

Health Insurance Appeals for Fully Insured Plans

If you have a complaint about your insurance coverage or services, then you have the right to file an internal complaint with the insurance provider. Complaints include appeals for denied claims. This handout outlines the complaint procedure for plans that are fully insured. Fully insured plans are regulated by state law and can be conducted through a health maintenance organization (HMO) or an insurance company.

The complaint procedure

Minnesota law requires all insurance providers to have a procedure for internal complaints. The procedure must have the following steps: (1) an initial review of your complaint, (2) an initial decision by the insurance provider, (3) a right to appeal if the decision goes against you, and (4) an appeal decision.

Obtain a copy of the complaint procedure

Your insurance provider must give you its complaint procedure in writing when you enroll; this is usually included in the certificate of coverage (also known as a contract). You may also call your insurance provider's customer representative and ask for a copy of the complaint procedure.

Start the procedure in writing

In most cases, in order to start the insurance provider's review process you must make a written appeal or complaint to the insurance provider. You may submit an appeal letter or a completed complaint form provided by the insurance provider.

1. *Initial review.* As part of the initial review, the insurance provider must provide for informal discussions and written correspondence between you and someone with the authority to help resolve your complaint. If you submit a complaint orally and the insurance provider does not resolve the problem to your satisfaction within

10 days, then the insurance provider must tell you that you can submit your complaint in writing.

2. *Initial review decision.* After receiving your written complaint, the insurance provider must notify you of its initial decision in writing within 30 days. The insurance provider may take a 14-day extension in certain circumstances, but it must tell you about the extension before the 30 days have expired.
3. *Appeal of initial decision.* If the initial decision goes against you, then you have the right to make a written request to appeal. The insurance provider must give you the option of having either a hearing (in which you present your position in person) or a written reconsideration (in which you present your position in writing). You may support your position with testimony, letters and explanations.
4. *Appeal decision.* If you request a *hearing*, the insurance provider must give you a written decision within 45 days of your written notice of appeal. If you submit a *written reconsideration* request, the insurance provider must give you a written decision within 30 days of your written notice of appeal.

If you disagree with the appeal decision, you may file an appeal through an external appeal process. If your insurance provider is a HMO, you should file the next appeal with the Minnesota Department of Health. If your insurance provider is an insurance company, you should file the next appeal with the Minnesota Department of Commerce. Call your insurance provider and ask if it is a HMO or insurance company if you do not know.

Emergency service—fast-track appeal

If you have a complaint about the insurance provider that involves an emergency, then you have the right to an expedited appeal. Call your insurance provider customer representative for more information on how to file a fast-track appeal.

External appeals and complaints to commissioners

At any time during the process, you may submit a complaint to the Minnesota Commissioner of Health if your insurance provider is a HMO or to the Commissioner of Commerce if your insurance provider is an insurance company.

Additional Resources

Minnesota Department of Health

651-201-5100

1-800-657-3916 (toll free)

Minnesota Department of Commerce

651-296-2488

1-800-657-3602 (toll free)