August 27, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9994-IFC, RIN 0991-AB69
P.O. Box 8016
Baltimore, Maryland 21244-1850

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration. Room N-5653
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
Attention: RIN1210-AB43

Internal Revenue Service
CC: PA: LPD: PR, Room 5025
P.O. Box 7604 Ben Franklin Station
Washington, DC 20044
Attention: REG-120399-10

RE: File Code OCIIO-9994-IFC, RIN 0991-AB69/ RIN 1210–AB43/REG–120399-10. Requirements for Group Health Plans and Insurance Issuers under the Patient Protection and Affordable Care Act Relating to Pre-Existing Condition Exclusions, Lifetime and Annual Limits, Rescission, and Patient Protections, Final Rule and Proposed Rule

Dear Sir or Madam:

The undersigned organizations, representing millions of consumers, thank you for the opportunity to comment on the interim regulations pertaining to patient protections under the Affordable Care Act. The protections addressed in these regulations are essential to people who face serious illnesses. They will provide children with access to coverage this year, and provide all people with access to coverage regardless of their health status in 2014; ensure that coverage continues to protect people who face serious and costly illnesses; prevent abusive retroactive cancellations of coverage; help people choose providers that will ensure continuous and coordinated care; and improve coverage for people who face an emergency and must obtain treatment out-of-network. We appreciate the thought and care with which the Departments have addressed these important issues and offer the following comments on additional protections that should be built into these rules.

Pre-Existing Condition Exclusions (26 CFR 54.9801-2 and 54.9815-2704T[1], 29 CFR 2590.701-3 and 2590.715-2704, 45 CFR 147.108 and 147.126)

[1] All references to Department of Treasury temporary rules in this comment letter are also intended as comments on the proposed rules with the same text and similar numbers published in the June 28 Federal Register.

We are pleased that the interim final rule (IFR) clearly prohibits the denial of coverage based on health status and the exclusion of coverage of specific benefits associated with a pre-existing condition for children under 19 in plan years beginning on or after September 23, 2010 and for adults in plan years beginning on or after January 1, 2014. The rule provides immediate and critical new protections for families with children with preexisting conditions who are purchasing coverage in the small group and individual markets. In order to strengthen the protections and to fulfill the promise of the Affordable Care Act (ACA), we recommend the following improvements to the interim final rule:

- ***The final rule should include excessive waiting periods in the definition of pre-existing condition exclusions.*** An excessive waiting period should be defined as any period longer than 90 days, in line with the ACA provision that will go into effect on January 1, 2014. Without such an inclusion, children with pre-existing conditions will continue to face delays in access to necessary coverage and care for their health conditions.[2]
- ***The final rule should explicitly allow the Secretary of Health and Human Services to use her/his regulatory authority under Section 2794 to prohibit unreasonable premium increases and/or excessive premiums for families with children with pre-existing conditions.*** Without such authority, insurers may charge newly covered children with pre-existing conditions excessively high premiums or significantly increase premiums for currently covered children based on their health status, making coverage unaffordable and unattainable for families. Allowing such high premiums and premium increases goes against the intention of this provision of the ACA, to expand health coverage to more children.

If states allow limited open enrollment periods for children, they should be required to have special enrollment periods in individual market policies as well as group policies. On July 28, the Administration issued new guidance regarding the sale of health plans to children with pre-existing conditions that permits open enrollment periods in the individual market, as allowed under state law. We appreciate this new guidance and request that for states without laws on the timing and duration of open enrollment periods, the final rule should, at a minimum, establish special enrollment period rules for the individual market, paralleling the rules of the group market. Special enrollment periods will provide families the opportunity to learn about and understand their coverage options and make educated decisions. Moreover, during the first year in which coverage is available to children without regard to pre-existing conditions, plans should not restrict enrollment periods or should allow liberal exemptions to any open enrollment periods, since it will take time for many families to learn about their new rights to coverage and seek enrollment.

