rationale before the deadline for a final internal adverse benefit determination. 29 C.F.R. § 2590.715-2719(b)(2)(ii)(C)(2).
- d. **Conflicts of interest.** 29 C.F.R. § 2560.503-1(b) and (h) prescribe requirements for full and fair internal review, including the requirement that claims procedures contain administrative processes and safeguards designed to ensure and verify that claim determinations are made in accordance with governing plan documents and that plan provisions have been applied consistently with respect to similarly situation claimants (29 C.F.R. § 2560.503-1(b)(5)); provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination, nor the subordinate of such individual (29 C.F.R. § 2560.503-1(h)(2)(iv), (3)(ii)); provide that where a benefit determination turns on a medical judgment, the appropriate named fiduciary shall

consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment (29 C.F.R. § 2560.503-1(h)(3)(iii)) and who is not an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual (29 C.F.R. § 2560.503-1(h)(3)(v)); and provide for identification of medical and vocational experts (29 C.F.R. § 2560.503-1(h)(3)(iv)). In addition:

- i. The plan and issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision, and
- ii. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits. 29 C.F.R. § 2590.715-2719(b)(2)(ii)(D).

5. **Notice requirements.** In addition to complying with the prior claims regulations, the plan and issuer must provide notice of an adverse benefit determination that includes sufficient information to identify the claim involved, and that includes a statement describing the availability of codes and their meanings; and must provide on request the diagnosis code or treatment code and its meaning. 29 C.F.R. § 2590.715-2719(b)(2)(ii)(E).

6. EBSA has a model notice of final internal adverse benefit determination on its website:
<http://www.dol.gov/ebsa/healthreform/>.

F. Deemed exhaustion without exercise of discretion.

1. If a plan or issuer fails to comply with all the requirements of 29 C.F.R. § 2590.715-2719(b)(2) with respect to a claim, the claim is deemed to have exhausted the internal claims and appeal process and may proceed to external review or to court pursuant to ERISA's civil enforcement provision or state law. The regulations provide that if the claimant pursues available remedies under ERISA or state law, "the claim or appeal is deemed denied on review *without the exercise of discretion by an appropriate fiduciary.*" 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F)(1).
2. However, de minimis violations "that do not cause, and are not likely to cause, prejudice or harm to the claimant" will not result in deemed exhaustion "so long as the plan or issuer demonstrates that the violation was for good cause or due to matters beyond the control of the plan or issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant." 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F)(2).
3. But "this exception is not available if the violation is part of a pattern or practice of violations by the plan or issuer."
4. A claimant may request a written explanation of a violation which shall be provided within 10 days, and shall contain a specific description of the plan or issuer's bases for asserting that the violation should not be a basis for deemed exhaustion.
5. If an external reviewer or court rejects the claimant's assertion of deemed exhaustion, the claimant shall have the right to resubmit and pursue the internal appeal, and the plan or issuer must provide notice of this right.

G. Continued coverage must be provided pending the outcome of an appeal pursuant to 29 C.F.R. § 2560.503-1(f)(2)(ii).

II. External Review Procedures.

- A. Prior to PPACA, many states had existing external review laws for insured plans. Indeed, as of July 2010, only five states – North Dakota, South Dakota, Alabama, Mississippi, and Nebraska – had no external review law. However, these laws varied widely: for example, some applied only to HMOs, and under some the external review determination was not binding on the health plan. *See* Phil Galewitz and Michelle Andrews, “New rules make it easier for public to appeal denials of health insurance claims,” July 22, 2010, *available at* <http://www.washingtonpost.com/wp-dyn/content/article/2010/07/22/AR2010072200005.html>.
- B. Healthcare reform establishes uniform standards for external review and makes external review applicable to self-funded plans.
- C. The regulations adopt the NAIC’s Uniform Health Carrier External Review Model Act promulgated July 23, 2010. *See* http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf.
- D. If a state external review process includes at a minimum the consumer protections of the NAIC Model Act, then the issuer must comply with the state external review process and is not required to comply with the federal external review process set forth in 29 C.F.R. § 2590.715-2719(d). *See* 29 C.F.R. § 2590.715-2719(c)(1)(ii). The regulation also sets out minimum standards for state external review processes. 29 C.F.R. § 2590.715-2719(c)(2). If the issuer is not bound by a state external review process meeting these requirements, it must comply with the requirements for federal external review set forth at 29 C.F.R. § 2590.715-2719(d).
- E. Minimum standards for a state external review process include that it must provide for review of denials based on medical necessity, appropriateness, health care setting, level of care, effectiveness of covered benefit (not eligibility or coverage). The process must provide for effective written notice and must provide for the issuer to pay the cost of external review, except that the process may require that the claimant pay a nominal filing fee, not to exceed \$25.

- F. State external review cannot require a minimum dollar claim amount. IROs must be assigned on a random basis or by another method that assures independence and impartiality of the assignment process and avoids conflicts of interest.

- G. EBSA has a model notice of a final external review decision on its website: <http://www.dol.gov/ebsa/healthreform/>.

III. Whistleblower Claims.

- A. The ACA includes a provision for “Protections for Employees” at Section 1558 (P.L. 111-148, Mar. 23, 2010). Section 1558 amends the Fair Labor Standards Act, 29 U.S.C. § 218C.
- B. Section 1558 provides, “No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee)” has done any of the following:
1. Received a credit under IRC § 36B – that is, the premium assistance tax credit;
 2. Received a subsidy under section 1402 of the Act, 42 U.S.C. § 18071, governing reduced cost-sharing for individuals enrolling in qualified health plans;
 3. Provided, caused to be provided, or is about to provide or cause to be provided to the employer, the federal government, or the attorney general of a State information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of, any provision of Title I of PPACA (or an amendment made by Title I);
 4. Testified or is about to testify in a proceeding concerning such violation;
 5. Assisted or participated, or is about to assist or participate, in such a proceeding; or
 6. Objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to be in violation of any provision of Title I (or amendment), or any order, rule, regulation, standard, or ban under Title I (or amendment).
- C. Title I of PPACA encompasses many well-known provisions affecting employees, including elimination of lifetime or annual limits,

prohibition on rescissions, preventive health services coverage, extension of dependent coverage, summary of benefits and coverage provisions, the claims and appeals process, establishment of exchanges, and the individual and employer mandates.

- D. This provision applies to a group health plan or health insurance issuer offering group or individual insurance coverage. Sec. 2706 (42 U.S.C. § 300gg-5).
- E. Enforcement responsibility for this provision rests with OSHA. The enforcement procedure is that set forth in the whistleblower protection provision Consumer Product Safety Improvement Act, 15 U.S.C. § 2087(c). An administrative complaint must be filed within 180 days after the violation. Following exhaustion of administrative remedies, a claimant may bring a de novo action in federal court.
- F. In an action under Section 2087(c), jury trial is available and the court has jurisdiction to grant all relief necessary to make the employee whole, including injunctive relief, compensatory damages, reinstatement, back pay, and compensation for special damages including litigation costs, expert witness fees, and reasonable attorneys' fees.
- G. OSHA is promulgating procedures for the investigation and handling of retaliation complaints under Section 1558. An interim final regulation is expected in July 2012.
- H. Section 1558 provides that nothing in the section diminishes any rights, privileges, or remedies of any employee under any federal or state law or under any collective bargaining agreement. The rights and remedies of Section 1558 may not be waived by any agreement, policy, form, or condition of employment.