

The New Health Law California Issue Briefs

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Appeals Process under the ACA



Health Consumer Alliance

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On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law.¹ The new health care law aims to increase access to health insurance through more accessible private insurance and an expansion of Medicaid (Medi-Cal in California). It also contains provisions addressing consumers' rights to appeal health plan decisions. The federal Department of Health and Human Services, Labor and the Treasury (the Departments) issued regulations providing further interpretation and guidance for the claims and appeals requirements under the ACA.² This issue brief discusses this new appeals process.

Which health plans do these new appeals requirements apply to?

The new appeals requirements under the ACA apply to group health plans and health insurance issuers offering group and individual health insurance products created after March 23, 2010. These requirements do not apply to grandfathered health plans.³

The ACA makes no change to Medicare and Medi-Cal appeals procedures. Those appeals processes are governed by separate federal laws.

Appeals Process

The Interim Final Rules and Amendments issued by the Departments standardize the appeals process that consumers can use to challenge decisions made by their health plan. Health plans must have an internal review process. If the plan denies an appeal through the internal process, consumers may have the right to seek an external review of the plan's determination. The external review must be conducted by an independent decision-maker (not employed by the health plan).

I. Internal review process

Under the ACA, group health plans and health insurance issuers offering group or individual health insurance coverage must have an internal appeals process.⁴ The new appeals requirements apply to group health coverage and individual health insurance in different ways; therefore the regulations have a separate set of rules for each.

A. Group health plans:

Health plans offering group health coverage, i.e., insurance through an employer, must initially incorporate the internal claims and appeals procedures set forth for employee benefit plans covered under the Employee Retirement Income Security Act of 1974 (ERISA). The claims procedure regulations provide minimum requirements for the processing of benefit claims for all ERISA employee benefit plans.⁵ In addition, these plans must update such procedures in accordance with standards established by the Secretary of Labor.⁶

The Interim Final Rules and Amendments on claims and appeals provide the following requirements:

- 1) Broadening the definition of an “adverse benefit determination” to include rescission of coverage whether or not there is an adverse effect on any particular benefit at the time.⁷ A rescission is defined as a “cancellation” or “discontinuance” of coverage that has a retroactive effect.⁸
- 2) Processing of urgent claims within 72 hours.⁹
- 3) Ensuring claimants receive a “full and fair review.” The plan or issuer must allow a claimant to review his/her claim file and present evidence and testimony as part of the internal claims and appeals process. In addition, the plan or issuer must provide to the claimant, free of charge, any new or additional evidence considered, relied upon or generated by the plan in connection to the claim. This includes providing the rationale for the denial, with as much advance notice as possible, to allow the claimant enough time to respond.¹⁰
- 4) Avoiding conflicts of interest to ensure impartial decisions on claims and appeals.¹¹ For example, a plan or issuer cannot provide bonuses based on the number of denials made by a claims adjudicator.
- 5) Providing notice of adverse benefit determination. The plan or issuer must ensure that the notice includes information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings.¹²
- 6) Providing notice in a culturally and linguistically appropriate manner.
 - If 10 percent or more of the population residing in the claimant’s county, as determined by the American Community Survey data published in the U.S. Census Bureau, is literate in the same non-English language, then the notice sent by the plan or issuer must include a statement, in the non-English language, about the availability of language services.¹³
 - In addition to the statement, a plan or issuer must provide notices in the non-English language (upon request), as well as customer assistance with oral language services, such as a hotline.¹⁴

7) If a plan or issuer does not comply with all of the requirements of the internal claims and appeals process, then a claimant is deemed to have exhausted the internal claims and appeals process and can seek an external review (if applicable).¹⁵ There are some exceptions to this rule, for example, if the violation by the plan is: a) de minimus, b) non-prejudicial, c) attributable to good cause or matters beyond the plan's or issuer's control, d) in the context of an ongoing good-faith exchange of information, and e) not reflective of a pattern or practice of non-compliance.¹⁶

In addition to these new requirements, group health plans and issuers must also provide continued coverage pending the outcome of an internal review.¹⁷

B. Individual health insurance coverage:

Health insurance issuers offering individual health coverage, i.e., coverage not from an employer or a government program, must generally follow the requirements for the internal claims and appeals process that apply to group health coverage, as described above.¹⁸ But health insurance issuers offering individual health insurance have three additional requirements established by the Secretary of Health and Human Services:

- 1) Expand the scope of allowable appeals to include initial eligibility determinations for individual health insurance coverage.¹⁹
- 2) Provide for only one level of internal appeals before issuing a final determination.²⁰
- 3) Maintain records of all claims and notices associated with the internal claims and appeals process for at least six years and make such records available for examination upon request.²¹

