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Hon. Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services
Hon. Hilda Solis, Secretary, U.S. Department of Labor
Hon. Timothy Geithner, Secretary, U.S. Department of Treasury
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9994-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

Submitted via the Federal Regulations Web Portal, http://www.regulations.gov

Re: Comments on Interim Final Rule on Preexisting Condition Exclusions for Children, Annual and Lifetime Limits, Rescissions, and Patient Protections and Request for Near-Term Guidance

Dear Secretaries Sebelius, Solis, and Geithner:

Aetna welcomes the opportunity to respond to the Departments of Health and Human Services, Labor, and Treasury (the "Departments") regarding the Interim Final Rule (the "IFR" or the "Regulation") on the Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections as issued in the Federal Register on June 28, 2010 (75 Fed. Reg. 37188).

Aetna is one of the nation's leading diversified health care benefits companies, providing members with information and resources to help them make better informed decisions about their health care. Our programs and services strive to improve the quality of health care while controlling rising employee benefits costs. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services for early retirees, including medical, pharmacy, dental, behavioral health, group life, long-term care and disability plans and medical management capabilities.

As a key stakeholder affected by the Patient Protection and Affordable Care Act ("PPACA"), Aetna is committed to working with the Departments in developing reasonable and administrable standards for the implementation of PPACA. Aetna is filing these comments in response to the Departments' request for comments on the

Regulation. Our comments include specific recommendations for changes to the Regulation, as well as requests for clarification on particular areas of the Regulation. In connection with this comment letter, Aetna is requesting near-term clarification from the Departments regarding certain issues arising under the IFR. Aetna believes that the issues on which near-term guidance is requested are of such importance that the Departments should issue FAQs in the near-term. For purposes of assisting the Departments with such near-term guidance, Aetna has prepared proposed questions and answers for the Departments to consider.

I. Annual and Lifetime Limits

A. Day and Visit Treatment Limits Are Not Annual Limits

Recommendation: The final Regulation should confirm that the annual and lifetime limits on the dollar value of health benefits does not apply to non-dollar treatment limits, including day and visit limits.

Rationale: The PHSA § 2711, as added by PPACA, and the IFR provide that group health plans and health insurance issuers offering group or individual coverage may not impose annual or lifetime limits on the dollar value of essential health benefits. 75 Fed. Reg. at 37190; 45 CFR § 147.126. Notwithstanding this general rule, a plan or issuer may impose "restricted" annual limits on the dollar value of essential health benefits for plan and policy years beginning before January 1, 2014. 75 Fed. Reg. at 37191; 45 CFR § 147.126(d). The IFR also allows for annual dollar limits on specific covered benefits that are not essential health benefits and for the complete exclusion of benefits for a condition. 75 Fed. Reg. at 37191; 45 CFR § 147.126(b).

The IFR currently states that the limitations that are prohibited under the IFR are limitations on the annual *dollar* value of essential health benefits. As such, the IFR appears not to impose any limits on the use of non-dollar treatment limits, such as day or visit limits. The specific reference to "dollar" value in the IFR is consistent with, and we think required by, the statute, which by its terms did not include treatment limits. We also believe this represents good policy since treatment limits such as day and visit limits are a recognized and valued tool used by plans and insurers to contain costs and ensure that providers are rendering treatment within appropriate industry standards. Examples of day and visit limits include a plan or policy providing for ten physical therapy visits, 60 days per year for a stay at a convalescent facility, and 120 visits per year for home health care. These limits are typically developed based on experience that visits or stays that are more extensive are not medically appropriate. If these treatment limits were prohibited, it is likely that plans and insurers would eliminate those benefits that are typically subject to day or visit limits, including others such as chiropractic treatments or skilled nursing visits, because being required to provide those benefits without limits would be cost prohibitive. Therefore, although we believe that the IFR allows these limits, express confirmation of this important point would be helpful.

