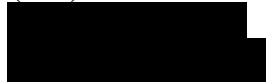


**Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, DC 20554**

In the Matter of)	
)	
The Joint Petition of Anthem, Inc., Blue Cross)	
Blue Shield Association, WellCare HealthPlans,)	
Inc. and the American Association of Healthcare)	
Administrative Management for Expedited)	
Declaratory Ruling and/or Clarification of the)	
2015 TCPA Omnibus Declaratory Ruling)	
and Order)	CG Docket No. 02-278
)	
Rules and Regulations Implementing the)	
Telephone Consumer Protection Act of 1991)	

**COMMENTS BY AMERICA’S HEALTH INSURANCE PLANS IN SUPPORT OF
ANTHEM, INC., BLUE CROSS BLUE SHIELD ASSOCIATION, WELLCARE
HEALTHPLANS, INC. AND THE AMERICAN ASSOCIATION OF HEALTHCARE
ADMINISTRATIVE MANAGEMENT JOINT PETITION FOR EXPEDITED
DECLARATORY RULING AND/OR CLARIFICATION OF THE 2015 TCPA
OMNIBUS DECLARATORY RULING AND ORDER**

Julie Simon Miller
Thomas M. Palumbo
AMERICA’S HEALTH INSURANCE PLANS
601 Pennsylvania Avenue, N.W.
South Building, Suite 500
Washington, D.C. 20005
(202) 778-3200



Counsel for America’s Health Insurance Plans

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I. Introduction and Summary

America's Health Insurance Plans ("AHIP") submits the following comments in support of the Joint Petition for Expedited Declaratory Ruling and/or Clarification of the 2015 TCPA Omnibus Declaratory Ruling and Order filed by Anthem, Inc., Blue Cross Blue Shield Association, Wellcare Health Plans., Inc., and the American Association of Health Management ("Joint Petition").

AHIP is the national trade association representing the health insurance community. AHIP's members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market and public programs such as Medicare and Medicaid. Our members have broad experience working with hospitals, physicians, patients, employers, state governments, the federal government, pharmaceutical and device companies, and other healthcare stakeholders to ensure that patients have access to and are fully utilizing needed treatments and medical services. AHIP strongly supports initiatives to improve the health and wellbeing of individuals, including important health care communications made to patients and enrollees in health plans offered by our members.

The provision of health insurance includes more than issuing and administering a policy; it entails proactively engaging with enrollees on a wide variety of related coverage issues and coordinating the effective utilization of benefits. This includes care management and coordination services as well as engaging in outreach and education activities intended to maximize enrollee health outcomes. These efforts often include conducting health care-related telephone contacts to ensure that enrollees are, among other things: adhering to treatment plans; picking up necessary prescriptions; scheduling necessary appointments; provided with timely and accurate information regarding scheduled treatments; have access to pre-operative, post-

treatment and homecare instructions; and are fully utilizing covered benefits and services.

These, as well as other kinds of telephone contacts detailed in our comments, play an essential role in improving health outcomes and promoting wellness among enrollees.

Accordingly, AHIP strongly supports petitioners' request that the Federal Communications Commission ("FCC") interpret its Telephone Consumer Protection Act ("TCPA") 2015 Omnibus Declaratory Ruling and Order (the "2015 Declaratory Order" or "Order") in a manner that is consistent with previous TCPA rules and related FCC decisions by continuing to allow consumers to receive non-telemarketing calls allowed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). AHIP submits that the FCC should, consistent with petitioners' request, issue a ruling and/or clarification of the 2015 Declaratory Order clarifying that: 1) the provision of a phone number to a "covered entity" or "business associate" constitutes prior express consent for non-telemarketing calls allowed under HIPAA for the purposes of treatment, payment, and health care operations; and 2) the prior express consent clarification in paragraph 141 and the non-telemarketing health care message exemption granted in paragraph 147, both in the 2015 Declaratory Order, be clarified to include HIPAA "Covered entities" and "business associates." Specifically, each use of the term "health care provider" in these paragraphs should be clarified to encompass "HIPAA covered entities and business associates".

II. Background

Telephonic communications play an essential role in supporting the innovative strategies through which health insurance plans are working to improve health outcomes for their enrollees.

Health plans, as HIPAA covered entities,¹ engage in a wide variety of critical health care communications to individuals, including prescription refill and physician office visit reminders, care coordination messages, the provision of home healthcare information, and pre- and post-operative instructions all of which are intended to help improve health outcomes. These are precisely the kinds of non-marketing healthcare communications designed to improve quality of care and health care outcomes that health plans have focused on developing innovative strategies around in an effort to improve enrollee health and wellness.