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

Adequacy of Transitional Annual Limits

The rules will phase out the use of annual dollar limits over the next three years, until 2014 when the Affordable Care Act bans annual limits on essential benefits. Plans issued or renewed beginning September 23, 2010 will be allowed to set annual limits no lower than $750,000. We understand the

[2] There is precedent in existing rules for considering a waiting period as part of a pre-existing condition exclusion period – see the definition of enrollment date for purposes of calculating the maximum pre-existing condition exclusion period in the group market (45 CFR 146.111.).

need for a transitional period to phase out annual limits and believe that while the first year limit of at least $750,000 is reasonable it is still on the low side. There will still be cases when individuals may find themselves with significant out of pocket expenses. For instance, the estimated average U.S. billed charges for the first year following a heart transplant were nearly $788,000 in 2008. Likewise, average first year billed charges for a heart-lung transplant were $1.1 million in 2008.[3] As these costs illustrate, patients undergoing such transplants may still be left with significant out-of-pocket costs, even with a $750,000 annual limit.

Modify Transitional Period:

Although we believe the transitional annual limit amounts are reasonable overall, we recommend that the rules provide further clarification regarding the timing of when annual limits are fully prohibited. The statute generally requires this section of the law to be effective six months after enactment (Section 1004) and provides that "with respect to plan years beginning prior to January 2014" plans can establish restricted annual limits as defined by the Secretary (Section 1001). To simplify the marketplace for consumers and to ease oversight and enforcement, it would be extremely helpful to clearly prohibit annual limits in all plans beginning on January 1, 2014. Thus, we suggest that the Secretary restrict annual limits for the 2013 plan year in such a way that any allowed limits expire on December 31, 2013. The rule should clarify that, for example, although an insurer may have a plan year that begins in October and may be able to apply an annual limit of $2 million from October 2013 to December 2013, once 2014 starts, the plan must not impose an annual limit of any value.

Decreases in annual limits should be prohibited, not just result in a loss of grandfathered status. We are concerned that the temporary rule (section d) and the rules on grandfathering[4] both allow a health plan to establish an annual limit when it had neither an annual nor lifetime limit before. As currently drafted, adding a new annual limit or lowering an annual limit would result only in the loss of grandfathering status. While we understand the need for a transitional period prior to 2014 in order to keep plans on the market and avoid large premium increases, this transition should pertain only to plans that previously had lifetime or annual limits. Under the statute, the Secretary is to "ensure that access to needed services is made available with a minimal impact on premiums." Therefore, 1) plans that did not previously have limits should not be permitted to decrease their coverage by imposing new restrictions; 2) plans that previously had lifetime limits but not annual limits should be prohibited from adopting an annual limit that is lower than the dollar value of their previous lifetime limit; and 3) plans should be prohibited from decreasing their annual limits. Any of these changes would decrease access to needed services.

Clarify application of transitional annual limits and prohibited annual limits. Regarding the transitional annual limits that plans may apply in years before 2014, we recommend that the rule clarify that the permitted limits may only be applied collectively—that is, that dollar "sublimits" on specific services are prohibited. For example, the rules should make clear that a plan that imposes a $750,000 limit for the coming plan year comprised of individual service limits that add up to $750,000 (for example, $10,000 for prescription drugs, $300,000 for hospital services, etc.) would not be in compliance with the ACA.

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[3] Milliman Inc., *2008 U.S. Organ and Tissue Transplant Cost Estimates and Discussion* (Brookfield, WI: Milliman Inc, April 2008).
[4] See 26 CFR 54.9815-1251T (g).

Additionally, insurance consumers often find themselves with inadequate access to care because of non-dollar service limits imposed by their health plans. We believe that the rules should clarify that these arbitrary limits, such as those on the number of hospital days, outpatient specialist visits, or other services, are not permitted under the ACA. Without such a clarification, we are concerned that insurance plans will simply replace their current dollar limits with annual service limits, nullifying the effects of this important consumer protection: limits on hospital days, for example, are easily translated into a monetary value and can be a subterfuge for annual dollar limits on care. Instead of allowing arbitrary service caps, the rules should clarify that medical necessity is the criteria upon which insurers must base their claim payment decisions. This standard will ensure that consumers receive timely, appropriate, and effective care. In order to control utilization, a plan might require prior authorization of visits that go beyond some amount that is based on typical treatment protocols, but should not ban additional visits all together. Services in the essential benefit package should be adequate in scope to achieve their purpose. [5]