B. Application of Annual and Lifetime Limits to Out-of-Network Services

Recommendation: The final Regulation should be amended to provide that the annual and lifetime limits on the dollar value of health benefits does not apply to benefits, items, or services delivered by out-of-network providers.

Additionally, the Departments should issue near-term guidance clarifying that plans and insurers may impose annual limits on benefits, items, or services delivered by out-of-network providers. A proposed question and answer for the near-term guidance is set forth below.

Rationale: As discussed above, the PHSA and the IFR set forth specific rules concerning the imposition of annual limits on essential benefits for years prior to and after 2014. Except for the restricted annual limits described in the IFR, a group health plan or issuer may not impose an annual limit on essential benefits. 75 Fed. Reg. at 37191; 45 CFR § 147.126.

Recognizing that eliminating annual limits would likely affect premiums, PPACA included a phase-in of the elimination of annual limits on essential benefits. The IFR also explicitly acknowledges the likely effect on premiums of the elimination of annual limits stating, "in order to mitigate the potential for premium increases . . . these interim final regulations adopt a three-year phased approach for restricted annual limits." 75 Fed. Reg. at 37191. It is unclear from the IFR whether the Departments were considering the effects on premiums of eliminating annual limits on essential benefits provided on an in-network basis or an out-of-network basis, and the IFR is silent regarding whether the annual limit rules apply in the same manner to in-network and out-of-network items and services. In contrast, the distinction between in-network and out-of-network services is explicitly addressed in the IFR Relating to Coverage of Preventive Services (75 Fed. Reg. 41726 (July 19, 2010)) ("Preventive Care IFR"), where the Departments concluded that a plan or insurer that has a network of providers is not required to provide benefits for items or services that are delivered by an out-of-network provider.

Providing benefits through in-network providers is an effective tool used by plans and issuers to control cost increases and promote quality and efficiency. In the Preventive Care IFR, the Departments explicitly recognize the important role of value-based insurance designs (i.e., in-network systems) to group health plans and issuers. 75 Fed. Reg. at 41729. The Preventive Care IFR allows cost-sharing for preventive care services delivered by an out-of-network provider while no cost-sharing may be imposed on preventive care services delivered by an in-network provider. The same rationale of supporting value-based insurance designs should apply to annual limits for services delivered by in-network and out-of-network providers, (i.e., plans and issuers who are prohibited from imposing annual limits on essential benefits delivered on an in-network basis should be permitted to impose annual limits on essential benefits delivered on an out-of-network basis). Requiring plans and issuers to eliminate annual limits on essential benefits provided on an out-of-network basis may result in prohibitive cost increases which could result in plans and issuers eliminating out-of-network systems altogether.

This conflicts with the goal of the Affordable Care Act as articulated in the IFR Relating to Status as a Grandfathered Health Plan (75 Fed. Reg. 34538, 34546) (June 16, 2010)), which is to allow those that like their healthcare to keep it. Permitting annual limits to be retained for services delivered on an out-of-network basis would (i) be consistent with the approach the Departments took in the Preventive Care IFR, (ii) foster the use of value-based insurance designs, and (iii) increase the likelihood that plans and issuers would continue to offer out-of-network services.

Proposed Near-Term Guidance FAQ: "Out-of-Network Dollar Limits"

Question: Do the annual limit restrictions, which prohibit a plan or insurer from imposing annual limits on benefits below a minimum dollar threshold prior to 2014, and fully prohibit annual limits in 2014, apply to items or services delivered by an out-of-network provider?

