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September 21, 2010

U.S. Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Attention: OCIIO–9993–IFC
P.O. Box 8016
Baltimore, MD 21244–1850

Submitted via the Federal eRulemaking Portal

Dear Sir or Madam:

The Association of Federal Health Organizations ("AFHO") appreciates this opportunity to provide comments on the Interim Final Rule relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act published at 75 Fed. Reg. 42,330 (July 23, 2010)(the "IFR"). AFHO is a national association of Federal Employees Health Benefits ("FEHB") fee-for-service plan carriers. AFHO's member organizations sponsor FEHB plans that provide health benefits to over three million federal and postal employees and annuitants.[1]

The FEHB Program's appeal process for eligibility issues, including rescissions, should be preserved

The IFR includes eligibility decisions and rescissions of coverage within the scope of adverse benefit determinations that are subject to internal appeal by the group health plan. *See* 75 Fed. Reg. at 43,332. However, rescission issues are outside the scope of the federal external review process. *See id.* at 43,336. This scheme unavoidably conflicts with the FEHB Program's current eligibility appeal process which resides entirely with the government agencies and the U.S. Office of Personnel Management ("OPM") as required by federal law.

FEHB eligibility issues, including, without limitation, rescissions, as defined at 45 C.F.R. § 147.128(a)(2), stem from the federal statutes and regulations that define who is eligible for FEHBP coverage (*see* 5 U.S.C. § 8901 *et seq.*; 5 C.F.R Ch. 890). OPM's regulations governing the FEHB Program expressly deem the federal government, not the group health / FEHB plan, responsible for

[1] AFHO's members include American Foreign Service Protective Association, American Postal Workers Union Health Plan, Compass Rose Benefits Group, Government Employees Health Association, Mail Handlers Benefit Plan, National Association of Letter Carriers Health Benefit Plan, National Rural Letter Carriers' Association, Panama Canal Area Benefit Plan, Special Agents Mutual Benefit Association, and Associate Member Blue Cross Blue Shield Association. AFHO members reserve the right to comment individually on this IFR.

making definitive FEHB Program enrollment / eligibility decisions. *See* 5 C.F.R. §§ 890.101, 890.104. Those OPM regulations also create a special government appeal process for eligibility issues. *See id.* §§ 890.104, 890.107. We therefore request that the FEHB Program be carved out from the claim's appeal regulations provision extending group health plan appeal rights to eligibility and rescission cases, 45 C.F.R. § 147.136(a)(2)(i) (published at 75 Fed. Reg. 43,358 (July 23, 2010). *See Maple v. United States*, 2010 WL 26401 (W.D. Okla. June 30, 2010).

Non-grandfathered group health plans should be allowed a longer compliance period

For over thirty years, the FEHB Program has had a successful two step benefit claim appeal process. At the first step, the enrollee may request reconsideration by the group health / FEHB plan. The second step involves an external review by OPM. The carrier is required to comply with OPM's decision. The enrollee may challenge OPM's decision in federal court under the Administrative Procedure Act. 5 U.S.C. § 8902(j); 5 C.F.R. §§ 890.105, 890.107.

Approximately ten years ago, the Labor Department established a detailed claim procedure and appeal rule for group health plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended (the "DOL claim rule"). 65 Fed. Reg. 70,246 (November 21, 2000). The Labor Department allowed ERISA-governed group health plans a period of 18 to 24 months to achieve compliance with the DOL claim rule, which is codified at 29 C.F.R. § 2560.503-1. 66 Fed. Reg. 35,886 (July 9, 2001):

> As published on November 21, 2000, the benefit claims procedure would be applicable to claims filed on or after January 1, 2002. The current action amends the regulation so that it will apply to group health claims filed on or after the first day of the first plan year beginning on or after July 1, 2002, but in no event later than January 1, 2003. This action provides a limited additional period within which group health plan sponsors, administrators, and service providers can bring their claims processing systems into compliance with the new requirements.

FEHB plans as exempt governmental plans within ERISA's definition (29 U.S.C. §§ 1002(32), 1003(b)(1)) remained subject to the FEHB Program's internal and external appeal procedure established by OPM.

