PRESS RELEASE

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Arizona Insurance Department Takes Steps to Assure Consumers Are Aware of Health Care Appeals Rights

The Arizona Department of Insurance has launched a broad range of initiatives to assure consumers are aware of the year-old Health Care Appeals program and are fully utilizing its benefits.

Arizona Insurance Director Charles R. Cohen expressed concern that the appeals program, established July 1, 1998, may be under-utilized.

"I am concerned that many insurance consumers may not be aware of their right to appeal denials of health care services or coverage to the Insurance Department or an external independent medical reviewer," Cohen said. "This is an important consumer protection law. We intend to make certain that insurance companies are apprising their policyholders of the rights they have under the appeals program."

Appeals can be made in cases where an insurance company denies claims for payment of services already received, and for the company's refusal to authorize a service or coverage for a service. To initiate the process, consumers or their physician must appeal directly to the insurer. The final step is an appeal to an external independent medical reviewer or the Insurance Department.

The Insurance Department is taking the following action:

- **Audits.** Starting this month, the Insurance Department will conduct random audits of health care insurers to make sure the companies are complying with the law and

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are fully informing consumers of their rights. The department plans to examine company records, and may contact consumers who had appeals denied or who did not seek an external appeal. Corrective orders identifying deficiencies will be issued, and in appropriate cases penalties will be assessed.

- **Official bulletins.** Cohen issued regulatory bulletins apprising insurers of new legislation that went into effect Aug. 6, and directing them to amend information packets they give to consumers to reflect exemptions from the appeals process. These exemptions provide that the appeals process is not applicable when coverage is provided under disability income, hospital indemnity, and long-term care insurance policies that pay fixed benefit amounts and do not reimburse expenses incurred.
  In another bulletin to the health care industry, Cohen stated, "The Department strongly cautions all health care insurers to review their activities in light of the expansive definitions in the health care appeals law."
- **News media.** The department is attempting to educate consumers by enhancing outreach efforts through news releases and interviews with the print and electronic media.
- **Industry seminar.** A seminar for insurers is scheduled for Sept. 27 at the Insurance Department. The purpose is to apprise insurers of changes in the law and to make sure they fully understand their responsibilities.

A survey conducted by the Insurance Department reveals that during the first 12 months the health care appeals law was in effect, 1,939 formal appeals were filed with insurance companies and that 946 were overturned by the companies themselves in favor of consumers. A total of 176 appeals were filed with the Insurance Department, and approximately one-third were overturned in favor of consumers.

Cohen said he is particularly concerned about the more than 800 consumers whose appeals were denied by their insurer, but failed to appeal to the next level of independent review.

"I want to know why," Cohen said. "Did they not know there was a provision for an external appeal? Did the insurance company not inform them of the external appeal process? Or, out of frustration, did they simply give up?"

The most common appeals to the Insurance Department included requests for treatment by an out-of-network specialist, and requests for specialized drugs.

Under the appeals program, there are four levels of review. The first three are handled within the insurance company. Depending on the situation, a decision must be reached as quickly as 24 hours and no longer than 60 days.

At the fourth level, the enrollee may request an External Independent Review. In a case involving medical necessity, the company sends the case to an external independent medical reviewer. If the company believes the appeal is an issue of coverage, it is sent to the Insurance Department, which has five business days to decide whether services or a claim are covered.

If the Insurance Department is unable to determine issues of coverage, the appeal is submitted to an external independent medical reviewer, who has 30 days to make a determination. Each June 1, the Insurance Department compiles and publishes a list of independent reviewers who are generally board certified or board eligible in a medical specialty. The list is based on names provided by insurers.

The appeals program applies to traditional health insurers, HMOs and pre-paid dental plans. It does not apply to self-insured or self-funded plans, workers compensation and Medicare.

Not covered by the appeals program are disputes over deductibles, grace periods, unfair discrimination, benefit reductions for various reasons, rate increases, misleading advertising, misrepresentations, and the timeliness of claims payments. Those and other issues are investigated by the Insurance Department as consumer complaints. The Department receives approximately 100,000 calls a year from consumers with complaints and questions.

Legislation to improve the appeal process and safeguard consumer rights is expected to be introduced next year by Sen. Ann Day of Tucson. Day is the sponsor of the original appeals legislation and is a leader of efforts to provide Arizona consumers with these important rights.

Cohen favors Sen. Day's plan to give the Insurance Department sole authority to choose the specific external independent medical reviewer, and the means to procure and compensate the reviewer. Currently the insurance companies, which provide the names of the reviewers to the Insurance Department, can choose a reviewer from a list assembled by the department. The reviewer is paid by the insurer.

Cohen said, "There is a perception that the consumer may not receive a fair and impartial decision if the external independent reviewer is selected and paid directly by the insurer. Public confidence is critical to the success of this program." In addition, legislation may be proposed to assure that consumers are advised of their appeal rights at the time of each denial.

The Health Care Appeals unit was established within the Insurance Department's Life and Health Division, led by Assistant Director Mary Butterfield. Steve Gelbart heads the appeals unit.

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