September 20, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCII0-9993-IFC
P.O. Box 8016
Baltimore, Maryland 2124

Re: Interim Final Rule regarding health appeals process for group health plans and individual health insurance coverage in the group and individual markets.

Via online submission

Overview

The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable, high-quality health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives. We have 21 years of experience providing education and counseling to Medicare consumers.

We thank you for the opportunity to comment on the proposed rules concerning the appeals process for Group Health Plans. Our comments are based on our experience assisting Medicare consumers with insurance appeals and our observations of the appeal structure in Medicare. While these rules do not affect Medicare directly, we believe that our experience with Medicare appeals gives us unique real world experience with appeals process and provide important lessons to be learned.

Medicare Rights is encouraged by the consumer protections included in the interim final rule. More specifically, Medicare Rights is pleased to see that plans or issuers throughout the appeals process are required to provide insurance consumers with any new or additional evidence considered, relied upon or generated by the plan or issuer in connection with the adjudicated claim. Moreover, we are encouraged to see that before the plan or issuer can issue an adverse benefit determination based on new evidence the plan must provide the rationale and the rationale must be provided quickly so that an insurance consumer has the opportunity to respond. In Medicare, such notice is not required and it creates significant barriers in the appeals process. It is difficult, if not

impossible, for consumers to be successful in an appeal if they are not provided with adequate notice about the basis of the denial and questions about evidence at each level of appeal.

But while there are many protections included in the proposed rule, there are improvements that can be made. Please find our comments below.

Should you have any questions or require additional information, please contact Doug Goggin-Callahan, Client Services Counsel, at 212-204-6275 or dgoggincallahan@medicarerights.org or Ilene Stein, Policy Counsel, at 202-637-0961, ext. 5, or istein@medicarerights.org.

Comments

Continued coverage during the appeals process (45 CFR §147.136(b)(2)(iii))

We appreciate that health insurance consumers will have continued access to their prescription medications and treatments during the appeals process. However, we are concerned that beneficiaries are not fully informed of the financial consequences if the appeal is lost. For example, if a consumer were to lose an appeal, the insurer could recoup payments for drugs the company made on a consumers behalf. It is important that consumers understand that they may be responsible for the entire cost of a prescription filled during the appeals process if they are unsuccessful in their appeal.

We believe that insurance plans should waive the cost of coverage received during the appeals process if the consumer loses the appeal. In the alternative, we believe that consumers must be provided with explicit notice of their financial responsibility for coverage received during the appeals process should they lose their appeal. In addition, Agencies should consider guidance to provide consumers the option of a payment plan if they lose an appeal and the insurer recoups past payments. The cost of drugs can be extremely expensive and consumers should have the opportunity to pay a plan money owed over time to alleviate potential financial burdens.

Levels of internal review (45 CFR §147.136(b)(3)(ii)(G))

The interim final rule requires a health insurance plan offering individual health insurance coverage to provide only one level of internal appeal before issuing a final determination, however, this requirement does not apply to group health plans. We are unclear why this distinction is made; moreover, we believe that both group health plans and individual plans should only have one level of internal review.

In our experience with Medicare consumers, the second level of plan review is no more thorough than the first. It serves as an additional delay before the final resolution.

Health appeal deadlines (45 CFR §147.136(b)(3)(ii)(B))

We are pleased to see that plans must notify consumers of decisions regarding urgent care within 24 hours, rather than 72 hours. We ask that the final rule make clear that decision deadlines are counted in calendar days rather than business days. Our experience with Medicare consumers suggests that without clarity plans will weaken consumer protections by assuming business rather than calendar days.

Escalation to the external reviewer (45 CFR §147.136(b)(2)(ii)(F))

As drafted the interim final rule allows a consumer to escalate his or her appeal to the external review entity when the plan fails to comply with the applicable deadlines. We support the consumer's right to escalate their appeal, however, we believe health plans should be required to automatically escalate appeals. While allowing a consumer to escalate an appeal provides an important safety net for when plans fail to do so, which is often the case in the Medicare context, the burden to escalate should be on the plan as they are the entity that has failed to follow the law.

Medicare Advantage and Medicare Advantage Drug plans are required to submit the appeal to the external review entity if they fail to comply with applicable timelines. This is advantageous for Medicare consumers. Many consumers are unaware of the applicable appeal deadlines for plans; moreover, they are unaware that the plan's failure to issue a decision constitutes a de facto denial and thus entitles them to send an appeal to the Independent entity.

In addition to automatically escalation for expired appeals, we ask that the final rule provide for automatic escalation of denials. Medicare Advantage plans are required to automatically escalate denials to the external review entity.

Fees charged to beneficiaries (45 CFR §147.136(c)(2)(iv))

The interim final regulation allows the imposition of a filing fee upon consumers seeking access to the external review entity. Although the rule states that consumers are reimbursed that amount if they win their appeal, we object to the imposition of the fee. In our experience with Medicare consumers, individuals are reticent to appeal for many reasons including poor health, fear of adverse repercussions and a lack of understanding of the appeals process. Any additional barrier will do nothing but further deter consumers from exercising their legal right to appeal.

If the Secretaries determine that such a fee is absolutely necessary, we request that the fee be waived if a consumer demonstrates financial hardship. Moreover, we believe a consumer should be able to make such a showing through self-attestation. There is precedent for the use of self-attestation of financial hardship in other administrative processes.

Explanation of external review decisions

The interim final regulation requires plans and issuers to provide very specific information when issuing an adverse benefit determination. We believe similar information should be provided by either a state or federal external review process. This information should include the basis upon which the decision was made including medical, legal or other standards. In our experience explanations, which lack clarity, specificity and reference to the basis of the decision cause great confusion. The lack of specificity in Medicare decision notices, provided by both plans and Original Medicare is a substantial hurdle for many of the consumers who we assist in the appeals process. If consumers are unable to determine why a decision was made, they are more likely to delay appealing the decision and consequently, miss their appeal deadlines.

Independent review organizations

We are concerned that the Independent Review Organizations (IROs) have the capacity to decide the full range of issues that arise in appeal. Questions about a plan or issuer's adherence to its contract should be immediately elevated to the appropriate state or federal court. In our experience, the independent reviewer is comprised of clinical reviewers; questions of state and federal law are beyond the purview of these reviewers expertise.

We also suggest that the Independent Review Organization's name be changed to the Independent Review Entity (IRE). In Medicare, the external reviewing entity is know as the IRE. Consistency between the appeals process for non-Medicare plans and Medicare plans will help ensure that as consumers age into Medicare they are more familiar with the Medicare appeals process.

Cultural and linguistically appropriate notice

Overall, we are pleased with provisions relating to the notice provided to consumers. We are, however, very concerned that a footnote would allow plans to provide determinations relating to urgent care in English, so long as follow-up notice is provided in an individual's non-English language. This exception is very troubling, particularly because it relates to consumers who need the item, service or medication most urgently. As aforementioned, consumers who do not understand why the service was denied are more likely not to appeal the decision. More pointedly, we do not believe the English determination meets federal notice requirements. Therefore, the appeals deadline clock cannot start until legally valid notice is provided by the issuer or plan.

We thank the agencies for the opportunity to submit comments.

Sincerely,

Ilene Stein, Esq.
Policy Counsel

Doug Goggin-Callahan, Esq.
Client Services & Program Counsel