STATE OF INDIANA

MITCHELL E. DANIELS, JR., Governor

IDOI

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Stephen W. Robertson, Commissioner

September 12, 2011

<u>Via e-mail to externalappeals@cms.hhs.gov</u>
Attention: Ellen Kuhn
Director, Appeals
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid

Dear Director Kuhn:

I am writing to you on behalf of the State of Indiana to request that CCIIO overturn its prior administrative decision regarding Indiana's external review process and find it in compliance with the NAIC-parallel process. This appeal is in response to Steve Larsen's July 29, 2011 letter concerning Indiana's external review laws and, in particular, declaring that Indiana's external review process does not meet all of the standards of the NAIC-parallel process (See Attached Exhibit A). We strongly disagree with the conclusion that Indiana does not meet the filing fee requirements and the independent review organization (IRO) selection requirement. Therefore, we hereby appeal the previous decision for the following reasons.

I. Indiana's statutes, current authority and certification processes addressing filing fees meet or exceed the NAIC-parallel standard and should be deemed compliant.

The attachment to your letter provides in pertinent part that "[u]nder the NAIC-parallel process standard, the State process may require a nominal filing fee not to exceed $25, provided that the fee is refundable to the claimant if the adverse determination is reversed, the fee is waived for cases of financial hardship, and that there is an annual limit of filing fees for any claimant not to exceed $75. (See 45 CFR 147.136 (c)(2)(iv)). Although Indiana's filing fee for the HMO market may not exceed $25, there are no provisions regarding refunding the fee if the adverse determination is reversed, waiving the fee for cases of financial hardship, or limiting the consumer filing fees to no more than $75 per year." We respectfully submit that this interpretation does not justify finding Indiana in noncompliance for the following reasons.

First, Indiana provides that for health maintenance organizations (HMOs) "[t]he enrollee may be required to pay not more than twenty-five dollars ($25) of the costs associated with the services of an independent review organization under this chapter. All additional costs must be paid by the health maintenance organization." Ind. Code § 27-13-10.1-2(e). The use of the term "may" emphasizes that the fee is not required. Moreover, the provision should be interpreted in context with the adjoining sentence that provides that "[a]ll additional costs must be paid by the [HMO]." This supports the inference that Indiana foresaw the potential deterrent from imposing

consumer filing fees for external review and attempted to guard against it by imposing a limit by expressly prohibiting all other fees. This intent comports with the spirit of the Affordable Care Act. Indiana has not expressly delegated authority to IROs, HMOs, or insurers to impose other fee requirements that would give rise to potential abuse that would create the need to add additional restrictions regarding refunding, waiver and limitation. Indiana has retained sufficient discretionary authority over such fees, however, to merit compliance with the federal rules.

Second, similar to the aforementioned concept of non-delegated authority, we emphasize IDOI's authority to review insurer and HMO form filings (Ind. Code § 27-13-7-11(a) and Ind. Code § 27-13-7-11(f)). Also, IDOI's authority to certify and de-certify IROs provides the department with the ability to establish and maintain a process for annual certification of IROs (Ind. Code § 27-13-10.1-8, et seq). It is fully within IDOI's current authority, via discretionary actions of a state administrative agency, to impose these additional requirements pertaining to fees. Despite the lack of express statutory text pertaining to refunding, waiver and limitation of fees, all of which you have highlighted in your letter, IDOI's existing discretionary authority should be regarded as complying with the new federal guidance. After all, neither the Affordable Care Act nor the regulation relating to external review processes specifies the method of implementation. Expressing the authority via the discretionary decision-making authority of a state regulatory agency, instead of explicitly worded statutory authority, should not merit distinction for purposes of this determination.

Third, and finally, is the practical reality of Indiana's current external review process. Thus far Indiana's external review laws have served their purposes of protecting Hoosiers and have not deterred them from appealing an insurer's determination. According to available records or in recent memory, IDOI's Consumer Complaints division has not received any complaint pertaining to the IRO filing fee, a request to waive the fee, or the external review process in general. Most importantly, according to a telephone survey performed by IDOI in 2011, all IROs that responded to the survey stated that the insured is never charged a filing fee. There is no need to amend the Indiana Code if the new requirements will not improve the existing level of consumer protection. Denying Indiana compliance on the ground that there is no express statute implementing the requirements potentially rises to the level of being arbitrary and capricious. Considering that there are other methods in place that adequately address this issue, HHS guidance to date has been less than forthcoming and any guidance rendered was after the fact only serves to further this point. Therefore, we respectfully request that you overturn your prior decision and find Indiana in compliance.

II. Indiana's method of assignment is random, independent and impartial, and the insurer's role is merely administrative and does not have any effect on the integrity of the process.

The attachment to your letter provides that "[u]nder the NAIC-parallel process standard, the State process must provide that IROs will be assigned on a random basis or another method of assignment that assures the independence and impartiality of the assignment process (such as rotational assignment) by a State or independent entity, and in no event selected by the issuer, plan or the individual. (See 45 CFR 147.136(c)(2)(vii)). In Indiana's IRO assignment process,

issuers have limited discretion in selecting an IRO for an external review from the list of IROs that are certified by the insurance department."

This is not an explicit statutory provision, nor is it in the NAIC model. Although the process provides that the State's commissioner make the assignment, CCIIO wrongly assumes Indiana's method allows for bias. Ind. Code § 27-8-29-13(b) provides the following for non-HMOs: "[w]hen a request is filed under subsection (a), the insurer shall: (1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 19 of this chapter; and (2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection." Similarly, Ind. Code § 27-13-10.1-2(b) provides the following for HMOs: "[w]hen a request is filed under subsection (a), the health maintenance organization shall: (1) select a different independent review organization for each appeal filed under this chapter from the list of independent review organizations that are certified by the department under section 8 of this chapter; and (2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection." The issuer's selection of the IRO is purely administrative.

