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Notice Requirements for Health Benefit Determinations

The Maine Health Plan Improvement Act and Bureau of Insurance Rule 850 entitle consumers to clear and understandable notice when benefits are approved or denied under health plans regulated by the Superintendent. The Bureau has received consumer complaints suggesting that utilization review notices provided by some health carriers do not meet required standards.

Specifically, as discussed below, notices advising enrollees that services have been determined to be medically necessary must also advise whether the service is covered.[1] Once a service has been approved, the approval cannot be withdrawn retrospectively unless fraudulent or materially incorrect information was provided at the time prior approval was granted.[2] Also, if benefits are denied and the enrollee appeals, the carrier cannot deny the appeal without a written explanation addressing the issues that were raised by the enrollee.[3]

Medical Necessity Authorizations

Maine law does not permit carriers (or their utilization review subcontractors) to tell enrollees only that a requested health care service has been determined to be medically necessary, without giving them the information they are really looking for – will I be covered? A number of prior authorization notices that have come to the Bureau's attention broadly state that the services have been approved as medically necessary and that benefits will be paid subject to coverage provisions and exclusions in the policy, sometimes without even describing which policy provisions and exclusions might put coverage at risk. It is the carrier, not the enrollee, that has the duty to determine whether the requested service is within the scope of coverage and whether a policy exclusion applies. A carrier may not simply decide whether or not the service is medically necessary without also advising whether the service is covered. If the carrier determines that coverage for the service is limited in any way, this limitation must be identified with specificity in the notice.

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[1] 24-A M.R.S.A. § 4304(6).

[2] 24-A M.R.S.A. § 4304(4).

[3] Rule 850, §§ (8)(G)(1)(c)(ii & iv), (9)(B)(2)(b)(ii & iv).

Carriers have expressed concern regarding certain specific situations in which it may be difficult to determine whether the services are covered within the 2-day time limitation for utilization review decisions. Carriers should promptly and clearly notify the enrollee and the enrollee's provider of the specific issue of concern and what additional information the carrier needs in order to make a final coverage determination. For example, if an enrollee is potentially subject to a pre-existing condition exclusion, the utilization review determination notice should clearly advise that the enrollee is still in his or her pre-existing condition look-back period and explain what additional information is needed in order to make a final coverage determination. For non-emergency services, the law specifically grants carriers additional time if necessary, providing that "If the information submitted is insufficient to make a decision, the carrier shall notify the provider within 2 business days of the additional information necessary to render a decision. If the carrier determines that outside consultation is necessary, the carrier shall notify the provider and the enrollee for whom the service was requested within 2 business days. The carrier shall make a good faith estimate of when the final determination will be made and contact the enrollee and the provider as soon as practicable."[4]

The prior authorization notice may advise enrollees that they must be enrolled in the plan at the time medical services are provided, consistent with the provision in the statute stating that "Nothing in this subsection requires a carrier to provide coverage for services performed when the insured or enrollee is no longer covered by the health plan."[5]

Denials of Benefit Appeals

Carriers are also reminded that all adverse benefit determination appeal decisions must include (1) a specific statement of the reviewers' understanding of the reason for the covered person's request for an appeal, and (2) the decision in clear terms in sufficient detail for the covered person to respond further to the health carrier's position. A "specific statement of the reviewer's understanding" means that the reviewers must specifically identify and respond to the actual reason or reasons the enrollee raised in his or her appeal request. The Bureau's complaint investigations reveal that too often appeal decisions simply restate the carrier's original reason for the denial without ever acknowledging or addressing the enrollee's stated reason for appealing the denial. Carriers should acknowledge and address each stated reason for appeal with an explanation of why they agree or disagree with the enrollee's reason for appeal, or, as applicable, why the stated reason for the appeal is not relevant to the decision, or why some other reason for the denial is controlling. Otherwise, the decision may give the impression that the carrier is intentionally ignoring the consumer's reason for the appeal, and fails to provide sufficient detail for the covered person to respond further to the carrier's position.

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NOTE: This Bulletin is intended solely for informational purposes. It is not intended to set forth legal rights, duties, or privileges, nor is it intended to provide legal advice. Readers should consult applicable statutes and rules and contact the Bureau of Insurance if additional information is needed.

[4] 24-A M.R.S.A. § 4304(2).

[5] 24-A M.R.S.A. § 4304(6).