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Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act

Comment On: IRS-2010-0021-0001
Group Health Plans and Health Insurance Issuers: Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act

Document: IRS-2010-0021-0007
Comment on FR Doc # 2010-18043

Submitter Information

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General Comment

New Yorkers for Accessible Health Coverage (NYFAHC) is a statewide coalition of 53 voluntary health organizations and allied groups who serve and represent people with chronic illnesses and disabilities, including mental illness for whom access to affordable, accessible comprehensive health coverage is essential to maintaining their well being. We appreciate this opportunity to comment on interim final rules implementing the Patient Protection and Affordable Care Act (ACA) provisions for group health plans and health insurance issuers regarding internal claims and appeals and external review processes.

We are pleased that states can now open their external review processes to self -insured plans and that self-insured pans can subject themselves to that process as a way of complying. New York has a highly successful external review program that is very well run by the State Department of Insurance. Advocates have worked to expand the scope of the program to more decisions, as PPACA will now allow, and also support the availability of the process to consumers in self-insured plans.
We do have a few concerns regarding the frequency, method, treatment or setting of recommended services; preventive services for women; and notice and appeal rights.

Adverse Benefit Determinations

The interim final rule does not clearly state that any adverse benefit determination eligible for internal review is also eligible for external review. The rules should be amended to include the denial of access to a specialist provider by a plan in the list of adverse benefit determinations which can be appealed. The Departments should also clarify how consumers can complain when they believe that a plan or issuer has made a decision that violates one of PPACA's new consumer protection provisions, like whether a plan meets the grandfathering criteria, or whether a young person is eligible for dependent coverage. The Department should release clear information about how consume

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Attachments

IRS-2010-0021-0007.1: Comment on FR Doc # 2010-18043

NYFAHC

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New Yorkers For Accessible Health Coverage

Member Organizations
American Association of Kidney Patients, New York chapter
American Cancer Society
American Diabetes Association
Brain Tumor Foundation
Cancer Care
Care for the Homeless
The Center for Independence of the Disabled, NY
Cystic Fibrosis Foundation, Greater New York chapter
Disabled in Action of Metropolitan New York
Epilepsy Foundation of Greater New York
Gay Men's Health Crisis
Hemophilia Association of New York
Huntington's Disease Society of America, New York and Long Island chapters
Interagency Council of Mental Retardation and Developmental Disabilities
Leukemia & Lymphoma Society, New York City chapter
Mental Health Association of New York City
Mental Health Association of Westchester County
National Alliance for the Mentally Ill – New York State
National Aphasia Association
National Marfan Association
National Multiple Sclerosis Society, Capital, Long Island, New York City, Southern, and Upstate chapters
New York AIDS Coalition
New York Association of Psychiatric Rehabilitation Services
SHARE: Self-Help for Women with Breast and Ovarian Cancers
SLE Foundation
West Islip Breast Cancer Coalition for Long Island

Cooperating Organizations
Alliance of Resident Theaters of New York
Brooklynwide Interagency Council of the Aging
Citizen Action of New York
Commission on the Public's Health System
Community Healthcare Network
Dance Theater Workshop
Greater New York Labor-Religion Coalition
Institute for Puerto Rican and Hispanic Elderly
Joint Public Affairs Committee for Older Adults
Lambda Legal Defense and Education Fund
Long Island Progressive Coalition
Medicare Rights Center
Metro New York Health Care for All Campaign
National Association of Social Workers, New York City chapter
New York State Health Care Campaign
New York State Nurses Association
New York State Psychological Association
New York Statewide Senior Action Council
Senior Services
Society for Hospital Social Work Directors, Metropolitan New York chapter
South Fork Community Health Initiative
William F. Ryan Community Health Center

September 21, 2010

Secretary Timothy Geithner
Department of the Treasury

Secretary Hilda Solis
Department of Labor

Secretary Kathleen Sebelius
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
P.O. Box 8016
Baltimore, MD 21244-1850

Attention: OCIIO–9993–IFC,

To Whom it May Concern:

New Yorkers for Accessible Health Coverage (NYFAHC) is a statewide coalition of 53 voluntary health organizations and allied groups who serve and represent people with chronic illnesses and disabilities, including mental illness for whom access to affordable, accessible comprehensive health coverage is essential to maintaining their well being. We appreciate this opportunity to comment on interim final rules implementing the Patient Protection and Affordable Care Act (ACA) provisions for group health plans and health insurance issuers regarding internal claims and appeals and external review processes.

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Adverse Benefit Determinations

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coverage. The Department should release clear information about how consumers can contest these decisions, and require health plans and insurers to inform consumers as well.

Notice and Information Issues

The model notices are well designed, and we are pleased to see that they include contact information for consumer assistance programs. The rules require an insurer or plan to include in the notice the reason or reasons for the adverse benefit determination, including a denial code, its meaning, a description of the standard, if any, used in the decision, and in the case of a final internal adverse determination, a discussion of the decision. We recommend that the consumers should also be provided with any guidelines of the plan or issuer relating to the subject matter of the dispute, regardless of whether they were relied upon in the determination.

