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Community Service Society | Fighting Poverty Strengthening New York

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Secretary Timothy Geithner
Department of the Treasury

Secretary Hilda Solis
Department of Labor

Secretary Kathleen Sebelius
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9994-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

Dear Secretary Sebelius:

The Community Service Society (CSS) of New York writes to comment on the interim final rules implementing the Patient Protection and Affordable Care Act (ACA) provisions regarding preexisting conditions, lifetime and annual limits on benefits, rescissions, and patient protections. CSS is a 160 year-old organization that seeks to address the root causes of economic disparity. The organization's mission is to promote policies that advance the economic security of working low-and moderate-income New Yorkers by bringing their perspectives to the policy conversation. We work to expand access to affordable, quality care for all New Yorkers, through advocacy and consumer assistance.

Overall, we commend the Departments for the progress these interim final rules make in implementing the consumer protections of the ACA. However, we have concerns regarding four sections of the new regulations: the rules prohibiting preexisting conditions exclusions; the rules restricting annual limits; the rules limiting rescissions; and the rules regarding coverage of emergency services

(patient protections). We will address these sections in the same order as the interim final regulations notice.

Prohibition of Preexisting Conditions Exclusions (26 CFR § 54.9815-2704T, 29 CFR § 2590.715-
2704 and 45 CFR § 147.108)

The ACA and these interim final rules prohibit preexisting conditions exclusions for group health plans or group health insurance coverage and individual health insurance coverage. The prohibition takes effect for plan or policy years beginning on or after January 1, 2014, but for enrollees under 19 years of age the prohibition becomes effective for plan or policy years beginning on or after September 23, 2010.

CSS recommends:

The interim final regulation should be changed to require insurers to allow young people with preexisting conditions to enroll in coverage at any time during the year, for at least the first year, rather than requiring them to wait for an open enrollment period. This is a significant change in the law, opening coverage to many young people. Educating all of the eligible children and their families will take time. Covering children is a high priority under the ACA, and the statute should be interpreted to maximize their ability to take advantage of new eligibility.

We also recommend that HHS consider establishing a waiver process under which children can apply to enroll in coverage outside an open enrollment period. The Massachusetts legislature recently enacted an annual enrollment period (Section 8 of Chapter 288 of Acts of 2010) that allows, in addition to the exemptions provided under ERISA, an additional opportunity for an individual to apply for a waiver from the restricted enrollment rule. The waiver allows individuals who inadvertently missed an open enrollment opportunity to purchase coverage, without allowing individuals to game the system.

Lifetime and Annual limits (26 CFR § 54.9815-2711T, 29 CFR § 2590.715-2711, 45 CFR
§ 147.126)

The ACA and the interim final regulations generally prohibit annual or lifetime caps on the dollar value of health benefits. The ACA allows insurers to establish a "restricted annual limit" on the dollar value of essential health benefits for plan years beginning prior to January 1, 2014. The interim final rules outline the following schedule of minimum permitted annual limits for this period:

- For a plan (or policy) year beginning on or after September 23, 2010 but before September 23, 2011, $750,000;

- For a plan (or policy) year beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000; and
- For plan (or policy) years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

CSS recommends:

We recommend that the interim final regulations be amended to increase the restricted annual limits and allow adjustments to these minimum limits in regions of the country with higher-than-average health care costs. In New York state, patients have run up annual bills in excess of $1 million for certain cancer treatments, severe trauma, and intensive neonatal care for extremely premature infants. Accordingly, the restricted annual limit for plan or policy years beginning on or after September 23, 2010 but before September 23, 2011 should be raised to $1,000,000. The restricted annual limit for plan or policy years beginning on or after September 23, 2011 but before September 23, 2012 should be raised to $1,500,000. And the rules should be amended to create a process by which the Secretary of Health and Human Services (HHS) can raise the restricted annual limits in regions like New York with higher-than-average health care costs.

The interim final regulations should also be clarified to close two potential loopholes. Insurance companies could evade the prohibition on dollar value by adopting new limits to the volume of care covered. It should be made clear that insurance companies may not institute new limits to the volume of care as a proxy for annual limits on the dollar value of care. Additionally, the rules should make it clear that annual limits on a category of service, such as a dollar limit on the amount of hospital care that will be covered in a year, is an impermissible violation of the prohibition on annual limits.

