



June 29, 2010

VIA RULEMAKING PORTAL

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
ATTN: OCCIO-9994-IFC
PO Box 8016
Baltimore, MD 21244-1850

Dear Sir/Madam:

Thank you for this opportunity to comment on interim final rules implementing sections of the Patient Protection and Affordable Care Act sections 2704 relating to pre-existing condition exclusions; 2711 relating to lifetime and annual limits on benefits; 2712 relating to rescissions; and 2719A relating to patient protections.

Advocacy for Patients with Chronic Illness, Inc. is a 501(c)(3) tax exempt organization that provides free information, advice, and advocacy services to patients with chronic illnesses nationwide. Of particular relevance here, we assist people with chronic illnesses to find health insurance that covers their pre-existing conditions, appeal insurance company denials of coverage, including denials of coverage for out-of-network emergency services, reverse rescissions, and strategize around lifetime and annual limits on benefits. Based on our experience working with thousands of patients nationwide, we are uniquely qualified to comment on the interim final rules.

Lybba is a 501(c)(3) tax exempt internet-based platform whose work intersects across three areas: translational research – speeding the adoption of laboratory and clinical insights through more effective collaboration, data exploration, and pattern analysis; patient empowerment – improving people's ability to choose the best care for themselves through access to the most helpful people and information; and clinical improvement – improving quality of care and reducing costs through better understanding of one's own practice and how it compares with other practices.

It is from these perspectives that we offer the following comments.

As a whole, we are heartened by the interim final rules. 29 C.F.R. § 2590.701-2704. The regulatory implementation of the statutory elimination of pre-existing condition exclusions beginning in 2014, and beginning at the start of the next plan or policy year after September 23, 2010 for individuals under age 19, is a milestone for the consumers we serve, all of whom by definition have pre-existing conditions. We cannot overstate the importance of this change in the law.

Similarly, the regulatory implementation of the statutory elimination of lifetime and annual limits on benefits in 29 C.F.R. § 2590.715.2711 will have tremendous significance for patients with chronic illnesses, many of whom have had to change jobs repeatedly due solely to a limitation on benefits. In particular, we applaud the implementation of the

phase-out of annual limits between now and 2014, when such limits will be banned entirely. As discussed in great depth in the preamble to the rules, the minimum annual limits for plan or policy years beginning on September 23, 2010, September 23, 2011, and September 23, 2012 are sufficient to protect patients without unduly burdening plans and issuers of insurance.

We do wish to offer one suggestion, however. The section of the rules that pertains to cost-sharing requirements for out-of-network emergency services provides that plans and issuers must pay out-of-network providers an amount equal to the greater of the median in-network reimbursement rate, the reasonable and customary reimbursement rate, or the Medicare rate for such services. 29 C.F.R. §§ 2590.715-2719A(b)(3)(i)(A), (B) and (C). As a general rule, consumers do not have access to information regarding reimbursement rates. We repeatedly have attempted to challenge an insurer's representation of the reasonable and customary rate for out-of-network services. Other than pointing to the particular out-of-network provider's usual and customary rate, we have been unable to locate data that would assist us to demonstrate that the insurer's representation of usual and customary rates is unreasonably low. This problem has been well documented. *See, e.g., "A Rip Off by Health Insurers?" New York Times* Editorial (February 18, 2008). We therefore recommend that the Departments consider ways in which consumers might be better informed regarding reimbursement rates so that they can enforce these rules.

At the very least, we believe that, in any explanation of benefits relating to out-of-network emergency services, the insurer should have to disclose (1) the median rate; (2) the usual and customary rate; and (3) the Medicare rate. In addition, upon request, a consumer should be provided with data supporting these rates, and the explanation of benefits should inform consumers that they have a right to request such data. If the rules regarding cost-sharing for out-of-network emergency services are to have teeth, the playing field between consumers and plans/issuers must be leveled. By requiring disclosure of rate-setting data, the cost-sharing requirements would be strengthened significantly without overly burdening insurers, who, under the rules, will have to have such data at hand, making disclosure nothing more than a ministerial act.

Again, notwithstanding this one suggestion, we wish to register our support for the approach taken in the interim rules. Thank you for allowing us to comment on these critical reforms. We are confident that they will greatly enhance the lives and the health of the thousands of patients we serve.

Sincerely,

Jesse Dylan
Founder
Lybba
8330 West 3rd Street
Los Angeles, CA 90048
(323) 653-2300
<http://www.lybba.org>

Jennifer C. Jaff, Esq.
Executive Director
Advocacy for Patients with Chronic Illness
18 Timberline Drive
Farmington, CT 06032
(860) 674-1370
<http://www.advocacyforpatients.org>