

Claims-appeals Rules Weaken Employer Plans in Claims Disputes as IROs Assume Fiduciary Duties

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Because of claims-appeals rules, independent review organizations (IROs) are assuming many of the fiduciary duties formerly assumed by the plan

Members of [The Phia Group](#), Braintree, Mass., recently discussed why claims and appeals requirements under health reform have sparked concern across the self-funded industry.

The health reform law requires non-grandfathered plans to make two potentially significant changes to their appeal process:

- (1) a new requirements for external review and
- (2) changes to internal appeal provisions that plans already have in place.

Recently issued rules and guidance weaken self-funded employer plans by removing their discretionary authority in many scenarios, attorneys say.

Claims' Rules Take Effect 9/23/2010

On July 23, the U.S. Departments of Labor, (DOL) Treasury and Health and Human Services (HHS) issued interim final rules on internal claims and appeals, and external reviews. They took effect Sept. 23, and imposed a set of compliance rules for claims, appeals and reviews on non-grandfathered self-funded plans, which were embodied in DOL Technical Release 2010-01.

The rule requires self-funded plans to engage at least three IROs to make binding resolutions to claim disputes. But at the moment, according to attorney **Adam Russo**, there are just 18 IROs in the country. "That's a small market to do business in," Russo said in a webinar his company sponsored on Sept. 29.

The rules also require that a plan never allow any conflict of interest influence the IRO it selects. Russo said it's going to be hard to prevent any conflict from entering. It's likely that IROs that agree with the plan more often will get more business, because the rule requires that plans bear the entire expense for external review.

Plans will begin to recognize which IRO is more favorable and they could use passive selection to line up the favorable IROs on important disputes, even though in theory they're supposed to be selected either by random, or on a rotating basis. Possible scenarios: (1) prolonging internal review when the

"wrong" IRO is in line; and (2) skipping internal review in order to expose the claim to the "favorable" IRO.

The rule disfavors plans in other ways. IRO review is a significant expense; but it's an expense that can be triggered on any claim dispute the participant wants, even if it's for as little as \$5, Russo said. Here are some other problems:

- All IRO reviews are done de novo, which means they do not defer to plan decisions or conclusions.
- The IRO may consider materials outside of the plan's claim file, including the opinion of the claimant's physician, practice guidelines and standards of care. Those guidelines and standards can be different from those used by the plan.

Plan documents usually say the plan has sole discretionary authority, but these new rules state that the IRO's decision will become the final binding decision on claims that go to external review. As a result, "the IRO is assuming many of the fiduciary duties formerly assumed by the plan," Russo said.