September 21, 2010

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

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, DC 20210

Internal Revenue Service
CC:PA:LPD:PR (REG-125592-10)
Room 5205
P.O. Box 7604, Ben Franklin Station
Washington, DC 20044

Re: Department of Health and Human Services, file code OCIIO-9993-IFC
Department of Labor, RIN 1210-AB45
Internal Revenue Service, REG-125592-10

Dear Director Angoff, Assistant Secretary Borzi and Deputy Commissioner Miller:

AARP appreciates the opportunity to comment on the Interim Final Rule. On behalf of our millions of members, we continue to have a strong interest in ensuring that implementation of the new health care legislation meets the needs of our members and all older Americans. AARP commends the Departments of Health and Human Services (HHS), Labor (DOL), and Treasury for issuing this interim final regulation on the internal claims and appeals and external review processes under the Patient Protection and Affordable Care Act. Although AARP believes that this interim final regulation is a good first step towards providing more transparency and accountability to claimants concerning their health benefits, issues surrounding conflicts of interest in both the internal and external review process are still problematic.

EXTERNAL REVIEW PROCESSES

Independent Review Organizations

One of AARP's major concerns with the interim final regulation is the lack of assurance that the independent review organizations (IROs) will be truly independent. Although the interim regulation attempts to address that concern by requiring contracting with three IROs and rotating the claims among those IROs, we do not believe that this will be adequate to assure independence. AARP suggests a certification process through which the IRO certifies under penalty of law that it is independent, as well as appropriate consequences for violations, such as disqualification from the program, fines, etc. The DOL or HHS should be able to audit the plan, insurer and/or IRO. Public disclosure of information by the IROs that is easily accessible to the claimants and the public, such as through a website, should be available and would provide greater transparency. For example, the IROs should provide such information as: (1) cases handled (redacted for privacy); (2) the name of the plan or insurer; (3) description of the issue; (4) approximate cost of the claim; (5) result (favorable to plan or insurer, or to participant); (6) the number of past reviews for each insurer or plan; (7) professional credentials of reviewer(s) used; and (8) compensation paid to each physician reviewer for the year and the two previous calendar years.

Time to Request External Review

AARP suggests that the time for a claimant to file a request for external review should be extended from four to six months. That will provide needed additional time for a claimant to obtain legal or other representation to help the claimant navigate the process. We believe, however, that most individuals will attempt to request an external review as soon as possible so as to expedite the determination of eligibility for benefits. We also suggest that the regulation specifically prohibit either an insurer or a plan from shortening the time period to request an external appeal through a plan or policy provision. *See, e.g*., *Burke v. PriceWaterhouse Coopers LLP Long Team Disability Plan*, 572 F.3d 76 (2d Cir. 2009) (a plan may provide a limitations period shorter than permitted by law).

Deference to Internal Appeals Decision

AARP strongly supports the requirement that the external review process should not give deference to the internal claims appeal decision. This is a necessary due process requirement to ensure a full and fair review of the claimant's appeal.

Receipt of Claim

AARP supports the requirement in the technical release which requires a preliminary review within five business days after receiving an external review request to determine if a claimant has provided all necessary information. If the claimant has not obtained legal or other representation, this is particularly important so that he or she may better navigate the process. We suggest that most of the guidance in the technical release should be included in the regulation so that the Secretary receives appropriate deference to her views.

State Standards for External Review

AARP notes that under the interim final regulations, external review is only provided in five specific areas, but the National Association of Insurance Commissioners (NAIC) Uniform Model Act includes more than these five areas and NAIC is revising its model to expand the number of areas included. Some states do not include external review of adverse benefit determinations in all the specified areas under the NAIC Uniform Model Act. To avoid uncertainty in these situations, the regulation should make it clear that if a claimant does not fall within one of the named areas, the claimant does not have to go through external review. Guidance would be helpful to better illustrate what types of adverse benefit determinations are included within those specified areas.

For the reasons set forth above, AARP reiterates the suggestion that the required time for a claimant to file a request for external review should be extended from four to six months.

If the minimum filing fee for claimants is retained, then AARP believes it is extremely important that the regulation retains an annual maximum on these fees. A frequent occurrence with a course of treatment is that separate claims may be denied and it would be prohibitively expensive for most individuals to have to pay separate filing fees for each appeal.

AARP submits that a State external review process should apply to all plans and issuers within a state. We believe that this will make the external review process more accessible and understandable for claimants. Absent the consistency of an adequate external review process within a state, we believe that the Federal external review process should apply.

INTERNAL CLAIMS AND APPEALS

Conflicts of Interest

Although the regulation attempts to resolve issues surrounding conflicts of interest, the regulation falls short of what is needed, especially when it comes to medical reviewers of claims.

For decades, claimants have confronted the same problems with insurers and their handling of claims. More often than not, a medical reviewer who too often rules in favor of the claimant and his or her receipt of benefits will not have that job for long. And, the insurers make sure that these reviewers know it.

The only way a reviewer can be truly "independent" is to be subject to review and termination by both sides. If the reviewers know that only the insurance companies pay them, they will be biased to side with them – more often than not. Only if there is effective review of their decisions, and consequences for poor ones, will there be true independence. A recent court decision suggested that even if a reviewer found 99% of the claimants who s/he reviewed not to be disabled the judge would not find that the reviewer was biased.

