COMPLIANCE OVERVIEW

Claims and Appeals Procedures for Employee Benefit Plans

Department of Labor (DOL) regulations require employee benefit plans to establish and maintain reasonable procedures for filing benefit claims and appeals, making claims and appeals decisions, and notifying claimants of benefit decisions. These regulations govern all employee benefit plans covered by ERISA, with special rules for group health plans and plans providing disability benefits.

To be reasonable, an employee benefit plan's claims procedures must satisfy specific requirements, including:

- Complying with deadlines for issuing claims decisions and making appeals determinations;
- Containing safeguards to ensure that claims decisions are made according to plan documents and that plan rules are applied consistently; and
- Not interfering with the initiation or processing of claims.

This Compliance Overview summarizes key provisions of the claims and appeals procedures for employee benefit plans.

LINKS AND RESOURCES

- DOL regulations on claims procedures
- Final regulations under the Affordable Care Act (ACA) regarding claims procedures for non-grandfathered group health plans
- Final regulations on claims procedures for disability benefits (effective April 2, 2018)
- COVID-19 Relief: Final rule, Notice 2020-01 and Notice 2021-01
- Biden administration's announcement for scheduled end of national emergency

Group Health Plans

- Must comply with DOL rules on benefit claims and appeals
- Additional requirements apply to non-grandfathered health plans
- Rules require that plans make claims and appeals decisions within specific time frames and provide certain information to claimants

Health Claim Deadlines

- 72 hours for urgent care claims
- 15 days for pre-service claims
- 30 days for post-service claim
- COVID-19 relief may provide participants with additional time to comply with claim deadlines

General Rules

Every employee benefit plan must establish and maintain reasonable claims and appeals procedures. To be reasonable, the procedures must comply with the deadlines and other requirements discussed below. In addition, the procedures must:

- ☑ Be included in the plan's summary plan description (SPD);
- ☑ Not interfere with the initiation or processing of claims (for example, requiring payment of a fee for filing a claim or appeal would be prohibited);
- ☑ Permit a claimant's authorized representative to act on the claimant's behalf in pursuing a claim or appeal (however, a plan can generally establish its own procedures for determining whether a person has been authorized to act on behalf of a claimant); and
- ☑ Contain safeguards to ensure that claims decisions are made according to governing plan documents and that plan rules are applied consistently to similarly situated claimants.

If a plan does not establish or follow reasonable claims procedures, a claimant will be deemed to have exhausted the administrative remedies available under the plan and is entitled to bring suit against the plan under ERISA. As a general rule, if a non-grandfathered group health plan or issuer does not **strictly comply** with the plan's claims and appeals procedures, a claimant may pursue other legal remedies without exhausting the plan's administrative process. This strict compliance standard also applies to claims for disability benefits.

COVID-19 Relief Extends Certain Employee Benefit Deadlines

Various deadlines related to employer-sponsored group health plans are extended during the COVID-19 outbreak period. The outbreak period began in March 2020, when former President Donald Trump declared a national emergency due to the COVID-19 pandemic, and it will continue until 60 days after the end of the COVID-19 national emergency (or such other date as announced by the federal government).

On Jan. 30, 2023, the Biden Administration announced its plan to end the COVID-19 national emergency on **May 11, 2023**. Under this timeline, the outbreak period will end on **July 10, 2023**. During the outbreak period, the following deadlines are extended (among others):

- The date within which individuals may file a benefit claim under the plan's claims procedure;
- The date within which claimants may file an appeal of an adverse benefit determination under the plan's claims procedure;
- The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination; and
- The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.

Under the relief, **these deadline extensions end when the outbreak period is over** or, if earlier, after an individual has been eligible for a specific deadline extension for one year.

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Maximum Time Period to Issue Claim Decisions

Group Health Plans

A group health plan must take into account any medical exigencies and/or the claimant's medical circumstances when resolving claims. At the latest, a plan must render decisions within:

- 72 hours for urgent care claims;
- 15 calendar days* for pre-service claims (pre-authorizations);
- 30 calendar days* for claims for services rendered;
- 72 hours for urgent care claims on appeal;
- 30 calendar days for pre-service claims on appeal; and
- 60 calendar days for claims for services rendered on appeal.

**The regulations allow a group health plan one 15-day extension for initial claim determinations (not including urgent care). The extension may be used when reasons beyond the plan's control require additional time to make a claim determination.*

Disability Benefits

A plan that provides disability benefits must resolve claims within:

- 45 calendar days* for initial claims; and
- 45 calendar days* for claims on appeal.

