A Consumer's Guide to Navigating the External Review Options Under the New Health Insurance Marketplace

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EXECUTIVE OVERVIEW

This Issue Brief provides consumers with important information about external appeals as they relate to health insurance plans available within the new Federal and State Health Insurance Marketplaces. To that end, this Issue Brief will provide consumers with:

- Information on the typical use and function of external appeals.
- A background on external appeals and the role of Independent Review Organizations (IROs).
- The options available within specific health insurance plans available under the Federal and State Insurance Marketplaces.

INTRODUCTION

For individuals and their families, navigating the healthcare system can be a challenge. There are many complex terms and rules within healthcare. This is true for health insurance as well. One very important area of health insurance for consumers is the topic of *appeals*. Basically, people with health insurance have the option to request an appeal if their insurance provider does not cover, or pay for, a specific service, test or treatment.

Appeals are divided into two categories: internal appeals and external appeals. When a consumer appeals a decision made by the health insurance provider, there is a chance that the decision will be reversed. If this happens, the health insurance provider will pay for the service, test or treatment in question. As you can see, the topic of appeals is very important for consumers.

This Issue Brief provides consumers with in-depth information about external appeals as it relates to the Health Insurance Marketplaces that were launched under the Affordable Care Act (also referred to as "Obamacare"). Generally, a consumer is only eligible for an external appeal after they have "exhausted" or completed their health plan's internal appeals process, which usually consists of a first and second level. Please note that this exhaustion requirement can be bypassed if your doctor has determined that the denial of care would seriously jeopardize your life or jeopardize your ability to regain maximum function. This is called an expedited external appeal.

Specifically, this Issue Brief will give consumers:

- Background information on health reform and Health Insurance Marketplaces.
- Descriptions of internal and external appeals, and how they work.

- Information on various health insurance programs and how they relate to external appeals.

BACKGROUND INFORMATION

The Affordable Care Act (ACA) was enacted in March 2010. On October 1, 2013, an important piece of the ACA – known as the Health Insurance Marketplace – was launched. The Marketplace is a web-based platform that offers consumers a new way to purchase health insurance.

The goal of the Health Insurance Marketplace is to make purchasing health insurance more consumer-friendly. The Marketplace can be found on the Internet, and each State has its own Marketplace, where health insurance options are collected. In general, the Marketplace is meant for individuals and families who are without insurance, or individuals and families on Medicaid insurance.

Health plans offered to consumers on the Marketplace must adhere to specific policies and regulations. The same is true for the method by which health plans may conduct internal and external appeals.

This Issue Brief provides an in-depth overview of the external review processes available under the Federal and State Exchanges in an effort to help unravel this confusing process for consumers. It also recognizes the importance of accredited independent review organizations (IROs) and their role in the external review process available under ACA.

Defining Internal and External Appeal Options

When using Exchange-related healthcare services, a consumer may encounter a denied claim, where a particular service (a test or treatment, for example) is not covered by the consumer's health insurance company. At that point, the consumer has the option to file an appeal. In general, there are three steps in an appeals process:

- A first level internal appeal.
- A second level internal appeal. (There may be one or two levels of internal appeal, depending on the plan document.)
- A third level external appeal.

The third level appeal is the only step that must occur on an external basis, meaning it is completed by an organization other than your health plan. This is where independent review organizations (IROs) enter the picture. Within the healthcare industry, IROs serve an essential function by guaranteeing expert, unbiased medical review of claims appeal cases.

An IRO usually enters the picture after the health plan's internal appeals process has been exhausted, although most leading health plans retain IROs at the internal appeals levels as well. This is done to ensure objectivity at each stage of process and is considered a *best practice*. After the enrollee exhausts their internal appeals process, they are generally eligible to initiate the external review process. The role of the IRO during the external review process is to act as an objective arbiter and decide if the health insurance plan is obligated to cover the health services in question.

ROLE OF THE IRO IN THE EXCHANGE ENVIRORNMENT

An IRO is an independent third-party medical review service provider that performs objective determinations on claims appeals based on documentation included in an enrollee's case file. Applicable documentation may include the patient's medical record, medical policy, coverage criteria, health plan guidelines, and other case-related documentation. When appropriate, IROs rely on peer-reviewed information and evidence-based medicine to render their determinations. Under ACA, certain health plans must use nationally accredited IROs to manage their respective ACA Federal External Review Processes.

Because accredited IROs adhere to specific standards of practice, their use promotes fairness and openness. Standards of practice require that participating IROs:

- Are up to date on all federal and state regulations, organizational processes, data security and internal operations;
- Work with credentialed physician peer reviewers who are appropriately licensed and current on the latest medical standards and technologies, are in active practice and perform the same procedures as the ones under review;
- Meet other important measures that help instill an environment of top-flight competence.

