



**Recent Federal Regulations Mandate Tough New
Minimum Health Benefit Appeal Rights***

Robin Fisk, Esquire

Fisk Law Office

Ashland, NH

On July 23, 2010, new interim final rules were published implementing the claim appeal and external review processes required for “health insurance issuers” and group health plans.¹ These new rules, authored jointly by the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and Treasury are intended to implement Sections 2712 (giving patients rights if a rescission occurs) and 2719 (requiring an effective appeals process) of the Public Health Services Act, as enacted by the Patient Protection and Affordable Care Act (ACA) at § 1001. The stated purpose is to bring some uniformity to the “patchwork of consumer protections . . . provided to participants, beneficiaries and enrollees” in group and non-group markets, ERISA and ERISA-exempt plans, and among the various states.² These new requirements enhance an important set of rights for enrollees and for providers assisting their patients with coverage disputes. They will also require changes to most plans’ and health insurers’ appeal systems and member materials.

These interim final rules (IFR) which are open for comment through September 21 will be effective for plan years beginning on and after September 23, 2010. Section 1251 of the Public Health Service Act, as added by the ACA, excludes “[Grandfathered Plans](#)” from the requirements.

¹ Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims Appeals and External Review Processes Under the Patient Protection and Affordable Care Act; 75 Federal Register 43330, July 23, 2010.

² 75 Fed. Reg. at 43339.

Internal Appeals

The ACA requires all group health plans (sometimes described as “self insured”) and health insurance issuers offering group or individual health insurance coverage to have an “effective appeal process.” The IFR implements this requirement by requiring all insured and self-insured group health plans to comply with the requirements for an effective internal claim and appeal process found in the existing ERISA regulations.³ The IFR also adds “more comprehensive” standards for internal appeal processes (see below). Although the requirements for internal appeals and external review apply to group plans and health insurance issuers (HII), it is sufficient if either the plan or the HII maintains the process.⁴

Additional Requirements for an Effective Internal Claim Appeal Process

In addition to requiring compliance with existing DOL rules (29 CFR § 2560.503-1) for appeals, the IFR adds six requirements for an effective internal claim appeal process:

- Amends the definition of Adverse Benefit Determination (ABD) to include a rescission of coverage;⁵
- Requires expedited benefit determinations to be made and notice sent as soon as possible, but no later than twenty-four hours after receipt of a claim, rather than the previously required seventy-two hours.⁶ The effective date for enforcing this requirement against self-funded nongovernmental group plans has been postponed to July 1, 2011.⁷

³ See 29 CFR 2560.503-1, available at http://edocket.access.gpo.gov/cfr_2009/julqtr/pdf/29cfr2560.503-1.pdf.

⁴ 75 Fed. Reg. at 43332.

⁵ 75 Fed. Reg. at 43358, adding 45 C.F.R. 147.136(a)(2)(i). Although the IFR also includes substantially similar changes to the Treasury regulations at 26 C.F.R. 54.9815 and the Department of Labor regulations at 29 C.F.R. 2590.715, all citations will be to the Public Health Service regulations unless otherwise noted.

⁶ 75 Fed. Reg. at 43359, adding 45 C.F.R. 147.136(b)(2)(ii)(B).

⁷ HHS Guidance “[Interim Procedures for Internal Claims and Appeals Under the Patient Protection and Affordable Care Act](#)” (September 20, 2010).

- Allows claimants to review any evidence considered by the plan or HII free of charge. This evidence must be provided in sufficient time to allow the claimant to respond before the due date for the coverage decision;⁸
- Before the plan or HII can issue a final internal adverse benefit determination (Final Determination) based on a new or additional rationale, requires the Plan/HII to inform the claimant of the rationale sufficiently in advance of the Final Determination to allow the claimant to respond before the due date for the decision;⁹
- Avoids conflicts of interest by barring any [dis] incentive applicable to hiring, compensation, termination, etc. that is based on the likelihood that an individual (such as a claims adjudicator) will support a denial of benefits. This precludes selecting a medical expert based upon his or her track record with prior decisions.¹⁰
- Requires a plan or HII to provide notices of appeal rights to individuals in a “culturally and linguistically appropriate manner.” (see below) In addition, the plan/HII must ensure that the ABD or Final Determination allows the claimant to identify services covered by the claim and the reason(s) for the decision, including denial code, its meaning, and any plan/HII standard relied on in the decision. A Final Determination must also include a discussion supporting the decision. The notice must describe appeal rights, how to file, and the contact information for any Office for Consumer Assistance ombudsman as established by Public Health Service Act § 2793.¹¹ Model notices are forthcoming. Model notices can be found on the Office of Consumer Information and Insurance Oversight’s website.¹² The effective date for enforcing these notice

