



Community Health Councils, Inc.



3731 Stocker Street
Suite 201
Los Angeles, CA 90008

Tel: 323.295.9372
Fax: 323.295.9467
www.chc-inc.org

August 27, 2010

Secretary Timothy Geithner, Department of the Treasury
Secretary Hilda Solis, Department of Labor
Secretary Kathleen Sebelius, Department of Health & Human Services
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 D.C. 20210

Re: *Interim Final Rules — Patient's Bill of Rights*

Dear Secretaries Geithner, Solis and Sebelius:

Community Health Councils writes to share our recommendations on the Interim Final Rules of the Patient Protection and Affordable Care Act's *Patient's Bill of Rights*. This new set of patient protections will benefit millions of Americans across the country and, as a community-based health policy and advocacy organization, we are grateful for the opportunity to provide input. Although the regulations make significant progress towards putting consumers back in charge of their health coverage and care, we believe further specificity and stronger language should be developed to fully protect consumers from weak interpretations of the rules. Our recommendations are as follows, detailed by consumer protection area.

Pre-Existing Condition Exclusions for Children Under Age 19

- **Ensure affordable policies for people with pre-existing conditions.** The new regulations help increase access to coverage by prohibiting insurance plans from denying coverage to children under age 19 based on pre-existing conditions. However, the regulations are silent on what rates may be charged to children with pre-existing conditions until 2014, when adjusted community ratings are required. Therefore, health insurance coverage available to these families may be drastically unaffordable as many states allow high premiums rates based on health underwriting. Some states like California have already recognized the risk the new regulations impose and are close to passing legislation (AB 2244) to limit premiums for children with pre-existing conditions. To prevent rendering the intent of the provision ineffective due to unaffordability, clear regulations should be introduced to prohibit insurers from charging children unreasonably high premiums. The Department of Health and Human Services (HHS) should also work closely with states to monitor affordability in the health insurance marketplace. HHS should require that annual rate submissions or proposals include documentation about any increases applied to policies covering children with pre-existing conditions, accompanied with a full accounting, actuarial analysis, and justification for the rate increases.
- **Require continuous open enrollment for children with pre-existing conditions** Families must be able to *enroll* their children in healthcare

coverage when they need it. Relying on annual open enrollment periods restricts families from having continuous access to healthcare services. During the first year, we recommend permitting families to enroll in insurance coverage at any time to allow for adequate notice and public education to families who can benefit from the policy change. After initial enrollment, if HHS returns to an annual open enrollment period, a waiver process for families who have extenuating circumstances should be developed to permit them to enroll in coverage outside of the open enrollment period.

- **Require health plans to cover young adults with pre-existing conditions to age 26.** As new coverage options through a parent's plan become available for young adults under the age of 26, this population must also be protected from discrimination based on pre-existing conditions. Unfortunately, more than 30% of young adults do not have health insurance, while 47% report being uninsured at some point in the last year.¹ Although new consumer protection regulations will be extended to Americans of all ages starting in 2014, if young people ages 19 to 26 are not exempt from discrimination earlier, their newly implemented insurance coverage options may be denied. Many states have created a new high risk pool for such patients yet the average premium rates are unaffordable for this younger population. Therefore, we urge you to modify the language of the new regulations to prohibit insurance plans from denying coverage based on pre-existing conditions from ages 19 to 26.

Arbitrary Rescissions of Insurance Coverage

- **Clarify burden of proof and require a third-party reviewer.** We are excited that under the new regulations, insurers and health plans will be prohibited from rescinding coverage except in cases of fraud, intentional misrepresentation of material facts or failure to pay premiums. However, the burden of proof by which to measure fraud or intentional misrepresentation is not clearly delineated in the rules. This gives insurers an opportunity to continue to take advantage of consumers. The current rules trust insurers over consumers to determine whether, for example, an omission was done intentionally or not and would then allow for rescission. Therefore, a health plan should only be allowed to initiate an investigation if it can prove to the state that it has reasonable evidence. In such cases, enrollees should be promptly notified with full disclosure of the alleged omission or misrepresentation, be given the opportunity to offer relevant evidence and notified of their rights to file an appeal. We also recommend a third-party review be required before an insurer can rescind coverage to protect consumers from losing coverage unnecessarily.

Lifetime and Annual Dollar Limits on Coverage

- **Extend the annual and lifetime cap rules by prohibiting caps on services.** The new regulations prohibit the use of lifetime dollar limits on essential benefits and phases in new rules on annual dollar limits on coverage leading to the prohibition of annual limits in 2014. While the rules prohibit monetary lifetime limits and restrict annual limits, health plans may likely apply non-monetary annual limits to coverage such as the number of physician visits and hospital days. Such limits would force families to forego necessary treatments to preserve their benefits and be additionally disruptive to high-utilizing chronic disease patients, undermining the clear intent of the law.
- **Closely monitor annual limits until "essential health benefits" are defined.** Because the interim rules allow a restricted level of annual caps on "essential health benefits" until 2014, it

¹ www.healthreform.gov "Young American & Health Insurance Reform: Giving Young Americans the Stability and Security they Need."

is critical that any limits are sufficient for patients to receive adequate and comprehensive medical care. The current language clarifies that insurers must show good faith efforts in defining “essential health benefits” until this term is defined by HHS. Unfortunately, the interim final rules do not clarify what constitutes a “good faith effort,” opening the door to potential abuse by the insurance industry to deem essential benefits as non-essential. We suggest that a “good faith effort” be defined at least as using standard medical practices or independent clinical evidence to determine which health services are essential benefits.

Selecting Primary Care Providers

- **Mandate notice of changes to an enrollee’s health insurance.** We are pleased by the regulations to improve access and continuity of care by allowing patients to choose their primary care provider and see obstetrical or gynecological care without a referral. However, the current rules are void of any timeline on when notice requirements go into effect or standards for notifying an enrollee of the changes to his/her plan. Therefore, HHS should require that the insurance plan immediately begin the notification process and stipulate a clear set of standards for notification, such as certified mail, so that the insurer knows to a reasonable certainty that the enrollee has received the notice. Optimally, multiple forms of affordable technology and information systems should be used to broaden the reach of communication including, at a minimum, making phone calls to enrollees similar to Medi-Cal processes.

Removing Insurance Company Barriers to Emergency Department Services

- **Establish fair standards for provider billing and clarify that the rules should not preempt stronger state laws.** Although, health plans and insurers will no longer be allowed to charge higher cost-sharing for emergency services out-of-network, families remain unprotected from out-of-network provider charges *not* paid by their health plan (“balance-billing”). While the new regulations protect *providers* from unreasonably low payments from insurers, consumers deserve equitable protections from extreme hospital bills in order to avoid medical debt. Therefore, any amount billed by a provider should be calculated at the lower of either the lowest rate that would be paid by Medicare or Medicaid or the actual unreimbursed cost to the hospital for the service. Lastly, the interim final rules must also clarify that stronger state protection against harmful balance-billing and financial assistance policies will hold.

The implementation of the Patient Protection and Affordable Care Act provides exciting yet challenging opportunities for administrators, officials and stakeholders across the nation. Community Health Councils is looking forward to working with you to build upon the strengths of our current healthcare system and to make needed reforms to improve quality, access, and affordability of care for children and families.

Should you require additional information or have any questions, please feel free to contact Laura Ewing, Policy Analyst, at 323.295.9372 extension 228.

Respectfully submitted,



Lark Galloway-Gilliam, MPA
Executive Director