DOL Announces External Appeals Requirements

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April A. Goff

The Department of Labor has provided additional details on how external reviews are to be handled as they pertain to non-grandfathered health plans.

Health care reform requires all non-grandfathered health plans to provide an *external* appeals process -- in addition to the plan's internal appeals process -- that participants can turn to.

While insured plans have generally been subject to such a process under state law, self-insured plans have been exempt from such requirements. Beginning with plan years starting on and after September 23, 2010, self-insured plans will have to comply with a federal external review process.

Here is how this external review process is expected to work:

- Plans will have to contract with at least three accredited independent review organizations (IROs) that will conduct the external reviews. The contracts must include specific provisions that are set forth in the Technical Release. To protect against bias and to ensure independence, the plan must rotate claims between these IROs.

- Plan participants and their beneficiaries must be given at least a four-month window to request an external review. The claimant generally has the right to seek an external review once he or she has exhausted the plan's internal review process, but the claimant may be able to bypass the internal review process in urgent care situations or when the plan has failed to follow required claims procedures.

- When a claimant requests an external review, the plan will have five business days to review the request to determine whether an external review is permitted. The plan may deny the request when the claimant is not eligible for participation in the plan. Once the plan determines whether the claim is eligible, it must issue a written notification to the claimant within one business day. If the application is denied because it is incomplete, the individual must receive additional time to provide the missing information.

- If the plan assigns the claim to an IRO, the plan must provide relevant documents to the IRO within five business days. The IRO must consider any information submitted by the claimant and must render its decision within 45 days of receiving the review request. During that time period, the plan may also reconsider its earlier decision and, if it decides to reverse its earlier denial, may withdraw the appeal from the IRO.

- If the IRO reverses the plan's decision, the plan must immediately provide coverage or payment for the claim.

As a practical matter, we expect that most employers will look to their third-party administrators to contract with IROs to administer the external claims procedure. Since these procedures must be implemented soon, we recommend those discussions take place now.

Please contact a member of Warner's Employee Benefits Group if you have any questions about Health Care Reform or the new claims procedures.