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Health care reform provision at-a-glance

Grievances and appeals

Since the Affordable Care Act was enacted, the 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.

This information is based on the latest guidance available as of August 31, 2011, including the June 2011 amendment to the interim final rules. Keep in mind we continue to receive guidance and more information from the federal government, so this information may change and be updated as we move forward.

To whom the provision applies

In general, the appeals provision applies to fully insured and self-insured plans that are not grandfathered. It doesn't apply to grandfathered plans. Our company is evaluating whether to apply the provision regardless of grandfathered status, which would 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 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
- Provide certain information to members, and allow members to review their file 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)

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've adjusted our internal review processes to comply with the legislation and developed a program to support a compliant external review process for self-insured customers. In addition, we continue to make required updates to adverse benefit determination notices.

We have a team of experts analyzing the requirements to ensure we are implementing them quickly and efficiently and in the best interest of our customers and clients. We continually review and analyze the requirements as more information becomes available. In some cases, the additional information requires us to update or adjust our interpretation. In the absence of final regulations, we continue to adapt as necessary.

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When changes will occur

The following table outlines key requirements and the date on which this change is required, according to the June 2011 amendment.

Requirement	Date required based on June 2011 amendment
Internal appeals process: Provide certain information to members, allow members to review their file and present evidence during review; continue coverage for members in some cases pending outcome	Next plan year after 9/23/10
Independent Review Organizations: Coordinate external reviews through one of three accredited IROs	Next plan year after 9/23/10 for two IROs, 7/1/12 for third IRO
Diagnosis and treatment information: Note on Adverse Benefit Determinations that this information is available on request	Next plan year on or after 1/1/12
Other data elements: Include on Adverse Benefit Determinations the amount and date of the claim, service provider and reason for denial	7/1/11, regardless of plan year dates
Appeals process description: Include enhanced description of internal/external appeals process and state-specific contact information, if applicable, for state's office of health insurance consumer assistance	7/1/11, regardless of plan year dates
Appeals process – bypass internal: Give claimants the right to bypass internal appeals and go to external appeal or litigation if the insurer or plan fails to "strictly comply" with the rule (exceptions for minor violations that are not reflective of a pattern or practice of noncompliance)	Next plan year on or after 1/1/12
Language notifications: Provide notices to certain consumers on how to request an adverse benefit determination in a language other than English	Next plan year on or after 1/1/12

Questions and answers

Q. What is an adverse benefit determination?

A. According to the interim final regulations issued by HHS, an adverse benefit determination includes a denial, reduction, termination of or failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on:

- 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

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Q. How are you updating adverse benefit determinations to comply with the regulations?
A. Based on the guidance currently available, we are adding the following items:
- A statement directing members to customer service for detailed information about a claim's diagnosis or procedure detail.
- More details about available internal and external review processes. (We currently include information about appeals processes on our websites, in EOBs and with all initial review denials and we will continue to do so.)
- A statement that notifies members about how to request notices in a language other than English. Languages will be included if more than 10% of the population in the member's county of residence speak a specific language. (We currently provide translated documents at the member's request and provide telephone claims and appeals assistance in non-English languages and will continue to do so.)

Q. Do the new requirements only apply to medical EOBs?
A. At this time, we are updating medical EOBs. We are also coordinating with our Pharmacy vendor to ensure Adverse Benefit Determinations sent to members are also in compliance with the new requirements.

Q. Do the new language and data requirements apply to the member portal?
A. Yes. In addition to updating printed documents, we're taking steps to comply with the requirements on any adverse benefit determinations provided electronically in the secure member website.

Q. Who uses your existing appeals processes?
A. Our current internal and external review processes support all fully insured customers (group and individual) and some of our self-insured customers.

Q. What are your existing appeals processes?
A. Most of our 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 can request external review by an independent review organization (IRO).

Q. For those groups with employees in more than one state, which external review process is followed? That of the employer's headquartered state or the state where the employee resides?
A. For multi-state employers, the external review process will be that of the state identified in the insurance policy or certificate as having primary jurisdiction over the policy (often the headquarters of the company). This is consistent with the way appeals were handled before health care reform was enacted.

Q. Is your organization following the federal or state process for ASO and fully insured business?
A. Currently we are following the federal process for ASO ERISA business. 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. These processes are deemed to meet statutory requirements until December 31, 2011. However, states may define new processes in the future based on the ACA regulations and guidance.

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Q. Which states do and do not have state-mandated external appeals processes?

A. According to a September 1, 2010, memo from HHS, these states do not have state-mandated processes and are 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.

Q. Does an ASO client have to use your appeals process?

A. ASO clients can either create their own, compliant external review process, or they can choose to use our review process. We have developed a standard appeals process for new and renewing ASO groups with nongrandfathered plans beginning September 23, 2010. The process is designed to allow for the most accurate and timely processing of the appeals:

- The ASO group with nongrandfathered plan(s) fully delegates appeals adjudication authority to us.
- We prefer to use the standardized first level mandatory review process with the second level voluntary process.
- After the first level process is complete, members are offered an external review at the same time they are offered the second level review.
- Second level voluntary options include panel review, independent peer medical review or other process consistent with the company reviewing the appeal.
- Members are not required to complete any voluntary level before pursuing an external review.

Q. Which IROs have you contracted with to do the external reviews required under ACA?

A. At this time we are contracted with the following URAC accredited organizations to conduct our third-party external reviews under ACA:

- MCMC – For more information, visit their website.
- Advanced Medical Reviews – For more information visit their website.
- AllMed – For more information, visit their website.

Q. Is the IRO decision binding on the plan?

A. For both state and federal external review processes, these decisions are binding on insurers and members, except to the extent other remedies are available under state or federal law. An insurer must pay benefits without delay, even if it intends to seek judicial review.