



**New Yorkers For Accessible Health Coverage**

**Member Organizations**

American Association of Kidney Patients,  
New York chapter  
American Cancer Society  
American Diabetes Association  
Brain Tumor Foundation  
Cancer Care  
Care for the Homeless  
The Center for Independence of the Disabled, NY  
Cystic Fibrosis Foundation, Greater New York  
chapter  
Disabled in Action of Metropolitan New York  
Epilepsy Foundation of Greater New York  
Gay Men's Health Crisis  
Hemophilia Association of New York  
Huntington's Disease Society of America, New  
York and Long Island chapters  
Interagency Council of Mental Retardation and  
Developmental Disabilities  
Leukemia & Lymphoma Society, New York City  
chapter  
Mental Health Association of New York City  
Mental Health Association of Westchester County  
National Alliance for the Mentally Ill –  
New York State  
National Aphasia Association  
National Marfan Association  
National Multiple Sclerosis Society, Capital,  
Long Island, New York City, Southern,  
and Upstate chapters  
New York AIDS Coalition  
New York Association of Psychiatric  
Rehabilitation Services  
SHARE: Self-Help for Women with Breast and  
Ovarian Cancers  
SLE Foundation  
West Islip Breast Cancer Coalition for Long Island

**Cooperating Organizations**

Alliance of Resident Theaters of New York  
Brooklynwide Interagency Council of the Aging  
Citizen Action of New York  
Commission on the Public's Health System  
Community Healthcare Network  
Dance Theater Workshop  
Greater New York Labor-Religion Coalition  
Institute for Puerto Rican and Hispanic Elderly  
Joint Public Affairs Committee for Older Adults  
Lambda Legal Defense and Education Fund  
Long Island Progressive Coalition  
Medicare Rights Center  
Metro New York Health Care for All Campaign  
National Association of Social Workers,  
New York City chapter  
New York State Health Care Campaign  
New York State Nurses Association  
New York State Psychological Association  
New York Statewide Senior Action Council  
Senior Services  
Society for Hospital Social Work Directors,  
Metropolitan New York chapter  
South Fork Community Health Initiative  
William F. Ryan Community Health Center

August 27, 2010

Secretary Timothy Geithner  
Department of the Treasury

Secretary Hilda Solis  
Department of Labor

Secretary Kathleen Sebelius  
Department of Health and Human Services  
Office of Consumer Information and Insurance Oversight  
P.O. Box 8016  
Baltimore, MD 21244-1850

Attention: OCIO-9994-IFC,

To Whom it May Concern:

New Yorkers for Accessible Health Coverage (NYFAHC) is a statewide coalition of 53 voluntary health organizations and allied groups who serve and represent people with chronic illnesses and disabilities, including mental illness for whom access to affordable, accessible comprehensive health coverage is essential to maintaining their well being. We appreciate this opportunity to comment on interim final rules implementing the Patient Protection and Affordable Care Act (ACA) provisions regarding preexisting conditions, lifetime and annual limits on benefits, rescissions, and patient protections.

The Departments make great progress in implementing the consumer protections of the ACA with these interim final rules. However, we have concerns regarding three sections of the regulations: the rules restricting annual limits; the rules limiting rescissions; and the rules regarding coverage of emergency services (patient protections). We will address these sections in the same order as the interim final regulations notice.

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

The restricted annual limits outlined in the interim final regulations should be slightly increased and allow adjustments in regions with higher-than-average health care costs.

The ACA and the interim final regulations generally prohibit annual or lifetime caps on the dollar value of health benefits. The ACA allows insurers to establish a "restricted annual limit" on the dollar value of essential health benefits for plan years beginning prior to January 1, 2014. The interim final rules outline the following schedule of minimum permitted annual limits for this period:



- For a plan (or policy) year beginning on or after September 23, 2010 but before September 23, 2011, \$750,000;
- For a plan (or policy) year beginning on or after September 23, 2011 but before September 23, 2012, \$1,250,000; and
- For plan (or policy) years beginning on or after September 23, 2012 but before January 1, 2014, \$2,000,000.

The interim final regulations should be amended to increase the restricted annual limits and allow adjustments to these minimum limits in regions of the country with higher-than-average health care costs. A patient with a heart or lung condition or needing a bone marrow or other transplant could incur medical bills over \$1,000,000 in one year. Accordingly, the restricted annual limit for plan or policy years beginning on or after September 23, 2010 but before September 23, 2011 should be raised to \$1,000,000. The restricted annual limit for plan or policy years beginning on or after September 23, 2011 but before September 23, 2012 should be raised to \$1,500,000. And the rules should be amended to create a process by which the Secretary of Health and Human Services (HHS) can raise the restricted annual limits in regions like New York with higher-than-average health care costs.