**When reasons beyond the plan's control require an extension, the regulations allow a disability plan two 30-day extensions for initial claims, and one 45-day extension for claims on appeal. The plan is required to provide the claimant with notice that the extension is needed prior to the expiration of the initial time period. The notice must also contain details regarding the reason for the extension.*

What is a disability benefit?

A benefit is considered a "disability benefit" if the claimant has to be disabled in order to obtain the benefit. It does not matter how the benefit is characterized or whether the plan as a whole is a retirement plan or a welfare plan. If the claims adjudicator must make a determination of disability in order to decide a claim, the claim must be treated as a disability claim for purposes of the DOL's claims procedures.

All Other Plans

All other plans must notify claimants of a denial within:

- 90 days* for initial claims; and
- 60 days* for claims on appeal.

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**If special circumstances require more time to process the claim, one extension is permitted (90 days for initial claims and 60 days for appeals). The claimant must be given written notice of the extension before the end of the first 60- or 90-day period. The notice must include an explanation of the special circumstances and the date a decision is expected to be made.*

Reduction or Termination of Benefits for Ongoing Treatment

In the event that a group health plan decides to terminate or reduce benefits that have already been granted, the claimant must be afforded an opportunity to seek review of the denial prior to the termination of benefits. To comply with this requirement, a group health plan must continue to provide coverage to the claimant until an internal appeal is resolved.

When appropriate, a claimant may file an urgent care claim to request that benefits be extended beyond the initially prescribed time period. If the urgent care claim is made at least 24 hours prior to the expiration of benefits, the plan must notify the claimant of its decision within 24 hours.

Under the ACA, anyone in an urgent care situation or receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal review.

Incomplete or Incorrectly Filed Claims

The regulations set forth how a plan must respond to claims that are not filed correctly or where the necessary information is not supplied.

Incomplete Claims

If a claimant files an incomplete urgent care claim, the plan is required to notify the claimant of the deficiency within 24 hours. For all other claims, the regulations do not include a time period in which plans must notify a participant of an incomplete claim. The time period allowed in order for the plan to make the determination is tolled on the date the plan provides the claimant with notice of the deficiency and begins to run upon receipt of the claimant's response. In addition, the plan may use any available extension in order to extend the time allowed for review.

Improperly Filed Claims

In the event a claimant improperly files a pre-service claim, the plan is required to notify the claimant of the deficiency within five calendar days (24 hours in the case of an urgent care claim) of the discovery of the defect. Unless the claimant requests the notice be provided in writing, oral notification of the defective filing is sufficient.

Adverse Benefit Determination - Definition

To trigger a claimant's right to appeal, there must first be an adverse benefit determination. An "adverse benefit determination" means a denial, reduction or termination of a benefit under the plan, including a failure to provide or pay for (in whole or in part) a benefit under the plan. It includes decisions based on eligibility to participate in the plan, plan coverage parameters and plan exclusions, such as experimental or medically necessary exclusions.

For non-grandfathered group health plans and plans providing disability benefits, an adverse benefit determination triggering a claimant's right to appeal includes a **rescission of coverage**. A rescission of coverage is a cancellation or discontinuation of coverage with a retroactive effect. A cancellation because of a failure to timely pay coverage premiums is not considered a rescission.

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Appeals – Providing a Full and Fair Review

The DOL's regulations require every employee benefit plan to establish procedures for claimants to appeal claim denials. Appeals must be conducted by an appropriate named fiduciary of the plan and must give a full and fair review of the claim and denial.

Basic Requirements

To provide a full and fair review, all plans must:

- Permit claimants to submit written documents and other information relating to the claim;
- Provide claimants, upon request and free of charge, with reasonable access to and copies of all documents, records and other information relevant to the claim; and
- Provide for a review that takes into account all information submitted by the claimant relating to the claim, whether or not that information was submitted or considered in the initial benefit determination.

The regulations clarify that "relevant information" includes all information a) relied upon in making the determination, b) submitted to the plan, c) considered by the plan, or d) generated in the course of making the benefit determination, without regard to whether such document was relied upon in making the determination.

Requirements for Group Health Plans and Disability Benefits

Group health plans and disability plans must also comply with the following requirements for a full and fair review:

- *Consultation with a qualified medical professional*—When a benefit determination is made using medical judgment, a plan must consult with an appropriately qualified independent medical professional. The regulations clarify that in order to be independent, the medical professional must be different from, and not a subordinate to, any individual that was consulted during the initial review of the claim. The plan must also identify medical or vocational experts whose advice was obtained in connection with the denial, even if the plan did not rely upon the advice in making the denial.
- *De novo review*—No deference may be afforded to the earlier claim decision. The claim must be reviewed by a named fiduciary with sufficient independence from the individual originally reviewing the claim.

