Congress of the United States
House of Representatives
Washington, DC 20515

July 25, 2011

The Honorable Hilda Solis
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210
Attn: RIN 1210-AB45

The Honorable Kathleen Sebelius
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9993-IFC2
P.O. Box 8010
Baltimore, MD 21244-8010

The Honorable Timothy Geithner
Internal Revenue Service
CC:PP:LPD:PR (REG-125592-10)
Room 5205
P.O. Box 7604
Ben Franklin Station
Washington, DC 20004

Re: Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes (RIN 1210-AB45)

Dear Secretary Solis, Secretary Sebelius, and Secretary Geithner,

We appreciate the opportunity to provide comments on the June 2011 Amendments to the July 2010 Interim Final Rule and all corresponding guidance implementing the requirements regarding internal claims and appeals and external review processes for group health plans and health insurance coverage in the group and individual market. As you know, the right to a fair and impartial appeal of a denial of a claim for health benefits was at the heart of the Patient's Bill of Rights. Dozens of consumer advocacy groups and Members of Congress fought decades to enact these protections as part of the Affordable Care Act for the 173 million Americans covered by private health insurance through employers or the individual market. Health insurers and plans have a strong financial interest in denying claims to control health costs. An impartial,

independent appeals process helps to ensure that insurers and plans act fairly and consumers obtain promised benefits.

We support several of the provisions of the proposed amendments that increase the protections for consumers. We applaud the Departments' decision to make external review decisions binding on the plan or issuer because this will allow both parties finality in the process and permit consumers to obtain benefits without delay in appeals ending in their favor. We also support the requirement that makes the physician's determination of urgency final for purposes of expedited notifications. Despite supporting several of the amendments, we are deeply concerned that other proposed changes will weaken important consumer protections and we offer the following recommendations.

Recommendation #1: Don't narrow the scope of which adverse benefit determinations can be appealed.

The June 2011 Amendments to the Interim Final Rule narrows the claims eligible for external review to those involving medical judgment or a rescission. The Affordable Care Act should be improving consumer protections and appeals rights for consumers, but this regulation narrows what is appealable taking the surprising step of limiting access to external review.

We take issue with the rationale stated in the Amendments that the scope was limited "to give the marketplace time to adjust to providing external review." Appeals of all claims denials, not just those involving medical judgment, have been occurring at the federal and state level. Members of Congress, federal employees, and Medicare beneficiaries can have any disputed claims denials resolved objectively through this process. According to the Office of Personnel Management (OPM), in 2010, eighty-four percent of the total disputed claims in the Federal Employee Health Benefits Program were denials for issues other than medical necessity. This creates a broader universe of claims beyond medical judgment which FEHBP members can appeal. Independent Review Organizations already have the capacity and staffing expertise to handle claims that involve more than medical judgment and thus more time is not needed for the market to evolve.

Further, claim denials based on medical judgment make up only a small fraction of overall claim denials. For example, in Maryland in 2007, of the 6.3 million preauthorizations or claims denied, less than 40,000 were due to a determination that the services were not medically necessary. Further, National Association of Insurance Commissioners (NAIC) data show that for the 14,000 complaints related to coverage denials filed with States in 2009, only eight percent were related to the determination that the service was not medically necessary. In addition, this narrowing of what claims are appealable invites insurers to reclassify denials as not involving medical judgment so fewer external reviews are available to consumers. For example, an item or service could be denied as being out of network. A plan could choose to classify that denial as a coverage denial rather than a denial involving medical judgment, thus making it harder for the

consumer to access an external appeal. However, out of network determinations can include judgment of not only convenience and choice, but of clinical or provider expertise and physical accessibility.

Narrowing the review process is particularly concerning due to the frequency with which adverse claim decisions are currently overturned in existing internal and external review processes. For example, the Government Accountability Office (GAO) found that 39 percent of internal appeals across the four States that collect this data resulted in the insurer reversing its original claim denial. Further, an America's Health Insurance Plans (AHIP) study of 37 States' external appeal processes found that 40 percent of external appeals resulted in claim denials being reversed from 2003 to 2004.

