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Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Attention: RIN 1210---AB45

VIA E-MAIL: E-OHPSCA2719.EBSA@dol.com

Re: Changes to Internal Claims and Appeals Processes in Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes

Dear Sir or Madam:

We are writing on behalf of the Employee Benefits Committee of the Chicago Bar Association to express concern and to request additional guidance in connection with 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 of 2010, Pub. L. 111-148 ("PPACA") (the "Interim Final Rules"). It is our understanding that these comments will be shared with the Departments of Treasury and Health and Human Services.

The Interim Final Rules set forth six new requirements for group health plans and health insurance issuers offering group health insurance coverage. These new requirements build upon and add to the requirement that plans and issuers implement an effective internal claims and appeals procedure established by the Department of Labor ("DOL") claims procedure regulation. We address each of these requirements in turn.

I. Definition of Adverse Benefit Determination and Continued Coverage

The first requirement clarifies the meaning of adverse benefit determination. Adverse benefit determination as defined in the DOL claims procedure regulation is deemed to include a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at that time.

The individual insurance industry will be significantly impacted by the new regulation because the new appeal rights apply to the issuance of a policy of insurance. The regulation imposes the appeal mechanisms of the policy of insurance even though no contract exists between the parties as there has been no offer and acceptance. The Departments found this stage important to prevent an insurer from denying coverage based on preexisting conditions. (See proposed rule Sec. 2590.715-2704 (75 FR 37229, 37190, 37198.) Please provide guidance on how the standards of review will be applied to an underwriting decision involving mixed data and multiple factors. The decision of an insurer to offer a policy to an applicant will also vary between the States which have different laws on guaranteed-issue and community-rating requirement, as well as premium rates. What rules will apply to reversing the underwriting decision to offer a policy at a certain premium rate are not defined.

Additionally, Section 2719 of the Public Health Services Act ("PHSA") as added by Section 1001 of PPACA imposes the appeal process for "coverage determinations," and a significant issue exists whether the decision to offer a policy is a coverage determination as contemplated by PPACA. Since Section 2719(a)(1) and the Interim Final Rules also require continued coverage during the appeal, the question arises what coverage exists when no policy has been entered into. The addition of an appeal right at this stage creates a remedy where the options of an applicant were limited. In general, guidance regarding how rescissions should be handled on appeal is necessary.

The other change to the definition is to incorporate appeal rights to a decision to rescind a policy or coverage. This change references section 2712 of the PHSA as added by Section 1001 of PPACA. Clarification is needed as to whether the appeal rights run from the date of the decision to rescind or the effective date of the rescission, and whether a participant's efforts to resolve the dispute prior to the effective date will stay the appeal period.

If the rescission is not medically based (such as for ineligibility), allowing participants the appeal right may grant them continued coverage, which forces the plan to pay for ineligible participants. Please clarify that coverage is required only for an "on-going course of treatment" and is not required for coverage generally. Please also clarify what is meant by an "on-going course of treatment." While it may be clear that chemotherapy is an ongoing course of treatment, are prescription refills covered? How about mental health appointments?

Also, please clarify that while continued coverage is required during an appeal, that requirement is satisfied by a plan procedure reasonably providing "advance notice and an opportunity for advance review" of the reduction or termination of an ongoing course of treatment, but that such procedure does not have to be the full appeals procedure. Finally, please clarify that although continued coverage may be required, once the opportunity for advance review has been fulfilled and an appeal is denied, the coverage may be terminated retroactively and not only prospectively.

II. Timeframe for Urgent Care Claims

A new rule under the Interim Final Rules provides that a plan or issuer must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim by the plan or issuer. This new standard, which is not required by PPACA, will not apply if the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health coverage. Under this new rule the existing ERISA regulations requirement for handling urgent claims continue to apply other than the rule for notification within 72 hours. A "claim involving urgent care" continues to be defined in the same manner as in the existing ERISA regulations.