Group health plans must provide an expedited review process for claims involving urgent care. This expedited process must allow claimants to request an expedited appeal orally or in writing. All information must be exchanged between the plan and claimant by phone or fax, or another similar method.

Additional Requirements for Non-grandfathered Group Health Plans and Disability Benefits

Under the ACA, to satisfy the requirements for a full and fair review, a non-grandfathered group health plan or issuer must comply with additional requirements. These requirements also apply to plans providing disability benefits, effective for claims submitted after April 1, 2018.

- *New evidence or rationale*—A plan must provide the claimant with any new or additional evidence relating to the claim or any new or additional rationale for a decision free of charge. This information must be provided as soon as possible and far enough in advance of the appeal deadline to provide the claimant with a reasonable opportunity to respond.

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- *Conflicts of interest*—Claims and appeals decisions must be made in a way designed to avoid conflicts of interest and to ensure the independence and impartiality of the decision-makers. Compensation, hiring, termination, promotion or similar decisions with respect to a claims decision-maker or medical expert cannot be based on the likelihood that the individual will support a benefits denial. Also, a plan cannot hire a medical expert based on his or her reputation for outcomes in contested cases, rather than his or her professional qualifications.

Maximum Time Period to File an Appeal

Group health plans and disability plans must allow a claimant to file an appeal up to 180 calendar days following receipt of a denial. All other plans must permit a claimant to file an appeal up to 60 days after receiving a denial.

Arbitration and Levels of Review

The regulations set forth restrictions on the use of arbitration and limit the number of mandatory internal levels of review.

Levels of Review	A plan may require up to two levels of mandatory internal review, but both levels must be completed within the overall time period allowed (for example, 30 days for each level of review for claims for services rendered).
Mandatory Arbitration	A plan's claims procedure may include mandatory arbitration as one of its two levels of review. The plan may not impose any fees on the claimant. The claimant is entitled to challenge the arbitrator's decision in court.
Voluntary Appeals	A plan may offer claimants an opportunity to voluntarily submit their dispute to a further level of appeal after all other levels of appeal are exhausted. The plan must provide the claimant with sufficient information about the voluntary level of appeal to enable the claimant to make an informed judgment about whether or not to use it. If the claimant declines to use the voluntary appeal, he or she will still be considered to have exhausted all available administrative remedies. If the claimant chooses to submit his or her claim to the voluntary appeal process, any applicable statute of limitations will be considered tolled.

Notification Requirements

Initial Claim Denials

The DOL's regulations require all plans to provide notification of an initial benefit denial to a claimant, including specific reasons for the denial, reference to the specific plan provision involved, a description of any additional information the claimant could provide to perfect the claim and a description of the plan's review procedures. The notice must be provided in writing or electronically. However, if the claim involves urgent care, notice may be given orally, with written or electronic notice provided within three days.

Group health plans and plans providing disability benefits must also include the following information in the initial denial notice:

- *Denial of claim based upon medical decision*—When a plan denies a claim based upon a determination of medical necessity, experimental treatment or other similar exclusion, it must either a) explain the scientific or clinical judgment of the plan in applying the terms of the contract to the claimant's medical condition, or b) inform the claimant of his or her right to such an explanation free of charge.

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- *Specific internal rules or protocols*—Where a group health plan utilizes a specific internal rule or protocol, it must include in its benefit denial a) an explanation of the protocol relied upon, or b) a statement that a copy of the protocol will be made available upon request. A similar rule applies to plans providing disability benefits.

- *Expedited review process*—If a claim involves urgent care, a group health plan must also provide a description of the expedited review process available to such claims.

Disability benefit claim denials must include an explanation for disagreeing with or not following:

- The views presented by the claimant of health care and vocational professionals who treated or evaluated the claimant;

- The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, regardless of whether the advice was relied upon in making the determination; and

- A disability determination made by the Social Security Administration (SSA) regarding the claimant.

The ACA contains additional content requirements for benefit denials from non-grandfathered group health plans and issuers. Benefit denial notices must include the following additional content:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount (the diagnosis and treatment codes and their corresponding meanings must be provided if a claimant requests them);

- The denial code and its meaning, as well as any standard used in denying the claim (such as a description of a medical necessity standard);

- A description of available internal appeals and external review processes, including information about how to initiate an appeal; and

- Contact information for any applicable office of health insurance consumer assistance to assist individuals with the internal claims and appeals and external review processes.