Waiver of Annual Limit Restrictions for Certain Health Plans

The rules provide that the Secretary of Health and Human Services may grant a waiver from annual limit restrictions to plans for which the application of the requirements "would result in a significant decrease in access to benefits or a significant increase in premiums." The rules state that future guidance will be provided on the scope and process of such a waiver. Such future guidance should clarify what is meant by "a significant decrease in access to benefits" and should also include specific criteria for what qualifies as a "significant increase in premiums." Guidance should further provide for notice to affected consumers and an opportunity for consumers to comment on proposed waivers.

The preamble to the rules discusses mini-med plans as being possibly subject to future waivers. While we understand the need to protect people who have already enrolled in these policies until they have access to another affordable plan in 2014, we are concerned that many consumers enroll in these plans without understanding how unprotected they are against major medical expenses. Consumers in these plans have found themselves without access to care and/or in debt when they experience illness. The Secretary should consider whether consumers are likely to get anything of value for their premium for a mini-med policy before granting a waiver. The Secretary should require prominent warnings to consumers and employers, including information on what essential benefits are not covered or are limited and information about how to find more comprehensive coverage. (See p. 6 for a discussion of waivers and dependent coverage.)

Notice Needed When Reaching an Annual Limit

The rule does not address notice requirements when a person is nearing an annual limit. We suggest that the insurer or health plan be required to notify enrollees when they are close to reaching an allowed annual limit (for example, when the plan has already paid out 75 percent of the amount of the annual limit). This may allow consumers time to plan financially, if possible, for the high out-of-pocket costs they may face for their treatments later in the year. In addition, the notice should include: contact information for enrollees who believe there is an error in calculating their health expenses or in the application of the limit; notice that they may be eligible for Medicaid or Medicare if they have a permanent disability and the government's webportal address (www.healthcare.gov) for further

[5] Until essential benefits are further defined, you could use a standard similar to Medicaid's standard that services be sufficient in amount, duration, and scope to reasonably achieve their purpose (42 CFR 440.230(b)).

information about their options; the date on which they will again be eligible for benefits under the health plan; and general information that the annual limit will be higher in future years.

Notice and Re-Enrollment Opportunity for Individuals Who Have Hit Lifetime Caps

Section (e) provides for notice and an enrollment opportunity for people who previously reached a lifetime limit. This notice should meet plain language standards and be furnished in Spanish as well as English and in other languages upon request. Also, it should clarify whether the 30 day enrollment period begins on the date the notice was postmarked or the date the notice was received. Following is an example of a consumer-friendly notice[6]:

> If you (or a family member) lost health coverage because you reached your plan's lifetime limits, you can now re-enroll. XXX plan no longer limits the dollar value of benefits it will cover over your lifetime. Individuals have 30 days to enroll after [receiving this notice? the date or postmark date on this notice?]. For more information, contact [plan administrator or issuer] at [phone number].

Additionally, we believe that clarification is needed regarding which former plan enrollees are eligible to re-enroll in under the prohibition on lifetime limits, particularly in the individual market. An example clarifying which individual market enrollees would be eligible and which, if any, would not be eligible would make it easier to understand who can benefit from this protection.

Premiums for Enrollees Who Have Reached Limits

We are concerned that the rules do not provide guidance on the premiums that insurers may charge to individuals who have the right to re-enroll in a plan due to a previous lifetime limit. The rule should clarify that such individuals cannot be subject to new underwriting and should be charged using no higher health status or claims history underwriting than when they were last enrolled in the plan. Without these standards, individuals with a right to re-enroll in coverage may be priced out of the market, undermining the intended protection. Similarly, the rules should also clarify that insurers may not subject those who have hit an allowed annual cap, but who will start coverage again at the beginning of the next plan year, to new underwriting.

