New Internal Claims and Appeals Requirements for Health Plans

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Non-grandfathered group health plans and health insurance issuers will be subject to new internal claims and appeals and external review requirements for plan years beginning on or after September 23, 2010. New guidelines were issued on July 23, 2010.

Internal Claims and Appeals Requirements

In addition to complying with the ERISA claims and appeals rules that may apply, group health plans will be required to meet the following requirements:

- Notice of an "urgent care" claim determination must be provided as soon as possible, taking into account any medical exigencies, but in no case later than 24 hours after receipt of the claim. Current ERISA rules allow 72 hours.
- A claimant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. The group health plan must provide the claimant (free of charge) any new or additional evidence or rationale for making a final adverse benefit determination. This information must be provided as soon as possible, so as to provide the claimant with an opportunity to respond prior to the determination.
- A group health plan cannot hire, compensate or promote a claim adjudicator or medical expert based on the likelihood that the individual will support benefit denials. Independence and impartiality must be maintained.
- If coverage is rescinded, the individual must be provided with claim procedure and appeal rights, regardless of whether the rescission impacts any particular benefit or outstanding claim.
- An adverse benefit determination must be communicated to the participant in a “culturally and linguistically appropriate manner” and must include several new pieces of information, including the date of service, denial code and its meaning, and information on the appeals process. See a complete list here.

Substantial Compliance Not Enough

If a group health plan fails to strictly adhere to new requirements, the claimant will be deemed to have exhausted the plan’s internal claims and appeals procedure and allowed to immediately initiate an external review or file a lawsuit in federal district court. A group health plan's substantial compliance with

the requirements is irrelevant.

Continued Coverage During Appeal

Coverage for an ongoing course of treatment must be continued pending the outcome of an appeal. To comply with this requirement, group health plans may not reduce or terminate benefits without providing a participant with advance notice and an opportunity for review.

Standards for External Review

State

Insured plans, and certain self-insured plans not subject to ERISA (such as a plan sponsored by a state or local government entity or a church plan) must comply with state standards for external review. Current state standards will be deemed acceptable for plan years beginning before July 1, 2011.

Federal

Self-insured group health plans subject to ERISA are required to comply with the federal standards for external review. The new regulations contain a general description of what the standards will entail can be seen here.

The standards themselves will be forthcoming in additional guidance to be issued by the agencies.

What To Do Now

Time is short. That means all group health plans – but especially those with a plan year beginning soon after September 23 – should be reviewed to determine how the new rules will affect them. The review should include the current claims and appeals process, contracts with third-party administrators and the hiring of medical experts and claim adjudicators.

Plan documents and summary plan descriptions will also need to be amended. Any communications regarding claims – including explanation of benefit letters – must comply with these requirements. Any deviation from the requirements will make the communication defective, and the claimant can immediately file suit in federal district court.

Contact Us

If you have any questions about the new claims and appeals processes or how the external review requirements will apply to your plan, please contact a member of Warner Norcross & Judd's Employee Benefits Team.