DC HEALTH LINK
Get the facts. Get covered.

DC Health Benefit Exchange Authority

Basic Health Plan Advisory Council

July 21, 2025

Agenda

- **Welcome and Call to Orde**r, *Linda Elam*
- **Internal Appeals and External Review Processes,** *Sabrina Corlette, Maude Holt, & Joanna Donbeck*
- **Healthy DC Plan Logos,** *Linda Wharton-Boyd*
- **Submission of Draft BHP Blueprint,** *Bonnie Norton*
- **Questions and Discussion,** *Linda Elam*
- **Close & Next Steps,** *Linda Elam*

Private Health Insurance Eligibility and Coverage Appeals Processes

Sabrina Corlette, ***Georgetown University***
Maude Holt, ***DC Office of Health Care Ombudsman and Bill of Rights***
Joanna Donbeck, ***DC HBX***

Basic Health Plan Advisory Council Meeting

July 21, 2025

Internal Appeals and External Review: Protections for Consumers in Marketplace Health Plans

Georgetown University
Sabrina Corlette, J.D.

Georgetown University Center on Health Insurance Reforms

Nationally recognized health insurance experts

- Part of McCourt School of Public Policy
- Legal & policy analysis
  - Laws and regulations
  - Market trends
- Publish reports, studies, blog posts, white papers
- Technical assistance

*Presentation supported by the Robert Wood Johnson Foundation's State Health & Value Strategies Project. Any views expressed are my own and do not represent the views of RWJF, SHVS, or Georgetown University

Clinton Establishes Health Care 'Bill Of Rights'

WASHINGTON (AllPolitics, Feb. 20) -- To address growing public frustration with managed health care systems, President Bill Clinton unveiled Friday morning a "consumer bill of rights" for more than 80 million patients covered by federal health care programs.

Internal Claims and Appeals – Right to Appeal

An enrollee who received an "adverse benefit determination" has a right to pursue an internal appeal

- Adverse benefit determination can include:
  - A denial, reduction, or termination of a benefit
  - Failure to provide or make a payment for a benefit
  - Failure to provide or make a payment based on eligibility for the plan
- Plans must provide patients with the rationale for their decision.

All individual market plans must have "an effective internal claims and appeals process"

- Plans must establish and maintain "reasonable procedures" for the filing of appeals of adverse benefit and eligibility determinations.
- Member has right to access personal file, present evidence, review insurer's rationale, and have sufficient opportunity to respond
- Appeal must receive "full and fair" review by health care professionals
- Notices must be "culturally and linguistically" appropriate

Internal Appeals Timeline

Adverse benefit determination → Patient has up to 180 days to request review → Plan must acknowledge request within 10 days → Prospective review: 30 days to complete → Retrospective review: 60 days to complete

In emergency, issuer must respond to appeal within 24 hours

Patients whose appeal is denied have a right to an independent, external review

External Review – Standards & Processes

Review Standards	Notices	Binding Decisions
• Review must be based on plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.	• Issuers must provide effective written notice to enrollees about their rights to external review • Details about external review process must be provided in summary plan description	• Decision of external review entity must be binding on issuer and claimant • Issuer must provide required coverage without delay

Written Records
• External review entity must maintain written records and make them available upon request

External Review – Entity Independence

Assignment	Accreditation	Conflicts of Interest
• Review entity must be assigned on a random basis or other method that ensure impartiality • May not be selected by the plan or issuer	• State must maintain list of approved review entities • Staff must be experienced in peer review; licensed physicians or mental health professionals • Review entities must be accredited	• Review entity must be free of conflicts of interest

External Review – Timeliness

Patient Rights	Time to File	Decision-making
• Patient must be able to request an expedited external review at the same time they pursue an internal appeal • Patient has right to request a hearing; review entity cannot unreasonably refuse the request	• Patient must have at least 4 months from date of adverse benefit determination or internal appeal decision to file • Patient must have at least 5 days to respond to requests from review entity	• External review entity must render its decision within 45 days of receipt of request

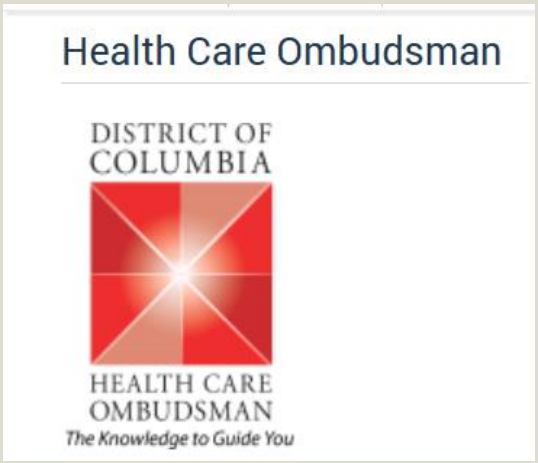
Expedited Review – 72 hour decision

- Patient entitled to expedited review if the adverse benefit determination concerns emergency services or where the standard external review timeframe would "seriously jeopardize the life or health" of the patient.
- If experimental or investigational, treatment will be less effective unless promptly begun

