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Kaiser Foundation Health Plan, Inc.
Program Offices

September 21, 2010

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

Re: *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* File Code OCIIO-993-IFC

Dear Sir or Madam:

Kaiser Permanente offers the following comments in response to the above-captioned Interim Final Rule ("IFR"), issued in the *Federal Register* on July 23rd. Kaiser Permanente is the largest private integrated healthcare delivery system in the U.S., delivering health care to approximately 8.7 million members in nine states and the District of Columbia. Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals which operates 36 hospitals and over 400 other clinical facilities; and the Permanente Medical Groups, independent physician group practices that contract with Kaiser Foundation Health Plan to meet the health needs of Kaiser Permanente's members. Most pharmacy, diagnostic, and laboratory services delivered to Kaiser Permanente members are performed within Kaiser Permanente.

Kaiser Permanente believes the Patient Protection and Affordable Care Act (PPACA) has the potential to represent an important step towards achieving universal coverage in the United States and towards establishing reasonable market rules that will allow plans to compete on quality and cost rather than on risk avoidance. It is in this context that we offer comments on the aforementioned rule.

Kaiser Permanente strongly supports the right of consumers to obtain timely and fair review of decisions regarding benefit eligibility, medical necessity and enrollment. We currently comply with state mandates regarding the payment of claims, medical review and eligibility for commercial health plans as well as requirements related to its participation in the Federal Employees Health Benefit Plan and Medicare managed care programs. For commercial plans, the IFR makes the claims and appeals process more uniform between self-funded and fully-insured plans and among the different types of fully-insured coverages (ERISA, non-ERISA

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and individual) while extending the individual's right to fair and full review. We offer the following comments:

1. Changes to Internal Claims and Appeals

a. Change to Urgent Care Standard.

The IFR shortens the maximum period for notifying a claimant of the issuer's determination of a preservice request for urgent care from 72 hours to 24 hours, although both the Claims Rule and the IFR require that the determination be made as soon as possible considering the claimant's medical condition.[1] In many circumstances, this 24 hour time frame is unworkable. It often is impossible for a plan to gather the necessary information from treating providers so quickly. Even if the information is available, the IFR creates an undue administrative burden by requiring plans to have medical reviewers and claims processors available essentially round-the-clock. The IFR already requires plans to make decisions as soon as needed based on the claimant's medical condition. By compressing the timeframe artificially to 24 hours, plans will be forced to make decisions without good information and consequently are more likely to make unsatisfactory determinations. Thus, this change could inadvertently result in more cases going to external review which could unnecessarily delay patients getting services.

Recommendation: Retain the current maximum timeframe of 72 hours but if the maximum timeframe is to be changed then modify it to 48 hours or the next business day, whichever is later, following receipt of a preservice request for urgent care.

b. Additional Content Requirements for Adverse Benefit Determinations

The IFR requires an adverse benefit determination (ABD) to include information sufficient to make identification of the claim(s) to which the ABD pertains easily identifiable for the claimant. We are particularly concerned about the requirement to include the diagnosis code, treatment code and corresponding meanings of these codes. It is not clear how these codes will enhance the ability of a claimant to identify the claim and/or to understand the reason(s) for the denial. To be user friendly, it would seem that for most claimants, the less technical the information, the more understandable the ABD notice would be.

Use of these codes not only fails to add clarity for patients, it adds to the administrative expense of processing claims. This level of detail is not typically provided in an initial claims determination, known as an explanation of benefits (EOB), and will require not only health plans and insurers to revamp their process for producing and transmitting EOBs but will require providers to provide additional information for all patients at the time of service. In some instances, such as when a plan determines that a preservice request is not a covered benefit, the diagnosis code(s) may be unknown and no procedure code would be applicable.

[1] *Compare* Claims Rule, 29 C.F.R. sec. 2550.503-1(f)(2)(i) *with* IFR, 75 Fed. Reg. 43330, 43355 & 43359 (to be codified at 29 C.F.R sec 2590.715-2719(b)(2)(ii)(B) and 45 C.F.R. sec 147.136(b)(2)(ii)(B)).

The administrative burden of adding detailed coding information will fall disproportionately on integrated delivery systems, like Kaiser Permanente. In our system, providers usually do not generate a claim or bill for their services unlike most of their counterparts in the fee-for-service world. While providers certainly record medical information from a patient visit in the member's electronic medical record, they usually do not include diagnosis and procedure codes which are used primarily for billing purposes. Adding these codes would delay production of the claim and increase costs, without any benefit for our members.

If detailed coding information is added to the EOBs, because of privacy rules, they would have to be sent only to the patient, rather than the subscriber. Many issuers, including us, have interpreted the Claims Rule and other mandates to permit the transmittal of benefit payment information to the plan participant or policyholder. While individual claimants could always request that such information be sent to a different address, it allowed plans and issuers to communicate with an adult who had the most direct contractual relationship with the plan or issuer. Transmitting notices on an individual claimant basis may make it more difficult for consumers to track family deductibles and other maximum cost share amounts computed on a family basis as the participant or policyholder will no longer receive all EOBs.