Answer: No. The IFR sets forth specific rules concerning the imposition of annual limits for years prior to and after 2014. However, the IFR is silent regarding whether the annual limit rules apply in the same manner to in-network and out-of-network items and services. In contrast, the distinction between in-network and out-of-network services is explicitly addressed in the IFR Relating to Coverage of Preventive Services (75 Fed. Reg. 41726 (July 19, 2010)), where the Departments concluded that a plan or insurer that has a network of providers is not required to provide benefits for items or services that are delivered by an out-of-network provider. The Departments have determined that the annual limit rules should be interpreted in a consistent manner and that a plan or insurer that has a network of providers should be permitted to impose annual limits for items or services that are delivered by an out-of network provider without restriction. As stated in the IFR Relating to Status as a Grandfathered Health Plan (75 Fed. Reg. 34538, 34546) (June 16, 2010)), a goal of the Affordable Care Act is to allow those that like their healthcare to keep it. This position increases the likelihood that out-of-network coverage options will continue to be offered by plans and insurers, thus supporting that goal.

C. Exclusion of All Benefits for a Condition Is Permissible

Recommendation: The final Regulation should retain the rule that exclusion of all benefits for a condition is not considered an annual or lifetime limit on the dollar value of essential health benefits.

Rationale: The IFR provides that group plans and insurers are not prohibited under the annual and lifetime limit rule from excluding all benefits for a condition. 75 Fed. Reg. at 37191; 45 CFR § 147.126(b)(2). Retaining the rule permitting exclusion of all benefits for a condition would provide certainty to plans and insurers that plans and policies do not need to be redesigned to cover benefits for conditions that the plan or insurer does not already cover. Such certainty is critical to planning and budgeting for benefits costs. Furthermore, plans and insurers are in the best position to evaluate the effectiveness and medical necessity of treatments, including whether certain conditions can be treated effectively, and such evaluations are an important tool to manage health care costs and eliminate wastefulness. Finally, in 2014, insurers offering coverage in the individual and

small group markets must provide coverage that includes essential health benefits. See PHSA §§ 2707(a). Additional restrictions on the ability of insurers to limit coverage are not required and would be inconsistent with the requirement to provide essential benefits.

II. Rescissions

A. Retroactive Correction of Routine Enrollment Errors

Recommendation: The final Regulation should be amended to provide that retroactive correction of an enrollment error that is discovered within 30 days of the effective date of coverage is not a rescission.

Additionally, the Departments should issue near-term guidance clarifying that notwithstanding the IFR's rules on rescission, a plan or insurer may retroactively correct an enrollment error that is discovered within 30 days of the effective date of coverage and that in circumstances where the plan terms are clear on who is eligible for coverage and such plan terms have been communicated to employees, plans and insurers may treat an employee-made enrollment error, which clearly conflicts with a plan's eligibility provision, as an intentional misrepresentation of material fact that would permit rescission. A proposed question and answer for the near-term guidance is set forth below.

Rationale: The PHSA § 2712 and the IFR provides that a group health plan and health insurance issuers offering group or individual health insurance coverage may not rescind coverage with respect to an enrollee except where the individual has performed an act or practice that constitutes fraud or makes an intentional material misrepresentation of a material fact, as prohibited by the plan or coverage. 75 Fed. Reg. at 37192; 45 CFR § 147.128(a). The IFR defines a rescission as a cancellation or discontinuance of coverage that has a retroactive effect. 75 Fed. Reg. 37192; 45 CFR § 147.128(a)(2).

Enrollment errors occur routinely because of the complexity of the enrollment process for many group health plans. An employee is often presented with a menu of enrollment options, and eligibility terms often vary between categories of employees (e.g., part-time employees may be subject to a different waiting period or eligible for different benefit plans than full-time employees). Information is often communicated and transmitted electronically, which requires users to understand systems and exercise care to avoid mistakes. Errors frequently occur, due to actions taken by the employer or the employee, or due to limitations of an employer's payroll system itself. These types of enrollment errors are usually caught by employers and insurers within a short period after the error occurs – often within 30 days. The errors are corrected by undoing the transaction and returning any premium that may have been paid by the employer or employee.

