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Interim Final Rules Impose New Requirements for Internal Claims/Appeals and External Review

Internal Claims/Appeals

Effective for plan years beginning on or after September 23 (January 1, 2011, for calendar year plans and policies), non-grandfathered group health plans (including non-Employee Retirement Income Security Act plans such as governmental and church plans) and health insurance issuers will be required under the Patient Protection and Affordable Care Act (PPACA) to comply with federal rules for administering health plan claims and appeals. ERISA plans already are required to adhere to existing Department of Labor (DOL) claim and appeal regulations, but interim final regulations issued jointly by the Department of the Treasury, the DOL and the Department of Health and Human Services (75 Fed. Reg. 43330) extend those requirements to non-ERISA group health plans and health insurance policies and also impose new requirements for all group health plans and insurers.

The new requirements imposed on all group health plans and health insurance issuers include the following: (1) an expanded "adverse benefit determination" definition; (2) a reduction of the 72-hour notification period for urgent care claim determinations to 24 hours (or fewer); (3) new claim/appeal file disclosure requirements; (4) conflict of interest protections that require claims and appeals to be handled by independent and impartial decision-makers; (5) more extensive adverse benefit determination notification disclosures, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, the denial code and the meanings of the codes, along with a description of the plan's or issuer's standard (if applicable) used in denying the claim; (6) a "strict adherence" to the internal claim/appeal rules standard, which differs from the "substantial compliance" standard that has been applied under the existing DOL claim/appeal regulations; and (7) requirements that a plan or an insurer must continue the claimant's coverage while a claim or an appeal is pending, and that administrator and insurers may not reduce or terminate benefits for an ongoing course of treatment without providing advance notice and an opportunity for advance review.

External Review

Effective for plan years beginning on or after September 23 (January 1, 2011, for calendar year plans and policies), non-grandfathered group health plans and health insurance issuers will be required to comply with either a state external review process or the federal external review

process requirements imposed by the PPACA.
Self-funded non-ERISA group health plans (such as governmental and church plans) and insured individual and group policies that are subject to state external review programs that follow the National Association of Insurance Commissioners (NAIC) Uniform Model Act must comply with the applicable state external review process. The interim final rules outline the requirements for state external review processes, which are consistent with the protections in the NAIC Uniform Model Act.

Self-funded ERISA group health plans and insured individual and group policies that are not subject to state external review programs that follow the NAIC Uniform Model Act must comply with the federal external review process. The interim final rules state that the agencies will be establishing the standards for the federal external review process and that such standards will resemble those that apply under the NAIC Uniform Model Act. The standards are expected to address compliance approaches for non-grandfathered self-funded group health plans that already have internal appeals processes that otherwise satisfy the federal external review requirements.

A copy of the interim final rules is available here.

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