Health Care Reform (PPACA) Update
Rules on Internal Claims Appeal and External Reviews Released

On July 23, 2010, the Departments of the Treasury, Labor ("DOL") and Health and Human Services ("HHS") released interim final regulations for group health plans and health insurance coverage relating to internal claims and appeals and external review processes under the Patient Protection and Affordable Care Act ("Affordable Care Act"). These regulations are under Section 9815(a)(1) of the Internal Revenue Code ("Code"), Section 715(a)(1) of the Employee Retirement Income Security Act ("ERISA") and Section XXVII of the Public Health Service Act (26 CFR 54.9815-2719T, 29 CFR 2590.715-27109 and 45 CFR 147.136). The following will summarize the provisions of these regulations.

Introduction

Group health plans and health insurance companies must to establish internal claims appeal and external review procedures. They must:

- Provide notice to enrollees "in a culturally and linguistically appropriate manner" of the availability of internal and external appeals procedures and the availability of the office of health insurance consumer assistance or ombudsman to assist the enrollee with the claims procedures (office or ombudsman must be established by the states);

- Allow the enrollee to review the enrollee's file and present evidence and testimony as a part of the appeals process; and

- Allow the enrollee to continue to receive health coverage pending the outcome of the appeals process.

To establish an external review process, group health plans and insurance companies must comply with any applicable state external review process or implement an effective external review process that meets minimum standards to be established by the Secretary.

These requirements are in addition to any ERISA claims procedures, although the existence of ERISA claims procedures may be used to establish the existence of an internal claims appeal process.

This provision is effective for plan years beginning on and after September 23, 2010 and does not apply to grandfathered health plans.

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Internal Claims and Appeals Process

All plans and insurance companies are required to comply with the 2000 claims and appeals regulations under Section 503 of ERISA, including insurance companies not otherwise subject to ERISA. The new regulations impose six additional requirements that group insured and self-insured plans (including groups not covered by ERISA) must comply with, in addition to the existing DOL ERISA regulations:

1. It extends the internal appeals process to cover rescissions as well as adverse benefit determinations. An adverse benefit determination eligible for internal claims and appeals processes under these regulations includes a denial of, reduction of, termination of, or failure to provide or make a payment for a benefit, including the following:

- 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 pre-existing condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate

2. It requires plans or insurance companies to notify members of determinations in urgent care claims within 24 hours rather than the 72 hours provided for in the DOL regulations.

3. Plans or insurance companies must provide claimants, without charge, any new or additional information relied upon or generated by the plan as soon as possible and far enough in advance of a determination to allow an opportunity to respond. If plans or insurance companies make an adverse determination on a new or additional rationale, they also must provide this to the claimant in time to allow a response.

4. Plans and insurance companies must ensure that internal reviewers do not have a conflict of interest. In particular, the rule prohibits hiring, compensating, terminating, or promoting the claims adjudicators or medical experts based on the likelihood that they will deny benefits.

5. Plans and insurance companies must provide culturally and linguistically appropriate notices as well as detailed information on diagnosis, treatment, denial codes, and the meaning of the codes, so that claimants can understand which claim was denied and why. The notice must explain the standard applied in the denial and inform the claimant of the availability of internal and external appeals and how to contact the consumer assistance or ombudsman office for assistance. The DOL and HHS will issue model notices. Model notices that can be used to satisfy all the notice requirements under these interim final

regulations will be made available in the future at http://www.dol.gov/ebsa and http://www.hhs.gov/ociio/.

6. If plans or insurance companies fail to strictly adhere to the requirements of the process, the claimant may proceed to an external appeal or judicial review, even if the error was minor and the plan or insurer substantially complied with the requirements.

Individual health plans must comply with the same rules, plus three separate requirements.

1. The internal appeals process also covers initial eligibility determinations, including pre-existing conditions denials.

2. Only one level of internal appeal is permitted, as compared to group plans where the DOL rules permit two levels of internal appeals.

3. Individual health insurers must maintain records of claims and appeals for six years. They must make these records available for examination upon request and without charge to regulators.

