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Statewide Parent Advocacy Network, Inc.
Empowered Families: Educated, Engaged, Effective!

Family Voices-NJ 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 Patient Protection and Affordable Care Act Submitted September 20, 2010

Thank you for the opportunity to comment on the internal appeals and external review processes under the Patient Protection and Affordable Care Act (PPACA). Family Voices is a national network that advocates on behalf of children with special healthcare needs and works to "keep families at the center of children's healthcare." Our NJ Chapter is housed at the Statewide Parent Advocacy Network (SPAN), NJ's federally designated Parent Training and Information Center, Family-to-Family Health Information Center, and chapter of the Federation of Families for Children's Mental Health.

Supplementary Information

I. Background

We strongly support the definition of "group health plan" inclusive of both insured and self-insured plans under ERISA. We also agree that the Affordable Care Act requirements can not be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of the Affordable Care Act. In NJ for example, we had mental health parity prior to the federal law and regulations.

II. Overview of the Regulations:

a. Scope and Definitions

We understand that these regulations apply to group health plans but disagree that they should not apply to grandfathered plans. Currently 75% of NJ's plans are exempt from state regulation under ERISA. We understand that under the PHS Act for group coverage, plans must "initially incorporate the internal claims and appeals processes…and update such processes in accordance with standards established by the Secretary of Labor". We also understand that, for individual coverage, plans "must

initially incorporate the internal claims and appeals processes set forth in applicable State law and update such processes in accordance with standards established by the Secretary of Health and Human Services" and that these interim rules provide the update for compliance.

For external review, the PHS Act allows for "either a State external review process or a Federal External review process" and that these regulations clarify which process applies. We agree that for those states currently requiring external review that there should be a transition period until July 1, 2011. For those states that do not currently require external review, we strongly support that they will be subject to a federal process "for plan years (in the individual market, policy years) beginning September 23, 2010".

We agree with the definition of adverse benefit determination to also include rescission of coverage.

b. Internal Claims and Appeals Process

<u>1. Group Health Plans and Health Insurance Issuers Offering Group Health Insurance Coverage</u>

We understand that there are 6 new requirements. Again, we strongly agree with the broader definition of adverse benefit determination to include rescissions. First, we strongly agree that an adverse benefit determination eligible for appeal should include a "denial, reduction, or termination of or failure to provide or make a payment (in whole or in part) for a benefit, including…that is based on: A determination of an individual's eligibility to participate in a plan…A determination that a benefit is not a covered benefit…imposition of a preexisting condition exclusion…benefit is experimental, investigational, or not medically necessary…" We would add two more requirements: once there is a written predetermination of benefits a plan cannot deny the claim and plans may not retroactively bill back for errors or at least put a time limit. Personally, my family was billed back for three years worth of claims "paid in error" which caused financial hardship.

Second, we agree that plans must notify claimants of a benefit determination (adverse or not), "not later than 24 hours" for urgent care. We are concerned however with the clause, "unless the claimant fails to provide sufficient information," which can be used as a delaying tactic. Our family has received letters predated with time limits (or claim would automatically be denied) saying there was missing information but not specifying what was missing. Even with phone calls, we'd send in what was requested, then were told something else was missing, including information that was on the original bill like CPT codes, ICD9 codes, tax id, etc. This is despite calling, checking both employee handbooks, and following all stated requirements when we were told it was a covered service. If this is happening to my family – the family of a knowledgeable advocate – imagine what is happening to other families with less knowledge and resources!

Third, we agree that there needs to be a "full and fair review". We strongly agree that new information must be provided free to claimants. We also strongly agree that claimants must be provided with the rationale for free and "sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond…" Again, there should be monitoring and sanctions if plans predate letters that are received just prior to the deadline.

Fourth, we agree with the criteria on conflicts of interest. This will ensure that all claims and appeals are adjudicated with impartiality. We also strongly support that plans "cannot provide bonuses based on the number of denials…"

Fifth, we strongly support new standards on notices to claimants. Notices must be provided "in a culturally and linguistically appropriate manner". The notices of final adverse benefit determination must include the "date of service,…provider,…amount,… ICD-9 code, ICD-10 code, or DSM-IV,…CPT code." We would also add the forthcoming DSM-V. There should be something to say one is a diagnosis and the other is a treatment code as plans have used this missing information to deny claims (or have sent denials with no date of service or provider). We would also add health literacy to the mix with notices at a 6th grade reading level as the majority of the states require this level for Medicaid notices. We strongly support the use of standardized model notices as recommended by the Departments. We will discuss these in detail later in the document.

