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Re: Comment on Claims and Appeals Process interim final rules pertaining to requirements for State's external review processes (26 CFR 54.9815-2719T)

Suggested Change - Summary
Section 54.9815-2719T(a)(2) defines an adverse benefit determination by a plan to include adverse benefit determinations defined in 29 CFR 25603-1 and any rescissions of coverage defined in 54.9815-2712T(a)(2). (Federal Register, Vol. 75, No. 141, Friday July 23, 2010, page 43350 & 43351)

But the types of adverse benefit determinations that can be appealed to a State's external review process specified in the interim final rule (54.9815-2712T(c)(2)(i) (Federal Register, Vol. 75, No. 141, Friday July 23, 2010, page 43352) are significantly narrower than all the various types of adverse benefit determinations defined in 54.9815-2719T(a)(2). The rules, as currently written, limit the types of adverse benefit determinations that can be appealed to a state's external review process to only those involving disputes over "medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit."

Another section of the proposed rules defines a Federal external review process that, it appears, may become a catch-all exteral review process for the many types of adverse benefit determinations that the state's external review process does not cover. (54.9815-2719T(a)(2), Federal Register, Vol. 75, No. 141, Friday July 23, 2010, page 43353).

I am respectfully suggesting that the definition of the types of adverse benefit determinations that state appeal processes are required to review [per 54.9815-2712T(c)(2)(i)] be re-written to include all the various adverse benefit determinations that are defined in section 54.9815-2719T(a)(2) of these rules.

This change will --

- Eliminate confusion for consumers and plans over what types of external reviews can be appealed to states' external review process vs. what types of appeals go before the new Federal external review process. It may be as simple as: a state's external review processes that can hear disputes involving all adverse types of benefit determinations will have jurisdiction and, if they cannot do this, the Federal appeals process will have jurisdiction for plans doing business in those states.

- Provide a consumer-friendly streamlined appeals process for more disputes. This is not a "hypothetical benefit" – it was estimated that 71.1% of unresolved disputes do not concern "medical claims in the proposed rules (Federal Register, Vol. 75, No. 141, Friday July 23, 2010, page 43343). State data shows that, of all complaints submitted to a state Department of Insurance by plan participants, 23% involved denials of coverage and 28% involved issues concerning payments and balance billing.[1] **Disputes involving the adequacy of plans' payments and balance billing under-payments are not currently included in the requirements for a State's review processes specified in 54.9815-2712T(c)(2)(i) even though they are defined as an adverse benefit determination in Section 54.9815-2719T(a)(2).** As it now is drafted, I can forsee a veruy prolonged appeal process if the denial involves both medical necessity and payment issue. First, an appealed to a state's external review process to rule on the

[1] Texas Department of Insurance, Office of Public Insurance Counsel, "Complaint Data," 2004. This data tracks the results reported by the Kaiser/Harvard "National Survey on Consumer Experiences With and Attitudes Toward Health Plans: Key Findings"(2001) that, of all the people who reported problems with their plan, 28% reported problems with delays or denials of coverage and 28% reported billing or payment problems.

medical necessity issues. Then, assuming that the state's external review rules in favor of the consumer on the medical necessity issues, the consumer would have to start the dispute process all over again to get the payment issues resolved and to, perhaps, eventually take the reimbursement issues to the Federal external review process to assure proper payment.

- Likely result in even fewer claims being appealed to an external review process. This is what AHIP's data shows.[2] The 2 states (Florida and New Jersey) that define the types of adverse determinations that are appealable to a State's external review which, I believe, most closely track the adverse benefit determination language of Section 54.9815-2719T(a)(2) had --
    - In 2003 an external appeals rate of .487/10,000 covered individuals vs. an external appeals rate of .877/10,000 covered individuals in all the other states.
    - In 2004 an external appeals rate of .716/10,000 covered individuals vs. an external appeals rate of .851/10,000 covered individuals in all the other states.

