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Health care reform provision at-a-glance

Appeals

Since the Patient Protection and Affordable Care Act was enacted, the U.S. Department of Health and Human Services (HHS) and other federal agencies have provided additional guidance about the appeals provision. Here's what you need to know.

Who's affected by the provision

In general, the appeals provision applies to fully insured and self-insured non-grandfathered plans. It doesn't apply to grandfathered plans. Our company is evaluating whether to apply the provision regardless of grandfathered status in order to provide a more consistent experience for our customers and members.

What the provision requires

For adverse benefit determination notices, plans must:

- Comply with federal language requirements
- Include diagnosis and treatment codes and explain what they mean
- Include certain details about the reason(s) for the determination
- Describe available internal and external review processes

For internal appeals, plans must:

- Have an internal claims appeals process
- Allow members to review their file, access certain documents free of charge and present evidence during the appeal
- Handle claims and appeals in a fair and impartial manner

For external appeals, plans must:

- Follow the state or federal appeals processes (see "Questions and Answers" for details)

When changes will occur

For most of our customers and members, the appeals process won't change immediately. For existing fully insured group members in states that already have external review, the process will stay essentially the same until July 1, 2011. For our ASO (administrative services only) groups, we're working to determine how we can support their efforts to implement a compliant external review process.

It's important for members to have access to both internal and external review processes. Our company has had appeals processes, including independent review, in place for several years. We're adjusting our internal review processes to comply with the legislation. In addition, we're developing a program to support a compliant external review process for self-insured customers.

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Questions and Answers

What is an adverse benefit determination?
According to the Interim final regulations issued by HHS, an adverse benefit determination is any decision involving:

- Eligibility to participate in a plan or coverage
- Whether a service is a covered benefit
- Use of pre-existing condition exclusions or other benefit limits
- Medical necessity and experimental treatment determinations

Who uses our company's existing appeals processes?
Our current internal and external review processes supports all fully insured customers (group and Individual) and some of our self-insured customers.

What are our existing appeals processes?
Processes are driven by state regulations, so they can vary by state. In general:

- Members can initiate an appeal if they believe a requested treatment should have been covered or individual circumstances create a unique situation
- In many cases, members who are dissatisfied with an internal appeal decision have the right to request external review by an independent review organization. The external review decision is binding on the plan

How will our company's existing appeals processes change?
We'll need to adjust our existing internal appeals, utilization management and notification processes to comply with the legislation.

What process will customers need to use for external appeals?
All fully insured customers, as well as self-funded customers subject to current state-mandated processes (non-ERISA groups in a few states), will continue to use the current process controlled by the state. Existing state laws are considered to be in compliance for policy years before July 1, 2011. Leading up to that date, the Department of Health and Human Services will review the state's laws to determine if they meet the consumer protection standards of the National Association of Insurance Commissioners Uniform External Review Model Act that were outlined in the Affordable Care Act.

Self-funded clients who aren't subject to a state-mandated process will have to adopt the federal external review process. Until further guidance about this process is available (no later than July 1, 2011), the administration will not take enforcement action against self-insured plans that comply with the DOL/IRS Technical Release 2010-01 or voluntarily comply with state external review processes (if made available by each state). We are developing a program to support a compliant external review process for self-insured customers. The new appeal rights will essentially consist of an internal appeal and then the external. We will coordinate the external review through one of three vendors (MCMC, AMR and another to be determined). This review will be binding on the plan and it will be responsible for the cost.

Which states do and do not have state-mandated external appeals processes?
According to a September 1, 2010, memo from HHS, these states do not have state-mandated processes and will be subject to the new federal external review processes:

- Alabama
- Mississippi
- Nebraska

All other states and the District of Columbia will follow state-mandated external review processes.