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Employer-Based Health Insurance: Denials and Appeals

Receiving a letter from your insurance company denying a specific medication or service can be stressful and frightening. It is important that individuals are aware of their options.

Denials and appeals processes ensure that individuals have the right to dispute denied claims and appeal them.

There are two main types of employer health insurance: **fully insured plans** and **self-insured (or self-funded) plans**. While there are some similarities between the two options, there are also some key differences.

For example, both are subject to the requirements and timelines for appealing a denied claim under an employer-sponsored plan established by the Employee Retirement Income Security Act (ERISA). Fully insured employer-sponsored health plans must also comply with state insurance laws, which can impose additional consumer protections and mandates that plans must follow.

Regardless of whether your employer plan is fully insured or self-insured, you should receive a packet of information upon enrollment that provides you with information about your coverage including information about the denials and appeals process. In addition, following enrollment, if you receive a denial notification, guidance on how to appeal the denial should be included.

The key requirements and timelines for denials and appeals established by ERISA for health plan claims are below.

1. Initial Claim Decision Timeframes

Health plans must notify claimants of a decision within the following ERISA timelines:

Type of Claim	Decision Deadline
Urgent Care Claims	72 hours
Pre-Service Claims (prior authorization)	15 days
Post-Service Claims (after receiving care)	30 days

If more time is needed (e.g., missing information), the plan may extend the timeframe by **up to 15 days**, but it must notify the member of the reason.

2. Internal Appeal Process for Denied Claims

If a claim is denied, the **internal appeal** process follows these rules:

Type of Claim	Deadline for Appeal	Decision on Appeal Deadline
Urgent Care Appeals	180 days	72 hours
Pre-Service Appeals	180 days	30 days
Post-Service Appeals	180 days	60 days

- **Full and Fair Review**: The member can submit additional evidence, request copies of claim-related documents, and review plan rules.
- **One Level of Appeal Required**: Fully insured plans typically require **at least one level** of internal appeal before the next step.
- **Work with your clinician to file your appeal**.

3. External Review Process

If the **internal appeal** is denied, the member can request an **external review** by an independent review organization (IRO) which is not affiliated with the plan.

- **Request Deadline:** Within **4 months** of the final internal denial.
- **Decision Timeline:**
  - **Standard Review**: Within **45 days**
  - **Expedited Review (for urgent claims)**: Within **72 hours**
- The insurer's **must** comply with the IRO's determination.

4. Litigation Under ERISA

If the external review is unsuccessful, the member may **file a lawsuit under ERISA Section 502(a)**.

- The lawsuit must be filed within the **plan's deadline** (often **one year** from the final denial, though this varies by plan).

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