THE NEW CONSUMER APPEALS PROCESS

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Introduction

On July 23, 2010, the United States Departments of Health and Human Services, Labor, and the Treasury published their final interim regulations regarding changes to the procedures for consumers to appeal decisions under group health plans and health insurance policies.[1] The new appeals regulations are among the most important consumer protections resulting from the Patient Protection and Affordable Care Act. The regulations establish enhanced protections for consumers who wish to appeal adverse health benefit decisions through their health plan's internal claims and appeals process. In addition, the regulations extend to all consumers the right to appeal decisions made by a health plan or a health insurer to an outside, independent decision-maker.

Background of the New Consumer Appeals Process

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, (collectively, "PPACA") added Section 2719 to the Public Health Service Act ("PHSA").[2] Section 2719 requires group health plans and issuers offering individual and group policies to implement "effective" internal claims and appeals and external review processes.[3]

Prior to PPACA, internal claims and appeals processes varied considerably among market segments.[4] Insured or self-funded plans subject to the Employee Retirement Income Security Act ("ERISA") were required to provide an internal claims and appeals process that complied with the Department of Labor's ("DOL") claims procedure regulation ("DOL claims procedure regulation"),[5] while group health plans that were not covered by ERISA, such as plans sponsored by state and local governments and churches, were not.[6] Meanwhile, most issuers offering individual health coverage were also not required to comply with the DOL claims procedure regulation, but were required to comply with applicable state internal claims and appeals processes.[7] However, internal claims and appeals processes varied from state to state.

Consumers were also subject to assorted external review protections prior to PPACA. Insured ERISA plans were generally subject to applicable state external review processes.[8] However, state external review procedures, like internal claims and appeals processes, varied from state to state.[9] More importantly, accessibility and consumer protections varied. For example, some states did not require the external reviewing entity's decision to be binding on the plan or issuer.[10] In other states, only denials based on medical necessity or disputes regarding experimental treatments were eligible for external review.

Moreover, although approximately 40 percent of benefit denials are reversed on external review,[11] some state processes limited external review to only certain types of health plans, and at least six states did not even have external review laws before PPACA was enacted.[12] Issuers in those states were not required to implement an external review process.[13] Meanwhile, the preemption provisions of ERISA generally prevented a state's external review process from applying to self-funded ERISA plans.[14] As a result, the only recourse for consumers in these plans who had exhausted the plan's or policy's internal review procedures was expensive ERISA litigation, under which the decision of the plan or insurance company was given deference by the courts.

New Consumer Appeals Process

The new appeals regulations were enacted to establish a fair and uniform appeals process and to ensure that consumers have a venue in which to challenge adverse decisions. They mandate a tiered review process that includes an internal review by the plan and an independent external review.

The new appeals regulations extend the internal claims and appeals procedure requirements that currently apply to self-funded or insured ERISA plans under the DOL claims procedure regulation to non-ERISA plans that have lost "grandfathered" status under PPACA.[15] In addition, they make important revisions to the DOL internal claims and appeals procedures.

The new appeals regulations also provide that all non-grandfathered health plans must offer the opportunity for an external review by an independent entity that is binding on the plan or issuer.[16] This external review will generally occur following the upholding of an adverse benefit determination at the conclusion of the internal appeals process or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted.[17]

Grandfathered plans and policies do not have to implement the new internal claims and appeals and external review processes.[18] The current DOL claims and appeals process remains in effect for ERISA plans that maintain their grandfathered status. Grandfathered non-ERISA plans are not required to comply with either the current DOL claims and appeals process or the new PPACA consumer appeals regulations. Of course, grandfathered plans may

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choose to make certain disqualifying changes and relinquish their grandfathered status, in which case they would be subject to the new PPACA claims and appeals processes.[19]

The Departments estimate that 31 million people are currently enrolled in group health plans subject to the new consumer appeals process.[20] This number is expected to grow to approximately 78 million by 2013.[21] The number of individual health insurance policies subject to the new consumer appeals process is expected to increase even more rapidly as 40 to 67 percent of all individual policies terminate each year.[22] Of course, newly purchased individual policies are not grandfathered, and are therefore subject to the new consumer appeals process.