Relationship between Dependent Coverage Extension and the Patient's Bill of Rights

The regulations prohibit health plans from setting annual benefit caps below certain dollar values, starting at $750,000 in 2010.[7] However, they also allow the Secretary to waive annual cap restrictions for certain plans, including mini-med plans, if doing so would avoid a major reduction in benefits or increase in premiums.[8] These waivers could cause unintended problems for young adults who might otherwise be eligible for meaningful insurance as a dependent on a parent's plan. Accordingly, the regulations should clarify how such waivers will affect the dependent coverage extension.

The Affordable Care Act (ACA) requires all plans providing dependent coverage to extend that coverage to any dependent under the age of 26.[9] However, until 2014, grandfathered plans may choose not to

[6] You may wish to get more guidance from literacy experts as you finalize your model notices.
[7] 26 C.F.R. § 54.9815-2711T(d).
[8] 26 C.F.R. § 54.9815-2711T(d)(3).
[9] Patient Protection and Affordable Care Act of 2010 § 1001(5); *see also* 26 C.F.R. § 54.9815-2714T.

cover adult dependents who are eligible to enroll in their own employer-sponsored insurance.[10] If a young adult's employer offers a mini-med plan, a type of plan that often provides extremely limited caps and benefits, the plan must generally comply with the Patients' Bill of Rights, and current regulations would bar the young adult access to a parent's health plan. However, if the Secretary decides to grant a waiver to the employer's mini-med plan, the young adult would be limited to sub-standard health care regardless of what might be otherwise available through a parent's plan. That result would lock young adults into insurance plans that do not comply with the ACA's fundamental protections, running contrary to Congress's clear intent to ensure meaningful health care for as many Americans as possible.

Therefore, the regulations on the Patient's Bill of Rights should clarify that a health plan receiving a waiver from annual cap restrictions does not qualify as eligible employer-sponsored insurance for the purposes of determining eligibility for the dependent coverage extension. A young adult with access to a plan with a waiver should still be allowed to join a parent's grandfathered plan.

Applicability to Student Health Plans

The Patients' Bill of Rights should expressly apply to student health plans. Further, when evaluating waivers from annual caps for those plans, the Secretary should carefully consider the consequences of withholding this basic protection from students on plans with minimal benefits.

Rules have not yet been issued regarding how student health insurance plans will be regulated. For now, it is unclear whether they will be considered group plans, individual plans, or a separate type of plan altogether.[11] However, the regulations on the Patients' Bill of Rights only expressly apply to group and individual health plans. According to 2006 Census data, nearly 20 million students were enrolled in a college or university.[12] Millions, of those are insured through student or individual market plans.[13] Those students should be able to rely on the basic protections provided for in the Affordable Care Act. Accordingly, the regulations should clarify that those protections will be available under any student plan.

The ban on restrictive annual limits is one of the most important protections for students. The Secretary has the discretion to waive these limits in order to preserve the viability of existing plans.[14] While we agree that student health plans should remain available, we strongly believe that those plans should be more than insurance in name only. A recent report by New York's attorney general found that, along with kickbacks to universities and very low per-illness limits, some student plans have annual benefit caps of $25,000 or less.[15] Because students pay hundreds or thousands of dollars for this type of coverage, many will incorrectly believe that they will be covered if they get sick or injured. Furthermore,

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[10] Health Care and Education Affordability Reconciliation Act of 2010 § 2301(a)(4)(B)(ii); *see also* 26 C.F.R. § 54.9815-2714T(g).
[11] *See* Patient Protection and Affordable Care Act of 2010 § 1560(c) ("Nothing in this title . . . shall be construed to prohibit an institution of higher education . . . from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State, or local law").
[12] United States Department of Commerce, US Census Bureau (2008, August) School Enrollment in the US: 2006. Retrieved from: http://www.census.gov/prod/2008pubs/p20-559.pdf.
[13] United States Government Accountability Office (2008, March) Health Insurance: Most College Students Are Covered through Employer-Sponsored Plans, and Some Colleges and States Are Taking Steps to Increase Coverage. Retrieved from: http://www.gao.gov/new.items/d08389.pdf.
[14] 26 C.F.R. § 54.9815-2711T(d)(3).
[15] Andrew M. Cuomo, Office of the Attorney General of New York, Letter to Schools (2000).

