



## Health Care Reform: Appeals Process Requirements

Most group health plans include an appeals process within the plan documents or summary plan description. For fully-insured and self-insured group health plans that are not grandfathered, there are specific requirements for those appeals processes for plan years beginning on or after September 23, 2010.

Failures to comply with the new requirements may subject the plan administrator or health insurance issuer to a \$100 per day per violation excise tax imposed under the Internal Revenue Code in addition to any civil claims resulting from a lawsuit filed by an affected participant.

**FULLY INSURED PLANS:** Fully insured plans already participate in the State process and will meet these requirements. No action is needed other than to ensure all plan documents are updated.

**SELF INSURED PLANS:** No state currently allows self-insured plans to participate in their external review process. As a result, self-insured plans will have to implement procedures to comply with these requirements at renewal after 9/23/10. Most third-party administrators, as well as KTB's partner Health Advocate, are providing an administrative service to manage the external review process on behalf of their clients (additional fees may apply). Contact your KTB agent for information on your options.

### **APPEALS PROCESS REQUIREMENTS**

1. Plans must establish an internal claims process that includes the following:
  - a. An adverse benefit determination now includes a rescission of coverage, except for the failure to timely pay the covered employee's portion of the premium or where the individual has not met the basic eligibility requirements under the plan.
  - b. The plan administrator must notify the claimant of benefits determinations involving an urgent care claim as soon as possible, but no later than 72 hours after receiving the claim.
  - c. If while reviewing a claim the plan administrator uses new or additional evidence, that evidence must also be provided to the claimant as soon as possible and with enough time to respond.
  - d. The written benefit determination or appeal must provide the claimant with the rationale for the decision.
  - e. Conflicts of interest on the part of decision makers are prohibited. Employers should review job descriptions and responsibilities of the individuals making benefits appeal determinations to ensure they are not also involved in other employment decisions.  
  
Plans are also prohibited from hiring medical experts on their reputation for denying contested claims. Medical experts can only be hired based on their professional expertise.
  - f. Explanation of benefits (EOBs) must now include the date of service, provider, amount, reasons for the denial including the denial code, and corresponding meanings of all codes, and standards for medical necessity used. The notice must inform the claimant that he or she may request the codes upon request. The EOB must also disclose the availability and contact information of any

health insurance consumer assistance office or ombudsman under the Public Health Services Act (such as the PA Insurance Department, NJ Department of Banking and Insurance, or the DOL's Employee Benefits Security Administration).

- g. Coverage must be provided pending the outcome of the internal appeal.
  - h. If the plan does not comply with **all** the above requirements, the claimant can go directly to the courts without exhausting the plan's appeal process first, even if the plan has substantially complied with the requirements or if the error was only: de minimis; non-prejudicial; attributable to good cause or matters beyond the plan's or issuer's control; made in the context of an ongoing, good-faith exchange of information; and not reflective of a pattern or practice of noncompliance. The plan must disclose the basis for its determination. If an external reviewer or a court rejects a claimant's request for immediate review on the basis of this standard, the claimant must have the opportunity to resubmit the claim to the plan for completion of the internal appeals process.
2. Provide notice to all enrollees, in a culturally and linguistically appropriate manner, of the available internal and external appeals processes and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist them with the appeals process.

This means that plans with participants who are literate in a non-English language must provide notices upon request in the non-English language if 10% or more of the population in the claimant's county (as determined by Federal census data) are literate only in the same non-English language. Affected counties will be posted on agency websites periodically.

3. Allow enrollees to review their files, present evidence and testimony as part of the appeals process, and receive continued coverage pending the outcome of the appeals process. Claimants with urgent care claims or who are undergoing an ongoing course of treatment may proceed with the expedited external review claim concurrently with the internal appeal.
4. Implement an external review process by an Independent Review Organization that meets applicable state requirements and guidance. State requirements and guidance are expected to be issued by the Department of Health and Human Services (HHS). Fully-insured plans already subject to a state requirement for an external review process must continue complying with that requirement until additional regulations are released. Plans must contract with at least 3 IRO's and ensure that claims are randomly submitted to the IRO's when requests for reviews arise.

## **What Employers Should Do Now:**

1. Plan sponsors and administrators should review any already established appeals process for compliance with these new standards. If no appeals process is currently in place, one should be developed and incorporated into the plan at the time of renewal. If not already in place, establish an external appeal procedure.
2. Revise, amend or draft group health plan documents to comply, such as summary plan descriptions, written plan documents, enrollment materials, benefit summaries, and all claim related notices.

*In response to the Patient Protection and Affordable Care Act and the Health Care and Education Tax Credit Reconciliation Act, collectively known as Health Care Reform, Kistler Tiffany Benefits has formed a Health Care Reform committee to monitor legislation and provide guidance to our valued clients. Our team is creating user-friendly tools and resources, as well as establishing best practices for our clients in regards to the application of this legislation. For more information regarding our services, please contact us at [reform@ktbenefits.com](mailto:reform@ktbenefits.com).*