



**National
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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

September 21, 2010

The Honorable Hilda L. Solis
Secretary
U.S. Department of Labor
Employee Benefits Security Administration
Office of Health Plan Standards and Compliance Assistance
Attention: RIN 1210-AB45
200 Constitution Avenue, N.W.
Room N-5653
Washington, DC 20210

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Attention: RIN 0991-AB70
OCHIO-9993-IFC
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445G
Washington, DC 20201

The Honorable Timothy F. Geithner
Secretary
U.S. Department of the Treasury
Attention: RIN 1545-BJ63
Internal Revenue Service
1111 Constitution Avenue, N.W.
Room 5205
Washington, DC 20224

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 (Affordable Care Act)

Dear Secretaries Solis, Sebelius and Geithner:

The National Business Group on Health appreciates the opportunity to submit comments on 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.

The National Business Group on Health represents approximately 298, primarily large, employers (including 64 of the Fortune 100) who voluntarily provide health benefits and other health programs to over 50 million American employees, retirees, and their families.

In 2000, the Department of Labor (DoL) issued a final rule governing the claims and appeals process for ERISA plans. The rule has worked well for both employees and employers to assure independent review of benefit denials. While the rule specifies the requirements for internal appeals in detail, many self-funded employer plans go above and beyond it to voluntarily provide for external review of adverse benefit determinations. Consultant data and data from a recent survey of our own members suggest that 40-50% of self-funded plans have external review for adverse health benefit determinations.

While we appreciate DoL's recent Technical Release 2010-02 that established an enforcement grace period for compliance with new internal appeals provisions until July 1, 2011 and more temporary "safe harbor" options for external review, we strongly recommend the Departments withdraw the Interim Final Rule and re-issue it in a proposed rule so that the changes in both internal appeals and the new external review requirements can receive full public comment. We base our recommendation on several factors. First, the 2000 DoL rule has worked well for almost 10 years and many plans also voluntarily provide an extra review externally. Second, the Interim Final Rule imposes additional, problematic requirements for internal appeals and the external review "safe harbor" and does not allow sufficient time or the capability of compliance because of the uncertainty about the number of accredited independent review organizations (IROs) currently available.

Alternatively, the Departments could modify the proposed Interim Final Rules to incorporate the following changes:

External Review

Recommendation: The Departments should deem that all employer plans having external review programs in effect as of March 23, 2010 in compliance with the statutory requirements for third party review. The Departments could then establish a sufficient transition period for all existing processes to meet consistent requirements for determinations.

Recommendation: For employer plans currently without external review, the Departments should require compliance when they develop a federal standard (uniform federal rules) governing the requirements for external review. The rule should have a transition timeframe consistent with approaches for states that do not currently meet external review requirements where plans would have to contract with an IRO by the 2012 plan year.

According to our own survey data, between 40-50% of self-funded health benefit plans voluntarily contract with at least one IRO to conduct independent external reviews of benefit denials. Given the scarcity of IROs and the likelihood that many of these do not have a national scope, plans are finding it very difficult to meet the January 1st deadline. The Utilization Review Accreditation Committee (URAC), one of the major accrediting bodies for IROs, currently has accredited only 43 IROs for external review. The “safe harbor” requires that non-grandfathered plans contract with at least 3 IROs beginning January 1, 2011 for most plans. As a result, employer plans that already have external review processes in place have been scrambling to make sure that their existing IRO contracts satisfy the “safe harbor” requirements and they are rushing to sign additional contracts to meet the required 3 IRO contracts. In addition, thousands of other nongrandfathered plans that do not currently have external review must also quickly sign 3 IRO contracts.

Internal Appeals

Urgent Care Claims

Recommendation: A formal rulemaking process should determine which types of urgent care claims or circumstances generally require more than the Interim Final Rules’ 24 hour requirement.

Recommendation: The rulemaking process should determine the feasibility of routinely adjudicating urgent care claims faster than the current 72 hour standard for ERISA plans.

In many cases, determinations cannot be made within 24 hours because of insufficient information though they can routinely be made under the DoL’s 72 hour requirement. Shortening the required time for urgent claims by two-thirds may not be feasible.

Deemed Exhaustion

Recommendation: The Interim Final Rule should deem the internal appeals process exhausted *only when an error is meaningful to the outcome of the claims determination.*

The Interim Final Rules state that an error, no matter how small or inconsequential, creates a situation where the claimant is deemed to have exhausted the internal appeal and can file a request for an external review. We do not believe that this standard is appropriate and will actually cause delays in decisions as those involved in the final decision check and double check to ensure they have not inadvertently overlooked any steps or information in the internal review process.

Coding

Recommendation: The Departments should drop the requirement in the Interim Final Rule to include diagnostic codes on benefit determinations.

Requiring that internal appeals decisions include codes raises both substantive issues and operational challenges. It is unclear whether including ICD-9 codes increases understanding or creates confusion. In addition, because of the transition occurring between ICD-9 and ICD-10, it will create operational challenges to require this information in the midst of the transition when some providers are ahead of others who lag behind.

Linguistically Appropriate Information

Recommendation: The Departments should only require plans to make linguistically appropriate materials available when plan participants' request them, rather than basing it on minimum thresholds for the non-English speaking plan participants.

We believe that this change will reduce administrative costs and burdens and minimize the production and provision of unnecessary materials. Plans can certainly voluntarily provide these materials on their own, but the Departments should only require plans to provide them upon request.

Thank you for considering our comments and recommendations on 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. We look forward to continuing to work with you as you implement the various provisions of the new law. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 585-1812, if you would like to discuss our comments in more detail.

Sincerely,



Helen Darling
President

cc: The Honorable Phyllis C. Borzi, Assistant Secretary, Employee Benefits and Security Administration (EBSA)
Mr. Jay Angoff, Director, Office of Consumer and Insurance Oversight (OCIO)
The Honorable Douglas H. Shulman, Commissioner, Internal Revenue Service (IRS)
Ms. Amy Turner, EBSA

Ms. Beth Baum, EBSA
Ms. Karen Levin, IRS
Mr. Jim Mayhew, OCIO
Ms. Ellen Kuhn, OCIO