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Submitted electronically via the Federal Rulemaking portal @ www.regulations.gov

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

Dear Sir or Madam:

Subject: 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 (Affordable Care Act) and Technical Release 2010-01 (RIN 1210–AB45)

Hewitt Associates (Hewitt) welcomes the opportunity to submit for consideration our comments relating to the interim final rules for group health plans and health insurance issuers relating to internal claims and appeals and external review processes under the Affordable Care Act that appeared in the *Federal Register* on July 23, 2010 and Technical Release 2010-01 that was released by the Department of Labor's (DOL's) Employee Benefits Security Administration (EBSA) on August 23, 2010.

Who We Are

Hewitt Associates (NYSE: HEW) provides leading organizations around the world with expert human resources consulting and outsourcing solutions to help them anticipate and solve their most complex benefits, talent, and related financial challenges. Hewitt works with companies to design, implement, communicate, and administer a wide range of human resources, retirement, investment management, health care, compensation, and talent management strategies. With a history of exceptional client service since 1940, Hewitt has offices in more than 30 countries and employs approximately 23,000 associates who are helping make the world a better place to work. For more information, please visit www.hewitt.com.

Existing External Review Processes

Section 2719(c) of the Affordable Care Act gives the Secretary the authority to deem the external review process of a group health plan or health insurance issuer, in operation as of March 23, 2010, to be in compliance with a state external review process or the federal external review process, as applicable. However, neither the interim final regulations nor the EBSA Technical Release explains when or how the agencies will determine whether an existing external review process complies with the law.

Some employers currently outsource the role of claims and appeals fiduciary to the group health plan administrator of a self-insured group health plan for *benefit* determinations (e.g., whether a particular service was "medically necessary"). (As stated in DOL regulation section 2590.715-2719(d)(1), the external review process does not apply to an adverse benefit determination where a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.)

When the DOL shortened the time frames for making benefit determinations and benefit determinations on review as part of regulations issued on November 21, 2000 (with effective dates no later than January 1, 2003 for group health plans), employers delegated this authority to make benefit determinations to group health plan administrators because they were better equipped to comply with the new requirements, including the shorter time frames for making a decision.

In *Metropolitan Life Insurance Co. v. Glenn*, 128 S.Ct. 2343 (2008), the U.S. Supreme Court considered conflict of interest as a factor when determining whether a plan administrator has abused its discretion in denying benefits. Arguably, the addition of an external review was included in the Affordable Care Act to also address this concern. *MetLife v. Glenn* seems to imply that if the payer of the benefit differs from the decision maker, then there is no conflict. This process is in place today for many employers that sponsor self-insured group health plans—at least in situations where the group health plan administrator is responsible for the final, mandatory benefit determination on review. Accordingly, Hewitt recommends that in this situation, the group health plan be deemed to be in compliance with the external review requirement and thus would not be subject to the external review process laid out in the EBSA Technical Release. In effect, the independent fiduciary third-party review would be considered to be the external review for purposes of these rules.

Because of the upcoming effective date, Hewitt urges the agencies to provide additional guidance as soon as possible regarding when the agencies will exercise their deeming authority so that those plans that will lose grandfathered health plan status can know whether they will need to adjust their current processes.

De Novo Review

The EBSA Technical Release requires that in reaching an external review decision, the independent review organization (IRO) will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process. Hewitt believes that the de novo standard goes beyond the statutory requirements and even beyond the Model Act promulgated by the National Association of Insurance Commissioners (NAIC Model Act). By requiring a de novo review of an internal claims decision, the IRO is prohibited from giving any deference to the plan in making its decision. This review standard will have the effect of making the internal claims and appeals process irrelevant.

The Affordable Care Act requires that a self-insured group health plan that is not subject to state law must comply with an external review process that meets minimum standards established by the Secretary that is similar to the process set forth in the NAIC Model Act.

The NAIC Model Act states that in reaching a decision, the IRO "is not bound by any decisions or conclusions reached during the health carrier's utilization review process." However, the NAIC Model Act does not also require a de novo review standard. Therefore, although the IRO is not bound by the utilization review process, it can choose to follow the carrier's decisions or conclusions. By adding the de novo requirement for self-insured group health plans, EBSA has exceeded its authority by imposing a standard not required by law and that is stricter than for fully insured plans. Further, imposing the de novo standard will remove the deferential standard for employer-sponsored group health plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA). Historically, in determining the appropriate standard of review, courts were guided by principles of trust law, including whether to use a deferential standard versus a de novo standard.

Hewitt urges EBSA to remove the de novo review requirement and instead require a deferential standard to the extent that the plan fiduciary has complied with the provisions of the "internal claims and appeals process."