Correcting common enrollment errors such as those just described does not operate as a rescission of coverage under the plain language of the IFR because the individual is not "covered under the plan" as required under the IFR. 45 CFR § 147.128(a)(1). Group health plans generally require that an individual be eligible for coverage before an individual will be "covered under the plan." The IFR does not discuss when an

individual should be considered to be "covered" under the plan or coverage for purposes of this rule, but makes clear that where a plan mistakenly *treats* an individual as covered for some period of time, retroactive termination of coverage would be treated as a rescission. (147.128(a)(3), Example 2). The enrollment errors described are administrative errors in advance of enrollment (often caused by the employee) and should not operate to extend coverage to otherwise ineligible individuals or to *treat* an otherwise ineligible individual as "covered" and entitled to protection under the rescission rule. Because the correction of these errors does not operate to rescind valid coverage under the plan, the rules relating to rescission should not apply when correcting the error.

A second approach to addressing the correction of routine enrollment errors would be for the Departments to clarify in the final Regulation that employee-made enrollment errors may be deemed by plans and insurers to be intentional misrepresentations of material fact. This rule would apply in circumstances where the plan terms are clear on who is eligible for coverage and such plan terms have been communicated to employees. In those circumstances, it would be appropriate to treat the enrollment error, which clearly conflicts with a plan's eligibility provision, as an intentional misrepresentation of material fact that would permit rescission.

Proposed Near-Term Guidance FAQ: "Correction of Routine Enrollment Errors"

Question: Do the rules on rescission apply to employer and employee enrollment mistakes in connection with group health coverage where such mistakes are discovered within 30 days of the effective date of coverage and promptly corrected upon discovery?

Answer: No. The IFR provides that a group health plan or health insurance insurer offering group or individual health insurance coverage must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, once the individual is "covered" under the plan or coverage. The IFR does not discuss when an individual should be considered to be "covered" under the plan or coverage for purposes of this rule, but makes clear that where a plan mistakenly *treats* an individual as covered for some period of time, retroactive termination of coverage would be treated as a rescission. (45 CFR § 147.128(a)(3), Example 2).

The Departments are aware that the enrollment process for many group health plans may be complex. An employee is often presented with a menu of enrollment options, and eligibility terms often vary between categories of employees (e.g., part-time employees may be subject to a different waiting period or eligible for different benefit plans than full-time employees). Information is often communicated and transmitted electronically, requiring users to understand systems and exercise care to avoid mistakes. Errors frequently occur, due to actions taken by the employer or the employee, or due to limitations of an employer's payroll system itself.

Given this complexity, the Departments believe that it would be appropriate to allow a short-term correction period following enrollment, during which an individual is not considered to be "covered" for purposes of the rescission rules if a mistake is discovered. Thus, notwithstanding the IFR's rules on rescission, a plan or insurer may retroactively

correct an enrollment mistake that is discovered within 30 days of the effective date of coverage. Such correction must take place promptly upon discovery and must place the employee in the financial position he or she would have been in had the mistake not occurred. For example, where an employer enrolls an employee in a coverage option the employee did not elect and the mistake is discovered within 30 days of the effective date of coverage, the employer may enroll the employee in the correct coverage option and treat such employee as if he or she had been enrolled in the correct coverage option from the first day of the coverage period (i.e., collect or refund premiums/contributions as applicable, and pay claims based on the correct coverage option).

Furthermore, in circumstances where the plan terms are clear on who is eligible for coverage and such plan terms have been communicated to employees, plans and insurers may treat an employee-made enrollment error, which clearly conflicts with a plan's eligibility provision, as an intentional misrepresentation of material fact that would permit rescission. For example, where an employee mistakenly elects coverage for an individual who is not eligible under the terms of the plan and the mistake is discovered within 30 days of the effective date of coverage, the employer may rescind such coverage, fully refund the premiums or contributions for such coverage and deny any claims for expenses incurred by that individual during the 30-day period.

B. Pending Claims During the Rescission Notice Period

Recommendation: The final Regulation should be amended to provide that a plan or insurer may pend claims during the 30-day notice period and internal appeal period.