Sixth, we strongly agree that if the plan fails to follow these requirements, "the claimant is deemed to have exhausted the internal claims…process…may initiate an external review…" We also agree that there must be "continued coverage pending the outcome of an internal appeal" for continuity of care. We also agree that plans are prohibited from "reducing or terminating on ongoing course of treatment without providing advance notice…opportunity for advance review". We further agree that claimants in urgent care can "proceed with an expedited external review at the same time as internal appeals."

2. Health Insurance Issuers Offering Individual Health Insurance Coverage

We agree that plans "offering individual health insurance coverage must generally comply with all the requirements for the internal claims and appeals process that apply to group coverage". In this area there are three additional requirements. First, these rules "expand the scope of group health coverage internal claims and appeals process for individual health insurance" which is important as eligibility determination in the individual market is based on health status.

Second, we agree with only one level of appeal for individual plans. This will allow claimants to immediately request an external review.

We also agree that individual plans must keep records of claims and appeals for 6 years, which is the same requirement for group plans under ERISA.

c. State Standards for External Review

The rules clarify when plans must abide by state or federal processes. We agree that if the plan uses the state process and includes the protections under the NAIC Uniform Model Act, then that plan must use the state process. Clarification is needed on the following language: "In such a case, to the extent that benefits under a group health plan are provided through health insurance coverage, the issuer is required to satisfy the obligation to provide an external review process, so the plan itself is not required to comply with either the State external review process or the Federal external review process". We understand that states are being encouraged to develop guidelines that meet the NAIC requirements but prefer that there be a federal model, rather than using "Federal enforcement only as a fallback measure". This would allow for more consistency rather than patients' rights being based on in which state the claimant resides. This is particularly important given the significant mobility of today's families. Having multiple state-based external review processes would be extremely confusing to families as they move from state to state!

We do support, however, that these rules "do not preclude a State external review process from applying to and being binding on a self-insured plan under some circumstances…such as nonfederal governmental plans…church plans not covered by ERISA…and multiple employer welfare arrangements, which can be subject to both ERISA and State insurance laws". But again it's only if they meet NAIC requirements. We would agree that these include external review based on medical necessity and level of care or effectiveness; written notice of claimant's rights; requiring claimant exhaustion of internal appeals or plan waiver of the same; and plans must pay for an Independent Review Organization and consumers can only be charged a nominal fee (not to exceed $25 and refunded if the claimant prevails). We would also agree that state plan requirements for IROs also include no minimum dollar requirement for external review, 4 months to file for external review, IRO random assignment, list of approved IROs, no conflicts of interest, claimants may submit additional information to IROs, decision is binding, 45 day limit on decision, expedited reviews, maintenance of records, and review for experimental treatment.

We further agree that in order for states to amend their laws to meet requirements, this will go into effect July 1, 2011.

However, clarification is needed in that it states these regulations "do not set a specific standard for availability of the State external review process that is considered to meet the minimum …protections of the NAIC. If it is determined…process is required…plans would be subject to the Federal external review process in States that do not apply the State external process….Alternatively, if it is determined that universal availability is not required, those plans…that are not subject to the State external review process would be, as are self-insured plans, subject to the Federal external review process." However we agree that the "Federal external review process should apply to all plans…if the State external review process does not apply to all issuers in the State."

d. Federal External Review Process

We agree that the definitions for adverse benefit determination and final internal adverse benefit determination are the same for internal appeals. However, more clarification is needed that the "adverse benefit determination or final internal benefit determination that relates to a …beneficiary's failure to meet the requirements for eligibility under the terms of a group health plan…is not within the scope of the Federal external review process." We strongly agree that the Federal external review process will "provide for expedited external review and additional consumer protections… involving experimental…treatment." We also look forward to the "sub-regulatory guidance on how non-grandfathered self-insured group health plans that currently maintain an internal appeals process that otherwise meets the Federal external review standards may comply or be brought into compliance with the requirements of the new Federal external review process".

e. Culturally and Linguistically Appropriate

We strongly agree with cultural and linguistic competency requirements. New Jersey was the first state to pass a statewide mandate for cultural competency training for healthcare providers (see www.state.nj.us/lps/ca/bme/press/cultural.htm), which should be mandated nationally. AT&T language lines and IBM computer translation programs can assist in communicating with patients in other languages by phone and email. We agree that, for plans serving less than 100, "the threshold is 25 percent of all plan participants". We also agree that, for plans covering 100 or more, "the threshold is the lesser of 500 participants, or 10 percent of all plan participants". We do not feel that this needs to be done on a county by county basis. We agree that if the threshold is met, "notice must be provided upon request in the non-English language" as well as all subsequent notices. We also agree in the English versions of all notices, there must be reference to the availability of other languages, in the multiple languages of the geographic area covered by the insurer. We further agree that this extends to other customer assistance such as telephone hotlines.

