

September 16, 2010

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

RE: The Affordable Care Act – Interim Final Regulations for Internal Claims and Appeals and External Review

To Whom It May Concern:

The National Council for Community Behavioral Healthcare (National Council) is pleased to respond to the Interim Final Regulations for Internal Claims and Appeals and External Review Processes.

The National Council, a non-profit association representing over 1,700 community mental health centers and other community-based mental health and addiction providers, is dedicated to fostering clinical and operational innovation and promoting policies that ensure the more than 6 million low-income children, adults, and families our members serve have access to high quality services. Our community mental health and addiction organizations have more than 40 years of experience and expertise in providing a range of clinic-based services and recovery supports for millions of individuals with multiple chronic health problems.

While many of our member agencies primarily serve individuals with mental illness and substance use disorders through Medicaid, Medicare, and community mental health funding, a significant number of our clients have private health insurance. Our member agencies are dedicated to helping clients navigate often unclear, inconsistent, and confusing rules to ensure that these clients secure reimbursement for services important to their mental and physical health. These regulations take an important step in establishing a baseline of protections for healthcare consumers, and will hopefully enable healthcare providers to help consumers with mental illness and substance use disorders navigate the healthcare system more effectively.

In any given year, about 4.4 percent of adults have a serious mental disorder and 8.3 percent of youths between ages 12 and 17 have at least one major depressive episode. In 2008, 8.3 million adults had suicidal thoughts, and almost nine percent of the population suffered from substance abuse or dependence.¹ These numbers represent a significant portion of the U.S. population that needs services to treat mental illness or addiction. Although a range of efficacious treatments is available to address symptoms of mental illnesses and substance use disorders, financial barriers often stand in the way of accessing effective treatment. For example, among the 5.1 million adults who reported having unmet need for treatment for mental health problems in 2008, more than half reported cost or insurance issues as a barrier

to receiving treatment.ⁱⁱ In a recent survey, primary care physicians have indicated that lack of access to mental health services is a serious problem—much more serious than for other commonly used medical services; two-thirds of primary care providers in the study could not obtain mental health services for at least some of their patients, a rate that was twice as high as for referrals to other specialists.ⁱⁱⁱ

In the backdrop of these statistics, the Federal government recently released interim final regulations on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. This law and these regulations will hopefully address many of the barriers to treatment that people with mental illnesses and addictions face. We hope that the Departments will make every effort to keep the spirit of the Parity Act in mind as they finalize rules for the Affordable Care Act.

With only the recent passage of the parity law, the National Council is especially attuned to the potential for people with mental illness and substance use disorders to be denied care. The internal claims and appeals and external review procedures provide consumers with recourse when plans deny reimbursement for care. It is not well understood how often internal claims and appeals are used, but we do know that external reviews are seldom used, even though nearly 50 percent of appeals result in favor of the consumer.^{iv} Surveys suggest that consumers face problems with accessing their healthcare in greater numbers than current numbers suggest. The National Council is concerned that individuals with mental health or substance use disorders do not have enough information about their rights, that barriers deter them from obtaining the care they need and that States do not have proper mechanisms to enforce the protections in place. Furthermore, the National Council believes that people with mental illnesses or substance use disorders may have particular difficulty navigating complex appeals processes.

The National Council strongly encourages the Departments to use these and future regulations on this topic to:

- A. Increase transparency about plan decision-making
- B. Reduce barriers to the appeals process
- C. Provide adequate supports to State insurance commissioners, consumer assistance offices, and providers to ensure effective enforcement of the law.

Increase Transparency

A lack of transparency about medical decision-making and plan policies has made it particularly challenging to understand how to improve internal claims and appeals and external review processes. The National Council supports efforts by the regulations to clarify the process for consumers, as well as the health providers who help them.

Transparency about the Process

The National Council supports stronger language requiring plans to include information about both internal and external review processes in plan marketing materials, plan websites, and plan information toll-free numbers. In addition, the National Council recommends that the regulations require plans to include the necessary forms with any adverse determination letters. Plans must be required to inform consumers about their right to both internal and external appeals at the first adverse determination.

Rationale for Adverse Determination

The National Council approves regulation requirements that plans must provide clear information about how a decision is reached and the basis for that decision, and that plans must now inform consumers about any new information regarding the determination. Requiring plans to provide a rationale for their decision-making and to clearly explain the basis for those decisions will incentivize the provision of appropriate care. These rules take an important step in making insurance plans more transparent.

The National Council is concerned that some plans will continue to use medical necessity criteria to limit access to necessary care, and urges the Departments to continue to strengthen transparency requirements for adverse determinations. Since insurance plans have not always had to be transparent about their medical necessity criteria, both consumers and providers have not been able to appeal adverse determinations effectively.

Further, the Departments should continue to require plans to ensure that medical necessity criteria are reasonable. As regulations for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act go into effect, the National Council is acutely aware how narrow definitions of medical necessity have limited access to mental health services.

A narrow definition may not recognize valid mental illnesses, such as post-traumatic stress disorder, as requiring services. Other definitions may require an unreasonable duration of symptoms before a person qualifies for care. For people with mental illness, it is critically important to break down barriers to care. The stronger transparency requirements and clear direction that criteria be reasonable will make an important improvement in establishing strong consumer protections.

The National Council urges the Departments to strengthen the language in the regulations to make sure that all plans must be transparent in how they have made medical decisions, and to specifically require that plans make medical necessity criteria available to both providers and to consumers.

Reduce Barriers

Expedited Process for Emergency Situations. The National Council strongly supports the reduction of decision-making time to 24 hours for medical emergencies for both internal and external appeals. For people in psychiatric crisis, it is critically important to facilitate access to care, particularly when individuals are in psychiatric crisis. Any effort to make coverage decisions more responsive will enable providers to ensure that individuals with mental health or substance use disorders receive the treatment they need.

