

IBC Compliant with Appeals Provision

We have been working diligently to meet the requirements of the appeals provisions of health care reform legislation. We want to assure you that Independence Blue Cross is in compliance with the requirements of the appeals provision that went into effect September 23, 2010. We would also like to provide you with a high-level overview of key elements of the provision, our implementation schedule, and information about requirements that will go into effect on July 2011.

Key elements of the provision

Key elements of the appeals provisions that went into effect on September 23, 2010, include:

- **Continuing coverage during internal appeals process.** The legislation requires health plans to continue to provide services and pay certain claims related to the Internal Appeal pending the outcome of the Internal Appeal. This rule prohibits a plan from reducing or terminating an ongoing course of treatment without providing advance notice to the claimant and the opportunity for advance review. This applies to any ongoing treatment, whether the subject of an expedited or standard Internal Appeal.
- **Full and fair review.** Health plans must send additional evidence used in the decision-making process to the claimant for review and comment before notifying the claimant of a final adverse determination. New or additional evidence must be sent free of charge and with sufficient advance notice to give the claimant an opportunity to respond before the date of determination.
- **Concurrent external/ internal expedited appeals process.** If the Internal Expedited Appeal is for urgent care or ongoing treatment, the claimant may file an external expedited review at the same time as requesting an Internal Expedited Appeal.
- **External Review rights.** Claimants have the right to an External Review for medical necessity and administrative appeals, and this right must be communicated to members when they submit an appeal. Previously, we were not required to offer an External Review for all commercial lines of business and all types of appeals.

External Review of appeals for all fully insured groups and individuals will be handled by the Pennsylvania Department of Health. Self-funded External Reviews will be handled by an Independent Review Organization.

- **One level of Internal Appeals for individual nongroup products.** For nongroup individuals, the provision provides one level of Internal Appeal and an External Review. Previously, individual HMO members had two levels of Internal Appeals.
- **Appeal process for denial of individual nongroup applications.** Individual medically underwritten products (IMUP) must follow the Department of Labor Internal Appeals process for prospects that are denied enrollment based on their medical history.

Implementation Schedule

The implementation schedule for the appeals provision is based on funding status and the renewal month/plan year:

- **Fully insured customers.** During the fourth quarter of 2010, we will implement the appeals provisions upon renewal. Effective January 1, 2011, the new appeals requirements will be implemented for all remaining fully insured customers. Independence Blue Cross will not allow fully insured customers to opt out of (grandfather) this provision.
- **Self-funded customers.** The provisions will be implemented upon renewal. Self-funded customers will be able to opt out of (grandfather) the provisions if they meet the grandfathering requirements.
- **Individual products.** The provisions were implemented on October 1, 2010.

Important note: The new health care reform appeals process will be based on the date the appeal was submitted and not on the date of service of the claim. For example, if a member of a group that renews October 1 submits an appeal on October 15 for a claim incurred on July 4, 2010, the claim will be reviewed under the new appeals process.

Additional requirements for July 2011

In late September, the government issued additional guidance on some of the more complex requirements of the appeals provisions and delayed implementation to July 1, 2011, for the following:

- **Including codes in EOB notices.** Explanation of Benefits (EOB) for denied claims must now include diagnosis codes and treatment codes as well as their corresponding meanings. The EOBs will continue to include the date of service, the name of the health care provider, the claim amount (if applicable), the reason for the denial, the denial code, and a description of the plan's standards (i.e., medical policy, contract, etc.) used to make a benefits determination.
- **Linguistically appropriate requirements.** Plans must provide notices in a "culturally and linguistically appropriate manner." All appeals notices must include a statement in a "threshold" non-English language that all subsequent notices, communications, and oral assistance will be available in that non-English language.

For the individual market, a threshold language is one in which 10 percent or more of the population in the claimant's county is literate in the non-English language. For the group market, a threshold language is one in which 25 percent or more of all plan participants are literate only in that language (if the group covers fewer than 100 participants at the start of the year) or one in which the lesser of 500 plan participants or 10 percent or more are literate in that language (if the group covers 100 or more participants).

- **Noncompliance standard.** This requirement sets a standard of strict adherence: a claimant will be deemed to have exhausted the internal appeals process if the health plan fails to strictly follow the regulations. This holds even if the plan has substantially complied with the regulations but has committed an error that is so small or minimal that it lacks significance.
- **24-hour urgent care claim review.** A health plan must notify a member of an urgent care initial benefits determination (whether adverse or not) as soon as possible, but no later than 24 hours after the receipt of the claim. The only exception is if the claimant fails to provide sufficient information to determine whether benefits are covered or payable. The current requirement is that a determination be made within 72 hours.

We will provide you with updates as more information becomes available on the July 2011 requirements. If you have any questions regarding the appeals provision of health care reform or any questions related to the appeals process for the denial of IMUP applications, please call The Administrators, Inc. at (800) 634-4428 or e-mail BenefitHelp@TheAdministratorsInc.com.



867 Sussex Boulevard, Broomall, PA 19008 • (610) 604-4500

www.TheAdministratorsInc.com