f. Secretarial Authority

We agree that, in keeping with the PHS Act, the Departments have the authority to "deem an external review process of a group health plan…in operation as of March 23, 2010 to be in compliance." This applies to plans under either the state or federal external review processes as applicable.

g. Applicability Date

We agree that implementation of the appeals process (for individual plans, policy years) is effective September 23, 2010. But we do not agree that these regulations do not apply to grandfathered health plans.

III. Interim Final Regulations and Request for Comments

We strongly agree with the Departments' determination that "it is impracticable and contrary to the public interest to engage in full notice and comment rulemaking before putting these regulations into effect, and that it is in the public interest to promulgate interim final regulations." However, we encourage widespread notice of the interim final regulations as soon as practicable, in multiple languages, and development of a process that allows for robust public input, including regional opportunities to hear concerns and recommendations from families and individuals.

IV. Economic Impact and Paperwork Burden

A. Summary

We again agree that the regulations take effect for group plans (individual plans, policy years), September 23, 2010 but again feel they should also apply to grandfathered plans.

B. Executive Order

We agree that this regulation is "economically significant" (…annual effect on the economy of $100 million in any one year)".

1. Need for Regulatory Action

We agree that the regulations will provide more consistency in consumer protections. Prior to the Affordable Care Act, ERISA group plans were required to have internal claims and appeals processes under DOL but other plans were not. For individual plans, the processes were under applicable state law. For external review, prior to PPACA some plans followed state regulations yet ERISA plans were exempt. Further, the external review process varied by state, and some states didn't have them at all. These new regulations take into account ERISA, and state internal appeals and external reviews.

2. Claims and Appeals Process

a. Summary

We agree that all plans offering group or individual coverage must now comply with DOL requirements and the new regulations for both internal appeals and external reviews. Again they must meet the NAIC requirements at minimum. The only exception besides grandfathered plans is if the state hasn't established external review meeting NAIC requirements, or ERISA plans that must follow the new federal regulations.

b. Estimated Number of Affected Entities

We agree with the definition of large plans as covering 100 or more individuals, and small group plans as less than 100. We agree with the current estimates of 72,000 ERISA plans and 2.8 million small group plans (97 million in large plans, 40.9 million in small plans); 126,000 governmental plans (36.1 million in large and 2.3 million in small plans); and 16.7 million under age 65 in individual plans. As stated earlier, we disagree that grandfathered health plans will be exempt. We feel that the estimate of 18% of large plans and 30% of small plans relinquishing grandfathered status in 2011 (increasing to 45% and 66% respectively by 2013) is too high. Please not that these numbers also differ from the projections presented in the regulations on grandfathered plans. We agree with the estimates that in 2011, 31 million will be enrolled in group plans under the regulations, increasing to 78 million by 2013. We understand that 40-67% of individual policies terminate annually. We also agree that not all entities will be affected equally, as in the case of ERISA plans previously in compliance with DOL regulations. We do agree the largest impact will be on individual plans for internal claims.

For external review, the only entities affected will depend on if their state external review met the NAIC minimum standards. Individuals most affected will be those in ERISA plans which will now fall under federal requirements. In summary, the number affected will depend on grandfathered status, ERISA, state internal claims and external review, and the number of new plans.

c. Benefits

We understand that "because of data limitations…the Departments did not attempt to quantify expected benefits". We do agree however that the appeals process will be more uniform. Again benefits will depend on ERISA, and state internal claims and external review processes. We agree that those in group plans will have requirements similar to individual plans. On one hand, beneficiaries may receive additional services incorrectly denied. On the other hand, plan expenses may be decreased "as a fuller and fairer system of claims and appeals processing helps facilitate enrollee acceptance of cost management efforts". We feel however that many individuals are currently unaware of their rights as only 1/3 currently appeal claims and almost 50% of the time the decision is reversed in the beneficiaries' favor on first appeal. We strongly agree that this consistency will reduce "complexity of claims and appeals processing requirements, thereby increasing efficiency". We also agree that this will result in "enhancing their transparency" and assist individuals understand "reasons underlying adverse benefit determinations and their appeal rights".

