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Community Health Advocates (CHA)

DOL ERISA Advisory Council: Claims & Appeals Procedures

September 12th, 2024

community health advocates

CSS Community Service Society

Community Service Society of New York

- CSS is a 175-year-old organization that seeks to promote equity in New York
- The Health Programs at CSS provide direct health consumer assistance (enrollment and Ombudsman services) as well as conducts policy analysis, organizing and advocacy.
- Community Health Advocates
  - CHA is NY's state consumer assistance program with a live-answer helpline and 25 CBO partners
  - Serves 36,000 New Yorkers annually, saving them over $35 million in health care costs

CHA has observed 7 issues with Claims & Appeals Processes

Claims Process

1. Plan representative misinformation
2. Improper Notices and EOBS
3. Access to Information about the Claims Submission Process
4. Prior Authorization Response Delays

Appeals Process

5. Inaccessible process and information
6. Failure of response or adequacy of response
7. Inadequate Networks

1: Representative Misinformation

- **Issue:** Plan reps and their agents give misinformation about claims processing and appeal procedures and provider network participation.
- **Recommendations**:

  Require:

  - training of plan reps and plan agents
  - plan to cover OON services at INN level if misinformation given about participation status
  - all plan calls to be recorded and reference # to always be given

2: Improper Notices and EOBs

Issue: Notices and EOBs use legalese and are too long. EOBs often don't include consumer's rights.

- For example, EOBs regarding surprise bills often do not state that a consumer has a right to an external appeal.

Issue: Notices of adverse benefit determinations often do not comply with requirements for manner and content.

- For example, plans often fail to include a meaningful clinical rationale for medical necessity denials, instead including boilerplate language.

Recommendations

- EOBs and adverse benefit determination notices should have plain language information and contain all legal rights.

- If a notice of adverse benefit determination does not comply with manner and content requirements, the adverse benefit determination should be automatically reversed.

3: Access to Claims Submission Requirements

- **Issue:** Claims submitted by consumers or out-of-network providers are often denied for deficiencies because of difficulty in determining claim processing requirements. Denials often state: "documentation submitted does not support the services billed.
  - These delays and denials disproportionately impact people receiving mental health and substance use disorder services.
- **Recommendation**: Information regarding plans' claims procedures should be publicly available and easily accessible to both in-network and out-of-network providers as well as consumers.

4. Prior Authorization Delays

- **Issue:** Plans often do not respond to requests for prior authorization or pre-certification in a timely manner, or at all.
- **Recommendations**:
  - Plans should be required to respond to requests for prior authorization or pre-certification within a specific timeframe.
  - If plans do not respond to the request within the required timeframe, the request should be deemed approved.
  - Plans should not be permitted to reverse prior authorization or pre-certification that has been granted after a consumer has relied upon it.

Example:
A CSS client who completed detox for alcohol use in a hospital was ready to be transferred to inpatient treatment, for which his plan required pre-certification. The hospital submitted pre-certification to the plan multiple times over several weeks but received no response. The client eventually went to treatment without pre-certification, and the plan then denied coverage.

5: Inaccessible Appeals Process & Information

Issue: Consumers routinely cannot access clinical criteria, Summary Plan Description (SPD), Designation of Authorized Representative form, and appeal forms needed to properly and meaningfully file appeals.

- Mailing or faxing appeals discourages consumers from including full medical records due to cost of printing and mailing or faxing.

Recommendations:

- Plans should provide online access to clinical criteria, SPDs, Authorized Representative form and appeal forms.
- Require automatic reversal of a denial if plan (or its agent) does not respond timely to requests for information.
- Plans should allow secure email submission and provide online portal for submitting appeals.

Example:
Consumer's notice denies surgery as not medically necessary because the clinical criteria and SPD's definition of "medically necessary" are not met. When consumer calls plan for clinical criteria, the plan representatives do not know what it is or how to obtain it. The consumer spends countless hours trying to obtain the documents from their plan and employer and then gives up.

6: Failure to respond to claim and appeals/ Inadequate response

Issue: Plans and their vendors fail to respond to consumer claims and appeals and the specific parity allegations in appeals. The consumer then must send proof that the claim or appeal was timely received or resubmit the claim or appeal, adding an additional time and cost burden.

- Example: CHA filed an external appeal for a client on July 8th. Plan's IRO was required to reach a decision within 45 days of receipt of the appeal. As of September 9th, IRO has not responded.

Recommendations

- Adopt a law or regulation providing that failure to timely respond to a claim/appeal period results in automatic payment or reversal of denial.
  - E.g., NY Ins. L. § 4904(e)
- Plans should be required to specifically respond to any allegations of parity non-compliance included in internal appeals.
- IROs should be required to forward any external appeal containing allegations of parity non-compliance to DOL, which should investigate and respond to the parity allegations, in addition to the IRO making a determination on the external appeal.

7. Inadequate Networks

Issue: Consumers receive bills due to network inadequacy

- In-network providers may be located too far from the consumer's residence or not be available within a reasonable time
- In-network providers may not have the appropriate training and experience to provide the requested service
- The requested service may be materially different from the service available in-network

Recommendations

- Establish time/distance standards (30 mins/30 miles) for providers with appropriate training and experience. If plan cannot comply, consumer should only be subject to in-network cost sharing for seeing an out-of-network provider.
- NY law says consumers should only be subject to in-network cost sharing if they prove, on internal or external appeal, that:
  - the in-network provider does not have the appropriate training and experience to provide the requested service, or
  - the service is materially different from the service available in-network, is likely to produce a more clinically beneficial outcome, and would likely not substantially increase the adverse risk.

Thank you!

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