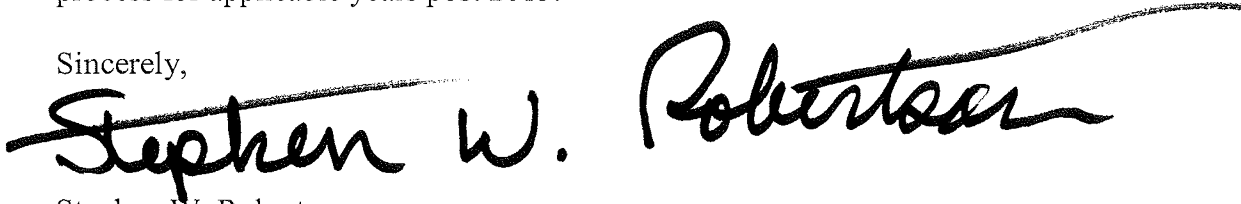
Moreover, Indiana Code prohibits collusion between IROs and issuers and authorizes the Indiana Department of Insurance (IDOI) to revoke IRO licenses and investigate any issues. The issuer can never select the same IRO again until selecting every other IRO licensed in Indiana. This is effectively a rotational assignment. From a mathematical perspective, there is little difference in randomly selecting the next IRO from the list and choosing the next IRO in the list if every IRO must be selected eventually, and no IRO selection can be repeated.

Furthermore, I assume the choice of the phrase "limited discretion" in your letter is based upon IDOI's previous letter regarding this issue. Such a phrase must be carefully interpreted. Discretion connotes some type of choice, symbolic of the possibility the issuer could choose a more preferable IRO to increase the chance their denial of a claim is upheld by the IRO. This is obviously not the intended meaning. In practice, issuers have no choice. Consider the metaphor of picking the IRO out of a hat. While the issuer controls the hand doing the picking, they are not exercising a choice; they are just moving the hand. And even if the issuer were somehow to be exercising some choice, this is the precise activity that is explicitly prohibited by corresponding statutes. (See Ind. Code § 27-8-29-13(d) and Ind. Code § 27-13-10.1-2(d)). In effect, requiring Indiana to shift to the new regulatory framework is merely an administrative shift of a purely operational burden from private issuers to state government.

With these other protections, such as statutory prohibition of conflicts of interest, in place to ensure independence and impartiality, Indiana's process provides the equivalent level of consumer protection as the NAIC-parallel process and concurrently alleviates the burden on IDOI to closely participate in each external appeal. Adopting this new standard will only serve to reduce the efficiency of the current regulatory framework without conferring a higher level of consumer protection. This runs counter to the goals of the Affordable Care Act. For this reason, we respectfully request that CCIIO overturn its original decision and find Indiana's IRO selection method compliant.

For the reasons mentioned above, Indiana respectfully requests that HHS overturn its original decision, and, therefore, find Indiana's external review law compliant with the NAIC-parallel process for applicable years post 2013.

Sincerely,



Stephen W. Robertson
Commissioner of Insurance
Indiana Department of Insurance

Exhibit A

Attachment – State of Indiana

Summary of Components – NAIC-Parallel Process

Please note that in addition to the summary below, the precise requirements of the NAIC-parallel process may be found at 45 CFR 147.136 and the exact paragraphs are noted in each bullet for your convenience.

The State of Indiana's external review process does not meet the required components of an NAIC-parallel process as follows:

- Under the NAIC-parallel process standard, the State process may require a nominal filing fee not to exceed $25, provided that the fee is refundable to the claimant if the adverse determination is reversed, the fee is waived for cases of financial hardship, and that there is an annual limit of filing fees for any claimant not to exceed $75. (*See* 45 CFR 147.136 (c)(2)(iv)). Although Indiana's filing fee for the HMO market may not exceed $25, there are no provisions regarding refunding the fee if the adverse determination is reversed, waiving the fee for cases of financial hardship, or limiting the consumer filing fees to no more than $75 per year.
- Under the NAIC-parallel process standard, the State process must provide that IROs will be assigned on a random basis or another method of assignment that assures the independence and impartiality of the assignment process (such as rotational assignment) by a State or independent entity, and in no event selected by the issuer, plan or the individual. (*See* 45 CFR 147.136 (c)(2)(vii)). In Indiana's IRO assignment process, issuers have limited discretion in selecting an IRO for an external review from the list of IROs that are certified by the insurance department.

In addition, under the NAIC- parallel process standard, the State process must provide for an expedited external review, including notification to the claimant of the determination, as expeditiously as possible, but not later than 72 hours after receipt of the request for external review (and if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision). (*See* 45 CFR 147.136 (c)(2)(xiii)). In Indiana, in the non-HMO market, IROs are granted a maximum of 3 business days to make an urgent care decision and an additional 24 hours to render that decision to the claimant.

However, we note that in Bulletin 185 Indiana sets forth the procedures for IRO certification including compliance with requirements under Affordable Care Act. In Section 1 ("Technical/Procedure"), IROs are required to submit information on their systems and methods including their process for providing a decision in the statutorily mandated amount of time. Read as a whole, we understand this bulletin to require IROs to certify that they will make urgent external review determination and notify the claimant of the same within the 72 hour timeframe required by the regulations implementing the Affordable Care Act. If CCIIO receives information that IROs are not conducting urgent external reviews and notifying claimants of their determination in accordance with the standard set forth in the regulations implementing the Affordable Care Act, CCIIO will revisit Indiana's compliance with this standard.