Alert 10-183

Health Care Reform – Guidance Issued on Internal Claims and Appeals, and External Review Processes

On July 23, 2010, the Department of Treasury, in conjunction with the Department of Labor and the Department of Health & Human Services ("HHS"), issued interim final rules for non-grandfathered plans implementing the internal claims and appeals and external review processes for group health plans and health insurance issuers under the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Health Care Reform Act"). The following discusses the requirements of these interim rules with regard to employer-sponsored group health plans.

Requirements for Internal Claims and Appeals Processes. The interim rules provide that group health plans and health insurance issuers offering group or individual health insurance coverage, but not offering grandfathered plans, must comply with the internal claims and appeals requirements as set forth in the regulations under ERISA. In addition, the rules impose the following requirements:

- Rescissions. The internal appeal process will apply to a rescission of coverage.
- Urgent Care. For claims involving urgent care, the plan or issuer must notify the claimant of a benefit determination as soon as possible, but not later than 24 hours (currently 72 hours) after the receipt of the claim by the plan or issuer.
- Full and Fair Review. A claimant must be allowed to review the claim file and present evidence and testimony as part of the internal claims and appeals process and, at no cost, must be provided with any new or additional evidence considered in connection with a claim. If a final adverse benefit determination will be based on a new or additional rationale, the claimant must be provided with advance notice of the new or additional rationale.
- Conflicts of Interest. Claims and appeals must be adjudicated in such a way as to ensure the impartiality and independence of the persons involved in making the decision, thus preventing conflicts of interest.
- Notices. Notice to participants must be culturally and linguistically appropriate. The notice must include additional information regarding the detailed information on the diagnosis, treatment, and denial codes, and the information regarding the appeal process.

Failure to Adhere to Internal Claims and Appeals Process. 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, including judicial review, if the plan or issuer does not strictly adhere to the requirements discussed above. Substantial compliance with ERISA's claims procedures will no longer be considered sufficient.

External Review Process. Plans and issuers must comply with either state or federal external review requirements. The rules clarify in which situations a state external review process will apply, and in which situations the federal external review process will apply.

- Complying with the State External Review Process. Insured plans and self-funded plans not subject to ERISA must comply with a state external review process that includes the consumer protections in the NAIC Uniform Model Act as of July 23, 2010. Until HHS determines whether a state external review process meets these requirements, for plan years beginning before July 1, 2011, existing state external review processes will be treated as meeting the minimum standards.
- Complying with the Federal External Review Process. Any plan or issuer that is not subject to a state external review process, which includes self-funded plans subject to ERISA, and all other plans where no state review process is in place or where the state external review process does not meet the protection standards of the NAIC Uniform Model Act, must comply with the federal external review process. The federal external review

process will not apply to adverse benefit determinations or final internal adverse benefit determinations that relate to a participant's (or a beneficiary's) failure to meet the requirements for eligibility under the terms of a group health plan. The rules do not include details as to the federal external review process; however, further guidance should be issued in the near future.

Effective Date. Plans will be required to comply with the guidelines and recommendations listed in the interim regulations as of the first day of the plan year beginning after September 23, 2010. Grandfathered health plans are not required to comply with these interim final rules.

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Group health plan sponsors should plan to update their internal claim and appeal procedures and, in many cases, add an external review process. Please contact one of the individuals listed below, or the Reed Smith attorney with whom you regularly work, to learn more about these regulations on internal claims and appeals and external review under the Health Care Reform Act.

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