Additionally, the Departments should issue near-term guidance clarifying that plans and insurers are permitted to pend claims during the 30-day notice period that is required in the case of rescission and the internal appeal period. A proposed question and answer for the near-term guidance is set forth below.

Rationale: The IFR provides that a group health plan or issuer must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded, regardless of, in the case of group coverage, whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. 75 Fed. Reg. 37193; 45 CFR § 147.128(a)(1). However, the IFR does not address whether claims must be paid during this 30-day notice period, and whether it would be permissible for a plan or insurer to hold or "pend" a claim during this period. Similarly, under the PHSA § 2719(a)(1)(C), a plan or insurer must provide continued coverage pending the outcome of an internal appeal. The IFR for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act (75 Fed. Reg. 43330 (July 23, 2010)) also does not address whether claims must be paid during this period.

Pending claims during the 30-day notice period creates the least administrative burden for the plan, employer, and participant because where rescission is permitted, the plan or insurer will have the ability to recover the amount of claims paid from the first day that

coverage was effective up through the date of the rescission (less premiums or contributions paid by the participant). Similarly, where a claim denial is upheld following an appeal, the plan or insurer would have no obligation to pay the claim. Therefore, requiring a plan or insurer to pay claims during the 30-day notice period or internal appeal period only to then have to recover the claims paid would create unnecessary administrative burdens for the plan, insurer and participant, and risk that the plan or insurer may not be able to fully recover amounts that were not properly owing. Accordingly, plans and insurers should be permitted to pend claims during the 30-day notice period and internal appeal period. If the plan or insurer were to conclude that rescission was not permitted, or if a claim denial was overturned on appeal, the pended claims would be paid.

Proposed Near-Term Guidance FAQ: "Pending Claims"

Question: Are plans or insurers permitted to pend claims (i.e., hold for later payment) during the 30-day notice period that is required in the case of rescission?

Answer: Yes. The IFR provides that a group health plan, or a health insurance insurer offering group or individual health insurance coverage, must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded, regardless of, in the case of group coverage, whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. However, the IFR does not address whether claims must be paid during this 30-day notice period, and whether it would be permissible for a plan or insurer to hold or "pend" a claim. Similarly, under the PHSA § 2719(a)(1)(C), a plan or insurer must provide continued coverage pending the outcome of an internal appeal. The IFR Regarding Internal Claims and Appeals and External Review Process (75 Fed. Reg. 43330 (July 23, 2010)) also does not address whether claims must be paid during this period of continued coverage.

The Departments have determined that, because the rules described above are silent concerning the requirement to pay a claim during the period of continued coverage, nothing in these rules would preclude a plan or insurer from pending claims incurred during the 30-day notice period or during the internal appeal period. This position also creates the least administrative burden for the plan, employer and participant. Where rescission is permitted (and no claims are pended), the plan or insurer has the ability to recover the amount of claims paid from the first day that coverage was effective up through the date of the rescission (less premiums or contributions paid by the participant). If claims are pended, the need to collect during this period is avoided. Similarly, where a claim denial is upheld following an appeal, the plan or insurer would have no obligation to pay the claim. Therefore, requiring a plan or insurer to pay claims during the 30 day notice period or internal appeal period only to recover the claims paid would create unnecessary administrative burden for the plan, employer and participant. Of course, if the plan or insurer were to conclude that rescission was not permitted, or if a claim denial is overturned on appeal, the pended claims would need to be paid.

C. Failure to Cooperate in Investigation of Fraud or Intentional Misrepresentation

Recommendation: The final Regulation should be amended to provide that an individual's refusal to cooperate, including not responding to a request for information within a reasonable period of time, with an investigation by a plan or insurer into whether fraud or intentional misrepresentation has occurred, may be deemed fraud or intentional misrepresentation, thereby allowing rescission of coverage.