We strongly disagree with the Departments' belief that "excessive delays and inappropriate denials of health benefits are relatively rare". The Family Voices Coordinator in NJ receives 2000 contacts/month, many of them related to denied services under insurance. We have heard from families that their children weren't going to receive therapy "because he is going to die anyway". Or the family who was billed $77,000 for an infant who never left the hospital after birth "because it wasn't an emergency". Carriers routinely deny physical, occupational, or speech therapy for

children “because it can’t be proven he would ever walk”. Children are also denied life sustaining formula for tube feeding as “nutritional supplements like vitamins”. Personally, I have had to appeal denials for 7 claims, the shortest lasting 1 ½ years and the longest 4 years, prevailing each time. Thus, we agree that “substantial harm can be suffered by…enrollees” due to inappropriately denied claims.

We do agree that “effective claims procedures also can improve health care, health plan quality, and insurance market efficiency”. We agree that there is no way to track plan difficulties due to disenrollments but we suggest perhaps former beneficiaries can be surveyed. We do agree that the new appeals process will “control costs by limiting access to inappropriate care” but conversely feel that more families will get the care that may have been inappropriately denied previously.

In summary, we agree this should reduce delays, inappropriate denials, avert serious loss, improve health care quality, consumer satisfaction, and insurance efficiency.

d. Costs and Transfers

We agree that the costs will be associated with internal appeals and external review processes, related disclosures, and bringing plans into compliance.

i. Internal Claims and Appeals

We agree that in ERISA plans there are 2.8 million plans and 138 million beneficiaries, that must comply with DOL regulations. We also agree that there are 126,000 governmental plans with 30 million participants and that the individual market covers 16.7 million. The Department estimates that 90% of the “claims volume in the non-Federal governmental group health plan market already complies with…DOL”. The Departments estimate that there are 179 issuers in the individual market which will cost $3.5 million in startup.

ii. Cost Required to Implement DOL Claims

Estimates show that there were an average of 10 claims per year per individual, 15% of which were denied, half of which were reversed. Estimate costs in appealed denials for claims with medical review (e.g. need a physician) was $154.07 and administrative only was $119.93. Perhaps the Departments should estimate the net loss of denying half of the claims which are eventually reversed.

For group plans the Department estimates the internal appeals and notice will be $1.5 million in 2011 and $3.8 million in 2013. For individual plans the estimate is $28.8 million in 2011 and $56.4 million in 2013.

iii. Additional Requirements for Group Health Plans

We agree that there will be “modest costs…because they merely clarify provisions of the DOL claims procedure regulation”.

Definition of adverse determination
We strongly agree that this includes rescissions. We also agree the burden of cost is included in the internal appeals as unfortunately “most rescissions are associated with a claim”.

Expedited notification of benefit determination involving urgent care

We agree that this would not incur substantial cost as DOL requirements require urgent care notification (usually 24 hours) and “the technological developments that have occurred since the …DOL claims procedure should facilitate faster notification at reduced costs”.

Full and fair review

We agree that this will require “additional evidence” which the Departments estimate as $1million in 2013.

Eliminating conflicts of interest

We agree that costs are minimal as “many plans…already have such requirements in place”.

Enhanced notice

We agree with the Departments’ belief that costs will be small “as only a small number of plans are…affected”.

Deemed exhaustion of internal process

We agree that the Departments are “unable to quantify” but that external appeals could reduce costs associated with litigation.

Continued coverage

We again agree that the Department’s are “unable to quantify” but that there would not be additional costs for plans under DOL, only in the individual market.

<u>iv. Additional Requirements for Issuers in the Individual Insurance Market</u>

We agree that there are three considerations which are expanding “the scope of internal claims…to cover initial eligibility,” only one level of internal appeal, and maintain records. We agree with the Departments that there will be “minimal costs associated…most issuers retain the required information”.

v. External Appeals

The Departments estimate there are 76.9 million in ERISA plans and 13.8 in self insured governmental plans. In states where there are no external reviews, there are 4.2 million plans (2.5 million ERISA, 1.2 million governmental, .6 million individual). In states with limited external review there are 15.6 million (8.4 million ERISA, 4.2 million governmental, 3 million individual). Only 44.2 million in non-grandfathered plans of the 110.5 million total above will fall under the new external review requirement. The Departments estimate there are 1.3 external appeals per 10,000 beneficiaries and that there will be 2600 in 2011 at an average cost of $605 each (total $1.6 million). For non-grandfathered plans the estimate is $2.9 million in 2012 and $3.9 million in 2013. Again as "40 percent of denials are reversed on external appeal" we urge the Departments to estimate cost savings if done properly initially as almost fully half of these were inappropriate denials.