In the Affordable Care Act, Congress decided that the DOL claim rule should be the minimum standard for all non-grandfathered group health plans. *See* new Public Health Service Act § 2719(a)(2) added by Affordable Care Act § 1001. Because ERISA-governed plans have been subject to the DOL claim rule for nearly a decade, the brunt of this change falls on non-grandfathered FEHB and other governmental plans.

Where DOL allowed ERISA-governed group health plans a compliance period of at least 18 months, HHS is allowing non-grandfathered FEHB plans with a maximum compliance period of eleven months if the plan year begins on January 1 – the date on which FEHB plan years begin. What's more, HHS has added many new and costly requirements onto the DOL claim rule.

We are aware that on September 20, 2010, the Labor Department announced a six month grace period from enforcement of those additional IFR requirements. ACA Technical Release No. 2010-02. While we appreciate this action, the operational and claim system issues confronting FEHB plans, in particular, require a longer grace period. We request that the compliance, or grace, period be extended to the beginning of the second plan year beginning on or after September 23, 2010.

HHS should reconsider certain IFR requirements

HHS should reconsider certain additional requirements imposed on non-grandfathered group health plans. Specifically, we ask HHS to reconsider the following new requirements that form part of the IFR:

- The DOL claim rule requires group health plans to decide urgent care claims within 72 hours. 29 C.F.R. § 2560.503-1(f)(2)(i). HHS has decided to reduce that period for non-grandfathered plans to 24 hours based on improved communications over the last decade. *See* 75 Fed. Reg. 43,333. While communications may have improved marginally, the customary practice of closing or curtailing business operations on weekends and holidays has not changed. For that reason, HHS should allow no less than one business day for making a decision on an urgent care claim. Also, no reduction in the current 72 hour period, which accommodates weekends and holidays, should occur until the effective date of the anticipated change for all ERISA-governed plans. *See* 75 Fed. Reg. 43,332.

- The IFR requires that the adverse benefit determination / explanation of benefits (EOB) sent to enrollees include detailed diagnosis and procedure information. *See* 75 Fed. Reg. 43,333-34. Compliance with this requirement will necessitate reprogramming plan claim systems, an expensive process that consumes a multitude of resources. In our view, the questionable benefit of modifying the EOB does not justify the expense and should be withdrawn.[2]

  In the vast majority of cases, the health care provider submits the claim and receives the payment. HHS is aware that under the HIPAA Standard Electronic Transactions 837 and 835, the plan and provider already share detailed diagnosis, treatment, and denial code information. The enrollee can obtain this information from the provider.

  As an alternative to sending enrollees detailed diagnosis and procedure information, HHS should give carriers who have not been subject to the DOL claim rule, such as FEHB plan carriers, time to develop an optional "on-request" capability. Such a capability would involve not only reprogramming systems to connect customer service agents with claims repositories so that they have electronic access to that information – currently any requests typically would have to be handled manually –

[2] The new requirement also runs counter, in our view, to the HITECH Act. In Section 13402 of that law, Congress expressed its intent that group health plans should be very careful when releasing protected health information in an unsecured format. Explanations of benefits to members are printed on paper, a medium which by regulatory definition is unsecure. *See* 74 Fed. Reg. 42,740, 42,740-42 (August 24, 2009)

but also developing business rules around when providing that information may or may not be appropriate. For example, a carrier should have the flexibility to defer providing the diagnosis when the diagnosis is sensitive or serious, and the enrollee inquiring appears to be unaware of the diagnosis. Instead, the plan should be able to help the enrollee obtain the information from the enrollee's provider.