Additionally, the Departments should issue near-term guidance clarifying that where a plan or insurer attempts, in good faith, to conduct an investigation to determine whether fraud or intentional misrepresentation has occurred and an individual refuses to cooperate with such investigation (including not responding to a request for information within a reasonable period of time), it would be appropriate for the plan or insurer to deem fraud or intentional misrepresentation to have occurred, thereby allowing rescission of coverage. A proposed question and answer for the near-term guidance is set forth below.

Rationale: As discussed above, the PHSA and the IFR provides that a group health plan and health insurance issuers offering group or individual health insurance coverage may not rescind coverage with respect to an enrollee except where the individual has performed an act or practice that constitutes fraud or makes an intentional material misrepresentation of a material fact, as prohibited by the plan or coverage. 75 Fed. Reg. at 37192; 45 CFR § 147.128(a). The IFR defines a rescission as a cancellation or discontinuance of coverage that has a retroactive effect. 75 Fed. Reg. 37192; 45 CFR § 147.128(a)(2).

The IFR does not outline or discuss the steps that a plan or issuer should take to establish whether fraud or intentional misrepresentation has occurred. At a minimum, these steps should include an investigation of the facts, including consideration of any of the facts that the individual considers relevant to the investigation. Such a process would be consistent with the existing Department of Labor claims regulations and the newly issued IFR Relating to Internal Claims and Appeals and External Review Processes (75 Fed. Reg. 43330 (July 23, 2010)) ("Appeals IFR"). In both the existing claims regulations and the Appeals IFR, a claimant must be provided substantial amounts of information explaining any adverse benefit determination, and a claimant must be provided an opportunity to respond to such information and provide additional information as desired. The Appeals IFR expressly states that "by helping to ensure prompt and precise adherence to contract terms and by improving the flow of information between plans and enrollees" the Appeals IFR "will bolster the efficiency of labor, health care, and insurance markets." 45 Fed. Reg. at 43342.

The flow of information between plans and enrollees is critical to making fair and uniform determinations on benefits, including determinations regarding rescissions of coverage. If a group health plan or issuer determines that rescission may be appropriate and attempts to gather additional information from the individual who may be subject to the rescission of coverage, the individual should not be permitted to frustrate the investigation or determination by refusing or failing to respond to requests for more

information from the group health plan or issuer. To allow otherwise would be contradictory to the goals of the Appeals IFR and would result in individuals being able to avoid rescissions of coverage even where the individuals have committed fraud or intentionally misrepresented material facts. Therefore, the Departments should issue guidance to clarify that where a plan or insurer attempts, in good faith, to conduct an investigation to determine whether fraud or intentional misrepresentation has occurred and an individual refuses to cooperate with such investigation (including not responding to a request for information within a reasonable period of time), it would be appropriate for the plan or insurer to deem fraud or intentional misrepresentation to have occurred, thereby allowing rescission of coverage.

Proposed Near-Term Guidance FAQ: "Failure to Cooperate"

Question: Can a participant who fails to cooperate in connection with an investigation of fraud or intentional misrepresentation (e.g., failure to respond to request for medical records) be deemed to engage in fraud or intentional misrepresentation, allowing the health plan to rescind coverage under the plan, policy, certificate, or contract of insurance?

Answer: Yes. The IFR provides that the only situations in which rescission of coverage is permitted are those in which an individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. However, the IFR does not discuss the steps that a plan or insurer must take to establish whether fraud or intentional misrepresentation has occurred. At a minimum, these steps should include an investigation of the facts, including consideration of any of the facts that the participant considers relevant to the investigation. Therefore, where a plan or insurer attempts, in good faith, to conduct an investigation to determine whether fraud or intentional misrepresentation has occurred and a participant refuses to cooperate with such investigation (including not responding to a request for information within a reasonable period of time), the Departments have determined that it would be appropriate for the plan or insurer to deem fraud or intentional misrepresentation to have occurred, allowing rescission of coverage.

III. Patient Protections

A. Geographic Limits on Choice of Primary Care Provider

Recommendation: The final Regulation should be amended to provide that a plan or insurer may limit a participant's choice of primary care provider, including a pediatrician for a child, to the geographic region in which the participant resides.

