



Physicians Caring for Texans

July 22, 2011

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Ave., NW.
Washington, D.C. 20210
Attn: RIN 1210-AB45

Re: RIN 1210-AB45; Groups Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes; as published in the Federal Register on June 24, 2011.

Dear Sir:

The Texas Medical Association (TMA) appreciates the opportunity to comment on the Department of Labor's¹ interim final rules regarding internal claims and appeals and external review processes for group health plans and health insurance issuers, which implement the requirements of Section 2719 of the Public Health Services Act, as amended by the Affordable Care Act (ACA).

TMA is a private voluntary, nonprofit association of Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its mission is to "Improve the health of all Texans." Its almost 46,000 members practice in all fields of medical specialization. It is located in Austin and has 119 component county medical societies around the state.

TMA has a keen interest in advocating for consumer and patient protection laws promoting fairness and transparency in the health insurance industry. For many years, establishing fair review processes for adverse benefit determinations has been a legislative and regulatory priority for TMA at the state level. The Department's July 2010 regulations² and the June 2011 interim final rules on internal claims/appeals and external review processes take critical steps towards this end.

TMA, therefore, appreciates the Department's efforts in drafting the interim final rules and request for comments and in appropriately seeking and considering stakeholder responses on this important

¹ Although this comment letter is specifically addressed to the Department of Labor, TMA intends for its comments to apply equally to identical language/provisions in the interim final rules of the Department of Treasury and Department of Health and Human Services, which were published simultaneously in the June 24, 2011 edition of the Federal Register at 76 Fed. Reg. 37208 et. seq.

² See 75 Fed. Reg. 43330 et seq.

issue. TMA respectfully offers the following comments on the interim final rules, as published in the Federal Register on June 24, 2011.

I. Deemed Exhaustion of Internal Claims and Appeals Processes (29 CFR 2590.715-2719(b)(2)(ii)(F))

First, TMA appreciates the Department's efforts in establishing a regulatory mechanism for deeming a claimant's exhaustion of internal claims and appeals processes when plans or issuers fail to meet the minimum requirements for a full and fair internal review established under 29 CFR 2590.715-2719(b)(2). As noted in the preamble to the June 2011 interim final rules, courts typically require claimants to exhaust administrative proceedings prior to going to court or seeking external review of benefit denials.³ Requiring exhaustion of administrative proceedings has some justification when plans and issuers offer full and fair internal procedures for resolving claims.⁴ However, there is little justification for requiring exhaustion of administrative proceedings if those proceedings fail to comply with the basic requirements of the law (i.e., those requirements set forth in 29 CFR 2590.715-2719(b)(2)).⁵

Acknowledging this fact, 29 CFR 2590.715-2719(b)(2)(ii)(F)(1) of the June 2011 interim final rules permits the claimant to immediately seek external review if the plan or issuer failed to adhere to the requirements for internal claims and appeals processes established under the regulations. TMA generally supports the language of 29 CFR 2590.715-2719(b)(2)(ii)(F)(1) in establishing a deemed exhaustion procedure. TMA contends that it is important for consumers to immediately avail themselves of an independent, external review if a plan fails to comply with the minimum regulatory requirements for a full and fair internal review. The consumer should not be further delayed by a plan's noncompliant internal claims process and should be entitled to "fast track" his claim to an independent body.

TMA, however, strongly recommends that the Department strengthen the "deemed exhaustion" provision of 29 CFR 2590.715-2719(b)(2)(ii)(F) by imposing a more stringent standard of plan/issuer compliance. To this end, TMA urges the Department to delete the newly-devised exception to deemed exhaustion in 29 CFR 2590.715-2719(b)(2)(ii)(F)(2), which permits plans to make certain de minimis violations of the regulations' internal claims and appeals requirements without triggering the deemed exhaustion provision. Further, TMA urges the Department to return to its original deemed exhaustion language (established in the July 2010 rules),⁶ which imposes a "strict adherence" standard.

Specifically, TMA supports the following language from the July 2010 rule:

In the case of a plan or issuer that fails to strictly adhere to all the requirements of this paragraph (b)(2) with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process of this paragraph (b), regardless of whether the plan or issuer asserts that it substantially complied with the requirements

³ 76 Fed. Reg. 37213.

⁴ *Id.*

⁵ *Id.*

⁶ *See* 75 Fed. Reg. 43356.

of this paragraph (b)(2) or that any error it committed was de minimis. Accordingly, the claimant may initiate any external review under paragraph (c) or (d) of this section, as applicable. The claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.⁷

In stark contrast to the June 2011 interim final rules, the above July 2010 rule establishes a strict compliance standard for plans and issuers seeking to avoid deemed exhaustion of their administrative proceedings. Additionally, the July 2010 rule expressly states that substantial compliance fails to prevent the plan/issuer from being subject to the rule's provision for deemed exhaustion of internal appeals and claims.