As requested in the petition, we urge the FCC to align its 2015 Declaratory Order with the HIPAA Privacy Rule's long-standing understanding of what is permitted as treatment, payment, and operations. The HIPAA Privacy Rule does not require covered entities to obtain an individual's written authorization or consent prior to using or disclosing protected health information for treatment, payment, or health care operations.² The United States Department of Health and Human Services ("HHS") has also made clear that wellness programs, disease management programs, and the like are not marketing activities requiring separate authorization to use protected health information.³ We urge the FCC to recognize the HHS policy goals that support such programs through the long-standing HIPAA rule and align across all modes of communication – whether e-mail, text, cell call, land-line, or mail – to permit HIPAA covered entities to engage in these important health outreach activities.

Further, AHIP recognizes and appreciates the considerable efforts the FCC undertook in developing the standards for communications in situations where consumers have previously given consent to be contacted by providing their telephone number to a covered entity,

¹ See 45 C.F.R. § 160.103.

² See 45 C.F.R. § 164.506(b).

³ See, e.g. *HHS HIPAA FAQs for Professionals*, December 2002, available at: <http://www.hhs.gov/hipaa/for-professionals/faq/280/what-programs-fall-under-hippa-definition-of-marketing/index.html>.

particularly those standards enumerated in the 2015 Declaratory Order. However, AHIP shares Petitioners' concern that the 2015 Declaratory Order may inadvertently limit the benefit of non-marketing healthcare communications by referencing only health care providers, and not other HIPAA covered entities and business associates. Interpreting the Order in such a manner risks discouraging and burdening important health care communications that are otherwise allowed by the more specific HIPAA regulation, and encouraged by federal and state public health policies.

At the outset, it is important to note that in the case of health insurance plans, an individual's telephone contact information is typically received as part of the enrollment process, which is then utilized to engage in various non-marketing, care management communications that previously may have been performed by health care professionals. These are the same type of messages identified in the 2015 Declaratory Order, specifically:

“...calls for which there is exigency and that have a healthcare treatment purpose, specifically: appointment and exam confirmation and reminders, wellness checkups, hospital pre-registration instructions, pre-operative instructions, lab results, post-discharge follow-up intended to prevent readmission, prescription notifications, and home healthcare instructions.”

Order at ¶146. Non-marketing telephone contacts, such as those at issue here, play an important role in efforts by health insurance plans to improve health outcomes for enrollees. This is consistent with the FCC's prior decisions acknowledging the same. In 2012, the FCC accepted the principle that autodialed prerecorded health-care related calls have an important role to play in our health care system. In exempting from several requirements applicable to prerecorded calls all health-care related calls to residential landlines subject to HIPAA, the FCC concluded that such calls “serve a public interest purpose: to ensure continued consumer access to health

care-related information” and do not “tread heavily upon the consumer privacy interests” that the TCPA was intended to protect.⁴

However, the 2015 Declaratory Order could be misconstrued so as to limit the scope of exempted calls to voice call or text messages “made *by or on behalf of a healthcare provider*” and thus risks a too narrow interpretation that would exclude all other relevant HIPAA covered entities other than “healthcare providers” (itself a term the Order leaves undefined), including health insurance plans and their contracted business associates which themselves increasingly serve a similar role in facilitating and managing the care of Americans. Order at ¶147 (emphasis added). We believe this is an unintended result which could expose health plans to potential regulatory enforcement action by the FCC, civil litigation and could lead to the curtailment of innovative non-marketing healthcare communications health plans engage in as a means of improving health outcomes for their enrollees.

III. Health Plans’ Use of Telephone Contacts for Improving Health Outcomes

Telephone contacts, such as those at issue here, play an important role in efforts by health insurance plans to improve health outcomes for enrollees. Health plans have a long history of developing innovative tools and strategies to ensure that enrollees receive health care services on a timely basis, while also emphasizing prevention and providing access to disease management services for their chronic conditions. Using systems of coordinated care, health plans work to ensure that physician services, hospital care, prescription drugs, and other health care services

⁴ See *Rules and Regulations Implementing the Telephone Consumer Protection Act of 1991*, Report and Order, -- 27 FCC Rcd 1830 ¶¶ 60, 63 (2012); see *id.* ¶ 60 n. 176 (noting that AHIP supported creation of such an exemption “because the exemption would allow the continuation of important communications by health care providers and health insurance plans such as prescription refills, immunization reminders, and post hospital discharge follow-up.”).

are integrated and delivered with a strong focus on preventing illness, improving health status, and employing best practices to swiftly treat medical conditions as they occur – rather than waiting until they have advanced to a more serious level. These initiatives frequently coordinate services and data (including contact information such as phone numbers) in both directions between different types of HIPAA covered entities.

