



CLIENT ACTION Bulletin

Employee Benefits

Guidance and Model Notices Issued on Reviews of Health Benefit Claims

SUMMARY

The Department of Labor (DOL) has issued *Technical Release 2010-01*, providing interim procedures for the external review process that nongrandfathered self-insured group health plans become subject to under the health reform law ("PPACA"). The guidance includes an interim enforcement safe harbor that applies beginning with plan years starting on or after Sept. 23, 2010, and until the Technical Release is superseded by guidance that federal agencies expect to publish before July 1, 2011. Separately, the DOL also released related model notices that affected plan administrators may use to inform individuals about adverse and/or final determinations about a claim filed for health benefits.

DISCUSSION

Background

The PPACA requires all group health plans and group health insurance that are not grandfathered (i.e., in existence and not substantially modified since March 23, 2010) to have a process for internally reviewing benefit claims and appeals. An interim final rule (IFR) on claims procedures was published on July 23, 2010 (see *Client Action Bulletin 10-17*), extending – with some modifications – the DOL's current rules governing claims reviews and appeals for ERISA-covered plans to non-ERISA plans. The PPACA also requires plan sponsors and insurers to provide for external reviews of denied appeals; the IFR requires states to adopt review procedures and standards that generally conform to the National Association of Insurance Commissioners' (NAIC) Uniform Health Carrier External Review Model Act that was in place on July 23, 2010. The DOL's new Technical Release provides guidance on the federal external review process with which nongrandfathered plans that are not subject to state requirements (e.g., self-insured plans or health insurance issuers in states that do not have existing external review laws) must comply.

The Federal Standard for External Reviews

The Technical Release provides the requirements for "standard" and "expedited" external reviews.

- **Standard external reviews** – The Technical Release establishes requirements for, among other things: the amount of time a plan must permit a claimant to request an external review; the amount of time permitted for a plan to make an initial assessment of a request and the basic facts considered in the preliminary review; the referral by the plan to an independent review organization (IRO); and the conditions required for IRO contracts. These conditions include a requirement to contract with at least three accredited IROs with no financial incentives to support denials of benefits.
- **Expedited external reviews** – The Technical Release specifies the conditions under which a plan must allow a claimant to request an expedited external review. In general, an expedited review process applies if an adverse benefit determination under the expedited internal appeal process involves a timeframe that would seriously jeopardize a claimant's life or health or ability to regain maximum function. A claimant also may seek expedited external review if a final internal adverse benefit determination concerns an admission, availability of care, continued stay, or healthcare item or service for which he or she received emergency services but has not been discharged from a facility. The Technical Release also establishes requirements for preliminary reviews and referrals to IROs for expedited reviews that are similar to standard reviews, as well as standards for the notices of final external review decisions.

Enforcement Safe Harbor

During the safe harbor period, the DOL and the IRS will not take any enforcement action against a self-insured group health plan that complies with procedures spelled out in the Technical Release. The procedures also

are based on the NAIC's Model Act. Alternatively, plans may voluntarily comply with a state's external review process that has been expanded to extend to self-insured plans. For insured group health plans, the insurance issuer has the primary compliance responsibility. A failure to comply with the internal and external review requirements subjects a health plan sponsor or health insurance issuer to a \$100 per day per violation excise tax.

The Department of Health and Human Services (DHHS) will similarly not take any enforcement action against insurance issuers in the group markets (i.e., for fully insured group health plans) during the enforcement safe harbor period that the DOL has established for self-insured arrangements. During this period, the insurer must comply with the interim compliance method that will be detailed on the Office of Consumer Information and Insurance Oversight Web site (www.hhs.gov/ociio). According to a notice published jointly by the DOL, the IRS, and the DHHS announcing the availability of the DOL's Technical Release, this method will involve either the use of a state external appeals process or a temporary process established by DHHS. The DHHS also will issue guidance before July 1, 2011, to provide information on which state external review laws satisfy the minimum standards of the NAIC Model Act.

Model Notices

The model notices that group health plan sponsors may use to inform beneficiaries of claims denial decisions or final external review determinations are available on the DOL's and DHHS's Web sites at: www.dol.gov/ebsa and www.hhs.gov/ociio/regulations/consumerappeals, respectively. The models consist of:

- a notice of an adverse benefit determination;
- a notice of a final internal adverse benefit determination; and
- a notice of a final external review decision.

The DOL expects to post on its Web site model language that plan sponsors and administrators may use in the summary plan descriptions (SPDs) that are given to participants and beneficiaries to describe the internal claims and appeals and the external review procedures.

ACTION

Employers that sponsor nongrandfathered self-insured group health plans should review the DOL's Technical Release to determine the steps necessary and the potential cost to comply with the requirements for the external review of benefit claims. Sponsors of group health plans that purchase insurance should check the DHHS Web site for the process that will apply to issuers of nongrandfathered group health insurance. And grandfathered self-insured plan sponsors should consider the requirements that will apply if they modify the plans in such a way as to lose their grandfathered status. In addition, state laws governing external reviews should be considered, particularly in states with insurance agencies that extend the requirements to self-insured plans.

Plan sponsors should immediately consider the need to contract with IROs, particularly because the enforcement safe harbor will only apply until July 1, 2011, at the latest. The IROs must be accredited by the accreditation body known as URAC (formerly known as the Utilization Review Accreditation Commission until 1996, when it began accrediting organizations beyond utilization reviewers); more information is available at: www.urac.org/programs/prog_accred_iro_po.aspx.

Plan sponsors and administrators of affected plans should consider using the model notices – or draft their own versions – to notify claimants of adverse determinations and final decisions. Other communications, such as SPDs, will have to be revised to reflect the new procedures.

For additional information about the DOL's *Technical Release 2010-01* and for assistance with complying with the requirements, please contact your Milliman consultant.