UnitedHealthcare®
A UnitedHealth Group Company

UnitedHealthcare Legal Services
185 Asylum Street Hartford CT 06103

July 25, 2011

Submitted via www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes (CMS-9993-IFC2)

Dear Sir or Madam:

UnitedHealth Group is pleased to provide the Departments of Labor, Health and Human Services and the Treasury (collectively the Departments) with our views on the Amendment to interim final rules (IFR), 76 Fed. Reg. 37208 (June 24, 2011), as corrected, implementing the internal claims, appeals and external review processes under the Affordable Care Act (ACA), 75 Fed. Reg. 43330 (July 23, 2010).

UnitedHealth Group (UHG) is dedicated to making our nation's health care system work better. Our 87,000 employees serve the health care needs of more than 75 million Americans, funding and arranging healthcare on behalf of individuals, employers and government, in partnership with more than 5,300 hospitals and 730,000 physicians, nurses and other health professionals.

We are writing to commend the Departments for maintaining an open regulatory process that seeks the views of those who are likely to be affected by new regulations, consistent with Executive Order 13563, *Improving Regulation and Regulatory Review.*[1]

Overall, the Amendment to the IFR better balances the public policy and consumer goals while reducing the costs and burdens associated with group and individual health plan administration under ACA. This comment letter addresses changes made to the following IFR provisions:

- Expedited Notification of Benefit Determinations Involving Urgent Care;
- Additional Notice Requirements for Internal Claims and Appeals;

[1] E.O. 13563, 76 Fed. Reg. 3821, Jan. 2011.

- Deemed Exhaustion of Internal Claims and Appeals Processes;
- Form and Manner of Notice (non-English language);
- Duration of Transition Period for State External Review Processes; and
- Scope of the Federal External Review Process.

Comments on the Amendment to the IFR

(1) Expedited Notification of Benefit Determinations Involving Urgent Care For Both the Individual and Group Markets

The Amendment to the IFR to retain the 72-hour rule for urgent care claims assures claimants that urgent care claims will be adjudicated quickly, while remaining consistent with existing ERISA requirements and clinical best practices.

As noted in the preamble to the Amendment, the 72-hour rule is an outer limit or a "backstop." Urgent care claims submitted to health plans must be processed as soon as possible, consistent with the medical exigencies. We also note that the Amendment further protects claimants by requiring that plans and issuers defer to the decision of the attending provider as to whether a claim constitutes "urgent care."

(2) Additional Notice Requirements for Internal Claims and Appeals

The adoption of a requirement that plans provide notice of the opportunity to request diagnosis and treatment codes upon request, and to provide this information upon request, improves the IFR on behalf of consumers. In particular, the Amendment addresses concerns with respect to patient privacy and doctor-patient communications that were raised by commenters under the IFR. These changes assure claimants that they will be able to obtain this information if requested, while reducing the potential for loss of privacy and confusion.

(3) Deemed Exhaustion of Internal Claims and Appeals Processes

While the Amendment addresses a portion of the policy concerns raised by creating a potentially appropriate exception to the "strict compliance" standard, we believe that the five-part test for the standard as drafted raises significant administrative complexities that will not serve consumers.

We believe that the Departments should consider an exception that looks to whether the violation is *de minimis* and non-prejudicial to the claimant. This type of exception would build upon federal court cases that have examined the question of deemed exhaustion, as well as prior sub-regulatory guidance issued by the Department of Labor as part of the benefit claims regulation.[2] This approach would improve the exception by creating an objective standard.

---

[2] Frequently Asked Questions on Benefit Claims, Q/A-F2 (May 2002), http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html.

(4) Form and Manner of Notice (non-English language)

We believe this modification provides a meaningful solution for consumers and employers. UHG is committed to providing effective translation services to claimants to assist them in understanding the benefits to which they are entitled and to support them in accessing vital and clinically appropriate health care benefits.

The Amendment to the IFR recognizes that there are efficient ways to offer translation services and ensures that translation services are responsive to consumer needs and concerns. The Amendment strikes a workable balance that requires the provision of oral and written translation services when countywide non-English language thresholds have been met.

(5) Duration of Transition Period for State External Review Processes

Giving States until January 2012 to bring their external review processes into compliance with ACA provides additional time for legislative and regulatory activity ensuring state-based solutions. Additional time for the States to approve legislation or regulations is welcome as a practical matter to assure an orderly transition.

At the same time, however, we urge the Departments to provide plans and issuers with the requisite time to allow for the programming and other system changes that will be required should final determinations regarding the appropriateness of a state's external review process not be made until October 31, 2011.

(6) Scope of the Federal External Review Process

The temporary suspension of the general rule for the scope of federal external review to an adverse benefit determination by a plan or issuer that involves medical judgment or rescissions brings the federal external review process into closer alignment with the NAIC Model Act. The modification provides better consistency for consumers, employers and insurers. In addition, it recognizes the significant costs and burdens that an overly broad federal external review standard would impose on health plans and sponsors of self-funded plans. We urge the Departments to make this change to the scope of federal external review permanent.

Under the revised rule, however, the new temporary scope of federal external review remains somewhat broader than the NAIC Model Act regarding what is generally considered a "clinical" matter subject to external review. We continue to believe, as stated in our prior comment letters, that the scope of external review should be consistent with the NAIC Model Act.

In addition, language in the IFR suggests that it is the IRO that makes the ultimate decision regarding whether a claim involves medical judgment. We urge the

Departments to carefully monitor the external review process from the effective date of the Amendment to ascertain IRO ability to correctly make such determinations.[3]

We note also the specific example from the Amendment that provides the IRO the authority to determine whether or not a plan is complying with the non-quantitative treatment limitation (NQTL) provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations. The determination of compliance with a federal law and regulations does not involve a medical determination or clinical judgment. While the NQTL provisions do regulate the plan's design and operation with respect to parity of medical management techniques (along with other non-clinical provisions such as network admission standards), the determination of compliance of the plan's design and operations is not itself a medical or clinical judgment. We would respectfully suggest it is not an appropriate area of authority for an IRO to make such a determination.

Conclusion

One of the President's stated goals of Executive Order 13563 was to fashion a regulatory process based, to the extent feasible and consistent with law, on the open exchange of information and perspectives among state and local governments, experts in the relevant disciplines and affected stakeholders in the private sector and the public as a whole. We believe the Amendment to the IFR implementing the internal claims, appeals and external review processes under ACA has taken the perspectives of stakeholders into account and, as a result, the Administration has promulgated an improved IFR that more carefully balances these complex policy and operational issues.

On behalf of the 75 million Americans we serve, thank you for your careful consideration of our views. We look forward to working closely with the Departments in the future. Please no not hesitate to contact me if you have any questions about these comments.

Sincerely,

Thomas J. McGuire
Senior Deputy General Counsel
UnitedHealthcare Employer & Individual

[3] The qualifications of an IRO to make such determinations remain unclear to us, and the practical considerations of such a two or three step "determination of eligibility for external review" process would appear to simply add cost to the system without adding any overriding benefit to the consumer.