September 21, 2010

Ellen Kuhn
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Attention: OCIIO-9993-IFC

Dear Ms. Kuhn:

The undersigned organizations are devoted to the health of children and appreciate the opportunity to submit this comment on the Group Health Plans and Health Insurance Issuers Relating to the Internal Claims and Appeals and External Review Processes Interim Final Rule with Comment Period (the Interim Final Rule). We strongly support the consumer protections contained in the Interim Final Rule, but would respectfully suggest changes that we believe will improve the Rule's impact on children. In particular, we urge that the Departments of Health and Human Services, Labor, and Treasury (the Departments) consider modifying the rule by encouraging that pediatric experts be consulted in internal appeals and external reviews; encouraging that the child's medical home (or primary care physician) be informed of the result of appeal and review, if the family agrees; and including all of the consumer protections from the National Association of Insurance Commissioners Model Act.

The Affordable Care Act includes numerous consumer protections that will improve the opportunity for families to access the care that their children need. In particular, if insurance coverage is denied for a particular clinical intervention, children and their families will have the opportunity to access an appeal of that decision, followed by an external review. Overall, we view the Interim Final Rule as very positive for children, families, and consumers, and we believe that establishing federal standards will improve access when children are denied coverage for services that their families rightfully believed were covered by their insurance.

In particular, we support the Departments' decision to require linguistically and culturally competent outreach to families, the shifting of the burden to the insurer to comply with all rules related to internal appeal before triggering an external review, the requirement to continue coverage pending the outcome of an internal appeal, and the decision to allow only one level of internal appeals in the individual market before triggering an external review. In addition, the requirement to provide a decision in the case of coverage for urgent care within 24 hours (as opposed to 72 hours as previously required) will likely help many families find ways to get their children the care that they need in situations that could pose serious risks to a child's immediate health and well-being.

Beyond this, we would respectfully recommend the following changes. First, we would urge that primary care and subspecialty pediatricians and maternity care experts be included in any

internal appeals and external review process. While the National Association of Insurance Commissioner's (NAIC) "Uniform Health Carrier External Review Model Act" (the Model Act) Section 8(H)(3) requires that appropriate health care professionals be consulted in regards to external review, it is unclear whether pediatric or obstetric expertise must be included. Children are not little adults, and the appropriate standard of care for pediatric medicine is often quite different than for adult medicine. Fewer studies have been conducted in children, and thus many drugs are used off-label. Clinical interventions are less frequently tested in double-blind or randomized controlled trials in children than in adults. What may appear to be inappropriate for adults can be medically necessary for children. In addition, the care of pregnant women is also important and very different than care for other populations. We would urge the Departments to consider requiring that an expert in maternity care also be included in internal appeals/external reviews in order to ensure that the unique health needs of pregnant women are addressed. Internal appeals and external reviews must adequately reflect the reality that these populations require special considerations, and we would urge that pediatric primary care and subspecialty pediatricians and obstetric experts be included in any internal appeal and external review process authorized by the federal government.

Additionally, we would urge that the Departments contemplate the value to children's families of informing a child's medical home (or primary care physician) of any benefit determination – whether adverse or not – if the child's family has granted approval to do so. Providers advocate for their patients and interact with insurance plans much more frequently than do patients and patients' families. Thus, informing the child's medical home of insurance decisions may increase the effectiveness of advocacy for pediatric patients' needs and streamline their treatment.

