Law Ensures Right to Appeal Coverage Denials

BY MARY ELLEN SCHNEIDER

New federal regulations mandated by the Affordable Care Act will give patients rights to appeal claims denials made by their health plans.

The rules will allow consumers in new health plans to appeal decisions both through their insurer's internal process and to an outside, independent entity. Most health plans already provide for an internal appeals process, but not all offer an external review of plan decisions, said the U.S. Department of Health and Human Services. The types of appeals processes often depend on state laws.

HHS officials estimate that in 2011 there will be about 31 million people in new employer plans and another 10 million in new individual market plans who will be able to take advantage of these new appeals opportunities. The rules do not apply to grandfathered health plans.

Health plans that begin on or after Sept. 23, 2010, must have an internal appeals process for consumers to appeal whenever the plan denies a claim for a covered service or rescinds coverage. The appeals process must offer consumers detailed information about the grounds for their denial and information on filing an appeal.

The rules aim to make internal appeals more objective by ensuring that the person considering the appeal does not have a conflict of interest. Health plans will also have to provide an expedited appeals process, which would allow urgent cases to be reviewed within 24 hours.

The appeals regulations also standardize rules for external appeals. Health plans must provide clear information about external appeals and expedited access to the process. The decisions made through external appeals will be binding. ■