The Preamble to these Interim Final Rules states that the DOL believes that electronic communications will enable faster decision-making today than in the year 2000 when the current 72 hour standard for review of a claim involving urgent care was included in the final DOL claims procedure regulation issued at that time. In theory, the position of the DOL might be correct. However, there probably is no one who needs to use a computer on a daily basis in the work place that has not had to deal with a total break down of their office network system for hours and sometimes days. This rule fails to account for that possibility as well as to allow time for communication between the plan or issuer and the claimant so that the plan or issuer fully understands the nature of the claim and why it is an urgent claim.

Furthermore, to turn around a claim involving urgent care in 24 hours is going to be a very expensive process for employers and providers. It is going to require employers and providers to pay overtime pay to employees who will have to work late at night or on weekends to consider and then approve, if it is determined appropriate, these urgent claim requests. The rule also does not take into account the need to consult with medical experts, who will now need to be available on a 24 hour basis as well. The employees who are required to review these claims will have additional stress added to their lives which could result in medical problems for themselves and their dependents. Employers are also required to follow the new rules, within a 24 hour period, and not make a mistake in the process, or run the risk of being deemed to have an unreasonable claims process (and lose judicial deference as a result). Such pressures could lead some employers to favor quick denials because they are running out of time.

In conclusion, this new rule may cause more harm than the benefit it seeks to provide. There must be some common sense applied here. It simply is not realistically possible to turn around urgent care claims in 24 hours. The 72 hour rule should continue to be followed.

III. Full & Fair Review

The Interim Final Rules impose claim review requirements in addition to those required by existing DOL claims regulations to ensure that a claimant receives a "full and fair review." Plans and issuers must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim. The evidence must be provided "as soon as possible" and "sufficiently in advance" of the date on

which the notice of adverse benefit determination on review is required to be provided. Evidence provided sufficiently in advance gives the claimant a reasonable opportunity to respond prior to that date. Additionally, before the plan or issuer can issue an adverse benefit determination on review based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. The rationale must be provided "as soon as possible" and "sufficiently in advance" of the date on which the notice of adverse benefit determination on review is required to be provided. Again, this time frame is to give the claimant a reasonable opportunity to respond prior to that date.

These new claims and appeals requirements will impose more time-consuming and expensive rules on plan administrators. Providing evidence free of charge and as soon as possible is a heavy burden. Additionally, there may be insufficient time for the plan to respond to the claimant's new arguments. The claimant could respond on the day before the appeal response is due and the plan is not entitled to an extension. The "back and forth" required by this rule also seems unnecessary given the new external review requirement which will provide a check on any possible unfairness caused by a plan administrator relying on new evidence or a new rationale.

In addition, the existing ERISA claims regulations, 29 C.F.R. § 2560.503-1, already provide similar protections to ensure a full and fair review of claims. Although the DOL views this new language as an amplification of existing claims regulations, this new requirement is repetitive and likely to cause confusion. The Interim Final Rules provide no guidance on how much time must pass between providing the rationale and the adverse determination, and in the case of an urgent care claim, the interval will be extremely brief. Without more guidance, plans and issuers run the risk of failing to comply with this new requirement. When viewed in connection with the new strict compliance requirements that do not allow de minimis errors, high costs may be involved.

To the extent that the Departments decide to keep this new requirement, please provide additional guidance on what is meant by "as soon as possible" and "sufficiently in advance," both terms that will otherwise need to be fleshed out by courts in costly litigation over the coming years.

IV. Avoiding Conflicts of Interest

PPACA requires that group health plans and health insurance issuers of group or individual health insurance "implement an effective appeals process for appeals of coverage determination and claims." For group health plans covered under Title I of ERISA, this requirement is consistent with 29 U.S.C. §1133(2) which states that participants whose claims have been denied be afforded "a full and fair review by the appropriate named fiduciary of the decision denying the claim." Under the Secretary of Labor's regulations, there is no requirement that this internal review be conducted by an independent fiduciary. See 29 C.F.R. §2560.503-1.

