Welcome!

Maryland Consumers' Health Insurance Appeal Rights Webinar

March 24, 2016

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HEAU's Mission

Established in 1986, our mission is to:

- Assist consumers with healthcare business disputes.
- Help healthcare consumers understand healthcare bills and insurance coverage.
- Identify improper billing or coverage determinations.
- Report billing or coverage problems to appropriate agencies, including the Consumer Protection Division's Enforcement Unit.

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HEAU as a National Model

Maryland's HEAU was used as a model for the consumer assistance programs established under section 2793 of the Affordable Care Act.

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Services

Free mediation services for consumers who:

- Have a billing dispute with their healthcare provider.
- Need assistance resolving a dispute about medical equipment or devices.
- Have an enrollment dispute with their private health insurance carrier.
- Have a coverage dispute with their private health insurance carrier.

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Medical Billing Disputes

- Balance Billing
- Over-billing or double billing
- Failure to submit claims to carriers
- Billing for failed or poor treatment
- Billing for services not rendered
- Malfunctioning medical equipment
- Medical Record costs
- Failure to provide services
- Other DME, pharmacy problems

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Coverage Disputes

- Carrier refuses to pre-authorize medical treatment
- Carrier refuses to pay for medical care already rendered
- Carrier pays less than expected for care
- Carrier rescinds coverage
- Carrier denies enrollment
- Carrier cancels policy

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Coverage Disputes

- Coordination of Benefits
- Network Adequacy Issues
- Fail-First requirements
- Step Therapy requirements
- Delays in authorizing treatment
- Mental Health Parity Compliance
- Discrimination in Plan Design

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HEAU Assistance

- HEAU does not mediate complaints for consumers who are enrolled in federal insurance programs such as Medicare, Medicaid, VA or TRICARE.

- We do handle disputes from Medicare beneficiaries enrolled in supplemental health insurance plans.

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HEAU's Success by the Numbers

- In FY 2015, HEAU assisted patients in recovering or saving more than $3.2 million dollars.

- In FY 2014, HEAU mediation resulted in carriers overturning or modifying 53% of medical necessity denials, 55% of coverage decisions and 49% of eligibility denials.

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Right to Appeal

- The Maryland Grievances and Appeals Law ensures a **consumer's right to appeal health insurance plan decisions**—to ask a carrier to reconsider its decision to deny payment for a service or treatment, or to rescind coverage.

- If the plan upholds its initial decision, consumers may be eligible for a second look by an independent 3rd party reviewer.

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Appeals Process

- Whenever a carrier refuses to cover a procedure, or pay a bill, they must put their denial in writing (***Explanation of Benefits*** or ***EOB***).
- They must give the reason, inform the consumer of their right to appeal and list HEAU as a resource.
- Consumer or a provider, on behalf of the consumer, can contact HEAU for assistance.

Appeals Process

- There is a *two level* appeals process for the review of adverse decisions (denials):
- **Internal Appeals** — The carrier reviews its own decision.
- **External Review** —An independent medical review of the carrier's decision, if the carrier upholds its original denial based on medical necessity.

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Internal Appeals (Carrier)

What can be appealed?

- All denials (in whole or in part)
- Including rescissions, eligibility issues, medical necessity denials, coverage issues

How long to file an appeal?

- 180 days from receipt of denial

How to file an appeal?

- In writing (unless urgent – then oral okay)

Internal Appeals

How long before a decision is made for internal appeals?

- Pre-service (prior-authorization): 30 calendar days
- Post-service: 60 calendar days
- Urgent care: 72 hours or less, (depending on case)

Internal Appeals

- Once the carrier makes a decision, it must inform the consumer in writing.
- This notice must explain the carrier's decision, notify the consumer of their right to an external appeal and list the appropriate agency to hear the external appeal.

External Appeals (IRO)

- What can be appealed to an outside entity?
- Depends on the:
  - type of plan
  - State of issue
  - nature of the denial

External Appeals

- If a claim is denied for not being medically necessary, medically inappropriate or is considered cosmetic or experimental/ investigational, you are entitled to an independent medical review.

- Contractual exclusions unrelated to medical judgment have no external review rights.

