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Consideration for Internal Appeals and External Review of Plan Denials

Healthcare reform places new requirements on internal appeals and external review of plan denials for non-grandfathered plans. There are certain key issues for plan administrators to consider as they contract with Independent Review Organizations (IROs) for external review and as they incorporate the new requirements into plan summaries.

IROs and External Review

To comply with the external review requirement, many self-insured group health plans will use the "safe harbor" federal external review procedures which require contracting with IROs to conduct external reviews. To be eligible for the safe harbor, a plan must contract with at least two IROs by January 1, 2012 and at least three IROs by July 1, 2012 and rotate assignments among them. There are a number of issues for plans to consider when contracting and working with IROs.

Collecting information on the IRO background will be important, focusing on such things as the expertise and specialties of each potential IRO, the training level of reviewers in understanding summary plan descriptions, plan designs, etc., and understanding the IRO's standard and expedited review timeline. The plan also needs to establish a process under which plan participants understand how to file for external review.

IRO contract issues must also be considered, including gathering information on the IRO's full pricing and billing structure in advance. Confirmation that the IRO is accredited by the Utilization Review Accreditation Commission (URAC) or a similar nationally-recognized accrediting organization is also required (there are currently 52 IROs approved). Plans should consider negotiating performance guarantees for turn-around times in contracts with IROs, and also clarify which entity has fiduciary status in the external review process. The plan administrator is ultimately responsible for providing documentation of the plan's terms, including any internal protocol or administration documentation between the plan and the claims administrator. However, the plan participant has the right to submit any new information that was not submitted during previous appeals. Plan participants will send requests for external review to the plan for compilation and submission to the IRO, so the plan should be sure that it includes the relevant plan provisions in the questions asked of the reviewer at the IRO. All information from the summary description and all previous appeal information is submitted to the IRO by the plan, so internal procedures and protocols that the plan has previously relied upon should be documented and included during external review.

Plan Summaries

Non-grandfathered group health plans must provide a description of available internal appeals and external review processes to participants. Current summary descriptions must be amended to incorporate the new internal appeals and external review processes. For plans subject to ERISA, summary plan descriptions (SPDs) are already required under the existing Department of Labor (DOL) claims procedures to include a description of plan claims procedures, including procedures for obtaining preauthorizations, approvals, and utilization review decisions; procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims; time limits; and available remedies for claim denials. These claims procedures can also be provided in a separate document accompanying the summary description.

The new claims and appeals and the federal external review safe harbor rules do not specify that a plan must include all of the new requirements in a plan summary, but plan sponsors should at least review the new requirements to ensure that they do not conflict with current plan document and summary language and determine if current plan document and summary language should be revised to include any of these new requirements.

No model language or guidance on what a summary description update should include has yet been issued. However, the agencies have indicated that model language describing the new internal claims and appeals and external review procedures will be posted on the DOL and Health and Human Services (HHS) websites in the future.

Decision Making Process

Insured plan sponsors may generally rely on their insurers for compliance with these new rules. Self-insured plans (and third-party administrators) must also evaluate and implement the rules. Non-ERISA self-insured plans (not previously subject to a claims procedure requirement) must adopt the existing DOL claims procedures and also comply with the new requirements. As a result of the increased compliance requirements, many employers with self-insured plans have begun to consider outsourcing the internal claims and appeals and external review decision making process entirely.

Should you have questions about this or any aspect of healthcare reform, contact your Conner Strong & Buckelew account representative toll free at 1-877-861-3220. For a complete list of Legislative Updates issued by Conner Strong & Buckelew, visit our online Resource Center.

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