



Secretary Timothy Geithner
Department of the Treasury

Secretary Hilda Solis
Department of Labor

Secretary Kathleen Sebelius
Department of Health and Human Services

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue
NW., Washington D.C. 20210
ATTENTION: RIN 1210-AB43

Health Care For All and Community Catalyst Comments on Interim Final Rules for 26 CFR Parts 54 and 602, 29 CFR Part 2590, and 45 CFR Parts 144, 146, and 147: Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Pre-existing Condition Exclusions, Lifetime Annual Limits, Rescissions, and Patient Protections

August 20, 2010

Dear Secretaries Geithner, Solis and Sebelius:

Thank you for the opportunity to provide comments on the interim final rules under the Patient Protection and Affordable Care Act (ACA) relating to pre-existing condition exclusions, lifetime and annual limits, rescissions, and other patient protections. Health Care For All (HCFA) and Community Catalyst are committed to the successful and fair implementation of the ACA, and seek to be a resource as implementation moves forward.

HCFA and Community Catalyst commend the Department of Health and Human Services (HHS), Department of Labor, and Department of the Treasury on their efforts to implement the ACA. These interim final rules represent an enormous step toward guaranteeing all Americans affordable, comprehensive health care coverage. By prohibiting pre-existing condition exclusions, these rules offer children who have a chronic medical condition an opportunity to obtain insurance from insurers who may have previously denied them coverage. The rules also help to alleviate a risk faced by many families face: reaching a lifetime or annual limit on their

health plan during the course of a prolonged illness. These regulations also establish rescission standards and help protect people from acquiring medical debt in a time of emergency by requiring insurers to meet new cost-sharing requirements for emergency services.

While we are pleased with the regulations overall, we have some concerns as they are currently drafted. Our recommendations, in light of these concerns, are outlined below.

1. Prohibition of Preexisting Condition Exclusions (26 CFR 54.9815-2704T, 29 CFR 2590.715-2704, 45 CFR 147.108)

We thank you for clarifying in the overview of these interim final rules that the prohibition of pre-existing condition exclusions applies to individual health plans in addition to group health plans. Banning pre-existing condition exclusions protects vulnerable consumers from denials in coverage.

We urge you to create standards and methods for notifying people who have been denied coverage by a group or individual health plan because of a pre-existing condition prior to the implementation of these rules. Notification should be written in a manner that a reasonable person would understand, and such notification should be sent prior to the effective date of these rules.

- Ensure that families are able to afford policies for people with pre-existing conditions.

While the regulations make a positive step in guaranteeing that insurers offer coverage to children with pre-existing conditions, this rule will not be effective if health insurance policies are prohibitively expensive for families. Especially in states that allow significant variation in premiums based on health underwriting, children with pre-existing conditions may be charged unaffordable premiums. **We urge HHS to work with states to monitor the health insurance marketplace to ensure that families are able to afford coverage for children with pre-existing conditions.**

- Ensure that children with pre-existing conditions may enroll in coverage.

Families must be able to enroll their children in health coverage when they need it. While we understand that, prior to the implementation of the individual mandate, there is potential risk for families to enroll in coverage only when they need services, we are concerned that relying on open enrollment periods may prevent some families from accessing coverage.

At least initially (for the first year), we recommend allowing families to enroll in insurance coverage at any time. This will allow adequate time for notice and public education to families who can benefit from this policy change. After that initial enrollment, we agree that an open enrollment period is adequate. However, HHS should develop a waiver process for families who have extenuating circumstances to enroll in coverage outside of that open enrollment period.

For example, in Massachusetts the legislature recently enacted an annual open enrollment period (Section 8 of Chapter 288 of Acts of 2010). In addition to the

exemptions provided under ERISA, the statute provides for a waiver from the restricted enrollment rule "to an eligible individual who certifies, under penalty of perjury, that such individual did not intentionally forego enrollment into coverage for which the individual is eligible and that is at least actuarially equivalent to minimum creditable coverage." This would allow for off-cycle enrollment for someone who inadvertently missed an open enrollment period, but preclude enrollment for someone who was deliberately gaming the insurance rules.

2. Lifetime and Annual Limits (26 CFR 54.9815-2711T, 29 CFR 2590.715-2711, 45 CFR 147.126).

We applaud the end to annual and lifetime limits. However, this rule could be undermined because "essential benefits" is not yet defined.

