From: William Giroux
To: E-OHPSCA2719.EBSA
Subject: RIN 1210-AB45
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Gentlemen:

This email contains 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, 29 C.F.R. Part 2590, RIN 1210-AB45.

1. Comments on External Review Processes.

Interim regulation section 2590.715-2719(c)(1) sets forth when state standards of external review are applicable and when federal standards of external review are applicable for non-grandfathered group health plans. Generally, the regulation provides that where benefits under a plan are provided through a health insurance policy that is subject to a state external review process that is binding on the health insurance issuer and the external review process contains the consumer protections in the NAIC Uniform Model Act, then the state external review process is applicable. However, to the extent that state external review provisions do not apply, the regulations provide for federal external review provisions.

"Under these interim final regulations, any plan or issuer not subject to a State external review process must comply with the Federal external review process. (However, to the extent a plan provides health insurance coverage that is subject to an applicable State external review process that provides the minimum consumer protections in the NAIC Uniform Model Act, the plan does not have to comply with the Federal external review process.) A plan or issuer is subject to the Federal external review process where the State external review process does not meet, at a minimum, the consumer protections in the NAIC Uniform Model Act, as well as where there is no applicable State external review process." 75 F.R. 43335 (July 23, 2010).

This approach fails to adequately address many group health plans that provide a combination of insured and self-insured coverage. In those cases, there are often benefit determinations that do not fit squarely within either the insured component of the plan or the self-insured component, as demonstrated by the following example.

Example: Company A sponsors a non-grandfathered group health plan that has two components. The first component is a high deductible group insurance policy with a $3,000 individual deductible and a $6,000 family deductible. The group insurance policy is subject to the insurance laws of State Y and those state insurance laws contain an external review process that contains the consumer protections set forth in NAIC Uniform Model Act. The second component of the plan is a self-insured reimbursement arrangement that is administered by Company B, a third party administrator. Under the self-insured reimbursement arrangement, an employee with individual coverage is responsible for the first $400 of the deductible under the high deductible group insurance policy. Any additional amount that the covered employee pays toward the group insurance policy deductible is reimbursed under the self-insured reimbursement arrangement. Similarly, an employee with

family coverage is responsible for the first $800 of the deductible, and is then reimbursed for any additional deductible under the self-insured reimbursement arrangement.

Under the plan and the group insurance policy, the insurance carrier first makes the determination of whether a particular medical procedure is covered under the plan. If the insurance carrier determines the procedure is covered under the group insurance policy, it must then determine whether the applicable deductible under the policy ($3,000 single, $6,000 family) has been met. If the applicable deductible has not been met, then a second determination must be made by Company B, the third party administrator of the self-insured reimbursement arrangement. Company B's determination is limited solely to the issue of whether the employee has already paid the initial portion of the deductible for which he is responsible ($400 single, $800 family). Once the employee has demonstrated that he has paid that amount, the employee would then be entitled to reimbursement of any additional deductible he paid. Company B makes no determination on whether the medical procedure is covered under the group insurance policy; that determination having been made by the insurance carrier.

Assume a covered employee with single coverage has surgery to his nose and the total charges for the surgery are $4,000. Further assume that the covered employee has not incurred any other medical expenses during the plan year, so that the full $3,000 deductible must be exhausted before the group insurance policy provides any coverage. The employee submits a claim to the insurance carrier for $1,000 and to Company B, the third party claims administrator, for $2,600 of the $3,000 deductible he paid. The insurance carrier examines the claim and determines that the surgery is not covered because it was cosmetic surgery and the insurance policy covers only that cosmetic surgery it is required to cover under applicable law (assume it is not required to cover cosmetic surgery to the nose under applicable law). Since the insurance carrier has determined that the surgery is not covered, Company B also denies the claim for reimbursement of the $2,600.

Under the interim regulations, it appears that the claim denial by the insurance carrier is subject to the State Y external review process, while the claim denial under the self-insured arrangement is subject to federal external review provisions. However, it makes no sense to have multiple external review processes apply, since the decision by Company B to deny the claim is based entirely on the insurance carrier's determination that the surgery is cosmetic and is not covered under the group insurance policy. Essentially, this is one claim with two parts. The only external review that should be done in this instance should be external review of the insurance carrier's determination under the State Y external review process. To have two separate external review processes apply to what is essentially one claim is both wasteful and can lead to conflicting decisions.

That should also be the case even if no amount were payable by the insurance carrier because the entire claim is less than the deductible under the group insurance policy. For instance, if the surgery in the prior example cost $2,900, the only claim would be reimbursement of $2,500 from the self-insured reimbursement arrangement component. Presumably, under the interim regulations, the denial would be subject to federal external review. However, the determination that the surgery is not covered because it is cosmetic is being made by the insurance carrier and its determination is presumably subject to the State Y external review process. Again, you have one claim being subject to two external review processes.

In this situation and similar situations, where a self-insured component of a plan follows the determination made by an insurance carrier under the insured component of the plan, the external review process of the insured component should be the applicable external review process. The only time when the federal external review process should apply to the self-insured component in these circumstances would be where the claims determination rests solely with respect to that component. For instance, if after a determination was made by the insurance carrier that a the nose surgery was covered by the plan, Company B then determined that the covered employee was not entitled to reimbursement for the deductible in excess of $400 because of a failure to demonstrate payment by the employee, that decision should be subject to a federal claims review process.

2. Comments on Timeframe for Urgent Care Claims.

Interim regulation section 2590.715-2719(b)(2)((ii)(B) provides that in the case of an urgent care claim, a benefit determination must be made within 24 hours after receipt of the claim by the plan or the administrator. This is a change from the 72 hour timeframe to respond with respect to urgent care claims set forth in the claims review regulations at 2560.503-1. The ONLY justification for this change is set forth in the preamble which states that "the Departments expect that electronic communication will enable faster decision-making today than in the year 2000". 75 F.R. 43333 (July 23, 2010). First, the Departments do not assert or provide any evidence that shortening the 72 hour timeframe to 24 hours will result in better claims determinations. Nor do they assert or provide any evidence that patient care is being negatively affected by having the current 72 hour timeframe. Second, the justification for the change to 24 hours from 72 hours implies that it is the communication involved with the decision that is time-consuming, and not the time needed to actually review and analyze the patient data and, where appropriate, consult with specialists. If an insurance carrier or claims administrator is not provided with an adequate amount of time to actually review and analyze patient data, as well as consult with specialists where appropriate, it is more likely that the carrier or claims administrator will initially deny the claim. This can result in a longer period time applying, since the claimant will then need to appeal the initial denial. Have the Departments done ANY analysis of whether shortening the timeframe from 72 hours to 24 hours for urgent care claims will have an adverse impact on claims review?

A 24 hour timeframe for making determinations on urgent care claims is not warranted unless it is necessary to improve patient care and/or claims determinations. Further, reducing the timeframe to 24 hours may result in more urgent care claims being initially denied because the 24 hour timeframe does not allow insurers and claims administrators adequate time to review and analyze patient data and, where appropriate, to consult with specialists. The fact that electronic communications have improved somewhat since 2000, in and of itself, is an inadequate reason for reducing the timeframe for initial determinations on urgent care claims, particularly if no analysis has been done as to the impact such a change will have on claims decisions.

Regards,

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