Internal Claims and Appeals Process

As noted above, the new appeals regulations require plans and issuers to implement an internal review process that complies with the requirements of the DOL claims procedure regulation and to incorporate any updates established by the Secretary of Labor.[23] As such, plans and issuers are prohibited from reducing or terminating an ongoing course of treatment pending the outcome of an internal appeal.[24] In addition, consumers receiving urgent care or ongoing courses of treatment may be allowed to pursue an expedited external review while the internal appeals process is in progress, in accordance with a provision of the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners ("NAIC Uniform Model Act").[25]

Group Health Plans and Health Insurance Issuers in the Group Market

In addition to the requirements specified in the DOL claims procedure regulation, the new appeals regulations provide that group health plans and health insurance issuers in the group market must incorporate six new requirements designed to strengthen consumer protections. First, plans and issuers must include within the scope of adverse benefit determinations subject to internal review a rescission of coverage, whether or not there is an adverse effect on any particular benefit.[26] This is broader than the definition in the DOL claims procedure regulation, which already provides that a denial, reduction, or termination of, or a failure to provide payment (in whole or in part) for a benefit is an adverse benefit determination eligible for internal claims and appeals processes. Arguably, the DOL claims procedure regulation does not allow an appeal by a consumer whose coverage was rescinded if there was no adverse effect on a particular benefit.[27] Applying internal claims and appeals processes to rescissions of coverage is intended to prevent health insurers and health plans from using rescission to retroactively invalidate coverage on technicalities, such as an unintentional mistake on an insurance application.[28]

Second, plans and health insurance issuers have less time to make urgent care claims decisions under the new appeals regulations. The current DOL claims procedure regulation requires notification of the benefit determination for such claims as soon as possible but not later than 72 hours after receipt of the claim.[29] The DOL claims procedure regulation was originally published in 2000. Since that time, improvements in health information technology and electronic communication allows for faster decision-making and notification. As a result, the new appeals regulations have reduced the turnaround time in urgent care cases and require notification of the benefit determination as soon as possible but not later than 24 hours after receipt of the claim.[30] Nevertheless, there is a special exception for circumstances in which the consumer fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan.[31]

Third, consumers must be automatically provided, free of charge, new or additional evidence used to make an adverse benefit determination and any new or additional rationale used to uphold a previous adverse benefit determination.[32] Plans and issuers must then give the consumer a reasonable opportunity to respond before the benefit determination is issued.[33] In addition, plans and issuers must allow consumers to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.[34] The new appeals regulations do not indicate whether plans and health insurance issuers must allow oral testimony, or, whether similar to the DOL claims procedure regulation, only written testimony is permitted.[35]

Fourth, plans and health insurance issuers must incorporate additional conflict of interest safeguards. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to a claims adjudicator or medical expert must be made independently of the likelihood that the individual will support a denial of benefits.[36] Nevertheless, the new regulations may not have done enough to ensure the impartiality and independence of reviews, as plans and issuers are still permitted to use in-house clinicians to review adverse coverage determinations.

Fifth, plans and health insurance issuers must provide broader content and increased specificity in consumer notices. Specifically, notice of adverse benefit determinations must include the denial code, diagnosis, and treatment codes and their corresponding meanings as well as a description of the standard, if any, used to deny the

claim. If the notice is for a final internal adverse benefit determination, this description must also include a discussion of the decision.[37] However, the requirement to insert this additional detailed medical information into the explanation of benefits ("EOB") exacerbates the already significant Health Insurance Portability and Accountability Act ("HIPAA") and state law privacy concerns present in EOBs, as the policy holder or employee receiving the EOB is not always the patient. Moreover, even if the policy holder is the patient, there is no assurance that another family member will not inadvertently or intentionally open or gain access to the notice. In addition, the plan or issuer must provide a description of available internal appeals and external review processes. This description must include information regarding how to initiate an appeal and contact information for available offices of consumer assistance created by PPACA to assist consumers with the internal and external review processes.[38]

Notice to consumers must also be provided in a "culturally and linguistically appropriate manner."[39] At the beginning of a plan year, this requirement is mandatory for plans that cover fewer than 100 participants if 25 percent or more of all plan participants are literate only in the same non-English language and for plans that cover 100 or more participants if the lesser of 500 participants or 10 percent of all participants are literate only in the same non-English language.[40] In the individual market, the threshold is 10 percent of the population residing in the county being literate only in the same non-English language.[41]

If the applicable threshold is satisfied, then notices must be available and provided upon request in the appropriate non-English language.[42] Once a consumer requests a notice in the non-English language, the plan must also provide all subsequent notices to the consumer in the non-English language.[43] In addition, any customer assistance programs offered with respect to the plan (such as call centers) must also provide assistance in the non-English language. Although the new appeals regulations improve the availability of effective notices to consumers literate only in a non-English language, they fail to protect other consumers who may require alternative formats, such as those with disabilities.

