September 21, 2010

Office of Consumer Information and Insurance Oversight
U.S. Department of health and Human Services
ATTN: OCIIO-9993-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

**Re: Interim Final Rules for Appeals of Health Insurance, 75 Fed. Reg. 141, 43330 (July 23, 2010) (to be codified as 26 CFR pts. 54 and 602; 29 CFR pt. 2950; and 45 CFR pt. 147)**

Please accept these comments from Community Catalyst, Health Care for All (HCFA), and Health Law Advocates (HLA), on the above referenced regulations issued by the Departments of the Treasury, Labor and Health and Human Services. HCFA seeks to create a consumer-centered health care system that provides comprehensive, affordable, accessible, culturally competent, high quality care and consumer education for everyone, especially the most vulnerable. We work to achieve this as leaders in public policy, advocacy, education and service to consumers in Massachusetts. Health Law Advocates (HLA) is a public interest law firm whose mission is to provide *pro bono* legal representation to low-income residents experiencing difficulty accessing or paying for needed medical services. Community Catalyst is a national non-profit advocacy organization working to build the consumer and community leadership that is required to transform the American health system through fully engaged consumers who have an organized voice. The interim regulations would give healthcare consumers the right to appeal denials of coverage to insurers and, if necessary, external review boards. We thank the Departments for promulgating these regulations so that we can have “a more

uniform, rigorous, and consumer-friendly system of claims and appeals processing that will provide a broad range of direct and indirect benefits that will accrue to varying degrees to all of the affected parties".[1] These appeals regulations will ensure that healthcare consumers receive the benefits they paid for and get the health care services they need.

Community Catalyst, HCFA and HLA are located in Massachusetts, which adopted a similar regulatory procedure.[2] HCFA and HLA worked closely with State regulators to ensure that the appeal and grievance procedures provided maximum consumer protections. These State regulations greatly benefit healthcare consumers. Prior to the implementation of the State requirements, HLA often assisted consumers who lacked any avenues of challenging coverage denials other than litigation. Adding an appeals process increased access to healthcare, especially with regard to lower-income consumers, while also reducing legal costs.

Over the past five years, when Massachusetts health care consumers appealed health plan denials to an external review board, the health plan's decision was overturned 39% of the time. This represents a significant amount of consumers who likely would otherwise gone without a needed medical service or faced enormous financial hardship by paying out of pocket. Also, in 2008 (the year of the most recent available statistics), Massachusetts consumers filed 9,800 internal appeals with fully insured health plans. Though data on the outcome of theses appeals is not readily available, the sheer number of appeals filed demonstrates that consumer dissatisfaction with health plan coverage determinations is commonplace and the appeals process provides an important measure

[1] 2. PHS Act Section 2719- Claims and Appeals (c. benefits).
[2] 105 Code Mass. Regs. § 128.001 *et seq*.

of recourse. Based on this experience, the federal regulations would have a similar beneficial effect.

While these regulations only apply to non-grandfathered plans, we encourage states and carriers to modify their review procedures for grandfathered plans as well so that all consumers have the same rights to appeal decisions.

In this context, Community Catalyst, HCFA, and HLA propose clarifying consumer rights in the following areas: (A) penalizing non-compliance; (B) internal appeals process; (C) strengthening the minimum requirements for external review processes; (D) Federal external review process

**A. Penalizing Non-Compliance**

The HHS' interim regulations state that, if a group health plan or health insurance issuer fails to comply with any of the regulatory requirements, the claimant is deemed to have exhausted the internal claims and appeals process. 45 C.F.R. § 147.136(b)(2)(ii)(F). We propose that the claim at issue should be deemed admitted if an issuer fails to comply with a regulatory requirement. This would more properly align an issuer's incentives.

In particular, an issuer may view the HHS' requirements as costly or burdensome. This gives the issuer an incentive to not comply with requirements in order to reduce its cost. No incentive for compliance exists, however. Whether or not the issuer complies with the requirements, the claimant's only remedy for a denied claim is to file an appeal with an external review board. Deeming a claim as admitted if an issuer fails to comply with the appeals requirements encourages compliance.

We realize that this proposal creates a risk that an issuer may have to pay additional claims. Failure to treat claims as admitted due to non-compliance, however,

creates a risk that issuers will avoid compliance in order to cut costs. Since the purpose of the HHS' interim regulations is to protect healthcare consumers, it is appropriate to penalize an issuer for non-compliance. Moreover, the external review process mitigates any risks to issuers.

**B. Internal Appeals Process**

These interim regulations provide a more defined internal appeals process than was previously available to consumers. This appeal process must occur in each carrier and comport with certain requirements. We appreciate the Departments' efforts in developing this process to include rescission as an adverse benefit determination so that it can trigger an external, independent review. We understand that in the past, rescission has been treated as an administrative determination and additional rights were withheld from healthcare consumers. This change will benefit numerous individuals wrongfully terminated from their coverage. We also appreciate the Departments' recognition that urgent claims require a more timely appeal by requiring determinations be made within 24 hours as opposed to 72 hours. For an individual in a crisis, even a few hours can make an enormous difference in their ability to get and continue receiving appropriate care.

