July 25, 2011

Phyllis Borzi
Assistant Secretary of Labor
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210
Mailed electronically via e-ORI@dol.gov

Attention: RIN 1210-AB45

Dear Assistant Secretary Borzi:

AARP appreciates the opportunity to comment on the amendment to the Interim Final Rule (IFR). On behalf of our millions of members, we continue to have a strong interest in ensuring that implementation of the Patient Protection and Affordable Care Act (ACA) meets the needs of our members and all older Americans. AARP appreciates the Department's continued efforts to listen and meet with all stakeholders on issues surrounding the internal claims and appeals and external review processes under ACA.

When it comes to benefit claims processing, AARP notes that the plan or the insurer holds all the cards. They are knowledgeable about all of the plan's provisions as well as the claims and appeals process; in contrast, most individuals do not regularly deal with the claims process. Because a robust claims review process is essential in order for patients to obtain services necessary for their health and well-being, we suggest that the Departments' recent IFR amendment and Technical Release 2011-02 (Technical Release) has fallen short of the promise of consumer protection under the ACA. In order to attempt to even the playing field for claimants, AARP urges the Department, in conjunction with the Department of Health and Human Services and Internal Revenue Service, to reach out to health care providers (e.g., hospitals, physicians, therapists) so that they understand these new rules and the implicit opportunity and imperative for them to advocate on behalf of their patients.

Urgent Care Claims

AARP suggests that the Departments should emphasize that urgent care claims must still be made as soon as practicable. Some recent analyses suggest that 72-hours is the permissible amount of time to make decisions on urgent care claims as opposed to treating the 72-hour time frame as the maximum amount of time available.[1] We urge the Departments to reinforce the notion that most urgent care claims must be decided as soon as practicable and thus well before the 72-hour maximum.

Diagnosis andTreatment Codes.

Incorrect diagnosis codes may result in claimants not receiving treatment or payment for services that were medically necessary and covered by their plan, or they may result in overbilling. *See, e.g.,* Jody Rohlena, *Medical Bill Mistakes*, CBS NEWS, (Feb. 16, 2011), http://www.cbsnews.com/stories/2011/02/15/uttm/main20032152.shtml; Ellen McGirt *Fight back: Malpractice in the billing department*, MONEY, Feb. 9, 2006, http://money.cnn.com/2006/02/06/pf/fightback1_money_0603/index.htm; Dina El Boghdady*, Killer Billing Errors, Duplicate Charges. Faulty Totals. Your Hospital's Mistakes Can Ruin You,* WASHINGTON POST*,* (June 27, 2004), http://www.washingtonpost.com/wp-dyn/articles/A7351-2004Jun26.html. Consequently, claimants' ability to receive a response to their request for their claim diagnosis codes in a timely fashion may be essential to the rendering of treatment or payment.

AARP suggests the following clarifications concerning the IFR amendment. First, the IFR amendment references the DOL claims procedures at 29 C.F.R. § 2560.503–1(h)(2)(iii). But the claims regulation does not specify any time frame by which information requested under that section must be provided, nor does the IFR amendment or the IFR itself. Consequently, under current law, there is no set time constraint within which the plan or insurer must respond to the claimant's request for diagnosis codes. Second, neither the claims regulation, the IFR, nor the amendment provides any penalty if the plan or insurer does not respond. Depending on the basis for the claims denial, receipt of the diagnosis codes may be crucial in order for the claimant to perfect his or her appeal.

We suggest the following clarifications to the IFR and its amendment. First, if the plan or insurer does not provide a response to the request in 45-days then the insurer must pay the claim. Alternatively, the failure of the plan or insurer to respond to the request for information about the claim should mandate a determination that the denial of the claim is arbitrary and capricious. Second, the IFR should make it clear that the time for filing an internal appeal does not begin running until the claimant receives the response to the request for the diagnostic code. The processing time for the response to the request for diagnosis codes should not diminish the time provided for taking an appeal. Third, although the DOL claims regulation at 29 C.F.R. § 2560.503–1(g)(2) suggests that oral

[1] *E.g.*, CIGNA, *Informed on Reform* (June 24, 2011), http://www.cigna.com/sites/healthcare_reform/pdf/06-23-11_claims-appeals_alertF.pdf.

notifications are only permitted for adverse determinations of urgent care claims, AARP suggests that the Departments should affirm that the diagnosis codes must be provided in writing if the claimant requests this information. Fourth, clarification of the interrelationship of the DOL claims regulation and the IFR relating to internal claims and appeals and external review processes under the ACA would be helpful to claimants, plans and insurers. Finally, the Departments should specifically reject the jurisprudence of *DiGregorio v. Hartford Comprehensive Employee Benefit Serv. Co.*, 423 F.3d 6 (1st Cir. 2005), where the court found that the participant had no right to her claim file unless she was able to show that the failure to receive the file was prejudicial. Of course, the difficulty with this holding is that a participant might not know she was prejudiced until she actually reviewed her claim file, or as here, the diagnosis codes. In order to clarify the regulation, AARP suggests that the Department should amend the rule or issue additional guidance such as FAQs, as appropriate.