Timely and cost-effective communication with health plan enrollees is essential to the success of the innovative strategies health plans have developed to improve health care quality and outcomes. This includes, for example, telephonic communications that remind enrollees to schedule appointments with their doctor and refill prescription drugs. In other cases, these messages provide information that can promote adherence with treatment regimens, encourage healthy activities, and improve the management of chronic conditions. Non-marketing telephonic communications are also an essential component of health plan efforts to improve and report on health care quality, and involve a wide range of activities including case management, identification of target populations with specific health care needs, and counseling. Telephone contacts are one of the tools utilized by health plans to promote engagement by individuals with their health and to meet quality requirements. These tools play a critical and recognized role in promoting health.

Indeed, not only are such enrollee communications essential in developing improvements to care quality and health outcomes, but in the case of government-funded programs such as Medicaid and Medicare (including Medicare Advantage health plans (“MA Plans”)), these communications are in fact required or encouraged. For example, plans are required under their contracts with the Centers for Medicaid and Medicare Services (“CMS”) to engage in enrollee care coordination and case management activities, which in many instances are conducted

through telephonic communications with enrollees. In particular, Medicare Advantage Special Needs Plans (“SNPs”)⁵ are required to conduct Health Risk Assessments (“HRAs”) of new enrollees within 90-days of the beneficiary’s effective enrollment date and thereafter reassess enrollees annually.⁶ Both initial HRAs and subsequent annual reassessments are expressly permitted to be conducted telephonically.⁷ As part of their annual reporting requirements, SNPs must document that they made at least three call attempts and sent a follow-up letter in efforts to contact an SNP enrollee both within 90-days of the effective enrollment date as well as in connection with annual reassessments.⁸

In addition, CMS requires each MA Plan to maintain a Quality Improvement Program (“QIP”) and conduct a Chronic Care Improvement Program (“CCIP”) as part of their required QIP. Again, telephonic communications with beneficiaries play an important role in delivering effective case management services, including among other things maintaining early and direct contact with beneficiaries post discharge.⁹ Similarly, managed care organizations that contract with state Medicaid agencies to administer Medicaid benefits are required to engage in telephonic communications with members for a variety of purposes, including the provision of disease prevention information, care management services, appointments, compliance with care regimens and other wellness program related services.

⁵ SNPs are Medicare Advantage plans that limit membership to people with specific diseases or characteristics, and tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the people they serve.

⁶ See, e.g. CMS, *Medicare Part C Plan Reporting Requirements Technical Specifications Document: Contract Year 2016*, July 25, 2016, available at: <https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/2016-Part-C-Reporting-Requirements-Tech-Specs7252016-v02.pdf>

⁷ Id.

⁸ Id.

⁹ See, e.g. CMS, *Medicare Advantage CCIP Open Door Forum Presentation*, March 6, 2013, available at: <http://optimalsolutionscloud.com/OpenDoorForum/CCIP-v2.pdf>

The positive effects of non-marketing health care communications in driving improvements in both the quality of care delivered as well as healthcare outcomes is well documented. Healthcare plans are at the forefront of developing and utilizing innovative strategies that rely on such communications as a means of improving care for enrollees. Numerous clinical studies support the benefits of non-marketing healthcare communications and underscore the benefits of enacting policies that allow health plans (and all HIPAA covered entities) to innovate around the same.¹⁰ For example, a recent analysis by the Commonwealth Fund noted the growing adoption of cell phone interventions by community health centers and clinics for chronic disease management.¹¹ Studies have demonstrated that health care interventions using cell phone voice and text messaging can be an effective approach to improve health and manage care.¹² Telephone interventions have been shown to improve adherence with controlling blood pressure in patients with hypertension¹³ and for prompting women to participate in follow-up regimens after abnormal pap smears.¹⁴

¹⁰ *The Effectiveness of Mobile-Health Technologies to Improve Health Care Service Delivery Process*, PLOS Medicine, January 2013, available at:

<http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001363>

¹¹ *Mobile Health and Patient Engagement in the Safety Net: A Survey of Community Health Centers and Clinics*, The Commonwealth Fund, May 2015 available at: <http://www.commonwealthfund.org/publications/issue-briefs/2015/may/mobile-health-and-patient-engagement-in-the-safety-net>

¹² See Santash Krishna and Suzanne Austin Boren, *Healthcare via Cell Phones: A Systematic Review*, Telemedicine and e-Health, April 2009 available at: <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0027335/>

¹³ Teresa Harrison, Timothy Ho, Joel Handler, Michael Kanter, Ruthie Goldberg, and Kristi Reynolds, *A Randomized Controlled Trial of an Automated Telephone Intervention to Improve Blood Pressure Control*, Official Journal of the American Society of Hypertension, Inc., September 2013, available at: <http://onlinelibrary.wiley.com/doi/10.1111/jch.12162/pdf>

