Health Care Reform
The Member's Right to Appeal
January 21, 2011

We are currently working in good faith to have all of our health care reform appeals process updates in place by July 1, 2011, the interim final rules grace period deadline (or sooner).

Background

The original appeals provision in the Patient Protection and Affordable Care Act (or the health care reform law) requires group health plans and health insurance issuers who offer group or individual health insurance coverage to provide full and fair internal and external appeals processes for all nongrandfathered plans. This provision went into effect for plan years beginning on or after September 23, 2010.

Since the law was enacted, the U.S. Department of Health and Human Services (HHS) and other federal agencies have provided more guidance on the appeals provision. In turn, we are making changes to fully comply with the law.

In general, the appeals provision applies to fully insured and self-insured nongrandfathered plans. 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*.**

Details of the provision

For any notices of adverse benefit determination (see the "questions and answers" section for a definition), plans must:

- Provide a written notice that is culturally and linguistically appropriate based on the federal language requirements.
- Include detailed information such as diagnosis, treatment and denial codes along with their meanings.
- Include certain details about the reason or reasons 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.
- Continue coverage for members in some cases, pending the outcome of the appeal.

For **external appeals**, plans must:

- Follow the state or federal appeals process (see the "questions and answers" section for details).

Timeline

The changes for the **internal appeal process** are in effect for new business and renewals on and after **September 23, 2010**.

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For our **ASO groups**, we have modified our existing external review programs to ensure a standard, compliant appeals process for new and renewing ASO groups beginning **September 23, 2010**. The process is designed to allow for the most accurate and timely processing of the appeals:

- The ASO plan fully delegates appeals adjudication authority to us.
- We will 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.

For most of our customers and members, the **external appeal process** won't change right away. For existing fully insured group members in states that already have external review, the process will stay essentially the same until **July 1, 2011**.

We will add a charge of $550 per external review for our ASO customers using our external appeals process, which will be included in their ASO bill as applicable. Additional details on that process will be shared soon.

These reviews will be completed in accordance with the requirements of the legislation.

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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 includes a denial; reduction or 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.

What are the existing appeals processes?
Most of our processes follow state regulations. In general, members can initiate an appeal if they believe a requested treatment should have been covered or their individual circumstances create a unique situation. In many cases, members who are not satisfied 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 existing appeals processes change?
We are adjusting 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 and self-funded customers subject to current state-mandated processes (non-ERISA groups in a few states) will continue to follow those state processes. Existing state laws are considered compliant for policy years before July 1, 2011. Leading up to that date, HHS is reviewing state 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), HHS will not take enforcement action against self-insured plans that comply with the Department of Labor/Internal Revenue Service Technical Release 2010-01 or voluntarily comply with state external review processes (if made available).

We are modifying our existing external review programs to ensure a compliant external review process for self-insured customers is available. The new appeal rights will essentially consist of an internal appeal and then an external appeal. We will coordinate the external review through one of three accredited independent review organizations. This review will be binding on the plan and it will be responsible for the cost.

If a customer requests a copy of contract with an external review organization, can we provide it?

It's our policy not to release copies of our contracts with vendors due to confidentiality reasons.

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 process:

- Alabama
- Mississippi
- Nebraska

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

How will we notify members of the appeals process?
We will update our existing notices to comply with the legislation. We currently include information about appeals processes on our websites, in explanation of benefits (EOB) statements and with all initial review denials.

How will EOB statements change as a result of the appeals provision?
For nongrandfathered plans, the health care reform law requires EOB statements with adverse benefit determinations to include the following additional information (not currently in our EOB statements):

- Diagnosis codes and meanings
- Treatment codes and meanings
- Expanded notifications for language assistance options
- Additional language on the grievances and appeals processes available to members

Because most of our EOB statements are considered adverse benefit determinations, we will be making changes by July 1, 2011, to comply with the legislation.