NAIC's Model State Law: Grievances and Appeals

The National Association of Insurance Commissioners (NAIC) is composed of the state government officials charged with regulating insurance companies in each state or territory. The NAIC has been developing Model State Laws for over 100 years to encourage uniformity in the regulation of insurance products.

To ensure that state regulators have the necessary state authority to monitor and enforce health insurers' compliance with the Patient Protection and Affordable Care Act (ACA), the NAIC has developed a set of Model State Laws to implement the ACA's consumer protections that became effective on Sept. 23, 2010. These Model Laws are intended to provide states with a minimum level of protection required by the federal law. States can decide to adopt more stringent requirements.

This fact sheet is part of a series intended to aid consumer advocates and legislators in understanding the purpose of the NAIC's Model State Laws, identifying opportunities to improve the laws from a consumer perspective, and highlighting potential efforts to weaken the state's law.

For the new federal right to appeal certain health plan decisions, NAIC has updated two existing Model Laws: the "Health Carrier Grievance Procedure Model Act" and the "Utilization Review and Benefit Determination Model Act." Both of these Models set out the minimum requirements a plan must meet to have an adequate *internal* process for reviewing consumer appeals. The ACA also gives consumers a right to access an independent, *external* review of their appeal. The NAIC has a longstanding Model Act on external appeals; it has not been updated, but any state that adopts the NAIC's Model Act on external appeals will be in compliance with the ACA.

What do the Model Acts do?

The NAIC's Model Acts on internal review conform to the ACA's minimum requirements by requiring the following specific protections:

- Provide consumers with the right to file an appeal with the health plan within six months of receiving a negative determination
- Allow consumers to appeal a broad range of plan decisions, including a decision to rescind (or retroactively cancel) a consumer's coverage
- Require that the health plan ensure the independence and impartiality of its reviewers, primarily by prohibiting plans from using bonuses, promotions or other enticements to encourage reviewers to rule against the consumer
- Require health plans to maintain a written record of all appeals for at least six years

- Require health plans to provide the consumer with any and all documentation, without charge, relevant to the appeal
- Require health plans to make a decision no later than 60 days after receiving the appeal. For urgent care requests, plans must make a decision within 24 hours
- Require health plans to provide consumers with culturally and linguistically appropriate information
- Require health plans to continue coverage of services and treatment throughout the appeals process if the patient is undergoing a course of treatment;
- Require health plans to inform consumers of their right to contact their state insurance commissioner or ombudsman/consumer assistance program for help with their appeal.

Three things that could improve the Model Acts

1. **Reduce administrative barriers.** Some health plans require consumers to go through *two* levels of internal review before they can access an independent external review panel. But studies have shown that the time and effort involved in the extra level of internal review discourage many consumers from pursuing their claims.[1] The federal rules allow consumers in *individual* market plans to skip the second internal review, but consumers in group plans don't get that protection. States could improve on the NAIC's Model Act by allowing all consumers in state-regulated insurance plans to access an independent external review if the plan rules against them after the first internal review.
2. **Expand the definition of rescissions.** The Models follow the ACA rules allowing consumers to appeal a health plan's decision to "rescind" or retroactively cancel coverage, unless the consumer has committed fraud or lied on his or her application. But neither the ACA nor the Model Laws address situations where a plan might cancel a consumer's coverage *prospectively*.
3. **Extend equal appeal rights to consumers in mini-med plans.**[2] Not all states regulate "mini-med" plans in the same way. The NAIC Models would allow states to exempt mini-meds from the requirements to have a full and fair internal review process. But states can provide all consumers with the same due process rights by clarifying that all plans, including mini-meds, must meet the new standards.

Three things that could weaken the Model Acts

Some stakeholders may attempt to weaken the NAIC's Model Language and make the state laws less protective of consumers. Consumer advocates and state policymakers may need to address:

1. **Exempting grandfathered health plans**. The ACA's provisions providing consumers with new rights to internal and external appeals do not apply to consumers in grandfathered health plans.[3] However, the NAIC's Model Laws are more expansive than the federal law and provide the appeal protections to *all* state-regulated plans – new plans and grandfathered plans. Advocates should be on the lookout for insurance industry efforts to exempt grandfathered plans from the Model Laws.
2. **Lowering professional standards for reviewers.** The NAIC Model Laws are more stringent than the federal rules because they require insurers to designate a "clinical peer" of the "same or similar specialty" to review the appeal. In other words, if a pediatrician

would typically manage a child's care, the health plan would be required to designate a pediatrician to review any appeal associated with that child's coverage. Because the federal rules give insurers more flexibility in who they appoint to review an appeal, advocates should be on guard for industry efforts to lower the standard.

3. **Reducing consumers' access to necessary information.** The NAIC Model Laws have tougher requirements than the federal rules on the following:
    - Timely access to documents. The NAIC model requires health plans to provide to the consumer all documents relevant to the case within three working days after the health plan receives the appeal. The federal rules don't include this timeliness requirement. Advocates should be aware that insurers may push to weaken the NAIC's requirement for prompt delivery of documents.
    - Access to a broad range of necessary documents. NAIC's model requires that, once a plan has made a decision on an internal appeal, it must provide to the consumer a range of documents that will help the consumer understand the decision. The federal rules don't require plans to provide the same breadth of documents, and health plans may lobby at the state level to allow plans to follow the less stringent federal requirements.

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[1] Geraldine Dallek and Karen Pollitz, "External Review of Health Plan Decisions: An Update ." The Henry J. Kaiser Family Foundation, May 2000.

[2] A "mini-med" plan is frequently defined as a plan that does not meet minimum state standards for health insurance coverage. They frequently cover only a limited range of services and have very low benefit caps.

[3] "Grandfathered" plans are those that were in existence prior to March 23, 2010. The ACA exempts them from many, but not all, of the ACA's consumer protections.