



Presentation to American Benefits Council

External Review Procedures for Self-Funded Group Health Plans: New Guidance

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The Agenda

- Brief recap of the July 23 interim final regulation (IFR) on claims and appeals
- Explanation of the August 23 external review guidance applicable to non-grandfathered self-funded group health plans
- Issues arising from the August 23 guidance



Recap of the Claims and Appeals IFR

- Applies only to non-grandfathered plans
- Existing DOL claims procedure rules continue to apply to internal claims and appeals, but with 6 changes:
 1. Broader definition of “adverse benefit determination”
 - Now includes a rescission of coverage
 2. Urgent care claims must be decided as soon as possible, but no later than 24 hours



Recap of the Claims and Appeals IFR *(con'd)*

3. Additional criteria to ensure a claimant receives a full and fair review
 - Provide, free of charge, any new or additional evidence considered, relied upon, or generated by the plan in connection with a claim sufficiently in advance to allow claimant response prior to the adverse benefit determination
 - Any new rationale for denying a claim on appeal must be disclosed to claimant in advance to allow claimant to respond prior to the final adverse benefit determination



Recap of the Claims and Appeals IFR *(con'd)*

4. New criteria to avoid conflicts of interest by decision makers
 - Plan cannot hire, promote or terminate claims reviewers based on the likelihood that an individual will support a denial of benefits
 - Bonuses based on the number of claims denied strictly prohibited
5. New notice standards
 - Provided in culturally and linguistically appropriate manner
 - Additional identifying information regarding the claim (i.e., date of service, amount)
 - Additional information regarding the reason for a claim denial (i.e., denial code and corresponding meaning)
 - Contact information for office of health insurance consumer assistance or ombudsman



Recap of the Claims and Appeals IFR *(con'd)*

6. Strict adherence to all requirements of internal claims and appeal process

- If a plan does not strictly adhere, claimant is deemed to have exhausted the internal claims and appeal process
- Substantial compliance does not count; de minimis errors do
- Upon deemed exhaustion, claimant may initiate external review or go to court



Recap of the Claims and Appeals IFR *(con'd)*

- Continued coverage
 - Plan must provide continued coverage pending the outcome of an internal appeal
 - Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review
- State external review process
 - Issuer subject - not ERISA-covered insured group health plan
- Federal external review process
 - Applies to ERISA-covered non-grandfathered, self-funded plans
 - IFR provides very general framework and DOL Technical Release 2010-01 fills in the gaps



Application of Federal External Review Process

- Plan years beginning on or after September 23, 2010
- Adverse benefit determination when plan fails to strictly adhere to internal claims and appeal rules
 - Claimant is deemed to have exhausted the internal process and can initiate external review of the denied claim
- Final internal adverse benefit determination
- Except: external review process is not available for any denial based on a determination that claimant is not eligible to participate under the terms of the plan



Interim Enforcement Safe Harbor

- DOL Technical Release 2010-01 provides an interim enforcement safe harbor for non-grandfathered self-funded group health plans
- Safe harbor applies for plan years beginning on or after 9/23/10 until superseded by future guidance
- DOL and IRS will not take any enforcement action against a plan that complies with either:
 - External review procedures set forth in the guidance; or
 - State external review process



Technical Release's External Review Procedures

- Based on the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners and in place on July 23, 2010
- Two sets of procedures provided: one for standard external review and one for expedited external review



Standard External Review Procedures

- Request for external review
 - Plan must permit it if filed within 4 months after the date of receipt of a notice of adverse benefit determination or final internal adverse benefit determination
- Preliminary review by plan
 - Within 5 business days after receipt of the external review request, plan must complete a preliminary review of the request
 - Preliminary review must determine whether:
 - Claimant is/was covered under the plan;
 - Denial based on claimant's ineligibility under terms of plan;
 - Claimant exhausted internal process, if required; and
 - Claimant provided all necessary information to process review



Standard External Review Procedures *(cont'd)*

- Preliminary review by plan *(con'd)*
 - Within 1 business day after completion of the preliminary review, plan must notify the claimant in writing if the request is not eligible for external review or if it is incomplete
 - If complete but not eligible, notice must include reasons for ineligibility and EBSA contact information
 - If not complete, notice must describe information needed to complete the request
 - Claimant has remainder of 4-month filing period or 48 hours from notice, whichever is greater, to cure defect
 - If eligible for external review, plan must assign the request to an independent review organization (IRO)



Standard External Review Procedures *(cont'd)*

- Plan's relationship with IROs
 - Plan must contract with at least 3 IROs that are accredited by URAC or similar organization
 - Plan must rotate external review requests among the contracted IROs and not provide any financial incentive to IRO to support the denial of benefits
 - Purpose is to prevent bias and ensure independence
 - Specific contractual requirements (discussed on following slides)
- Reversal of plan's decision
 - If IRO reverses plan's denial, plan must immediately provide coverage or payment for the claim