Because health plans may still apply non-monetary limits, such as numerical limits on physician visits or hospital days, HHS and US DOL should ensure that consumers understand what benefit limits can be applied and how they are in effect in their plans. These non-monetary limits are damaging to the adequacy of coverage for consumers, particularly those with chronic disease such as cancer, heart disease, and diabetes who have high utilization of health care. It should be made clear that insurance companies may not institute new limits to the volume of care as a proxy for annual limits on the dollar value of care. Additionally, the rules should make it clear that annual limits on a category of service, such as a dollar limit on the amount of hospital care that will be covered in a year, is an impermissible violation of the prohibition on annual limits.

Finally, the Secretary of HHS's future guidance on waivers of the annual limit rules should not permit insurance companies to continue to market limited benefit plans with annual limits far below the restricted annual limits. The preamble to the regulations states that the Secretary of HHS will be issuing further guidance related to the scope and process for applying for a waiver of the limited annual benefits rule. This guidance should not allow providers of "mini-med" plans to continue selling limited benefit plans with annual limits far below the restricted annual limits set out in this rule. The recession and related job loss have left many consumers out of work for long periods of time, leading to loss of work-related coverage; some consumers have used up the coverage they are permitted through COBRA or state mini-COBRA laws. These economic difficulties make consumers extremely vulnerable to being taken advantage of by companies that charge premiums while offering illusory coverage with very low annual limits. The ACA's ban on annual and lifetime limits is intended to



protect consumers from these predatory plans, and the rules should not allow companies to continue to offer coverage that does not protect consumers.

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

The ACA and these interim rules limit rescission of insurance coverage to cases of fraud, intentional misrepresentation of material fact, and failure to pay premiums. The interim rule's also requires that a plan or insurance issuer provide at least 30 days advance written notice before coverage may be rescinded.

The interim rules still allow insurance companies too much discretion in determining whether a consumer has committed fraud or an intentional misrepresentation of fact. The rules should provide a clear standard explaining that the burden of proof is on the plan or insurer when determining whether a consumer's fraudulent act or misrepresentation was intentional. Further, the rules should outline a process requiring external review of the determination by an impartial party before the rescission takes effect.

Patient Protections (26 CFR § 54.9815-2719AT, 29 CFR § 2590.715-2719A, 45 CFR § 147.138)

The ACA and the interim final regulations require a health plan or coverage that provides any benefits for emergency services to do so without requiring prior authorization and without regard to whether the provider is in-network with respect to emergency services. A plan with a network of providers that provides benefits for emergency services may not impose any administrative requirement or limitation on benefits more restrictive for out-of-network emergency services than that in effect for in-network emergency services.

The ACA's protections regarding coverage of emergency services are designed to protect consumers from receiving excessive bills for emergency services received without prior authorization or from out-of-network providers. They are also designed to eliminate the uncertainty that consumers face when forced to visit an out-of-network emergency room. Consumers may not be able to control which emergency room an ambulance takes them to. In many regards, the interim final rules regarding coverage of emergency services are extremely well-designed to protect consumers from these common experiences for consumers today.

The rules' failure to prohibit balance billing, however, leaves consumers open to receiving unaffordable bills from providers and prevents consumers from knowing, in advance, what level of debt they will incur during an emergency visit to an out-of-network provider. The rules should be changed to prevent or reduce balance billing by out-of-network providers for emergency services.

Hospital billing reform measures in the ACA show the intent of Congress to make hospital billing fairer to consumers, but these protections are too narrowly drawn to protect insured consumers from balance billing by out-of-



network emergency providers. Section 9007 of the ACA provides new requirements for tax-exempt hospitals regarding financial assistance and billing. This section prohibits tax-exempt hospitals from using gross charges when billing financial assistance-eligible individuals for emergency care; instead, the rule requires that they charge these individuals “not more than the amounts generally billed to individuals who have insurance covering such care.”

Similarly, the interim rules under consideration should include a requirement that hospitals charge out-of-network patients no more than the amounts generally billed to in-network patients, or patients covered by Medicare. New York State has adopted this approach in our hospital financial assistance law for uninsured patients and patients who have hit their maximum benefits caps. Alternatively, a patient’s bill could be based on the rate the plan or issuer is required to pay under the rules. Hospitals should not be permitted to bill consumers protected by this statute using gross charges.

Further, if a facility negotiates an agreement with an insurance plan to provide services at in-network rates, all providers practicing at the facility should be required to accept the negotiated rates. The rules should also clarify that any state laws that provide more protection for consumers in this regard are not pre-empted by the ACA.

We appreciate this opportunity to comment these proposed rules. Thank you for your attention in this matter.

Sincerely,

Heidi Siegfried, Esq.  
Program Director