- Provide better consumer protections when plans are deceptively issuing adverse benefit determinations to control costs. I do not believe it is merely a coincidence that the use of invalid U&C data by many plans was discovered in New Jersey[3] as this is one of the very few states that allows payment and balance billing disputes to be appealed to the State's external review process. Systematic deceptive practices by plans viz a viz all types of adverse benefit determinations will be more readily detected and acted upon by state insurance commissioners if a wide variety of disputes can be easily appealed to states' external review processes. (Note: as Section 54.9815-2712T(c)(2)(i) is currently written, only plans' abuses of medical necessity determinations are appealable and, therefore, only systematic abuses in this one area will be readily discoverable via a states' external review processes.)

Legal Background

Patient Protection and Affordable Care Act

Sec. 2719 and Sec. 2719(4)of the Patient Protection and Affordable Care Act requires "…group health plans or health insurance issuers to implement an effective appeals process for appeals of coverage determinations **and claims** under which the plan or issuer shall, at a minimum…. provide an external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans." (*emphasis added*)

Various definitions of "appeals of coverage and claims" in the proposed regulations vs. definitions of appealable coverage determinations and claims in the NCCI Model Act

29 CFR 25603-1 defines a adverse benefit determination as follows (Source: Federal Register, Vol. 65, No. 225, Tuesday November 21, 2000, page 70271):

> "The terms "\adverse benefit determination: means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or failure to provide to make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise

[2] American Health Insurance Plans, Center for Policy and Research, "Update on State External Review Programs," January 2006, Appendix C.

[3] See Bernard R. Siskin, "Plaintiff's Supplemental Expert Report Dated June 15, 2006" in McCoy vs Health Net and others & Wachtel vs Guardian Life and others, U.S. District Court, New Jersey produced as an exhibit by the Senate Commerce Committee, Oversight & Investigations Staff, 2009

provided because it is determined to be experimental or investigational or not medically necessary or appropriate."

54.915-2712T(a)(2)(ii)(A) specifies that a plan must treat any rescissions in coverage as an adverse benefit determination (Source: Federal Register, Vol. 75, No. 141, Friday July 23, 2010, page 43350 & 43351):

> "… a plan must treat a rescission of coverage (whether or not the recession has an adverse effect on any particular benefit at that time) as an adverse benefit determination."

But the language in 54.9815-2712T(c)(2)(i) for what types of adverse benefit determinations can be appealed to a State's external process does not track this definition of adverse benefit determinations that are in the proposed rules :

> " The State process must provide for the external review of adverse benefit determinations (including final adverse benefit determinations) by issuers (or, if applicable, plans) that are based on the issuer's (or plan's) requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit." (Source: Federal Register, Vol. 75, No. 141, Friday July 23, 2010, page 4335)

The National Association of Insurance Commissions, "Uniform Health Carrier External Review Model Act" Section 3(A) defines an adverse benefit determination as-

> "'Adverse determination' means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated."

Implications for other provisions in the proposed rules

If the language in 54.915-2712T(a)(2)(ii)(A) is re-written so that the state's external review process encompasses all the different types of adverse benefit determinations specified in section 54.9815-2719T(a)(2) of these rules, then some appeals to states' external review will primarily involve disputes over the adequacy of payments and balance billing issues. Accordingly, I suggest that the following clause section be added to 54.915-2712T(a)(2)(viii):

> " In disputes that primarily involve payments, any member of the Academy of Actuaries qualified as a health actuary with professional experience in reimbursement issues meets this criteria for an IRO so long as s/he otherwise complies with all the other requirements for independence in this subsection 54.915-2712T(a)(2) and no more than 20% of the actuary's revenues are from plans and/or payers in the State having jurisdiction for the external review."

Please contact me if you require additional details on any of the points I have raised.

Respectfully submitted

J Vincent Drucker

Disclosure of Potential Conflicts of Interest

I am not an actuary. I have no current source of revenue from any of the suggestions submitted above, as I am retired. My spouse has no sources of revenue from any of the suggestions submitted above. My spouse and I have no contracts that would allow us to have, in the future, any revenues from any of the suggestions submitted above. I have no children under 18 years of age or partners that would have any revenues from any of the suggestions submitted above.