VENABLE LLP

employee benefits & executive compensation alert

www.Venable.com
SEPTEMBER 2010

Authors

Thora A. Johnson
tajohnson@Venable.com
410.244.7747

Martha Jo Wagner
mjwagner@Venable.com
202.344.4002

Jessica Kuester
jekuester@Venable.com
202.344.4516

Our Employee Benefits and Executive Compensation attorneys have a diversified national practice. We assist clients of all shapes and sizes - businesses in virtually every industry sector, 501(c)(3)s and other tax-exempt organizations, and governmental entities under 414(d) - on compensation and benefit-related issues.

New Federal External Claims Review Procedures (What does a health plan have to do?)

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("PPACA"), will shortly require certain group health plans to comply with either state or federal external review procedures.[1] Specifically, under PPACA, a participant in a non-grandfathered group health plan has the right to have an adverse benefit determination reviewed by an external reviewer after the plan's internal claims and appeals procedures have been exhausted. And, as described in more detail below, many group health plans will need to take steps now in order to timely comply with PPACA's external review requirements.

Which procedures apply?

Department of Labor ("DOL") Technical Release 2010-01, issued August 23, 2010, describes the procedures for determining whether the state or federal external review procedures apply to your plan. The external review procedures that apply differ depending upon whether your plan is fully-insured or self-insured and whether a state external review procedure is available for your plan.

- Self-insured group health plans governed by ERISA must comply with the federal external review procedures in every case.
- If a state external review process is available, fully-insured group health plans must comply with the state process. If such a process is not available, fully-insured plans must comply with the federal external review process.
- If a state external review process is available and the state has elected to apply this process to self-insured plans that are not generally governed by ERISA, such as governmental and church plans, those plans must comply with the state process. If the state process does not apply, those plans must comply with the federal external review process.

How may your plan comply?

DOL's technical release establishes two federal safe harbors for self-insured plans:

- If a state makes its external review process available to self-insured group health plans, a group health plan may voluntarily elect to utilize that process.
- Alternatively, a self-insured group health plan may meet the external review requirements described below.

The second safe harbor is also available to fully-insured plans that are not covered by any state external review process.

If all of the requirements of either safe harbor are met by an eligible group health plan, enforcement action will not be taken against that plan. Eligible plans that do not elect to fit within either safe harbor, however, are not necessarily in violation of the law or applicable federal guidance.

What's required by the second safe harbor?

The steps that follow are highlights of the required components of the second safe harbor.

Request for external review. After receipt of the final internal adverse benefit determination – or an initial adverse benefit determination in certain limited circumstances – a claimant must have four months to file an external appeal.

Preliminary review. Within five business days of receipt of such an appeal, the group health plan must complete a preliminary review to determine whether the claim is eligible for full external review. To make this determination, the plan must resolve threshold issues such as whether the claimant failed to meet eligibility requirements, failed to exhaust the applicable internal appeal process, or failed to provide all

necessary information and forms to process an external appeal. The plan must then quickly notify the claimant that the claim is eligible for full external review or provide the claimant with the reason(s) that it is not.

Referral to independent review organization. The group health plan must assign the claim to an independent review organization ("IRO") for de novo review. The IRO must be selected in a random or other unbiased manner from among the IROs that contract with the plan and must not be eligible for financial incentives that would encourage claim denial. Within five business days of its assignment, an IRO must receive all documentation and information considered by the plan. An IRO must provide the plan with any new or additional documentation or information it receives from the claimant and, upon receipt, the plan may reconsider its decision. If the plan decides to reverse its earlier decision denying the claim, it must quickly provide notice to the claimant and the IRO.

Contract between the plan and IRO. Group health plans must contract with at least three IROs, each of which must be accredited by a nationally-recognized accrediting organization. The contract between the plan and the IRO must meet detailed specific requirements. For example, the contract must require the IRO to use legal experts, when necessary, to make coverage determinations and require the IRO to review all information and documentation timely received, including additional information or documentation provided by the claimant during the external review process. The IRO must comply with specified time frames for notifying the claimant of the initiation of an external review, forwarding information received from the claimant to the plan, reviewing the claim, and providing notice of its decision. All claims and notices must be maintained by the IRO for six years.

Notice of IRO's decision. The IRO's decision must be made within 45 days of receipt of a request for external review. It must contain certain specific information, including a general description of the reason for the request for the external review, references to evidence or other documentation, a discussion of the principle reason(s) for its decision, and a statement that judicial review may be available. If the IRO reverses the plan's adverse benefit determination, the plan must immediately provide coverage or payment for the claim.

Expedited external review. Group health plans must allow an expedited review:

- Of an initial internal adverse benefit determination where completion of an expedited internal review or a standard external review would seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function and the claimant has requested expedited internal review.
- Of a final internal adverse benefit determination where completion 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 final adverse benefit determination concerns the admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services and the claimant has not been discharged from a facility.

The expedited external review process includes the same steps as the standard external review process – a request for review, a preliminary review, a referral to an IRO, and notice of the IRO's decision – but the time frames for each step the plan or IRO must take are much shorter. Each of these steps must be done as expeditiously as possible and all of the steps must be done collectively within 72 hours of receipt of a request for expedited review. If the notice provided within this time frame is not in writing, written notice must be provided within 48 hours of the initial notice.

What do I need to do now?

If your group health plan is not grandfathered, you need to decide which of the external review procedures apply to your plan and which of the available procedures you want to utilize. Further, if you decide to take advantage of the second safe harbor under the federal procedures, you need to take immediate steps to secure contracts with three IROs. We would be happy to answer any questions that you may have about any of the new external review procedures, health care reform in general, or any other employee benefits matters. Please contact any member of our Employee Benefits & Executive Compensation team to discuss these issues.

---

[1] Non-grandfathered group health plans must comply with state or federal external review procedures by the first plan year beginning on or after September 23, 2010, or January 1, 2011 for calendar year plans.

Please contact any of the attorneys in our Employee Benefits & Executive Compensation group if you have any questions regarding this alert.

Harry Atlas
hiatlas@Venable.com
410.528.2848

Jennifer Berman
jsberman@Venable.com
410.244.7756

Brad Cohen
bcohen@Venable.com
310.229.9942

Robin Gilden
rcgilden@Venable.com
310.229.9967

Kenneth Hoffman
krhoffman@Venable.com
202.344.4810

Meredith Horton
mphorton@Venable.com
202.344.8290

Thora Johnson
tajohnson@Venable.com
410.244.7747

Jessica Kuester
jekuester@Venable.com
202.344.4516

Andrea O'Brien
aiobrien@Venable.com
301.217.5655

Barbara Schlaff
beschlaff@Venable.com
410.244.7494

Lisa Tavares
latavares@Venable.com
202.344.4075

Martha Jo Wagner
mjwagner@Venable.com
202.344.4002

John Wilhelm
jawilhelm@Venable.com
703.760.1917

If you have friends or colleagues who would find this alert useful, please invite them to subscribe at www.Venable.com/subscriptioncenter.

CALIFORNIA MARYLAND NEW YORK VIRGINIA WASHINGTON, DC

1.888.VENABLE | www.Venable.com

©2010 Venable LLP. This alert is published by the law firm Venable LLP. It is not intended to provide legal advice or opinion. Such advice may only be given when related to specific fact situations that Venable has accepted an engagement as counsel to address.