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General Comment

1. The Interim Final Rules state that individual health insurance coverage must provide only one level of internal appeal before issuing a final determination. Is a voluntary second level of internal appeal permitted if the claimant has the right to proceed to external review after the first level appeal?

2. The Interim Final Rules shortened the timeframe for review of an initial claim for urgent care. The Interim Final Rules did not similarly shorten the timeframe for an expedited internal appeal of urgent care. We suggest that clarification be given on whether HHS also intended to shorten the urgent internal appeal timeframe.

3. The Interim Final Rules permit the claimant to file an expedited internal and external appeal simultaneously. It could be difficult for states processing external appeal requests to know whether and when an expedited internal appeal was filed with the plan. In addition, it could be difficult for external appeal agents to obtain all relevant information from the plan and the insured if the case is still being reviewed by the plan at the time of the external appeal. Also, suppose the health plan upholds the denial but on different grounds from the original denial (for example changing from medical necessity to experimental/investigational) – the external appeal agent would not be using the correct/current standard of review. Or, suppose the health plan overturns the denial but the external appeal agent upholds the denial? Another option to consider is permitting the plan and insured to jointly agree to waive any internal appeal and requiring the plan to provide written notice of the waiver to enable the insured to proceed directly to external review.

4. The model notices require information be included about “other resources to help you”, including information about the Employee Benefits Security Administration and a consumer assistance program. Is it mandatory or optional for State Health Department or Insurance Department information to be included in that section?