



Interim Final Rules on Internal Claims and Appeals and External Review Processes:PPACA

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New Rules Guarantee Patients' Right To Appeal Insurance Claim Denials - Kaiser Health News

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New Rules Guarantee Patients' Right To Appeal Insurance Claim Denials

Topics: Insurance, Health Reform

By Phil Galewitz and Michelle Andrews

Jul 22, 2010

This story was produced in collaboration with **The Washington Post**.

Patients will find it easier to appeal the denials of health insurance claims under rules being issued Thursday by the Obama administration, which is trying to boost political support for the new health care law by highlighting potential advantages for consumers.

The regulations guarantee consumers the right to appeal denials — directly to their insurers and then, if necessary, to external review boards.

The external-review requirement will apply, for the first time, to companies that are self-insured — ones that pay their employees' claims directly rather than buying insurance to cover their workers.

"This is huge," said Sara Rosenbaum, head of the department of health policy at the George Washington University School of Public Health and Health Services.

Most states already guarantee consumers the right to external appeals, though their rules vary widely and five states — North and South Dakota, Alabama, Mississippi and Nebraska — don't have laws requiring an external review.

"The rules issued today will end the patchwork of protections that apply to only some plans in some states, and simplify the system for consumers," according to a White House fact sheet.

However, the rules don't apply to "grandfathered" plans — those that existed on March 23, when the health law was enacted. Plans can lose their "grandfathered" status if they make significant changes to their plans regarding costs or benefits.

Still, by next year, an estimated 31 million people in employer-sponsored plans and another 10 million people in individual plans will benefit from the new appeals rights, according to the White House.

Advocates hope the changes will give consumers a fairer shot at fighting back when their claims are denied. Insurers deny claims for many reasons: they may determine that a treatment is not medically necessary, for example, or that it's experimental. Sometimes denials relate to coverage of pre-existing health conditions.

America's Health Insurance Plans, the main health insurance lobby, supports efforts to "create uniformity or consistency" in the appeals process, said spokesman Robert Zirkelbach, who has not yet seen the final rules. "We have encouraged every state to have a third-party review system," he said.

But appealing insurers' denials is easier in some states than others. Many consumers don't know that they can appeal insurers' denials. "Not enough consumers know this is an option that they have," said Angel Robinson, the consumer advocate in the Iowa Insurance Division.

To change that, the administration is providing \$30 million in grants to states to strengthen consumer assistance offices.

Administration officials said they are hoping the states that do not have an external review system will set one up using the new federal rules. But if they don't a federal review system will be set up for them.

Under the regulations, states are "encouraged" to adopt the new standards by July 2011.

The new regulations take effect for plan years beginning Sept. 23. But they won't automatically apply to residents in states that have their own existing external review laws until next July. That's to give states time to adjust to the new standards.

If states fail to change their rules by next July, their residents will then be able to rely on the federal standards. But federal officials are still trying to figure out how that would be done.

The system can be hard for patients to navigate.

When Craig Washington suffered a stroke in June 2009, his health plan denied more than \$28,000 in claims for the two weeks he was hospitalized in Chicago. The insurer said his stroke was due to a pre-existing condition, and since he'd been uninsured before starting a new job that April as executive director of Roseland Community Hospital Foundation, the plan denied his claims. Washington lost two appeals with his health plan.

Now, he's appealing to an independent state review panel. "It's exhausting," he says.

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 - [Statement of U.S. Secretary of Labor Hilda L. Solis on passage of health care reform by U.S. House of Representatives](#)
 - [Statement of Assistant Secretary of Labor Phyllis C. Borzi on Health Care Reform](#)
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Affordable Care Act Regulations and Guidance

- Interim Final Rules on Internal Claims and Appeals and External Review Processes: [Regulation](#) • [Fact Sheet](#) • [NAIC Uniform External Review Model Act](#)
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EBSA Health Related Information

- [Consumer Information on Health Plans](#)
 - [Compliance Assistance for Health Plans](#)
 - [Health Benefits Education Campaign](#)
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Related Web Sites

- [White House Web Page on Health Reform](#)

