



Administrative Appeals and New Consumer Protections under the Affordable Care Act

- A. New requirements for internal claims and appeals processes
- B. State external review processes must include, at a minimum, the consumer protections found in the NAIC Uniform Model Act
- C. Plans that are not subject to a State external review process must provide an “effective” Federal external review process
- D. Effective September 23, 2010, Insurers were required to implement an ACA-compliant appeals process for coverage determination and claims on all new plans
- E. Plans that are “unchanged” since September 23, 2010 are considered “grandfathered,” thus appeals under those plans are not subject to the ACA’s procedural protections
- F. The type of changes that will bring a plan under the ACA include: a significant cut in benefits; an increase in co-insurance, co-pays, deductibles or out-of-pocket limits; decrease in employee premium contributions by more than 5%, or addition of an annual limit on coverage
- G. Plans that the insurer believes are grandfathered must include a statement to that effect in any materials provided to participants – failure to do so results in a loss of grandfathered status

13 new minimum consumer protection standards – external appeals

- The process must provide for external review of adverse benefit determinations (and final internal adverse benefit determinations) based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- The process provides for external review of adverse benefit determinations (and final internal adverse benefit determinations) involving experimental or investigational treatments or services and must have at least all of the protections that are available for external reviews based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- Issuers (or plans) are required to provide effective written notice to claimants of their rights to external review in their summary plan descriptions and plan materials and on each notice of adverse benefit determination. These notice requirements may not be articulated in a State's external review statute but may be established in other areas of State law, rules, or procedures - for example, those that apply to internal appeals, claims payment practices, or other areas of State oversight.
- If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if -- (a) the internal appeal process timelines are not met; or (b) in an urgent care situation, the claimant files for an external review without having exhausted the internal appeal process. These requirements may not be articulated in a State's external review statute but may be established in other areas of State law, rules, or procedures - for example, those that apply to internal appeals, claims payment practices, or other areas of State oversight.
- The cost of an external review must be borne by the issuer (or plan), and the claimant cannot be charged a filing fee in excess of \$25 per external review.
- There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for external review.
- The claimant must have at least 60 days to file for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.
- The Internal Review Officer (IRO) must be assigned impartially. The claimant and issuer (or plan) should have no discretion as to the IRO that is chosen.

- If the State contracts with, or otherwise identifies one or more IROs to provide external review, the State must have a process in place for quality assurance of IROs.
- If the State contracts with, or otherwise identifies one or more IROs to conduct external reviews, the State must ensure conflict of interest protections on the part of the IRO when it participates in external review decisions.
- The IRO decision is binding and must be enforceable by the State.
- For standard external reviews (those not involving urgent care), the IRO must inform the issuer and the claimant, in writing, of its decision within 60 days from receipt of the request for external review.
- The process must provide for expedited external review of urgent care claims. In such cases, the IRO must inform the issuer and the claimant of an urgent care decision within four business days or less (depending on medical exigencies of the case) from receipt of the request for review. If the IRO's decision was given orally, the IRO must provide written notice of its decision within 48 hours of the oral notification.

Overview – Appeals under NM Office of Superintendent of Insurance (OSI)

- Claim filed and adverse determination made
- After final internal appeal, claimant files external appeal with Superintendent of Insurance within 120 of determination
- DoI staff conducts initial review within 10 days of request
- Superintendent or attorney-designee conducts a review, including full hearing, within 45 days of request
- Hearing officers prepare findings of fact & conclusions of law, Superintendent reviews, and DoI issues a final order within 45 days

Notice Requirements – OSI’s Internal Appeal

- Enrollment materials issued to claimants must contain clear, concise description of internal and external grievance procedures in boldface type
- Persons denied coverage must be given a copy of “grievance” (appeal) procedures
- Claimants must be notified that a representative of the healthcare insurer and managed health care bureau of the OSI are available upon request to assist with grievance process – this information, including a toll free number, must be included in the Summary of Benefits and enrollment materials
- Grievance procedure must be provided to consumers at each decision point in the grievance process and immediately upon request
- Insurer must provide a detailed written explanation of the Grievance procedure and a copy of the grievance form to a claimant when the health care insurer makes either an adverse determination or an adverse administrative decision. The explanation must describe how the health care insurer reviews and resolves grievances and must provide a toll free number, fax number, email address, mailing address of the health care insurer’s consumer assistance office
- Insurer must provide consumer assistance brochures approved by the Superintendent
- Notices must be “culturally and linguistically appropriate”

Consumer Protections in OSI Appeal Process

- Insurer must provide continuing coverage pending outcome of internal appeal
- Insurer may not reduce or terminate an ongoing course of treatment without first notifying claimant sufficiently in advance of the action so claimant may appeal and obtain a determination on review
- Insurer must allow those in urgent care situations receiving ongoing course of treatment to proceed with expedited external review at same time as internal review