Under the Interim Final Rules, the internal claims procedures of ERISA would now require that the appeals process be determined by an independent adjudicator, as well as reviewed by an independent external adjudicator. Failure to strictly adhere to this requirement or any of the

other requirements contained in the interim rules would be deemed exhaustion of the internal claims, thereby permitting the participant or beneficiary judicial review of the claim. Neither of these requirements is set forth in the legislation or legislative history. It is unreasonable to assume that Congress' intent was to overturn the overwhelming regulatory and case law precedent which did not impose an independent requirement on the internal claims review process nor presumed exhaustion for failure to rigidly comply with the claims procedure regulations. This regulation could lead to more employment based claims and will likely create discovery issues in claims litigation. The expense of such requirements under the interim rules will undoubtedly lead employers to pass on such costs to participants, reduce benefits, or result in higher deductible plans in order to avoid processing the bulk of health claims.

V. Notice Requirements

The Interim Final Rules require plans and issuers to provide notices in a "culturally and linguistically" appropriate manner in accordance with the standards described in the preamble. Additionally, any notice of an adverse benefit determination must include new content that is intended to be "sufficient to identify the claim involved." Recently, the DOL issued model notices to help satisfy these new content requirements. To avoid placing plans and issuers into a cycle of "the never ending claim," the following comments are submitted for further consideration.

The Interim Final Rules require plans and issuers to provide notices in a "culturally and linguistically" appropriate manner. Plans and issuers are considered to have met this requirement if the notices are "provided in a non-English language" based on thresholds of the number of participants "who are literate in the same non-English language." These thresholds are adapted from the style and format requirements for summary plan descriptions. If the threshold is met, the notice must be provided upon request in the non-English language. Additionally, the plan or issuer must (1) include a prominent statement in the English version of all notices offering such notices in the identified non-English language (2) provide all subsequent notices in the non-English language and (3) answer questions or provide assistance with claims and appeals in the non-English language. Based on the recently issued model notices, the new "culturally and linguistically" appropriate requirements will undoubtedly increase the cost of plan administration and increase the number of external claim reviews.

The model notices contain several "free form" sections that require the plan or issuer to provide detailed information regarding the decision made on the claim. The "free form" sections require the plan or issuer to provide (1) "Background Information," (2) "Final Decision" information that includes a list of all documents and statements that were reviewed in making the final decision and (3) "Findings" which discuss the reason or reasons for the decision. Pursuant to the regulation, having to provide such detailed and personalized information in "all subsequent notices" in any non-English language will undoubtedly increase the cost of plan administration. Based on this requirement alone, plans and issuers will be required to hire and train additional claims personnel that are proficient in non-English languages. As the Departments undoubtedly know, drafting personalized correspondence in a non-English language is not the same as drafting a legally sufficient adverse benefit determination in Spanish, Japanese, Russian, Polish,

Chinese, etc. As a result of the foregoing requirements, plan administrative expenses will increase. Additionally, plan expenses will increase even further when one considers that these "free form" adverse benefit determinations in a non-English language will form the basis for any external review thereby requiring the independent reviewing agency to secure translations services and/or hire individuals with the ability to read and interpret multiple languages.

Further, the model notices issued by the DOL will likely create a "never ending claim." Although the purpose of the Interim Final Rules is to create a reasonable review process, the model notices appear to overtly encourage every individual to appeal any adverse benefit determination. Recognizing that there is no easy solution, it would appear prudent to add some additional provisions to these notices that balance the ability to appeal with the time, cost, effort of appealing. As currently drafted, the notices will likely result in an high percentage of unworthy claims being externally reviewed. We understand and respect the need to protect plan participants - we think this should be balanced, however, with the cost containment aims of health care reform.

By way of example, the "Model Notice of Final Adverse Benefit Determination" includes questions and answers that are provided on an "Important Information about Your Rights to External Review" supplement. This information provides the claimant with, among other things, information regarding the steps that he or she should take if they disagree with the decision; it describes the urgent claim review and informs the claimant that if the independent review organization overturns the adverse decision, the plan will provide coverage. We recommend that the model notice also inform participants that an IRO's decision will be subject to reversal by a court - unless the Departments are taking the position that IRO decisions may not be challenged by an plan or issuer. If the Departments are taking the position that IRO decisions may not be challenged by a plan or issuer in court, please provide us with that information, along with your basis for taking such a position.