TMA contends that the July 2010 requirement of "strict adherence" *without exception* is both reasonable and appropriate for numerous reasons. First, strict adherence is a reasonable compliance standard, because the requirements that the plan/issuer must satisfy to avoid deemed exhaustion are truly the *minimal* standards necessary to create a full and fair review in the internal review process. The Department narrowly tailored its requirements to inject a basic level of fairness into the plan/issuer's internal claims and appeals process, which is a process that is inherently replete with conflicts of interests. Accordingly, the requirements imposed on plans/issuers under paragraph (b)(2) are quite straightforward and are not unduly burdensome. For example, the regulations require the plan/issuer to allow a claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.⁸ This is not an overly prescriptive requirement. A plan should easily be able to satisfy these types of minimal requirements. And, if a plan fails to *strictly* comply with these requirements, the claimant should be authorized to immediately seek recourse outside of the plan (i.e., through an external review).

Second, strict adherence is a reasonable standard, because the plan/issuer's compliance with aforementioned requirements is entirely within the plan/issuer's control. If the requirements articulated in (b)(2) were largely or solely dependent upon the actions of others, then an exception would be more defensible (although still unnecessary). However, in this instance, the plan/issuer is in control of its own compliance and can avoid deemed exhaustion by following the basic procedures delineated in the rules. Leniency for plan/issuer noncompliance is simply not warranted. Plans often subject claimants to very precise standards and delay processing the claimant's internal appeal if such standards are not adhered to. Fairness would dictate that the plan be held to a similar level of accountability and that plan failures (both small and large) be met with consequence.

Third, strict adherence is a reasonable standard, because the penalty for noncompliance with the regulatory requirements for internal claims and appeals is not excessively punitive to the plans/issuers. Importantly, noncompliance does not result in a death penalty sanction being issued against the plan. If a plan or issuer fails to meet the standard, the claim determination is not

⁷ *Id.*

⁸ 29 CFR 2590.715-2719(b)(2)(ii)(C).

automatically deemed approved. Rather, the consumer's claim is merely expedited by bypassing a potentially biased internal review process and moving forward to an external review by an independent review organization (IRO). The stakes for the plan are, therefore, not unduly high. Yet, the stakes are sufficient to encourage plan compliance with the rules (as is necessary for consumer protection). It is, therefore, clear that the Department's original July 2010 rules took a very balanced approach regarding deemed exhaustion. This is an approach that must be retained.

Fourth, "strict adherence" is both a necessary and appropriate standard for plan compliance, because it is the *only* standard that will be understood and easily applied by *all* of those affected by the rules (namely, the plans, claimants, external reviewers, and courts). While TMA appreciates the Department's efforts in attempting to create a very narrowly-drawn exception to the deemed exhaustion provision, TMA notes that the new language creates ambiguity where none previously existed in the July 2010 rules.

More specifically, the de minimis exception in (F)(2) states (in part) as follows:

... the internal claims and appeals process of this paragraph (b) will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan or issuer demonstrates that the violation was for good cause or due to matters beyond the control of the plan or issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan or issuer.

While a "strict adherence" standard is easily enforced and understood by all, the above language creates a complicated framework that will cause substantial consumer confusion and will lead to differing results and utilization of the deemed exhaustion provision by otherwise similarly-situated claimants.

In the rule preamble, the Department itself notes that many claimants will face uncertainty regarding whether a particular violation satisfies the exception.⁹ As a result of this confusion, claimants will likely do one of two things before seeking deemed exhaustion, depending upon their financial resources. Claimants with resources may do as the Department anticipates, (i.e., "incur a cost to seek professional advice, because they will not be able to make ... [the] judgment [of what is a de minimis violation] on their own behalf."¹⁰ In contrast, claimants without resources may simply forgo deemed exhaustion altogether (even when plans *substantially* violate the rules), because they are fearful of having their immediate external review denied and facing further delay when forced back into the internal appeals process.

Put simply, the uncertainty created by the de minimis exception (and the attendant increased costs and heightened potential for delay) will act as very real deterrents to many consumers who otherwise would have utilized the deemed exhaustion provision under a strict compliance standard. Thus, the exception *severely* undercuts the utility of the deemed exhaustion provision and disadvantages those consumers with fewer financial resources.

⁹ 76 Fed. Reg. 37220.

¹⁰ *Id.*

Further, the exception opens the door to potential plan/issuer abuse. A plan or issuer may push the envelope and routinely assert that substantial violations are “de minimis,” because they know that it is unlikely that many consumers (especially impoverished consumers) will challenge the plan/issuer’s representation and seek deemed exhaustion. Notably, the Department attempted to guard against this type of abuse by including a statement in the rule that “the exception is not available if the violation is part of a pattern or practice of violations by the plan or issuer.” However, it is unclear how the “pattern” will *ever* be formally established if claimants are greatly deterred (by expense and uncertainty) from challenging the violation in the first place. Such violations may go undetected for long periods of times if they are never (or infrequently) challenged before an IRO. Thus, this provision (although well-intentioned) is not likely to have the desired protective impact.