- HHS should reconsider the strict liability rule providing that any group health plan failure to comply with the IFR allows the claimant to by-pass the plan's internal appeal process. *See* 75 Fed. Reg. 43,334. This rule, although well meaning, will increase the number of unnecessary external appeals and lawsuits. HHS should adopt the substantial compliance standard accepted by the majority of federal circuit courts of appeals. *See e.g., Cooper v. Hewlett-Packard Co.*, 592 F.3d 645, 652 (5th Cir. 2009); *White v. Aetna Life Insurance Co.*, 210 F.3d 412, 414 (D.C. Cir. 2000). Under that standard, technical non-compliance is excused so long as the statute's purposes have been fulfilled. *Robinson v. Aetna Life Insurance Co.*, 443 F.3d 389, 393 (5th Cir. 2006).

<u>HHS should reaffirm its support for the practice of sending EOBs to the enrollee</u>

HHS also should reaffirm that the customary practice of sending EOBs to the enrollee, even when the enrollee is not the patient, complies with the HIPAA Privacy Rule, codified at 45 CFR part 160 and part 164, subparts A and E. In December 2000, the HHS stated as follows

> *Comment:* A commenter noted that the definition of ''disclosure'' should reflect that health plan correspondence containing protected health information, such as Explanation of Benefits (EOBs), is frequently sent to the policyholder. Therefore, it was suggested that the words ''provision of access to'' be deleted from the definition and that a ''disclosure'' be clarified to include the conveyance of protected health information to a third party.
>
> *Response:* The definition is, on its face, broad enough to cover the transfers of information described and so is not changed. We agree that health plans must be able to send EOBs to policyholders. Sending EOB correspondence to a policyholder by a covered entity is a disclosure for purposes of this rule, but it is a disclosure for purposes of payment. Therefore, subject to the provisions of § 164.522(b) regarding Confidential Communications, it is permitted even if it discloses to the policyholder protected health information about another individual.

65 Fed. Reg. 82,607 (December 28, 2000). In our view, that response remains valid today, and HHS should reaffirm the continuing vitality of this response.

<u>Carriers should not be required to accept oral testimony in internal appeals</u>

In accordance with Public Health Service Act § 2719(a)(1)(C) (added by the Affordable Care Act, § 1001), the IFR requires carriers to permit claimants to "present evidence and testimony" in internal appeals. 45 C.F.R. § 147.136(b)(ii)(C). However, the IFR does not

define the word "testimony," which could be construed to mean either oral statements in a trial-type adjudicatory proceeding or a written statement. We believe that requiring carriers to offer claimants the opportunity to testify orally would make it much more difficult and expensive to conduct expeditious internal appeals. Accordingly, we recommend revising the IFR to clarify that a carrier fully discharges its obligation under the Rule by providing claimants with the opportunity to submit written testimony.

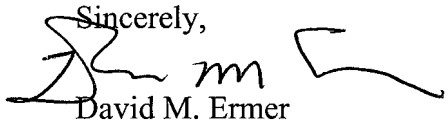
HHS should preserve the FEHB Program's External Appeal Process

In our view, the external appeal process provisions of new Public Health Service Act § 2719(b) are inapplicable to the FEHB Program which by operation of the FEHB Act, 5 U.S.C. §§ 8902(j), 8902(m)(1), & 8913, is regulated by OPM, not state authorities, and possesses its own federal external review process. Indeed, HHS piggy backed on the FEHBP's external review process by delegating to OPM the federal external review process for non-grandfathered insured plans operating in states without a federally approved external review process. See 75 Fed. Reg. 75,601 (September 16, 2010). We ask HHS to state in the preamble to the final rule that the FEHBP's external appeal process is not subject to Section 2719(b).

Should HHS disagree with our view, the Affordable Care Act authorizes the HHS Secretary to approve an external review process in operation as of the date of enactment. As discussed above, the FEHBP external review process was in effect on March 23, 2010, and its successful history evidently lead HHS to delegate to OPM the federal external review process for non-grandfathered insured plans operating in states without a federally approved external review process. We urge the HHS Secretary to exercise her authority under new Public Health Service Act § 2719(c) by approving the FEHBP external review process, which OPM has established at 5 U.S.C. § 890.105, 890.107 in accordance with Section 8902(j) of the FEHB Act without delay.

Thank you for your consideration of these comments.

Sincerely,



David M. Ermer
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cc: Board of Directors
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