TUFTS Health Plan

September 21, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: Interim Final Rules Relating to Internal Claims and Appeals and External Review Processes (RIN-0991-AB70)

Submitted via Federal eRulemaking Portal: www.regulations.gov

Dear Sir or Madam:

I am writing on behalf of Tufts Health Plan to offer comments in response to the Interim Final Rules Relating to Internal Claims and Appeals and External Review Processes (RIN-0991-AB70).

Tufts Health Plan insures around 740,000 members. Since 1979, Tufts Health Plan has been committed to providing a higher standard of health care coverage and to improving the quality of care for every member. Tufts Health Plan's Health Maintenance Organization (HMO) and Point of Service (POS) plans are ranked number two according to the National Committee for Quality Assurance's (NCQA) health insurance plan rankings and its Medicare Advantage plan, Tufts Health Plan Medicare Preferred, is ranked number four in the nation.

We believe the requirements under the existing Department of Labor claims procedure regulations provide the claimant with sufficient information and protections to appeal adverse benefit determinations. We agree these current claims procedure requirements should be expanded to apply uniformly to self-funded plans and the individual market. However, the additional requirements set forth in the Department of Labor's Interim Final Rules (IFR) published on July 23, 2010, are too broad in application and fall short of the intended goal, resulting in unnecessary administrative costs to employers that offer self funded plans and carriers.

The following requirements should be eliminated or modified:

1. Requirements to include diagnosis code and treatment code (and the corresponding meanings) to adverse benefit determinations. The current DOL requirements require the group health plan to provide sufficient detail in the adverse determination so the claimant can understand the basis for the denial of coverage and the process to initiate an internal

appeal (i.e. reasons for the adverse determination, reference to the plan provisions/clinical criteria and a description of the plan's review procedure). The IFR requirement to include diagnosis code and treatment code (and the corresponding meanings) to adverse benefit determinations provides no additional relevant information to claimants. Claimants will be confused by the technical descriptions of the CPT and ICD codes. In addition, these new requirements will cause employers that offer group health plans and carriers to incur significant administrative costs making system changes to add these fields to EOBs, which in the end provide no useful information to the claimant.

2. Requirement to notify the claimant of urgent care determination within 24 hours of the request. Under current DOL claims procedure, group health plans must notify the claimant of an urgent care determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim. The current DOL process requires a plan to respond within a shortened timeframe (in some instances this will be within 24 hours) when the medical circumstances warrant such a response. The IFR requirement prescribing a determination for urgent care claims within 24 hours in all circumstances is unnecessary and should be removed so that group health plans have the flexibility to respond within the 72 hour timeframe according to the medical exigencies of each request.

3. Notices in a culturally and linguistically appropriate manner. We support the DOL's goal to provide assistance to enrollees with limited English proficiency. We request that the DOL re-examine the threshold requirements set forth for group health plans. Group health plans and insurance issuers do not have the literacy information at the group level required to determine if the group meets the threshold requirements set forth in the IFR. We recommend that the DOL look to the process used by Medicare Advantage plans and develop threshold requirements based upon service area or state.

4. External Review Process.

- Scope of review. We support extending external review rights to enrollees of self-funded health plans and the individual market. We believe the IFR requirements go too far in expanding the scope of claims eligible for external review to include benefit denials that are not based on medical necessity. Many states, such as Massachusetts and Rhode Island, offer external review for adverse determinations based upon medical necessity. It is unclear why the federal review process is broader and different from the process followed by states. These benefit denials are based upon straight contract interpretation of the plan benefit and do not require the review of clinical information. There would be no legal basis to overturn the internal appeal decision at the external review level. We believe offering an external level of review for benefit denials that are not based upon medical necessity adds no value to the review process for the claimant.

- Modify implementation timeline. On August 23, 2010, the DOL issued Technical Release 2010-01, relating to interim procedures for self-insured plans with respect to the Federal external review process. The Technical release set forth an enforcement grace period for compliance with the federal external review process

If you have any questions, please do not hesitate to contact me by email at Kristin_lewis@tufts-health.com.

Sincerely,

Kristin L. Lewis
Vice President, Government Affairs, Public Policy
& Compliance
Tufts Health Plan