States Implement Health Reform

February 2011

Right to Health Insurance Appeals Process

Overview

The 2010 Affordable Care Act (ACA) provides consumers with the right to appeal decisions made by their health carrier to an outside, independent decision panel, no matter which state they live in or what type of health insurance they have.

When consumers or employees enroll in private market health insurance, they must rely on a contract that defines the medical services covered and reimbursed and services not covered. Because medical needs vary widely for patients and services vary significantly among providers, patients may face a denial or limitation on a particular treatment or receive what may be perceived as insufficient care. While many states already have "patient rights" laws, millions of insurance enrollees—especially those in self-insured and federally regulated plans—had no guarantee of an independent or "external" appeal process to address denial of coverage.

This section of the act, modeled on numerous existing state laws, establishes a uniform, inclusive process to appeal denials.

Key Federal Provisions

The act specifically requires (in section 1001) that group health plans and health insurance issuers in both the group and individual markets "implement an effective appeals process for coverage determinations and claims."[1] Plans must comply with either a state external review process or the federal external review process.[2]

The appeals process must be in place by six months after enactment—Sept. 23, 2010.

The process must at a minimum:

- have in effect an internal claims appeals process;
- provide notice to enrollees of available internal and external appeals processes and the availability of any applicable assistance; and
- allow enrollees to review their files, present evidence and testimony and receive continued coverage pending the outcome.

To comply with the requirements in 2010 and 2011, group plans were expected initially to incorporate the claims and appeals procedures specified in federal regulation (29 CFR §2560.530-1) and to update their processes in accordance with any standards established by the secretary of labor.[3] Similar procedures exist for individual health coverage.

Group health plans and health insurance issuers must comply with the applicable state external review process that, at a minimum, "includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners (NAIC)."

If a state has not established standards that meet the NAIC model requirements or if the plan is issued by a self-insured large employer and therefore is not subject to state insurance regulation, it must implement an effective external review process that meets the minimum standards established by the secretary. Separate but similar appeals rights apply to Medicaid, Medicare and other government-sponsored programs.

Limited coverage insurance plans—for example, to cover a single medical condition or temporary insurance coverage—are exempt from these external appeals requirements.

Legislative and State Roles

Laws or regulations in 47 states already require that state-regulated insurance health policies include an independent patient appeals process. States that do not provide an external appeals process by law are Alabama, Mississippi and Nebraska. These states do provide internal appeals processes, however. The 2010 federal law specifies that insurers "must comply with the applicable state external review process" that meets the minimum state NAIC model. It permits more extensive state-specific requirements (including those already in place before 2010). State insurance departments can expand their role in administering or enforcing this provision.

For 2011 and beyond, state legislatures have some flexibility and can choose to amend their laws (often termed "managed care consumer protections"). According to the Department of Health and Human Services (DHHS)," states

are encouraged to make changes in their external appeals laws to adopt these standards before July 1, 2011."

Large self-insured employer plans still are not state-regulated but must comply with federal provisions. For all existing (2010 plan year) health policies that choose "grandfathered status," —e.g., they will continue to offer the same or near-identical benefits in 2011—the new federal appeals process will not apply.[4]

Expanded Consumer Assistance

Another section of the ACA allows states to designate an independent office of health insurance consumer assistance or ombudsman that will—directly or in coordination with state health insurance regulators and consumer assistance organizations—respond to inquiries and complaints concerning health insurance coverage and help file complaints and appeals.[5,6]

Timetable

The federal requirements which became legally effective on Sept. 23, 2010, apply to all newly issued and many existing health insurance policies.

The appeals process also will apply to all private market policies offered through the American Health Benefit Exchanges beginning in January 2014.

Funding Issues

Beginning in 2010, DHHS must award grants ($30 million in 2010) to states to enable them to "establish, expand, or provide support for an Office of Health Insurance Consumer Assistance or Health Insurance Ombudsman." These are detailed in a companion NCSL brief, *Consumer Assistance Programs*.

The Effect on the Public

Due to this provision, in combination with existing state laws, an estimated 100 million Americans should have a more uniform, federally ensured right to appeal individual cases of denials by insurers, phased in beginning in 2010. The process is designed to be "consumer-friendly." The NAIC Model Act and most states specify that the costs of appeal processes are borne entirely by the insurer. Rulings resolving appeals are due within 45 days of filing or within 72 hours if "expedited" due to medical urgency.

According to several studies, the use of external appeals in recent years led to rulings favorable to patients in about 50 percent of cases and rulings in favor of the insurer in the other 50 percent. This extensive experience was used to model the federal law.[7]

Additional Resources

Excerpt from NCSL Timeline[8]

- HHS Fact Sheet Protecting Consumers
- Model Notice of Final External Review Decision
- Model Notice of Final Internal Adverse Determination

HHS Center for Consumer Information and Insurance Oversight (CCIIO) http://www.hhs.gov/cciio/regulations/consumerappeals/index.html

Interim Final Rules, published by HHS July 23, 2010, http://www.edocket.access.gpo.gov/2010/pdf/2010-18043.pdf

Interim Procedures for External Review, 2010 http://www.hhs.gov/cciio/regulations/interim_appeals_guidance_.pdf

National Association of Insurance Commissioners (NAIC) Uniform External Review Model Act, 2010; http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf

NCSL Brief, *Consumer Assistance Programs: Federal and State.* Denver, Colo.: NCSL, November 2010; http://www.ncsl.org/documents/health/HRConsumer.pdf.

Notes

1. Section 1001, as amended by §10101, of the Patient Protection and Affordable Care Act (PPACA), Pub. L. 111–148 adds Section 2719 to the Public Health Service Act.

2. Provisions are contained in interim final regulations (45 CFR §147.136) issued July 2010.

3. Section 503 of ERISA, codified as 29 CFR §2560.530-1, requires that employee benefit plans provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and to afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

4. For the first fiscal year of the program $30 million was appropriated; "such sums as necessary in subsequent fiscal years" was authorized.

5. Congressional Research Service. Private Health Insurance Provisions in PPACA-CRS, May 2010.

6. For information about the definition of a grandfathered plan, see http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html.

7. HHS provided the following examples of consumer appeals: In 2009, "one State's existing consumer assistance program helped nearly 3,000 residents and recovered over $7 million in benefits on behalf of consumers."

8. National Conference of State Legislatures, *Health Reform Implementation: Immediate Health Insurance Reforms Become Effective* (Washington D.C.: NCSL, September 2010).

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