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August 26, 2010

Mr. Jay Angoff

Office of Consumer Information and Insurance Oversight

Department of Health & Human Services

Attention: OCIIO-9994-IFC

P.O. Box 8016

Baltimore, MD 21244-1850

Electronic Submission to regulations.gov:

Document ID HHS-OS-2010-0014-0001

Re: Preexisting Condition Exclusions, Lifetime and Annual Limits,  
Rescissions, and Patient Protections

Dear Mr. Angoff:

The Bazelon Center for Mental Health Law—a national legal-advocacy organization representing children and adults with serious mental illnesses—is pleased to submit the following comments on the Interim Final Rules for Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections under the Affordable Care Act. We appreciate the opportunity to provide feedback on these important regulations.

General Comments

We strongly support the Departments' efforts to provide robust regulations that ensure the protection of health insurance consumers, and continued access to high quality, affordable care. We applaud the efforts of the Departments to honor the intention of the Affordable Care Act to end discriminatory practices that too often affect consumers, including those with serious mental illnesses.

Additional Comments

The Bazelon Center would like to submit additional comments on the following aspects of the interim final regulations:

- I. Preexisting Conditions
- II. Lifetime and Annual Limits
- III. Rescissions
- IV. Patient Protections

## V. Monitoring and Oversight

### **Preexisting Conditions**

We applaud and strongly support the interim final rules regarding preexisting condition exclusions. This provision is particularly important for people with serious mental illnesses, who often fail to qualify for coverage –particularly for individual or small-group insurance– because their disorder constitutes a preexisting condition, or who face lengthy waiting periods or exclusions on coverage for services provided for that preexisting illness. We urge the Departments to strengthen these regulations by broadening the definition of preexisting condition exclusions to cover additional forms of discrimination. These include:

- Waiting periods in excess of 90 days should be included within the definition of preexisting condition exclusions.
- Coverage exclusions of or arbitrary restrictions on benefits, especially those benefits that are included among the “essential health benefits” package required for some plans under the Affordable Care Act, should be considered as preexisting condition exclusions. We are particularly concerned about benefits in the area of rehabilitation and habilitation services and devices.

### **Lifetime and Annual Limits**

We commend the Departments for including strong protections in regards to lifetime and unreasonable annual limits on “essential health benefits” as defined in the Affordable Care Act. Lifetime and annual limits often serve as a barrier to care, or lead to treatment delays and interruptions for beneficiaries and negatively affect continuity of care. We also believe that the interim final regulations could be enhanced in a number of ways.

First, we encourage the swift promulgation of regulations that define the exact scope of services to be included among the essential health benefits package in order to ensure that consumers benefit fully from the protection from lifetime and unreasonable annual limits as intended by the Affordable Care Act. We welcome the provision that requires plans to make a “good faith effort” to comply with a reasonable interpretation of the term essential health benefits until such regulations are released. However, this requirement does afford plans much discretion in determining the scope of benefits to which the restriction on limits apply in order to demonstrate such an effort, and may lead to much variability in the range of benefits subject to the prohibition on lifetime and unreasonable annual limits among insurers and plans. We urge the Departments to issue additional guidance on “good faith efforts” that establishes a clear, objective definition of and offers examples that illustrate adherence to such efforts. Such clarification should also be crafted to ensure that plans include the full range of services typically needed by patients with chronic conditions in order to remain in compliance with the good faith requirement.

We are also concerned that although the law bans lifetime and unreasonable annual dollar limits, plans are permitted to apply non-monetary limits, such as restrictions on the number of physician or mental health visits, or length of stay in the hospital. This is particularly problematic for individuals with chronic conditions who often require more frequent and intensive services. We urge the Departments to monitor and disseminate information to consumers on trends in the

application of non-dollar limits. It may also be helpful to require that plans ensure that beneficiaries are made aware that non-monetary limits may be employed and clarify whether such limits apply to their plan. Similarly, we believe that consumers must be provided with adequate information about their benefits in order to make informed choices and benefit fully from their insurance coverage. Plans should, therefore, be compelled to provide clear and specific details to consumers regarding annual limits, such as how frequently a particular service can be utilized before an annual limit is reached.

Another necessary clarification concerns the application of the prohibition on lifetime and unreasonable annual limits to self insured plans. Such plans need not adhere to the essential benefits package standards required of other plans, and, therefore, clarification is needed to illustrate if and how the lifetime and annual limit prohibition pertains to self-insured plans.