The DOL and Department of Health and Human Services' Office of Consumer Information and Insurance Oversight ("OCIIO") have provided model notices that can be used to satisfy all notice requirements under the new appeals regulations, including: (1) a notice of adverse benefit determination; and (2) a notice of final internal adverse benefit determination.[44]

Sixth, if a plan or health insurance issuer fails to strictly adhere to the internal claims and appeals procedure requirements, the consumer is deemed to have exhausted the internal claims and appeals process, whether or not the plan or health insurance issuer substantially complied or the error committed was *de minimis*.[45] This is a departure from the "substantial compliance" test widely adopted by courts when evaluating challenges to ERISA procedures.[46] As a result, the consumer will be able to initiate external review and pursue any available remedies, such as judicial review.

Internal appeals processes generally provide consumers and plans with an efficient and cost-effective means for timely resolution of disputed benefit claims. If bypassed, disputes that could more appropriately be resolved during an internal review will be transferred to expensive external review processes or litigation. The consumer may also pursue any remedies available under ERISA or applicable state law for the plan's failure to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If the consumer pursues remedies under ERISA, then the claim or appeal is deemed to have been denied on review without the exercise of discretion by the appropriate fiduciary—which means that a *de novo*, rather than deferential, standard of judicial review will apply.

Health Insurance Issuers Offering Individual Health Insurance Coverage

Health insurance issuers offering individual health insurance coverage must generally comply with all of the requirements for the internal claims and appeals process that apply to plans offering group health coverage. As a result, an individual health insurance issuer is subject to the DOL claims procedure regulation and the six additional requirements in the new appeals regulations detailed above. Moreover, the new appeals regulations provide that issuers offering individual health insurance coverage must have an internal appeals process that complies with three additional requirements.

First, issuers offering individual coverage must allow consumers to appeal initial eligibility of coverage determinations.[47] Approximately 10 to 15 percent of applicants are declined coverage in the individual market.[48] These eligibility determinations are often based on the health status of the applicant, including pre-existing conditions. With the prohibition against pre-existing condition exclusions taking effect for policy years beginning on or after September 23, 2010 for children under 19 and for policy years beginning on or after January 1, 2014 for all others, applicants in the individual market will now have the opportunity for a review of a denial of eligibility of coverage to determine whether the issuer complied with the new provisions in making the determination.

Second, health insurance issuers offering individual health insurance coverage must limit their internal

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claims and appeals process to one level of review.[49] Accordingly, after an issuer has reviewed an adverse benefit determination once, the consumer is allowed to seek external review of the determination by an independent entity. In contrast, group health plans are permitted two levels of internal review. The Departments believe there is no need for a second level of internal appeal in the individual market since the issuer itself conducts all levels of the internal appeal. This is unlike the group market, in which a third party administrator may conduct the first level of the internal appeal and the employer the second level.[50] In addition, multiple levels of internal reviews are often difficult for some consumers to navigate, and may serve as a deterrent to accessing the care to which they are entitled.

Third, health insurance issuers offering individual health insurance coverage are required to maintain records of all claims and notices associated with their internal claims and appeals process. These records must be maintained for at least six years and must be made available for examination upon request.[51]

Enforcement Grace Period

On September 20, 2010, the DOL issued Technical Release 2010-02 ("T.R. 2010-02"), which established an enforcement grace period until July 1, 2011 for compliance with some of the new internal claims and appeals provisions and stated that, for that period, the DOL and the Internal Revenue Service ("IRS") would not take any enforcement action against a group health plan, and HHS would not take any enforcement action against a self-funded nonfederal governmental health plan, that is working in good faith to implement the additional standards but does not yet have them in place.[52] Presumably, a plan participant or policy holder would be able to enforce these requirements as the documents granting this grace period do not address the rights of private parties in private litigation.

