Independence Administrators

Health Care Reform News

# Health Care Reform — Changes to internal claims and appeals processes and external review processes

**September 30, 2010** — Interim Final Rules issued by the Department of Health and Human Services (HHS), the Department of Treasury, and the Department of Labor (DOL) (the Departments) impose new requirements for internal claims and appeals processes and an external review process.

**When do the new requirements take effect?**
They apply to plan years that begin **on or after September 23, 2010**. For calendar year plans, that means January 1, 2011, plan years.

**Who is affected?**
**All insured and self-insured health plans** and insurers who issue coverage for insured group health plan must comply.

**Are "grandfathered" plans exempt?**
**Yes**. Grandfathered plans are not required to comply.

## INTERNAL CLAIMS AND APPEALS

The new regulations establish requirements for internal claims and appeal processes; they also expand the definition of "adverse determination" to include rescinded coverage. They incorporate the existing DOL claim and appeal requirements, and they add **six new requirements**:

1. Plan members can appeal any **rescission of coverage** just as they can appeal a claim or benefit denial, whether or not a claim is involved.

   In general, rescission means a retroactive cancellation or discontinuance of coverage for reasons *other than* a required premium or contribution towards the coverage cost not being made on time.

2. Plans must notify claimants of benefit determinations involving urgent care **within 24 hours**. The existing DOL standard was 72 hours.

3. Plans must provide claimants with any "**new or additional evidence** considered, relied upon, or generated" in connection with the claim and any additional rationale for denying a claim or benefit. The claimant must receive this information free of charge and enough in advance of an adverse determination to give him or her a reasonable opportunity to appeal the determination.

4. The plan's processes must ensure that the persons who make the determinations are **independent and impartial**.

5. Determination notices must be written in a **culturally and linguistically appropriate** manner. (More information appears below.)

   Any claim denial must include enough **information for the claimant to identify the involved claim**. This includes dates, the health care provider, the diagnosis code, the treatment code, explanations of what the codes mean, and the standards used in denying the claim.

   The government recently issued model notices that satisfy these requirements.

6. If a plan does not adhere to these requirements strictly, the claimant can pursue other remedies, such as **external or judicial review**, as if the internal claims and appeals process were exhausted.

## CONTINUED COVERAGE

Plans must provide a plan member with continued coverage pending the outcome of the internal appeal process. In general, plans may not reduce or terminate an ongoing course of treatment without giving the plan member advance notice and an opportunity for advance review.

Also, plan members who are in urgent care situations or receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal appeals process.

## EXTERNAL REVIEW PROCESS

When the plan has made its final internal determination, or if the plan does not adhere to the internal appeals requirements, a plan member may pursue an external review.

The plan needs to provide an external review process that complies with either a state process or the federal process.

**State external review process**
State external review processes apply to health plans that are subject to state laws. For a state process to apply instead of the federal process, it must meet certain minimum requirements based on consumer protections included in the NAIC Uniform Model Act as of July 22, 2010.

State processes must allow for external review of adverse determinations to cover at least medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. However, states can establish broader requirements.

Other requirements include that the plan (or the state) pay the cost of having an independent review organization (IRO) perform the review. Also, plans cannot impose a minimum dollar amount for claims to qualify for external review

**Federal external review process**
If the state rules don't apply, a health plan must provide an external review process that meets the federal requirements. The federal requirements are based on the Uniform Health Carrier External Review Model Act adopted by the National Association of Insurance Commissioners (NAIC). And the external review process will provide for expedited external reviews and consumer protections regarding claims for experimental or investigational treatment.

The regulations do not clearly define the scope of claims that qualify for review under the federal process. Rescissions and claim denials meet the federal guidelines.

## CULTURALLY AND LINGUISTICALLY APPROPRIATE

Plans must provide notices of claim denials, and about internal appeals and external reviews, in a culturally and linguistically appropriate manner. This means that if the number of plan members who are literate **only** in the **same non-English** language reaches a certain threshold, the plan must provide the information in that language. Also, English versions of notices must state that plan members can request to get their notices in that language.

If a plan covers fewer than 100 members at the start of the plan year, the threshold is 25% of all plan members being literate in the same language.

If a plan covers 100 or more members, the threshold is the lesser of 500 members or 10% of members.

## NEXT STEPS FOR PLAN SPONSORS

***Be sure to take these important steps:***

- **Plan documents.** It is very important that you amend your plan documents to reflect any changes you make.
- **Stop loss coverage.** Be sure to notify your stop loss carrier promptly of any changes you make.

## FOR MORE INFORMATION

You can find information about appeals and review online. View the Fact Sheet and more information about internal appeals and external review processes at www.healthcare.gov for more information.

*This communication is not intended to provide either legal or tax advice. Please consult with your legal counsel or professional advisors to determine the effects of the statutes and regulations regarding health care reform on you and your plan members.*