Within the healthcare industry, accreditation is considered the gold standard for the provision of IRO services. Consumers can rely on accredited IROs to ensure consistency, efficiency and accuracy in internal and external reviews recommendations. The accrediting body for IROs is URAC; more information on IRO accreditation standards is available at www.urac.org.

FEDERAL EXTERNAL REVIEW OPTIONS

The federal external review process is based on a Model Act published by the National Association of Insurance Commissioners (NAIC). The Model Act serves as the foundation for the following ACA-mandated external review programs:

- State Based Exchange Review Program
- Federal External Review Program (FERP)
- Multi-State Plan Program (MSPP) External Review Program
- Pre-existing Condition Insurance Plan (PCIP) External Review Program

The following sections discuss the parameters of these programs in greater depth.

State Exchange External Review Program – For enrollees participating in a qualified health plan (QHP) in a state that meets parallel or similar requirements (see below), reviews will be performed by IROs in their respective states. In order for IROs to be eligible to perform these reviews in a NAIC-parallel or NAIC-similar state, in general the IRO must undergo an application, certification, or request for proposal (RFP) process.

In North Carolina, for example, the North Carolina Department of Insurance has certified five URAC-accredited IROs to perform external reviews on behalf of eligible North Carolina consumers, according to Susan Nestor, Director of the Health Insurance Smart NC program, the agency that oversees North Carolina's external review program. Three of these five IROs are NAIRO members.

Guidance and regulations issued in 2010 and 2011 give states several options by which plans can meet external appeal process requirements:

- **NAIC-parallel.** A state may be considered "NAIC-parallel" if it meets the 16 consumer protections issued in the July 2010 rules. The standards are based on NAIC's Uniform Health Carrier External Review Model Act.
- **NAIC-similar.** A state is deemed "NAIC-similar" if its external review process offers "similar" standards to those issued in the July 2010 interim final rule. The similar standards apply until January 1, 2016.
- **Other.** In cases where a state is considered neither "NAIC-parallel" or "NAIC-similar," issuers offering non-grandfathered plans in the state must provide external review via one of two options: 1) Utilizing the HHS-administered federal external review process or 2) Contracting with an accredited IRO to review external appeals on their behalf. Please see the FERP discussion below for additional information.

Table 1, below, identifies which external review process applies to each state, as described above. These state processes are incorporated into the FERP and MSPP programs, as applicable.

Table 1

Meets Parallel	**Meets Similar**	**HHS Administered Process/Independent Review Organization Process**
Arkansas	Arizona	Alabama
California	Delaware	Alaska
Colorado	District of Columbia	Florida
Connecticut	Indiana	Georgia
Hawaii	Kansas	Louisiana
Idaho	Massachusetts	Montana
Illinois	Michigan	Pennsylvania
Iowa	Minnesota	West Virginia
Kentucky	New Mexico	Wisconsin
Maine	Texas	
Maryland	Wyoming	
Mississippi		
Missouri		
Nebraska[1]		**Territories**
Nevada		American Samoa
New Hampshire		Guam
New Jersey		Northern Mariana Islands
New York		Puerto Rico
North Carolina[2]		Virgin Islands
North Dakota		
Ohio		
Oklahoma		

Oregon		
Rhode Island		
South Carolina		
South Dakota		
Tennessee		
Utah		
Vermont		
Virginia		
Washington		

Source: The Center for Consumer Information & Insurance Oversight (CCIIO)

1. Beginning January 1, 2014, for all claims submitted on or after January 1, 2014.
2. Beginning January 1, 2016.

Federal External Review Program – The federally-administered external review process applies to denials, also known as "adverse benefit determinations," that involve (a) medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational); and (b) rescissions of coverage (whether or not the rescission has any effect on any particular benefit at that time).

If the state's process does not meet the federal consumer protection standards in accordance with the Model Act or if the plan is an ERISA/self-funded plan that is ineligible for a state process, insurers must use a federally-administered external review process and may choose one of the following external review processes to offer to consumers:

- The accredited Independent Review Organization (IRO) contracting process; or
- The HHS-Administered Federal External Review Processes.

ERISA or self-funded plans (as of July 1, 2012 pursuant to Technical Release 2011-02) are required under the ACA to contract with a least three accredited IROs and rotate assignments among the IROs. We encourage ERISA plans to consult the NAIRO website (www.nairo.org) to identify qualified and accredited IROs.