On March 18, 2011, the DOL issued Technical Release 2011-01 ("T.R. 2011-01"), which extended the enforcement grace period until plan years beginning on or after January 1, 2012 with regard to the following internal claims and appeals requirements: (1) the requirement to make an initial decision on an urgent care claim within 24 hours of receipt of the claim; (2) the requirement to provide notices in a culturally and linguistically appropriate manner; and (3) the requirement for strict compliance with all new claims and appeals procedures. Moreover, T.R. 2011-01 modifies the enforcement grace period by abandoning the requirement in T.R. 2010-02 that plans work in good faith to implement these standards for the enforcement grace period to apply.[53]

With respect to the new content requirements for notices of adverse benefit determinations and final adverse benefit determinations, the enforcement grace period has been extended in part only. Specifically, with respect to the requirement to disclose diagnosis codes and treatment codes (and their corresponding meanings), the enforcement grace period has been extended until plan years beginning on or after January 1, 2012. However, the enforcement grace period will be extended with respect to the other content requirements from July 1, 2011 until the first day of the first plan year beginning on or after July 1, 2011 (which is January 1, 2012 for calendar year plans). Therefore, enforcement with respect to the following provisions will take effect on a rolling plan year basis, starting on the first day of the first plan year beginning on or after July 1, 2011: (a) the disclosure of information sufficient to identify a claim (other than the diagnosis and treatment information); (b) the reasons for an adverse benefit determination; (c) the description of available internal appeals and external review processes, and; (d) for plans and issuers in states in which an office of health consumer assistance program or ombudsman is operational, the disclosure of the availability of, and contact information for, such program.

External Appeals

Pursuant to the new appeals regulations, all non-grandfathered health plans must offer the opportunity for an external review by an independent entity that is binding on the plan or issuer. This requirement will be new for many health plans, including self-funded ERISA plans and self-funded government and church plans.

A plan's or issuer's external review process must satisfy state or federal standards, whichever applies. The new appeals regulations provide rules for determining which process applies, as well as guidance regarding each process. In general, if a plan is insured, state external review requirements apply if they satisfy certain minimum standards outlined in the new appeals regulations. Meanwhile, if a plan is self-funded, federal external review standards generally apply. However, the federal standards have yet to be issued.

State External Review

State external review procedures generally apply to non-grandfathered insured plans. Following the final interim regulations, these plans must continue to comply with applicable state insurance law external review procedures so long as those procedures satisfy certain minimum standards adapted from the NAIC Uniform Model Act.[54] Pursuant to one of the NAIC Uniform Model Act requirements, state external review

procedures must provide for the review of adverse benefit determinations only with regard to the "medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit."[55] This standard excludes external review of rescissions of coverage, which, in contrast, are treated as an adverse benefit determination for purposes of internal claims and appeals and the federal external review process. Thus, the scope of adverse benefit determinations eligible for state external review is narrower than those eligible for the internal claims and appeals process and federal external review.

By requiring that state insurance law external review procedures only have to satisfy minimum consumer protections, the new appeals regulations fail to incorporate important protections found in the NAIC Uniform Model Act. For example, the new appeals regulations fail to expressly require state external review procedures to allow consumers to be represented by a third party, including counsel. In addition, the new appeals regulations fail to expressly acknowledge that the standard of review is *de novo* for external reviews of adverse benefit determinations. A *de novo* standard applies to the federal external review process and allows an objective review of the facts surrounding an adverse benefit determination.

Nevertheless, if the state procedures are found to be sufficient, the plan may continue to operate under those rules. If not, the plan will be subject to the new federal external review procedures once they are established.

An enforcement grace period has been established to provide states the opportunity to amend their procedures to satisfy the minimum NAIC Uniform Model Act standards.[56] Specifically, in states with external review laws in effect on March 23, 2010, for plan or policy years beginning prior to July 1, 2011, a health insurance issuer is deemed to comply with the new consumer appeals requirements if it follows that state's external review process during this transition period. In states that have passed external review laws between March 23, 2010 and September 23, 2010, the process provided under those laws will apply in that state. After the July 1, 2011 transition date, a state's review procedures must be specifically approved by HHS or the federal review procedures will apply.[57]

In states that had not passed an external review law that was in effect on September 23, 2010, a health insurance issuer must follow an interim external review process administered by the Office of Personnel Management ("OPM").[58] The interim process divides external reviews into two categories: standard and expedited reviews. A consumer must request a standard external review in writing within four months after receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. The consumer may submit the request electronically, by facsimile, or by mail.

Review will be conducted by an independent third party with clinical and legal expertise and with no financial or personal conflicts with the health insurance issuer. The examiner will review all of the information and documentation timely received. In reaching a decision, the examiner will review the claim *de novo* and will not be bound by any decisions or conclusions reached during the health insurance issuer's internal claims and appeals process.

Prior to reaching a decision, the examiner will forward any information submitted by the consumer to the health insurance issuer for reconsideration. After completing its reconsideration, the health insurance issuer may reverse its adverse benefit determination or final internal adverse benefit determination. Within one business day after making a decision to reverse, the health insurance issuer must provide written notice of its decision to the consumer and to the examiner. The examiner must terminate the external review upon receipt of the reversal notice from the health insurance issuer.

If the health insurance issuer does not reverse its benefit determination, the examiner must review the claim and provide written notice of the final external review decision as expeditiously as possible, but not later than 45 days after it receives the request for the external review. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the health insurance issuer must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The determination is binding except to the extent other remedies may be available under state or federal law to either the health insurance issuer or to the consumer. Judicial review may also be available to the consumer.

A consumer may request an expedited appeal if the claim involves a medical condition for which the timeframe for completing an internal or external appeal would seriously jeopardize the life or health of the consumer or his or her ability to regain maximum function; or it concerns an admission, availability of care, continued stay, or healthcare item or service relating to emergency care in cases in which the individual has not been discharged from the facility.

The process for an expedited external review mirrors the process for a standard external review, except that the examiner must immediately determine if a request is eligible for external review and the examiner must provide notice of the final external review decision as expeditiously as the medical circumstances require but not later than 72 hours (depending on the medical circumstances of the

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case) after the examiner receives the request for the external review. The examiner must deliver the notice of the final external review decision to the claimant and the health insurance issuer. This notice can be initially provided orally, but must be followed up in writing within 48 hours.

The interim process reflects the intent of the NAIC Uniform Model Act of ensuring the independence of the external review process. However, this interim process does not include many of the requirements set forth in the NAIC Uniform Model Act, including random assignment to independent review organizations. Nevertheless, it achieves the goal of this provision by ensuring that there is no financial relationship between the issuer and the body making the final external review decision.

Federal External Review

If the applicable state external review process requirements do not meet the minimum standards specified in the regulations, or if the plan is self-funded, then federal external review standards apply. Under the federal external review process, external review is available for certain adverse determinations, including denials of claims and adverse coverage determinations and rescissions based on medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of a covered benefit, as well as determinations involving whether treatment is experimental or investigational.[59] However, federal external review is not available for participants and beneficiaries in group health plans to resolve disputes about eligibility to participate in an employer-sponsored group health plan other than those disputes that are related to rescissions.[60] As a result, plans subject to the federal external review process will have the last word on eligibility determinations.

The federal external review procedures and requirements have yet to be issued. The DOL's Employee Benefits Security Administration ("EBSA") has issued a technical release, EBSA Technical Release 2010-01, which provides interim federal external review procedures for self-funded group health plans not subject to a state external review process and establishes an enforcement safe harbor for compliance with the federal external review requirements during the transition period.[61]

Under EBSA Technical Release 2010-02, for plan years beginning on or after September 23, 2010, a self-funded plan will be treated as satisfying the external review compliance safe harbor during the transition period and no enforcement action will be taken if it either complies with the requirements in Technical Release 2010-01 or it voluntarily complies with a state external review process in any state in which it operates, provided that the state makes its external review process available to plans that are not subject to state law, such as self-funded plans. For self-insured non-federal governmental health plans in territories and states without external review processes in effect on or before September 23, 2010, these plans must either contract with independent review organizations ("IROs") as set forth in Technical Release 2010-01 or use the interim federal external review process for health insurance issuers in states without external review laws as established in the technical guidance detailed above. Prior to July 1, 2011, the Departments will issue guidance on the standards for the federal external review process that will replace the interim process. This safe harbor is effective until superseded by future guidance on the federal external review process.

The interim federal external review procedures divide external reviews into two categories: standard and expedited reviews. A consumer must request a standard external review in writing within four months after receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. Within five business days of receipt of the external review request, the plan must complete a preliminary review of the request to determine whether: (1) the claimant was covered under the plan at the time the service was requested or provided; (2) the adverse determination does not relate to the failure to meet the eligibility requirements; (3) the claimant exhausted the plan's internal appeal process (unless it was not required); and (4) the claimant has provided all information and forms required to process an external review.

Within one business day after completing the preliminary review, the plan must provide the claimant with written notice of whether the request is eligible for external review. If the request is complete but not eligible for external review, the notice must include the reasons for why the request is ineligible. If the request is incomplete, the notice must describe the information necessary to make the request complete and the plan must allow a claimant to perfect the request within the four-month filing period or within 48 hours following the receipt of the notice, whichever is later.

If the request is eligible for external review, the plan must assign an accredited IRO to conduct the external review. To ensure unbiased and independent decisions, plans must contract with at least three IROs and either rotate claims assignments among them or use other independent, unbiased methods for selection, such as random selection. In addition, the IRO may not be eligible for any financial incentives based on the

likelihood that the IRO will support the denial of benefits. However, there still may be an inherent conflict of interest, as the plan contracts with the IRO and pays the expenses associated with a review.

The assigned IRO must timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice must include a statement that the claimant may submit additional information. The IRO must consider this additional information if submitted within 10 days when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days. This two-step process may create confusion. Consumers must be cognizant of this short deadline in advance if they need to collect medical records or conduct additional research.

Prior to reaching a decision, the IRO will forward any information submitted by the consumer to the health insurance issuer or plan for reconsideration. After completing its reconsideration, the health insurance issuer or plan may reverse its adverse benefit determination or final internal adverse benefit determination. Within one business day after making a decision to reverse, the health insurance issuer or plan must provide written notice of its decision to the consumer and to the IRO. The IRO must terminate the external review upon receipt of the reversal notice from the health insurance issuer or plan.

If the health insurance issuer or plan does not reverse its benefit determination, the IRO must review the claim and provide written notice of the final external review decision as expeditiously as possible, but not later than 45 days after it receives the request for the external review. In reaching a decision, the assigned IRO will review the claim *de novo* and will not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the health insurance issuer or plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. As a result, it appears that the plan must pay the claim before appealing the decision in court. The determination is binding except to the extent other remedies may be available under state or federal law to the health insurance issuer, plan or consumer. It is unclear, for example, whether or to what extent self-funded plans will be able to challenge the decisions of the IRO under ERISA or other law.

A consumer may request an expedited appeal if the claim involves a medical condition for which the timeframe for completing an internal or external appeal would seriously jeopardize the life or health of the consumer or his or her ability to regain maximum function; or it concerns an admission, availability of care, continued stay, or healthcare item or service relating to emergency care in cases in which the individual has not been discharged from the facility.

The process for an expedited external review mirrors the process for a standard external review, except that, immediately upon receipt of the request, the plan must make a preliminary review determination of whether the request meets the standard external review criteria and must immediately notify the claimant as to eligibility for an expedited review. Upon a determination that a request is eligible for an expedited external review, the plan will refer the matter to a contracted IRO for review. The plan must provide or transmit all necessary documentation and information considered in making the adverse or final internal adverse benefit determination to the IRO electronically, by phone, by facsimile, or by other expeditious method. The IRO must provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours following receipt of an expedited external review request.

The Departments intend to issue an amendment that makes modifications to the 2010 new appeals regulations in the near future. As a result, implementation and enforcement of the above standards have been delayed until the amendment is released.

Conclusion

The new consumer appeals regulations replace the existing patchwork of protections with a simpler and more uniform internal and external review process. In addition, the regulations establish enhanced consumer protections and extend many of the components and features of the DOL's claims procedure regulation and the NAIC Uniform Model Act to all consumers to prevent inappropriate denials and excessive delays when consumers challenge adverse decisions. Legal counsel representing consumers and healthcare providers in the consumer appeals process should be fully aware of the new procedures and protections as well as the limitations and disadvantages that consumers still must overcome.

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Endnotes

1 Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Consumer Appeals, 75 Fed. Reg. 43330 (July 23, 2010) (codified at 26 C.F.R. pts. 54, 602 (2010); 29 C.F.R. pt 2590 (2010); 45 C.F.R. pt. 147 (2010)).

2 Patient Protection and Affordable Care Act, Pub. L. 111–148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act, Pub. L. 111–152, 124 Stat. 1029 (2010).

