Interim Final Rules for Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act

The Departments of Health and Human Services, Labor and Treasury recently issued an interim final regulation (IFR) regarding the requirement that group health plans and health insurance issuers implement an effective internal claims and appeal process, as well as an effective external review process (see also the previous *GT Alert*, Agencies Issue Guidance on Health Reform Provisions).

The IFR builds upon and enhances existing ERISA claims procedures applicable to group health plans and adds some new requirements. Existing ERISA claims procedures require adjudication of claims and appeals within specified time frames that vary depending on the type of claim (urgent care, pre-service, concurrent care, or post-service), the sufficiency of the information, and the number of appeals. For insurers (including those participating in the individual market) and plans not currently subject to ERISA (e.g., many non-federal government and church plans), these claims procedure requirements will become applicable to them for the first time. The Departments shall issue guidance shortly on the external review process, including guidance on when an external review process in existence as of March 23, 2010 will be deemed to be in compliance with the Act.

Internal Claims and Appeals Process

Group health plans (whether insured or self-insured) and health insurance issuers offering group health insurance coverage must comply with the Department of Labor's (DOL) claim procedure and six new requirements in the interim final regulations:

1. *Definition of Adverse Determination.* The definition of an adverse determination, which historically has been defined to include a denial, reduction, or termination of, or a failure to provide or make a payment for a benefit, has been revised to include a rescission of coverage (i.e., a termination of coverage with retroactive effect). Rescission of coverage is an adverse determination regardless of whether there is an adverse effect on any particular benefit at that time.

2. *Expedited Notification of Benefit Determination Involving Urgent Care.* A plan or issuer must notify a claimant of a benefit determination regarding urgent care (whether adverse or not) as soon as possible, but no later than 24 hours after receiving the claim. This shortens the current ERISA claims procedure, which generally requires a determination not later than 72 hours after receiving the claim.

3. *Full and Fair Review.* A plan or issuer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the plan or issuer in connection with the claim. Such evidence must be provided sufficiently in advance in order to provide the claimant an opportunity to respond prior to the date on which the notice of the determination must be given. The claimant must also receive the rationale relied upon in an adverse benefit determination on review (i.e., internal appeal), before that determination is issued so that the claimant has an opportunity to respond.

4. *Eliminating Conflicts of Interest.* A plan or issuer must ensure that claims and appeals processes are handled with independence and impartiality. The IFR requires that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual involved in claims determinations must not be based on the likelihood that the individual will support a denial of benefits. For example, bonuses cannot be based on the number of claims denials. In addition, a plan or issuer may not contract with a medical expert based on the expert's reputation for outcomes in contested cases, rather than based on the expert's professional qualifications.

5. *Enhanced Notice.* In addition to complying with existing notice requirements, a plan or issuer must provide notice to enrollees in a culturally and linguistically appropriate manner. If a threshold number of people are only literate in a specific language, notices must be provided in such language. Any notice of adverse benefit determination or final internal adverse benefit determination must also include information sufficient to identify the claim involved. Along with the notice, the plan or insurer must provide a description of available internal appeals and external review processes, and of how to initiate an appeal. Finally, the plan or issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes. Model notices will soon be available at http://www.hhs.gov/ociio/.

6. *Deemed Exhaustion of Internal Process.* Under existing rules, a claimant must generally exhaust all internal claims and appeals processes before bringing suit. If a plan or issuer fails to adhere **strictly** to all the requirements of the internal claims and appeals process with respect to a particular claim, the claimant will be deemed to have exhausted the internal claims and appeals process, and may initiate an external review and pursue any available remedies under applicable law.

Continued Coverage

A plan or issuer must provide continued coverage pending the outcome of an internal appeal. Individuals in urgent care situations and those receiving an ongoing course of treatment may be allowed to proceed with expedited external review at the same time as the internal appeals process.

Additional Requirements for Issuers in the Individual Insurance Market

Health insurance issuers offering individual health insurance coverage must generally comply with all the requirements described above. Three additional requirements also apply:

1. The internal claims and appeals process is expanded to cover initial eligibility determinations for individual health insurance coverage.

2. Health insurance issuers offering individual health insurance coverage must have only one level of internal appeals.

3. Health insurance issuers offering individual health insurance coverage must maintain records of all claims and notices associated with their internal claims and appeals processes. Records must be maintained for six years, and must be made available for examination on request.

State Standards for External Review

The IFR provides a basis for determining whether a group health plan or health insurance issuer must comply with a State or Federal external review process. The Departments may determine that an external review process of a plan or issuer that was in effect as of March 23, 2010, to be in compliance with a state or Federal (as applicable) external review process. For health insurance coverage, if a State external review process is binding on the plan (e.g., an insured plan or a self-insured plan where ERISA does not apply such as a church plan) or issuer and includes certain enumerated consumer protections of the NAIC Uniform Model Act in place on July 23, 2010, then the plan or issuer must comply with that State external review process.

For plans and issuers subject to existing State external review processes, these processes will continue to apply until July 1, 2011, regardless of whether they meet the minimum standards articulated above.

Federal External Review Process

If a plan or issuer is not subject to a State external review process (e.g., a self-insured ERISA plan), or if the applicable State external review process does not meet the NAIC Uniform Model Act requirements, the plan or issuer must comply with the Federal external review process. The Federal process will apply for plan years beginning from September 23, 2010 and guidance on the Federal process is expected shortly. Claims eligible for review under the Federal external review process are "adverse benefit determinations" and "final internal adverse benefit determinations," defined the same way as they are for purposes of internal claims and appeals (thus including rescission of coverage).This **excludes** determinations that relate to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of a group health plan (i.e., worker classification and similar issues).

The IFR sets forth the standards that apply to claimants, plans, and issuers under the Federal external review process. The Federal 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.

Applicability Date

The requirements to implement effective internal and external claims and appeals processes apply for plan years (in the individual market, policy years) beginning on or after September 23, 2010.

Grandfathered Plans

The IFR does **not** apply to grandfathered health plans.

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