¹⁴ Suzanne Miller, Siu-kuen Hui, Kuang-Yi Wein, John Scarpato, Fang Zhu, Joanne Buzaglo, and Enrique Hernandez, *Tailored Telephone Counseling to Improve Adherence to Follow-up Regimens after an Abnormal Pap Smear Among Minority, Underserved Women*, Patient Education Counseling, August 2013, available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3852173/>

In addition, a May 2014 report¹⁵, commissioned by the Department of Health and Human Services (“HHS”), identifies five categories of mobile health programs that use text messaging to communicate with consumers, health care professionals, and others:

- Health Promotion and Disease Prevention – delivering health information and prevention messaging to promote healthy behaviors or referrals to services;
- Treatment Compliance – providing patient reminders to take drugs or attend medical appointments to improve management of asthma, diabetes, or other conditions;
- Health Information Systems and Point-of-Care Support – offering clinical support for health professionals and community health workers through telemedicine;
- Data Collection and Disease Surveillance – obtaining real-time data on disease outbreaks from community health workers, patient self-reports, or clinic and hospital records; and
- Emergency Medical Response – maintaining alert systems that disseminate information in an emergency or during disaster management and recovery.

Health plans have demonstrated strong leadership in this area. For example, some health plans initiate phone calls or send text messages to remind members of upcoming appointments, home visits, or other notifications aimed at improving their health. These communications include:

- Case management communications to members with helpful instructions on processes such as post-discharge follow-up and medication adherence;
- Preventative care communications for screenings, vaccinations, and available services; and
- Health plan benefits communications regarding provider/benefit changes, plan enrollment reminders, and even weather emergencies affecting an upcoming appointment.

Health plans have implemented innovative measures, designed around and dependent on an enrollee’s voluntary consent to participate (and corresponding ability to withdraw such consent at any time), to promote the health and well-being of their enrollees. In many cases, these efforts

¹⁵ *Using Health Text Messages to Improve Consumer Health Knowledge, Behaviors, and Outcomes: An Environmental Scan*, prepared for the U.S. Department of Health and Human Services by the Mathematica Policy Research and Public Health Institute, May 2014, available at: <http://www.hrsa.gov/healthit/txt4tots/environmentalscan.pdf>

are conducted through non-marketing healthcare communications with a plan's enrollee. Plans have developed programs that encourage providers to identify enrollees that can benefit from care management or other wellness program services already covered under an enrollee's plan, but which the enrollee may not be aware are otherwise available. These care management and wellness services include, among others, behavioral health programs, condition management services, maternity and lifestyle improvement programs and shared decision making services. In a typical case, after a provider has identified a covered program or service that an enrollee would benefit from receiving, it is often incumbent upon health plans to proactively communicate with the enrollee to ensure they are following through with their enrollment in such programs, scheduling necessary appointments, engaging with the appropriate program providers as well as provide those enrollees with corresponding reminders and transmitting related care management information.

In addition, health plans invest significant resources to ensure their communications are relevant and valuable to each of their enrollee's unique health status and situation. This allows plans to identify individuals that may benefit from participating in covered benefits and services related to an enrollee's specific health condition and conduct related wellness outreach efforts. For example, this may include notifying an enrollee who suffers from diabetes that their plan offers certain weight management or dietary programs they may otherwise be unaware are available and are covered under their respective plan. In all instances, an enrollee's decision to utilize such benefits and services is voluntary, and if undertaken, can be discontinued by an enrollee at any time. However, as a result of such wellness outreach efforts, and because these are services and benefits already available to and covered by an enrollee's existing plan, it is no surprise that health plans report an extremely high enrollee participation rate in such programs. This indicates

enrollees view and appreciate these kinds of proactive, individually tailored outreach efforts by health plans as a positive and constructive means of engaging in available healthcare services, and do not associate such communications with undesired “telemarketing” efforts that would otherwise merit preclusion under the TCPA.

The 2015 Declaratory Order, by referencing only providers, risks curtailing precisely these kinds of innovative efforts being undertaken by health insurance plans and other HIPAA covered entities to promote and foster the health and well-being of their respective enrollees.

IV. Conclusion

AHIP agrees with Petitioners’ position that the TCPA rules should be clarified to ensure that they are interpreted in a way that is harmonized, consistent with the FCC’s prior decisions and HIPAA, to allow consumers to receive necessary and vital non-telemarketing calls allowed under HIPAA. Accordingly, we support Petitioners’ request that the FCC revise its 2015 Declaratory Order to clarify that: 1) the provision of a phone number to a “covered entity” or “business associate” constitutes prior express consent for non-telemarketing calls allowed under HIPAA for the purposes of treatment, payment, and health care operations (as suggested by Petitioners in Exhibit A to their Joint Petition); and 2) that the prior express consent clarification and the non-telemarketing health care message exemption be clarified to include HIPAA “Covered entities” and “business associates” (as suggested by Petitioners in Exhibit B to their Joint Petition).