Exceptions and Appeals:

Knowing Your Patients' Rights

The Patient Protection and Affordable Care Act (ACA) established new protections to challenge adverse health plan coverage decisions. This fact sheet was created to help HIV providers assist their patients with these processes.

Requesting Coverage For Non-Formulary Drugs- Exceptions

The Qualified Heath Plans (QHPs) available through the federally facilitated ACA marketplaces are required to have an exceptions process to request coverage for non-formulary medications. QHPs must respond to standard formulary exception requests within 72 hours. If the request is granted, the drug must be covered for the duration of the prescription, including for refills.

Expedited exception requests may be requested for exigent circumstances, such as for treatment for a serious health condition or to continue a course of treatment. If approved, the medication will be covered for the duration of the exigency. Expedited requests must be processed within 24 hours.

Requesting Exceptions

- Check with your contracted health insurers to learn how to request exceptions for non-formulary medications.
- Cost sharing for drugs covered through the exceptions process must count toward the plan's annual cost sharing limit.
- Be prepared to document that an exception for the requested drug is necessary, because drugs in the plan's formulary will not be equally effective, or because of harmful side effects or drug interactions associated with formulary medications.
- For expedited requests, be prepared to document that without the medication the patient could experience serious negative, potentially life-threatening, health outcomes.
- Plans may grant exceptions, but can then require the highest level of cost sharing for non- formulary requested medications.
- If an exception is denied, an enrollee, an enrollee's designee or the prescribing physician may request review by an independent review organization.

Appealing A Plan's Adverse Coverage Decision

The appeals processes described below apply to health plans available in individual and group health insurance markets that were not in existence before March 23, 2010, or that have made significant changes to benefits or cost sharing since then.

Internal Appeals at the Plan

Plans are required to have internal processes for patients to appeal service or treatment claim denials.

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- Internal appeals processes vary by plan. ***Check with contracted plans to learn details of their appeals processes.***
- Internal appeals can be submitted up to 180 days after a denial notice.
- Medical providers can submit expedited appeals for urgent care requests. Plans are required to respond to expedited appeals as soon as possible, ***but no later than 72 hours after the request is submitted.***
- Plans ***must respond within 30 days for non-urgent appeals for care that has not been received (prior authorization).***
- Plans ***must respond within 60 days for non-urgent appeals for care that has been received.***
- *Plans are generally required to continue coverage for previously approved care and treatment while an appeal is being considered.*
- Appeal denial notices must include the rational for the rejection of the claim, as well as information on additional internal and external appeal processes and consumer assistance resources.

External Review by a Third-Party Independent Review Organization

If a plan denies an appeal it must provide information for requesting external review by an Independent Review Organization (IRO).

- Patients may submit external review requests up to four months after receiving health plans' internal appeal denial notices.
- Patients can appoint their medical providers or other representatives to file external review requests on their behalf.
- Additional information supporting external reviews may be submitted up to 5 days after initial request submissions.
- Expedited review requests for urgent care issues ***must be responded to within 72 hours.***
- Non-urgent requests ***must be responded to within 45 days.***

Help With The Appeals Process

Nearly half of the states have Consumer Assistance Programs available to help patients navigate appeals process. **Learn More**.

This information was compiled from the resources noted below. Visit them to learn more.

Centers for Medicare and Medicaid Services
https://www.cms.gov/

Appeals: Eligibility & Health Plan Decisions in the Health Insurance Marketplace
https://marketplace.cms.gov/outreach-and-education/appeals-eligibility-and-health-plan-decisions.pdf

Consumer Assistance Programs
https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/

Center for Consumer Information and Insurance Oversight ACA: Working with States to Protect Consumers
http://www.cms.gov/CCIIO/Resources/Files/external_appeals.html

U.S. Department of Labor - Internal Claims and Appeals and External Review Regulations and Guidance
http://www.dol.gov/ebsa/healthreform/regulations/internalclaimsandappeals.html

Internal Claims and Appeals and External Review Process Overview
https://marketplace.cms.gov/technical-assistance-resources/internal-claims-and-appeals.pdf