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New Internal Appeals and External Review Requirements

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Under the Patient Protection and Affordable Care Act of 2010 (PPACA), all nongrandfathered group health plans and health insurance issuers must institute new internal claims and appeals procedures, along with an external independent review requirement for plan years beginning on or after September 23, 2010. Interim Final Regulations were issued on July 23, 2010 by the Departments of Health and Human Services (HHS), Treasury, and Labor to implement this new provision. This article describes these six new requirements for internal appeals processes and the new requirements for external reviews, which affect not only all health plans subject to ERISA, but since it also impacts health insurers, many non-ERISA health plans as well.

Internal Claim Appeals

First, any group health plan must adopt—in addition to the “regular” ERISA claim determination and appeals rules—a new “urgent care” determination process of 24 hours or less from the time of receipt of the claim, taking into account any medical emergency situation. This is a

reduction from the current 72 hour “urgent care” requirement.

Second, the regulations redefine the term “adverse claim determination” to include coverage rescissions. Thus, all of the following are now considered “adverse claim determinations”:

- A determination of an individual’s eligibility to participate in a plan or health insurance coverage;
- A determination that a benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

Third, a claimant must be provided with the opportunity to review all internal records used to make an adverse claim determination, and offer additional information into the record that must be considered as part of the internal appeals process. This and any additional information used to make an adverse determination must be

provided to the claimant “as soon as possible” so that the claimant can review it and have an opportunity to respond prior to a final determination.

Fourth, a group health plan is prohibited from hiring, promoting, or compensating a claims adjudicator or medical expert based on the likelihood that the individual will support benefit denials. A key of these new regulations is that independence and impartiality, and not a conflict-of-interest, must be maintained.

Fifth, the regulations require a plan to provide a notice to participants “in a culturally and linguistically appropriate manner.” This provision applies to internal and external claims appeals processes. Plans and insurance issuers are considered to provide relevant notices in a culturally and linguistically appropriate manner if notices are provided in a non-English language based on thresholds based upon the number of people who are literate in the same non-English language.

For employer-based plans, the threshold for the number of non-English speakers varies based upon the number of participants in the plan. For plans with fewer than 100 participants (not family members) at the beginning of the plan year, the threshold is 25 percent of participants being literate only in the same non-English language. For plans with 100

or more participants, the threshold is the lesser of 500 or participants or 10 percent of all plan participants. For example, a plan with 1,000 participants would have a threshold of 100 participants who only speak the same non-English language. In the case the threshold is met, then all plan materials, including claim determinations, would need to be translated into that language.

Lastly, if the plan fails to strictly follow all of the requirements of the internal claims and appeals process, the claimant can file for an external review and also pursue remedies through a judicial proceeding.

External Reviews

Employer-based health plans must follow either state-based external review process or the new federal external process. Under the regulations, if a state external review process meets the minimum protections of the National Association of Insurance Commissioner’s (NAIC) Uniform Model Act, then the plan must comply with the state process. In that case, if the plan is insured, the insurance carrier (and not the employer) must comply with the federal or state external review process.

For self-funded plans, which normally would have ERISA pre-empt any state review process, the regulations pierce that protection and enable a state to

apply its external review process (if it meets the minimum of the NAIC Uniform Model Act) to self-funded plans as well.

For both insured and self-funded plans, if a state does not have an applicable external review process, then the federal review process applies.

Summary

It is important to note that both the internal claims determination and appeals process as well as the external review procedures do not apply to grandfathered health plans. For non-grandfathered plans however, these new regulations will mean significant work for the upcoming plan year.

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