The preamble to the regulations states that the Secretary of HHS will be issuing further guidance related to the scope and process for applying for a waiver of the limited annual benefits rule. We urge the Secretary, in this guidance, not to allow providers of "mini-med" plans to continue selling limited benefit plans with annual limits far below the restricted annual limits set out in this rule. The recession and related job loss have left many consumers out of work for long periods of time, leading to loss of work-related coverage; some consumers have used up the coverage they are permitted through COBRA or state mini-COBRA laws. These economic difficulties make consumers extremely vulnerable to being taken advantage of by companies that charge premiums while offering illusory coverage with very low annual limits. The ACA's ban on annual and lifetime limits is intended to protect consumers from these predatory plans, and the rules should not allow companies to continue to offer coverage that does not protect consumers.

Prohibition on Rescissions (26 CFR § 54.9815-2712T, 29 CFR § 2590.715-2712, 45 CFR

§ 147.128)

The ACA and these interim final rules limit rescission of insurance coverage to cases of fraud, intentional misrepresentation of material fact, and failure to pay premiums. The interim rule's also requires that a plan or insurance issuer provide at least 30 days advance written notice before coverage may be rescinded.

CSS recommends:

CSS believes that the interim rules would allow insurance companies too much discretion in determining whether a consumer has committed fraud or an intentional misrepresentation of fact. HHS should consider providing a clear standard explaining that the burden of proof is on the plan or insurer when determining whether a consumer's fraudulent act or misrepresentation was intentional. Insurers should be required to include allegations of the facts they will rely on to justify the proposed rescission in the written notice. Further, we urge HHS to outline a process requiring external review of the determination by an impartial party before the rescission takes effect.

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

The ACA and the interim final regulations require a health plan or coverage that provides any benefits for emergency services to do so without requiring prior authorization and without regard to whether the provider is in-network with respect to emergency services. A plan with a network of providers that provides benefits for emergency services may not impose any administrative requirement or limitation on benefits more restrictive for out-of-network emergency services than that in effect for in-network emergency services.

CSS recommends:

The ACA's protections regarding coverage of emergency services are designed to protect consumers from receiving excessive bills for emergency services received without prior authorization or from out-of-network providers. They are also designed to eliminate the uncertainty that consumers face when forced to visit an out-of-network emergency room. The interim final rules regarding coverage of emergency services are well-designed to protect consumers from these common experiences.

The rules' failure to prohibit balance billing, however, leaves consumers open to receiving unaffordable bills from providers and prevents consumers from knowing, in advance, what level of debt they will incur during an emergency visit to an out-of-network provider. CSS urges HHS to adjust the rules to prevent or reduce balance billing by out-of-network providers for emergency services.

Hospital billing reform measures in other sections of the ACA show the intent of Congress to make hospital billing fairer to consumers, but these protections are too narrowly drawn to protect insured consumers from balance billing by out-of-network emergency providers. Section 9007 of the ACA provides new requirements for tax-exempt hospitals regarding financial assistance and billing. This section prohibits tax-exempt hospitals from using gross charges when billing financial assistance-eligible individuals for emergency care; instead, the rule requires that they charge these individuals "not more than the amounts generally billed to individuals who have insurance covering such care."

Similarly, the interim rules under consideration should include a requirement that hospitals charge out-of-network patients no more than the amounts generally billed to in-network patients, or patients covered by Medicare. New York state has adopted this approach in our hospital financial assistance law for uninsured patients and patients who have hit their maximum benefits caps. Alternatively, a patient's bill could be based on the rate the plan or issuer is required to pay under these rules. Hospitals should not be permitted to bill consumers protected by this statute using gross charges.

Further, if a facility negotiates an agreement with an insurance plan to provide services at in-network rates, all providers practicing at the facility should be required to accept the negotiated rates. The rules should also clarify that any state laws that provide more protection for consumers in this regard are not pre-empted by the ACA.

Thank you for considering our comments. If you have any questions, please contact Elisabeth Benjamin at ebenjamin@cssny.org or at (212)614-5461 or Carrie Tracy at ctracy@cssny.org or at (212)614-5401.

Sincerely,

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