ACHP
ALLIANCE OF COMMUNITY HEALTH PLANS

September 21, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

Re: **OCIIO-9993-IFC**– Interim Final Rule for Group Health Plans and Health Insurance Coverage Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act

Dear Director Angoff:

The Alliance of Community Health Plans (ACHP) is pleased to submit comments in response to the Interim Final Rule with Comment on Section 2719 of the Public Health Service Act, which was added by Sections 1001 and 10101 of the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148).

ACHP is a national leadership organization representing community-based and regional health plans and provider organizations that collectively provide health care and coverage for approximately 18 million Americans. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems. Member plans share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality.

For plan years beginning on or after September 23, 2010, Section 2719 sets forth standards for internal claims and appeals and external review processes for group health plans and health insurance issuers offering group or individual health insurance coverage. Section 2719 provides the Secretaries authority to deem external review processes in operation on March 23, 2010 to be in compliance with Section 2719 of the PHS Act. Section 2719 does not apply to grandfathered plans within the meaning of Section 1251 of the PPACA.

ACHP agrees that all enrollees should have access to well-defined claims review and external appeals processes. We appreciate the challenges faced by the Departments in implementing Section 2719 of the PHS Act under a short timeline. Effective implementation of the standards depends upon regulations that are clear and easy to understand for all stakeholders and facilitate interactions among health plans, employers and other plan sponsors, and consumers. The complexity of existing and new state or federal external review processes and requirements imposed on differing types of plans and issuers under the IFR may cause confusion and uncertainty. Also, the very short timeframe for implementation of new regulatory requirements, some very burdensome and costly,

1729 H Street, NW, Suite 400 • Washington, DC 20006 • p: 202-785-2247 • f: 202-785-4060 • www.achp.org

underscores the need for the Department to consider the good faith efforts by plans for regulatory compliance; to phase in the new requirements imposed under the IFR over time; and to exercise its authority to deem external review processes in effect on March 23, 2010 to be in compliance with requirements imposed under Section 2719 of the PHS Act.

Definition of Adverse Benefit Determination

Under the IFR, the definition of the term "adverse benefit determination" includes a rescission of coverage (as defined in section 147.128(a)(2) of title 45 Code of Federal Regulations) and which, for example, includes circumstances under which an enrollee is disenrolled retroactively by an insurer after receiving notice from an employer that the *employee is no longer eligible* for coverage. This is a common occurrence, and if the term rescission of coverage applies in this and other similar circumstances, it will increase the number of appeals. We seek clarification on the scope of the definition of "adverse benefit determination" and urge that retroactive disenrollment for employees no longer eligible *not* be included in the definition of rescission.

Internal Claims and Appeals Process

Deadline for Notices Relating to Urgent Care Claims

The IFR requires plans or issuers to notify any claimant of a benefit determination, adverse or otherwise, involving urgent care not later than 24 hours after receipt of the claim. We believe that the reduction from 72 hours under prior regulations to 24 hours under the IFR is too severe and will not afford plans and issuers sufficient time to properly review a claim. This not only increases costs – for example, by requiring claims offices to operate 7 days a week – but also increases the potential for errors. We urge reconsideration of the 24-hour requirement.

There are several points in this provision that we believe require clarification:

- Our reading of the requirement imposed under the IFR for the 24-hour urgent care notice requirement is that it applies only with respect to an initial benefit determination and does not apply with respect to an appeal of that initial benefit determination or otherwise. ACHP seeks clarification on the scope of the applicability of this requirement.

- We also seek clarification on the applicability of the requirements for cultural and linguistic appropriateness in the case of urgent care notices. If such a notice must be provided within 24 hours of receipt, and a plan must comply with requests to provide a linguistically appropriate urgent care notice, it will be very difficult to meet the 24-hour deadline.

- Clarification is also needed on whether plans must provide linguistically appropriate notice when a notice of benefit determination is sent to a provider requesting the service on behalf of, or in addition to, the patient.

Requirements for Full and Fair Review

ACHP member plans are committed to providing claimants full and fair review of a claim. The IFR imposes several new requirements on plans and issuers to respond or provide further information, but does not take into account the additional time required to comply with those requirements for the level of appeal involved. For example, with respect to an adverse benefit determination which is based on new or additional rationale, the IFR requires that determination to be provided with 30 days of the request for appeal. Yet the plan must provide the claimant with the rationale sufficiently in advance of the final initial adverse benefit determination, and afford the claimant the opportunity to respond. Under these requirements, the plan or issuer must provide the claimant a pre-denial notice before giving a final adverse benefit determination notice; in essence, this will require the plan to afford the claimant an additional level of appeal. This will create confusion for the members and also raises concerns that the plan may not receive a response from a claimant until the last moment (for example on the 29th day of the 30-day claim review period). The plan or issuer would not have sufficient time to consider and respond to facts or issues raised in the claimant's last minute response. We recommend that an extension be provided to plans and issuers under these and similar situations, to afford all parties sufficient time to consider the merits of the positions set forth with respect to the claim. For example, in the case of this type of pre-denial notice for change in rationale, the claimant could be required to respond to the change in rationale under a shorter time frame.

We seek clarification about the new requirement imposed under the IFR that plans and issuers notify a claimant with any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim. Does this notice requirement apply for *each* instance the plan or issuer receives new information with respect to the claim? For example, if additional information is submitted by the provider who initiated the claim on behalf of the claimant, must the plan or issuer notify the claimant or could the plan or issuer treat that submission as having been made by the claimant, without the need for additional notice to both the provider and claimant? Also, if there is no cut-off point for additional information, plans may not be able to make a decision within the required timeframe. How does this requirement reconcile with the 24-hour time period allotted for response to urgent claims?

Additional Information Required in Notices

ACHP believes that the additional information which must be provided in notices of adverse benefit determination, including diagnosis and treatment codes, raises HIPAA privacy concerns, may cause confusion, and will be extremely complex to implement.

Under HIPAA, a plan or issuer may issue explanation of benefit statements to the policyholder and not to the patient/member. Requiring diagnosis and treatment codes on adverse benefit determinations, including explanations of benefits, calls into question privacy protections of the member and patient and may conflict with state laws requiring confidentiality of sensitive diagnoses. ACHP is concerned that plans and issuers will be subject to privacy challenges in those cases where a notice of adverse benefit determination is issued to a patient who is not the policyholder or subscriber, for example, the dependent spouse or child. Under the IFR, it is unclear whether these diagnosis and treatment codes are deemed to be data elements that are part of the

minimum necessary information for purposes of benefit determination notices, so that issuers are protected from privacy challenges under these circumstances. We also request clarification on whether the issuer is responsible for translating codes to meet the linguistic requirements of the regulation.

A single claim may have many diagnosis and treatment codes associated with it, and this will be confusing for members. There are more than 17,000 ICD-9-CM codes and more than 140,000 ICD-10-CM codes. Corresponding definitions of ICD-9-CM, ICD-10-CM, and CPT codes are not standard elements in claims at this time and these codes are not generally included in physician or hospital billings. For the explanation associated with the codes to be understandable to a claimant, plans and insurers will have to use the long version of the codes, which means configuration changes or information technology upgrading and the purchase of the "long form." If the Department requires inclusion of diagnosis and treatment codes, we recommend that only the primary diagnosis and treatment code be included in the notice and that the "short form" description of the applicable code should be all that is required under the IFR.

ACHP also seeks clarification of the requirement that a description of the standard that was used in denying the claim be included in a notice of adverse benefit determination. The Department of Labor claims procedure regulation currently requires a plan to make available to the claimant upon request the internal rule, guideline, protocol or similar criterion used by the issuer to make its determination. We are concerned that a change in the trigger for required inclusion of this information from "upon request" to automatic inclusion in every notice of adverse benefit determination, including explanations of benefits, will be very difficult to implement for plan years beginning on or after September 23, 2010, due to the scope and difficulty of implementation in a short timeframe.

External Review

ACHP seeks clarification on the issue of whether a plan or issuer that is required to comply with a state external review process must now include denials not based on utilization review under the state external review process. For example, the State of New York requires external appeals for claims relating only to utilization review denials, yet the IFR indicates that non-utilization review denials are also subject to external appeals. This creates two different standards for external review applicable to self-insured and fully-insured employers, respectively. Under the IFR, failure to adhere to strict compliance with requirements for internal claims and review results in external review. Insurers and employers require specific guidance with respect to which appeals are subject to external review and how they may ensure compliance with the regulations. For example, in the case of external review under state law that only accepts utilization review denials, it is unclear how insurers and employers are to afford their members the right to immediate external review for non-utilization review denials. For states with an external review process in place on September 23, 2010 that is limited to utilization review determinations, we recommend that issuers subject to the federal external appeals process be required only to provide access under the federal interim external appeals process in connection with adverse determinations for utilization review determinations.

Culturally and Linguistically Appropriate Notices

ACHP recognizes the significant need for culturally and linguistically appropriate notices, and urges the Department to set requirements that take into account difficult operational issues that plans will face in providing these notices. Plans and issuers do not, as a matter of course, inquire about or identify the culture and language of enrollees or members. However, they do provide materials in another language upon request, and we urge the Department to require linguistically appropriate notices *upon request*. Imposing a requirement for notices in different languages based on enrollment percentage thresholds could require hundreds of different types of notices. ACHP recommends that plans operating in states with similar linguistic requirements be given "safe harbor."

The IFR is unclear on the precise nature of materials and types of information that must be presented in a culturally and linguistically appropriate manner; it merely refers to relevant notices. For example, does the requirement apply only to notices of internal claims and appeals and external appeals? Are issuers responsible for providing translation of documents prepared by an IRO? We also seek guidance on the extent to which customer assistance must be provided in a culturally and linguistically appropriate manner; for example, would the use of a language line service that provides a verbal translation of these documents satisfy this requirement?

Secretarial Authority on Timing of Implementation, Good Faith Efforts

The extremely short deadline for compliance with the provisions of the IFR creates myriad administrative and operational difficulties, especially given the potential for different interpretations of the requirements and the legal standards established for compliance under the IFR. We urge the Department to consider the good faith efforts by plans and issuers to comply with new and complex regulatory requirements, to phase in those requirements over time, and to exercise its authority to deem external review processes in effect on March 23, 2010 to be in compliance with requirements imposed under Section 2719 of the PHS Act.

Thank you for your consideration of our views. We would be happy to answer any questions about these recommendations or provide additional information.

Sincerely,

Howard Shapiro
Director of Public Policy