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New Appeal Regulations For Health Plans Require Final Claims Decision To Be Made By External Reviewer

The Department of Health and Human Services issued new appeal regulations under the recently enacted Patient Protection and Affordable Care Act ("Affordable Care Act"). These regulations give claimants the right to appeal decisions made by their health plan to an outside, independent decision maker, regardless of what state they live in or what type of health coverage they have, i.e., both group and individual coverage. If a particular health plan or insurance is governed by a state law, the state regulations will apply as long as the protections offered to consumers is at least as strong as the National Association of Insurance Commissioners ("NAIC") Model Act. At a minimum, the state external review process must provide:

- External Review of plan decisions to deny coverage for case based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- Clear information for consumers about their right to both internet and external appeals – both in the standard plan materials, and at the time the company denies a claim.
- Expedited access to external review in some cases – including emergency situation, or cases where their health plan did not follow the rules in the internal appeal.
- Health plans must pay the cost of the external appeal under State law, and States may not require consumers to pay more than a nominal fee.
- Review by an independent body assigned by the State. The State must also ensure that the reviewers meet certain standards, keep written records, and are not affected by conflict of interest.
- Emergency process for urgent claims, and a process for experimental or investigational treatment.
- Final decision must be binding so, if the consumer wins, the health plan is expected to pay for the benefit that was previously denied.[1]

For plans governed by ERISA or not otherwise covered by a state law external appeal process, a federal external review program will be required. Since these are still interim rules, a framework for the federal external review process has not been established. However, the federal review process will likely be modeled along the NAIC Model Act.

[1] Source: "Fact Sheet: The Affordable Care Act: Protecting Consumers and Putting Patients Back in Charge of Their Care," dated July 22, 2010.

These regulations are clearly a win for consumers who have long complained that the internal appeals process is biased towards insurance companies. Unfortunately, it will take some time for consumers to reap the benefits of these changes. Health plans that were in effect on March 23, 2010 and have not been significantly modified since then are considered "grandfathered" and not subject to these regulations. However, over time, expect to see an external review process become a standard component of the claim review process.

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