Non-ERISA insurers that elect to use the HHS-Administered Federal External Review Process, along with consumers whose plan is participating in the HHS-Administered Federal External Review Process, will work with the designated federal contractor that performs all functions of the external review. This designated contractor is a URAC-accredited IRO.

Multi-State Plan Program – The scope of the MSPP external review process extends to all final denials of claims under a Multi-State Plan (MSP), including those not based on medical judgment as identified in regulations promulgated by the Departments of Health and Human Services, Labor, and the Treasury (the "Tri-Departments") (Source: 45 C.F.R. § 147.136(d)(1)(ii)(A)). OPM will receive a request for external review, and make an initial assessment on whether the denial is based on medical judgment. If OPM determines the adverse determination is based on medical judgment, it is forwarded to and IRO for

external review. A request not involving medical judgment will be resolved internally by OPM to ensure uniform and equitable administration of MSPP contracts.

In most states, if not all, the Department of Insurance (DOI) or another state agency uses an existing process for the collection and resolution of consumers' health insurance-related complaints. That process will also apply to MSP enrollees who have complaints about their coverage. OPM's MSPP process for external review will be limited to requests specific to one or more claims and will not apply to other types of complaints that are traditionally resolved by state agencies (state external review).

The final rule defines a claim as a "request for: (i) payment of a health-related bill; or (ii) provision of a health-related service or supply." (Source: 45 C.F.R. § 800.501(a)(l)) A claim may be prospective or retrospective, i.e., a request for preauthorization or for reimbursement. A URAC-accredited IRO has been tasked with managing the MSPP external review process.

Pre-Existing Condition Plan (PCIP) – OPM's National Healthcare Operations (NHO) Group administers the PCIP Program for U.S. citizens and individuals legally in the United States who meet PCIP eligibility requirements. PCIP is responsible for resolving disputed health insurance claims between members and the health insurance carrier. The PCIP Program has one health insurance option (Standard Option). The Health Plan under the PCIP Program contracts with the Centers for Medicare & Medicaid (CMS) to provide certain health benefits to all members enrolled in PCIP.

Under the contract, PCIP members are entitled to pursue claims disputes by following a formal dispute resolution process described in the plan's brochure. After giving the plan the opportunity to reconsider its decision, members may request OPM to review the plan's denial of benefits or benefit limitation. In some cases, because of the complexity of the medical issue/condition involved, it is necessary to obtain an external medical review determination from an IRO medical peer reviewer before OPM makes a final decision on the claim. A URAC-accredited IRO has been tasked with managing the PCIP external review process.

FREQUENTLY ASKED QUESTIONS

How do I know which plans and programs are available in my state?
The availability of some programs depends on the state in which you live. To find out if the Multi-State Plan Program is available in your state, visit: www.opm.gov/healthcare-insurance/multi-state-plan-program.

To find out if the Pre-Existing Condition Insurance Plan is run by the federal government, your state or has expired, visit: www.pcip.gov/PCIP_States.html.

How do the proposed external appeal policies protect consumers?
Health plans involved in state-based Exchanges will be required to implement strong consumer protections in their external appeals process. As noted above, issuers offering health plans on the Exchanges must adhere to at least the 16 consumer protection standards of the Model Act (See Appendix I).

What are the timeframes for external reviews in the Exchange environment?
There are several timelines of note. After receiving an adverse benefit determination, the consumer has four (4) months to file a request for an external review. For standard external reviews, the IRO will alert

the consumer of its decision about the adverse benefit determination within 45 days. For expedited external reviews, IROs will provide their decision within 72 hours.

What is the scope of external review and the steps that must be completed to begin a Federal external review process?

Program	Scope of External Review	Required Steps to Implement the Review Process
State Exchange	➢ Standard and expedited reviews of adverse benefit determinations and final internal adverse benefit determinations of medical/clinical, coding, rescission, and legal claims ➢ Available to consumers whose states meet HHS parallel or similar external review requirements	➢ Exhaust the internal appeals of the enrollee's respective plan ➢ If the enrollee is dissatisfied with the internal review process, within 4 months of exhausting internal process the enrollee may submit a written request to implement the external review
Federal External Review Program (FERP)	➢ Standard and expedited reviews of adverse benefit determinations and final internal adverse benefit determinations of medical/clinical, coding, rescission, and legal claims ➢ Available to consumers in those states that do not meet the Model Act's consumer protection requirements	➢ Exhaust the internal appeals of the enrollee's respective plan ➢ If the enrollee is dissatisfied with the internal review process, within 4 months of exhausting internal process the enrollee may submit a written request to implement the external review
Multi-State Plan Program (MSPP)	➢ Medical and dental health claim denials and pre-authorization request denials ➢ Available to consumers participating in the Multi-State Plan Program	➢ OPM will review whether your insurance company's denial was justified by examining the terms of coverage and the specific circumstances surrounding the denial. ➢ If medical expertise is needed for review of a denial, OPM will contact the contracted IRO ➢ To file a request for External Review call OPM toll free at (855) 318-0714. Please gather the following documents and information prior to calling OPM: ➢ The letter from your insurance company stating that the company has denied your appeal. This may not be required if you are requesting an expedited review for emergency services or if your ➢ Insurance identification card ➢ Physician or other health care provider's contact information ➢ Any "explanation of benefits" (EOB) you received from your insurance company or other medical documents related to the denial. ➢ Dates of service or scheduled dates of service.
Pre-Existing Condition Insurance	➢ Medical health benefits reviews of disputed claims and pre-service requests (prior approval and precertification ➢ Available to consumers participating in the	➢ Exhaust the internal appeals of the enrollee's PCIP plan ➢ If the PCIP affirms a decision to deny, modify, reduce, or terminate coverage of or payment