External Review – Costs

Filing Fees	Cost of Claim
• Federal law allows nominal filing fees • DC: No filing fees are charged	• No minimum claim threshold allowed

DC Office of Health Care Ombudsman and Bill of Rights



The mission of the Office of Health Care Ombudsman and Bill of Rights is to guide, advocate and help people navigate through the health care system by helping them understand their health care coverage, assist in appealing health insurance decisions, including public health care programs, i.e., Medicaid, Medicare, Tri-Care and assisting District residents and those who have claims, medical procedures and prescriptions that have been denied by insurance companies that are regulated by the District of Columbia Department of Insurance, Securities and Banking.

Questions?

Georgetown University Center on Health Insurance Reforms

https://chir.georgetown.edu/

Sabrina Corlette

Sabrina.corlette@georgetown.edu

https://www.linkedin.com/in/sabrina-corlette-73784a55/

BHP Appeals Requirements - 42 CFR § 600.335

Notice Requirement:

- Eligibility determinations must include a notice of the right to appeal the determination, and instructions regarding how to file an appeal.
- Notices must be provided and the appeals process must be conducted in a manner accessible to individuals with limited English proficiency and persons with disabilities

Appeals process: Individuals must be given the opportunity to appeal the following actions through the appeals rules of the State's Medicaid program, unless granted an exception by HHS:

1. BHP eligibility determinations; and
2. Delay, denial, reduction, suspension, or termination of health services, including a determination about the type or level of service, after individuals exhaust appeals or grievances through the BHP standard health plans.

Exception: Subject to HHS approval, a state may request to follow an appeals process for BHP eligibility determinations and health service matters that differs from the State's Medicaid program. In its request, the State must provide a clear description of the responsibilities and functions delegated to such an entity and ensure that:

1. The State has oversight of any entity delegated the authority to administer appeals;
2. The agency to which eligibility determinations or appeals decisions are delegated complies with all relevant Federal and State law, regulations and policies; and
3. The agency to which eligibility determinations or appeals decisions are delegated informs applicants and beneficiaries how they can directly contact and obtain information from the agency.

BHP Eligibility Appeals

- HBX will be seeking an exception to follow the QHP eligibility appeals process which includes:
  - an internal review by HBX; and
  - an independent review by the Office of Administrative Hearings (OAH).

- This mirrors the Medicaid process, which has an internal review by Department of Human Services (DHS) and an independent review by OAH.

BHP Coverage Denial Appeals

- HBX will be seeking an exception to follow the QHP coverage denials appeals process which includes:
  - **BHP insurer level** (DC Code § 44–301.04(c)):
    - Internal carrier appeal
    - External review by an independent review organizations

- Complaints and grievance process with **Department of Securities, Insurance and Banking (DISB)** regarding more clear-cut claim denials where there's a statutory benefit mandate but doesn't rise to medical necessity determination.
  - *Can be initiated without exhaustion of insurer level appeals process*

- Appeals to **Health Care Ombudsman** (DC Code § 7–2071.04) for coverage denials (prescription drugs / durable medical equipment / surgical procedures deemed not medically necessary etc.) and navigation issues (eligibility & enrollment, accessing appointments, provider lists, etc.)

Healthy DC Plan Logos

Linda Wharton-Boyd, *HBX*

DC HEALTH LINK

Logo Options for Healthy DC Plan

Option 1

Option 2

Option 3

gmmb for what matters

Submission of Draft BHP Blueprint

Bonnie Norton, *HBX*

Thank You!

Additional questions?

Please email Bonnie.Norton@dc.gov

or Melissa.Quick@dc.gov

Housekeeping Items

Meeting Facilitators:

- **Dan Meuse,** State Health & Value Strategies
- **Jessica Schubel**, Day One Strategies

Meetings will be **recorded** and **minutes** will be taken; both will be **posted online** with other meeting materials.	Meetings will held **Mondays at 4 pm.**	Meetings are for Advisory Council members to ask questions and provide feedback. There will be a separate public comment request.	Please remain **on mute** unless speaking.

DC HEALTH LINK

Save the Date!

The Healthy DC Plan Community Leadership Meeting

Tuesday, September 16, 2025

11:00 am

Martin Luther King Jr. Public Library

Conference Center