



**National
Business
Group on
Health**

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

July 25, 2011

Submitted electronically via: www.regulations.gov

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

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9993-IFC2
P.O. Box 8010
Baltimore, MD 21244-8010

CC:PA:LPD:PR (REG-1255922-10)
Room 5205
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Amendment to 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 (Affordable Care Act)

Dear Sir or Madam:

The National Business Group on Health is pleased to comment on the amendment to the interim final regulations implementing the Patient Protection and Affordable Care Act's (Affordable Care Act's) requirements regarding internal claims and appeals and external review processes (Amendment).

The National Business Group on Health represents approximately 330 primarily large employers, including 64 of the Fortune 100, who voluntarily provide health benefits and

other health programs to over 50 million American employees, retirees, and their families.

As our members prepare for implementation of the Affordable Care Act's requirements for internal claims and appeals and external review processes, a primary concern will be minimizing the administrative and cost burdens associated with these processes. Allowing plan sponsors flexibility to adapt their compliance procedures to existing plan claims and appeals procedures will reduce these burdens and allow plan sponsors to devote more resources toward maintaining and improving health benefits for their employees. Therefore, the National Business Group on Health welcomes the Amendment's provisions that:

- Permit plans to make pre-service urgent care claims decisions within no more than 72 hours, consistent with the original rule under the DOL claims procedure regulation, provided the plan defers to the attending provider with respect to the decision as to whether the claim constitutes "urgent care";
- Permit plans to provide diagnosis and treatment codes and their meanings to plan participants upon request;
- Allow a *de minimis* exception to the rules for deemed exhaustion of internal claims and appeals processes; and
- Limit the Federal external review process to adverse benefit determinations involving medical judgment.

The National Business Group on Health believes that these provisions will reduce administrative and cost burdens and allow plan sponsors much-needed flexibility in claims and appeals and external review processes.

The National Business Group on Health supports the Department of Labor's, the Department of Health and Human Service's, and the Department of Treasury's (collectively, the Departments') efforts to protect plan participants' right to full and fair reviews of claims while implementing the Affordable Care Act's requirements. However, our members continue to have concerns with the complexity and substantial costs involved with certain claims and appeals and external review requirements. **Therefore, the National Business Group on Health supports:**

- (1) **Permanently limiting the scope of claims eligible for external review to those involving medical judgment;**
- (2) **Allowing plans, rather than external reviewers, to determine whether a claim involves medical judgment and therefore is eligible for external review;**

- (3) Excluding legal, contractual, plan design, and plan interpretation decisions from the scope of claims eligible for external review;**
- (4) Eliminating the requirement that plans provide customer assistance processes with oral language services in non-English languages; and**
- (5) Eliminating the requirement that plans include in each notice a statement in the relevant non-English language about the availability of language services.**

We provide further discussion of these recommendations below.

I. Scope of Claims Eligible for Federal External Review

Many National Business Group on Health members sponsor self-insured group health plans and therefore have implemented (or are in the process of implementing) a Federal external review process. Because our members continue to have difficulty contracting with independent review organizations (IROs), we welcome the extended timeline provided in DOL Technical Release 2011-02 for contracting with IROs. As noted above, we also support the Departments' suspension of the original rule regarding the scope of claims eligible for external review for plans using a Federal external review process. However, our members continue to have concerns about the ability of IROs to make accurate and consistent decisions involving issues that go beyond medical judgment. These concerns include the following:

- While IROs have experience making determinations involving medical necessity and experimental treatments, for example, they do not have sufficient expertise to make accurate and consistent decisions that take into account group health plans' legal and contractual issues, particularly when these issues relate to plan sponsors' plan design decisions.
- Plan sponsors generally have broad authority to decide legal, contractual, and plan design issues, and IROs, who do not necessarily have the expertise to make these decisions, should not be permitted to interfere with such decisions.
- For most plans, the plan administrator has discretionary authority under ERISA to interpret the plan, and allowing IROs to do so (for example, by making coverage decisions) would create confusion as to whether IROs are acting as plan fiduciaries under ERISA.
- Allowing IROs to make coverage decisions will result in plan sponsors and IROs having inconsistent plan interpretations, which may result in plan sponsors having to amend their plan documents every time such inconsistency occurs to ensure uniform coverage among plan participants.