Recommendation: Adopt a standard that requires plans and issuers to identify diagnosis and treatment procedures in an EOB in a manner calculated to give claimants meaningful information when provision of such information directly relates to the claim for benefits.

c. Provision of Culturally and Linguistically Appropriate Manner.

Kaiser Permanente supports the provision of information to members who are literate only in a non-English language so they may understand and exercise their appeal rights. We are concerned, however, about the complexity and administrative burden in the IFR requirements, especially when coupled with existing state law requirements. We believe that the needs of these members can be met in a more efficient manner.

The IFR's requirement to determine threshold languages by membership of each group is problematic. Not only does this require detailed analysis of constantly shifting groups, but our preliminary analysis indicates that Kaiser Permanente will need to translate documents into approximately forty different languages. Rather than a group analysis, we suggest that thresholds be determined based on the size of the self-funded plan or issuer's membership in the state. California, for example, divides issuers into three different categories based upon the size of their enrollment and then requires a set number of threshold languages based upon a needs assessment as well as additional threshold languages if the enrollment of non-English speakers surpasses a set number or percentage.[2] The size of the enrollment and the number of threshold languages should be subject to review over time, as the California statute requires.[3] This approach permits uniform administration across the entire enrollment. While we understand the need to be inclusive, we suggest it would be a better use of limited health care

[2] *See* Ca. Health & Safety Code sec. 1367.04(1)(A).
[3] *See* Ca. Health & Safety Code sec. 1367.04(3).

resources to use higher population thresholds and translate documents for the majority of non-English users. For members who use languages that are less prevalent, health plans should provide interpretive services to assist them with the claims and appeals process.

As mentioned above, some states, such as California, already mandates translation of vital documents and access to interpretation services to assist members in understanding their covered benefits and to assist them in obtain benefits and appealing benefit determinations. [4] Rather than requiring issuers to comply with multiple standards, we suggest that compliance with a state statute that achieves the same purposes be deemed compliant with the IFR's standards.

In addition, we suggest that the IFR use the same standard and methodology for determining the threshold languages for all lines of business (large group, small group and individual) so that an issuer may implement one standard. Having a set standard for all lines of business would help streamline the process for determining threshold languages.

Recommendation: Require plans and issuers to identify threshold languages based upon the number of persons they cover and a needs assessment, which should be conducted periodically; to provide notices only in the threshold languages; and, to maintain a customer assistance process that provides translation service to all enrollees who are literate in a non-English language.

d. Deemed Exhaustion When Strict Adherence Standard Not Met

The IFR replaces the current *de minimus* standard with a strict adherence standard that deems exhaustion of all internal remedies when a plan or issuer fails to strictly adhere to all the requirements of the Claims Rule and the IFR. The claimant may initiate external review and pursue other available remedies including litigation based upon an allegation that the standard has not been met. We believe this rule will inadvertently undermine the internal review process. Given the complexity of the IFR requirements as well as the IFR's subjective standards such as the one identified with respect to the provision of additional evidence and new rationales, allegations that the plan failed to strictly adhere to the rule will be common. Additionally, precious resources and time will be wasted determining whether or not there was strict adherence, rather than focusing on the merits of the actual claim for benefits. This seems to be a costly and inefficient way to deal with minor errors. Claimants should not be allowed to skip internal appeal procedures unless they can demonstrate that the error of the plan or issuer directly affected their ability to obtain full and fair review of their claim.

Recommendation: Retain the *de minimus* standard or in the alternative require the claimant to demonstrate the error of the plan or issuer directly affected their ability to obtain full and fair review of their claim.

[4] *See* Ca. Health & Safety Code sec. 1367.04 *et seq.*

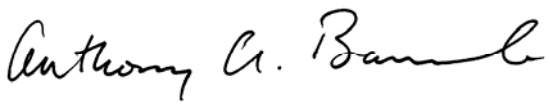
2. External Appeals

We believe that external review should be limited to medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, as it is in the NAIC Model Act. Although many states require external review, it may be available only when a claim involves medical necessity or when a certain type of plan such as group coverage is at issue. It is not clear that states will have the resources available to them to handle the increased number of external reviews that may be filed. Moreover, with a limited number of accredited Independent Review Organizations (IROs) and increased demand for their services, external review for self-funded plans is likely to become more expensive. State regulators and IROs have little experience in reviewing appeals regarding issues other than medical necessity, and to the extent that external review is available for more than medical necessity determinations, the potential for inconsistent interpretation of benefit provisions increases. Consequently, claimants and applicants may not be treated uniformly because benefit and eligibility requirements are not interpreted consistently. In such an environment, issuers may find that benefit and eligibility administration becomes unpredictable.

Recommendation: Limit external review for all types of coverage to medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, which is the NAIC Model Act standard.

We appreciate the opportunity to comment on this IFR. If you have questions or concerns, please contact me at 510.271.6835 (email: anthony.barrueta@kp.org).

Sincerely,



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