Rationale: The PHSA § 2719A(a) and the IFR provide that group health plans and health insurance issuers offering coverage to individual or group health plans must allow an individual to choose his or her primary care provider and must allow a child to designate a pediatrician as his or her primary care provider. 75 Fed. Reg. 37193; 45 CFR § 147.138(a). Furthermore, if a plan or insurer requires a participant to designate a

primary care provider, the plan or insurer must permit each participant to designate "any participating primary care provider who is available to accept" the participant. 75 Fed. Reg. 37193; 45 CFR § 147.138(a)(1)(i). These rules only apply to plans or insurers with networks of providers.

Although the rule only applies to plans or insurers with networks of providers, the IFR is silent on whether a plan or insurer may require that the designated primary care provider be within the geographic region of the network of providers in which the participant resides. Nevertheless, reading the rule to require that a designated primary care provider be within the geographic region of the network of providers in which the participant resides would be consistent with the rule's provision that a provider must be "available to accept" the participant because "available," by definition, means that something is able to be used or obtained. A provider who is in a participant's geographic region is able to be used and will be able to provide primary care services while a provider in another geographic region is likely too far away from the participant's residence for the participant to be able to use the primary care provider effectively. Networks of providers, which are usually grouped by geographic region, are designed to allow participants access to a wide-range of providers within their area who are properly credentialed and who agree to provide services at a negotiated rate. The use of geographically based provider networks is a common practice and a reasonable one to continue, and accordingly, the final Regulation should clarify that the continued use of geographic regions is permitted under this rule.

B. Calculation of Median Amounts for Payment of Out-of-Network Emergency Services

Recommendation: The final Regulation should be amended to provide that plans and issuers are permitted to determine the median of negotiated in-network rates for purposes of paying out-of-network emergency services using any reasonable good faith method provided that the plan or issuer uses the method or median rate for a set period of time.

Additionally, the Departments should issue near-term guidance clarifying that plans and insurers are permitted to determine the median of negotiated in-network rates using any reasonable good faith method provided that the plan or issuer uses the method or median rate for a set period of time. A proposed question and answer for the near-term guidance is set forth below.

Rationale: The PHSA § 2719A(b) and the IFR provide that if a participant obtains emergency services out-of-network, a health plan or insurers may only charge the copayment or coinsurance applicable to in-network emergency services and must provide benefits equaling the greatest of three amounts: (1) the median of negotiated in-network rates; (2) the generally applicable out-of-network cost; or (3) the Medicare rate. 75 Fed. Reg. at 37194; 45 CFR § 147.138(b)(3). A provider may "balance bill" over the amount that the plan or issuer is required to pay. Id.

The IFR contains two simple examples involving nine and ten providers that illustrate one way in which median payments can be calculated. See 45 CFR § 147.138(b)(3)(iii),

Examples 3 and 4. It is common for plans and insurers to have thousands of different payment agreements with providers, which are revised on a rolling basis throughout the year. Determining the median of negotiated in-network rates based on changing rates will be administratively difficult for plans and insurers. Accordingly, plans and insurers should be permitted to determine the median of negotiated in-network rates using any reasonable good faith method provided that the plan or insurers uses the method or median rate for a set period of time, for example, one year.

Proposed Near-Term Guidance FAQ: "Calculating Median In-Network Rate"

Question: Can a plan or issuer develop its own reasonable good faith method for determining the median rate for in-network services, and once such method is developed, continue to use that method for a set period of time (e.g., a year)?

