Where can plan participants find information about filing an appeal or complaint?

Participants have access to both a complaint and appeal process. Complaints typically involve issues such as dissatisfaction about the plan's services, quality of care, the choice of and accessibility to providers, and network adequacy. Appeals typically involve a request to reverse an adverse coverage decision made by the plan.

The Member/Customer Service Department of the plan in which the participant is enrolled can assist in resolving complaints or with accessing the appeals process. The Member/Customer Service contact information is provided on participants' ID cards. Complete information regarding the process is included in the health plan Member Handbooks, Evidence of Coverage for a fully-insured plan, and the Sourcebook for Flexible Spending Accounts. The State Health Benefits Program also has an appeals process for administrative decisions.

Self-Funded Plan:
When a member of the State Health Benefits Program (self-funded plan) receives a final, adverse decision from their health plan, they may appeal the denial to their plan/claims administrator (internal appeal process). If the plan/claims administrator issues an unfavorable final decision, then the member may appeal to the Director of the Department of Human Resource Management (DHRM) (external appeal process). Appeals regarding denied claims are review by an independent review organization.

Before filing a health care appeal to the Director of DHRM, the member must exhaust all health care appeals through their plan/claims administrator. They must submit the appeal request in writing within four months of the final, adverse decision by the plan/claims administrator. Note that they may only appeal adverse benefit determinations by the plan/claims administrator that are based on the health plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational.

In some circumstances, the member has the right to an expedited appeal. An expedited appeal means the independent review organization will render a decision in a shorter timeframe. However, in order to request an expedited appeal, it must meet the criteria listed in the plan's Member Handbook.

When the health plan appeal is submitted to the Director of DHRM, the denial of coverage is reviewed by an independent review organization. If the appeal is not expedited, the member will receive an "Appeal Notice" informing them to submit additional supporting documentation to the independent review organization

within five days of receiving the notice. It will be the responsibility of the independent review organization to confidentially examine the final denial of claims to determine whether the decision of the plan is objective, clinically valid, and compatible with established principles of health care. Once the independent review organization has made a decision, it must provide written notification to the member, DHRM, and the plan/claims administrator. The outcome of the independent review may be either to overturn or uphold the denial. If the independent review organization upheld or partially upheld the plan/claims administrator's denial, the member will be notified that, if desired, he or she may exercise the appeals process under the Administrative Process Act (APA).

Flexible Spending Account (FSA) Appeals:
When a member is enrolled in a flexible spending account and they receive an adverse decision from the FSA vendor/administrator, they may appeal the denial to their plan/claims administrator (internal appeal process). If the plan/claims administrator issues an unfavorable final decision, then the member may appeal to the Director of the Department of Human Resource Management (DHRM) (external appeal process). Appeals regarding denied claims are review by the claims administrator.

Fully-Insured Plan:
Members in the Kaiser Permanente regional plan (fully-insured plan) or TRICARE Supplement plan may appeal claims decisions to the State Corporation Commission (SCC) after they have exhausted internal appeals with the health plan. Only appeals involving eligibility or policy may be sent to the Director of DHRM.

Administrative Appeals:
Administrative appeals are appeals regarding decisions made based on DHRM policies such as eligibility for a benefits program. In these cases, the appeals are reviewed by DHRM, and the Director of DHRM may offer an informal fact-finding consultation. A decision will be rendered. If the appeal remains denied, specific written reasons will be given, including specific references to law, regulation, contract provisions or relevant policies which formed the basis for the denial.