many student plans have extremely low medical loss ratios—sometimes with as little as 30 cents of every dollar going towards medical care—suggesting that those plans could offset the costs of increased benefit caps by achieving reasonable medical loss ratios.[16] Accordingly, the Secretary should carefully consider how withholding annual limit protections would affect students and should especially scrutinize claims that a waiver would be required to preserve the viability of student plans.

Rescissions (26 CFR 54.9815-2712T, 29 CFR 2590.715-2712, 45 CFR 147.128)

The regulation prohibits plans from rescinding coverage "unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by terms of the plan or coverage." [45 CFR § 147.128(a)(1)] This addresses—and will hopefully end—the practice of insurers retroactively cancelling coverage based on mistakes or unintentional omissions on an enrollee's application. While the incidence of rescission is relatively low at an estimated 10,700 per year, the consequences can be devastating, usually happening at a time when a patient has accumulated a significant medical bill.

We appreciate the clarification that more protective federal or state laws may apply without preemption and the admonition in the regulation's preamble that the Department will be watching for "attempts in the marketplace to subvert these rules." This watchfulness is necessary given insurers' continued battle over rescission rules in the states. For example, the Association of California Life and Health Insurance Companies (ACLHIC), an industry trade association of life and health insurance companies, filed a lawsuit on August 16 in the Sacramento Superior Court, two days before a new anti-rescission regulation was to go into effect in California.

Clarify "Material Fact"

Since rescission is such a drastic action, the terms used to describe the circumstances in which rescission is still possible should be clear to consumers. As such, the term "material fact" needs clarification and should be narrowly defined. Consumers otherwise may not be clear what information is material to the issuance of a health insurance policy.

Clarify Burden of Proof

In addition, the regulation should explicitly note that insurers bear the burden of proving that a consumer has committed fraud or intentional misrepresentation of a material fact. Consumers should be informed that the insurer bears the burden of proof in the 30-day advance notice of rescission that plans must provide them.

Standards Regarding Health Questionnaires

One way for insurers to collect health information on prospective plan enrollees is through a health questionnaire. Potential enrollees should be informed in writing that information collected on a health questionnaire by an insurer, or an employer on an insurer's behalf, can potentially be cited as evidence of fraud or intentional misrepresentation at the time of application or at any time during the life of the policy.

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[16] *Id.*

In addition, the regulation should set minimum standards for the content of health questionnaires. Without commonsense protections, a confusing, ambiguous, or misleading questionnaire may be set as a trap for consumers and allow insurers to violate the spirit of the rescission restrictions. At a minimum, questionnaires should use clear, unambiguous, lay-person language in discussing a prospective enrollee's medical history. Questions should only elicit medical information that is reasonable and necessary for medical underwriting, and each question should clearly state the time frame covered. Also, questions should not require an applicant to guess what symptoms are significant to the health insurer or to understand the medical significance of symptoms or conditions. Applicants should also have the opportunity to indicate where they are unsure of an answer.

30-Day Advance Notice of Rescission

In the past, many consumers have faced rescission without the benefit of any advance notice, so a 30 calendar-day window in which to begin the process of contesting the insurer's decision or to find alternative coverage is a good start. The notice should be delivered by certified mail with return receipt requested, or by similar timely method that provides proof of delivery, to ensure the notice arrives in the hands of the enrollee. The 30-day clock should begin when the enrollee receives the notification, not when it is sent.