For all of the foregoing reasons, TMA once again urges the Department to return to the July 2010 language regarding deemed exhaustion, which imposes a strict compliance standard without a de minimis exception. It is clear that accommodating the insurance industry by creating an exception to the strict compliance standard is unnecessary and will, ultimately, prove to be unworkable. Moreover, deviating from a strict compliance standard will truly disserve the consumer by increasing costs and discouraging some claimants from utilizing the deemed exhaustion procedure altogether. In contrast, maintaining a strict compliance standard will *not* disserve insurers. The only conceivable “harm” the plan would suffer by imposing a strict compliance standard is the loss of the ability to further delay the consumer’s claim by forcing the consumer to exhaust its internal (often biased) processes. This is a “harm” the plan *should* incur for its own failures, regardless of the gravity of those failures. Upon application of a strict compliance standard, the claim would then be decided in a forum fair to both the plan AND the claimant. TMA fails to see how this is an unjust or undesirable result.

II. Binding External Review (29 CFR 2590.715-2719(c)(2)(xi) and 29 CFR 2590.715-2719(d)(2)(iv))

Next, TMA strongly supports the language of interim final rules 29 CFR 2590.715-2719(c)(2)(xi) and 29 CFR 2590.715-2719(d)(2)(iv). These two provisions include identical language establishing the binding nature of external review decisions in the context of state and federal external review processes, respectively. Specifically, these provisions state that the external review decision:

... is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal Law, and except that the requirement that the decision be binding shall not preclude the plan or issuer from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the plan or issuer must provide benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan or issuer intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

TMA contends that the above language is a vital consumer protection measure that: (1) ensures that the IRO's decision is honored by the plan/issuer unless or until the decision is appropriately overturned through judicial review and (2) aids consumers in being promptly paid or provided with coverage for final, favorable external review decisions. Absent such a provision, health plans and issuers would be free to argue that they are not required to provide benefits or make payment on a claim after completion of the external review process, because they either disagree with the external review decision or intend to pursue judicial review of the decision. The resulting coverage/payment delay would cause substantial harm to consumers desperately in need of the benefits/payments to which an *independent* body held they were entitled. The language of the interim final rule prevents this unfair result and incorporates a much-needed element of fundamental fairness into the rules by minimizing conflicts of interests in benefit determinations (including those involving rescissions) and giving meaningful effect to the decision of the IRO.

Notably, the interim final rules (quoted above) differ from the July 2010 rule in two significant ways. First, the interim final rules add express language (which was previously merely implied) mandating payment by the plan "without delay" upon the issuance of an external review decision favorable to the claimant regardless of the plan's objections or future legal challenges to the decision. TMA strongly supports this additional language. The rules' clarification of the timing element (i.e., that plan/issuer payment obligations are *immediately* triggered upon the plan/issuer's receipt of notice of the claimant's favorable IRO decision) should inure to the benefit of consumers, as is appropriate and was presumably intended by the July 2010 rules.

Second, the June 2011 interim final rules add language stating that the binding nature of the IRO decision does not preclude the plan/issuer from choosing to pay a claim or otherwise provide benefits at any time during or after the external review process (even following a final external review decision that denies the claim or otherwise fails to require such payment or benefits). TMA strongly supports the inclusion of this language as an additional consumer protection measure.

TMA agrees with the Department's statement in the preamble that nothing in the underlying law (i.e., Public Health Services Act Section 2719(b)) or the July 2010 regulations (establishing the binding nature of the IRO decision) prevented a plan or issuer from *choosing* to provide coverage or payment for a benefit at any time.¹¹ The National Association of Insurance Commissioners (NAIC) Uniform Health Carrier External Review Model Act and the July 2010 regulations are both silent on the issue of a plan/issuer voluntarily making payments and/or providing coverage. The Model Act and the July 2010 regulations only expressly addressed those instances where the plan/issuer was *compelled* to make a payment and/or provide coverage (namely, after an IRO decision favorable to the claimant).¹² However, given that some commenters raised the concern that the July 2010 rules may be interpreted as precluding such voluntary payment by the plan/issuer, TMA strongly supports inclusion of the additional language to eliminate any lingering confusion surrounding this issue.

For the foregoing reasons, TMA appreciates the Department's efforts in clarifying the impact of an IRO's binding decision. The aforementioned additions should aid consumers in receiving the benefit of their bargain with health plans/issuers in a timely and efficient manner.

¹¹ 76 Fed. Reg. 37217.

¹² *Id.*

III. Conclusion

Once again, TMA thanks you for the opportunity to provide these comments. If you should have any questions or need any additional information, please do not hesitate to contact me or the following staff of the Texas Medical Association: Lee A. Spangler, JD, TMA Vice President, Division of Medical Economics; or Kelly Walla, JD, LLM, TMA Associate General Counsel at TMA's main number 512-370-1300.

Sincerely,

A handwritten signature in black ink, appearing to read 'ChC', is positioned below the word 'Sincerely,'.

Christopher Crow, MD, MBA
Chair, Council on Socioeconomics
Texas Medical Association