Issue Brief – External Review Options Available Under the Federal Facilitated and State Marketplaces

Prepared by Richard Scott and Gib Smith

INTRODUCTION & BACKGROUND

The Patient Protection and Affordable Care Act (PPACA) was enacted in March 2010. This landmark health legislation is altering the way health insurance providers are able to offer health insurance, and likewise transforming the way in which consumers are able to purchase insurance. Primarily, these changes are being driven by the creation and launch of the Health Insurance Marketplace (also known as the Health Insurance Exchange) – the government-run insurance exchange that provides consumers with an online portal for locating and purchasing appropriate health insurance options.

As in other insurance marketplaces, health plans offered to consumers on the Exchanges must adhere to specific policies and regulations. This is true for the method through which health plans conduct internal and external appeals as well.

As background, PPACA addresses the topic of external review in Section 2719, which itself references an influential document from the National Association of Insurance Commissioners (NAIC) known as the Uniform Health Carrier External Review Model Act (known as the "Model Act"). According to Jolie Matthews, Senior Health and Life Policy Counsel with NAIC, the Model Act serves as the baseline level of requirements that health plans must adhere to when conducting external appeals. This regulatory baseline applies to all programs, including the federal external review process (FERP), multi-state plan programs (MSPPs), and pre-existing condition insurance plans (PCIPs). The U.S Office of Personnel Management (OPM) was tasked with managing the external review process under FERP, MSPP and PCIP, and is responsible for providing guidance regarding the State-based Exchange programs.

This Issue Brief provides an overview of the external review processes available under the Federal and State Exchanges in an effort to help unravel a sometimes confusing process for all stakeholders, including health plans, consumers and independent review organizations (IROs). It also recognizes the importance of using accredited IROs in the external review process available under the ACA (Affordable Care Act), and the leading organization behind accredited IROs – the National Association of Independent Review Organizations (NAIRO).

FEDERAL EXTERNAL REVIEW OPTIONS

The federal external review process is based on the National Association of Insurance Commissioners' (NAIC) Health Carrier Uniform External Review Model Act (Model Act), which was adopted in 2008. It 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 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. This IRO is also a NAIRO member.

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 an 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. The IRO is also a NAIRO member.

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 Services (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 advisory opinion from an IRO medical consultant before OPM makes a final decision on the claim. A URAC-accredited IRO has been tasked with managing the PCIP external review process. The IRO involved with managing the PCIP external review process is also a NAIRO member.

ROLE OF THE IRO IN THE EXCHANGE ENVIRORNMENT

An IRO is an independent third-party medical review resource that provides objective determinations on claims appeals based on documentation included in an enrollee's case file. Applicable documentation may include medical reports, health plan guidelines, and other case-related documentation. Whenever appropriate, IROs rely on peer-reviewed information and evidence-based medicine to render their determinations. Under PPACA, certain health plans must use accredited IROs to manage their respective ACA Federal External Review Processes.

Because accredited IROs adhere to well-documented standards of practice, their use promotes equitability within the appeals process and a baseline level of transparency. Standards of practice require that participating IROs are up to date on all federal and state regulations, organizational processes, data security and internal operations; that they utilize experienced and credentialed peer reviewers who are appropriately licensed and current on the latest medical standards and technologies; and that they 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. Regardless of the venue, stakeholders within healthcare can utilize accredited IROs for internal and external reviews to ensure consistency, efficiency and accuracy in these recommendations.

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. 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. 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. 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.