Plan (PCIP)	Pre-existing Condition Insurance Program	for health services, the person may appeal the decision to an IRO by sending a written notice to the PCIP administrator within 30 days of receipt of the grievance committee's written decision. ➢ The administrator will gather all relevant documents and deliver them to the IRO within three business days of receiving the person's request for appeal. ➢ The IRO will review the complaint and make a decision.

APPENDIX I

Consumer Protections for the External Appeals Process

The NAIC Model Act serves as the baseline for external appeals, and contains significant consumer protections. An applicable state external review process must meet all the minimum consumer protections contained in the Model Act. Some of the key consumer protections include:

- The external review process must be based on specific criteria, namely the issuer's (or plan's) requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- Consumers will receive written notice of their rights for external review of an adverse benefit determination from the health plan or issuer.
- To the extent the State process requires exhaustion of an internal claims and appeals process, exhaustion must be unnecessary where the issuer (or, if applicable, the plan) has waived the requirement, the issuer (or the plan) is considered to have exhausted the internal claims and appeals process under applicable law (including by failing to comply with any of the requirements for the internal appeal process, as outlined in paragraph (b)(2) or (b)(3) of this section), or the claimant has applied for expedited external review at the same time as applying for an expedited internal appeal.
- The health insurer is responsible for the cost of the IRO for conducting the external review. (Note: In rare cases, the consumer is responsible for covering a $25 filing fee.)
- There is no minimum dollar amount that a benefit must meet for a consumer to be eligible to request an external review.
- The consumer has four (4) months after receiving an adverse benefit determination to file a request for an external review.
- IROs must be selected on a random basis, and not chosen by the issuer, plan or individual.
- States must provide approval of a list of IROs that are accredited by a nationally recognized private accrediting organization, such as URAC.
- Eligible IROs, and their clinical reviewers, must not have a conflict of interest that will influence its review determinations.
- Consumers are granted at least five business days to submit to the IRO additional information that the IRO must consider when conducting the external review.

- IROs must provide written notice to the consumer and the issuer of its decision to uphold or reverse the adverse benefit determination within no more than 45 days after the request.
- The consumer is eligible for expedited external review if the adverse benefit determination concerns emergency services or is life-threatening. In such cases, the IRO must make its decision within 72 hours.

FURTHER READING

The following resources provide helpful links to key resources, rules and publications cited in this Issue Brief.

1. Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges. A rule by the Personnel Management Office on 03/11/2013. https://www.federalregister.gov/articles/2013/03/11/2013-04954/patient-protection-and-affordable-care-act-establishment-of-the-multi-state-plan-program-for-the.

2. Code of Federal Regulations. Section 147.136 – Internal claims and appeals and external review processes. http://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/xml/CFR-2011-title45-vol1-sec147-136.xml.

3. The Center for Consumer Information & Insurance Oversight. Affordable Care Act: Working with States to Protect Consumers. http://cms.gov/cciio/resources/files/external_appeals.html.

4. The Center for Consumer Information & Insurance Oversight. HHS-Administered Federal External Review Process for Health Insurance Coverage. http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/csg-ext-appeals-facts.html.

ABOUT NAIRO

NAIRO (National Association of Independent Review Organizations) is a collaborative group of leading companies that provide independent medical reviews, which help payors and medical managers to improve quality of care, medical utilization and patient safety. IROs play a critical role in improving the nation's healthcare system. An IRO acts as a third-party medical review resource, providing objective, unbiased medical opinions that support effective decision making, based only on medical evidence. IROs deliver conflict-free decisions that help clinical and claims management professionals better allocate healthcare resources and reduce waste. Learn more at www.nairo.org.