Deemed Exhaustion of the Internal Claims and Appeals Process

The interim final regulations state that if a plan or issuer fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a claim, the claimant will be deemed to have exhausted the internal claims and appeals process and may pursue an external review or other available remedies such as judicial review. The interim final regulations state that it does not matter if the plan or issuer asserts that it substantially complied with the requirements or that the error was de minimis.

The agencies do not provide any guidance regarding who will determine if the plan failed to strictly follow the internal claims and appeals process. If it is the claimant who decides this, then there is nothing to prohibit them from always determining that the plan made some mistake and therefore he or she is entitled to external review or judicial review. Further, Hewitt fails to understand why the plan or issuer is not allowed the opportunity to assert its compliance or why the agencies do not provide an exception for de minimis errors that do not affect the decision on the merits of a claim. The purpose of this law is to ensure that the claimant has a fair process by which to obtain benefits under a plan. That purpose is not abandoned if a de minimis exception is allowed for inadvertent errors that do not affect or are not relevant to the outcome of a claim.

New or Additional Evidence

The interim final regulations add a requirement to the internal claims and appeals process that requires the plan or issuer to provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim. In addition, any such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. Similarly, for final internal adverse benefit determinations based on a new or additional rationale, the claimant must be provided with the rationale as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to give the claimant a reasonable opportunity to respond prior to that date.

The requirement that the plan or issuer must provide the claimant, free of charge, with any new or additional evidence as soon as possible meets the objective of having a fair and transparent process. However, Hewitt believes that the requirement that the evidence be provided sufficiently in advance of the date on which the notice of adverse benefit determination must be provided may make it impossible or impractical with the relatively short time frames currently applicable to self-insured group health plans to give a claimant additional time to respond before the benefit determination on review is due. The reviewer has no control over when the new evidence is provided. If the new evidence arises on a date close to or immediately before the notice deadline date, it is not possible to provide enough time for the claimant to respond to the new evidence before the deadline date.

Therefore, Hewitt recommends that for internal determinations prior to the final internal appeals process, the final regulations eliminate the requirement that the new evidence be provided with sufficient time for the claimant to respond. Instead, Hewitt recommends that the final regulations require only that the new evidence must be provided as soon as possible after it is received by the reviewer. This approach allows the claimant to address the new evidence either immediately, if there is still some time remaining, or at the later appeal stage in the internal review process. For the final internal appeals stage, if a new rationale arises, Hewitt recommends that the final regulations allow the plan to extend the notice deadline for a reasonable period to afford the claimant time to respond before the extended deadline date.

Notice Requirements

The interim final regulations require a plan or issuer to include in any notice of adverse benefit determination or final internal adverse benefit determination information sufficient to identify the claim involved. This includes the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. In addition, the notice must include the reason(s) for the adverse benefit determination or final internal adverse benefit determination, including the denial code and its corresponding meaning and a description of the plan's or issuer's standard, if any, that was used in denying the claim.

When insurance carriers are adjudicating medical claims, they will have a diagnosis and/or treatment code. However, other group health plan administrators do not receive this type of information. This is especially true in adjudicating claims for health reimbursement arrangements (HRAs) processing items such as prescription eyeglasses.

Therefore, Hewitt recommends that the agencies modify the notice requirement to require a diagnosis or treatment code or other items listed above only where it is applicable to the claim determination. Where a diagnosis or treatment code is not applicable to the claim determination, requiring a simple, clear description of the claim will allow the claimant to know which items or services are being disputed.

Expedited Notification of Benefit Determinations Involving Urgent Care

The regulations under 29 CFR 2560.503–1(f)(2)(i) require notification in the case of urgent care claims not later than 72 hours after the receipt of the claim. The interim final regulations shorten this time frame to 24 hours. Hewitt is concerned that a 24-hour time frame is not a reasonable amount of time in which to obtain a valid and thorough benefits determination. Furthermore, in the current health care environment, it is very rare for there to be a pre-service urgent care claim. If an individual's life or health is in such danger as to require immediate treatment, the emergency room staff is not going to deny the individual treatment. In this case, the claim would then become a post-service claim.

Requiring a 24-hour turnaround time for a benefits decision unless the individual fails to provide sufficient information would require plans and issuers to invest a significant amount of time and resources to staffing and altering their programs to accommodate this new requirement. And, yet, this process would almost never be used because of the extremely rare occurrence of urgent care pre-service claims.

Therefore, Hewitt recommends that the agencies reinstate the 72-hour time frame for making pre-service urgent care claims decisions.

Closing

If you have any questions or comments, please contact the undersigned at the telephone number or e-mail address provided below.

Sincerely,

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