One suggestion to improve the independence of reviewers is random audits of independent reviewers. A panel of physicians or other appropriate providers could perform random sampling of the determinations of the reviewer. If there is a significant disagreement between the panel and the reviewer, there could be one of two remedies: to suspend that reviewer, or put the reviewer on "probation" for two years during which the reviewer must pay an independent panel to perform random audits of his or her medical reviews.

Adverse Benefit Determination

AARP is pleased that an adverse benefit determination now includes rescission of coverage. Loss of insurance coverage or benefits clearly adversely impacts consumers, potentially leaving them without coverage when they need it most.

Continued Coverage

It is unclear whether the requirement to provide continued coverage pending the outcome of an internal appeal only applies to concurrent care claims or also applies to rescission of coverage. AARP submits that this provision should apply to both types of appeals. As reported in the media stories of an insurer aggressively targeting breast cancer patients to rescind their insurance, continued coverage throughout the appeals process is crucial to a patient's health and may make the difference between life and death. *See* Susan Heavey and Lewis Krauskopf, *Health Insurers End Cancellations; Enforcement Key*, Reuters, Apr. 20, 2010, available at: http://www.reuters.com/article/idUSTRE63T3VR20100430.

Urgent Care

AARP supports the change in the timing of notification to the claimant or his or her representative to no more than 24 hours where urgent care is at issue. We agree that electronic notification should make this feasible and note that the recent infrastructure improvements around health information technology and electronic health records will also aid in this change.

Plan and Policy Terms

The regulation should require more specificity in the definition of certain terms including "experimental," "medically necessary," and "usual and customary." Plans and insurers may have different definitions and formulas for determining when claimants meet these terms, but claimants do not know what they are. More detailed information would be necessary in order to appeal a claim denial.

Provision of Claims File

A claimant should have the right to receive every document in the claims file, whether or not the plan or insurer relied on, or even looked at, the document. The claimant should be assured that the information that he or she provided to the insurer or plan is in the claim file; the regulation is only focused on the information considered, relied on or generated by the plan or insurer. Finally, the regulation should specifically state that the Secretary rejects courts' interpretation requiring a claimant to prove prejudice or detrimental reliance. *See, e.g.*, *DiGregorio v. Hartford Comprehensive Employee Benefit Serv. Co.*, 423 F.3d 6 (1st Cir. 2005) (holding participant had no right to her claim file unless she was able to show that the failure to receive it was prejudicial).

Claims Provision of New Information or Rationale to Claimants

We applaud the requirement that insurers or plans must provide claimants with any new information and/or rationale in a timely manner so that the claimants may respond. This requirement will prevent plans and insurers from using post-hoc rationalizations for their decisions and allow claimants to have a full opportunity to make their case. The regulation should specifically state that the Secretary rejects the court decisions in such cases as *Midgett v. Washington Group Intl Long Term Disability Plan,* 561 F.3d 887 (8th Cir. 2009), and *Metzger v. Unum Life Ins. Co. of America,* 476 F.3d 1161 (10th Cir. 2007), holding that the plan does not have to share evidence developed during the claim process.

One open issue is the procedure if the new information or rationale is provided close to when a decision will be reached. The regulation should provide a minimum amount of time that the claimant must be given to respond along with the possibility of an extension upon request. Because most claimants will want a fast resolution to their claims appeal, we suggest that the claimant must be given a minimum of ten (10) business days to respond to the new information or rationale with the opportunity to request additional time

Denial Notice Requirements

AARP applauds the requirement that plans must provide notices to claimants in a "culturally and linguistically appropriate manner." This is consistent with the Department of Labor's regulation on the style and format of summary plan descriptions. 29 C.F.R. § 2520.102-2. In addition, this requirement acknowledges the growing diversity of consumers of all ages and will help ensure that all consumers can understand and exercise their rights.

AARP also suggests that the Summary Plan Description should provide at least general information concerning the opportunity to request an external review of an adverse benefit determination. AARP suggests that the Department of Labor amend its Model Statement of ERISA Rights for health plans in order to include such language.

Explanation of Benefits and Denial Notices

AARP supports the requirements surrounding the denial notices and explanation of benefits. However, under the current DOL claims procedure, this requirement is neither followed nor enforced; and indeed most claim denials do not come close to meeting these requirements. In particular, the insurer or plan does not provide an explanation of the information needed to appeal the benefit denial.

Non-Compliance with Internal Appeals Requirements

AARP applauds the requirement that the plan or insurer must strictly comply with the regulation. The regulation should specifically state that the Secretary rejects the court decisions such as *Lacy v. Fulbright & Jaworski Limited Liability Partnership Long Term Disability Plan*, 405 F.3d 254 n.5 (5th Cir. 2005) (permitting substantial compliance with the current claims regulation).

Individual Health Insurance Coverage

We support the regulation's requirement that in the individual health insurance market an individual should have the right to appeal initial eligibility determinations for individual health coverage. We believe that this is also consistent with the provision permitting an appeal of a decision to rescind coverage.

Thank you again for your consideration of these comments and suggestions. If you have any questions, please feel free to contact me or Nora Super on our Government Relations staff at (202) 434-3770.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Relations & Advocacy