COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE
Frankfort, Kentucky

BULLETIN
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The following Bulletin is to advise the reader of the current position of the Kentucky Department of Insurance (the "Department") on the specified issue. The Bulletin is for informational purposes only and is not legally binding on either the Department or the reader.

TO: Health Insurers Issuing or Renewing Health Benefit Plans in Kentucky

FROM: Sharon P. Clark, Commissioner

RE: Claims and Internal Appeals Preemption Issues

DATE: November 18, 2011

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The Patient Protection and Affordable Care Act of 2010 ("PPACA") was signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act was enacted on March 30, 2010. Together, these Acts are referred to as the Affordable Care Act ("ACA") which reorganizes, amends, and adds to the provisions in the Public Health Service Act (PHS Act) relating to group health plans and health insurers in the group and individual markets.

With respect to internal claims and appeals processes, Section 2719 of the PHS Act requires insurers to incorporate the internal claims and appeals processes related to the U.S. Department of Labor (DOL) claims at 29 CFR 2560.503-1 and updates those processes as directed by the Secretary of Labor. Also, with respect to the individual health insurance market, insurers must initially incorporate the internal claims and appeals processes set forth in applicable state law and update those processes in accordance with standards established by the Secretary of the U.S. Department of Health and Human Services (HHS).

There are provisions in the regulations promulgated by HHS that preempt, in whole or in part, Kentucky's internal appeal procedures outlined in KRS Chapter 304, Subtitle 17A. This Bulletin outlines provisions of the federal law that impact the state's internal appeal statutes and regulations, to the extent those provisions have been identified. Any state laws that do not meet the federal minimum standards are preempted.

Although Section 2719 of the PHS Act does not apply to grandfathered plans, the Department is applying this Bulletin to all insurers issuing or renewing health benefit plans in the Commonwealth of Kentucky, regardless of whether the health benefit plans are grandfathered.

/s/ Sharon P. Clark
Sharon P. Clark, Commissioner
Kentucky Department of Insurance

Internal Appeal Preemption Guide

Effective Date: January 1, 2012

Issue	Current Kentucky law	New standard
Scope of Adverse Benefit Determination	304.17A-600(1) defines an "adverse determination" as "a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are: 1. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer or its designee; and 2. Benefit coverage is therefore denied, reduced, or terminated. "Adverse determination" does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan.	With respect to internal claims and appeals, the federal definition of "adverse benefit determination" is broader than the Kentucky definition of "adverse determination." Consequently, for the purposes of internal appeals, the Kentucky definition of "adverse benefit determination" is replaced by the following: "Adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on: • A determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to health benefit plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review; • A determination that a benefit is experimental, investigational, or not medically necessary or appropriate; • A determination of an individual's eligibility to participate in a plan or health insurance coverage; • A determination that a benefit is not a covered benefit;

		• The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or An adverse benefit determination includes any rescission of coverage whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.[1]
Definition of Urgent Care	304.17A-600(17) defines "urgent care" as "health care or treatment with respect to which the application of the time periods for making nonurgent determination: 1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or 2. In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.	In addition to the definition of "urgent care" provided in KRS 304.17A-600(17), a "claim involving urgent care" includes any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care. A claim involving urgent care is subject to the internal claims and appeal processes. Urgent care appeals may also be referred to an "expedited appeal" as referenced in KRS 304.17A-617(2)(b). A plan or issuer shall notify the claimant of any adverse benefit determination with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim by the plan or issuer, provided that the

[1] The Federal External Review Process for self-insured plans under ERISA includes a "rescission" in the definition of adverse benefit determination for the purposes of external review. For the State External Review process, the State determines the scope of claims eligible for external review but, at a minimum, must provide for an external review of an adverse benefit determination as defined by the NAIC Model. The Model provides for an external review of adverse benefit determinations that are based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. Rescissions are not included in this definition. So, for the state process, a rescission is included in the definition of an adverse benefit determination for the purposes of an internal appeal but, there is no external review of a rescission decision.

	"Urgent care" shall include all requests for hospitalization and outpatient surgery.	plan or issuer defers to the attending provider with respect to the decision as to whether a claim constitutes "urgent care." The 72-hour timeframe is only an outside limit and, in cases where a decision must be made more quickly based on the medical exigencies involved, the requirement remains that the decision should be made sooner than 72 hours after receipt of the claim.
Full and fair review upon appeal	304.17A-617, 304.17A-619, and 806 KAR 17:280 Sections 7 and 8.	To clarify the requirements for a full and fair review, the Department emphasizes that: An insurer's claims and appeals procedures must: • Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination; • Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; • Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and • Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the

		initial benefit determination. Additionally, • The insurer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the insurer in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date; and • Before the insurer can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.
Conflict of Interest	304.17A-617(2)(c) sets forth the conflict of interest standard for the internal appeals process	The insurer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in the decision. NOTE: In addition to ensuring impartiality of the medical expert making the appeals decision, the federal rules provide that insurer decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (claims adjudicator or medical expert) must not be made based on

		the likelihood that the individual will support a denial of benefits.