⁸ 75 Fed. Reg. at 43359, adding 45 C.F.R. 147.136(b)(2)(ii)(C)(1).

⁹ 75 Fed. Reg. at 43359, adding 45 C.F.R. 147.136(b)(2)(ii)(C)(2).

¹⁰ 75 Fed. Reg. at 43359, adding 45 C.F.R. 147.136(b)(2)(ii)(D).

¹¹ 75 Fed. Reg. at 43359-60, adding 45 C.F.R. 147.136(b)(2)(ii)(E)(1)-(4).

¹² See www.hhs.gov/ociio/regulations/consumerappeals/index.html.

- The plan or HII must provide continued coverage pending the outcome of an appeal of a decision to terminate or reduce an ongoing course of treatment.¹⁴

If the plan or HII fails to comply with these requirements—even “de minimis” non compliance—the internal processes are deemed exhausted and the claimant is entitled to any available external remedies, including any state law remedy because the HII has failed to provide a reasonable claims appeal process.¹⁵ However, the effective date for enforcing this strict compliance requirement against self-funded nongovernmental group plans has been postponed to July 1, 2011.¹⁶

Effective for policy years beginning on or after September 23, 2010, HIIs offering policies in the individual market must comply with the requirements of the ERISA internal claims and appeal procedures at 29 CFR § 2560.503-1, and the six requirements added above. (Certain standards specifically intended for multiemployer plans do not apply.) In addition, HII offering individual policies must:

- Offer rejected applicants an opportunity to review the reasons why their coverage application was denied and to challenge incorrect information used in making the decision;¹⁷
- Offer only one level of internal review before the participant is entitled to external review or judicial review, as applicable. (The second level of review is deemed unnecessary for individual plans because this level is often used to allow a group plan’s sponsor to review the decision.);¹⁸

¹³ HHS Guidance “[Interim Procedures for Internal Claims and Appeals Under the Patient Protection and Affordable Care Act](#)” (September 20, 2010).

¹⁴ 75 Fed. Reg. at 43360, adding 45 C.F.R. 147.136(b)(2)(iii).

¹⁵ 75 Fed. Reg. at 43360, adding 45 C.F.R. 147.136(b)(2)(ii)(F).

¹⁶ HHS Guidance “[Interim Procedures for Internal Claims and Appeals Under the Patient Protection and Affordable Care Act](#)” (September 20, 2010).

¹⁷ 75 Fed. Reg. at 43360, adding 45 C.F.R. 147.136(b)(3)(ii)(A).

¹⁸ 75 Fed. Reg. at 43361, adding 45 C.F.R. 147.136(b)(3)(ii)(G).

- Retain for at least six years records of all notices and claims pertaining to its internal claims and appeal process and make them available for review by claimants and state/federal oversight agencies.¹⁹

Provisions Pertaining to External Review

Prior to the enactment of the ACA, self-insured group health plans were subject to the ERISA requirements for external reviews while insured plans were required to comply with any applicable state external review law. Further, states' laws varied significantly with some external review laws applying to some insurance products, but not others. Six states had no external review laws.

The IFR establishes minimum external review requirements for HII and non-grandfathered self insured group health plans (Non Grandfathered Plans).

Must an Insured Plan Comply with State or Federal External Review Requirements?

