The U.S. Department of Health and Human Services, the Labor Department and the Treasury Department on July 22, 2010, announced regulations that provide the insured with the right to appeal decisions made by their health plans. The Affordable Care Act provisions will ensure that consumers have access to a fair, thorough and uniform appeals process if their claims are denied.

The interim final rules give consumers:

Internal Appeals

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.
- 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 all denied claims to an independent reviewer not employed by their health plan.

While 44 states provide for some form of external appeal, the laws governing these processes vary greatly and fail to cover millions. the new rules encourage states to make changes in their external appeals laws to adopt the following National Association of Insurance Commissioners standards before July 1, 2011:

- 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 internal and external appeals - 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 the health plan did not follow the rules in the internal appeal.
- Health plans must pay for the cost of the external appeal under state law, and states may not require consumers to pay for more than a nominal fee.
- Review by an independent body assigned by the state. The state must ensure that the reviewers meet certain standards, keep written records and are not affected by conflict of interests.
- 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 denied previously.
- If the state laws don't meet these standards, consumers in those states will be protected by comparable federal external appeals. In addition, people in health plans that are not subject to state law, including self-insured employer plans, will be protected by the new federal standards.