The regulation should also make clear what kind of information must be contained in the 30-day notice. At a minimum, the notice should include:

- a detailed explanation of the reason for rescission, including the legal standard for rescission and the ways in which the insurer believes the consumer has committed fraud or intentional misrepresentation of a material fact;
- a statement acknowledging that the insurer, not the beneficiary, bears the burden of proof;
- an affirmation of the beneficiary's right to obtain copies of any and all information used in making this determination and an explanation of how this documentation can be obtained;
- a description of any federal or state consumer protections that exist, such as the right to an appeal;
- a description of how an appeal can be initiated and of the levels of appeal available to the consumer;
- a statement that tells the consumer about his/her right to fight the insurer's decision to rescind in court;
- a clear indication of the date the rescission decision takes effect and the date of the retroactive loss of coverage; and
- an itemized accounting of pending or previously-reimbursed medical expenses that will be recouped by the insurer, with provider's name and contact information.

Guarantee the Right to External Review of a Rescission

The regulation cross-references PHS Act section 2719 on appeal rights. The interim final regulations for section 2719 [45 CFR § 147.136 (c)] raise questions about the level of appeal available to consumers facing a rescission. In that regulation, rescission of coverage is specifically listed as an adverse benefit determination, regardless of whether or not there is an adverse effect on any particular benefit at that time, and is subject to internal administrative appeal. However, with respect to external review, the regulation allows states to maintain their current external review processes as long as they meet the

minimum standards of the NAIC Uniform Model Act. The NAIC Uniform Model Act does not explicitly include rescission under the definition of "adverse determination." Therefore, states maintaining their own external review process rather than adopting the federal standard (likely most states) do not appear to be required to give consumers the right to external appeal of rescissions.

A consumer whose plan has been rescinded should have the right to an external appeal to a third party. Questions of whether an omission constitutes fraud, whether information is "material," and whether a misstatement was "intentional" seem ideally suited for third party review since health plans have a clear interest in reading those terms broadly. The reviewer should have the legal expertise to review the issue of whether there was intentional misrepresentation of a material fact or fraud, not just medical expertise. Coverage should remain in place pending the outcome of the review. Without the availability of an external review process, the health plan has the final say unless a consumer bears the expense and burden of a court case.

Provider Access

<u>Choice of Health Care Professional (26 CFR 54.9815-2719AT, 29 CFR 2590.715-2719A, 45 CFR 147.138)</u>

Improve Notice to Consumers

We generally support this section of the regulations. Federal rules about choice of health care professionals have been very helpful in the Medicaid managed care context, and we expect that they will assist other consumers as well. However, we suggest that the model notice be improved to be in plain language, translated into Spanish, and also available in other languages. New enrollees should receive prominent notice about any provider assignment—it should not be buried in a subscriber contract. In addition, the plan should be required to explain how to find participating providers and should regularly update their lists of participating primary care providers. Plans should explain consumers' right to choose providers and pediatricians in any web listing of providers and any provider directories as well as in initial enrollment materials.

Below is one suggestion of how to make the model notice more readable. [17]

> In XX plan, you must have a primary care doctor [or nurse]. You [and your family members] have the right to choose any primary care doctor in our network, as long as that doctor serves people in your age group and is taking new patients. You can get a list of primary care doctors in our network at [web address and/or phone number]. Tell us who you have picked. Until you choose your doctor, we have chosen a doctor who has agreed to serve you. This doctor is: ____ , but you can switch to a different doctor at any time. For more information, contact y.
>
> Alternatively, if the plan does not make an immediate provider assignment, the last sentences would read:
> Please choose a primary care provider by (insert date). If you do not choose a provider we will assign one to you. Once you have picked your primary care provider please let us know by calling XXX-XXX-XXXX. But you can switch to a different doctor at any time. For more information, contact y.

[17] You may wish to get more guidance from literacy experts as you finalize your model notices.

Designation of Pediatrician As Primary Care Provider

We support the new rule that requires plans to allow a parent/guardian to designate a participating pediatrician as their child's primary care provider. We suggest two additions to the regulations:

1) ***Require notice to consumers*** of this right (similar to the notice requirements we have described above), including information about how to find participating pediatricians. Plans should regularly update their lists of participating pediatricians.
2) ***Explain that pediatric subspecialists can also be designated as primary care providers, if they are willing, for a child who needs that subspecialty.*** For some children with serious chronic conditions, pediatric subspecialists (such as a pediatric oncologist) oftentimes provide children with their routine and ongoing care, and families should be afforded the ability to designate them as the primary care provider.