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Overview of Health Plan Types

Fully Insured Plans	Self Funded Health Benefit Plans
The employer pays a per-employee premium to an insurance company, and the insurance company assumes the risk of providing health coverage for insured events and for all incurred administrative expenses.	The employer acts as its own insurer by assuming the financial risk to cover employees' medical expenses through paying medical claims from its own resources. The employer acts often hires an insurance company to be a third party administrator of its plan.
Participation: Small, mid-sized and some large employers.	**Participation:** Employees of state, federal and local governments, hospitals, and large corporations with multi-state operations.
Full appeal rights.	Limited appeal rights.
Subject to Maryland regulation if the plan is based in Maryland.	Subject to federal rather than state regulation.

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External Appeals

- MIA Regulated Plans – medical and contractual denials can be externally reviewed by the MIA

- Other plans (self-insured, self-funded non federal gov., FEHBP) – generally speaking available for disputes that involve medical judgment and rescissions.

Who Decides on External Appeal

- Independent Review Organization
  - Expert in treatment of patient's medical condition
  - Knowledgeable about recommended health care service/treatment
  - Consider evidence-based practice guidelines, nationally accepted clinical standards, peer-reviewed medical literature – in addition to plan's internal rules.
  - Independent – no conflicts of interest

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External Reviewer – Maryland Plans

- Fully Insured (Maryland) – MIA
- Self-Insured (Maryland) – MIA (by agreement) or Private IRO
- Self Funded, Non-Federal Gov't Plans – MIA (by Agreement), Private IRO, HHS
- FEHBP - OPM

External Appeals

How long to file and appeal?

- 4 months from receipt of notice

Decision must be made within 45 days of date of request for external review unless urgent, then as expeditiously as possible, no later than 72 hours. (MIA – 24 hours).

Maryland Health Connection Individual Eligibility Appeals

Applicants/enrollees may appeal initial or redeterminations of eligibility for:

- Enrollment in QHP
- QHP Enrollment Periods
- Medicaid/CHIP
- APTC/CSR, including amount
- Basic Health Plan
- Enrollment in catastrophic plan

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MHC Appeals/HEAU

The HEAU can assist the consumer with filing and mediating:

- Denials of enrollment in a QHP
- APTC/CSR Denials (or amount)
- Enrollment in a catastrophic plan

HEAU <u>does not</u>:

- handle Medicaid/CHIP appeals
- represent consumers at the hearing.

Appeals

An consumer has 90 days to appeal on the basis that:

- there has been an incorrect determination or redetermination of eligibility for
  - enrollment in a QHP
  - eligibility for Medicaid/MCHP Premium
  - eligibility for APTC/CSR
- MHC failed to provide timely notice of an eligibility determination or redetermination
- Individual exemptions from the minimum essential coverage requirement
- Appeals from an employer as to whether it provides its employee with minimum essential coverage that is affordable

Specialty Drugs Law

- HMOs and health plans must limit prescription drug costs to no more than $150 a month for a one month supply of medication for consumers meeting the following criteria:
  - Has a rare medical condition, or
  - Has a complex or chronic medical condition that has no known cure, is progressive and can be debilitating or fatal if left untreated or undertreated, and
  - Needs specialty prescription drugs costing $600 or more per month.

Specialty Drugs Law

- It applies to Maryland-regulated health plans only. It does not apply to self-insured health plans or plans regulated by other states.

- The law affects plans issued on or after January 1, 2016.

Specialty Drugs Appeals

- Carrier action warranting an appeal:
  - Refuses to pre-authorize drug or denies to re-authorize continued use.
  - Declines to cap monthly drug cost to no more than $150 when all criteria met.
  - Doesn't classify the consumer's medical condition as a rare medical condition.
  - Doesn't classify the consumer's condition as chronic or complex based on the law's definition.

HEAU Help

- File complaint on-line or via mail
- Select the complaint form for the type of complaint (billing, MHC appeal, other appeal)
- Sign Medical Authorization or Authorized Rep form
- Submit supporting documents

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HEAU Contact Information

Hotline

- 410-528-1840
- 877-261-8807

Website

www.MarylandCares.org

E-Mail

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Questions?

Thank you!