



August 26, 2010

The Honorable Kathleen Sebelius  
Secretary  
U.S. Department of Health & Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

The Honorable Hilda Solis  
Secretary  
U.S. Department of Labor  
200 Constitution Ave., N.W.  
Washington, D.C. 20210

The Honorable Timothy Geithner  
Secretary  
U.S. Department of the Treasury  
1500 Pennsylvania Avenue, N.W.  
Washington, D.C. 20220

Dear Secretaries Sebelius, Solis, and Geithner:

AARP is pleased to comment on the Interim Final Rule (IFR) published on June 28, 2010, in the *Federal Register* implementing certain insurance and patient protection provisions of the Patient Protection and Affordable Care Act (ACA). Specifically, the IFR, jointly published by the Departments of the Treasury, Labor and Health and Human Services, addresses the provision of the ACA that prohibits preexisting condition exclusions first for children under 19 years of age and then, effective for plan or policy years beginning on or after January 1, 2014, for all individuals. The IFR also addresses the provisions of the ACA that restrict lifetime and annual dollar limits on benefits, limit rescissions and provide for certain patient protections such as direct access to primary care providers and hospital emergency services without prior authorization.

The provisions being implemented by this IFR apply in general to group health plans and health insurance coverage in the group and individual market. Congress included these protections in the ACA to bring an end to practices by issuers and plans that inappropriately limit enrollees' access to covered services and expose them to significant out-of-pocket costs. The resulting gaps in coverage can discourage utilization of needed medical care and adversely affect health outcomes. They may also result in crushing financial burdens for patients and their families.

AARP commends the Departments for their efforts to implement these provisions of the ACA consistent with the intent of the statute, on a timely basis and in a way that anticipates the complexity of applying the different requirements to different coverage situations. The following comments on specific provisions of the IFR reflect AARP's interest in improving the effectiveness of the implementation of the ACA's consumer protections and enhancing consumer understanding of how the enactment of health reform affects their coverage options.

***PHS Act Section 2711, Lifetime and Annual Limits***

Section 2711 of the ACA prohibits annual limits on the dollar value of essential health benefits generally but allows "restricted annual limits" with respect to essential health benefits for plan or policy years beginning before January 1, 2014. Grandfathered individual market policies are exempt from this provision. In defining "restricted annual limits," the ACA requires the implementing Departments to ensure that access to needed services is made available with a minimal impact on premiums.

The IFR clarifies that section 2711 does not prevent a plan or issuer from excluding all benefits for a condition, but if any benefits are provided for a condition, then no annual limits can be imposed so long as the benefits are considered essential health benefits. Also noted is that "other requirements of Federal or State law may require coverage of certain benefits."

Given that plans and issuers are unlikely to have guidance for some time from the implementing Departments that specifies what items and services are included under "essential health benefits" (beyond the required broad statutory categories of services), AARP is concerned that plan enrollees (meaning participants and beneficiaries of a group health plan or subscribers in the case of an individual policy), may be confused as to what benefits are and are not subject to an annual limit. Will an enrollee know, for example, that the State in which he or she lives requires insured plans to include coverage for treatment of substance abuse or alcohol abuse while the status of such services as essential health benefits may not yet be determined? Other examples of benefits that are often subject to annual benefit limits include bone marrow treatments, reconstructive surgery, cancer and HIV treatments, and infertility treatments. These treatments can be quite costly to consumers and for those with specific conditions can have a detrimental impact on a person's economic security if health insurance no longer covers them. Accordingly, we urge the Departments to provide more specific clarification on the meaning of condition-based exclusions. Consistent with the presentation of this IFR, addressing this issue in a question/answer format may be most helpful.

To meet the goals of ensuring access to essential health benefits while mitigating the potential for premium increases that may result from new limits on enrollee cost-sharing responsibilities, the Departments have provided in this IFR for a phased elimination of annual limits on the dollar value of benefits. AARP believes that the dollar thresholds for annual limits established by the IFR, rising from \$750,000 effective for plan or policy

years beginning on or after September 23, 2010 to \$2 million for the last year of the transition, are reasonable.