Patient Access to Obstetric and Gynecological Care

We are pleased to see that the interim final rule reflects the protections provided in the Affordable Care Act that allow for direct patient access without referral to obstetric and gynecological care ("ob/gyn"), and provide the following comments and suggestions to strengthen this rule.

We commend the Departments for specifying in the Interim Rule that the self-referral provision applies to all medical professionals authorized by a state to provide ob/gyn care, not just physicians. Given that there are many types of medical professionals providing ob/gyn care for women, this important provision will help ensure that women have meaningful access to the ob/gyn provider of their choice.

To further ensure that women enjoy the full protections envisioned in the Affordable Care Act, we recommend the final regulations clarify and reflect the following points.

- **The Federal law provides a floor, not a ceiling**. According to the American Congress of Obstetricians and Gynecologists (ACOG), 43 states currently have some type of law providing for direct access or self-referral to ob/gyn care. To ensure that the federal law does not pre-empt any state laws providing greater protections, and that women in these states do not lose any additional rights afforded by these state laws, the final regulations should clarify that the rule imposes a federal floor, not a ceiling, that does not pre-empt any state law providing greater access to such care.
- **The right of direct access/self-referral applies without regard to the insured's age**. The final regulations should specify that direct access rights apply to all women – without regard to age. We are concerned that without this important clarification, plans may attempt to impose an age limitation on the self-referral rule.
- **Plans may not impose different limits on self-referral ob/gyn visits than those that would apply to other types of care, such as primary care.** Without clarification, we are concerned that plans may impose limits on the number of self-referral visits that may differ from other limits imposed on other types of care. To prevent plans from imposing such limits that would undermine this important protection, the final regulations should specify that direct access rights apply to all women without limit—meaning that plans cannot impose limits on the

number of direct access visits that are different than any other limits imposed on visits to access primary care providers. Similarly, the final regulations should specify that plans cannot limit the type of ob/gyn care for which a woman may self-refer. Rather, a woman should be able to self-refer or have direct access to an ob/gyn provider for any type of ob/gyn care that is within that provider's state authorized scope of practice.

- **An insured woman must be allowed her choice of provider.** The final regulations should specify that similar to the protections for the designation of a primary care provider, a woman may self-refer to an ob/gyn provider of her choice (participating in the plan network).
- Plans may not impose higher cost-sharing on women who self-refer for ob/gyn care than on women who are referred to an ob/gyn by their physician. Without this protection, plans may try to discourage women from using self-referrals by increasing their cost-sharing. Cost-sharing should be either a flat copayment that is the same whether the woman self-refers or not, or a coinsurance amount that is based on the cost of the visit, and preventive care as detailed in Section 2713 cannot be subject to cost-sharing.

Emergency Services

We support the definition of emergency services, consistent with EMTALA, that encompasses medical screening and stabilization services. People who experience an emergency are often admitted to the hospital for stabilization, and they should continue to receive these emergency stabilization services without higher cost-sharing.

Section (v) (A) says that emergency services are provided "without regard to any term or condition of coverage, other than the exclusion of or coordination of benefits." This language is confusing. Do you mean to say that the plan cannot apply any additional coverage requirements or restrictions to out-of-network emergency services? Or is this section meant to refer to emergency services generally, whether they are in or out-of-network? Permitting "exclusion of benefits" is overly broad. Plans should not be permitted to exclude benefits for emergency services unless those benefits are also excluded in a non-emergency setting.

