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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-2010-0021-0012
Comment on FR Doc # N/A

Submitter Information

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Government Agency Type: State
Government Agency: non-profit

General Comment

Please accept the following submission regarding Interim Final rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Process under the Patient Protection and Affordable Care Act.
If you have any questions, please contact Beth Capell at (916) 497-0760 or bcapell@jps.net
Thank you.

Attachments

IRS-2010-0021-0012.1: Comment on FR Doc # N/A

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 Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210
Attention: RIN1210-AB45

Re: Interim Final rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Process under the Patient Protection and Affordable Care Act
RIN 1545-BJ63, RIN 1210-AB45, and RIN 0991-AB70

Dear Secretaries Geithner, Solis and Sebelius:

Health Access California, a coalition of more than a hundred consumer, community and other groups committed to quality, affordable health care for all Californians and the organizational sponsor of HMO reform implemented in California more than a decade ago, offers comments on internal appeals and external review under the Affordable Care Act.

Health Access recognizes that there are many important provisions of the proposed rule that will provide important protections to consumers in other states as well as Californians whose care is regulated by the Department of Labor rather than the California Department of Insurance or the California Department of Managed Health Care. In 1999, California adopted the HMO Patient Bill of Rights, including independent medical review and standards for internal appeals. These protections have functioned well for over a decade: we were the organizational sponsor of these measures and have continued to monitor their implementation over the last decade. We offer these comments based on that experience.

Internal Appeals

Under existing California law, internal appeals must be completed within 30 days. This requirement has been in place, protecting consumers for over a decade. Health plans

and carriers have generally complied with it. We see no reason why 45 days is necessary, even for employer-based coverage.

The language in (E) (2) requires that the Notice include "the denial code, its corresponding meaning, as well as the plan's or issuer's standard." We agree that an insurance company code is not sufficient for anyone except an insurer (or the clerk in the provider's billing office). However, we believe that the section should be strengthened by the specification that the internal and external appeals notices must contain a **plain language** statement of the reasons for the denial of care or benefits. It is all too common for the notice language or so-called explanation to contain insurance and/or medical jargon that serves as a deterrent to the consumer's understanding of the reason for the decision or actually filing a grievance or appeal. In addition, insurers must be required to make available to consumers and their providers whatever documents the insurer relied upon in denying the claim in whole or in part.

External Appeals

- Grounds for appeals, qualification of reviewers

We support the provisions of the proposed rule that require external review for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit. While technically California law is limited to disputes based in whole or in part on medical necessity, in practice some of the disputes that have been resolved through independent medical review have involved settings, levels of care or effectiveness of a benefit. For such reviews, it is important that reviewers have not just clinical expertise but clinical expertise relevant to the care at issue. For example, it makes no sense to have a podiatrist review a dispute over back surgery or cancer therapy.

We also support including in external review any adverse benefit determination, including rescission, denials or exclusion for pre-existing conditions and determinations of whether care or service is a covered benefit. Assertions by insurers about covered benefits, rescission, and exclusions of pre-existing condition may be used as a means to deny medically necessary or appropriate care. Sadly in California, a series of disputes involving care for children with autism were initially determined to encompass medically necessary care but were later found by the Department of Managed Health Care not to be "covered benefits" and thus not subject to external review. Similarly reconstructive surgery of an ear for a child born without an ear was found not to be a covered benefit because it was regarded as cosmetic surgery rather than reconstructive surgery. Each of these instance raised both legal and clinical questions.

Health Access supports expanding external review to any adverse benefit determination. We also support assuring that reviewers have relevant expertise, both clinical expertises relevant to the case at hand as well as legal expertise for those cases such as rescission and covered benefits where legal expertise is relevant.

- Urgent appeals

For more than a decade, California provided for urgent appeals within 24 hours where there is an imminent and serious threat to the health of the enrollee. This is a standard that can and should be met to protect patients.

