Government of the District of Columbia
Office of the Chief Financial Officer

Natwar M. Gandhi
Chief Financial Officer

MEMORANDUM

TO: **The Honorable Kwame R. Brown**
Chairman, Council of the District of Columbia

FROM: **Natwar M. Gandhi**
Chief Financial Officer

DATE: **June 15, 2011**

SUBJECT: **Fiscal Impact Statement – "Health Benefits Plan Members Bill of Rights Emergency Amendment Act of 2011"**

REFERENCE: **No Bill Number Available—Draft Legislation Shared with OCFO on June 13, 2011**

Conclusion

Funds are sufficient in the FY 2011 through FY 2014 budget and financial plan to implement the provisions of the proposed legislation.

Background

The proposed legislation would amend the Health Benefits Plan Members Bill of Rights Act of 1998,[1] which is the District's grievance and appeals law for customers of commercial health plans in the District of Columbia, to bring it into compliance with the requirements of the federal Patient Protection and Affordable Care Act of 2010 (PPACA).[2] PPACA requires that all individual and group health plans meet certain standards with regard to providing an appeals process for consumers who are dissatisfied with a coverage or claims determination. The proposed legislation incorporates the required federal standards.

Specifically, it would:

- Make the District's external appeals process binding on health plans;
- Broaden the scope of issues that are appealable in accordance with federal law;
- Require health insurers to notify members when claims are denied, setting forth the reasons for the denial and procedures for appealing the determination through internal and external review;

[1] Effective April 27, 1999 (D.C. Law 12-274; D.C. Official Code § 44-301.01 *et seq*.).
[2] Approved March 23, 2010 (Pub. L. No. 111-148; 124 Stat. 119).

- Require that the grievance system included in the insurer's health benefits plan incorporate the right of a member to file a grievance regarding an insurer's decision to rescind coverage;
- Clarify that coverage determinations and claims denials are subject to review;
- Provide that during the formal internal appeals process, the member and the member's representative have the rights to review the member's file; to request and receive free of charge copies of all documents and records relevant to the claim; and to present evidence and testimony as part of the appeals process;
- Require an insurer that denies a member or member representative's appeal of a rescission to provide the member or member representative and the Department of Insurance Securities and Banking (DISB) with a written statement that explains why the insurer found that there was fraud or misrepresentation of a material fact and informs the member that he or she has a right to appeal to DISB;
- Clarify that only one level of internal review is required before a patient can appeal to an independent body;
- Allow self-funded plans to use the District's appeal system, if they wish at their own expense; and
- Make other technical changes to comply with federal law.

In addition, the proposed legislation would set forth procedures to protect the confidentiality of mental health information during internal and external appeals. Such procedures are not described under current law and could lead to the inappropriate disclosure of information.

Lastly, it should be noted that if the District, as well as other states, don't incorporate the new standards by July 2011, health plans will no longer be able to use their state's appeals procedures; instead, they will have to use a federally administered appeals process. The District's appeals system is handled by the D.C. Office of the Health Care Ombudsman and Patient Bill of Rights ("Office of the Ombudsman") in the Department of Health Care Finance (DHCF). Thus, implementation of the proposed legislation would allow the Office of the Ombudsman to continue to handle these appeals.

Financial Plan Impact

Funds are sufficient in the FY 2011 through FY 2014 budget and financial plan to implement the provisions of the proposed legislation. The proposed changes to the District's grievance and appeals law for customers of commercial health plans would not have an impact on the budget and financial plan, as they are not expected to create additional burden for the staff of the Office of the Ombudsman, which administers the law.