- **Work with states to closely monitor annual limits until "essential health benefits" is defined by HHS**

Under the interim rules, restricted annual caps may exist on "essential health benefits" until 2014, at which time an annual cap on essential health benefits is prohibited, while non-essential health benefits remain limited. The overview of the interim final rules clarifies that the effect of this rule until "essential health benefits" is defined by HHS means that insurers must show good faith efforts in defining the term "essential health benefits." We are concerned that insurers will consistently deem essential health benefits as not essential, allowing them to place unlimited annual and lifetime caps on these services.

The interim final rules do not clearly stipulate any basis for determining what constitutes a "good faith effort," opening the door to potential abuse by the insurance industry. This puts wide discretion on insurers, who may determine that medically necessary services are not "essential health benefits," making such treatments susceptible to unregulated caps. Therefore, **we urge you to work with states to monitor the restrictions on annual limits for essential health benefits. A good faith effort should be defined as using generally accepted medical practices or independent clinical evidence to determine which health services are deemed essential benefits.** It is critical to ensure that insurers are held to a minimum standard until "essential health benefits" is defined.

- **Prohibit insurers from circumventing the annual and lifetime cap rules by extending the prohibition of caps to services.**

We are concerned that only annual and lifetime limits based on dollar amounts will be prohibited. Where service limits are easily converted to dollars, the effect would be the same on consumers. Annual limits on the number of visits, days of hospital care, and other benefits that are easily translated into a dollar amount should not be permitted by 2014 or beyond. For instance, limits on number of hospital days should not be permitted, as they have a per diem value that translates to an annual limit. This practice will force families to forego necessary treatments to preserve their benefits, and undermine the clear intent of the law. Therefore, **we urge you to close this loophole by explicitly**

prohibiting annual or lifetime limits on “essential health benefits” by dollar amount and volume of services.

In addition, we urge you to clarify that the rules prohibiting lifetime and annual limits apply to individual services, as well as in the aggregate. Insurers should not be able to place lower limits on specific health services. For instance, an insurance policy restricted to a \$750,000 annual cap in 2010 should not also have a limit on hospitalization charges of \$100,000 per year. The annual limit should serve as the floor for all limits on individual essential health benefits.

- **Define “significant decrease” narrowly in paragraph (b)(3) of this section.**

We are concerned with the lack of clear standards by which the HHS Secretary may waive the restrictions on annual limits from 2011 to 2014 for certain group health plans. As written, the rules permit the Secretary of HHS to waive restrictions on annual limits if compliance with the phase-in period on restricted annual limits for “essential health benefits” would “result in a significant decrease in access to benefits under the plan or health insurance coverage or would significantly increase premiums for the plan or health insurance coverage.”

If this term is defined broadly, such that any decrease in benefits for any population of enrollees triggers the Secretary’s waiver authority, insurers may justify lower annual limits for the phase-in period for *all* enrollees because a very small population of enrollees faces minimal restricted benefits as a result of these rules. For instance, limited benefit plans may face significant increases in premiums, but the coverage provided is bare bones, leaving families at risk of reaching benefit limits. **We encourage the Secretary to define “significant decrease” narrowly in this section, and to consider consumer protections against insurer abuses in weighing the risks. Alternatively, a waiver of these rules may be conditioned on closing the plan to new enrollees, to prevent the insurer from preying on other consumers.**

- **Expand on the requirements for insurers to notify parties who had previously been denied coverage due to reaching lifetime limits of the 30-day open enrollment period.**

We are concerned that confusion may arise around the 30-day open enrollment period for people who are no longer enrolled in a health insurance plan due to reaching a lifetime limit. Presently, the rules mandate an open enrollment period for these individuals, and require insurers to notify them. However, it is unclear when this 30-day period goes into effect. The rules can be read to imply that it goes into effect upon the postmarking of the notification or the receipt of the notification. **We encourage you to require insurers to begin their 30-day open enrollment period upon the receipt, and not the postmark, of notification by parties who are no longer enrolled in the group health plan due to reaching a lifetime limit.** Doing so would guarantee the longest period possible for such people to acquire coverage.

