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Interim Final Rules on New Appeals Process

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Under the Patient Protection and Affordable Care Act, a non-grandfathered group health plan must adopt an improved internal claims and appeal process and follow minimum requirements for external review. On July 23, 2010, interim final regulations were issued implementing these requirements (the Interim Final Rule). The appeals process rules are effective for **plan years beginning on or after September 23, 2010.** It does not apply to grandfathered health plans.

Key provisions of the Interim Final Rule include information on:

- How to comply with updated internal claims and appeals processes;
- Determining whether a state or federal external review process applies for appeals, along with guidance for each process; and
- Requirements for notices in connection with the appeals process.

SUMMARY OF THE INTERIM FINAL RULE

-Internal Claims and Appeals Process for Group Health Plans

Health care reform requires group health plans to implement an effective internal claims and appeals process. These plans, as well as health insurance issuers providing their health insurance coverage, must follow the Department of Labor's claims procedure rules for group health plans.[1]

In addition to the existing DOL claims procedure regulations, group health plans must follow a number of new requirements:

1. ***New Definition of "Adverse Benefit Determination."*** The definition of the term adverse benefit determination is found in the claims procedure regulations. It includes a denial, reduction, termination of, or failure to pay for (in whole or in part), a benefit under the plan. It includes decisions based on an individual's eligibility to participate in the plan, a benefit not being a covered benefit, imposition of an exclusion, or a benefit being experimental or not medically necessary. Denials can include both pre- and post-service claims.

   The Interim Final Rule adds rescissions of coverage to the definition of the term adverse benefit determination. A rescission is a cancellation or discontinuation of coverage that has a retroactive effect. A cancellation because of a failure to timely pay premiums for coverage is not considered a rescission.

2. ***Expedited Notice for Urgent Care Claims.*** Under the Interim Final Rule, group health plans must notify claimants of a benefit determination involving an urgent care claim more quickly. The new deadline is as soon as possible, taking into account the medical circumstances, but not later than **24 hours** after the plan gets the claim. There is an exception to the deadline if the claimant does not provide enough information to

[1] www.federalregister.gov/a/00-29766

the plan. The prior rule required the notice to be given within 72 hours. The change is attributable to faster decision-making capabilities, due to electronic communication.

3. ***Full and Fair Review***. In addition to complying with the claims procedure regulations' existing requirements, group health plans must follow additional rules to make sure claimants receive a full and fair review. Specifically, the plan must give the claimant any new evidence related to the claim or new rationale for a decision, free of charge. It must be provided as soon as possible and early enough before the appeal deadline to let the claimant respond.
4. ***Avoiding Conflicts of Interest***. Group health plans must make sure that all claims and appeals are decided in a way that avoids conflicts of interest. The decision method must be designed to ensure the independence and impartiality of the decision-makers. The decision to hire a person involved in deciding claims or appeals must not be made based on the likelihood that they will support a denial of benefits. For example, a plan cannot provide bonuses based on the number of denials made by a claims adjudicator. Also, a plan cannot hire a medical expert based on his or her reputation for outcomes in contested cases, rather than his or her professional qualifications.
5. ***Deemed Exhaustion of Internal Claims and Appeals Processes***. If a plan fails to comply with these rules, the claimant will be deemed to have exhausted the plan's internal claims and appeals process, even if the plan claims that it substantially complied with the requirements. That means that the claimant is free to pursue other remedies, such as external review or a lawsuit.
6. ***Continued Coverage Pending Outcome of Internal Appeals***. Under the new rules, a plan must continue to provide coverage to the claimant until an internal appeal is resolved. Generally, this means that plans may not reduce or terminate an ongoing course of treatment without advance notice and an opportunity for advance review. Also, anyone in an urgent care situation or receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal appeal.

-<u>External Review Standards</u>

Group health plans must comply with either a state external review process or the federal external review process. The Interim Final Rule provides guidance on which process must be followed.

- ***State Standards for External Review***

  If a state external review process that applies to and is binding on an insurance issuer includes the consumer protections in the NAIC Uniform Model Act in place on July 23, 2010, then the issuer must comply with that state external review process. In that case, where benefits under a group health plan are provided through health insurance coverage, the issuer must provide the external review process and the group health plan itself is not obligated to do so. Some self-insured group health plans may be subject to the state external review process if they are not subject to ERISA preemption.

  Any plan or issuer that is not subject to a state external review process must comply with the federal external review process. A plan or issuer will be subject to the federal process if there is no state external review process or if the state external review process does not meet the minimum requirements of the NAIC Uniform Model Act.

  The Department of Health and Human Services will determine whether a state external review process meets the minimum requirements. HHS will also provide a transition period for plan years beginning before July 1, 2011, where existing state external review processes will be treated as meeting the minimum requirements. This transition period will give states the opportunity to review and amend their processes. For plan years beginning on or after July 1, 2011, the federal external review process will apply unless HHS determines that the state process meets the minimum standards.

- ***Federal External Review Process***

  The health care reform law requires a federal external review process to be established. The Interim Final Rule does not establish that process, but it does describe the standards that will be included. Plans or issuers that are not subject to a state external review process will have to follow the federal process. For an insured

group health plan, if either the issuer or the plan complies with the federal process, then the obligation is satisfied for both the plan and the issuer.

The federal external review process will apply to most adverse benefit determinations or final internal adverse benefit determinations, including rescissions. However, it will not apply to denials based on a participant or beneficiary's ineligibility for the plan.

The standards to be issued for the federal external review process will include procedures for initiating and conducting the review, an expedited external review process for certain claims, additional consumer protections for claims involving experimental or investigational treatment, and additional notices and disclosures to claimants.

-Required Notices

The Interim Final Rule provides new standards regarding notice to enrollees. Group health plans must provide notices required by the claims procedure regulations in a culturally and linguistically appropriate manner. The notices must also include the following additional content:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code and its meaning, and the treatment code and its meaning;
- The reason for the denial must include the denial code and its meaning, as well as any standard used in denying the claim;
- A description of available internal appeals and external review processes, including information about how to initiate an appeal; and
- Contact information for any applicable office of health insurance consumer assistance to assist individuals with the internal claims and appeal and external review processes.

For additional information please click on the following link or contact your Lawley Benefits Consultant:

www.federalregister.gov/a/2010-18043.