**As Health Plans Outsource Operations, Independent Review Organizations (IROs) Step In to Fulfill Key Duties**

*Health plans are increasingly turning to IROs to provide internal appeal reviews, treatment determinations and other valuable administrative functions*

**Overview: The ACA and Insurer Appeals**

The Patient Protection and Affordable Care Act (ACA) – commonly known as Obamacare – is transforming the way that healthcare stakeholders operate at multiple points along the continuum of payment and delivery. With its backbone as an "insurance reform" law, the ACA has targeted the operating practices of health plans with a series of new policies, from coverage rules to a focus on quality initiatives.

A cumulative effect of these diverse and disruptive regulations is a shift in business practices for the nation's health insurance companies. Now more than ever, health insurers are outsourcing time- and cost-intensive business operations, such as first level physician reviews and internal appeals, to vendors that specialize in these domains, says Andrew Rowe, President of the National Association of Independent Review Organizations (NAIRO).

"Health plans are looking to focus on their core competencies and outsource whatever tasks they can achieve at a lower cost to other organizations," says Rowe.

Amid this new-forming landscape, IROs have emerged as a trusted resource for health plans seeking to streamline their operating procedures and partner with a specialized entity that can provide a high and appropriate level of review services at a more affordable price.

**Background: Driving the Change**

For health plans, one of the key provisions driving change within the ACA is the rule known as Medical Loss Ratio (MLR), which requires insurers to spend a certain percentage of their premium revenues on clinical services and quality improvement. The percentage is based on the type of health plan, according to the following general rules:

- Insurance companies in individual and small group markets are required to spend 80 percent of premium dollars on medical care and quality improvement.
- Large group markets (typically 50 or more employees) are required to increase the threshold of spending on medical care and quality improvement to 85 percent.

The MLR regulation is intended to cap the total amount of dollars from premiums that insurance companies spend on administrative costs, executive salaries, marketing, overhead and profits. If an insurance company fails to meet the standards described above, they must provide consumers with a cash rebate to make up the difference in their spending ratios. In 2012, insurers paid out roughly $1.1 billion in rebates to individuals and families.[1]

**A New Frontier**

As evidenced above, health reform in general – and the MLR provision in particular – is encouraging a new wave of market dynamics, thereby creating opportunities for IROs to step in and provide a value-added service within the insurance market. "The next frontier is that health plans are looking to see where they can reduce their administrative expenses," says Rowe.

While IROs originally came into being to provide unbiased and conflict-free third level external appeals on behalf of states and their eligible consumers, today they have become trusted providers of internal appeal decisions for insurers as well, and their growth in providing high-quality services continues to expand.

“The notion of taking these reviews and outsourcing them to URAC-accredited IROs is something that health plans are increasingly embracing,” says Rowe.

With IROs taking on more tasks, such as physician pre-authorization requests/reviews and other related duties, health plans can focus on their core strengths. For example, by outsourcing preauthorization reviews/requests, health plans free up time for their medical directors to focus on higher value-added tasks like quality improvement, reviewing clinical trials and updating policy language, among others.

**The Value-Add of IROs**

Of course, leading IROs make a strong case for shouldering this new workload. Industry-leading IROs are equipped with dynamic web portals and electronic workflow capabilities that are designed to streamline the back-and-forth communication between two entities.

“A business process outsourced for physician review can do it faster, better and cheaper than what a health plan can do it for,” adds Rowe, who has witnessed various methods of outsourcing – from complete outsourcing of all major pre-authorizations to partial/seasonal outsourcing based on an insurer’s internal workflow and bandwidth of full-time employees.

Health plans tend to have revolving cycles in pre-authorization requests depending on when their group plan’s year begins and ends, and when beneficiaries are requesting services. With their vast experience in the appeals and reviews process, URAC-accredited IROs can deliver much-needed efficiency to health plans in this era of quality-focused health reform.

When it comes to utilization review determinations, today’s URAC-accredited IROs are equipped to deliver three types of services:

- Retrospective reviews, conducted after services are provided to a patient.
- Concurrent reviews, which take place during a hospital stay or course of treatment.
- Prospective reviews, also known as pre-certification reviews or prior authorizations, which occur before a patient is admitted or receives treatment.

Because IROs maintain a staff of independent review specialists, they are a fitting complement to the outsourcing needs of health plans. In addition, IROs have the capability to assist health plans in determining coverage for treatments and procedures, level of care, legal and clinical interpretations of policy, and other administrative issues. When conducting internal appeal reviews, today’s leading IROs consider the following elements:

- Medical necessity/Appropriate care.
- Experimental/investigational treatments.
- Administrative reviews and/or legal and clinical interpretations of policy, insurance contract and eligibility.

“Independent review organizations have evolved from doing compliance-based reviews to on-demand specialty-matched reviews to handle internal appeals,” says Rowe. “That market is now well-developed and only growing as the industry moves forward.”

**References**


1. U.S. Department of Health and Human Services. Health care law saved an estimated $2.1 billion for consumers. http://www.hhs.gov/news/press/2012pres/09/20120911a.html. Accessed October 4, 2013.