Health Insurance Appeals for Fully-Insured Plans

If you have a complaint about your insurance coverage or services, then you have the right to file an internal complaint with the insurance provider. Complaints include appeals for denied claims. This handout outlines the complaint procedure for plans that are fully insured. Fully insured plans are regulated by state law and can be conducted through a health maintenance organization (HMO) or an insurance company.

Fully-insured vs. self-funded plans

The first step in filing a complaint is to know whether your plan is fully-insured or self-funded. Here are some of the differences between the two types of plans:

Fully-Insured Plans	Self-Insured Plans*:
1. Doctors and hospitals are paid by your health insurance company.	1. Doctors and hospitals are paid by an administrative service company, which collects money from your business.
2. Your health insurance company collects a monthly premium from each enrolled employee.	2. The administrative service company is paid a fee to mange your employer's self-funded program.
3. Fully-insured plans are governed by state laws.	3. Self-insured plans are governed by federal laws through the Department of Labor.

(*See handout *HIAC-h3, Is Your Health Plan Self-Insured*, for more information.)

If you are still not sure if your plan is fully-insured or self-funded, you can check with your human resources department or contact your insurance company.

The complaint procedure

Minnesota law requires all insurance providers to have a procedure for internal complaints. The procedure must have the following steps: (1) an initial review of your complaint, (2) an initial decision by the insurance provider, (3) a right to appeal if the decision goes against you, and (4) an appeal decision.

Obtain a copy of the complaint procedure

Your insurance provider must give you its complaint procedure in writing when you enroll; this is usually included in the certificate of coverage (also known as a contract). You may also call your insurance provider's customer representative and ask for a copy of the complaint procedure. Under the Affordable Care Act (ACA), the process of internal appeals must be provided in writing, in a language understood by the recipient.

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Start the procedure in writing

In most cases, in order to start the insurance provider's review process you must make a written appeal or complaint to the insurance provider. You may submit an appeal letter or complete a complaint form provided by the insurance provider.

1. ***Initial review.*** As part of the initial review, the insurance provider must provide for informal discussions and written correspondence between you and someone with the authority to help resolve your complaint. If you submit a complaint orally and the insurance provider does not resolve the problem to your satisfaction within 10 days, then the insurance provider must tell you that you can submit your complaint in writing.
2. ***Initial review decision.*** After receiving your written complaint, the insurance provider must notify you of its initial decision in writing within 30 days. The insurance provider may take a 14-day extension in certain circumstances, but it must tell you about the extension before the 30 days have expired.
3. ***Internal Appeals.*** If the initial decision goes against you, then you have the right to make a written request for an internal appeal. The insurance provider must give you the option of having either a hearing (in which you present your position in person) or a written reconsideration (in which you present your position in writing). The health insurance company must also offer to help you put your complaint in writing. You may support your position with testimony, letters and explanations.
4. ***Internal Appeal decision.*** If you request a *hearing*, the insurance provider must give you a written decision within 45 days of your written notice of appeal. If you submit a *written reconsideration* request, the insurance provider must give you a written decision within 30 days of your written notice of appeal.
5. ***External Appeals.*** Your insurance company must notify you of your right to an External Appeal, and how to proceed. If you disagree with the appeal decision, you may file an appeal through an external appeal process. If your insurance provider is a HMO, you should file the next appeal with the Minnesota Department of Health. If your insurance provider is an insurance company, you should file the next appeal with the Minnesota Department of Commerce.

   The health company can also waive the right to exhaust all internal reviews, which is generally required, before moving on to an external appeal. There is a $25 fee for an external appeal, which is refunded, if the insurance company's position is reversed. You do not have to pay more than $75 out-of-pocket in fees for external reviews in a "plan" year. External reviews must be requested within six months from the date of the decision of the internal review.

Emergency service—fast-track appeal

If you have a complaint about the insurance provider that involves an emergency, then you have the right to an expedited appeal. Call your insurance provider customer representative for more information on how to file a fast-track appeal. Under ACA, there are additional protections that allow you to file for simultaneous external review in an urgent situation, or if you have not received an internal appeal decision in a timely manner.

External appeals and complaints to commissioners

At any time during the process, you may submit a complaint to the Minnesota Commissioner of Health if your insurance provider is a HMO or to the Commissioner of Commerce if your insurance provider is an insurance company.

Additional Resources

Minnesota Department of Health (for HMO's)

(651) 201-5100
(800) 657-3916 (toll-free)

Minnesota Department of Commerce (for insurance companies)

(651) 539-1600
(800) 657-3602 (toll-free)