The IFR requires an Issuer to comply with any applicable state external review law if HHS determines that the law meets the minimum consumer protections contained in the National Association of Insurance Commissioners (NAIC) Uniform Health Carrier External Review Model Act (NAIC Model Law), adopted in April 2010.²⁰

The IFR identified these minimum consumer protections as:

- Provides external review for ABDs and Final Determinations made based on any of the following:
 - o medical necessity;
 - o appropriateness;
 - o healthcare setting;
 - o level of care; or
 - o effectiveness of a covered benefit;²¹

¹⁹ 75 Fed. Reg. at 43361, adding 45 C.F.R. 147.136(b)(3)(ii)(H).

²⁰ The NAIC Model Law is *available at* www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf.

²¹ 75 Fed. Reg. at pg. 43361, adding 45 C.F.R. 147.136(c)(2)(i).

- Requires issuers to give claimants effective written notice of their right to external review;²²
- If the state law requires exhaustion of internal processes, it is deemed unnecessary if:
 - o the HII waives exhaustion;
 - o internal processes are deemed waived by operation of law; or
 - o the claimant asks for simultaneous expedited internal and external reviews²³
- Requires the cost of the external appeal to be paid by the HII or plan. Also acceptable if the state imposes no more than a “nominal” (≤ \$25) fee on the claimant and refunds it if the claimant prevails or waives it for financial hardship;²⁴
- Does not set a minimum \$ threshold for an external review;²⁵
- Allows a claimant ≥ four months following notice of the ABD or Final Determination to file for external review;²⁶
- Requires that the Independent Review Organization (IRO) be assigned by some process assuring independence and impartiality;²⁷
- Maintains a list of accredited IROs qualified to conduct reviews based on the type of issue;²⁸
- Ensures that no approved IRO or clinical reviewer has a conflict of interest;²⁹
- Gives the claimant the right to submit additional written information within five days which will be shared with the plan/HII and considered in the decision;³⁰

²² 75 Fed. Reg. at pg. 43361, adding 45 C.F.R. 147.136(c)(2)(ii).

²³ 75 Fed. Reg. at pg. 43361, adding 45 C.F.R. 147.136(c)(2)(iii).

²⁴ 75 Fed. Reg. at pg. 43361, adding 45 C.F.R. 147.136(c)(2)(iv).

²⁵ 75 Fed. Reg. at pg. 43362, adding 45 C.F.R. 147.136(c)(2)(v).

²⁶ 75 Fed. Reg. at pg. 43362, adding 45 C.F.R. 147.136(c)(2)(vi).

²⁷ 75 Fed. Reg. at pg. 43362, adding 45 C.F.R. 147.136(c)(2)(vii).

²⁸ 75 Fed. Reg. at pg. 43362, adding 45 C.F.R. 147.136(c)(2)(viii).

²⁹ 75 Fed. Reg. at pg. 43362, adding 45 C.F.R. 147.136(c)(2)(ix).

³⁰ 75 Fed. Reg. at pg. 43362, adding 45 C.F.R. 147.136(c)(2)(x).

- Requires the decision be binding on the parties unless other state/federal remedies are available;³¹
- Requires the IRO to provide a written decision for a standard appeal within forty-five days of receiving a request;³²
- Requires the IRO to provide a decision on an expedited appeal ASAP or within seventy-two hours of the request;³³
- Requires HII to describe the external review process in each SPD, policy, certificate of coverage, or Evidence of Coverage. (The model notice from the NAIC Model Law § 17 should be the standard for these notices);³⁴
- Requires the IRO to maintain written, auditable records and report to the state on review activities as required by NAIC Model Law § 15;³⁵ and
- Requires a process substantially similar to the procedures in the NAIC Model Law at § 10 for external review of ABDs involving experimental or investigational treatment.³⁶

In the interim, states have a transition period until July 1, 2011, to make conforming amendments to existing laws..State laws will be treated as acceptable for plan years beginning before July 1, 2011. Thereafter, HIIs operating in states with external review laws that do not meet the minimum consumer protections must use the federal process.

HIIs operating in states without external review laws must use the federal process effective for plan years beginning on or after September 23, 2010. On September 1, 2010, HHS issued interim procedures for its federal external review process.³⁷

³¹ 75 Fed. Reg. at pg. 43362, adding 45 C.F.R. 147.136(c)(2)(xi).

³² 75 Fed. Reg. at pg. 43362, adding 45 C.F.R. 147.136(c)(2)(xii).