Thirdly, we would urge that all of the consumer protections from the NAIC Model Act be applied to state external review laws. We can think of no reason (unless one of these structures does not help the consumer in practice) that some of these structures should be excluded and others included. In particular, requiring that insurers produce reports on the frequency and type of internal appeals and external reviews (as required by Sec. 15(B)) could be an important component of plan quality; consumers may want access this information through the state web portals associated with the Exchanges. Posting this information on-line should allow families and consumers to make better-informed decisions before deciding which insurance plan to purchase for their families. Additionally, it is unclear why there are no references in the Interim Final Rule to the utilization management, preauthorization, and the applicable medical necessity criteria used by many insurers. Appropriate references to these common insurance structures could benefit children as these structures may give families the peace of mind that their children will get the services they need prospectively. Finally, it may be appropriate to request that Independent Review Organizations submit their reports to HHS as well as to State Insurance Commissioners. By providing these materials to HHS, the Secretary (and in particular the Office of Consumer Information and Insurance Oversight) would have the data needed to reflect appropriate information for consumer use.

We would also note that the Essential Benefits package for children with Exchange coverage will expressly include dental and vision care. Thus, we would urge the Departments to work with the NAIC to update the Model Act's Section 4.B "Applicability," to include these types of coverage

in the definition of insurance to allow a beneficiary the opportunity for external review. It appears that if these types of coverage are not included, external review for adverse determinations regarding vision and dental coverage may not be available to children and their families.

In regards to the Departments' invitation for comment regarding state level carve-outs of insurance structures that are not required to abide by external reviews, we would urge that all plans be required to provide access to the external review process. In the example in the Interim Final Rule preamble, it is noted that some states may choose not to require HMOs to follow all of the external review rules applicable to other insurers. If states do not correct this situation, we believe that the federal government should step in as it will be easier for consumers and providers to access a uniform process that is well-established. This policy will also spur states to provide applicable consumer protections from the NAIC Model Act to all of the insurance plans in the state, some of which the Departments have, surprisingly, failed to include.

In regards to the Departments' invitation for comment regarding cultural and linguistic effectiveness, we would urge the Departments to apply a more stringent standard than the Medicare Advantage standard. The Interim Final Rule would require individual market plans to provide non-English language materials if the proportion of literate non-English speakers is 10% or higher in each county covered by the plan (this appears to be the Medicare Advantage standard).

We would urge the Departments to consider the realities of children in non-primary English speaking households. Children are in proportionately non-English speaking households more often than any other age cohort, and unfortunately, they can often be forced to serve as translators for parents. Children in U.S. households where English is not the primary language experience multiple disparities in health care.[1] Children in non-English primary language families are almost three times more likely to have had no usual source of care (USC), and their parents are more likely to report that their child's USC never/sometimes spends enough time with the child, never/sometimes explained things in an understandable way, and never/sometimes was able to provide needed telephone help or advice.[2] Perhaps of greatest significance in regards to internal appeals and external reviews is that these children already have significantly more difficulty accessing specialty care, presumably the most common type of coverage denied leading to appeal/review. This significant difficulty in obtaining specialty care affected approximately two thirds of Asian/Pacific Islander children, half of white children, and one third of Latino children.[3]

Application of the Medicare Advantage standard to this population becomes even more difficult to justify as pediatric enrollees in Medicare Advantage are likely non-existent.

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[1] Flores, Glenn, MD and Sandra C. Tomany-Korman, MS, "The Language Spoken at Home and Disparities in Medical and Dental Health, Access to Care, and Use of Services in US Children," PEDIATRICS Vol. 121 No. 6 June 2008, pp. e1703-e1714 (doi:10.1542/peds.2007-2906)
[2] Id. at e1706.
[3] Id. at e1706-e1707.

Clearly, the special needs of this population call for a more stringent standard to allow families a reasonable chance to succeed in appealing an adverse determination. We would urge that the proposed standard be lowered significantly to give children that are denied coverage a chance to have their parents/guardians and their medical homes (or primary care physicians) more effectively advocate on their behalf.

Thank you very much again for the opportunity to comment. If you have any questions regarding this comment, please contact Robert Hall with the American Academy of Pediatrics at 202/724-3301 or RHall@aap.org.

Sincerely,

American Academy of Pediatrics
Easter Seals
Family Voices
First Focus
March of Dimes Foundation
Voices for America's Children