3 Paragraph (b) of 26 C.F.R. § 54.9815–2719T, 29 C.F.R. § 2590.715 – 2719, 45 C.F.R. § 147.136 requires group health plans and health insurance issuers offering group or individual health insurance coverage to implement an effective claims and appeals process.

4 *Id.* at 43339.

5 29 C.F.R. § 2560.503–1. An employer health plan is self-funded if the employer pays the benefits directly or through a trust fund established for that purpose. An employer health plan is insured if the benefits provided under the plan are financed by the purchase of an insurance policy, and an insurance company pays the losses.

6 75 Fed. Reg. 43330, 43339.

7 *Id.* In general, individual insurance policies are not subject to ERISA. However, an individual insurance policy may be subject to ERISA if there is sufficient involvement by the employer in the administration of the policy.

8 *Id.* Insured state and local governmental plans, insured church plans, and health insurance issuers offering individual coverage were also generally subject to applicable state external review processes.

9 75 Fed. Reg. 43330, 43339.

10 The District of Columbia, Oklahoma, and Oregon have not required insurers to comply with the external reviewer's decision.

11 AHIP Center for Policy and Research, An Update on State External Review Programs, 2006 (July 2008).

12 75 Fed. Reg. 43330.

13 Prior to the enactment of PPACA, all states except Alabama, Mississippi, Nebraska, North Dakota, South Dakota, and Wyoming had external review laws. 75 Fed. Reg. 43330, 43340.

14 ERISA, 29 U.S.C. § 1144(a) provides: "Except as provided in subsection(b) of this section, the provisions of this subchapter ...shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

15 75 Fed. Reg. 43330, 43332; 29 C.F.R. 2560.503–1.

16 75 Fed. Reg. 43330, 43339 (codified at 26 C.F.R. § 54.9815-2719T; 29 C.F.R. § 2590.715-2719; 45 C.F.R. § 147.136).

17 See Departments of Health and Human Services, Labor, and the Treasury final interim regulations relating to status as a grandfathered health plan, 75 Fed. Reg. 34538 (June 17, 2010) (codified at 26 C.F.R. pts. 54, 602 (2010); 29 C.F.R. pt 2590 (2010); 45 C.F.R. pt. 147 (2010)).

18 In general, plans and policies are "grandfathered" if they existed as of March 23, 2010 (PPACA's enactment date).

19 See 75 Fed. Reg. 34538 (June 17, 2010).

20 75 Fed. Reg. 43330, 43340.

21 *Id.*

22 Adele M. Kirk. The Individual Insurance Market: A Building Block for Health Care Reform? (May 2008).

23 The DOL is considering further updates to 29 C.F.R. § 2560.503–1 and expects to issue future regulations that will propose additional, more comprehensive updates to the standards for plan internal claims and appeals processes. 75 Fed. Reg. 43330, 43332.

24 *Id.* at 43334 (codified at 26 C.F.R. § 54.9815-2712T(b)(2); 29 C.F.R. § 2560.503-1(f)(2)(ii); 45 C.F.R. § 147.128).

25 *Id* (codified at 26 C.F.R. § 54.9815-2719T; 29 C.F.R. § 2590.715-2719; 45 C.F.R. § 147.136).

26 *Id.* The regulations restricting rescissions generally define a rescission as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Rescissions of coverage must also comply with the requirements of the regulations restricting rescissions. *Id.*

27 *Id.*

28 A plan or issuer may rescind coverage in the case of an individual's act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

29 29 C.F.R. § 2560.503–1(f)(2)(i).

30 Under the DOL claims procedure regulation, a "claim involving urgent care" is a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. 29 C.F.R. § 2560.503–1(m)(1).

31 75 Fed. Reg. 43330, 43333 (codified at 26 C.F.R. § 54.9815-2719T(b)(2)(ii)(B); 29 C.F.R. § 2590.715-2719(b)(2)(ii)(B); 45 C.F.R. § 147.136 (b)(2)(ii)(B)).

32 *Id.* (codified at 26 C.F.R. § 54.9815-2719T(b)(2)(ii)(C); 29 C.F.R. § 2590.715-2719(b)(2)(ii)(C); 45 C.F.R. § 147.136 (b)(3)(ii)(C)).