³³ 75 Fed. Reg. at pg. 43362, adding 45 C.F.R. 147.136(c)(2)(xiii).

³⁴ 75 Fed. Reg. at pg. 43362, adding 45 C.F.R. 147.136(c)(2)(xiv).

³⁵ 75 Fed. Reg. at pg. 43362, adding 45 C.F.R. 147.136(c)(2)(xv).

³⁶ 75 Fed. Reg. at pg. 43362, adding 45 C.F.R. 147.136(c)(2)(xvi).

³⁷ HHS, Office of Consumer Information and Insurance Oversight "[Technical Guidance for Interim Procedures for Federal External Review Relating to Internal Claims and Appeals and External](#)

What External Review Requirements Apply to a Non Grandfathered Self-Insured Plan?

On August 23, 2010, DOL published a Technical Release (Technical Release) describing an interim enforcement Safe Harbor for non-grandfathered self-insured group health plans (Non Grandfathered Plans).³⁸ This Technical Release states that neither DOL nor the Treasury will take enforcement action (including assessing excise taxes) against a Non Grandfathered Plan that adopts either of two interim compliance methods. Beginning September 23, 2010, a Non Grandfathered Plan may meet the safe harbor *either* by:

- Complying with the procedures outlined in the Technical Release for external reviews and expedited external reviews; *or*
- Voluntarily complying with a state’s external review law if the state chooses to expand access to its process to Non Grandfathered Plans.

Which External Appeal Process Applies?

Plan Type & Location	State External Review Process Applies	Federal External Review Process Applies
Insured plan in State with Compliant External Review Law	√	
Insured Plan in State with Non Compliant External Review Law	Plan years before 7/1/2011 √	Plan years after 7/1/2011 √ HHS Technical Guidance applies ³⁹
Insured Plan in State without an External Review Law		√ HHS Technical Guidance applies
Self-Insured Plan		√ DOL Technical Release 2010-01 applies ⁴⁰

[Review for Health Insurance Issuers in the Group and Individual Markets under the Patient Protection and Affordable Care Act.](#)” (September 1, 2010).

³⁸ DOL Technical Release 2010-01 “[Interim Procedures for Federal External Review Relating to Internal Claims and Appeals and External Review Under the Patient Protection and Affordable Care Act](#)” (August 23, 2010).

³⁹ HHS “Technical Guidance”.

The determination of what process applies will be made as of the date of the Final Determination (including the date a Final Determination is deemed complete by operation of law) or, for expedited review when internal/external reviews will be processed simultaneously, the date of the ABD.⁴¹ *Note:* The interim processes described in the DOL’s Technical Release and those described in HHS’ Technical Guidance are similar in approach, but contain procedural differences.

Plans and Hlls Must Give Culturally and Linguistically Appropriate Notices of Internal Claims and Appeal Processes

The IFR requires that notices of appeal rights be provided in a “culturally and linguistically appropriate manner.” The rule sets out the following requirements for providing notice of appeal rights in other than English *upon request*.⁴²

Product	Non English Language Notice of Appeal Rights Required if—
Groups of < 100 Participants	≥ 25% of Participants literate only in that language
Groups of ≥ 100 Participants	Lesser of 500 or 10% of Participants literate only in that language
Individual	10% of the county population literate only in that language. County percentages posted here by September 23, 2010.

All English notices must contain a statement in the required other language saying that notices are available in that other language. Once a participant requests the non English version, all future notices must be in the other language.

⁴⁰ DOL Technical Release 2010-01. DOL, HHS, and DOI are authorized to deem an external review process in use on March 23, 2010, as compliant with either a state or federal external review requirements. 43337.

⁴¹ 75 Fed. Reg. at 43362, adding 45 C.F.R. 147.136(c)(3)(ii).

⁴² 75 Fed. Reg. at 43363, adding 45 C.F.R. 147.136(e).

In addition, HlIs offering individual policies must ensure that any customer assistance, such as telephone hotline, that assists with filing claims or appeals offers assistance in the alternative language.

**The original version of this article appeared in the author's blog, "Managed Care Contracting & Provider Payment," which is located at <http://managedcarecontracting.typepad.com/>.*

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