*Noticing and information provisions*

These interim regulations reinforce the DOL policy that the claimant may receive, free of charge, any new or additional evidence relied upon by the plan or issuer, in connection with the claim. A claimant is only able to fully exercise her rights when she has seen all of the evidence in favor and against her appeal. This provision affords a claimant this option. Along with requirements regarding information, these interim

regulations require that all notices be culturally and linguistically appropriate. We recommend that the Departments be as clear as possible with these noticing requirements. It is possible that a plan or issue would just provide a 'babel card' recommending that the claimant get the document translated from English into the claimant's native language. This might not result in a fair, equitable process for the claimant. Additionally, appeals notices have traditionally been written using complicated insurance terms. These notices are complicated and confusing for claimants. The Departments should clarify that the notices need to be written at a 4th Grade reading level and then provide draft language to plans and issuers of these notices to ensure they are readable.

*Coverage pending appeal*

These interim regulations provide for coverage pending outcome of the appeal. This provision is of special significance for healthcare consumers who are engaged in ongoing treatment for their condition. Coverage pending appeal affords a consumer the relief that they will not be bombarded by bills as they work through their appeal. Additionally, since a significant portion of appeals are found in favor of the consumer (sometimes upwards of 60%), this prevents duplicate payment by the carrier and the consumer and eliminates the hassle of the consumer obtaining a refund.

**C. Strengthening External Review Requirements**

The HHS' interim regulations state that, if an issuer denies a claim, the claimant may appeal the denial under a State's external review process. 45 C.F.R. § 147.136(c). The interim regulations also set forth the minimum requirements for an external review process. 45 C.F.R. § 147.136(c)(2). We appreciate that the Departments have emphasized the need for the external review to be independent and impartial because

healthcare consumers deserve fair reviews. Community Catalyst, HCFA and HLA propose several changes to strengthen these minimum requirements: clarification of the notice of appeal rights; allowing the IRO to request information necessary for a fair decision; requirements for external appeals; and written notice of decision.[3]

*Clarify notice of appeal rights*

These regulations require plans and issuers provide notice to enrollees of their right to appeal a decision for external review. The regulations do not, however, specify the nature in which this notice should take. This notice should be clear and in a manner intended to be understood by the claimant. Ideally, the plan or issuer should include the form with which the claimant could file a claim with the external review entity to facilitate the appeal for the claimant.

*Allow the IRO to request information*

One of these requirements is that a claimant must be allowed five days to submit additional medical records or information and that the reviewing entity must consider this information. 45 C.F.R. § 147.136(c)(2)(x). It does not appear though that a reviewer can request additional information on its own. This is problematic as a pro se claimant simply may not be able to identify all medically relevant information. The Massachusetts regulations solve this problem by authorizing a reviewer to request "such additional information or documentation as [it] deems necessary to render a decision." 105 Code

[3] The interim regulations also provide for a Federal external review process in situations where no applicable State process exists. 45 C.F.R. § 147.136(d). The HLA's proposal also applies to the Federal review process as it does not differ substantially from the required State process.

Mass. Regs. § 128.412. We propose that the Departments add a similar minimum requirement for State review processes.[4]

*Requirements for external review of appeals*

These regulations requested comment on the requirements for external review of appeals. The requirements listed all serve the same goal of providing a fair process for healthcare consumers. We recommend that the regulations allow six months, or 180 days, for a claimant to file an external appeal. This will mirror the NAIC model act as well as numerous state laws that allow for this additional time. A claimant or her family is likely dealing with health-related challenges at the same time as her appeal is pending. A claimant should be allowed to take the time needed to deal with his or her medical care without fear of time running out for her external review.

*Written notice of decision*

In addition, the interim regulations require an external reviewer to provide written notice of its decision. 45 C.F.R. § 147.136(c)(2)(xii). The regulations do not, however, appear to explicitly require a reviewer to provide a written decision to all parties or describe what such a decision must contain. The Massachusetts regulations require a reviewer to provide a written final decision to the parties. In addition, this final decision must "set forth the specific medical and scientific reasons for the decision." 105 Code

[4] The HHS' interim regulations also incorporate the consumer protections contained in the National Association of Insurance Commissioner's Uniform Health Carrier External Review Model Act ("NAIC Uniform Model Act"). 45 C.F.R. § 147.136(c)(1). Even if the NAIC Uniform Model Act authorizes reviewers to request medical information, explicitly stating in the regulation that this authority exists would minimize possible confusion.

Mass. Regs. § 128.415(B). We propose that the Department add similar minimum requirements for State and Federal review processes.

**D. Federal external review process**

These regulations also provide guidance regarding the Federal external review process, which will apply to those plans not governed by the States. The Federal external review process should apply to as many plans and issuers as possible so that as many consumers as possible can be protected. Specifically, the Federal external review process should apply to any plan or issuer for whom the state external review process does not apply. The regulations also require that the notice provided to claimants be sufficient. We recommend that the Departments clarify that electronic notice and phone calls (not voicemails) may be considered sufficient notice and that these forms of notice should be evaluated.

These regulations also require that the appeals review notices be culturally and linguistically appropriate.

*Cultural and linguistic appropriateness*

The noticing requirements allow for two different processes for non-English notices based on whether the claimant is in the group or individual market. While we understand that these two markets have some differences between them, the linguistic noticing requirements should not be different. In addition to the administrative complexity this creates, it does not take into account jurisdictions for whom the insurance markets are merged. More importantly, the standard of 10% of the population residing in

a given county is more than sufficient for the group market as well and no differentiation is needed.

We appreciate the opportunity to comment on this interim final rule and would be pleased to provide additional information in any of these areas. Please contact Michael Miller at mmiller@communitycatalyst.org (617-275-2924) or Georgia Maheras at gmaheras@hcfama.org (617-275-2922) should you have any questions.

Thank you,

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