Agencies Release Amended Procedures for Internal Claims and Appeals and External Review

June 2011

The Departments of Health and Human Services (HHS), Labor (DOL), and Treasury on June 22, 2011 released an amendment to the interim final rules relating to internal claims and appeals and external review processes that were issued on July 23, 2010. The amendment to the interim final regulations is intended to respond to previous comments provided to the agencies, as well as to help group health plans and health insurance issuers comply with the regulations. Also on June 22, 2011, the DOL’s Employee Benefits Security Administration (EBSA) issued Technical Release 2011-02 providing additional guidance on external review for group health plans and health insurance issuers as well as revised model notices.

These new internal claims and appeals and external review processes were implemented under the Patient Protection and Affordable Care Act (Affordable Care Act) (P.L. 111-148). Under the Affordable Care Act, group health plans and health insurance issuers that are not grandfathered health plans, or that lose their grandfathered health plan status, are required to comply with these new rules, including an external review process. This report focuses solely on the changes to the processes that apply to coverage provided by group health plans or group health insurance coverage.

Internal Claims and Appeals Process

Generally, group health plans and health insurance issuers offering coverage subject to the Employee Retirement Income Security Act (ERISA) must continue to comply with the DOL claims procedure regulations. However, the interim final regulations added six new requirements, including: 1) broadening the definition of adverse benefit determination; 2) shortening requirements for urgent care determinations; 3) enhancing full and fair review requirements; 4) avoiding conflicts of interest; 5) notice and timing requirements; and 6) deemed exhaustion of the internal claims and appeals process with no de minimis exception. Below is a summary of the changes that the amendment to the interim final regulations made.

Expedited Notice of Benefit Determinations Involving Urgent Care

The July 2010 interim final regulations provided that a plan or issuer must notify a claimant of a benefit determination involving urgent care, whether adverse or not, as soon as possible but not later than 24 hours after receipt of the claim. Based on comments received, the new guidance permits plans and issuers to continue to follow the original DOL claims procedure regulations that require decisions of pre-service urgent care claims as soon as possible but no later than 72 hours. However, the plan or issuer must defer to the attending provider with respect to whether the claim constitutes urgent care.
Additional Notice Requirements

**Diagnosis and Treatment Codes.** The agencies are eliminating the requirement to automatically provide the diagnosis and treatment codes as part of a notice of adverse benefit determination or final internal adverse benefit determination that had been required in the July 2010 interim final regulations. Instead, the plan or issuer must provide notification of the opportunity to request the diagnosis and treatment codes and their corresponding meanings in all notices and are required to provide this information on request. Further, the new guidance clarifies that any request for diagnosis or treatment codes cannot be considered to be a request for (and therefore trigger the start of) an internal appeal or external review.

**Culturally and Linguistically Appropriate Form and Manner of Notice.** The Affordable Care Act requires group health plans and issuers to provide relevant notices in a culturally and linguistically appropriate manner. The July 2010 interim final regulations set forth thresholds for providing notices in a non-English speaking language. In the group market, the threshold differs depending on the number of plan participants. The new guidance establishes a single threshold for the group and individual markets. With respect to group health plans and health insurance issuers, the threshold percentage of people who are literate only in the same non-English language will be set at 10% or more of the population residing in the claimant’s county, as determined based on the American Community Survey data published by the United States Census Bureau. This information is available on the EBSA website and will be updated annually if there are changes. The new guidance also removes the “tagging and tracking” requirement that would have required individuals who request a document in a non-English language to be “tagged” and “tracked” so that any future notices would be provided automatically in the non-English language.

**Language Statement in Notice.** The new guidance requires that each notice sent by a plan to an address in a county that meets the above threshold include a one-sentence statement in the relevant non-English language about the availability of language services. Sample sentences are included in separate guidance. For ease of administration, some plans may choose to use a one-sentence statement for all notices within an entire state (or for a particular service area) that reflects the threshold language or languages in any county within the state or service area.

**Language Hotline.** The new guidance requires a plan to provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request. For this purpose, plans are permitted to direct claimants to the same customer service telephone number where representatives can first attempt to address the consumer’s questions with an oral discussion, but also provide a written translation upon request in the threshold non-English language.

