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Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-1850

Attention: OCIIO-9993-IFC

Comments on 45 CFR Part 147, 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, submitted electronically at http://www.regulations.gov.

Dear Ladies and Gentlemen:

On behalf of the 3.2 million members of the National Education Association, I am pleased to provide comments on 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, 75 Fed Reg. 43330-43364 (July 23, 2010).

NEA has long supported health care reform efforts that would provide access to affordable and comprehensive health care coverage for all Americans while, at the same time, working towards improving the U.S. health care system. NEA greatly values and appreciates the hard work of the Departments of the Treasury, Labor, and, Health and Human Services in drafting and finalizing these and other regulations related to the new health care law. These interim final rules are especially important as they further strengthen state and federal laws to protect and support NEA members, their families and all consumers who are faced with an adverse benefit determination.

The following are the NEA's comments on the interim final rule at 75 Fed Reg. 43330-43364:

1) **Require continued coverage pending the outcome of the external review process.**

NEA believes that during the external review process, plans and issuers should be prohibited from reducing or terminating a claimant's benefits, similar to the requirement in the internal review claims and appeals process outlined in the interim final rule.

The interim final rule states that plans and issuers cannot reduce or terminate coverage without providing advance notice and an opportunity for advance review during the internal claims and appeals process, which would then allow a claimant to request another level of review. Section 147.36 (b) (F) (iii) states that "benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review."

However, there is no similar requirement in the interim final rule to provide continued coverage pending the outcome of an external review. As a result, plans and issuers would have the opportunity to reduce or terminate the benefits of claimants during the external review process. The external review should be completed first so that benefits are not erroneously reduced or terminated. In addition, as currently written, insurance companies would have a financial incentive to deny appeals at the internal claims and appeals level so they can reduce or terminate benefits while the external appeal is pending.

2) **Expedited review should be allowed for non-emergency services on a case-by-case basis.**

NEA believes that the interim rule should allow for an expedited external review, on a case- by- case basis, if the patient is not receiving "emergency services."

Both the state and federal external review processes provide for an expedited external review process if the adverse benefit determination or final internal adverse benefit determination would jeopardize the claimant's ability to regain maximum function or concerns an admission, availability of care, continued stay or health care service for which the claimant received emergency services but has not been discharged from a facility.

It is common for plan participants in inpatient mental health and substance abuse treatment settings to be prematurely discharged to an outpatient setting at the direction of their plan administrator/issuer long before the patient and his/her doctor believe they are ready, usually-- for cost reasons. In many cases, these patients are not receiving "emergency services" per se but are, none the less, in mid-treatment and would potentially suffer severe setbacks if discharged too early.

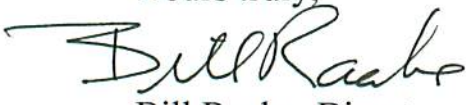
3) **Please clarify the date on which claims will be subject to the new rules when a plan loses grandfathered status.**

NEA believes that claims incurred during the time period that a plan has grandfathered status, but still being processed by the plan administrator/issuer after it loses grandfathered status, should be eligible for the internal claims and appeals and external review processes.

The interim final rule does not specify whether claims incurred but not processed before the date the plan loses grandfathered status would be eligible for internal claims and appeals and external review. Since the processing of a health care claim can go on for an extended period of time, the date on which the plan loses its grandfathered status should be the determining factor for when the internal and external review processes can occur, not the date of service.

Thank you again for all the hard work and for clarifying the issues that have come up for NEA members and their health plans. We look forward to your responses on these comments.

Yours truly,



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