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NEW CONSUMER RIGHTS FOR APPEALING ADVERSE BENEFIT DETERMINATIONS OF HEALTH INSURERS

New rules apply to health insurance plans or policy years beginning after September 23, 2010.

These rules provide a consumer right to an independent (external) review of a health insurer's denial of a claim.

State vs. Federal review

- Fully-insured group health plans: if the state review process includes the consumer protections of the Model Notice of Adverse Benefit Determination Act (as revised in September) and is binding on insurers, these plans must comply with the applicable state review standards.
- ERISA-covered, self-insured plans: federal review
- Non-ERISA, self-insured plans: potentially subject to the state review process

For ERISA plans:

- The old internal review procedures still apply with some additional consumer rights.
- If a claim is still denied after the internal review procedures are exhausted, there is a new right to an appeal to an external reviewer.
- Where the denial involves urgent care or an ongoing course of treatment, there is a potential right to expedited simultaneous internal and external review.
- An issuer generally cannot reduce or terminate benefits related to an ongoing course of treatment without notice and an opportunity for review.

ERISA Amendments:

- Rescission of coverage is now subject to internal claims and appeals procedures.
- The plan or issuer has 24 hours to make a benefit determination involving urgent care.
- If new information or evidence is considered during the internal appeals stage, the plan or issuer must automatically (without request) inform the insured.
- An adjuster's willingness to deny benefits cannot affect conditions of the adjuster's employment (hiring, promotion, benefits, termination).
- Some plans (depending on the population of the insureds) must provide notices in a language other than English.
- Any notice of adverse benefit determination must include
    - a specific description of the claim (date and provider of service and diagnosis and treatment codes and descriptions)
    - the reason for denial, including the denial code and the standard of review the insurer used
        - If it is a notice of final determination, the notice must include a written explanation of or the denial.
    - a description of the internal and external review processes, including how to request an appeal
    - the name of, and contact information for, the consumer assistance program.
- If the insurer fails to comply with the rules for internal review, the consumer may skip straight to the external review process.

As always, if you have any questions or concerns about Health Care Reform, Employee Benefits or other issues in general, please feel free to contact us.

Mark C. Abramson
C. Phillip Baither, III
William V. Beach
Peter N. Lavalette
Lisa L. Nagel
Stephen J. Stanford
Jason M. Van Dam