Additionally, adverse benefit determinations for non-grandfathered group health plans and disability benefits must be provided in a culturally and linguistically appropriate manner. To satisfy this requirement, a group health plan or issuer must provide information in a non-English language if a threshold is met for the number of people who are literate in the same non-English language.

Appeal Denials

The content requirements for notifying claimants of denials on appeal are similar to those for initial denials. For appeal denials, all notices must also be provided in writing or electronically. They must specify the reason for the denial, refer to the specific plan provision involved, state that the claimant is entitled to receive access to and copies of documents and other information relevant to the claim, describe any voluntary appeal procedures available under the plan and state the claimant's right to bring suit under ERISA.

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A non-grandfathered group health plan or issuer subject to the ACA's requirements must also include the additional content described above. Plans that provide disability benefits must explain the basis for disagreeing with a determination by medical or vocational professionals or the SSA.

Appeal denial notices sent by group health plans and disability plans must also include the following information:

- *Denial of appeal based upon medical decision*—When a plan denies an appeal based upon a determination of medical necessity, experimental treatment or other similar exclusion, it must either a) explain the scientific or clinical judgment of the plan in applying the terms of the contract to the claimant's medical condition, or b) inform the claimant of his or her right to such an explanation free of charge.
- *Specific internal rules or protocols*—Where a group health plan utilizes a specific internal rule or protocol, it must include in its benefit denial a) an explanation of the protocol relied upon, or b) a statement that a copy of the protocol will be made available upon request. A similar rule applies to plans providing disability benefits.
- *Alternative resolution options*—Notices must include a statement that claimants may have other voluntary alternative dispute resolution options, such as mediation and that more information is available from the local DOL office and state insurance regulatory agency.
- *Contractual limitations*—In addition to explaining a claimant's right to bring suit under ERISA, the appeal denial notice for disability benefits must describe any contractual limitations period that applies to the right to bring an ERISA action, including the calendar date on which the contractual limitations period expires for the claim.

External Appeals Process

The ACA requires non-grandfathered group health plans and issuers to comply with either a state external review process or a federal external review process.

State External Review Process

The ACA provides that, if a state external review process that applies to and is binding on an issuer includes certain minimum consumer protections, the issuer must comply with the state external review process. In that case, where benefits under a group health plan are provided through health insurance coverage, the issuer is responsible for providing the external review process, not the group health plan itself. The Department of Health and Human Services (HHS) determines whether a state external review process meets the minimum requirements. A federal external review process applies in states where the external review process does not meet the minimum standards.

Federal External Review Standards

The ACA requires non-grandfathered group health plans (including self-insured plans) in states without an applicable state external review process to implement an effective external review process that meets minimum federal standards. Self-insured health plans must either (a) voluntary comply with a state external review process, or (b) comply with the federal external review process for self-insured plans. Health insurance issuers that are required to follow a federal external review process can follow either the interim federal review process for self-insured plans, or they can follow a federal review process administered by HHS.

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COMPLIANCE OVERVIEW

Overview of Time Limits for Claims and Appeals

TYPE OF PLAN	GROUP HEALTH			DISABILITY
TYPE OF CLAIM	URGENT CARE	PRE-SERVICE CLAIM	CLAIM FOR SERVICES RENDERED	ALL
Plan must issue initial claim decision	72 hours (24 hours for certain concurrent care claims)	15 days	30 days	45 days
Plan may extend time needed to make initial benefit determination	None	15 days	15 days	30 days[1]
Plan must notify claimant if claim was filed improperly	24 hours[2]	5 days	30 days[3]	45 days
Plan must notify claimant if claim is incomplete	24 hours[2]	15 days[3]	30 days[3]	45 days
For claimant to provide missing information	48 hours	45 days	45 days	45 days
For claimant to file appeal after initial adverse determination	180 days	180 days	180 days	180 days
For plan to make determination of appeal after initial benefit determination	72 hours	30 days	60 days	45 days
For plan to extend determination on appeal	None	None	None	45 days

Note: *The regulations define "days" as calendar days.*

1. A second 30-day extension is also permitted.
2. This expedited time frame applies only in cases where the request involves a pre-service claim.
3. No time limit is specified, but a plan must still respond within original time frame allowed, but may use an extension, if necessary.

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