We applaud the Departments for establishing reimbursement standards for out-of-network emergency services. These standards will help to minimize balance billing. However, we suggest the following modifications:

1) ***Clarify that stronger state laws are not pre-empted***. In (C)(3)(i) and in the preamble, clarify that these rules do not pre-empt state laws that prohibit balance billing. California, Colorado, Delaware, Florida, Maryland, and West Virginia are examples of states that have further protected consumers from balance billing by, for example, (a) requiring HMOs to hold consumers harmless, or (b) requiring providers to accept a rate negotiated by the state as payment in full, or (c) prohibiting a class of providers (such as hospitals) from billing the patient more than the plan's cost-sharing amounts.[18] Other states may have restricted billing through, for example, hospital community benefit requirements. (See Families USA, *Medical Debt: What Are States Doing to Protect Consumers,* 2009, http://www.familiesusa.org/assets/pdfs/medical-

[18] California also uses a "reasonable person" standard for emergency care, rather than the "prudent layperson" in EMTALA (Health and Safety Code Sec. 1371.4).

debt-state-protections.pdf, for a brief summary of these laws.) Where states have stronger protections than the federal law for consumers who go out-of-network, these protections should continue to hold. In order to allow for these stronger state laws, the rule should add a 3(D) to the reimbursement alternatives: "An amount set by state law." (Maryland currently requires reimbursement for various types of emergency services at various percentages above Medicare rates, and as we understand it, providers receiving these rates cannot balance bill.)

2) ***Prohibit balance billing for all emergency services in network facilities.*** At a minimum, when the consumer receives emergency services at an in-network facility, and has been assigned providers by the facility, the emergency providers should not be permitted to balance bill. At the very least, a plan should be able to negotiate a contract with a hospital and with facility-based providers such that there are some emergency providers available at all times that are willing to accept either the plan's rates or the rates set forth in this rule as payment in full.
3) ***Require notice of the plan's payment.*** Consumers need to receive notice about how their plan paid an out-of-network provider so that they can dispute any remaining charges with either their plan or the provider.
4) ***Advise consumers of how to minimize balance billing.*** In most emergency cases, consumers will not be able to do anything to find in-network providers; they will be busy dealing with the emergency at hand. However, occasionally, they, their family members, or hospital personnel may be able to help connect them with in-network providers at the facility for stabilization care, for example, if they are aware of the issue and have an easy way to locate in-network providers. Therefore, plan materials should advise consumers of their rights when they receive emergency services out-of-network, of any possibility of balance billing, and who to call at the plan in an emergency for help coordinating care and minimizing these charges.
5) ***Count all out-of-pocket expenses for emergency services towards consumers' in-network deductible.*** Plans use high out-of-network deductibles to discourage consumers from going out of network. However, consumers should not be penalized for using out-of-network services involuntarily, and they have little or no control in emergency situations. They purchase insurance to guard against the risks of unforeseen illnesses and insurance does not do its job when it leaves consumers unprotected against emergencies. Therefore, out-of-pocket expenses for out-of-network emergency care should count toward a consumer's in-network deductible.

Balance billing is a serious and costly problem for consumers, and it is particularly appalling when the consumer is in an emergency and can do nothing to avoid the charges. We urge the Departments to revisit this issue in promulgating network adequacy standards for plans participating on the Exchange.

Expiration Date of Department of Treasury Temporary Rules and Proposed Department of Treasury Rules

We do not understand the June 21, 2013 expiration date of various temporary rules (54.9815-2704T, 54-9815.2711T, 54.9815-2712T, 54.9815-2719AT.) We want to be sure that there is no gap between the time that temporary provisions expire and the plan year after January 2014 when permanent protections go into effect. We request that you clarify this timing either in the rules themselves or in the preamble. In fact, many of the rules listed as temporary will be needed even after 2014 so we are baffled by this expiration date. The federal register of June 28 also publishes proposed rules with the same text as the temporary rules. The register does not note a different effective date or expiration date for the proposed rules so this does not clarify the matter.

Conclusion

Thank you for your work on these important issues. The statute and rules provide a strong, long-sought floor of consumer protection. The changes we suggest above will further clarify these protections and help to assure that plans provide meaningful coverage.

Sincerely,

Families USA

AARP

American Diabetes Association

American Heart Association/American Stroke Association

Consumers Union

Health Care for America Now

National Partnership for Women and Families

National Women's Law Center

Service Employees International Union

The Arc of the United States

United Cerebral Palsy

USAction

U.S. PIRG

Young Invincibles