

Changes to Obama health care program limit patient appeals

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The Obama administration has changed several rules governing patient appeals under the health care overhaul signed into law in March 2010. The changes are largely the result of intense pressure on the part of private insurers, who have lobbied against any measure in the bill that might infringe upon their profit margins.

As originally conceived under the Patient Protection and Affordable Care Act (PPACA), and detailed by the Department of Health and Human Services (HHS) in July 2010, the rules allow patients to take their complaints about denial of coverage to an outside arbiter if internal reviews through their insurers are unsuccessful. They also provide federal standards for patients seeking these appeals, replacing state policies when these do not meet the federal standards.

The main change to the rules will significantly restrict the conditions under which a patient can challenge denial of coverage. Specifically, patients will only be allowed to appeal if their insurer declines to pay for care on the basis of a medical judgment or cancellation of coverage. As HHS admits in its documents on the changes, “this amendment suspends the broad scope of claims eligible for the Federal external review process.”

Patient advocates note that this will have the effect of denying challenges related to common practices in the health insurance industry. Claims rejected on the basis of diagnostic coding errors or failure to receive pre-authorization for a service will not be covered by the federal appeals. Any patient who has had to navigate the convoluted health insurance claims process knows that coding errors and pre-authorizations are often at the center of a denied medical claim.

Stephen Finan, senior policy director of the American Cancer Society Cancer Action Network, commented, “Transparency and independence are crucial to ensure that a fair and objective appeal is conducted.

Unfortunately there are numerous barriers and burdens placed on the consumer that could prevent a timely and objective resolution to a denial.”

The new version of the appeals process is also slanted against the consumer by halving the time a patient has to file a complaint, from four months down to two. Private insurers will also have the option of hiring their own consultants, instead of relying exclusively on an outside board of review.

Another change would extend the time an insurer has to notify a claimant on a determination of a claim involving urgent care. Under the July 2010 regulations, insurance companies would be required to provide an answer on eligibility for urgent care claims no later than 24 hours after receipt. After strenuous lobbying by the insurance industry, this time frame has now been extended to 72 hours.

The HHS document notes that it had received positive feedback on the 24-hour proposal, particularly from “consumer advocates and medical associations, including mental health providers who noted the 24-hour standard was especially important for people in psychiatric crisis.”

But this argument has now been rejected. Patients are expected to trust that insurers will treat the 72-hour time frame only as an “outside limit” and “backstop,” and that decisions will be made “more quickly based on the medical exigencies involved.” If that is the case, why did the insurance industry work so hard for the 24-hour provision to be scrapped?

In a further concession to the insurers, regulations that would have required them to provide more information on denial of services notices have also been relaxed. As drafted in July 2010, these notices were required to include diagnosis and treatment codes. This has now been changed, substituting instead a

requirement that the insurer “provide notification of the opportunity to request the diagnosis and treatment codes (and their meanings) in all notices...and a requirement to provide this information on request.”

Authors of the amendment claim this change has been made “[a]fter considering all of the comments, and the costs and benefits of the additional disclosure.” In fact, the only “comments” carrying any weight have been those of the insurance lobby, while the patient denied care is granted the “opportunity” to seek out this information, inevitably being given the run-around and put on hold when they phone the consumer help-line.

These changes limiting patients’ rights to appeal denial of coverage are the latest exposure of the Obama administration’s claims that the health care legislation has anything to do with improving care. At the heart of the “reform” is the drive to slash costs for government and big business, while making deep cuts to the provision of treatments and services for the vast majority of ordinary Americans.

When the insurance industry has voiced objections to any of the nominal protections for patients contained within the bill, the White House has been quick to grant waivers to the employers, or rewrite sections of the legislation in the interest of the private insurers.



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