Finally, we recognize and appreciate the need to include the authority of the Secretary of Health and Human Services to waive restrictions on annual limits if compliance would result in a significant decrease in access to benefits or a significant increase in premiums. We do, however, believe that additional consumer protections must be included to ensure that such waivers do not disproportionately and negatively impact specific population groups, such as those with disabilities or poor health status.

## **Rescissions**

We applaud the inclusion of strong regulations that prohibit insurers from rescinding coverage except in cases of fraud or intentional misrepresentation of a material fact. We are particularly pleased that the regulations set a federal floor for rescissions and clarify that additional federal or state laws may apply in connection with the regulations if they offer more protection for insurance consumers. We also urge the Departments to consider strengthening the interim final rules in the following ways:

- In the case of suspected fraud or intentional misrepresentation of a material fact, we believe that consumers under review should be allowed adequate time to offer relevant evidence to their insurer, as well as be given the opportunity for an independent, third-party review of any rescissions.
- We also urge the Departments to consider providing plans with a standardized model insurance application and informational or health history questionnaire that clearly instructs consumers on how to fairly and accurately complete the application. To further strengthen such model documents, we recommend that the standard in §2715 of the ACA that mandates the provision of plan documentation and materials presented in a “culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee,” be similarly applied to the suggested model application and instructions.

## **Patient Protections**

We applaud the Departments for addressing key patient protections which will ensure consumer choice and access to care. We are particularly pleased with the provision that allows patients to

select any primary provider that accepts their insurance. We also commend the protections that will ensure that parents can choose any available participating pediatrician to be their children's primary care provider, and prohibit insurers from requiring a referral or prior authorization for obstetrical or gynecological or out of network emergency care.

We encourage the Departments to strengthen these protections in a number of ways. First, we believe that primary care providers eligible to be designated by beneficiaries should be defined in functional terms; such a definition should not be based solely on the type of practitioner that is providing the care. We urge the adoption of a definition of primary care that could conceivably include providers of specialty care, or primary care providers who are practicing under the umbrella of specialty providers or practices, such as the following definition proposed by the Institute of Medicine (IOM):

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.<sup>1</sup>

This is particularly important for people with serious mental illnesses. For many of these individuals, the only routine health they receive is provided by their mental health providers in community behavioral health settings. It will be important to clarify whether enrollees will be able to select a participating community behavioral health center (CBHC) as their primary care provider if primary care services or providers are integrated under the umbrella of the CBHC.

Additionally, we believe that it is important to strengthen the protections relating to the provision of emergency care without prior authorization. We support the regulations that protect patients from undue cost-sharing and administrative burdens without needing prior authorization should they receive out-of-network emergency care, but suggest that corresponding guidance be issued to protect beneficiaries from similar unreasonable burdens that may result from the receipt of in-network emergency.

### **Monitoring and Oversight**

We also encourage the Departments to promulgate further guidance regarding the monitoring of health plans for violations of the prohibitions and restrictions set forth in these Interim Final Regulations. There is a great need for a strong, well-defined mechanism for enforcement and oversight of plans, and suggest that additional guidance be included to describe such a mechanism. The regulations should also clarify who may submit challenges to a plan's adherence to these regulations (whether it be consumers, providers, state agencies, or advocacy organizations), as well as what entity will be responsible for reviewing such claims.

We are particularly concerned about the monitoring of self-insured ERISA plans. It may prove especially difficult for the Department of Labor to adequately regulate and enforce applicable provisions in the law and regulations in the large self-insurance market. The system for reporting concerns and the process by which concerns will be reviewed must be further delineated to ensure transparency, adequate enforcement, and plan accountability.

We thank you again for the opportunity to comment on these regulations, and appreciate your consideration of our proposed recommendation. We welcome the opportunity to discuss any of these thoughts in greater detail. Please contact Allison Wishon Siegwarth at 202-467-5730 x 113 or [allisonw@bazon.org](mailto:allisonw@bazon.org) for additional information or further clarification.

Most sincerely,

Chris Koyanagi  
Policy Director

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<sup>i</sup> Institute of Medicine, Committee on the Future of Primary Care, *Primary Care: America's Health in a New Era* (Washington: National Academy Press, 1996), p. 31.