Notices	KRS 304.17A-607(1)(j), KRS 304.17A-617(2)(e), 806 KAR 17:280 Section 4(1)(i)5. and Section 7(2) and Section 8(2)	An insurer must provide notice to enrollees, in a culturally and linguistically appropriate manner. Insurers are considered to provide relevant notices in a culturally and linguistically appropriate manner if notices are provided in a non-English language as described in the 2010 interim final regulations based on thresholds of the number of people who are literate in the same non-English language. If an applicable threshold is met, notice must be provided upon request in the non-English language. In addition, the insurer must also include a statement in the English versions of all notices, prominently displayed in the non-English language, offering the provision of such notices in the non-English language.[2] Once a request has been made by a claimant, the insurer must provide all subsequent notices to a claimant in the non-English language. In addition, to the extent the insurer maintains a customer assistance process that answers questions or provides assistance with filing claims and appeals, the insurer must provide such assistance in the non-English language. Additionally, an insurer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes the following: • Information sufficient to identify the claim involved including the date of service, the health care provider, the claim amount (if applicable),

[2] The June 24, 2011 Interim Final Rule establishes a single threshold with respect to the percentage of people who are literate only in the same non-English language for both the group and individual markets, set at 10 percent or more of the population residing in the claimant's county, as determined based on American Community Survey data published by the United States Census Bureau. This guidance will be updated annually if there are changes to the list of the counties determined to meet this 10 percent threshold for the county's population being literate only in the same non-English language. Currently, there are no Kentucky counties that meet the applicable threshold requirement.

		and a statement describing the availability, upon request, of the diagnosis code (such as an ICD-9 code), the treatment code (such as a CPT code), and the corresponding meanings of these codes; • The specific reason or reasons for the adverse benefit determination including the denial code (such as a CARC and RARC) and its corresponding meaning, as well as a description of the insurer's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision; • A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; • Disclosure of 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.
Deemed Exhaustion	KRS 304.17A-623(3)(b) provides that an insurer shall provide for an external review of an adverse determination if the covered person has completed the insurer's internal appeal process, or the insurer has failed to make a timely determination or notification as set forth in KRS 304.17A-619(2).	In the case of an insurer that fails to adhere to all the requirements of the internal claims and appeals process with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process. [See, 45 CFR 147.136(b)(2)]. Accordingly, the claimant may initiate an external review or pursue any available remedies under state law on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. The internal claims and appeals process will not be

		deemed exhausted based on *de minimus* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the insurer demonstrates that the violation was for good cause or due to matters beyond the control of the insurer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. Please Note: • The *de minimus* exception is not available if the violation is part of a pattern or practice of violations by the insurers; • The claimant may request a written explanation of the violation from the insurer, and the insurer must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted; • If an external reviewer or a court rejects the claimant's request for immediate review on the basis that the plan met the standards for the exception, the claimant has the right to resubmit and pursue the internal appeal of the claim; • If an external reviewer or court rejects the claim for immediate review, the insurer shall provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim; and • Time periods for re-filing the claim shall begin to run upon claimant's receipt of notice of the rejection of immediate review.

Continued Coverage of an appealed service or course of treatment	304.17A-607(1)(i) and 304.17A-615	An insurer is required to provide continued coverage pending the outcome of an internal appeal. An insurer is prohibited from reducing or terminating an ongoing course of treatment without providing advance notice and an opportunity for advance review. Additionally, individuals in urgent care situations and individuals receiving an ongoing course of treatment may be allowed to proceed with expedited external review at the same time as the internal appeals process.
Concurrent external and internal review	KRS 304.17A-623(3)(b) requires an insurer to provide for an external review of an adverse determination if the covered person has completed the insurer's internal appeal process… and KRS 304.17A-623(10) (regarding expedited external reviews).	Covered persons may pursue an expedited external review while simultaneously pursuing an expedited internal appeal under the following circumstances: 1) The scenarios listed in 304.17A-623(10), or 2) The covered person is requesting review of a determination that a recommended or requested service is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested service that is the subject of the review would be significantly less effective if not promptly initiated.
One level of appeal for individual coverage	In practice, the Department has permitted more than one level of internal appeal provided all levels of internal appeal are completed within applicable statutory time frames governing internal appeals. KRS 304.17A-617(2)(a)	Insurer's offering individual health insurance coverage may have only one level of internal appeals. An insurer providing group health benefit plan coverage may provide more than one level of internal appeal, but the process for multiple levels shall not take more than 60 days from the date of initial appeal by the member to issuance of the final adverse benefit determination.