Culturally and Linguistically Appropriate Notices

The ACA recognized that there are many individuals who do not speak English proficiently and therefore required notices to be provided in a culturally and linguistically appropriate manner. AARP has always believed that individuals should receive all necessary information in a manner that permits them to make informed choices about their health benefits.

The IFR amendment changes the determination of the threshold for providing linguistically appropriate notices from the number of enrollees in a plan (who are not proficient) to the number of persons in a county (who are not proficient). We believe that the 10% county threshold is too high, and will not achieve the scope of coverage the ACA envisioned. Instead we suggest that the threshold be 5% of a plan's enrollees. This is consistent with both the DOJ/HHS LEP Guidances as well as recently revised regulations from the Centers for Medicare & Medicaid Services governing marketing by Medicare Part C & D plans. Given that plans and insurers are already using these guidelines for Medicare, our suggested standard will provide consistency and not add an additional burden.

DOL regulation, 29 CFR § 2520.102-2(c), requires plans to provide those participants who are not proficient in English with language access services. The threshold for these services depends on the size of the plan as well as the number and percentage of persons who are proficient in English. Although a particular county may not meet the current threshold requiring language services under the IFR, particular workforces may meet the DOL thresholds. Accordingly, at a minimum, to the extent that the administrator or sponsor is requesting language access services so it can comply with DOL regulation, 29 CFR § 2520.102-2(c), the final rule should include a provision requiring group health coverage providers to offer translation services in languages that do not meet the requisite threshold for an applicable non-English language under the current interim rule thresholds, if requested by the plan administrator or sponsor. Moreover, to the extent that an administrator or sponsor requests language services for their workforce, even if the workforce does not meet the DOL or interim rule thresholds, we believe that group health coverage providers should be required to offer such services.

Federal External Review

IRO Changes Applicable to ERISA Plans.

We appreciate that the Departments decided that consumers in both insured and self-insured plans will be protected by the external review process, even if the effective dates are different. However, one of AARP's major concerns with the IFR and its amendment is the lack of assurance that the independent review organizations (IROs) will be truly independent. For decades, claimants have confronted the same problems with insurers and their handling of claims. Too often, a medical reviewer who tends to rule in favor of the claimant and his or her receipt of benefits will not be favored by the insurers. For reviewers to be truly "independent," they should be subject to review and termination by both sides. Where reviewers are paid by the insurance plans, there is an inherent conflict of interest and a bias to side with insurers. True independence requires an effective review of decisions, and consequences for poor ones. A recent court decision suggested that even if a reviewer found 99% of the claimants who s/he reviewed not to be disabled, the judge would not find that the reviewer was biased. Although the IFR, its amendment and Technical Release attempt to address that concern – most specifically by using a list of approved IROS that are accredited by a nationally recognized private accrediting organization -- we do not believe that this will be adequate to assure independence. None of these rules or guidance provides a certification process with specific requirements that the accrediting organization will use. AARP suggests that either the accrediting organization or the IRO should certify under penalty of law that the IRO is independent and does not have a conflict of interest. In addition, there is no consequence if there is a violation (such as disqualification from the program, fines, etc.) of any of the standards for either the accrediting organization or the IRO itself.

Furthermore, at least one of the Departments should be authorized to audit the plan, insurer and/or IRO. A panel of physicians or other appropriate providers could perform random sampling of the determinations of the reviewer. If there is a significant disagreement between the panel and the reviewer, there could be one of two remedies: to suspend that reviewer, or put the reviewer on "probation" for a period of time during which the reviewer would be obligated to pay an independent panel to perform random audits of his or her medical reviews.

Finally, public disclosure of information by the IROs that is easily accessible to the claimants and the public, such as through a website, should be available and would provide greater transparency. For example, the IROs should provide such information as: (1) cases handled (redacted for privacy); (2) the name of the plan or insurer; (3) description of the issue; (4) approximate cost of the claim; (5) result (favorable to plan or insurer, or to participant); (6) the number of past reviews for each insurer or plan; (7) professional credentials of reviewer(s) used; and (8) compensation paid to each physician reviewer for the year and the two previous calendar years.

