

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



AAP Headquarters

141 Northwest Point Blvd
Elk Grove Village, IL 60007-1098
Phone: 847/434-4000
Fax: 847/434-8000
E-mail: kidsdocs@aap.org
www.aap.org

Reply to

Department of Federal Affairs

Homer Building, Suite 400 N
601 13th St NW
Washington, DC 20005
Phone: 202/347-8600
Fax: 202/393-6137
E-mail: kids1st@aap.org

Executive Committee

President

Judith S. Palfrey, MD, FAAP

President-Elect

O. Marion Burton, MD, FAAP

Immediate Past President

David T. Tayloe, Jr, MD, FAAP

Executive Director/CEO

Errol R. Alden, MD, FAAP

Board of Directors

District I

Edward N. Bailey, MD, FAAP
Salem, MA

District II

Henry A. Schaeffer, MD, FAAP
Brooklyn, NY

District III

Sandra Gibson Hassink, MD, FAAP
Wilmington, DE

District IV

Francis E. Rushton, Jr, MD, FAAP
Beaufort, SC

District V

Marilyn J. Bull MD, FAAP
Indianapolis, IN

District VI

Michael V. Severson, MD, FAAP
Brainerd, MN

District VII

Kenneth E. Matthews, MD, FAAP
College Station, TX

District VIII

Mary P. Brown, MD, FAAP
Bend, OR

District IX

Myles B. Abbott, MD, FAAP
Berkeley, CA

District X

John S. Curran, MD, FAAP
Tampa, FL

August 26, 2010

Jim Mayhew

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW.
Washington, DC 20201

Attention: OCHIO-9994-IFC

Dear Mr. Mayhew:

The American Academy of Pediatrics (AAP), a non-profit professional organization of 60,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults appreciates this opportunity to submit comments regarding the interim final rules for Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections (6 CFR Parts 54 and 602, 29 CFR Part 2590, 45 CFR Parts 144, 146, and 147).

The Academy is very supportive of many aspects of this new regulation, especially the opportunity for more than half a million children to receive coverage through their parents insurance even though they have pre-existing conditions, but recommends changes to the regulations in regard to annual limits rules, the imposition of waiting periods for children with pre-existing conditions, and the definition of an appropriate pediatrician.

Thank you very much for your attention to the views of the American Academy of Pediatrics.

Sincerely,

Judith S. Palfrey, MD, FAAP
President

Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections (6 CFR Parts 54 and 602, 29 CFR Part 2590, 45 CFR Parts 144,146, and 147)

The Academy's Access Principles call for all children to have access to quality health insurance as well as all recommended and needed services. The Affordable Care Act lays the groundwork to achieve this goal, with its focus on improving the nature of the health insurance available to individuals and families. Nevertheless, the Interim Final Rules for Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections (the Patients' Bill of Rights) can be improved so that health insurance for children, and especially Children and Youth with Special Health Care Needs (CYSHCN), is strengthened.

Overall, the Academy congratulates the Departments of Treasury, Labor and Health and Human Services (the Departments) on promulgating the Patients' Bill of Rights after promulgating so many other impactful rules for the pediatric population. The rescissions section is particularly positive for children, both as regards to parents or other caregivers making attestations for children and a reasonable period for notice of a cancellation. Beyond the rescissions rules, the Patients' Bill of Rights is clearly designed to strike a balance between cost and consumer protections. However, the Academy recommends changes in approach that will better meet the needs of children and their families. Program cost increases do not outweigh improving insurance coverage for the pediatric population. In particular, the Departments have missed the opportunity to enhance insurance for children by allowing insurers' to impose long breaks between guaranteed issuance of insurance for children with pre-existing conditions, interpreting the annual and lifetime limits provisions exceedingly narrowly, and defining primary care provider to exclude pediatric specialty providers.

Pre-Existing Conditions Exclusions. The Academy agrees with the Departments' interpretation of the statute to apply to grandfathered plans. The Academy supports the policy put forth in the Patients' Bill of Rights that prohibits not just an exclusion of coverage of specific benefits associated with a preexisting condition, but also prohibits a complete exclusion from a plan or coverage based on a preexisting condition. This policy will help make health insurance more accessible to CYSHCN who may have turned to Medicaid or CHIP as a result of being unable to find coverage in the private health insurance market.