The IFR also provides that for plan or policy years beginning before January 1, 2014, the Secretary may establish a program under which annual limit restrictions may be waived if compliance with those limits would result in a significant decrease in access to benefits under the plan or coverage or would significantly increase its premiums. The preamble also advises that “guidance from the HHS regarding the scope and process for applying for a waiver is expected to be issued in the near future.” AARP agrees that a temporary waiver may be warranted for an issuer or group health plan for which the restricted annual limits would cause a significant premium increase or otherwise reduce the value of coverage. We look forward to the forthcoming guidance detailing the waiver process. We also urge, however, that such guidance require plans or issuers that receive waivers to provide adequate notice to enrollees as well as include in that notice the plan’s justification that, without such a waiver, a premium increase or other decrease in value of the coverage would be unavoidable. In addition, we urge that the requirements for waiver eligibility be clearly specified and published in the *Federal Register* and the process itself be publicly transparent.

***PHS Act, Section 2712, Prohibition on Rescissions***

Under section 2712 of the PHS Act, as added by the ACA, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. This requirement applies to new and grandfathered plans and coverage.

AARP commends the Departments for emphasizing in this IFR that the statute’s requirement related to rescissions establishes a federal floor that will offer far greater protections than many state laws. As noted in the rule’s preamble, “Under the new standard for rescissions . . . plans and issuers cannot rescind coverage unless an individual was involved in fraud or made an intentional misrepresentation of material fact.” AARP supports the inclusion in the IFR of a clarification that other requirements of Federal or State law may apply in connection with a rescission or cancellation of coverage beyond the standards established in section 2712 if they are more protective of individuals.

AARP also commends the Department for its implementation of the ACA’s notice requirement with respect to rescissions. Under the IFR, a group health plan, or a health insurance issuer offering group health insurance coverage, will have to provide at least 30 calendar days advance notice to an individual before coverage may be rescinded. This is a reasonable time for notice given the new standard that restricts rescissions to instances of intentional misrepresentation or fraud. AARP will be very interested in future guidance issued by the Departments related to any notice requirements for cancellations of coverage other than in the case of rescission and urge that the guidance be developed with the goal of providing timely, clearly readable and easily understood (i.e., plain English) content to affected persons. As with the Health Insurance Portability and

Protection Act, AARP recommends that the rules protect individuals who may not receive the required notice so that they have sufficient opportunity to enroll in other coverage without losing portability protection.

***PHS Act Section 2719A, Patient Protections/Emergency Services***

Section 2719A of the PHS Act, as added by the ACA, provides that a group plan and an issuer covering emergency services do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network). "Emergency services" means a medical screening examination that meets the prudent layperson standard. For a network plan or coverage, the plan or issuer may not impose any limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services. This provision does not apply to grandfathered health plans.

AARP believes that the Departments have provided for implementation rules of this very important patient protection that seek to recognize the varying types of plan and issuer characteristics, with their differing relationships to hospital emergency departments that may or may not be part of their networks. Balance billing for hospital emergency services that are obtained out of a plan's network can lead to significant financial burdens for patients even if circumstances required that they obtain emergency medical services from an out-of-network hospital or in a non-preferred provider tier for which their plan imposes significant cost-sharing responsibility. The IFR seeks to provide a reasonable standard for group health plans or issuers in reimbursing out of network providers to assure against excessive balance billing of the patient. This new patient protection will be limited in its effect, however, if enrollees are not fully aware of their potential out-of-pocket liability. We urge that the Departments require that plans and issuers make the consequences of using out of network emergency department services clear (using plain English explanations) in a notice that is provided to all plan enrollees and that is also included as part of a summary plan description or similar plan document. The notice requirements should provide standards for when notice in languages other than English must be provided.

Thank you for the opportunity to comment on these important issues. If you have any questions, please feel free to contact Nora Super of our Federal Government Relations staff at (202) 434-3770.

Sincerely,



David Certner  
Legislative Counsel and Legislative Policy Director  
Government Relations and Advocacy