The "urgent review" section provides in pertinent part that:

> "the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one which your health may be in serious jeopardy or, in the opinion of your physician; you may experience pain that cannot be adequately controlled while you wait for a decision on your claim. If you believe your situation is urgent, you may request a review by (insert instructions) . . . ."

Without a more balanced approach, the terms "your health may be in serious jeopardy" and "in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your claim," will clearly lead to more external reviews. For example, does "serious jeopardy" mean life threatening or simply that the claimant does not want to wait for the external review process to take its course.

In addition to the foregoing comments on the substance of the notices, we urge the DOL to also consider requiring a full-page (8 ½" by 11") Appeal Filing versus having the claimant detach the appeal form "at the bottom of this page." The submission of small (3 inch) notices to plans and

issuers is fraught with an endless possibility of reasons for lost and misplaced notices and puts an inordinate amount of responsibility of plans and issuers to intake and process "detached notices."

VI. Strict Adherence to the Claims Procedures

The Interim Final Rules provide that, if a plan or issuer fails to strictly adhere to all the requirements of the internal claims and appeals process, the claimant is deemed to have exhausted the internal process. The claimant may then pursue other remedies through either the external review process or judicial review. This rule of strict adherence applies regardless of whether a plan or issuer has substantially complied with the rules or whether an error was de minimis. If the claimant seeks relief in court, the determination will be deemed a denial and will not be given deference by the court.

This new rule, which is not required by PPACA, varies from the existing standard that allows for inadvertent and de minimis mistakes in compliance with the regulations. "Not every deviation by a plan from the requirements of the regulation justifies proceeding directly to court. A plan that establishes procedures in full conformity with the regulation might, in processing a particular claim, inadvertently deviate from its procedures. If the plan's procedures provide an opportunity to effectively remedy the inadvertent deviation without prejudice to the claimant, through the internal appeal process or otherwise, then there ordinarily will not have been a failure to establish or follow reasonable procedures." US Department of Labor, Employee Benefits Security Administration, Frequently Asked Questions about the Claims Procedure Regulation, FAQ F-2, at http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html.

While the present ERISA claims regulations do state that failure to establish and follow reasonable claims procedures results in exhaustion of plan's internal proceedings, such default does not require absolute and strict adherence to the claim procedure regulations. Case law also affirms the ERISA's exhaustion doctrine and provides very limited exceptions which do not include strict and rigid adherence to the plan's internal proceedings. Obviously, the courts do not wish to decide ERISA claim cases with little or no administrative record to review. See Kathryn J. Kennedy, "The Perilous and Ever-Changing Procedural Rules of Pursuing an ERISA Claims Case," 70 U. of Missouri-Kansas City of School of Law 329, 362 (2001).

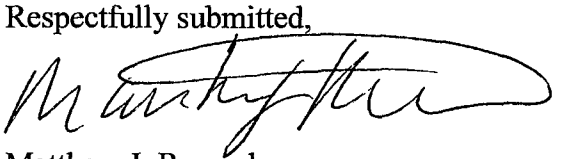
In addition, the lack of an administrative record for the courts to review if the claim is presumed to be exhausted internally will result in higher litigation costs for both sides. According to a survey of employer health benefits conducted by the Henry J. Kaiser Family Foundation/Health Research and Educational Trust, the long-term trend shows a 14 percent increase in the amount of costs that workers are paying for family health coverage. The additional costs required by the interim rules may well increase long-term costs into the double digits.

Conclusion

In general, our comments focus on the fact that the new requirements under the Interim Final Regulations will be expensive for employers - either because they will be costly to implement or because they create uncertainty and/or greater exposure to litigation. This uncertainty and

additional cost may, in conjunction with other health care reform requirements, ultimately cause more employers to reduce benefits or abandon altogether their practice of providing health care coverage. We hope that our comments can aid the Departments in adding certainty to the claims process, while also adding mechanisms to manage litigation risk. Cost containment is a part of health care reform - we hope that our comments are a positive step towards that goal that will enhance and improve the employer-provided health care system for years to come.

Respectfully submitted,



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