II. External independent review

If a claimant's internal appeal is denied, the claimant may have the right to have the claim reviewed by an independent reviewer, not employed by the health plan, through an external appeals process. This applies to claims that involve 1) medical judgment as determined by the external reviewer; or 2) a rescission of coverage.²²

The Departments encourage states to establish external review processes that meet the minimum consumer protections of the National Association of Insurance Commissioners (NAIC) Uniform Model Act.²³ States can continue to use their current external review process until December 31, 2011.²⁴ If there is no applicable state external review process, the plan or issuer is required to comply with the requirements of the federal external review process.²⁵ After January 1, 2012, the federal external review process will apply unless the Department of Health and Human Services (HHS) determines that a state's process meets certain minimum requirements.

A. External Review Process in California

California's external review process, called "Independent Medical Review," meets the standards of the NAIC-parallel process. Therefore issuers of non-grandfathered health insurance plans and policies in California must continue to comply with the state's external review process. In turn, California may not reduce the

consumer protections in its external review process below the levels that applied on July 29, 2011.²⁷ Failure to uphold the existing consumer protections could result in a redetermination that the issuers of non-grandfathered health insurance plans and policies in the State of California must use the federally administered external review process.²⁸

B. NAIC-parallel requirements

California has met the NAIC-parallel requirements. This means that the external review process in California has parallel standards to those in the NAIC Uniform Model Act, which include the following minimum consumer protections:²⁹

- 1) An external review of “adverse benefit determinations” based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of covered benefit;
- 2) Effective written notice to claimants about their right to an external review;
- 3) Exhaustion of internal appeals is required prior to external review, unless (a) the issuer (or plan) waives the exhaustion requirement; (b) the issuer (or plan) is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process except those failures that are based on de minimus violations that do not cause, and are not likely to cause, prejudice or harm to the claimants; or (c) the claimant simultaneously requests an expedited internal appeal and an expedited external review.
- 4) The cost of an independent review organization (IRO) to conduct an external review is paid by the issuer (or plan), although the process may require a nominal filing fee from the claimant requesting external review.
- 5) There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for external review.
- 6) Allow at least four months to file a request for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.
- 7) IROs are assigned by the state or an independent entity, on a random basis or other method that ensures independence and impartiality, and by no means assigned by the issuer, the plan, or the individual.
- 8) Maintain a list of approved IROs (only those that are accredited by a nationally recognized private accrediting organization) qualified to conduct the external review based on the nature of the health care service that is the subject of the review.
- 9) Approved IROs must have no conflicts of interest that will influence their independence.
- 10) Claimants are notified and allowed to submit additional information in writing to the IRO, which the IRO must consider when conducting the external review. The IRO must allow the claimant at least 5 business days to submit any additional information and any additional information submitted by the claimant must be forwarded to the issuer (or plan) within one business day of receipt by the IRO.
- 11) The IRO decision must be binding on the claimant, as well as the plan or issuer (except to the extent other remedies are available under state or federal law).
- 12) For a standard external review, the IRO must provide written notice to the issuer (or plan) and the

claimant of its decision to uphold or reverse the adverse benefit determination no later than 45 days after the receipt of the request for external review.

- 13) Provide for an expedited external review with notice of the decision no later than 72 hours after receipt of the request for external review (and if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision).
- 14) Issuers (or plans) must provide a description of the external review process in (or attached to) the summary plan descriptions, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to participants, beneficiaries, or enrollees.
- 15) The IRO must maintain written records and make them available upon request to the state.
- 16) There must be a process for external reviews involving experimental or investigational treatment.

Some other resources on grievances and appeals of health plan decisions include:

- U.S. Department of Health & Human Services
www.healthcare.gov/law/provisions/appealing/appealinghealthplandecisions.html
- California Office of the Patient Advocate
www.opa.ca.gov/healthcare/patient-rights/patient-rights.aspx
- California Department of Insurance www.insurance.ca.gov/0100-consumers/0060-information-guides/0050-health/HealthInsurance.cfm#consumerinquiriesand

