September 17, 2010

Jay Angoff, Director
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services (HSS)
Attention: OCIIO-9993-IFC
P. O. Box 8016
Baltimore, MD 21244-1850

Dear Mr. Angoff,

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents more than 94,700 family physicians and medical students nationwide. Specifically, I am writing to offer our comments on the interim final rule regarding internal claims and appeals and external review processes under the Patient Protection and Affordable Care Act as published in the July 23, 2010, *Federal Register*.

We interpret that these rules apply to both insured and self-insured group plans as well as individual plans with anniversary or effective dates on or after September 23, 2010. They exclude grandfathered plans. Plans falling into these categories must implement effective, internal claims and appeals processes as well as a review process. These interim final rules also provide a basis for determining whether a State or Federal review process is applicable.

The interim final rule separates group plans from individual plans when describing the rules for internal claims and appeals processes. The rules set forth 6 new requirements from previous Department of Labor (DOL) claim procedure regulations for group plans, which are provided below:

First, the definition of an adverse benefit determination is broader. The definition adds to the DOL's prior definition and now includes rescission, which includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or part) for a benefit based on:

- a determination of a person's eligibility to participate;
- a determination that a service is not a covered benefit;
- the imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion or other limitation; or
- a determination that a benefit is experimental, investigational or not medically necessary or appropriate.

Second, the interim final rule also reduces the length of time within which a benefit determination must be made with respect to urgent care. Per the interim final rule, a determination must be made within 24 hours, versus the

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previous 72 hours, from the time the urgent care claim is received by the plan, and a notice of the decision must be issued within that time, too.

Third, the interim final regulations provide additional criteria to ensure that a claimant receives a full and fair review. Moreover, the claimant must be provided with the rationale of the decision.

Fourth, the interim final regulations provide new criteria with respect to avoiding conflicts of interest. The independence and impartiality of the person(s) making the decision must be assured, and the choice of who reviews claims cannot be based on the likelihood that the person will support the denial or the contracting of the expert be based on a reputation for outcomes in contested cases.

Fifth, the interim final regulations require a plan or issuer to provide notice to enrollees in a culturally and linguistically appropriate manner as well as include information sufficient to identify the claim involved, including date of service, provider, amount, diagnostic and treatment code(s), and the reason for the adverse benefit determination, including the denial code(s). The plan or issuer must also provide a description of the available appeals and review processes, including how to initiate one and the contact information for assistance.

Finally, the rules provide that if a plan or issuer fails to adhere to all of the requirements of the internal claims review and appeals processes, the claimant may initiate an external review.

Issuers of individual health insurance coverage must comply with all the requirements above, plus three additional requirements:

- The scope of the internal claims and appeals process is broadened to include initial eligibility determinations, since eligibility is frequently based on the individual's health status, including pre-existing conditions. For plan years after January 1, 2014, a prohibition on pre-existing conditions exclusions takes effect.

- Only one level of internal appeal is required.

- Individual health insurance issuers must keep all records of claims and appeals for at least 6 years, which is the same for group plans under Employee Retirement Income Security Act (ERISA) recordkeeping requirements.

The interim final rule also outlines whether a State or Federal external appeals process is applicable. If a plan includes the minimum consumer protections provided under the National Association of Insurance Commissioners' Uniform Model Act, then the State external review process applies. If not, the Federal external appeals process applies. We agree with the Departments that these minimum consumer protections should apply, and we also agree with the Departments' acknowledgement that State appeals processes are more effective when they are administered consistently across the market. The Departments request comments regarding whether the Federal external review process should apply to all plans and issuers if the State external process does not apply to all issuers in the State (e.g., a particular health maintenance organization in a State). The Departments acknowledge that currently there are inconsistent claims and appeals processes, which lead to a patchwork of consumer protections. We agree with this statement. If, after the proposed opportunity to comply with established external claims and appeals processes has expired, a plan or issuer that has not implemented needed

changes, a Federal external process should be instituted. We conclude that the rules and administration process for both consumers and providers of healthcare are simplified simply by being consistent.

As noted earlier, the interim final regulations require a plan or issuer to provide notice(s) to enrollees in a culturally and linguistically appropriate manner. The requirement to provide such notice is based on thresholds of the number of people who are literate in the same non-English language. In the group market, the threshold differs depending on the number of participants in the plan. The following guidelines would apply:

- For plans covering fewer than 100 participants at the beginning of a plan year, the threshold is 25% of all participants being literate in the same non-English language
- For plans covering 100 or more participants at the beginning of a plan year, the threshold is the lesser of 500 participants or 10 percent of all participants being literate in the same non-English language.

In the Individual market, the threshold is 10 percent of the population residing in the county being literate in the same non-English language. HSS will publish information that issuers may consult to estimate these county levels.

We agree with respect to the requirement that notices be provided in a culturally and linguistically appropriate manner. However, we note the term "participants" is not specifically defined in the interim rules. Having found no information to the contrary, we made the assumption that it means "lives," including employees and their eligible dependents. We also generally agree with the method of determining the threshold of the number of people who are literate in the same non-English language to initiate the alternative notice. This method assumes the number of participants and the English literacy of the participants is evaluated by issuers at the beginning of each plan year, and the AAFP assumes the intention is for an annual review, although that is not specifically stated in the interim rule.

The costs of such translations or who would be responsible for such translations is not clear in the rules. The Departments indicated that cost estimates could not be made, but they feel the impact would be minimal. The AAFP feels the costs, although difficult to assess, have the potential to be significant if no method or authority is established for translation. We encourage the Departments to clarify this aspect of the rule. We do agree, however, that for large groups, alternative non-English notices should continue to be determined on a county-by-county basis versus across a plan or issuer's market as the variation in concentration may be great.

In conclusion, we appreciate the opportunity to comment on this interim final rule. If you have questions, please contact Laura Schmidt at 913-906-6000, extension 4134.

Sincerely,

Ted Epperly MD

Ted D. Epperly, M.D.
Board Chair

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