

ADVISORY | EMPLOYEE BENEFITS

August 26, 2010

FEDERAL EXTERNAL REVIEW PROCEDURE FOR GROUP HEALTH PLANS

The health reform law requires non-grandfathered group health plans to meet new standards for processing internal claims and appeals, and also requires these plans to implement a new external review procedure. On August 23 the federal agencies charged with interpreting these requirements released several pieces of guidance on the external review procedure and provided model notices for both internal and external claims decisions. Links to these documents appear at the end of this memorandum.

The new guidance applies to self-insured group health plans that are not subject to state external review procedures. It builds on interim final regulations published on July 23, which interpret the many of the new rules for claims and appeals. See Covington memorandum *Guidance on New Claims Procedures and External Review Processes* (July 27, 2010).

The July 23 regulations provided that a group health plan or insurance issuer that is subject to state requirements for external review of claims (which apply to many insured plans, and to some non-ERISA self-insured plans and multiple employer welfare arrangements) must comply with the state's process at least through plan years beginning before July 1, 2011. At that time, if a state's review process fails to meet certain minimum standards, those plans would instead be subject to the federal review process. In the meantime, the Department of Health and Human Services ("HHS") will work with non-compliant states to develop an appropriate process.

In contrast, plans that are not subject to a state's external review process must comply with federal external review standards in plan years beginning on or after September 23, 2010. Accordingly, the federal standards apply to most self-insured group health plans governed by ERISA. Non-ERISA plans (such as government plans and church plans) and insured plans also must meet federal external review standards if these

Highlights

- ✓ New federal external review process applies to non-grandfathered self-insured health plans.
- ✓ Plans have two compliance options: apply existing state process, if available to self-insured plans, or apply new federal process.
- ✓ External appeal process includes standard and expedited review procedures.
- ✓ Plans must contract with at least three independent review organizations ("IROs"). Appeals must be assigned to an IRO on an unbiased basis.
- ✓ Contract between plan and IRO must include specified provisions.
- ✓ Plans must immediately implement IRO reversals of prior plan denials of benefits.
- ✓ IRO decisions are binding unless plan or claimant has other remedies available.
- ✓ Compliance with the new rules serves as an enforcement safe harbor.

plans are not subject to a state external review process.

INTERIM ENFORCEMENT SAFE HARBOR

The new guidance provides an interim enforcement safe harbor for non-grandfathered self-

insured group health plans that are not required to comply with state external review processes. A plan can comply with the safe harbor in one of two ways:

- The plan can choose to comply voluntarily with state external review standards, but only if the state extends its review standards to self-insured plans.
- Alternatively, a plan can comply with the interim federal external review process in the Department of Labor's ("DOL") Technical Release 2010-01, described below.

The interim enforcement safe harbor is effective for plan years beginning on or after September 23, 2010, and will remain in effect until superseded by future guidance on the federal external review process. Plans that meet the safe harbor requirements will not be subject to penalties or enforcement actions by the DOL or by the IRS.

Fully insured plans that are not subject to state external review procedures will be eligible for a different interim enforcement safe harbor to be published by HHS.

OVERVIEW OF FEDERAL EXTERNAL APPEALS PROCESS

The new federal external appeals process in Technical Release 2010-01 is based on the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners (the "Model Act"), but does not include all of the Model Act's consumer protections. For example, the federal process does not include special rules for appeals involving experimental or investigational treatments.

The new federal process includes two review procedures – one for standard external review and one for expedited external review.

STANDARD EXTERNAL REVIEW PROCESS

The standard external review process, which applies to any external review that is not an expedited review, includes the following requirements:

Request for External Review. A plan must allow a claimant to file a request for an external review as long as the filing is submitted within four months after the claimant receives an adverse benefit determination or a final internal adverse benefit determination.

Preliminary Review. The plan must complete a preliminary review within five business days after receiving the external review request. This preliminary review must determine:

- whether the claimant was covered under the plan at the time the health care item or service was requested (or was covered at the time an item or service was provided, if the appeal involves a retrospective review);
- whether the internal adverse benefit determination is based on the claimant's failure to meet an eligibility requirement that would not be subject to external review;
- whether the claimant has exhausted the internal review process, if the claimant is required to do so; and
- whether the claimant has submitted all the necessary documents and information to process the external review.

Within one business day after completing the preliminary review, the plan must notify the claimant in writing whether the request is complete and eligible for external review.

- If the filing is eligible for external review but not yet complete, the notice must indicate what further information or documents are required and allow the claimant the remainder of the four-month appeal period (but no less than 48 hours after the claimant receives the notice) to perfect the appeal request.
- If the claim is not eligible for external review, the notice must describe the reasons why the claim is ineligible and provide contact information for the DOL's Employee Benefits Security Administration.