Answer: Yes. The IFR provides that if a participant obtains emergency services out-of-network, a health plan only may charge the copayment or coinsurance applicable to in-network emergency services and must provide benefits equaling the greatest of three amounts: (1) the median of negotiated in-network rates; (2) the generally applicable out-of-network cost; or (3) the Medicare rate. A provider may "balance bill" over the amount the plan is required to pay. Although the IFR contains a simple example involving nine providers that is intended to illustrate one way in which median payments can be calculated (45 CFR § 147.138(b)(3)(iii), Example 3), we are aware that insurers may have thousands of different payment agreements with providers, which are revised on a rolling basis throughout the year. Because the rate is constantly changing, the Departments have determined that the insurer can develop its own reasonable method for determining the median rate for in-network services. However, once such method is developed, the insurer must continue to use that method for a set period of time (e.g., a year).

C. Limit the Calculation of Provider Payments for Out-of-Network Emergency Services to Situations Where There Is Balance Billing

Recommendation: The final Regulation should be amended to provide that in circumstances where no balance billing is imposed on a participant for emergency services delivered by an out-of-network provider, it is not necessary for a plan or insurer to follow the out-of-network emergency provider payment methodology.

Additionally, the Departments should issue near-term guidance clarifying that the provider payment methodology for out-of-network emergency services is limited to situations where there is balance billing, and accordingly, if no balance billing is imposed, it is not necessary to follow the provider payment methodology set forth in the IFR. A proposed question and answer for the near-term guidance is set forth below.

Rationale: As discussed in the Preamble to the IFR, the reason that the Departments needed to develop a method to ensure that plans or insurers pay a reasonable amount to an out-of-network provider is because in many cases, balance billing is used. Specifically, the Preamble states, "...[I]t is necessary that a reasonable amount be paid

before a patient becomes responsible for a balance billing amount." 75 Fed. Reg. at 37194. If no balance billing is imposed, it should not be necessary to follow the provider payment methodology set forth in the IFR. For example, where a participant is informed in his or her certificate of coverage and explanations of benefits (EOBs) that the participant is not responsible for balance billing for out-of-network emergency services and that the participant should contact the insurer to take care of any balance billing that the provider might pursue, the participant is not exposed to balance billing. In that case, when the participant obtains emergency services out-of-network, the insurer would pay either the entire billed charge of the provider or pay the provider a fixed payment and negotiate with the provider to resolve any excess charges above the fixed payment. Because the participant would not be exposed to balance billing and would have an enforceable right under the participant's coverage document, the rationale for imposing the provider payment methodology should not apply. Accordingly, plans and insurers should be permitted to pay either the entire billed charge of the out-of-network provider or pay the out-of-network provider a fixed payment and negotiate with the out-of-network provider to resolve any excess charges above the fixed payment the plan or insurer made.

Proposed Near-Term Guidance FAQ: "No Balance Billing"

Question: Is the rule specifying a provider payment methodology for out-of-network emergency services limited to situations where there is balance billing?

Answer: Yes. As discussed in the preamble to the IFR, the reason that the agencies needed to develop a method to ensure that plans or insurers pay a reasonable amount to a provider is because in many cases, balance billing is used. Specifically, the preamble states, "...[I]t is necessary that a reasonable amount be paid before a patient becomes responsible for a balance billing amount." 75 Fed. Reg. 37194. If no balance billing is imposed, it is not necessary to follow the provider payment methodology set forth in the IFR. For example, where a participant is told in his or her certificate of coverage and in his or her EOBs that the participant is not responsible for balance billing for out-of-network emergency services and that the participant should contact the insurer to take care of any balance billing that the provider might pursue, the participant is not exposed to balance billing. In that case, when the participant obtains emergency services out-of-network, the insurer would pay either the entire billed charge of the provider or pay the provider a fixed payment and negotiate with the provider to resolve any excess charges above the fixed payment the plan or insurer made. Because the participant would not be exposed to balance billing and would have an enforceable right under the participant's coverage document, the rationale for imposing the provider payment methodology would not apply.

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Aetna is pleased to have the opportunity to provide comments regarding the Interim Final Rule relating to Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections. Thank you for considering our comments and our suggestions for near-term guidance. Should you have any questions, please feel free to contact me.

Sincerely,

Steven B. Kelmar