External Review

Plans and insurance companies must comply with either a state external review process or the federal external review process. If a state has in place an external review process offering at least as much protection as the NAIC Model Act, an insurance company must comply with the state law. Plans and insurance companies not subject to state law (self-insured employee benefit plans), or located in states without external review laws as protective as the NAIC Model Act, must comply with a federal external review process yet to be established.

For health insurance coverage, if a state external review process includes, at a minimum, the consumer protections in the NAIC Uniform Model Act in place on July 23, 2010, then the issuer must comply with the applicable state external review process and not with the federal external review process. In such a case, to the extent that benefits under a group health plan are provided through health insurance coverage, the issuer is required to satisfy the obligation to provide an external review process, so the plan itself is not required to comply with either the state external review process or the federal external review process.

These regulations do not preclude a state external review process from applying to and being binding on a self-insured group health plan under some circumstances.

While the preemption provisions of ERISA ordinarily would prevent a state external review process from applying directly to an ERISA plan, ERISA preemption does not prevent a state external review process from applying to some self-insured plans, such as nonfederal governmental plans and church plans not covered by ERISA preemption, and multiple employer welfare arrangements, which can be subject to both ERISA and state

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insurance laws. A state external review process could apply to such plans if the process includes, at a minimum, the consumer protections in the NAIC Uniform Model Act.

These regulations set forth the standards that would apply to claimants, plans, and issuers under this federal external review process, and the substantive standards that would be applied under this process, which are similar to a state external review process. They also provide that the federal external review process, like the state external review process, will provide for expedited external review and additional consumer protections with respect to external review for claims involving experimental or investigational treatment.

These requirements do not apply to grandfathered health plans. How non-grandfathered self-insured group health plans may comply or be brought into compliance with the requirements of the new federal external review process will be addressed in future "sub-regulatory guidance."

For a state external review to apply instead of the federal process, the state external review process must include the following elements from the NAIC Uniform Model Act:

- Provide for the 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.

- Require issuers to provide effective written notice to claimants of their rights.

- Make exhaustion of internal review unnecessary if: the issuer has waived the exhaustion requirement, the claimant has exhausted the internal claims and appeals process under applicable law, or the claimant has applied for expedited external review.

- Provide that the issuer must pay the cost of an independent review organization ("IRO") for conducting the external review.

- Not impose a restriction on the minimum dollar amount of a claim for it to be eligible for external review (for example, a $500 minimum claims threshold).

- Allow at least four months after the receipt of a notice of an adverse benefit determination or final internal adverse benefit determination for a request for an external review to be filed.

- Provide that an IRO will be assigned on a random basis or another method of assignment that assures the independence and impartiality of the assignment process.

- Provide for maintenance of a list of approved independent review organizations qualified to conduct the review based on the nature of the health care service that is the subject of the review.

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- Provide that any approved IRO has no conflicts of interest that will influence its independence.

- Allow the claimant to submit to the IRO in writing additional information that the IRO must consider when conducting the external review and require that the claimant is notified of such right to do so.

- Provide that the decision is binding on the plan or issuer, as well as the claimant, except to the extent those other remedies are available under state or federal law.

- Provide that, for standard external review, within no more than 45 days after the receipt of the request for external review by the IRO, the IRO must provide written notice to the issuer and the claimant of its decision to uphold or reverse the adverse benefit determination.

- Provide for an expedited external review in certain circumstances and, in such cases, the state process must provide notice of the decision as expeditiously as possible, but not later than 72 hours after the receipt of the request.

- Require that issuers include a description of the external review process in the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to claimants.

- Follow procedures for external review of adverse benefit determinations involving experimental or investigational treatment, substantially similar to what is set forth in the NAIC Uniform Model Act.

Existing state external review requirements that do not contain these essential elements will govern plans and insurers for a transitional period until the first plan year beginning after July 1, 2011, after which the federal process will govern unless the state updates its statute to comply. As required by the statute, the various Departments will establish an external review process similar to the state process to govern self-insured plans and insured plans not governed by state law.

These regulations are effective on September 21, 2010 (effective 60 days after publication in the Federal Register). However, the rules generally apply to group health plans and group health insurance issuers for plan years beginning on or after September 23, 2010.

For additional information on Health Care Reform, please visit www.midamgroup.com/html/healthcare-reform.htm

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