Referral to Independent Review Organization. Once an eligible request for external review is complete, the plan must assign the matter to an independent review organization (an "IRO") that

is accredited by URAC (an independent non-profit organization that promotes health care accreditation, education, and measurement) or a similar organization. To avoid bias and ensure the independence of any IRO, plans must contract with at least three IROs, and must assign claims to an IRO on an unbiased basis, such as by rotation or random selection. A plan cannot provide the IRO with any financial incentive based on the outcome of any review or series of reviews.

Reversal of Plan Decision. If the IRO reverses the plan’s adverse benefit determination or final internal adverse benefit determination, the plan must immediately provide coverage or payment for the claim.

CONTRACT BETWEEN THE PLAN AND THE INDEPENDENT REVIEW ORGANIZATION

A contract between a plan and an IRO must specify that:

- the IRO will use legal experts as appropriate;
- the IRO will notify the claimant in writing of the appeal’s eligibility and acceptance for external review and of the claimant’s right to submit additional information to the IRO within 10 business days after the claimant’s receipt of the notice;
- the plan will provide, within five business days after the appeal is assigned to the IRO, the documents and information that the plan relied on in making the adverse benefit determination;
- the IRO can reverse the adverse determination if the plan fails to provide the required information;
- the IRO must forward any additional information submitted by the claimant to the plan within one business day after receipt. Upon receipt of the additional information, the plan can reconsider its adverse determination, but the external review will continue until the plan notifies the IRO that it has reversed its decision;

- the IRO must consider certain information (described in more detail below);
- the IRO’s written notice of its final decision must include specified information (described in more detail below); and
- the IRO must maintain records of a claim and all notices for six years and must provide access to the claimant, the plan, and government agencies to the extent permitted by federal and state privacy laws.

Information Considered by the Independent Review Organization. The IRO’s review is *de novo*: the IRO does not give deference to the plan’s decision. The IRO must consider all information and documents that are timely provided by the claimant. The IRO must consider the following types of information and documents, to the extent of their availability and as the IRO considers appropriate:

- the claimant’s medical records;
- recommendations by the claimant’s attending health care professional;
- reports from appropriate health care professionals and other documents submitted by the plan, the claimant, or the claimant’s treating provider;
- the terms of the plan, except to the extent the plan terms are inconsistent with applicable law;
- appropriate practice guidelines, which must include evidence based-standards and may include practice guidelines developed by the federal government or national or professional medical societies, boards, or associations;
- any applicable clinical review criteria developed and used by the plan, except to the extent the criteria are inconsistent with the plan or applicable law; and
- the opinion of the IRO’s clinical reviewer.

Notice of Independent Review Organization’s Decision. The IRO must provide written notice to the plan and the claimant of its final decision within 45 days after the IRO’s receipt of the request for external review. The decision of the IRO must include:

- a general description of the reason for external review and identifying information regarding the claim (similar to the information required for internal review notices as described in the July 23 regulations);
- the date that the IRO received the assignment for reviewing the claim and the date of the IRO's decision;
- references to evidence or documents that the IRO considered in reaching its decision;
- a discussion of the principal reason(s) for the IRO's decision;
- a statement that the IRO's decision is binding, except to extent other remedies are available to the claimant or to the plan under federal or state law;
- a statement that judicial review may be available to the claimant; and
- contact information for any applicable federal ombudsman or health insurance consumer assistance.

EXPEDITED EXTERNAL REVIEW PROCESS

A plan must allow for expedited external review in the following circumstances:

- following an initial adverse benefit determination, if the claimant requests an expedited internal appeal and the timeframe of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or
- following a final internal adverse benefit determination, if the timeframe of a standard external review would seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or if the claim involves emergency treatment and the claimant has not been released from the treating facility.

Upon receipt of the request for expedited external review, the plan must immediately notify the claimant whether the request is complete and eligible for external review. If the claim is eligible, the plan must assign the claim to an IRO

and provide the IRO with all relevant information electronically, by phone, fax, or by other expeditious means. The IRO's process should be equivalent to a standard review, but must be completed as quickly as circumstances require, and in all cases within 72 hours after the IRO receives the review request.

MODEL NOTICES

The DOL has provided three model notices: an initial internal adverse benefit determination and a final internal adverse benefit determination for use by plans, and a final notice of the IRO's external review decision. Links to these model notices are included below.

CONCLUSION

The agencies indicated that they are developing further guidance on the external review process, including additional consumer protections. They will issue guidance no later than July 1, 2011, to replace the interim process. In the meantime, compliance with the federal review process outlined in Technical Release 2010-01 or with available state external review processes will serve as compliance with the external review process requirements.

Because this latest guidance was issued as a notice and Technical Release, rather than as a proposed or interim final regulation, the agencies have not included a request for comments. Non-grandfathered plans will have to act quickly to assure timely compliance.

LINKS TO NEW GUIDANCE

[Technical Release 2010-01 Summary Notice](#)

Model Notices:

- [Initial Internal Adverse Benefit Determination](#)
- [Final Internal Adverse Benefit Determination](#)
- [Final External Review Decision](#)

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