**Deemed Exhaustion of Internal Claims and Appeals Process**

The July 2010 interim final regulations permitted claimants to immediately seek review if a plan or issuer failed to “strictly adhere” to all of the regulatory requirements for internal claims and appeals processes, regardless of whether the plan or issuer asserted that it “substantially complied” with the regulations. Further, in such circumstances, the reviewer would have to resolve the dispute de novo.
The new guidance provides more flexibility for plans and issuers such that a claimant can seek immediate external review or court action unless the violation was:

- De minimis;
- Non-prejudicial;
- Attributable to good cause or matters beyond the plan’s or issuer’s control;
- In the context of an ongoing good-faith exchange of information; and
- Not reflective of a pattern or practice of non-compliance.

The new guidance allows a claimant, upon written request, to request an explanation of the plan’s or issuer’s basis for asserting that it meets this standard. If the external reviewer or court rejects the claimant’s request for immediate review based on meeting the new standard, the claimant will have the right to resubmit and pursue the internal appeal of the claim.

External Review

Scope of Federal External Review Process

The July 2010 interim final regulations provided that any adverse benefit determination (including a final internal adverse benefit determination) could be reviewed unless it related 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 were not within the scope of the federal external review process). With respect to claims for which external review has not been initiated before September 20, 2011, the new guidance temporarily suspends the July 2010 interim regulations and temporarily narrows the scope of federal external review to claims that involve: 1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or 2) a rescission of coverage.

The suspension will give the marketplace time to adjust to providing external review and will allow the agencies time to evaluate independent review organizations’ (IRO) capacity for handling external reviews. The guidance states that the agencies expect to lift the suspension by January 1, 2014, at which point the agencies may decide to return to the original July 2010 rules or permanently modify the scope of claims eligible for external review through the rulemaking process.

IROs and Self-Insured Plans

**Binding IRO Decisions.** The new guidance clarifies that the IRO decisions are binding. The plan must provide benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. The guidance also notes that nothing in the law precludes a plan or issuer from choosing to provide coverage or payment for a benefit.

**Contracting With IROs.** On August 23, 2010, EBSA issued Technical Release 2010-01 that provided an interim enforcement safe harbor regarding external review for self-insured plans subject to ERISA and/or the Internal Revenue Code. Among the standards set forth in the Technical Release was a requirement
that plans contract with at least three IROs. Subsequently, in subregulatory guidance, the agencies provided that not contracting with three IROs would not be a per se violation of the law and that compliance would be determined on a case-by-case basis.

In Technical Release 2011-02, EBSA is now amending its enforcement policy so that to be eligible for the enforcement safe harbor, self-insured plans will be required to contract with at least two IROs by January 1, 2012 and with at least three IROs by July 1, 2012 and to rotate assignments among them. These requirements remain part of an enforcement safe harbor, and a plan may use an alternative process to meet the standards regarding random assignment. However, the Technical Release states that the DOL and IRS will look closely at any process other than the rotational assignment when making its case-by-case determinations. At a minimum, the DOL and the IRS expect plans to document how any alternative process constitutes random assignment, as well as how it ensures that the process is independent (not subject to undue influence by the plan) and without bias.

Duration of Transition Period for Existing State External Review Processes

In general, if state laws do not meet the minimum consumer protections of the NAIC Uniform Model Act, insurance coverage is subject to the federal external review process. The July 2010 interim final regulations provided a transition period for plan years beginning before July 1, 2011 to give states time to amend their laws to meet or go beyond the NAIC Uniform Model Act. The new guidance is ending the transition period on December 31, 2011. Therefore, before January 1, 2012, an applicable state external review process will apply in lieu of the federal external review process requirements.

Effective Date and Comments

The amendment to the interim final regulations become effective July 22, 2011. Comments on the amendment must be submitted on or before July 25, 2011.

More Information


The full text of technical Release 2011-02 is available at: http://www.dol.gov/ebsa/newsroom/tr11-02.html

The revised model notice of adverse benefit determination is available at: http://www.dol.gov/ebsa/IABDModelNotice1.doc

The revised model notice of final internal adverse benefit determination is available at: http://www.dol.gov/ebsa/IABDModelNotice2.doc

The revised model notice of final external review decision is available at: http://www.dol.gov/ebsa/IABDModelNotice3.doc
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