Binding IRO Determinations

We commend the Departments for requiring that a plan must provide or continue to provide benefits in accordance with the IROs final decision, regardless of whether the plan seeks judicial review of the decision, and that the plan must continue to provide the benefits until a judicial decision overturns the IRO's determination.

State External Process Review

Under the guise of creating "so-called" temporary, transitional rules for state external review processes, the Technical Release undercuts many of the consumer protections established in the IFR. In particular the "so-called" temporary, transitional rules raise two major barriers to claimants' use of state external review processes – time and money. These very simple, but important, consumer protections should be reinstated.

Filing fees

The Technical Release changes the temporary standards for a State-administered external review process to be considered an NAIC-similar process by permitting a plan to charge a claimant $25 for every external review with no annual cap on the amount charged. Compared with the unamended IFR, the plan also does not have to permit a waiver for the claimant's hardship nor reimburse the claimant if the claimant wins. There is no rationale given for this change, and with good reason. It makes little sense and may be one of the largest obstacles to a claimants' use of the external appeals process.

AARP believes it is extremely important that the regulation retains an annual maximum on these fees, as well as a hardship waiver. A frequent occurrence with a course of treatment is that separate claims may be denied and it would be prohibitively expensive for most individuals to have to pay separate filing fees for each appeal. We note that neither the IFR, IFR amendment, nor Technical Release defines a claim so that one hospitalization could be interpreted as having multiple claims (if, for example, the explanation of benefits forms are determined to be separate claims). As we know, significant medical bills push many individuals into bankruptcy, even if they have medical coverage.

Time to Request External Review.

AARP is deeply concerned that the time for a claimant to request an external review has been *decreased* from the original IFR. In our initial comments, AARP suggested that the time for a claimant to file a request for external review should be *extended* from four to six months. Instead of increasing the time period, the IFR Amendment reduces the appeal time to sixty (60) days. While there does not seem to be any rationale for digressing from the NAIC model language, it is even more disquieting that the regulation does not specifically prohibit either an insurer or a plan from shortening the time period to request an external appeal through a plan or policy provision. *See, e.g.*, *Burke v. PriceWaterhouse Coopers LLP Long Team Disability Plan*, 572 F.3d 76 (2d Cir. 2009) (a plan may provide a limitations period shorter than permitted by law). Although sixty (60) days is extremely

short, the idea that a plan or insurer could reduce that time frame to something even less dramatically undercuts a claimant's right to appeal.

Maintenance by IROs of Written Records

Again, without any rationale, the Technical Release eliminates the provision that a state process must require the IROs to maintain written records and make them available upon request to a state. We note that this requirement is similar to requirements under the NAIC Uniform Model Act. Maintenance of records provides important consumer safeguards because they permit historical review of an IRO's actions to determine if they are independent and consistent. Moreover, an IRO's maintenance of records provides necessary openness and transparency, consistent with the Labor Department Initiatives.

Education And Outreach Efforts

AARP supports and encourages efforts to help educate states as to ACA's provisions and the implementation of state external review processes, especially in implementing consumer protections that meet the requirements of the IFR.

Implication of the Transition Rules.

Finally, we note that even if the transition occurs as currently planned (January 1, 2014), these temporary rules will have implications for a period of time long after the transition occurs. External appeals filed up until 2014 may take a significant period to resolve, especially if litigation is involved. For that reason alone, we believe that the Departments should reconsider the reduction in consumer protections for State-administered external review and do so in a manner that is similar to the NAIC process.

Model notices

AARP recommends that the Departments test the model forms before consumer panels in order to make them more consumer-friendly. In addition, we note that the Model Notice of Final External Review Decision does not include the language assistance disclosure -- differing from the other two Model forms -- and we do not understand the reason for this omission. Finally, given that the explanation of benefits forms currently used by most plans and insurers do not comply with the current claims regulation, *see, e.g., Turpin v Highmark*, Docket No. 99-1886 (W.D. Pa.), we suggest that the Department verify whether the forms used by providers comply with the regulation.

Thank you again for your consideration of these comments and suggestions. We would be pleased to meet with you to further discuss these comments. Should you require further clarification, please feel free to me contact me or Leah Cohen Hirsch of our Government Affairs staff at (202) 434-3770.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs