GroupHealth

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Public Policy / Government Relations
GHQ-E4N

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September 21, 2010

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

Re: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes
File Code OCIIO-9993-IFC

Submitted via eRulemaking Portal: www.regulations.gov

Dear Sir or Madam:

Group Health Cooperative (Group Health) appreciates the opportunity to provide comments on the Interim Final Rules Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act (PPACA). We agree with many of the comments offered by both Alliance of Community Health Plans (ACHP) and America's Health Insurance Plans (AHIP) on these topics, and will not repeat those comments here. However, we wish to provide additional comments on several aspects of the proposed rule, including the implementation time line; definition of an adverse benefit determination; urgent care notice deadline; concurrent external review; additional information required within the notices; and requirements for culturally and linguistically appropriate notices.

Group Health is one of America's oldest and largest consumer-governed health care organizations. Founded in Seattle in 1947, the organization is governed by a member-elected, all-consumer board of trustees. It is a leader in integrated care, and an important voice for health care reform. We provide coverage and care to nearly 650,000 residents in Washington State and Northern Idaho who are covered by our health plans and get their care from Group Health physicians and nurses in one of our medical centers or from our more than 9,000 contracted community providers.

1. Implementation Time Line

Group Health agrees with the Departments that all enrollees should have access to well-defined Internal Claims Review and External Appeals processes. We understand and appreciate the need for the Departments to implement the new appeals process outlined in PPACA, and will diligently continue our implementation efforts to meet the effective date of September 23, 2010. We are concerned, however, with the very short implementation deadline in relation to the considerable amount of process changes required by these rules.

The interim final rule (IFR) poses many challenges to current Internal Claims and Appeals processes. For example, the compression of the initial claims determination deadline from the current 72 hour standard to 24 hours presents a series of complex issues, as addressed further in this letter. Additionally, the new standards for culturally and linguistically appropriate notices are vast and broad sweeping, requiring both an extensive analysis of individual plans composition, and a separate analysis of participants within each group plan. Moreover, many of the implementation requirements within the IFR will require considerable examination of possible interplay with current state law, increasing implementation complexity and confusion.

Adding to the burden of the tight implementation time line is the uncertain potential of costly consequences if plans and carriers do not strictly adhere with any requirements within the Internal Claims and Appeals section of the IFR. A claimant is deemed to have exhausted the Internal Claims and Appeals process if a carrier or plan does not strictly adhere with any requirements pertaining to such, including the very complex and burdensome culturally and linguistically appropriate notices requirement. Upon such a failure, the claimant may initiate an external review and pursue any available remedies under applicable law, such as judicial review.[1] While Group Health supports the spirit of the IFR, and compliance by the implementation deadline, the remedy of an automatic external review and/or judicial review can become quite costly and administratively burdensome when a plan or carrier uses good faith efforts to comply with applicable processes by September 23, 2010. Therefore, the Departments should strongly consider establishing a "safe harbor" time period for plans and carriers who use good faith efforts to comply by the deadline.

2. Definition of Adverse Benefit Determination

The IFR incorporates rescissions into the term "adverse benefit determination," as defined in section 147.128(a)(2) of title 45 Code of Federal Regulations.[2] As currently written, the IFR appears to include within the definition of "adverse benefit determination" group retroactive administrative corrections made to terminate an employee's coverage for ceasing to meet eligibility. It is very common for employers to terminate an employee's health coverage on the last day of employment, yet employers often pay premiums for group coverage a month or two in advance. In this situation, the carrier will most likely retroactively cancel the employee's coverage back to the date of the employee's termination, because notification of the termination was not communicated to the carrier until after the employee's termination date. Group Health supports a clarification to the IFR that enables flexibility for administrative corrections that occur in a group health plan environment on a daily basis, without the inclusion of such administrative corrections in the Internal Claims and Appeals processes.

3. Urgent Care Claims Notice Deadline

While Group Health supports the need for members to receive claim determinations for urgent care within an expedited time period, we are concerned that the compression of the current 72 hour standard to 24 hours is too severe, and will not allow plans and carriers sufficient time to thoroughly review a claim prior to determination of payment. Furthermore, state and federal law currently requires plans and carriers to cover emergency services, resulting in few outright denials of these services. Therefore, a compressed claims determination 24 hour deadline is not necessarily needed.

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[1] 75 Fed. Reg. 43334 (July 23, 2010).
[2] 75 Fed. Reg. 43332 (July 23, 2010).

Moreover, in many review situations, plans or carriers must consult with the treating provider for more information, including the receipt of additional medical records, to properly review the submitted urgent care claim. If the provider does not staff his/her office over the weekend or on holidays, the claim will essentially be held beyond the 24 hour review period, waiting on more information from the provider. While the member will be informed under the terms of the regulations of the insufficiency of information necessary to complete the claim review, the delay is a foreseeable occurrence that cannot be cured by the plan or the carrier alone.

Furthermore, the culturally and linguistically appropriate urgent care notices will be challenging to produce within a 24 hour time frame. If the IFR requires that plans and carriers provide linguistically appropriate notices when a notice of urgent care benefit determination is requested, it will be very difficult to meet the 24 hour deadline if an uncommon non-English language translation is necessary. Plans and carriers must therefore not only staff for weekends and holidays for the underlying claim reviews, they must also staff for translation services during these time periods, compounding the cost of implementation and sustaining the 24 hour urgent care claims determination requirement.

As an alternative to the current 24 hour urgent care claim determination requirement, we suggest the Departments clarify the IFR to allow plans and carriers 24 "business" hours to make urgent claim determinations. A requirement consisting of 24 business hours will effectively allow for the thorough review of claims, access to necessary medical records and consultation with providers during normal business hours, while still providing members with a timely benefit determination.

4. Concurrent External Review

In requiring expedited simultaneous internal and external reviews when requested by the member, the IFR creates situations of possible costly do novo review of internal appeals determinations. Under current state law pertaining to appeals processes, an independent external review organization analyzes the carrier's final internal adverse appeal determination after all information involved in the determination is provided to the independent external review organization. However, in the case of a simultaneous internal and external review, as prescribed by the IFR, an external review organization may have less information to use in its own evaluation, including the carrier's previous internal review analysis. In addition, allowing for simultaneous reviews creates the possibility that while the carrier may overturn its previous internal denial, the external review organization may elect to deny the claim. In such cases, even if the carrier honors its own decision, it not only bears the cost of the underlying claim, it has also unnecessarily bore the cost of the conflicting external review.

5. Additional Information Required in Notices

The IFR currently requires that any notice of adverse benefit determination or final internal adverse benefit determination include information sufficient to identify the claim involved, including diagnosis, treatment and denial codes.[3] Group Health has, and will continue to be, supportive of providing clear, concise and transparent information to all of our members. On the other hand, including all diagnosis and treatment codes pertaining to each claim may actually cause further confusion for the claimant, rather

[3] 75 Fed. Reg. 43333 (July 23, 2010).

than providing clear and concise information. Additionally, the corresponding meanings of the codes are not always understandable to a person without expertise in the healthcare industry. Furthermore, the confusion imposed by the use of these codes, along with their applicable explanations, may be amplified if translation to a non-English language is required.

6. Culturally and Linguistically Appropriate Notices

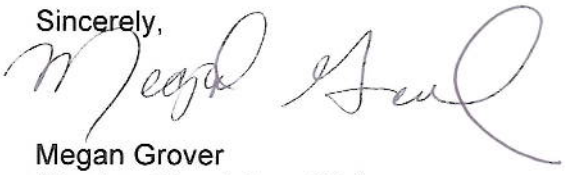
Group Health recognizes the significant need for culturally and linguistically appropriate notices, with the goal of providing clear and transparent information on Internal Claims Appeals and External Review processes. However, it is not current industry practice for carriers to inquire about or identify the culture and language composition of each employer group. In the alternative, carriers routinely offer materials in another language upon request to comply with existing state law. The administrative requirements to implement and maintain the requirements within the IFR are quite onerous, especially for small groups, who will meet the designated threshold by covering only a couple of participants who are literate in the same non-English language.

An alternative for group plans that will fulfill the need for culturally and linguistically appropriate notices, yet is more practical for plans and carriers is to calculate the non-English language threshold for an employer group, is to use the method detailed in the IFR for calculating a carrier's individual member composition. In this situation, plans and carriers could use the county in which the group is headquartered as the county of "residence." Furthermore, this alternative would streamline the administrative process and lower the cost of providing culturally and linguistically appropriate notices for carriers who offer both individual and group plans to members within the same service area.

Moreover, an additional option to promote the availability of culturally and linguistically appropriate notices, while not dramatically increasing administration costs is to provide a "safe harbor" for compliance with the requirement in the IFR for those plans and carriers operating within states that currently require the availability of such notices under state law.

We appreciate the opportunity to provide these comments for your consideration, and your willingness to consider these comments as you further develop clarifications on the Internal Claims and Appeals and External Review processes.

Sincerely,



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