Consumers should be given a copy of any materials submitted by the plan or issuer to the IRO for consideration in the external review. The plan or issuer should send a copy of the file to the consumer at the same time that it sends a copy to the IRO. The consumer should have 5 days to review the file and respond with evidence.

Finally, IROs or state agencies making external review determinations should be required to report the substance of each decision, in a redacted format to protect consumer privacy, so that consumers with an issue to appeal to research how similar disputes have been resolved.

Qualifications of reviewers

We support the Department clarification that Independent Review Organizations (IRO) used in state or federal external review processes must be accredited and follow clear standards to prevent conflicts of interest. These rules will greatly increase consumer confidence in the review process and produce fairer outcomes. The Department could improve on the rules, however, by ensuring that review of legal issues is performed by reviewers with legal expertise, and that reviewers of medical issues are experts in the particular field of medicine at issue.

Some decisions that will be presented for review by IROs are legal issues. For example, a case might present questions about whether a plan issuer has complied with state or federal law. IROs typically employ reviewers with clinical expertise, to review medical questions, but not legal expertise. While the technical guidance issued by the Departments of Labor and Health and Human Services regarding interim procedures for federal external review in the group and individual markets require external reviews to be conducted by reviewers with legal and clinical expertise,[1] the interim final rules do not indicate that IROs employed in state review must have legal experience. To ensure that these questions receive appropriate review, the Department should direct cases with legal issues to state or federal regulatory agencies, or require IROs to employ reviewers with legal expertise.

We also recommend that the Department include strict standards for medical reviewers employed in external reviews, similar to the standard found in the NAIC Model Act. The act specifies that the reviewer must be an expert in the treatment of the covered person's medical condition that is the subject of the external review, and must be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition.

Standards of Review

We urge the Department to clarify that a state external review process must provide for de novo review of adverse benefits decisions. Additionally, the external reviewer should be able to consider the best interest of the consumer in making a determination.

The NAIC Uniform Health Carrier External Review Model Act specifies that "the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process . . . or the health carrier's internal grievance process. . ."[ii] Similarly, the technical guidance issued by the Departments of Labor and Health and Human Services regarding interim procedures for federal external review in the group and individual markets state that an examiner will "review the claim de novo and not be bound by any decisions or conclusions reached during the plan's [health insurance issuer's] internal claims and appeals process" in reaching a decision.[iii]

We assume that the Department's requirement that a state external review process provide at a minimum the consumer protections of the NAIC Uniform Model Act includes the de novo standard. We urge the Department to make this requirement explicit through further guidance.

Additionally, the reviewer should be allowed to consider the best interest of the consumer in making a determination. New York state's statute requires that an "external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the health care plan acted reasonably and with sound medical judgment and in the best interest of the patient."[iv]

Consumer assistance and representation

We support the Department's decision to require plans or issuers to include in appeals notices information about government agencies and consumer assistance programs or ombudsprograms that can assist them with their appeals. The Department should also provide telephone and website or e-mail contact information prominently on the notice. The model notices should also explain to consumers when their health care provider can act as an authorized representative for the consumer in the appeals process. We urge the Department to make the interim final rules more explicit about a consumer's right to representation in an appeal. NYFAHC supports the awarding of fees to consumer representatives when decisions are reversed.

NYFAHC

NAIC minimum consumer protections

The interim final rules designate a list of consumer protections found in the NAIC model act as the "minimum standards for State external review processes. We believe that the following consumer protections, also found in the NAIC model act, are also essential minimum standards that should be added to the regulations:

- Consumers have the right to file internal and external appeals simultaneously for expedited review
- The standard of external review is de novo
- The carrier must immediately act to implement a reviewer's decision
- The IRO must consider medical records, attending professional's recommendation, consultant reports, and practice guidelines in addition to carrier's criteria
- Consumers have the right to be represented by someone the consumer has designated in writing
- Besides being accredited, an IRO must meet time frames for review; have qualified reviewers with relevant medical expertise and no conflicts of interest and no disciplinary history; maintain confidentiality; and have a phone system capable of receiving information at all hours and instructing callers.

We appreciate this opportunity to comment these interim final rules. Thank you for your attention in this matter and don't hesitate to contact me at 646.442.4147 or hseigfried@cidny.org should you have any questions.

Sincerely,

Heidi Siegfried, Esq.
Program Director

[i] U.S. Department of Labor, Technical Release 2010-01, August 23, 2010; Department of Health and Human Services, Technical Guidance for Interim Procedures for Federal External Review Relating to Internal Claims and Appeals and External Review for Health Insurance Issuers in The Group and Individual Markets under the Patient Protection and Affordable Care Act.
[ii] NAIC Uniform Health Carrier External Review Model Act Section 8(D)(2).
[iii] U.S. Department of Labor, Technical Release 2010-01, August 23, 2010; Department of Health and Human Services, Technical Guidance for Interim Procedures for Federal External Review Relating to Internal Claims and Appeals and External Review for Health Insurance Issuers in The Group and Individual Markets under the Patient Protection and Affordable Care Act.
[iv] New York State Insurance Law § 4914(b)(4)(A).