Fairness requires that the Departments grant all consumers whose claims have resulted in an adverse benefit determination equal access to the Federal external review process rather than the staggered access proposed in the Amendments to the July 2010 Interim Final Rule.

Recommendation #2: Eliminate the safe harbor allowing self-insured plans to select and pay the Internal Review Organization.

We are concerned with the safe harbor, established in the August 2010 Technical Release 2010-01, which allows self-insured group health plans to pick, contract, and compensate the Independent Review Organizations that will adjudicate external appeals. When a self-insured plan does this, they have immunity from actions by the Department of Labor or the Internal Revenue Service with regard to having an independent appeals process available to consumers. This sets up a clear and inherent conflict of interest.

It is self evident that an organization that is both selected and compensated by an insurer cannot truly be independent. Any precautions such as requiring contracting with multiple IROs or random assignment of one of these IROs on a specific appeal do not remedy this conflict of interest. Therefore, we urge the elimination of this safe harbor.

However, if the Departments continue to allow self-insured group health plans to select and pay IROs, the Departments must collect sufficient data and perform oversight necessary to ensure that these plans have contracted with the requisite number of IROs and are actually using a truly independent mechanism to assign each claim to an IRO. Further, the Departments must take any other steps necessary to ensure that this process remains a truly independent external review.

Recommendation #3: Adopt the July 2010 Interim Final Rule for form and manner of notice requirements related to the group market.

According to the U.S. Census Bureau, approximately 26 million people in the U.S. five years or older speak English less than 'very well.' Because of this inability to speak English 'very well,'

the form and manner of notice requirements should ensure that these individuals are able to understand notices from their insurers. This is particularly important because the ability to comply with these notices often has a direct affect on an individual's ability to access needed medical services. Although the uniform requirement for the individual and group market created by the Amendments to the Interim Final Rule would create a consistent standard, this consistency should not come at a cost to those with limited English proficiency.

The group and the individual markets have different characteristics that favor different approaches to adequately address the limited English proficiency traits of the population. While relying on county level data to determine the English proficiency of the population works well for those who obtain coverage in individual market, this method would be inadequate for a group plan that includes a defined population in which the population of individuals with limited English proficiency can be determined. As such, the Departments should adopt the July 2010 Interim Final Rule that set a 25 percent threshold for group plans that cover 100 people or less, meaning that such plans must provide notices in a culturally and linguistically appropriate manner if 25 percent of all plan participants are literate only in the same non-English language. For employers with more than 100 employees, the threshold should remain the lesser of 10 percent or 500 participants, as set forth in the July 2010 Interim Final Rule.

Recommendation #4: Adopt the July 2010 Interim Final Rule "tagging and tracking requirement."

While we recognize the need to "balance the objective of protecting consumers by providing understandable notices . . . with the goal of simplifying information collection burdens on plans and issuers," eliminating the requirement that plans and issuers track those individuals who request a document in a non-English language and send all future notices in the non-English language is unwise.

If a person has requested a notice or document in a non-English language, at the very least, that person should be given the ability at that time to receive all future notices and documents in non-English. Putting the additional burden on the individual to recognize that a specific notice or mailing is important to them and require them to request the document in an alternate language is overly burdensome for the individual and the potential harmful consequences of misunderstanding notices are just too great. For example, failing to comply with certain notices, such as missing deadlines or failing to provide additional information, can make the difference in whether individuals have access to needed medical care. Complying with the "tagging and tracking" requirement announced in the July 2010 Interim Final Rule would help ensure consumers obtain necessary information to proceed with their cases.

Recommendation #5: Adopt the July 2010 Interim Final Rule 24-hour requirement for expedited notifications for benefit determinations involving urgent care.

The 24-hour limit for notifications of benefit determinations for urgent care set forth in the Interim Final Rule strengthens consumer protections at this critical point of care. This shortened time limit decreases the time patients must wait to obtain needed medical care and potentially improves patient care and health care outcomes. Although the proposed Amendments to the July 2010 Interim Final Rule would require decisions to be made "as soon as possible" and sets the 72-hour limit to merely serve as a "backstop," we fear that far too many patients will be unnecessarily forced to wait the entire allowable 72-hour period and that their health and well being could suffer as a result. Because patients are already experiencing some heightened medical crisis while they await this required determination, the Departments should set a 24-hour backstop to protect patients from any unnecessary delay.

