FEHB Program Carrier Letter

All Carriers

U.S. Office of Personnel Management
Federal Employee Insurance Operations

Letter No. 2011-20 **Date: November 18, 2011**

Fee-for-Service [14] Experience-rated HMO [14] Community-rated HMO [16]

SUBJECT: Internal Claims and Appeals and External Reviews under the Affordable Care Act

On June 24, 2011, the United States Department of Health and Human Services, the Department of Labor, and the Department of Treasury (the Departments) jointly issued amendments to the interim final regulations governing internal claims and appeals, and external review processes, for group health plans. 76 Fed. Reg. 37208. The amended interim final regulations ("amended regulations") implement section 2719 of Patient Protection and Affordable Care Act ("Affordable Care Act") and apply to group health plans that were not grandfathered plans for plan years beginning on or after September 23, 2010. The original interim final regulations had been published on July 23, 2010 at 75 Fed. Reg. 43330 ("original regulations").

OPM issued Carrier Letter 2010-20 on October 19, 2010 requiring all FEHB Program carriers to comply with the original regulations for plan year 2011 regardless of whether the plan was considered grandfathered under the Affordable Care Act. OPM also advised that FEHB carriers could take advantage of the enforcement grace period the Departments had granted in Technical Release 2010-02 for certain provisions of the regulations. This grace period was extended for some of the provisions until plan years beginning on or after January 1, 2012 by Technical Release 2011-01, and additional guidance was set forth in Technical Release 2011-02.

This Carrier Letter is to advise FEHB Program carriers that **all** FEHB Program plans, regardless of whether the plan is considered grandfathered or not under the Affordable Care Act, must comply with the internal claims and appeals requirements in the amended regulations for plan year 2012. The FEHB brochure template was updated for plan year 2011 to incorporate the timeframes required by the original regulations, and was further updated for plan year 2012 to comply with the amended regulations. Please note that OPM will continue to conduct external reviews for the FEHB Program in accordance with 5 U.S.C. Sec. 8902(j) and 5 C.F.R. Sec. 890.105.

We have updated the website template referenced at the beginning of Section 8 of the brochure providing language detailing member rights for appeals to OPM according to the amended regulations (Attachment 1). The language notifies members that their appeals may be deemed exhausted and they may file an immediate appeal to OPM if the plan does not substantially comply with the regulatory appeals process; it incorporates the procedures and time periods for appeals, and the documentation claimants are required to provide; and it notifies members that they may receive notices and services in a culturally and linguistically appropriate manner. This template must be customized for each plan to the extent necessary. However, the majority of customized text involves the addition of hyperlinks to

available information. **Plans must post this attachment to the website address referenced in the brochure.**

Deemed Exhaustion of Internal Claims and Appeals Processes

The original regulations provided that if a plan or issuer did not "strictly adhere" to all of the internal claims and appeals process requirements of the original regulations, the claimant would be deemed to have exhausted the plan's or issuer's internal claims and appeals process, allowing the enrollee to appeal directly to OPM. The amended regulation liberalizes the strict adherence aspect for certain minor violations and provides that the plan must "substantially comply" with the requirements for internal claims and appeals. This means that a violation of the procedural regulations governing the claims and appeals process will not cause a claims appeal to be deemed exhausted if the violation is:

(1) De minimis;
(2) Non-prejudicial;
(3) Attributable to good cause or matters beyond the plan's or issuer's control;
(4) In the context of an ongoing good faith exchange of information; and
(5) Not reflective of a pattern or practice of non-compliance.

Therefore, when a member immediately appeals a disputed claim to OPM based on either a carrier's failure to follow the FEHB claims or reconsideration process or any assertion that the process is deficient, the carrier may, if appropriate, assert that its adjudication of the claim or reconsideration review was substantially compliant with the amended regulation.

If the member believes that the carrier has not been substantially compliant with the requirements of the amended regulations, the member may request that the carrier provide an explanation of how the carrier either was or was not substantially compliant with the regulations. If a carrier asserts substantial compliance, the carrier must provide an explanation to the enrollee with information on each element of the standard. This explanation must be made available within ten days of the request. The member may use this explanation to determine whether or not to appeal directly to OPM. Please note that the web template includes a space for you to include the correct contact information for a member to request an explanation.

If the member chooses to appeal directly to OPM, OPM will inform the carrier. If the carrier asserts substantial compliance, the carrier must provide the explanation to OPM with information on each element of the standard. OPM will then determine whether or not to accept and review the enrollee's appeal and inform both the enrollee and the carrier of the decision. Note that if OPM rejects the member's request for immediate review on the basis that the FEHB plan substantially complied with the amended regulations, the member may resubmit the reconsideration request and pursue the appeal through FEHB administrative procedures.

We have updated the template to reflect this change.

Form and Manner of Notice

Under the amended regulation, notices must be made available to members in any language where 10 percent or more of the population of the enrollee's county is literate only in the same non-English language as determined based on American Community Survey data published by the United States Census Bureau. A full list of the affected counties is available at http://www.federalregister.gov/articles/2011/06/24/2011-15890/group-health-plans-and-health-insurance-issuers-rules-relating-to-internal-claims-and-appeals-and#t-3. The plan must include, in the English versions of all notices, a statement in any applicable non-English language clearly indicating how to access language services, including how to request a copy of the notice in any applicable non-English language. The plan must also provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language.

We have updated the template to reflect this change.

Additional Notice Requirements for Internal Claims and Appeals

The plan's notification of an adverse benefit determination must include the following:

- Information sufficient to identify the claim involved, including the date of service and the health care provider,
- The claim amount (if applicable), and
- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

The amended regulation does not require plans to automatically provide the diagnosis and treatment codes as part of a notice of adverse benefit determination (or final internal adverse benefit determination). Plans must only provide notification of the availability, upon request, of the diagnosis and treatment codes (and their meanings) in all notices of adverse benefit determination (and notices of final internal adverse benefit determination), and then provide this information upon request.

The amended regulations also require that plans disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist enrollees with the internal claims and appeals and external review processes. Please note that there is no applicable office of health insurance consumer assistance or ombudsman established under the PHS Act for the FEHB Program. **Therefore, notices to FEHB Program enrollees, regardless of their state of residence, do not need to include this information.**

Updated Brochure Language

Please note that the 2012 standard brochure language in Sections 3, 7 and 8 was updated to reflect the amended regulations. This includes the requirement that plans provide expedited review of

urgent care claims and notify enrollees of their decision as soon as possible but not later than 72 hours after the receipt of the claim.

If you have not done so already, we encourage you to review the amended regulations and other regulations and guidance relevant to this carrier letter. The amended regulations are available at http://www.federalregister.gov/articles/2011/06/24/2011-15890/group-health-plans-and-health-insurance-issuers-rules-relating-to-internal-claims-and-appeals-and and more on internal claims and appeals and external review is available at http://cciio.cms.gov/programs/consumer/appeals/index.html. If you have any questions concerning this Carrier Letter, please contact your contract specialist.

Sincerely,

John O'Brien
Director
Healthcare and Insurance