Plan/IRO Contract Requirements

- IRO must use legal experts where appropriate to make coverage decisions under the plan
- IRO must notify claimant of his/her request's eligibility and acceptance for external review and that claimant may submit in writing within 10 business days additional information, which the IRO must consider during its review
- Plan must provide to IRO within 5 business days after IRO's assignment the documents and information considered in the plan's denial of the claim
 - If plan does not provide documents and information, IRO may terminate its review and reverse the claim denial
 - In this situation, IRO must notify claimant and plan within 1 business day



Plan/IRO Contract Requirements *(cont'd)*

- IRO must forward to the plan within 1 business day any information submitted by the claimant
 - Plan may reconsider its claim denial in view of this additional information
 - If plan decides to reverse its earlier denial and provide coverage or payment, the external review may be terminated
 - Plan must provide written notice to claimant and IRO within 1 business day following reversal of its decision
 - Upon receipt of notice from plan, IRO must terminate its review



Plan/IRO Contract Requirements *(cont'd)*

- IRO must review all documents and information timely received
 - IRO reviews the claim de novo and is not bound by any decisions or conclusions made by the plan during its internal process
- In addition to the documents and information provided, IRO will consider additional information and documents to the extent available and appropriate, including:
 - Claimant's medical records;
 - Health care provider's recommendations and reports;
 - Terms of the applicable plan;
 - Appropriate practice guidelines;
 - Any applicable clinical review criteria developed and used by the plan; and
 - Opinion of the IRO's clinical reviewer



Plan/IRO Contract Requirements *(cont'd)*

- IRO must complete its review and provide notice of decision to plan and claimant within 45 days
 - Likely means 45 calendar days, because business days is not specified (is specified in other places)
 - Notice must contain:
 - General description of the reason for the external review request and information sufficient to identify the claim;
 - Date IRO received assignment and date of its decision;
 - References to the evidence or documentation IRO considered;
 - Discussion of the main reason(s) for its decision
 - Statement that IRO's decision is binding and that judicial review may be available to claimant
 - Model notice available on DOL's website



Plan/IRO Contract Requirements *(cont'd)*

- Record retention
 - IRO must maintain records of all claims and notices associated with the external review process for 6 years
 - IRO must make records available for examination by the claimant, plan or State or Federal oversight agency upon request, except where disclosure would violate privacy laws



Expedited External Review Procedures

- Claimant must be allowed to request an expedited external review in the following situations:
 - Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of claimant or would jeopardize claimant's ability to regain maximum function and claimant has filed a request for an expedited internal review
 - Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of claimant or would jeopardize claimant's ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services but has not been discharged from a facility



Expedited External Review Procedures *(cont'd)*

- Preliminary review: plan must immediately determine whether the expedited request satisfies the reviewability requirements for standard external review and immediately send the required notice of the plan's eligibility determination
 - Immediately is not defined; likely means within 24 hours
- Assignment to IRO: If plan determines the request to be eligible for external review, plan will assign it to an IRO pursuant to standards for assignment of standard external review requests
 - Plan must expeditiously (e-mail, fax, telephone) provide the IRO with all necessary documents and information
 - IRO must consider any available and appropriate documents and information to same extent as in a standard external review



Expedited External Review Procedures *(cont'd)*

- Notice of final decision
 - IRO must be required to provide notice of its final external review decision as expeditiously as claimant's medical condition or circumstances require, but not more than 72 hours after IRO receives the request
 - If notice is not provided in writing, IRO must provide written confirmation of its decision to the claimant and the plan within 48 hours after its notice



Voluntary Compliance with State Process

- If a State chooses to expand access to its external review process to ERISA-covered self-funded group health plans and such a plan voluntarily complies with the State's external review process, then the IRS and DOL will not take enforcement action against that plan
 - Presumably the plan must have some connection to the State whose process the plan complies with (i.e., corporate headquarters, significant number of employees)
 - Will plans have to comply with more than State process?
 - External review processes vary from State to State
 - May require similar contractual terms as the Federal process described above



Issues to Consider

- Must claims procedures be revised to describe the new external review process in detail?
 - Unclear
 - Argument that SPDs do not need to contain full details of process because the IFR and Technical Release do not lump external review in with the DOL claims procedure requirements
 - Difficult to bind a claimant to rules that are not fully explained in the plan's written materials
- Will third-party administrators (TPAs) act on behalf of the plan in determining eligibility of external review requests?
 - To be determined
 - If yes, likely will require amendments to the TPA contract



Issues to Consider *(con'd)*

- How will plans find accredited IROs?
 - Search of URAC's website yielded 43 accredited IROs
 - Are there enough IROs to contract with all of the non-grandfathered self-funded group health plans in the country?
- How much will external review cost plans?



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