Statement for the Record
U.S. Department of Labor
ERISA Advisory Council

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On behalf of AHIP
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On behalf of AHIP, thank you for the opportunity to testify today to the ERISA Advisory Council. AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

Our member health insurance plans' priorities include ensuring that their enrollees and plan participants receive the care they need, when they need it, in the most appropriate setting and that their coverage is as affordable as possible. When AHIP member health plans act as a third-party administrator (TPA) on behalf of an employer our responsibility is to be good financial stewards. We negotiate payment rates for covered items and services, review claims to make sure medically necessary care was provided in accordance with the benefits and that payments are proper. Almost always, claims are processed and paid swiftly. Occasionally, a submitted claim may not be covered or may not be covered in full for a particular patient, resulting in what is termed an "adverse benefit determination," a category that includes claims denials. Health plan participants and their providers can appeal adverse benefit determinations, which will then be reviewed, and reversed if appropriate following review by the health plan or TPA, including by medical professionals, if necessary.

Appeals are an important member service provided by the plan or TPA. Health plans are committed to informing their members about their appeal rights and to facilitating an efficient appeals process on their behalf. Information about how to file an appeal from an adverse benefit determination, including a full or partial claim denial, is included on all adverse benefit determination documents. For example, when a claim is denied, a member will receive an Explanation of Benefits (EOB), including a dedicated page that explains how to initiate an appeal. This information is written in a manner that any member would understand. Health plan members can also find this information on their summary of benefits and coverage (SBC) or on the health plan's website or mobile app. When there are questions about how to proceed with an appeal, members can reach out via phone, web chat, or email to speak with a customer service representative for guidance.

Health insurance plans typically have a structured process to make the appeals process accessible to members following a denied claim. Some parts of the process to ensure accessibility include:

1. **Clear Communication**:
    - **Denial Letter**: When a claim is denied, the insurance company sends a denial letter or an EOB. This document outlines the specific reasons for the denial and provides detailed instructions on how to file an appeal.
    - **Contact Information**: The denial letter includes contact information for the insurance company, making it easy for members to reach out for assistance or clarification.

2. **Defined Appeal Process**:
    - **Internal Appeals**: Members can request an internal review of the denied claim. This involves submitting additional information or documentation to support the claim. The health plan/TPA is required to review the appeal and provide a decision within a specified timeframe.
    - **External Review**: If the internal appeal is unsuccessful, members have the right to request an external review by an independent third party. This ensures an unbiased evaluation of the claim.

3. **Support and Resources**:
    - **Consumer Assistance Programs**: Many states offer consumer assistance programs that help members understand their rights and navigate the appeals process. These programs can provide guidance on how to file an appeal and what information to include.
    - **Online Resources**: Health insurance plans provide online portals where members can access forms, track the status of their appeal, and find additional resources and FAQs.

4. **Timely Responses**:
    - **Deadlines**: Health insurance plans are required to adhere to specific deadlines for responding to appeals. This ensures that members receive timely decisions and can take further action if necessary.

5. **Legal Protections**:
    - **ERISA Compliance**: ERISA mandates that plans have a fair and transparent appeals process. This includes providing clear reasons for denial and allowing for a thorough review.

By providing clear instructions, accessible resources, and a structured process, health insurance plans aim to make the appeals process for health care services and prescription drugs as straightforward for their members.

In many circumstances, a claim may be denied due to missing information, meaning subsequent review with more information or details could result in a different determination. Most health plans/TPAs have clear processes in place to allow plan

members to supplement or perfect claims following an adverse benefit determination, in addition to outreach that is often done to the member to obtain that information prior to the determination.

Health insurance plans rely on health care professionals, including physicians, to play a crucial role in the claims and appeals process. Their responsibilities include:

1. **Medical Review**:
    - **Initial Claims Review**: Physicians review medical claims to ensure that the treatments and services provided are medically necessary and align with the insurance policy's coverage criteria.
    - **Clinical Expertise**: They use their medical knowledge to assess whether the requested treatments are appropriate based on the patient's medical history and current condition.

2. **Appeals Process**:
    - **Internal Appeals**: When a claim is denied, physicians are involved in the internal appeals process. They will re-evaluate the denied claim, considering any additional information or documentation provided by the member or their health care provider.
    - **External Review Preparation**: If an internal appeal is unsuccessful, these physicians may help prepare the case for an external review by an independent third party.

3. **Policy Development**:
    - **Guideline Creation**: Physicians contribute to developing clinical guidelines and policies that determine coverage criteria for various treatments and procedures.
    - **Updating Protocols**: They stay updated with the latest medical research and advancements to ensure that the insurance company's policies reflect current best practices in health care.

Health insurance plans are dedicated to maintaining efficient, transparent, and accessible appeals processes to ensure that members receive the care they need. They achieve this by clearly communicating the reasons for claim denials and providing detailed instructions on how to file an appeal. Additionally, they offer multiple levels of review, including internal and external appeals, to ensure fairness and thorough evaluation.

Insurance companies also invest in consumer assistance programs and online resources to guide members through the appeals process. By continuously updating clinical guidelines and policies based on the latest medical research, they strive to maintain accuracy and fairness in their decisions. Insurance companies' commitment to transparency and accessibility helps build trust and ensures that members can confidently navigate the appeals process to secure necessary medical care.