CONNER STRONG

Legislative Update

August 30, 2010

Health Reform Rules on Claims, Appeals, and External Review – Model Forms Released

Under the health reform law, all **non-grandfathered plans** must comply with new federal internal appeals and external review requirements as explained in our recent Update. The new claims and appeal rules generally apply to group health plans for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans), but **do not** apply to grandfathered plans. Click here to review the grandfather plan definition and rules.

The agencies have now jointly released a notice providing additional guidance and model forms related to the claims, appeals, and external review provisions for issuers and self-insured group health plans under the new health reform law. The guidance announces the availability of Technical Release 2010-01. This essentially establishes an interim enforcement safe harbor for non-grandfathered self-insured group health plans not subject to a state external review process, and therefore subject to the federal external review process. The Technical Release includes the following requirements:

- Plan participants may request external reviews up to 4 months after receipt of notices of adverse benefit determinations (ABDs) or final ABDs (denials of internal appeal).
- Plans must conduct preliminary reviews of requests within 5 business days to determine whether claimants were covered at the time they received or requested health care services, ABDs are not related to claimants' failure to meet terms of plan eligibility, claimants have exhausted required internal appeals, and claimants have provided all necessary information for the reviews.
- Plans must notify claimants in writing of the results of the preliminary review within 1 business day after completion. For claims ineligible for external review, plans must state the reason(s) and provide a Department of Labor (DOL) phone number: 866-444-3272. For incomplete requests, notices must describe the missing information and give claimants the longer of either the remainder of the 4 month period to file claims or 48 hours after receipt of notices to provide the information.
- Plans must refer reviews randomly or in some other unbiased manner to one of the accredited independent review organizations (IROs) with which they have contracts. Plans must contract with at least 3 IROs, none of which has any financial interest in supporting benefit denials. IROs will review claims anew (de novo) and not be bound by internal appeals decisions.

- Plans must immediately cover or pay for services for external review decisions that reverse internal appeal ABDs.
- Plans must permit claimants an expedited review if ABDs or final ABDs involve conditions for which the external review time frame (45 days after receipt of requests for review) would seriously jeopardize their life, health, or their ability to regain maximum function or for emergency services for which the claimants are still being treated.
- Plans must immediately conduct preliminary reviews and send notices to claimants of eligibility for external review.
- Plans must refer eligible requests for external review to IROs and send all necessary information from the internal appeals process.
- IROs must notify claimants of decisions within 72 hours after requests for expedited external review.

This interim enforcement safe harbor applies for plan years beginning on or after September 23, 2010 and will last until superseded by future guidance on the federal external review process that is being developed and that will apply after this interim period. During the effective period of the interim enforcement safe harbor, the DOL and the Internal Revenue Service will not take any enforcement action against a group health plan that complies with the prescribed interim compliance methods under either Technical Release 2010-01 or state external review law.

The following new model forms were also released for use in announcing claims determinations and reviews:

- Notice of adverse benefit determination
- Notice of final internal adverse benefit determination
- Notice of final external review decision