3. Summary

We agree with the Departments final estimates of $50.4 million in 2011, $78.8 million in 2012, and $101.1 million in 2013 as summarized in table 3.

C. Regulatory Flexibility Act-Department of Labor and Department of Health and Human Services

We agree that because the Department "made a good cause finding that a general notice of proposed rulemaking is not necessary" they are not required to "either certify that the regulations would not have a significant impact on a substantial number of small entities or conduct a regulatory flexibility analysis." Although we do feel that there will be a likely impact on small entities, we do not have any suggestions at this time on minimizing this impact.

D. Special Analysis – Department of the Treasury

We agree that "this Treasury decision is not a significant regulatory action" and that therefore "a regulatory assessment is not required."

E. Paperwork Reduction Act

1. Department of Labor and Department of the Treasury

We understand that the Departments are seeking input on "whether the collection of information is necessary for the proper performance of the functions of the agency…accuracy of the agency's estimate…enhance the quality, utility, and clarity of the information,…minimize the burden of collection".

a. Department of Labor and Department of the Treasury: Affordable Care Act Internal Claims and Appeals and External Review Disclosures for Non-Grandfathered Plans

We agree with the Departments estimate that 93% of large and all small plans use “a third-party provider, or…5 percent of the covered individuals”. Burden of hours is estimated to be 300 in 2011, 500 in 2012, and 700 in 2013. Costs are estimated at $11,000, $19,000, and $26,000 respectively. For plans using third party providers, costs are estimated at $243,000 in 2011, $443, 000 in 2012, and $607,000 in 2013. The estimated total annual burden cost is “$121,500 (Employee Benefits Security Administration; $121,500 (Internal Revenue Service”.

2. Department of Health and Human Services

We understand that the Departments are looking at compliance with DOL and implementation of external review.

a. ICR Regarding Affordable Care Act Internal Claims and Appeals and External Review Disclosure for Non-Grandfathered Plans

We agree with the Department’s estimates that the burden of hours will be 566,000 in 2011, 989,000 in 2012, and 1.2 million in 2013. Costs will be $28.1 million in 2011, $57.1 million in 2012, and $70.1 million in 2013. Estimated total burden cost is $20,700,000.

b. ICR Regarding Affordable Care Act Recordkeeping Requirement for Non-Grandfathered Plans

We agree with the Department estimates of an annual burden of 1800 hours at a cost of $105,000.

F. Congressional Review Act

We agree that these interim final regulations are “subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act”.

G. Unfunded Mandates Reform Act

We agree that these rules are not subject to the Unfunded Mandates Reform Act because they are being issued as interim final regulations.

H. Federalism Statement

We agree these rules have federalism implications because it directly affects “States, the relationship between the national government and the States, or on the distribution of power and responsibilities among various levels of government”. However this is mitigated by the fact that most states “will enact laws or take other appropriate action resulting in their meeting or exceeding the Federal standard.”

Model Notices

We will also be commenting on the model notices provided by the Departments found at www.dol.gov/ebsa/pdf/externalreviewmodelact.pdf .

Appendix A

Notice of Appeal Rights

The notice states that "If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim," with a footnote to contact the plan. We would suggest if the denial is due solely to missing information, that the Explanation of Benefits (EOB) have a checklist of which information is needed to process the claim e.g. provider name, date of service, amount, etc.

There is a footnote (2) which states appeals for claim denial time limit is 180 days "Unless your plan or any applicable state law allows you additional time." We would suggest that EOBs be standardized statewide with applicable state law time limits.

Appendix B

Model External Review Request Form

The bottom of the page reads:
"Is the health coverage you have through your employer a self-funded plan? _____. If you are not certain please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer."

We would recommend simplifying it to read "Please contact your employee benefits department to find out if your plan is self-funded and eligible for external review."

We also strongly disagree (page 76-69) that item 4 " … I have included a copy of my certificate of coverage or my insurance policy benefit booklet, which lists the benefits under my health benefit plan" should be required for external appeals.

We also strongly disagree (page 76-70) that the physician form only applies if the denial will "…seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function…" This would, in effect, negate therapies such as occupational, physical, and speech for children. It is also not in keeping with the definition of medical necessity to maintain function or prevent deterioration of the condition.

Finally, we would expect that these notices be double sided with English on one side and Spanish on the other with information about their availability in other languages. As the Family to Family Health Information Center in NJ, we work with families and professionals to help them collaborate to improve health care access and quality for children with special healthcare needs. Thank you again for the opportunity to comment on the internal appeals and external review processes under the Patient Protection and Affordable Care Act.

Sincerely,

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