September 21, 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: 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, Proposed Rule, 75 Federal Register 141 (July 23, 2010).

To Whom It May Concern:

On behalf of the HIV Health Care Access Working Group (HHCAWG), we are writing to express our support for the consumer protections included in the interim final rules relating to internal claims and appeals and external review processes. HHCAWG is a coalition of more than 100 national and community-based AIDS service organizations representing HIV medical providers, advocates and people living with HIV and AIDS and providing critical HIV-related health care and support services. The Working Group is actively engaged in efforts to increase early and affordable access to quality, comprehensive care for people living with HIV and AIDS.

For many people living with HIV and other chronic illnesses which require complex care and treatment, the complicated internal appeals and external review procedures for service denials make it difficult for individuals to assert their rights and challenge adverse decisions. The protections included in the Patient Protection and Affordable Care Act (PPACA) and the relevant interim final rules will make it easier for people to navigate the internal and external appeals processes following adverse decisions by non-grandfathered plans offered in the individual and group markets. We strongly support the added consumer protections included in the law and regulations.

To ensure that the new safeguards adequately protect consumers, we urge you to identify ways to work with the state exchanges to make sure that information regarding both the internal
appeals and external review processes is publicized and available to beneficiaries beyond the requirement that this information be provided in the plan’s terms of enrollment and in the notice sent to members following an adverse benefit determination. Section 2793 of the PPACA provides $30 million to states to establish consumer assistance offices or strengthen existing ones, and these funds should be used to ensure that consumers know their rights, for instance by providing consumers with other sources of information regarding the internal appeal and external review requirements beyond the information that health insurance carriers are required to provide.

Finally, we urge you to clarify that with regard to the minimum consumer protections required for state external review procedures to apply, the independent review organization (IRO) is not bound by the definition of medical necessity in the plan contract, but rather must consider all of the factors contained in the National Association of Insurance Commissioners’ Uniform Health Carrier External Review Model Act. These factors include: the covered person’s medical records; the attending health care professional’s recommendation; consulting reports from appropriate health care professionals; the most appropriate practice guidelines, including evidence-based standards; and the opinion of the IRO’s clinical reviewer. We believe that broadening the factors to be considered by the reviewing entity will ensure that the decision is truly independent and fair.

We appreciate the opportunity to comment on the interim final rules and thank you for your continued leadership on the implementation of the health reform law. If you have further questions, please contact Robert Greenwald, Treatment Access Expansion Project (rgreenwald@taepusa.org).

Submitted on behalf of the HIV Health Care Access Working Group Steering Committee,