- Having to adopt plan amendments every time an IRO makes a coverage decision that is inconsistent with the plan sponsor's will conflict with the Affordable Care Act's requirement that plan sponsors provide 60 days *advance* notice of any material modification in coverage.
- Inconsistencies between plans' and IROs' plan interpretations could make plan sponsors' administrative and coverage costs highly unpredictable, which could result in plan sponsors having fewer resources to devote to maintaining and improving employees' health benefits.

In addition, our members are concerned with the broad scope of determinations, described in the Amendment's Preamble, that the Departments consider to involve "medical judgment." For example, whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a plans' wellness program has, until now, been decided by plan administrators. Inserting the external review process into such decisions could significantly increase administrative and costs burdens associated with wellness programs, which would run counter to the Affordable Care Act's provisions that encourage adoption of wellness programs.

Likewise, our members are concerned with expanding the scope of claims eligible for external review to include determinations involving: (1) frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified in recommendations or guidelines specified in the Affordable Care Act and (2) whether a plan is complying with nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act. Expanding external review to include these determinations essentially would allow IROs to make legal and plan design decisions, which we do not believe was the underlying intent of the external review provisions of the Affordable Care Act. As noted above, allowing IROs to make such decisions could result in the IRO taking the plan sponsor's role.

Finally, the National Business Group on Health believes that the plan—not the external reviewer—should decide whether a claim involves medical judgment. This decision involves plan interpretation, which generally falls within the plan administrator's discretionary authority under ERISA. Allowing an IRO this authority would create confusion as to whether the IRO is acting as a plan fiduciary under ERISA.

For the reasons described above, the National Business Group on Health recommends:

- (1) In final regulations, *permanently* limiting the scope of claims eligible for external review to those involving medical judgment;
- (2) Specifying in final regulations that whether a claim involves medical judgment will be determined by the plan;

- (3) Providing in final regulations an exclusive list of the types of claims that will be considered to involve medical judgment; and
- (4) Specifying in final regulations that the scope of claims eligible for external review does not extend to legal, contractual, plan design, or plan interpretation decisions.

II. Form and Manner of Notice

National Business Group on Health members employ and provide health benefits for employees under a wide variety of work arrangements, including full-time, part-time, seasonal, and temporary. In addition, our members often operate multiple lines of business in multiple locations (sometimes in all 50 states). Providing notices to such widely dispersed plan participants and beneficiaries often involves significant administrative and cost burdens for our members, and therefore, we commend the Departments' efforts to simplify information collection burdens of plans and issuers.

However, we believe the Amendment's form and manner of notice requirements could result in administrative and cost burdens for plan sponsors that substantially outweigh the benefits for plan participants and beneficiaries. For example, because the Amendment requires non-English language statements in every notice sent to a county that meets the 10% threshold for people literate only in the same non-English language, a plan sponsor could be required to maintain a separate version of a notice even if there is only one plan participant residing in a county that meets the 10% threshold. Likewise, the requirement to provide oral language services in applicable non-English languages could result in a plan sponsor having to maintain such services for a single participant residing in a county that meets the 10% threshold—even if no other participants speak the applicable non-English language. In addition, a plan sponsor would have to evaluate its participant population every year to determine if plan participants have moved from counties that do not meet the 10% threshold to counties that do (or between counties where applicable non-English languages differ), thereby requiring revised notices and additional oral language services. These requirements will be especially burdensome for employers that operate in multiple states or multiple counties within a state.

The National Business Group on Health believes that the requirement to provide notices in applicable non-English languages upon request adequately ensures that notices will be provided in a culturally and linguistically appropriate manner, as required by the Affordable Care Act. Many of our members voluntarily provide oral language services and notices in non-English languages when they have substantial numbers of non-English-speaking plan participants, but requiring such measures with respect to every county that meets the Amendment's 10% threshold could present substantial costs with minimal benefit for plan participants and beneficiaries. For these reasons, the National Business Group on Health recommends:

- (1) Eliminating the requirement that plans provide customer assistance processes with oral language services in applicable non-English languages and

- (2) Eliminating the requirement that plans include in each notice a statement in the applicable non-English language(s) about the availability of language services.

Thank you for considering our comments and recommendations on the amendments to the interim final regulations implementing requirements regarding internal claims and appeals and external review processes. We look forward to working with you as you continue to implement the various provisions of the Affordable Care Act. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in more detail.

Sincerely,

A handwritten signature in black ink that reads "Helen Darling". The signature is written in a cursive, flowing style.

Helen Darling
President