- ¹ Patient Protection and Affordable Care Act (ACA), 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010).
- ² Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal and External Claims and Appeals, 75 Fed. Reg. 43,330, 43,331-2 (July 23, 2010) (to be codified at 26 C.F.R. pts. 54 and 602; 29 C.F.R. pt. 2590; 45 C.F.R. pt. 147). These interim final regulations implement the requirements regarding internal claims and appeals and external review processes for group health plans and health insurance coverage in the group and individual markets under the ACA. These regulations provide plans and issuers with the guidance necessary to comply with the law. On June 24, 2011, the Departments released amendments to the interim final rules: Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes, 76 Fed. Reg. 37,208 (June 24, 2011) (to be codified at 26 C.F.R. pts. 54 and 602; 29 C.F.R. pt. 2590; 45 C.F.R. pt. 147).
- ³ 29 C.F.R. § 2590.715-2719(a); see ACA §1251 (allowing individuals to retain coverage under a group health plan or health insurance coverage in which the individual was enrolled on March 23, 2010 (a grandfathered plan)); see also Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538 (proposed June 17, 2010) (to be codified at 26 C.F.R. pts. 54 and 602; 29 C.F.R. pt. 2590; 45 C.F.R. pt. 147).
- ⁴ ACA § 1001, as amended by 10101(g), 42 U.S.C.A. 300gg-19 (West 2011) (amending PHSA 2719).
- ⁵ 29 C.F.R. § 2560.503-1 (2011).
- ⁶ 75 Fed. Reg. 43,330, 43,332. Also note that the Department of Labor is considering updates to 29 C.F.R. 2560.503-1 and expects to issue future regulations with updates to the standards for plan internal claims and appeals processes.
- ⁷ 29 C.F.R. § 2590.715-2719(a)(2)(i) (2011).
- ⁸ 75 Fed. Reg. 43,330, 43,332-3; 29 C.F.R. § 2590.715-2719(b)(2)(ii)(A) (2011); 45 C.F.R. § 147.136 (b)(2)(ii)(A) (2011).
- ⁹ 45 C.F.R. § 147.136(b)(2)(ii)(B) (2011).
- ¹⁰ 45 C.F.R. § 147.136(b)(2)(ii)(C) (2011).
- ¹¹ 45 C.F.R. § 147.136(b)(2)(ii)(D) (2011).
- ¹² 45 C.F.R. § 147.136(b)(2)(ii)(E)(1) (2011).
- ¹³ 45 C.F.R. § 147.136(e)(3) (2011), as amended by 76 Fed. Reg. 37,208, 37,214, 37,234.
- ¹⁴ 45 C.F.R. § 147.136(e)(2)(i) (2011), as amended by 76 Fed. Reg. 37,208, 37,214, 37,234.
- ¹⁵ 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F) (2011).
- ¹⁶ 45 C.F.R. § 147.136(b)(2)(ii)(F) (2011), as amended by 76 Fed. Reg. 37,208, 37, 213, 37,233.
- ¹⁷ 29 C.F.R. § 2590.715-2719(a)(2)(iii) (2011). A plan or issuer must comply with 29 C.F.R. § 2560.503-1(f)(2)(ii), which provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.
- ¹⁸ 45 C.F.R. § 147.136(a)(3)(i) (2011).
- ¹⁹ 75 Fed. Reg. 43,330, 43,334. The ACA prohibits pre-existing condition exclusions taking effect for policy years beginning on September 23, 2010 for children under 19 and for all others for policy years beginning on January 1, 2014. Applicants to the individual market should seek a review of the denial of eligibility of coverage to determine if the issuer is complying with the new provision in making determinations.
- ²⁰ 45 C.F.R. § 147.136(b)(3)(ii)(G) (2011).
- ²¹ 45 C.F.R. § 147.136(b)(3)(ii)(H) (2011).
- ²² 45 C.F.R. § 147.136(d)(1)(ii) (2011), as amended by 76 Fed. Reg. 37,208, 37, 216, 37,233.
- ²³ 75 Fed. Reg. 43,330, 43,335. The version of the NAIC Uniform Model Act in place on the date the interim final rules were published can be found at: http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf According to the interim final rules (75 Fed. Reg. 43,330, 43,334), if the NAIC Uniform Model Act is later modified, the Departments will determine to what extent additional requirements must be added.
- ²⁴ 45 C.F.R. § 147.136(c)(3) (2011), as amended by 76 Fed. Reg. 37,208, 37,215, 37,233.
- ²⁵ 45 C.F.R. § 147.136(d) (2011).
- ²⁶ Letter from Steve Larson, Director, Center for Consumer Information and Insurance Oversight, to Edward G. Heidig, Interim Director, Department of Managed Health Care (Jul. 29, 2011) (on file with National Health Law Program); see also CCIO, Affordable Care Act: Working with States to Protect Consumers, http://ccio.cms.gov/resources/files/external_appeals_preliminary_determinations_8_1_11.html (last visited Aug. 18, 2011).
- ²⁷ Id.
- ²⁸ Id.
- ²⁹ 45 C.F.R. § 147.136(c) (2011). For a complete list of the 16 NAIC requirements see U.S. Dep't of Labor, Guidance on External Review for Group Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage, and Guidance for States on State External Review Processes, Technical Release No. 2011-02 (June 22, 2011).



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