September 21, 2010

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Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
PO Box 8016
Baltimore, Maryland 21244-1850
Attention: OCIIO-9993-IFC, RIN 0991-AB70

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration, Room N-5653
US Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
Attention: RIN 1210-AB45

Internal Revenue Service
CC: PA: LPD: PR, Room 5025
PO Box 7604, Ben Franklin Station
Washington, DC 20044
Attention: REG-125592-10

RE: 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

The Independent Living Resource Center San Francisco is a non-profit organization whose core values include choice, consumer leadership, full access to and inclusion in the community. We serve people with all types of disabilities by providing direct services and educating the community. We appreciate the opportunity to comment on interim final rules that implement provisions of the Patient Protection and Affordable Care Act regarding internal claims and appeals, and external review processes for group health plans and health insurance coverage in the group and individual markets. The promulgation of the interim final rules is an important step in creating a fair and uniform appeals process that guarantees internal review as well as external review by an independent entity that is binding on a plan or issuer.

The interim final rules require that health plans and health plan issuers provide notices to enrollees in a culturally and linguistically appropriate manner. The interim final rules make no mention of notices that ensure effective communication with enrollees with disabilities under either the Americans with Disabilities Act of 1990, as amended, or the Rehabilitation Act of 1973, as amended. We strongly recommend that the final rule specifically require that health plans and health plan issuers ensure effective communication with respect to notices and appeals information when communicating with enrollees with disabilities, including the provision of notices in alternative formats.

The scope of the external review should include review of rescissions and denials of insurance coverage based on eligibility. We urge the expansion of the range of adverse benefit determinations that can be subject to state and federal external review processes. Under the interim final regulations, external review processes are required to assess a narrower set of adverse benefit determinations than internal appeals. We believe this disparity is not in the best interest of consumers. Minimum state standards must provide, at a minimum, the consumer protections of the Uniform Health External Review Model Act – this standard is too narrow as it excludes external review of rescissions and other adverse benefit determinations. We recommend that the Departments require all adverse benefit determinations considered under the internal review to subject to external review under either state or federal law.

The interim final regulations do not explicitly state that external reviews much make a de novo assessment of adverse benefit determinations. We strongly recommend that a de novo standard of external review be set forth in the Departments' regulations and that this standard be one of the minimum requirements for state and federal review processes. The interim final regulations allow consumers to provide evidence and testimony during internal claims appeals. We believe that consumers need to also have this opportunity during the external review.

The statute and interim final regulations require plans and insurers to provide continued coverage pending the outcome of an internal claims review process. There is no such requirement when consumers are pursuing external review of an adverse benefit determination. Continuation of coverage is especially important to individuals in urgent care situations and those receiving an ongoing course of treatment. People with disabilities and chronic conditions will be particularly susceptible to negative outcomes when services addressing a complex or serious medical conditioned are stopped during an external appeal.

In order to prevent the exhaustion of one or more appeal opportunities all notices and all other information about enrollees' appeal rights should explicitly state when or if a prescribing healthcare provider may act as an authorized representative for the purposes of exercising appeal rights. We recommend that this be included in federal regulations as one of the minimum protections.

The interim final rule requires decision-makers to avoid conflicts of interest in order to render impartial decisions but the rules do not require those making important claims decisions to have an appropriate degree of medical or clinical education and training when rendering a decision related to medical necessity or appropriateness. This can result in the decisions of physicians and other providers being overturned by individuals with no medical or clinical expertise. The final regulation should require the final decision-maker at the internal and external levels of appeal to have appropriate medical and clinical credentials.