

**LEGISLATIVE BRIEF:**

**NEWS RELATED TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

**INTERNAL APPEALS AND EXTERNAL GRIEVANCE REVIEW REQUIREMENTS FOR NON-GRANDFATHERED PLANS**

Federal agencies have released an amendment to the Interim Final Regulations defining the internal claims and appeals procedure and external review process that non-grandfathered plans must have in place for enrollees to dispute adverse decisions through the Patient Protection and Affordable Care Act (PPACA). The regulation is effective for plan years beginning after September 23, 2010, although enforcement grace periods and safe harbors are in effect for certain requirements until 2012.

This Legislative Brief has been updated to summarize changes to the initial regulations and technical guidance issued earlier by the Department of Labor. Changes that were made as a result of the recent amendment are *italicized*.

**Internal Appeals Procedures**

PPACA requires non-grandfathered plans, including self-funded plans, to implement a new internal claims and appeals procedure. This procedure includes the current requirements for claims review under ERISA, but with seven additional requirements:

- » Adds “rescission” to the definition of adverse benefit determination.
- » Requires plans to notify a claimant of a benefit determination relating to urgent care to “as soon as possible” and not later than 72 hours. *This time period is extended by the amendment, which also states that plans must defer to the attending health care provider in determining if a claim is urgent.*
- » Requires that claimants be given free of charge any evidence or rationale relied upon or generated in connection with a claim sufficiently ahead of a review date and provides additional criteria to ensure that a claimant receives a full and fair review.
- » Includes new conflict-of-interest protections.
- » Provides new standards regarding content and notice information given to enrollees. *This information includes a notice under the amended rule that International Classification of Diseases (ICD) codes and their meanings will be provided upon request and not automatically as the original rule required.*
- » *Under the amended rule, plans must provide information in a “culturally and linguistically appropriate manner” if a claimant lives in one of 255 counties in the U.S. and Puerto Rico where 10 percent or more of the population is literate in the same non-English language. These counties are described in Table 2 within the amended rule.*
- » Requires that if a plan fails to “strictly adhere” to all requirements of the internal claims and appeals process with respect to a claim, the claimant will have the right to pursue external review or any other available recourse including judicial review.

Plans that did not have to comply with ERISA’s claims regulations previously will now have to become familiar and comply with these regulations, in addition to those listed above.

**External Review Requirements**

Federal guidance issued previously established two safe harbor options for non-grandfathered health plans required to establish an external review process under the ACA. The previous guidance indicated that the plan could either:

1. Voluntarily comply with a state external review process, or
2. Comply with standards set forth in a previously issued Technical Release 2010-01.

Newly issued Technical Release 2011-02 changes the enforcement standard to provide a safe harbor for plans (or their TPAs) that have contracted with at least two IROs by January 1, 2012 and with at least three IROs by July 1, 2012 and rotate claims assignment among them. Any process other than rotational assignment will be reviewed by the Department of Labor and the IRS on a case-by-case basis.



## External Review Requirements, continued:

The Department of Health and Human Services (HHS) has issued a separate technical memo explaining the steps required for plans, including self-funded government plans, to meet a federally-administered external review process as opposed to a state process. Plans must make this determination and inform HHS of it before January 1, 2012.

Additional changes in the amended regulation:

- » The scope of claims eligible for external review is narrowed to include only those that involve medical judgment and rescissions of coverage. Interpretations of plan terms would not be included, but a determination regarding whether an enrollee should be eligible for a “reasonable alternative” to receive a wellness reward would be included.
- » “De minimis” violations of regulatory procedures would not automatically trigger external review as the previous rule required.

## Additional Resources

Federal regulators have made revised model notices available regarding adverse benefit determinations and final external review decisions in the “Internal Claims and Appeals and External Review” section of the [Employee Benefits Security Administration \(EBSA\) website](#).

**If you have questions about your plan’s compliance with these requirements or how to implement them, please contact your attorney.**

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