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December 23, 2013

Ms. Lois Johnson
General Counsel
Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02116

Subject: Amendments to 958 CMR 3.00 – Health Insurance Consumer Protection

Dear Ms. Johnson:

Thank you for the opportunity to comment on the Amendments to 958 CMR 3.00 – Health Insurance Consumer Protection. Aetna has the following comments and concerns:

- (1) 3.301 C1: Requires carriers to provide the appellant any new or additional information reviewed seven days prior to resolution of the case. This is not possible for expedited cases and there does not appear to be an exception for expedited cases. It would also be very challenging for other appeals and may actually be at the consumer's disadvantage, particularly if medical records are needed, which means we would have to wait for their receipt and then allow at a minimum seven days at the end of the review for the appellant to review the documents (and potentially us to do another review if they provide anything in rebuttal of our information).
- (2) 3.302 B: Requirement is to request an authorization to release authorization for medical records within one day of receipt of the grievance. One day of receipt is not enough time to assess if medical records need to be reviewed.
- (3) 3.304 B: Requires that the acknowledgment letter have the date by which the decision is made. Currently our letters advise consumers that we will resolve in a particular number of days, we don't provide a specific date and would prefer maintaining that flexibility.
- (4) 3.306 C: This requirement states that the carrier shall assemble a reasonably complete medical record for its internal review. We rarely receive a full medical record but rather the specific information needed for each case. We need such flexibility for each case and so do the providers and consumers.
- (5) 3.307 B1: States that the resolution letter must include the diagnosis and treatment codes. We do not do that because the Affordable Care Act relaxed that requirement due to privacy concerns. Instead we currently offer them upon request as indicated in the federal guidelines.
- (6) 3.307 B5: States that carriers need to include a copy of the criteria used in making the decision. Currently we cite the criteria but do not provide the criteria unless requested because the criteria can be many pages long. Also, we encourage the members to discuss these issues with their provider(s) and then determine what they really need to review and we provide that information upon request. Sending a lot of information automatically will be overwhelming to most members.
- (7) 3.307 B6: States that carriers need to specify treatment options by geographic area and language. We may not always have the appropriate language for the member or know the appropriate geographic area. Additional clarity on this provision is needed.

- (8) 3.308: We have questions around this whole reconsideration process. Will there be more information forthcoming from the department around timeframes of what is considered reasonable and what is good cause?

Again, thank you for the opportunity to provide comments. Should you have any questions, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Timothy B. Meyer". The signature is fluid and cursive, with a large, stylized initial "T" and a distinct "B" in the middle.

Timothy Meyer

Vice President, State Government Affairs, Northeast Region