Internal Appeals. The National Council supports regulations that individual health plans may only have one level of internal appeals before moving to an external appeals process. Research suggests that an external appeals process provides a more objective review of the medical evidence, and that consumers are more likely to have their cases overturned in external reviews.^v Further, requiring consumers to go through multiple levels of internal claims and appeals may serve as an ongoing barrier to necessary care. Therefore, the National Council suggests that the Departments change the regulations so that all health plans

may have only one level of appeal before moving to an external review process. Multiple levels of internal reviews only serve as a deterrent for consumers to access care that they need.

At the very least, the National Council recommends that people with mental illness be exempted from requirements to exhaust internal claims and appeals processes. This exemption would ensure the appropriate implementation of the new parity law and would minimize the impact on people with mental illness. There is precedent for this in Minnesota, where the attorney general exempted youth with mental illness from internal review processes due to a lawsuit.^{vi}

Filing Fee. The IFR allows a \$25 filing fee for external reviews, with a maximum of \$75 per year. Most States do not allow consumers to be charged a filing fee, and the National Council objects to the regulations allowing this fee. The fee does not cover the costs of the external review (estimated at \$605 by the Departments), and therefore, only serves as a barrier to the review process. Since so few consumers utilize the external review process, this seems like an unnecessary use of utilization management.

The National Council was pleased to see that a maximum annual cost has been established and that the fee should be waived for financial duress. However, the IFR does not define “financial duress,” and we are concerned that these costs could serve as a deterrent for some individuals with mental health or substance use disorders. While many individuals with private insurance can comfortably pay an additional \$25, there is a critically important minority for which this cost would prevent them from utilizing the appeals process. The National Council proposes that the Departments provide some guidance to plans in determining financial duress. For example, in 2010, a family of four who earns \$33,075.00 will be at 150% of the Federal Poverty Level.^{vii} This breaks down to \$2,480.63 per month to pay for housing, food, insurance, gas, clothing and other necessities for four people. Families with this kind of budget might have private health insurance, but would have difficulty with additional fees.

The National Council understands that the States are not required to charge a filing fee, but we recommend that the Departments make every effort to discourage their use. In addition, the Departments should require plans to inform consumers that the \$25 filing fee will be reimbursed to the consumer if he or she wins the appeal.

Review Responses. Currently, the IFR does not address circumstances in which either the internal review process or the external review process overturns a portion of a medical decision. Given the complexity of medical practice, the National Council strongly encourages the Departments to add language permitting nuanced responses to medical cases in both internal and external reviews.

Regulation Impact. The Departments requested comments on whether the Federal external review process should apply to all plans and issuers in a State if the State external review process does not apply to all issuers in a State. The National Council contends that the regulations should continue to serve as a baseline of protections, not a ceiling. Any

protections in a State stronger than those outlined in the Federal external review process should not be superseded.

At the same time, the National Council recognizes that there are inconsistent protections within States as well as across State lines, increasing the complexity of implementation of these regulations. If a State has different standards for different issuers, the Departments should give the State until July 1, 2011 to resolve those differences, and may need to work with States to provide model language and regulatory guidance. If a State does not modify its own laws to cover its entire population, then the State will have to be responsible for monitoring two different standards. However, if the existing protections for the population (e.g., managed care only) are weaker than the Federal regulations, then the new Federal law would cover the entire population in the State.

Provide Adequate Supports

The Departments are planning to rely on State Insurance Commissioners and State Consumer Affairs offices to enforce and assist in the implementation of these new regulations. The National Council applauds the plans to provide model forms and language as well as implementation grants to consumer assistance offices. In addition, it is appropriate to provide time to the States to enforce these new rules.

However, the National Council is concerned that these offices may not have the capacity to enforce these new regulations effectively. Less than half of States have consumer assistance offices, and insurance commissioner offices are often small.^{viii} We strongly encourage the Departments to provide as much guidance and technical support as possible.

In addition, health providers are often a crucial link for both internal appeals and external review processes. Yet, they are not mentioned in the regulations at all. The National Council urges the Departments to amend the regulations to require that plans make all internal and external appeals process information and forms available to health providers. In addition, health providers should be included in all information packets for both consumer affairs and insurance commissioner offices. Finally, the National Council recommends that providers be included in the consumer assistance grants or that the Departments issue an additional set of provider assistance grants. The National Council is committed to the health of its clients and would like every opportunity to ensure that our members can support individuals with mental health or substance use disorders in accessing the care they need.

We thank you for the opportunity to comment on the Interim Final Regulations for Internal Claims and Appeals and External Review.

Sincerely,



Linda Rosenberg
President/CEO

ⁱ Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD.

ⁱⁱ Id.

ⁱⁱⁱ Beyond Parity: Primary Care Physicians' Perspectives On Access To Mental Health Care Peter J. Cunningham, *Health Affairs*, 28, no. 3 (2009): w490-w501, (Published online 14 April 2009), doi:10.1377/hlthaff.28.3.w490.

^{iv} Pollitz, Karen, Crowley, Jeff, Lucia, Kevin, and Eliza Bangit (Revised May 2002).

"Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation." Georgetown University, Institute for Healthcare Research and Policy. Prepared for the Henry J. Kaiser Family Foundation. <http://www.kff.org/insurance/externalreviewpart2rev.pdf>

^v Pollitz, et al. (2002).

^{vi} Id.

^{vii} <https://www.cms.gov/MedicaidEligibility/downloads/POV10Combo.pdf>

^{viii} Managed Care State Laws and Regulations, Including Consumer and Provider Protections. National Conference of State Legislators. Updated: March 2008; Reposted May 2010. <http://www.ncsl.org/default.aspx?tabid=14320>.