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Consumers May Be Unaware Of Their Right To A Review Of Health Plan Decisions

TOPICS: INSURANCE, DELIVERY OF CARE, HEALTH REFORM

By Susan Jaffe | June 10, 2011

Millions of Americans gained the right this year to appeal decisions made by health plans to an outside, independent decision-maker. But many of these consumers might not know they have the new option -- and when they find out, it might be too late.

Federal officials say that, beginning this year, about 44 million people are entitled for the first time to an external appeal, under the 2010 health care law. They are enrolled in self-insured health plans offered through an employer that weren't grandfathered, or exempted, under the law. Employers with self-insured health plans pay for claims from their own funds instead of through insurance companies, although they often have insurers administer the plans.

In an external review, consumers who have been denied coverage make their cases to an arbiter -- who has no financial stake in the decision -- that the medical services are necessary and should be paid for by the health plan. A study by the Government Accountability Office this year found that consumers in plans already offering these outside reviews prevailed in as many as 54 percent of the cases. Under the health law, the employer or insurer is required to hire an outside review organization that takes a fresh look at the case and must follow a strict timeframe for processing the appeal. The decision is final and the insurance plan must follow it.

The provision took effect for most plans Jan. 1. But in response to self-insured plans' concerns about being able to meet some of the requirements, the government said it wouldn't require the plans to tell members about their external appeals rights until plan years beginning after July 1. Since most plans start their new year in January, that means they won't have to notify members about their right to external appeals and how to file them until next year.

However, the government isn't granting enrollees more time to file appeals, said an official at the Department of Health and Human Services, who spoke only on the condition of not being identified. Patients have 180 days from the date of initial denials to file internal appeals to the plan. If the appeals are rejected, they then have another four months to appeal to outside arbiters.

Consumer advocates worry the timing issue could create a Catch-22 for workers. Some beneficiaries might not realize they have the right to take their denied claim to an outside reviewer. Others might find out too late to make the deadline, they say.

"The Affordable Care Act provides important new appeal rights, but it's equally important that the plans tell consumers they have those rights," said Cheryl Fish-Parcham, deputy director for health policy at Families USA, a health advocacy group.

Insurance representatives disagree, saying many plans are making efforts to let consumers know about the new appeals rights.

"We have talked to our members and employer customers quite a bit about this issue and what we've heard from them is that they are putting these processes in place and they are notifying consumers," said Robert Zirkelbach, a spokesman for America's Health Insurance Plans, a trade group that represents more than 1,300 insurers. "They are not waiting."

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Most group health plans have had internal appeals procedures for about a decade and some have instituted external reviews as well. In addition, most states require some sort of outside appeal, but the rules vary in scope and don't apply to employers' self-insured plans, which cover about 57 percent of workers, retirees and their dependents. The health law extended the right to internal and external reviews to self-insured plans that are not grandfathered.

There's another potential obstacle for patients trying to exercise their rights to external appeals. Only 37 independent review organizations are fully accredited, according to the online directory published by URAC, a Washington, D.C.-based nonprofit that certifies groups that meet national standards. Another 14 are in the process of becoming accredited. Yet federal officials expect more than 2,500 external appeals this year.

The health law requires each self-insured plan to contract with three review organizations so that appeals can be processed expeditiously, but federal officials are bending that rule, too. After recognizing that insurers had difficulty finding three review groups, officials agreed to give the plans more flexibility, said Steve Wojcik, vice president for public policy for the National Business Group on Health, which represents 330 large employers, most of which have self-insured health plans. One contract will be enough, he said, "as long as you're confident that the process is unbiased and independent."

Still, he said, down the road when the appeals process is fully implemented "this capacity issue is potentially very significant because there have to be a sufficient number of [independent review organizations] to handle the increased expected caseload within the prescribed amount of time the law requires."

Wojcik said the new appeals requirements might prompt health plans to approve more claims than in the past to avoid scrutiny from external reviewers.

"And the downside is this will mean higher costs for everyone because the plans are covering things they wouldn't normally have," he said. "It's a case of 'be careful what you ask for.' "