- Healthcare.gov
- [IRS Web site on the Affordable Care Act](#)
- House Committees Health Insurance Reform at a Glance: [Summary](#) • [Implementation Timeline](#) • [Consumer Protections](#) • [For Employers](#)

EBSA News

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Administration Announces New Affordable Care Act Measures to Protect Consumers and Put Patients Back in Charge of Their Care

New Regulations Give Patients Right To Appeal Health Plan Decisions; New Grants Program Strengthens State and Territory Consumer Assistance Programs

Washington – Today, the Obama Administration is announcing both new regulations to empower consumers to appeal decisions made by their health plans or insurance companies and the availability of resources that will be used to help give consumers more control of their health care decisions. These provisions of the Affordable Care Act will help support and protect consumers and help end some of the worst insurance company abuses.

The new appeals regulations were issued by the Departments of Health and Human Services (HHS), Labor, and the Treasury. Consumers in new health plans in every State will have the right to appeal decisions, including claims denials and rescissions, made by their health plans. This includes the right to appeal decisions made by a health plan through the plan's internal process and, for the first time, the right to appeal decisions made by a health plan to an outside, independent decision-maker, no matter what state a patient lives in or what type of health coverage they have.

In addition, grant applications from the \$30 million Consumer Assistance Program are now available to help States and Territories establish consumer assistance offices or strengthen existing ones. The new funds will be used to provide consumers with the information they need to pick from a range of coverage options that best meets their needs, appeal decisions by plans to deny coverage of needed services, and to select an available primary care provider of their choosing.

"The Affordable Care Act puts patients in control of their healthcare," said HHS Secretary Kathleen Sebelius. "Today, if your health plan tells you it won't cover a treatment your doctor recommends, or it refuses to pay the bill for your child's last trip to the emergency room, you may not know where to turn. The Affordable Care Act

provisions announced today will provide patients with new important new rights and resources that will help ensure they get the care they need."

"The appeals rules today will extend important protections and simplify the system for consumers," said Labor Secretary Hilda Solis. "And they will ensure that consumers in new health plans have access to internal and external appeals processes that are clearly defined, impartial, and designed to ensure that, when health care is needed and covered, consumers get it."

"The Affordable Care Act provisions we're announcing today will ensure that consumers have access to a fair, thorough and uniform appeals process if their claim is denied," said Michael Mundaca, Assistant Treasury Secretary for Tax Policy. "With these new patient protections, we're providing consumers with another strong defense against insurance company abuses."

"The Consumer Assistance Program will support patients both now as we transition to a more competitive, patient-centered health insurance marketplace in 2014 and once that new marketplace is established," said Jay Angoff, Director of the Office of Consumer Information and Insurance Oversight within HHS. "These programs can help consumers understand what type of coverage they need, how they can enroll - and then help them if they run into any trouble getting the benefits they've paid for."

For more information about the new appeals regulation or Consumer Assistance Grants program, go to http://www.healthcare.gov/news/factsheets/protectconsumers_factsheet072210.pdf.

U.S. Department of Labor news releases are accessible on the Department's Newsroom page. The information in this news release will be made available in alternate format (large print, Braille, audio tape or disc) from the COAST office upon request. Please specify which news release when placing your request at 202.693.7828 or TTY 202.693.7755. The Labor Department is committed to providing America's employers and employees with easy access to understandable information on how to comply with its laws and regulations. For more information, please visit the Department's Compliance Assistance page.

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[The Affordable Care Act: Protecting Consumers and Putting Patients Back in Charge of Their Care](#)

July 22, 2010

The Affordable Care Act will help support and protect consumers and end some of the worst insurance company abuses. For too long, consumers have been forced to fend for themselves in a health care system that did not provide them with the support and assistance they needed and deserved. Today, the Obama Administration is announcing new regulations that will allow consumers to appeal decisions made by their health plans and the availability of resources that will be used to help give consumers more control of their health care decisions. Today's announcements include:

New regulations that give consumers in new health plans in every State the right to appeal decisions, including claims denials and rescissions, made by their health plans.⁽¹⁾ The rules issued by the Departments of Health and Human Services, Labor, and the Treasury give consumers:

The right to appeal decisions made by their health plan through the plan's internal process,

For the first time, the right to appeal decisions made by their health plan to an outside, independent decision-maker, no matter what State they live in or what type of health coverage they have. States will work to establish or update their external appeals process to meet new standards, and consumers who are not protected by a State law will have access to a Federal external review program.

