On July 22, 2010, the Departments of Health and Human Services (HHS), Labor (DOL), and Treasury released an interim final rule relating to internal claims and appeals and external review processes under the Patient Protection and Affordable Care Act (P.L. 111-148) (the “Affordable Care Act”), as amended by the Health Care and Education Reconciliation Act (P.L. 111-152) (the “Reconciliation Act”).

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 this revised claims and appeals rule, including an external review process. Historically, employer-sponsored group health plans utilized an internal claims and appeals process outlined in DOL regulations at 29 CFR 2560.503–1 (DOL claims procedure regulation). While the interim final rule also addresses changes to claims and appeals processes for individual health insurance coverage, this report focuses solely on 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 regulation. For most employers, this is a two-step process that begins with a benefit determination (the claim for benefits) and a benefit determination on review (the appeal of an adverse benefit determination). In addition, the interim final rule adds six new requirements that are described below. The agencies highlight that, for fully insured health insurance coverage, if the plan or the health insurance issuer complies with the internal claims and appeals process, the process is considered satisfied for both the plan and issuer. The preamble states that the DOL is considering additional, more comprehensive updates to the DOL claims procedure regulation in future guidance.

**Broadened Definition of Adverse Benefit Determination**

The interim final rule follows the definition of an adverse benefit determination contained in the DOL claims procedure regulation but adds rescission of coverage to the definition. Therefore, “adverse benefit determination” includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on:

- A determination of a participant’s or beneficiary’s eligibility to participate in a plan;
- A determination that the benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits;
■ A determination that a benefit is experimental, investigational, or not medically necessary or appropriate; or

■ A rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

As with the existing DOL claims procedure regulation, an adverse benefit determination can include both pre-service claims (such as a claim resulting from a utilization review) or post-service claims. In addition, the agencies utilize the term “final internal adverse benefit determination.” This term refers to the upholding of an adverse benefit determination at the conclusion of the internal appeals process or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted.

**Updates to Requirements for “Urgent Care” Benefit Determinations**

The interim final rule shortens the time for responding to an urgent care claim (whether adverse or not) from 72 hours to 24 hours. Specifically, a plan or issuer must now respond to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim by the plan or issuer, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance coverage.

As plan sponsors know, an urgent care claim is defined by ERISA as any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

■ Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

■ In the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

**Enhancing Full and Fair Review Requirements**

Under the DOL claims procedure regulation, when a claimant appeals an adverse benefit determination, he/she must be given an opportunity to submit written comments, documents, and records relating to the claim for benefits and to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits. The interim final rule updates the full and fair review requirements by adding the following to the DOL claims procedure regulation:

■ The plan or issuer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by or at the direction of the plan or issuer in connection with the claim; and

■ Before the plan or issuer can use a new or additional rationale to deny an appeal, the claimant must be provided, free of charge, with the rationale.

This “new” or additional information must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination must be provided, so that the claimant has a reasonable opportunity to respond before that date.

**Avoiding Conflicts of Interest**

Building on current ERISA requirements, all claims and appeals must be decided in a manner that ensures the independence and impartiality of the persons involved in making the decision. The interim final rule
specifically indicates that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

**Notice**

Plans and issuers must continue to comply with the notice and timing requirements of the DOL claims procedure regulation that currently applies to group health plans and requires:

- The notice to be written in a manner calculated to be understood by the claimant and generally include any specific reason(s) for the adverse determination, reference to the specific plan provision on which the determination is based, a description of any additional information required to perfect the claim, and a description of the internal appeal process;

- Information regarding internal rules or protocols and information about the scientific or clinical judgment when a denial is based on medical necessity, for example; and

- That the notice be provided in accordance with specified time frames for urgent care claims, pre-service claims, and post-service claims.

In addition to the above, the interim final rule directs that the notices must be provided in a culturally and linguistically appropriate manner and also sets forth new content requirements. A plan or issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

- The denial code and its corresponding meaning, as well as a description of the plan’s or issuer’s standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.

- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

- Disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist enrollees with the internal claims and appeals and external review processes.

The preamble states that the agencies intend to issue model notices that could be used to satisfy all the notice requirements under this interim final rule in the very near future.

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

The interim final rule provides that, in the case of a plan or issuer that fails to strictly follow the internal claims and appeals process requirements, the claimant will be deemed to have exhausted the internal claims and appeals process, regardless of whether the plan or issuer asserts that it substantially complied with these requirements or that any error it committed was de minimis. Accordingly, upon such a failure, the claimant may initiate an external review and pursue any available remedies under applicable law, such as judicial review. The interim final rule provides that if a claimant pursues available remedies under ERISA Section 502(a), his/her claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.
Continued Coverage Pending Outcome of Appeal

In addition to the new requirements outlined above, the interim final rule requires a plan and issuer to provide continued coverage pending the outcome of an internal appeal, including following the requirements of the DOL claims procedure regulation, which generally prohibits a plan or issuer from reducing or terminating an ongoing course of treatment without providing advance notice and an opportunity for advance review. Additionally, individuals in urgent care situations and individuals receiving an ongoing course of treatment may be allowed to proceed with expedited external review at the same time as the internal appeals process, under either a state external review process or the federal external review process, in accordance with the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners (NAIC Uniform Model Act).