3. Prohibition of Rescissions (26 CFR 54.9815-2712T, 29 CFR 2590.715-2712, 45 CFR 147.128)

Thank you for restricting the basis for rescission to cases of fraud, intentional misrepresentation of material fact, and failure to pay premiums. Consumers are more secure knowing that insurers will not be able to rescind their policies for other reasons or accidental omissions.

- **Please clearly delineate the burden of proof that an insurer must show to rescind a policy based upon fraud or intentional misrepresentation of material fact.**

We are concerned that the burden of proof for insurers that rescind policies based upon fraud or intentional misrepresentation of material fact is too low to adequately protect consumers. The burden of proof for such rescissions must be set at a standard where insurers are certain that an enrollee's fraudulent or misrepresentative behavior was in fact intentional. Such a standard is absent in the current rules.

For example, the rules now appear to allow the rescission of an insurance plan when an enrollee has made an intentional omission that constitutes fraud. However, it is very difficult to determine whether an omission occurred intentionally or accidentally, and the rules seem to trust insurers to determine whether that the omission occurred intentionally.

We urge you to establish a policy for insurers to determine whether an act, practice, or omission constitutes fraud, or whether a material misrepresentation of fact was made intentionally or accidentally. If an insurer is unsure that an enrollee has committed fraud or misrepresented material facts, we urge you to place the burden of proof on the insurer to show that any omission constitutes fraud, or that any misrepresentation is intentional.

In addition, we recommend that you require a third-party review of the issue *before* an insurer can rescind coverage. This will ensure that consumers are protected from losing coverage because of a policy rescinded for a reason other than fraud.

4. Patient Protections (26 CFR 54.9815-2719AT, 29 CFR 2590.715-27190A, 45 CFR 147.138)

We support the definition of emergency services, consistent with EMTALA, that covers medical screening and stabilization services. People who experience an emergency are often admitted to the hospital for stabilization, and they should continue to receive these emergency stabilization services without higher cost-sharing. Allowing insurers to charge more for out-of-network emergency services than in-network services increases consumers' risk of incurring debt. We also commend your efforts in guaranteeing women the ability to choose a gynecologist and obstetrician as their primary care provider.

While we applaud the Departments for improving new cost-sharing standards for insurers on hospital emergency services, we strongly recommend establishing clear protections against unfair balance-billing. Multiple factors contribute to medical debt, and both insurers and providers play a role in shifting costs to consumers. While the rules address inequities that

arise from poor practices by insurers, they still expose beneficiaries to undue risk of medical debt by allowing out-of-network providers to balance bill them for care.

This is of particular concern because certain hospital pricing and billing practices have come under fire recently as unfair, unclear, and overly aggressive. In response, some states have enacted laws that set firm standards around hospital billing or ban balance-billing outright. The ACA also establishes new requirements for tax-exempt hospitals with regard to financial assistance, pricing and billing (Section 9007). These interim final rules should be modified to reflect fair standards for provider billing. Doing so will help to ensure that consumers – even those with insurance coverage – pay only what they can afford. We recommend that you:

- **Clarify that the rules do not preempt stronger state laws that prohibit balance-billing.**

Several states – notably California, Colorado, Delaware, Florida, Maryland, and West Virginia – have further protected consumers from balance-billing by requiring HMOs to hold consumers harmless, requiring providers to accept a rate negotiated by the state, or prohibiting a class of providers (such as hospitals) from billing the patient more than the plan’s cost-sharing amounts. Where states have stronger protections than the federal law for consumers who go out-of-network, these protections should hold. In order to allow for these stronger state laws, the rule should add a section 3(D) to the reimbursement alternatives: “An amount set by state law.”

- **Require providers to meet fair billing standards and clarify that these rules do not preempt stronger state laws.**

Hospitals routinely charge “self-pay” patients – including insured patients whose plans do not have contracts with hospitals – up to 2.5 times more than what commercial insurers pay and over 3 times the Medicare rate.¹ Unlike commercial insurers and government payers, patients are not well-positioned to negotiate for fairer prices. Furthermore, charges differ widely from hospital to hospital, and pricing information can be hard to find.² As a matter of public policy, it is unrealistic to expect consumers in emergency situations to choose hospitals based on pricing or negotiate a fairer rate. Therefore, the rule should be modified to establish a reasonable, objective baseline for provider charges and to require hospitals to work with patients who cannot afford to pay.