- No cost for appeal

Health Access strongly opposes any cost to the consumer for an appeal. Study after study demonstrates that consumers are hesitant to complain. Indeed in California which precludes fees or costs to consumers for filing appeals, less than 1% of those who have the right to independent medical review have ever exercised that right. Given the infrequency of appeals, there is no reason to impose further barriers by charging fees. While $25 may not seem like much money to insurance company executives making hundreds of thousands or millions of dollars a year, to anyone making less than the median income it is real money and a real barrier.

- Standard for review

Health Access respectfully suggests that the rules should set a standard for review for claims of medical necessity. Here is the standard that has been used in California for over a decade:

Section 1374.33 (b) of the Health and Safety Code:

(b) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the enrollee and any of the following:
(1) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
(2) Nationally recognized professional standards.
(3) Expert opinion.
(4) Generally accepted standards of medical practice.
(5) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

This standard takes into account both the needs of the individual ('the specific medical needs of the enrollee") and the evolving standards of science as well as the opinions of experts. Unlike many definitions of medical necessity, it does not preclude care for those with degenerative or incurable conditions such as multiple sclerosis.

- Conflicts of interest

Health Access strongly supports the suggested protections against conflicts of interest by reviewers both internal and external.

Health Access suggests the rule would be improved by requiring each state to contract with and pay the external reviewing organization, using fees imposed on carriers to

support this activity. If an insurer can pick the reviewing organization and pay it, the insurer will call the tune. This is industry self-regulation and is bound to fail. Even the best of conflict of interest cannot prevent a reviewing organization from being responsive to the needs of the customer—and for that reason alone, the customer should be the regulator, not the insurer.

- Provision of evidence to consumers

Health Access supports the requirement that any documents that are provided to the reviewing organization must also be provided to the consumer. Prior to the enactment of law requiring this, there were numerous abuses in California in which the insurer picked the reviewing organization and then drowned the reviewer in documents to which the consumer and the consumer's physician had no access.

- Binding on insurer

The section that enumerates the minimum standards for state external review processes requires that the decision is binding on the insurer (or plan). The requirements in California law provide that independent medical reviews are binding on the insurer. In addition, when a health plan failed to comply promptly, the Department of Managed Health Care fined that plan or undertook other significant administrative remedies. We urge that similar sanctions be provided for insurers that fail to comply with the decision of a reviewing organization.

- No weakening of California law

In a number of respects, California law works better for consumers than the proposed rule. In those instances, our preference is for California law to remain in place. In the ensuing discussion of the implementation of health care reform, some industry representatives continue to argue in favor of a national standard to simplify the administration of this new law. While the federal law will introduce new policies and consumer protections, in some cases existing state laws already afford those protections, or are even more protective that the federal law. We urge that the regulation clearly enunciate the responsibility of the states to guarantee consumers the rights contained in this legislation without infringing on the broader or more protective language in existing state statutes.

- State compliance by 7/1/11.

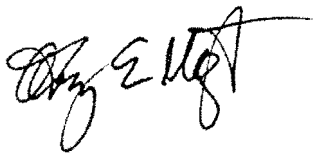
Under California law, grievances denied in whole or in part on medical necessity are subject to independent medical review. To the extent that the proposed rule requires review on other grounds, it may necessitate a change in California law.

Unfortunately, to change California law prior to July 1, 2011 would require a two-thirds vote majority of our legislature as well as the signature of the Governor. While it would be our hope that a substantial majority of legislators would support such basic patient protections, we have no assurance that this will be the case and much reason to be

skeptical. This deadline may be reasonable in states where a super-majority is not required for urgent legislation or where the legislative session is concluded prior to July 1. A deadline of July 1 may have the effect of weakening the very patient protections this rule is intended to provide. We would urge that for states such as California where urgent action prior to July 1 requires extraordinary majorities, we be given until January 1, 2012. We would also suggest that the Secretary through a waiver process could take into account the fact that California has a functioning independent medical review process that meets or exceeds most but not quite all the provisions of the proposed rule so that California is allowed time to come into full compliance in recognition of the legislative barriers we face and the considerable compliance that already exists.

If you need more information or have questions, staff should contact Beth Capell, Capell & Associates, at (916) 497-0760 or Elizabeth Abbott on my staff at (916) 497-0923, ext. 201.

Sincerely,



Anthony Wright
Executive Director