However, the Academy is concerned that the Departments did not address within the bounds of the Patients' Bill of Rights that insurers may still impose waiting periods that can stretch for many months during a time when a family may have received a devastating diagnosis regarding their child's health. A waiting period for coverage can be just as problematic as denial of coverage for a child who may need services promptly. The Academy urges the Departments to modify the Patients' Bill of Rights to address this problem.

Lifetime and Annual Limits. Section 2711 of the Affordable Care Act, which sets forth that annual and lifetime limits will no longer apply to many types of insurance, holds the promise to have great impact on children and families, and especially CYSHCN. During the health reform debate, the Academy was very pleased to learn that children with large annual health care costs covered by private insurance would have those caps lifted and that children with large lifetime

health care costs offset by private insurance would not reach those limits early in their young lives. Unfortunately, the Patients' Bill of Rights interprets this section of the Affordable Care Act in ways that will not meet the needs of many in this vulnerable population.

Initially, the caps that the Patients' Bill of Rights sets forth are too low for the sickest children, and will clearly compromise their care. A child with cancer or multiple chronic conditions may easily utilize more than \$750,000 in health services in one year. Additionally, it is doubtful why this number increases to \$1.25 million in 2012, and \$2 million before January, 2014. If a cap must be implemented, the Academy would urge the Departments to impose a much higher cap that does not arbitrarily change throughout the time before 2014.

Next, the fact that the caps apply only to an as-yet undefined set of "Essential Benefits" is also troubling. All children should receive the medically necessary services that they need without caps, even if they are beyond the list of Essential Benefits listed in the new law. CYSHCN will derive the benefits of hospital coverage, coverage for rehabilitation and habilitation services and coverage for pediatric benefits, which are all listed as Essential Benefits in the Affordable Care Act. The Academy would urge the Departments to recognize the importance of these benefits to all children and thus, would urge that the Departments allow children be granted access to the medically necessary services they need under this rubric. Caps should not apply to medically necessary benefits in the pediatric population.

Additionally, the use of a good faith standard regarding insurance companies that impose a cap is troubling. Because Essential Benefits are not defined, it appears that the Departments plan to grant insurers the option of deciding which benefits qualify, as long as those determinations are made in good faith. Granting insurance companies discretion over these life or death decisions for the sickest children is highly problematic because the goal of private insurers is to improve shareholder value, not to provide benefits to those insured. An insurers' decision about which benefits are essential will likely not be made with the needs of insured children in mind, but instead has a great chance to be influenced by a need to increase shareholder value and medical loss ratios.

Finally in regards to lifetime and annual limits, it is highly disappointing that sec. 54.9815-2711T(d)(3) could effectively eviscerate this important component of the Affordable Care Act. This section of the Patients' Bill of Rights establishes a poorly-defined program encouraging plans to apply for a waiver of the annual and lifetime limit rules. It appears that if plans are granted such a waiver, they may be able to avoid the imposition of the new annual and lifetime limits rules under the law. The need for such a program is highly questionable, and its impact on the lives of some of the sickest children and their families could be devastating. If such a program must be retained, the Academy would urge that the rules for it be highly transparent, with many opportunities for public input and that families of CYSHCN should be considered in every aspect of its establishment and implementation.

Choice of Health Care Professional. The Academy has often stressed that children have health care needs that differ from those of adults, and as such the Academy is very pleased to see that the Patients' Bill of Rights changes insurance to require plans that offer a provider panel to permit families to designate a pediatrician as a child's primary care provider. However, for

children with significant medical needs, a traditional pediatrician may not be the most appropriate designee. For example, a child with significant respiratory problems may see his pediatric pulmonologist more regularly than his general pediatrician, and his pediatric pulmonologist may in fact become the provider who regularly coordinates his care. In such a situation, the child's family, in consultation with their clinicians, should be able to select as the primary care physician the provider who most often interacts with their child and whose expertise is most appropriate for the ongoing care that the child requires. The Academy suggests that the regulation be modified to clarify that in the instance of CYSHCN, plans allow a family to designate a pediatrician, pediatric sub-specialist, or other specialist handling the child's care as the child's primary care provider.