Recommendation #6: Adopt the July 2010 Interim Final Rule requirement that an individual be notified of the diagnosis and treatment codes and their meanings in instances when an insurer provides notice of an adverse benefit determination or final internal adverse benefit determination.

When an individual experiences an adverse benefit determination, the individual should receive all "information sufficient to identify the claim involved." This has long been an area of abuse by plans and insurers. Since 1974, ERISA has required specific reasons for a denial of benefits and plans and issuers largely ignored this requirement. DOL had to strengthen its regulations in 2000 to further make this requirement clear and Congress also had to require such in the Mental Health Parity Act of 2007. Since the associated diagnosis and treatment codes and their meanings could help individuals in identifying the claim involved, insurers should include this information in the notice of an adverse benefit determination as directed by the Interim Final Rule.

Unfortunately, the Amendments to the Interim Final Rule weakens this protection by requiring that individuals request this information rather than receive it automatically. If this takes effect, it will increase the burden on consumers attempting to take action to obtain health benefits they were denied. Because consumers should not be forced to carry this additional burden, the Departments should require insurers to automatically provide diagnosis and treatment codes and their meanings in notices of adverse benefit determinations.

We recognize that some groups have raised privacy concerns and encourage the agencies to create a rule that balances the need for privacy with the need for easy access to information needed to pursue an appeal.

Recommendation #7: Don't shorten the window for external appeals. Adopt the four-month time requirement for appeals of denied claims set forth in paragraph (c)(2) of the July 2010 Interim Final Rule.

The July 2010 Interim Final Rules would subject a plan or issuer to the Federal Review Process

if a State external review process does not meet the minimum consumer protection standards of a NAIC-similar process, which includes providing four months to file a request for external review after a claim is denied. However, the June 2011 Technical Release 2011-02 released contemporaneous to the June 2011 Amendments to the Interim Final Rule would not require this four-month window until after January 1, 2014. Instead, in the interim period, plans or issuers must only provide a two-month appeals window.

We strongly urge the Departments to allow claimants four months to file for an external review after their claim is denied. We believe it is unreasonable to temporarily shorten the time claimants have to file their appeal. If an individual receives this notice while struggling with complications of an injury or illness, or even upon exiting the hospital after an extended hospitalization, it will be easy for these two months to elapse before the individual is able to gather all of the necessary information and submit his or her appeal. As a result, many patients will likely miss the opportunity to appeal an insurer's erroneous decision and thus not receive the benefits they deserve and need.

This short time frame is especially problematic for those with limited English proficiency. Because individuals with limited English proficiency must request documents in languages other than English or wait for access to a consumer assistance program to help them understand a denial notice, many consumers could miss this time window.

Further, the high prevalence of reversal of claims denials in both existing internal and external review processes, as discussed under Recommendation #1, demands a longer time period to provide adequate opportunity for consumers to take action to protect their rights.

Conclusion

We recall that when encouraging the Senate to pass health reform, President Obama remarked in his weekly radio address on December 19, 2009 that independent external appeals are a key component of a Patients' Bill of Rights. He bemoaned the fact that the Patients' Bill of Rights was within reach roughly a decade ago, only "to fall victim to the same special interest lobbying that has blocked passage of health insurance reform for so many decades." But, Congress has now succeeded with the passage of the Affordable Care Act. We must now move forward with internal and independent, external appeals rights that protect patients' abilities to challenge an unfair decision by an insurance company. That's why we've joined together to send you these comments. While we greatly appreciate the regulations set forth to strengthen consumer rights, we believe more can and should be done, and request that in many areas the regulations revert to the stronger consumer protections set forth in the July 2010 Interim Final Rule.

Sincerely,

SANDER LEVIN
Member of Congress

GEORGE MILLER
Member of Congress

HENRY WAXMAN
Member of Congress

PETER STARK
Member of Congress

ROBERT ANDREWS
Member of Congress

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