AMERICAN NURSES ASSOCIATION

8515 Georgia Avenue, Suite 400
Silver Spring, Maryland 20910-3492
301 628-5000 • Fax 301 628-5001
www.NursingWorld.org

Karen A. Daley, PhD, MPH, RN, FAAN
President

Marla J. Weston, PhD, RN
Chief Executive Officer

July 25, 2011

Submitted electronically to http://www.regulations.gov

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9993-IFC2

RE: "Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes." CMS-9993-IFC2; RIN 0938-AQ66. 76 Federal Register 122, June 24, 2011.

Dear Dr. Berwick:

The American Nurses Association is writing to comment on the June 24, 2011 amendments (Amendments) to the July 23, 2010 interim final rule (IFR), "Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes." The ANA represents the interests of the nation's 3.1 million registered nurses, the single largest group of health care professionals in the United States.

We applaud CMS for continuing to work with all stakeholders to try to develop a workable appeal process that ensures that consumers have a meaningful opportunity to contest denials of health insurance coverage. For example, we are pleased that rescissions remain subject to external appeal for self-funded plans and nonfederal government plans, and that plans must strictly comply with the rules, with the only exception being *de minimis* violations that do not harm or prejudice the claimant, that were for good cause or beyond the plan/issuer's control, taking place in the context of an ongoing good faith exchange.

ANA has two concerns about the June 2011 IFR that could benefit from additional amendment. In keeping with CMS's goal of ensuring adequate protection of consumers, we offer the following comments:

1. ANA recommends that the examples of situations in which a claim is considered to involve "medical judgment" should include adverse benefits determinations that are made based on the appropriateness of the individual providing the service.

The June 2010 IFR provided for a broad scope of claims which ANA believes is strongly supported by the Affordable Care Act's (ACA) provisions protecting consumers. However, under the June 2011 Amendment, the broad scope of claims is suspended to those that involve "medical judgment" (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, and those involving a rescission of coverage.

While ANA appreciates that the "medical judgment" standard is retained in the IFR, we are very concerned by the limitation on what constitutes the scope of that medical judgment. The examples of medical judgment included in the Preamble are helpful, but omit a crucial example that will become increasingly significant as plans seek efficiencies and quality improvements based on interdisciplinary, patient-centered care. **In addition to the example of determinations based on the "appropriate health care setting," the list of specific examples should also include determinations based on the "appropriate health care provider."** While the subsequent example speaks to whether treatment by a "specialist" is medically necessary or appropriate, too often the interpretation of "specialist" is confined to physicians. This excludes other providers, such as advanced practice registered nurses, who may be the more appropriate and/or consumer chosen practitioner. This comports with the non-discriminatory language found in the ACA (Section 2706. "Non-Discrimination in Health Care"), which reads in whole:

> ''SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.
> ''(a) PROVIDERS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.
> ''(b) INDIVIDUALS.—The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage."

ANA also requests that the IFR be further amended to include the examples of medical judgment in consumer education materials and employer compliance materials on the DOL and HHS websites.

2. ANA believes that the shortening of the time frame for a consumer to file an external review creates an undue burden on individuals and should be changed to comport with the NAIC Model Act's four month window.

Under the June 2010 IFR, and as called for under the NAIC Model Act, the external appeal process must allow the consumer/claimant least four months to file a request for external review after receipt of the notice of adverse benefit determination or final internal benefit determination. Under the Amendment, this period has been reduced to 60 days, a period that may foreclose the chance for patients, some who may be very sick, to seek a reversal of an adverse decision. This seems to us to be an especially arbitrary change, for which no explanation is given. The four months required by the Model Act recognizes the potential need for more than a couple of months to initiate an appeal and does not impose undue burden on plans and issuers. If a state process allows fewer than four months to appeal during this interim period before 2014, consumers who are unable to meet the state's appeal deadline should have the option of using the federal appeals process for the remainder of the four months.

ANA appreciates the difficulty in developing a review and appeals process that balances consumers' rights for a meaningful opportunity to contest denials of health insurance coverage with the constraints and obligations placed upon plans. ANA hopes that the Final Rule will be amended to reflect the two consumer protections noted above. Thank you for the opportunity to comment. Please direct any questions you may have about ANA's concerns to Cynthia Haney, JD, Sr. Policy Fellow, at cynthia.haney@ana.org or 301-628-5131.

Sincerely,

Marla J. Weston, PhD, RN
Chief Executive Officer
American Nurses Association

Cc: Karen A. Daley, PhD, MPH, RN, FAAN
President
American Nurses Association