Next year, an estimated 31 million people in new employer plans and 10 million people in new individual plans will benefit from the new appeals rights announced today. The number of individuals in employer plans who will benefit is expected to rise to 78 million by 2013, for a total potential of 88 million Americans who will be guaranteed the right to appeal decisions made by their health plan.

A \$30 million grant program to establish and strengthen consumer assistance offices in States and Territories. The new Consumer Assistance Grants Program will help States establish consumer assistance offices or strengthen existing ones. The new funds will be used to provide consumers with the information they need to pick from a range of coverage options that best meets their needs.

New Regulations To Help Consumers Appeal Decisions By Their Health Plans

The new rules issued by the Departments of Health and Human Services, Labor, and the Treasury will standardize both an internal process and an external process that patients can use to appeal decisions made by their health plan.

Today, if your health plan tells you it won't cover a treatment your doctor recommends, or it refuses to pay the bill for your child's last trip to the emergency room, you may not know where to turn. Most health plans have a process that lets you appeal the decision within the plan through an "internal appeal" - but depending on your State's laws and

your type of coverage, there's no guarantee that the process will be swift and objective. Moreover, if you lose your internal appeal, you may not be able to ask for an "external appeal" to an independent reviewer.

The rules issued today will end the patchwork of protections that apply to only some plans in some States, and simplify the system for consumers. And they will ensure that all consumers in new health plans have access to internal and external appeals processes that are clearly defined, impartial, and designed to ensure that, when health care is needed and covered, consumers get it.

Internal Appeals

The internal appeals process will guarantee a venue where consumers may present information their health plan might not have been aware of, giving families a straightforward way to clear up misunderstandings. Under the new rules, new health plans beginning on or after September 23, 2010 must have an internal appeals process that:

Allows consumers to appeal when a health plan denies a claim for a covered service or rescinds coverage;

Gives consumers detailed information about the grounds for the denial of claims or coverage;

Requires plans to notify consumers about their right to appeal and instructs them on how to begin the appeals process;

Ensures a full and fair review of the denial; and

Provides consumers with an expedited appeals process in urgent cases.

External Appeals

If a patient's internal appeal is denied, patients in new plans will have the right to appeal to an independent reviewer. External appeals have helped consumers get the care they deserve: one study found that - in States that had external appeals - consumers won their external appeal against the insurance company 45% of the time.(2)

While 44 States provide for some form of external appeal, the laws governing these processes vary greatly and fail to cover millions of Americans. The new rules will ensure that consumers with new health coverage in all States have access to a standard external appeals process that meets high standards for full and fair review.

These standards were established by the National Association of Insurance Commissioners (NAIC). States are encouraged to make changes in their external appeals laws to adopt these standards before July 1, 2011. The NAIC standards call for:

External review of plan decisions to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

Clear information for consumers about their right to both internal and external appeals - both in the standard plan materials, and at the time the company denies a claim.
Expedited access to external review in some cases - including emergency situations, or cases where their health plan did not follow the rules in the internal appeal.
Health plans must pay the cost of the external appeal under State law, and States may not require consumers to pay more than a nominal fee.
Review by an independent body assigned by the State. The State must also ensure that the reviewers meet certain standards, keep written records, and are not affected by conflicts of interest.
Emergency processes for urgent claims, and a process for experimental or investigational treatment.
Final decisions must be binding so, if the consumer wins, the health plan is expected to pay for the benefit that was previously denied.
If State laws don't meet these standards, consumers in those States will be protected by comparable Federal external appeals standards. In addition, people in health plans that are not subject to State law - including new self-insured employer plans - will be protected by the new Federal standards.

