Association of Federal Health Organizations
P.O. Box 19791, Washington, DC 20036
Established 1983

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U.S. Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Attention: OCIIO-9994-IFC
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

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 concerning the Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections published at 75 Fed. Reg. 37,188 (June 28, 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]

Restrictions on Rescission

AFHO wishes to raise the following concerns about the regulators' approach to implementing the Affordable Care Act's restrictions on rescission.

Our first concern is a scope issue. Rescissions, as defined at 45 C.F.R. § 147.128(a)(2), only arise in the FEHB Program as a result of eligibility decisions made by the federal government, in accordance with 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), not by the group health / FEHB plan (as the IFR anticipates). The U.S. Office of Personnel Management's ("OPM") regulations governing the FEHB Program expressly deem the federal government, not the group health / FEHB plan, responsible for FEHB Program enrollment / eligibility decisions. *See* 5 C.F.R. § 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 anti-rescission rule and the claim's appeal regulations provision extending group health plan appeal rights to rescission cases, 45 C.F.R. § 147.136(a)(2)(i) (published at 75 Fed. Reg. 43,358 (July 23, 2010).

[1] AFHO's members include American Foreign Service Protective Association, American Postal Workers Union, 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 interim regulation.

In the alternative, the regulators should revise the IFR to recognize that retroactively cancelling coverage of those enrollees or dependents who were erroneously enrolled, or whose enrollments continued after they lost eligibility in a FEHB or another governmental plan, is not a rescission because they were not entitled to such governmental plan coverage from the moment they no longer satisfied the applicable statutory or regulatory eligibility requirements.

Absent this clarification, the IFR results in the inequitable treatment of similarly situated ineligible individuals. For example, the former spouse of an FEHB plan enrollee who properly and timely notified either the employer or carrier of a divorce would lose benefits immediately while the spouse of an enrollee who failed to provide such notice because of negligence or mistake would be insulated from retroactive cancellation. In view of the False Claims Act, 31 U.S.C. § 3729, and the Improper Payments Elimination and Recovery Act of 2010, we do not believe that Congress intended the IFR to produce such a result.

Our second concern relates to the fact the IFR, 45 C.F.R. § 147.128(a)(1), requires group health plans to continue to pay claims on a member subject to a rescission during the thirty day advance notice period. We suggest that that the regulators modify the IFR to permit group health plans and health insurance issuers the option to pend those claims during the advance notice period in the interest of avoiding overpayments.

Out of Network Emergency Care

The Affordable Care Act (§ 1001 adding Public Health Service Act § 2719A(b)(1)(C)(ii)(II)) requires non-grandfathered group health plans and health insurance issuers to cover out-of-network emergency services (as defined at § 2719A(b)(2)(B)) such that "the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network." AFHO accepts this obligation. However, the regulators go beyond the statutory requirement to create a complicated formula for the plan allowance on which the benefit payment is based. The regulation provides that the plan allowance must be the greater of (A) the median in-network provider reimbursement rate, (B) the standard out-of-network provider reimbursement rate, or (C) the Medicare Part B reimbursement rate. 45 C.F.R. § 147.138(b)(3). This formula is nowhere found in the statute. In *Santa Fe Industries, Inc. v. Green*, 430 U.S. 462, 471 (1977), the U.S. Supreme Court observed that

> The rulemaking power granted to an administrative agency charged with the administration of a federal statute is not the power to make law. Rather, it is "the power to adopt regulations to carry into effect the will of Congress as expressed by the statute." *Dixon v. United States,* 381 U.S. 68, 74, 85 S. Ct. 1301, 1305, 14 L. Ed. 2d 223 (1965), quoting *Manhattan General Equipment Co. v. Commissioner,* 297 U.S. 129, 134, 56 S. Ct. 397, 400, 80 L. Ed. 528 (1936).

We understand that the regulators introduced this formula based on an anti-abuse concern that unscrupulous plans or issuers could defeat the § 2719A's purpose by paying "an unreasonably low amount to a provider, even while limiting the coinsurance or copayment associated with that amount to in-network amounts." 75 Fed. Reg. 37,194. The regulators can resolve this issue by

providing in the IFR that the plan allowance for emergency services shall be the plan's generally used out of network reimbursement rate as now defined at 45 C.F.R. § 147.138(b)(3)(B).[2] This alternate approach would deter potential abuse without overly complicating claims administration.

We also ask the regulators to expressly state in the IFR that the group health plan or health insurance issuer may pay out of network emergency services claims to the member rather than the healthcare provider when permitted by the plan document (in the case of an FEHB plan, the OPM contract establishing the plan and the plan's contract statement of benefits or brochure) or policy.

Thank you for your consideration of these comments.

Sincerely,

David M. Ermer
AFHO General Counsel

cc: Board of Directors
Daniel A. Green, OPM
Anne Easton, OPM
Sylvia Pulley, OPM
William Stuart, OPM

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[2] That provision reads as follows:

> The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee. The amount in this paragraph (b)(3)(i)(B) is determined without reduction for out-of-network cost sharing that generally applies under the plan or health insurance coverage with respect to out-of network services. Thus, for example, if a plan generally pays 70 percent of the usual, customary, and reasonable amount for out-of-network services, the amount in this paragraph (b)(3)(i)(B) for an emergency service is the total (that is, 100 percent) of the usual, customary, and reasonable amount for the service, not reduced by the 30 percent coinsurance that would generally apply to out-of-network services (but reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency service had been provided in-network).