External Review Process

The interim final rule requires plans and issuers to comply with either a state or federal external review process and provides guidance for determining which will apply. The preamble states that although most self-insured group health plans would be subject to the federal external review process, ERISA preemption does not prevent a state external review process from applying to some self-insured plans, such as nonfederal governmental plans and church plans not covered by ERISA preemption, and multiple employer welfare arrangements, which can be subject to both ERISA and state insurance laws. Further, to the extent that benefits under a group health plan are provided through health insurance coverage (i.e., fully insured health benefits), the issuer is required to satisfy the obligation to provide an external review process, so the plan itself is not required to comply with either the state external review process or the federal external review process.

State External Review Process

For health insurance coverage, if a state external review process that applies to and is binding on an issuer includes, at a minimum, the consumer protections in the NAIC Uniform Model Act in place on July 23, 2010, then the issuer must comply with the applicable state external review process and not with the federal external review process. The interim final rule lays out the elements from the NAIC Uniform Model Act that will be considered the minimum consumer protections that must be included for a state external review process to apply.

Transition Rule for Existing State External Review Processes

In order to allow states time to amend their laws to meet or go beyond the minimum consumer protections of the NAIC Uniform Model Act, the interim final rule provides a transition period so that existing state external review processes will be treated as meeting the minimum standards for plan years beginning before July 1, 2011. Thus, for plan years beginning before July 1, 2011, a health insurance issuer subject to an existing state external review process must comply with that state external review process and not the federal external review process.

Federal External Review Process

An employer-sponsored group health plan that is subject to ERISA will be subject to the federal external review process. In addition to self-insured group health plan benefits, the interim final rule confirms that in the case of health insurance coverage (i.e., fully-insured health benefits) either a plan or issuer is able to satisfy the federal external review process.

The interim final rule states that the federal external review process is available with respect to any adverse benefit determination or final internal adverse benefit determination (i.e., once the traditional claims and appeals process would have been exhausted). However, the federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health

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plan (i.e., worker classification and similar issues). Presumably, this means that an adverse benefits
determination relating to eligibility is exhausted at the end of the internal review process and the claimant is
not entitled to an external review process.

According to the interim final rule, the federal external review process will be similar to the process set forth
in the NAIC Uniform Model Act and will meet standards issued by the Secretary, including:

- Providing a description of how a claimant initiates an external review; procedures for preliminary reviews
to determine whether a claim is eligible for external review; minimum qualifications for independent
review organizations (IROs); a process for approving IROs; a process for random assignment of external
reviews to approved IROs; standards for IRO decision making; and rules for providing notice of a final
external review decision.

- Establishing an expedited external review process for an adverse benefit determination or a final internal
adverse benefit determination for urgent care.

- Providing additional consumer protections for claims involving experimental or investigational treatments.

- Providing that the external review decision is binding on the plan or issuer as well as the claimant, except
to the extent other remedies are available under state or federal law.

- Establishing external review reporting requirements for IROs.

- Establishing additional notice requirements for plans and issuers regarding disclosures to participants
and beneficiaries describing the federal external review process.

- Requiring plans and issuers to provide information relevant to the processing of the external review,
including, but not limited to, the information considered and relied on in making the adverse benefit
determination or final internal adverse benefit determination.

The preamble notes that the agencies will be issuing more guidance in the near future on the federal
external review process.

**Notification**

Plan sponsors will need to update summary plan descriptions, policies, certificates, membership booklets,
and related materials with respect to the new external review process. Notices must be provided in a
culturally and linguistically appropriate manner. This requirement largely pertains to the language of the
notice which varies depending on the number of participants in the plan and the number of non-English
speaking participants who participate.

**Employers With Existing External Review Processes**

The interim final rule states that the agencies may deem the external review process of a group health plan
or health insurance issuer, in operation as of March 23, 2010, to be in compliance with a state or federal
external review process, as applicable. While not entirely clear, this could be good news for employers that
currently use a third-party administrator, such as a health plan, as the claims and appeals fiduciary (final
reviewer). The agencies plan to address this issue in sub-regulatory guidance.

**Effective Date**

The interim final rule becomes effective September 21, 2010. However, the application of these new
requirements under the Affordable Care Act is generally effective for plan years beginning on or after
September 23, 2010. So, for non-grandfathered health plans with a calendar year plan year, the new claims
and appeals requirements could apply as early as January 1, 2011.

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Agencies Are Accepting Comments
The agencies are asking for comments on all provisions of the interim final rule. Comments are due on or before September 21, 2010.

More Information

For more information on the Affordable Care Act, please refer to Hewitt’s Special Report and other materials for employers at: http://www.hewitt.com/healthcarereform

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