There is precedence for setting fair limits for hospital charges. Most notably, Section 9007 of the ACA, as amended, expressly prohibits tax-exempt hospitals from using gross charges. It also further limits charges to patients who qualify for financial assistance programs to the “amounts generally billed” to insured patients. Many states have restricted billing through hospital community benefit and financial assistance requirements. For example, California, Illinois, New Jersey, Minnesota, New Hampshire, New York have limited hospital charges to self-pay patients. Many of these states also

¹ Anderson, Gerard F. *From ‘Soak the Rich’ to ‘Soak the Poor’: Recent Trends in Hospital Pricing*, Health Affairs, 26 no. 3 (2007): 780-789.

² We note, however, that Section 2718(e) of the PPACA, as amended, requires all hospitals to annually publish their standard charges for items and services.

have strict requirements for hospital financial assistance policies, payment plans, and debt collection.³

The rules as currently drafted require insurers to pay out-of-network providers a “reasonable amount” using an objective baseline: the greatest of the Medicare rate; the median of negotiated in-network rates; or the usual, customary and reasonable rate for out-of-network providers. While this standard may protect providers from unreasonably low payments from insurers, we believe that consumers need equitable protections from hospital price-gouging in order to avoid medical debt. **Any amount billed by providers should be calculated at the lower of either the lowest rate that would be paid by Medicare or Medicaid, or the actual unreimbursed cost to the hospital for the service, as determined by the cost-to-charge ratio calculated in a hospital’s most recently settled Medicare Cost Report.** At a minimum, any amount consumers may be balance-billed should be based on the same rate paid by their insurer rather than the hospital’s chargemaster list. Furthermore, hospitals that balance bill patients should be required to first inform and screen them for eligibility in financial assistance, payment plan or community benefit programs to ensure they are paying only what they can afford.

- **Prohibit balance-billing for all emergency services in network facilities.**

At a minimum, when the consumer receives emergency services at an in-network facility, and has been assigned providers by the facility, the emergency providers should not be permitted to balance-bill. At the very least, a plan should be able to negotiate a contract with a hospital and with facility-based providers such that there are some emergency providers available at all times that are willing to accept either the plan’s rates or the rates set forth in this rule.

- **Require notice of the plan’s payment.**

Consumers need to receive notice about how their plan paid an out-of-network provider so that they can dispute any remaining charges with either their plan or the provider.

- **Advise consumers of how to minimize balance-billing.**

Plan materials should advise consumers of their rights when they receive emergency services out-of-network, of any possibility of balance-billing, and who to call at the plan in an emergency for help coordinating care and minimizing these charges. Consumers receiving bills from providers should also receive notice of available financial assistance programs and payment plans.

- **Clarify the standards for notifying an enrollee of the changes to his/her plan imposed by these rules.**

³ See Families USA, *Medical Debt: What Are States Doing to Protect Consumers*, 2009, <http://www.familiesusa.org/assets/pdfs/medical-debt-state-protections.pdf>, for a brief summary of these laws. For a comprehensive view of state laws, see Community Catalyst’s *Free Care Compendium*, an online guide to the hospital financial assistance and billing laws in all fifty states. http://www.communitycatalyst.org/projects/hap/free_care/pages?id=0003

The timeline and standards for insurers to notify enrollees of their rights to designate any primary care provider, pediatrician, obstetrician or gynecologist who is available to accept them as their primary care provider are not adequate. Although the rules provide model language for notifying enrollees of these changes and stipulate that the notice must “be included whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits,” they fail to set any standards for notice, and do not stipulate when such notice requirements go into effect. **We encourage you to mandate notice of changes to an enrollee’s health insurance.** Considering how important the choice of a primary care provider, HHS should require this notice as soon as possible. HHS should further stipulate standards for notification, such as by certified mail, such that the insurer knows to a reasonable certainty that the enrollee has received the notice.

Thank you for your continued openness to comments during key decisions in implementing ACA. We hope to be a resource to you as you consider the final regulations. Please do not hesitate to contact Georgia Maheras at (617) 275-2922 or gmaheras@hcfama.org or Christine Barber at (617) 275-2914 or cbarber@communitycatalyst.org.

Sincerely,



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