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# Health Care Reform: Internal Claims and Appeals and External Review Process

*In March, President Obama signed the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA), together referred to as the Act. This e-alert is the latest in a series of e-alerts and describes additional information about new internal claims and appeals rules and a new external review process required by PPACA.*

PPACA adds section 2719 to the Public Health Safety Act (PHSA)[1], providing new internal claims and appeals and external review processes. This section applies to non-grandfathered health plans as of the first day of the first plan year beginning on or after September 23, 2010.

On July 23, 2010, the Department of Health and Human Services (HHS), Department of Labor (DOL) and Department of the Treasury (the Departments) jointly issued regulations regarding the new internal claims and appeals and external review processes.

## Internal Claims and Appeals Process

In general, group health plans (and health insurance issuers offering group health insurance coverage) must comply with all the existing requirements for internal claims and appeals, as described in the Employee Retirement Income Security Act (ERISA) claims procedure regulations. The PPACA regulations add six new requirements.

1. The regulations define adverse benefit determination in the same manner as under the existing ERISA claims regulations, with the addition of treating a rescission of coverage as an adverse benefit determination. Generally, a rescission of coverage under PPACA and the related guidance includes a cancellation or discontinuation of coverage with a retroactive effect.
2. The regulations accelerate the timeframe for notifying a claimant about urgent care claims to as soon as possible, but not later than 24 hours after receipt of the claim.
3. The plan must provide the claimant, at no cost, with any new or additional evidence considered in connection with the claim as part of the appeals process. Similarly, if the plan will issue a denial on review based on new or

**POSTED:**

Aug 14, 2010

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additional rationale, the plan must provide the claimant that rationale free of charge. In either case, the new evidence or new rationale must be provided to the claimant as soon as possible and sufficiently in advance of the deadline for providing notice of the adverse benefit determination on review to allow the claimant a reasonable opportunity to respond prior to that date.

4. The plan must ensure that all claims and appeals are adjudicated in an impartial manner. Specifically, decisions regarding hiring, compensation, termination, promotion or other matters with respect to any individual must not be based upon the likelihood that the individual will support a denial of benefits.
5. The regulations expand the notice requirements related to adverse benefit determinations. The Departments intend to issue model notices for these purposes.
    - Plans must provide required notices in a culturally and linguistically appropriate manner. If the plan covers fewer than 100 participants at the beginning of a plan year and 25% or more of all plan participants are literate only in the same non-English language, the plan must provide notices upon request in that non- English language. If the plan covers 100 or more participants at the beginning of a plan year and the lesser of 500 or more participants or 10% of all plan participants are literate only in the same non-English language, the plan must provide notices in that non-English language.
    - The notice must include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
    - The reason for denial must include the denial code and its corresponding meaning or a description of the plan's standard used in denying the claim.
    - The plan must describe the available internal appeals and external review process.
    - The plan must provide the contact information for any applicable office of health insurance consumer assistance or ombudsman to assist with internal claims and appeals and external review processes.
6. If a plan fails to strictly adhere to the requirements of these regulations, the claimant is deemed to have exhausted the internal claims and appeals process, regardless of whether the plan substantially complied with the process or any error committed was only de minimis. The claimant is then

entitled to pursue any available remedies under ERISA or state law. If the claimant pursues remedies under ERISA, the claim or appeal is deemed denied on review without exercise of discretion by an appropriate fiduciary.

For insured plans, if either the plan or the insurance issuer complies with the internal claims and appeals process, the requirements are satisfied.

Plans must also maintain coverage while internal appeals are pending.

## Individual Coverage Claims and Appeals

Health insurance issuers offering individual coverage must generally comply with all of the requirements applicable to group health coverage. The regulations include the following additional requirements applicable to individual coverage.

- The scope of the claims and appeals process extends to include initial eligibility determinations for individual coverage.
- Insurance issuers offering individual coverage must maintain only one level of internal appeals.
- Insurance issuers offering individual coverage must maintain records of all claims and notices associated with internal claims and appeals processes for at least six years.

## External Reviews

PHSA section 2719 and the regulations provide that plans must comply with either a state external review process or a federal external review process. The regulations describe whether a state or the federal process will apply.

- **State Standards**—Applicable state external review processes will apply to insured coverage and non-ERISA self-funded plans (such as governmental plans and church plans), provided the state process satisfies the NAIC (National Association of Insurance Commissioners) Uniform Model Act related standards, as in effect on July 23, 2010. If the state process does not satisfy the NAIC Uniform Model Act standards, then affected plans must comply with the federal external review process instead.
  Based on the NAIC Uniform Model Act, a State's external review process must:
  - Allow review of decisions based on medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit
  - Require written notice of external review rights
  - Allow the exhaustion rules for internal appeals to be waived in certain limited

situations
- Require the insurance issuer (or the plan) to pay the cost of an independent review organization (IRO) for conducting the review
- Not require a minimum dollar amount for external review
- Allow an individual at least four months to request an external review
- Provide that the IRO will be assigned on a random basis or in another impartial manner and provide a list of approved IROs
- Allow the claimant to submit to the IRO written information regarding the review
- Make the IRO decision binding on the insurance issuer and plan, subject to other available legal remedies
- Require the decision from the IRO within 45 days of receipt of the external review request by the IRO. Expedited review may occur in certain circumstances, requiring a decision within 72 hours of receipt of the request
- Require insurance issuers to describe the external review process in pertinent plan documents (for example, a summary plan description)
- Require the IRO to maintain written records regarding external reviews
- Follow certain procedures for review of experimental and investigative treatments

PHSA section 2719 allows the Departments to consider existing state external review processes in effect on March 23, 2010 to satisfy the external review requirements. To allow states time to conform external review processes to these requirements, the regulations provide a transition period for plan years beginning before July 1, 2011. During this time, existing State external review processes will be treated as meeting the minimum standards described in the regulations. Accordingly, affected plans should follow existing processes during this time period.

- **Federal Standards**—Plans that are not subject to a State external review process (for example, self-funded ERISA plans) must comply with the federal external review process. The Departments did not describe a federal review process in these regulations but indicated that more guidance is forthcoming. In the interim, the regulations state that the federal external review process will be similar to the NAIC Uniform Model Act process. More specifically, the federal process will:
  - Describe how a claimant initiates an external review, procedures for a preliminary review to determine eligible claims, minimum qualifications for IROs, a process for approving IROs, a process for assigning reviews to

approved IROs, standards for IRO decision making and rules for providing notices to the claimant
- Provide for expedited external review of certain claims
- Provide additional consumer protections for claims involving experimental or investigative treatments
- Make the IRO decision binding on the plan, subject to other available legal remedies
- Establish external review reporting requirements for IROs
- Establish additional notice requirements for plans to describe the external review process
- Require plans to provide information relevant to processing the review to claimants

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[1]PPACA adds section 715(a)(1) to the Employee Retiree Income Security Act of 1974 (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of Part A of Title XXVII of PHSA into ERISA and the Code and make them applicable to group health plans and health insurance issuers providing insurance coverage to group health plans. PHSA section 2719 is included in the effective sections.