New Consumer Assistance Grants

The Affordable Care Act provides consumers with significant new protections including the ability to choose a health plan that best suits their needs, to appeal decisions by plans to deny coverage of needed services, and to select an available primary care provider of their choosing. The new Consumer Assistance Grants program will provide nearly \$30 million in new resources to help States and Territories educate consumers about their health coverage options, empower consumers, and ensure access to accurate information. Grants will be made available to support States' efforts to establish or strengthen consumer assistance programs that provide direct services to consumers with questions or concerns regarding their health insurance.

All States and Territories may apply for these grants, which will help expand consumer assistance efforts on the State level, including:

Helping consumers enroll in health coverage;
Helping consumers file complaints and appeals against health plans;
Educating consumers about their rights and empowering them to take action; and
Tracking consumer complaints to help identify problems and strengthen enforcement.
Eligible applicants include State insurance departments, State attorneys general offices, independent State consumer assistance agencies, and other State agencies. States and Territories may also partner with non-profit organizations that have a track record of working with consumers. Applications are available now by visiting www.Grants.gov and searching for CFDA number 93.519.

What Will This Mean for You?

Under these rules, if your health plan denies coverage of a test - for example an MRI - you and your doctor can appeal that decision to the plan and, if the plan still refuses to cover the test, to an external reviewer. If the external reviewer agrees with you, your plan must pay for the test.

If your plan decides to rescind your coverage altogether based on the fact that information on your application for coverage was not accurate, you can appeal that decision. If your appeal is successful, the plan must reinstate your coverage.

If you go to the emergency room and your plan won't pay the bill, you'll have the chance to provide information to the plan about why you needed emergency care - and take your request to an external reviewer if your appeal to the plan is denied.

Consumer Assistance Grants have the potential to benefit millions of Americans. These grants will fund programs that will support consumers both now as we transition to a more competitive, patient-centered health insurance marketplace in 2014 and once that new marketplace is established.

If you learn that your employer is cancelling coverage, and you know it will be hard to find coverage for your family on the individual market, you may need someone to help explain your options. A State consumer assistance program will provide that support, helping you figure out what you need, describing ways you can get coverage, and ultimately helping you enroll in coverage.

Just last year, one State's existing consumer assistance program helped nearly 3,000 residents and recovered over \$7 million in benefits on behalf of consumers. In another State, a similar program assisted about 13,000 residents and helped nearly 8,000 of them enroll in coverage.

Builds on Other Initiatives to Protect Patients' Rights

The rules released today build on a series of efforts under the Affordable Care Act to strengthen consumer and patient rights. Other actions include:

Prohibiting Insurance Companies from Rescinding Coverage. In the past, insurance companies could search for an error, or other technical mistake, on a customer's application and use this error to deny coverage when he or she got sick. The new law makes this practice illegal.

Extending Coverage for Young Adults. Under the new law, starting next year, young adults will be allowed to stay on their parent's plan until they turn 26 years old. (In the case of grandfathered group health plans, this right does not apply if the young adult has available health coverage at work.) Some plans have begun implementing this policy early. Check with your insurance company or employer to see if you qualify.

Eliminating Lifetime Limits on Coverage. Under the new law, health plans will be prohibited from imposing lifetime dollar limits on essential benefits, like hospital stays.

Regulating Annual Dollar Limits on Insurance Coverage. Under the new law, health plans' use of annual dollar limits on the amount of insurance coverage a patient may receive will be restricted for new plans in the individual market and all group plans. In 2014, the use of annual dollar limits on essential benefits like hospital stays will be banned for new plans in the individual market and all group plans.

Prohibiting Denying Coverage of Children Based on Pre-Existing Conditions. The law prohibits insurance companies from denying coverage to children under the age of 19 due to a pre-existing condition.

Footnotes

To help individuals who like the coverage they have keep it, some plans that were in effect on March 23, 2010, and that were not significantly modified thereafter will be "grandfathered." Grandfathered health plans are not subject to these regulations. For more information about the definition of a grandfathered plan, see http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html.

Kaiser Family Foundation, Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation, 2002. <http://www.kff.org/insurance/externalreviewpart2rev.pdf>.

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC 20210. It will be made available in alternate formats upon request: Voice phone: 202.693.8664; TTY: 202.501.3911. In addition, the information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.