

UPMC HEALTH PLAN

July 22, 2011

Two Chatham Center
Eleventh Floor
112 Washington Place
Pittsburgh, PA 15219
412-434-1200
412-454-7527 (fax)

www.upmchealthplan.com

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

Re: Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Process.

UPMC Health Plan is pleased to submit the following comments in response to the Amendment to interim final rule regarding Group Health plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Process (the “Amendment”).

First and foremost, we thank the Department of Health and Human Services, the Department of Labor and the Internal Revenue Service (collectively, the “Agencies”) for their tireless efforts to draft a comprehensive regulation that will afford consumers access to a timely and equitable appeal process that is readily administrable by insurers and group health plans. We commend the Agencies for their careful consideration of the comments they have received since the release of the interim final rule (“IFR”) and for the changes they made to the IFR as the result of that feedback. We are grateful for the Agencies’ willingness to forestall the effective dates of some of the requirements imposed by the IFR, both through this Amendment and via previous guidance. In particular, we support the Agencies in affording States more time to implement compliant external review processes. We firmly believe that States are in the best position to understand the needs of their constituents and to develop appeal processes that best serve both insurance and group health markets. The extra time given States to formulate effective appeal processes will assure that most States maintain appropriate control going forward.

Likewise, we commend the Agencies for their commitment to review each State’s existing external review process to determine whether it is “NAIC-similar.” We believe that allowing insurers and health plans to continue to comply until 2014 with State review processes that meet nearly all of the long-term requirements will reduce the threat of market disruption, while continuing to afford members access to the appeal rights to which they are entitled. We have

concerns, however, about the timeframes set forth in the Amendment in these regards. First, the Agencies have committed to conducting reviews and informing States whether the processes are “NAIC-similar” on or before July 31, 2011. States whose appeal processes are not deemed to be NAIC-similar will then have the right to file an appeal, with determinations to be rendered by HHS on or before October 1, 2011. While we are hopeful that Pennsylvania’s review process will be deemed NAIC-similar in the first instance, to the extent it is not, we are concerned with our (and our employer groups’) ability to fully transition to a federal review process (including amending and reissuing all relevant member materials to reflect resultant changes) by January 1, 2012. We ask that the Agencies issue further guidance in this regard, which extends to insurers and plans limited grace periods relative to the current tight timeframes.

We are equally supportive of the Agencies willingness to limit the disclosure of diagnostic and treatment code information to those members who request it. We, like others commenting upon the IFR, were concerned about the potential HIPAA implications of routinely including such information on EOBs. With that said, we would further recommend that an insurer’s or group health plan’s obligation to provide such codes be limited to those instances where either or both the diagnostic and/or treatment codes were relevant to the decision at issue. Members often have multiple diagnoses, none or few of which may factor into a given decision under review. We believe that further limiting disclosures in this manner will assure that those members who desire to receive information relevant to their appeals are provided access to such information without compromising the minimum necessary standards espoused by HIPAA.

Next, we are generally pleased with the revision to the obligations initially imposed under the IFR with respect to the scope of external review for self-funded plans. We, along with many who commented upon the IFR, believe that members of self-funded plans should be afforded access to the same scope of review advocated by the NAIC Uniform Model Act and by most States with existing external review processes. We firmly believe that only those appeals requiring medical judgment should be subject to external review; this limitation should apply to appeals of rescissions as well. Beneficiaries are already afforded an internal review process for claims hinging upon legal or contractual issues, which are often decided by experts in those areas. Independent external reviewers are medical and not legal experts and, as such, have no expertise in deciding non-medical claims. For these reasons, we support the Agencies in limiting the scope of review to those hinging upon medical judgment and advocate that this limitation be made a permanent part of future regulations.

With that said, we firmly believe that insurers and health plans should, absent extenuating circumstances, be the determiners of whether appeals involve matters of medical necessity. First, insurers routinely make these determinations -- both when deciding whether denials are subject to external reviews and when channeling internal appeals to the proper in-house decision-makers. Secondly, charging independent review organizations (IROs) with making these threshold determinations would presumably require insurers to pay IROs whether or not the appeal at issue is ultimately reviewable. At a time when it is imperative for all stakeholders to

better manage costs, it is imprudent to needlessly increase costs in this manner. For these reasons, we ask that the Agencies consult with industry experts and other stakeholders (including insurers and IROs) to establish criteria and standards, which set forth the instances when threshold decisions must be made by IROs.

Additionally, DOL Technical Release 2010-01 permitted States to expand access to their State external review processes to self-funded plans not subject to applicable State laws. Self-funded plans that chose to voluntarily subject themselves to these State review processes met their responsibilities to provide effective external review to their members. While this option is referenced in the preamble to the Amendment in footnote 13, it is somewhat unclear whether this option is still available to self-funded plans going forward and, if it is, for how long. We respectfully seek guidance and clarification in this regard, which will allow self-funded groups to plan accordingly.

We fully support the Agencies' recommended modification to insurers' and plans' obligations to provide notices to beneficiaries in a culturally and linguistically appropriate manner. Since the release of the IFR, we have diligently attempted to develop processes by which to gather the information necessary to determine the non-English speaking thresholds of our many employer groups; this was not information that we (or other insurers) generally maintained. We believe that the requirements as amended will allow us to adequately serve those members for whom English is not a first language without the unnecessary costs and burdens associated with (1) expanding the type and extent of information gathered from groups and (2) implementing a new (and potentially expensive and labor-intensive) tagging and tracking process for affected-beneficiaries.

The Agencies specifically ask whether health insurance issuers should be required to provide language services in languages that do not meet the requisite thresholds if requested by administrators or sponsors of groups. We believe it is essential that issuers respond to the needs of their members and employer groups, including by providing services necessary to assist members and groups to fully understand their benefits, rights and obligations. For this reason, we (and other insurers) have been providing a wide range of language (and other) assistance services for years. We do so because of market demand and good business, not because of edict or regulation. As such, we are confident that a regulation or mandate of this nature is unnecessary.

Finally, while we fully understand the complexities attendant to drafting a comprehensive appeals regulation, we find the resultant patchwork of regulation, amendment to regulation, sub-guidance and varied Q&A somewhat difficult to follow. We are concerned that, going forward, insurers, plans, consumers and other stakeholders may have a difficult time trying to fully decipher their obligations and rights, as well as determine the applicable deadlines and effective dates under the regulations. For this reason, we respectfully recommend that, when drafting the final rule, the Agencies pull together the IFR, its Amendment and related-guidance into one

comprehensive regulation, which more clearly defines the rights and obligations of all concerned.

Thank you for providing us the opportunity to offer input into the Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Process. We appreciate your consideration of these comments and look forward to working with you in the future.

Sincerely,

A handwritten signature in blue ink, appearing to read 'D. Vukmer', with a long horizontal line extending to the right.

Daniel B. Vukmer
Vice President & General Counsel
Chief Compliance Officer