33 *Id.*

34 *Id.*

35 29 C.F.R. § 2560.503-1(h)(2)(ii).

36 75 Fed. Reg. 43330, 43333 (codified at 26 C.F.R. § 54.9815-2719T(b)(2)(ii)(D); 29 C.F.R. § 2590.715-2719(b)(2)(ii)(D); 45 C.F.R. § 147.136 (b)(2)(ii)(D)).

37 75 Fed. Reg. 43330, 43333 (codified at 26 C.F.R. § 54.9815-2719T(b)(2)(ii)(E); 29

C.F.R. § 2590.715-2719(b)(2)(ii)(E); 45 C.F.R. § 147.136 (b)(2)(ii)(E)).

38 PHSA section 2793 establishes offices of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

39 75 Fed. Reg. 43330, 43337(codified at 26 C.F.R. § 54.9815-2719T(b)(2)(ii)(E); 29 C.F.R. § 2590.715-2719(b)(2)(ii)(E); 45 C.F.R. § 147.136 (b)(2)(ii)(E)).

40 This threshold is adapted from the DOL's regulations regarding style and format for a summary plan description, at 29 C.F.R. § 2520.102–2(c).

41 The Department of Health and Human Services has county level estimates on its Web site at http://www.hhs.gov/ociio/.

42 To facilitate requests for notices in non-English language, if an applicable threshold is met, the plan or issuer must include, within the English version of all notices, a statement in the non-English language offering to provide notice in the non-English language.

43 75 Fed. Reg. 43330, 43337(codified at 26 C.F.R. § 54.9815-2719T(e); 29 C.F.R. § 2590.715-2719(e); 45 C.F.R. § 147.136 (e)).

44 These notices are available at http://www.dol.gov/ebsa and http://www.hhs.gov/ociio/.

45 75 Fed. Reg. 43330, 43334 (codified at 26 C.F.R. § 54.9815-2719T(b)(2)(ii)(F); 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F); 45 C.F.R. § 147.136 (b)(2)(ii)(F)).

46 *See* Robinson v. Aetna Life Ins., 443 F.3d 389 (5th Cir. 2006). Schneider v. Sentry Long Term Disability, 422 F.3d 621 (7th Cir. 2005). Moore v. LaFayette Life Ins. Co., 458 F.3d 416 (6th Cir. 2006). White v. Aetna Life Ins. Co., 210 F.3d 412 (D.C. Cir. 2000)(citing Heller v. Fortis Benefits Ins. Co., 142 F.3d 487 (D.C. Cir. 1998).

47 *Id.* (codified at 26 C.F.R. § 54.9815-2719T(b)(3)(ii); 29 C.F.R. § 2590.715-2719(b)(3)(ii); 45 C.F.R. § 147.136 (b)(3)(ii)).

48 75 Fed. Reg. 43330, 43345; *See also* FUNDAMENTALS OF UNDERWRITING IN THE NON-GROUP HEALTH INSURANCE MARKET 10–12 (Apr. 13, 2005).

49 75 Fed. Reg. 43330, 43345.

50 *Id.* at 43334.

51 *Id.* (codified at 26 C.F.R. § 54.9815-2719T(b)(3)(ii); 29 C.F.R. § 2590.715-2719(b)(3)(ii); 45 C.F.R. § 147.136 (b)(3)(ii)).

52 *See* U.S. DEPARTMENT OF LABOR, INTERIM PROCEDURES FOR INTERNAL CLAIMS AND APPEALS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (Sept. 20, 2010) *available at* http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-02.pdf.

53 The "good faith" requirement does not apply during the extended or the original enforcement grace period.

54 75 Fed. Reg. 43330, 43335.

55 *Id.*

56 *Id.* at 43336.

57 *Id.*

58 *See* DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF CONSUMER INFORMATION AND INSURANCE OVERSIGHT, TECHNICAL GUIDANCE FOR INTERIM PROCEDURES FOR FEDERAL EXTERNAL REVIEW RELATING TO INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW FOR HEALTH INSURANCE ISSUERS IN THE GROUP AND INDIVIDUAL MARKETS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (Sept. 20, 2010) *available at* http://www.hhs.gov/ociio/regulations/consumerappeals/interim_appeals_guidance.pdf.

59 75 Fed. Reg. 43,330, 43,336.

60 *Id.*

61 T.R. 2010-01 is available at http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf.