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JC 8.20.10

September 21, 2010

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Attention: RIN 1210-AB45
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

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

CC:PA:LPD:PR (REG-125592-10)
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

RE: File Code RIN 1210-AB45/ OCIIO-9993-IFC/ CC:PA:LPD:PR (REG-125592-10). Proposed Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act

Dear Sir or Madam:

On behalf of the more than 2.2 million workers represented by the Service Employees International Union (SEIU), including hundreds of thousands who receive health benefits through union sponsored insurance plans and Taft-Hartley benefit funds, we thank you for the opportunity to comment on the proposed Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act (IFR).

We wish to voice our support for certain provisions of the IFR. In particular, we support:

1. the IFR interpretation of continued coverage as meaning compliance with the requirements of 29 CFR 2560.503-1(f)(2)(ii),
2. the application of continued coverage only to the internal appeals process, and
3. the provisions for providing notice that is culturally and linguistically appropriate.

In addition, we would not support an expanded interpretation of continued coverage or a requirement that continued coverage be provided throughout the external review.

I. We Support the IFR Interpretation of Continued Coverage as Meaning Compliance With the Requirements of 29 CFR 2560.503-1(f)(2)(ii).

Section 1001 of the Patient Protection and Affordable Care Act requires that a plan provide continued coverage pending the outcome of the appeals process. In order to fulfill this requirement, the IFR requires a plan to comply with the Department of Labor (DOL) claims procedures set forth in 29 CFR 2560.503-1(f)(2)(ii). We support this interpretation.

If comments are submitted by other parties proposing a more expansive interpretation of continued coverage, we would not support such an expansion. As the IFR stands, no individual would be forced to cease ongoing treatment without first having the opportunity for an appeal. At the same time, the IFR ensures that plans which currently follow the DOL claims procedures will not have increased burdens associated with continued coverage. This is important because expansion of continued coverage beyond 29 CFR 2560.503-1(f)(2)(ii) could have a deleterious effect on a plan's beneficiaries and participants through reduced benefits or increased costs.

For example, if a group health plan terminates benefits because an individual's work hours drop below eligibility, the plan should not be required to pay claims pending the outcome of an appeal. If the individual incurred an extremely high claim and the appeal process later confirmed that the termination was correct, the plan would have paid for the claim with plan assets. By paying claims for an ineligible individual, the plan could be in a position of having to cut benefits or increase premiums or contributions.

We emphasize that if the IFR are changed to require additional services, beyond those already covered by 29 CFR 2560.503-1(f)(2)(ii), to be covered pending the exhaustion of the internal appeals process, group health plans could face additional and significant costs that could result in reductions in benefits or increased premiums or contributions.

II. We Support the Application of Continued Coverage Only to the Internal Appeals Process

We support the IFR that apply the continued coverage provision to the internal appeals process but allow for plans to cease payment for ongoing treatment that is a non-covered treatment at the exhaustion of the internal appeals process. The external review process will play an important role ensuring all individuals receive the health insurance coverage individuals and their employers pay for. However, if comments are received recommending that plans be required to provide continued coverage through an external review process, we would not support such a change.

The IFR allow for an expedited external review process to occur concurrently with an internal appeal of a denial of an ongoing treatment. We applaud this provision. However, there is no guarantee that an external review would be completed before or simultaneously with an internal appeal. An expansion requiring continued coverage through the external appeals process could therefore result in plan assets being used to pay for non-covered services and result in benefit cuts or increased premiums or contributions.

For example, according to 29 CFR 2560.503-1(f)(2)(ii) and the IFR, if a plan has approved coverage for rehabilitative treatment and later determines the treatment is not medically necessary, the plan must give notice and an opportunity for appeal prior to ceasing coverage of the treatment.

The plan may cease coverage at the exhaustion of the appeals process if the internal appeals process determines it is not medically necessary and therefore a non-covered service. If the participant requests an external review, the plan should not be required to pay for the rehabilitative services beyond the exhaustion of the internal appeals process, even if the external review is not yet complete. This is because if the external review concurs with the internal appeals process, then the rehabilitative treatment is a non-covered service and should not be paid for with plan assets.

In addition, we ask for clarification on when a plan may terminate benefits if a rescission goes to an external review. The Patient Protection and Affordable Care Act requires a plan to give 30 days notice prior to a rescission of benefits. We believe that a plan should be able to terminate coverage 30 days after notice is received, even if there is a request for external review. If a plan cannot terminate benefits until the end of the external review, then an individual could use the external review process to continue to have claims paid that may be difficult or impossible for the plan to recoup. This could be a particular problem if an individual fraudulently enrolled in benefits and uses the external review process to try to lengthen the period during which claims are paid because of the fraudulent enrollment.

III. We Applaud the IFR for Provisions for Providing Notice That Is Culturally and Linguistically Appropriate

Notice about the internal appeals and external review procedures will mean nothing to individuals who are unable to understand the notice. We applaud the agencies for taking a strong stance that plans must provide notice in a language that is appropriate to the plan participants. We want to particularly point out the importance of two provisions of the IFR:

1. Once a request is made by an individual to provide notice in a non-English language, that all subsequent notices must be provided in that language, and

2. the plan must ensure any customer assistance process maintained by the plan must be provided in any non-English language required when the plan meets the thresholds listed in the IFR.

The two provisions listed above are necessary to ensure individuals have real access to the protections afforded them in the Patient Protection and Affordable Care Act. If a plan is able to revert to sending notices in English, then the individual may be unaware of appeals rights when a specific claim is denied. Providing access in other languages to the customer service process is necessary to ensure notice is provided in a culturally appropriate manner. Health systems vary so widely throughout the world that simply translating a written notice including terms specific to health insurance may not provide culturally appropriate information to an individual who is not familiar with how health insurance operates. In addition, many people who are not familiar with health insurance and have never had to appeal a claim rely on other customer assistance services to explain a complicated process in a time of emotional stress.

On behalf of our 2.2 million members, SEIU thanks you for your diligence in ensuring that the intent of the Patient Protection and Affordable Care Act is fulfilled through regulations and that working families receive the health insurance benefits they are entitled to receive.