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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 Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-563

U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210
Attention: RIN 1210-AB43

Re: Interim Final Rules for 26 CFR Part 54 and 602, 29CFR Part 2590, and 45 CFR Parts 144, 146, and 147: Requirements for Group Health Plans and Health Insurance Issuers under the Patient Protection and Affordable Care Act Relating to Pre-Existing Condition Exclusions, Lifetime Annual Limits, Rescissions and Patient Protections.

Dear Secretaries Geithner, Solis and Sebelius:

Health Access California, a coalition of more than a hundred consumer, community, labor and other organizations committed to quality, affordable health care for all Californians, offers comments on the new Patient Bill of Rights included as part of the Affordable Care Act.

Health Access California was the organizational sponsor of the package of legislation that constituted the HMO Patient Bill of Rights enacted in California between 1996 and 1999. For the last decade, we have been actively engaged in the implementation of the HMO Patient Bill of Rights, including the creation of a new regulator to oversee HMOs and PPOs, the Department of Managed Health Care. We have participated in numerous regulatory processes at that department and at the California Department of Insurance.

Unfortunately, the federal law as enacted with respect to patient rights is in many respects less advantageous to consumers than existing California law. We respect the reality that the new federal law is a significant improvement for consumers in most states. We seek to assure that California law is not pre-

empted in those instances in which it provides better protections for consumers than federal law.

A. Pre-Existing Condition Exclusions: Children

Health Access strongly supports guaranteed issue of insurance with no pre-existing condition exclusions for children under age 19.

As the organizational sponsor of implementing legislation at the state level, AB2244 by Assemblymember Mike Feuer in the 2010 California legislative session, we have been in the midst of struggling with how to implement this principle at the state level.

Open Enrollment Periods: We support guaranteed issue with no pre-existing condition exclusions at all times during the year. Unfortunately, the recent federal guidance with respect to open enrollment periods does not specifically state whether guaranteed issue is available only during the open enrollment period or all twelve months of the year. There has been considerable disagreement at the state level between consumer advocates and insurers about the correct interpretation of federal law. AB2244 as currently amended defers to federal interpretation of federal law, rules, regulations and guidance on this point.

Affordability: During our negotiations with insurers over children's coverage over the last few weeks, insurers and health plans in California have stated that if left unregulated, premiums for sick children could be as much as ten or even twenty times as high as premiums for healthy children. They base this estimate on the cost of the children that have been denied coverage. No good data is available since virtually everything about denials of coverage is currently treated as proprietary information, even the number of denials and the rate of denials.

AB2244 as currently amended provides that sick kids can only be rated up twice as much as healthy kids during the open enrollment period. However, it allows unlimited pricing if there is guaranteed issue outside the open enrollment period. This is odious to us but we were unable to reach any other compromise with the insurers and Governor Schwarzenegger. This odious compromise is better than existing California law under which sick kids can be denied at any time and there is no limit at any time on pricing of premiums. We are unclear as to what federal law permits prior to 2014 in terms of capping premiums for sick kids.

Rate disclosure: We ask that HHS ask the states to monitor rates for children, including any increase in rates, changes in benefit design, and the range between the lowest risk and the highest risk. Given the threat that rates for sick kids will be as much as ten or twenty times the premiums for healthy kids, it is essential that at a minimum this market-driven pricing be made public. In California, unless corrected by pending legislation, the notice of rate increases for individual coverage is "private and confidential".

B. Pre-Existing Condition Exclusions: Exclusion of an entire condition: Maternity, HIV/AIDS

The IFR states that all treatment for a condition may be excluded. Here is what this means in California: 80% of the individual health coverage excludes maternity care. That means that of the two million plus Californians with individual health coverage, perhaps as many as two million have coverage that does not include maternity coverage.

We are also troubled that the provision could be interpreted to exclude all care for HIV/AIDS

We strongly encourage that the rule be amended to require inclusion of all conditions and not to allow exclusion of any specific condition.

C. Lifetime and Annual Limits

Limitation on benefits: We join other consumer organizations in opposing other limits on benefits that are an attempt to circumvent the requirement to end lifetime limits and phase out annual limits. In California, literally hundreds of thousands are covered by hospital only coverage that may include one or two doctor visits or none. Other so-called health insurance policies cover the second day of hospitalization but not the first and most expensive day. Hundreds of thousands of policies cover only a limited list of generic prescription drugs and provide no coverage for brand-name drugs even when there is no therapeutic equivalent.

These limited benefit policies do real harm to real people. On turning 50, Susan Braig, Altadena, CA, thought she would do the responsible thing so she bought what she thought was catastrophic health coverage. When she got breast cancer, almost none of her costs were covered because almost all of her care was done on an outpatient basis but her policy was a hospital-only policy. Another woman, an early retiree bought what she was told was comprehensive coverage comparable to what was offered to large employers only to discover after she was bitten by a rattlesnake while clearing out her backyard that the first day of hospitalization, costing \$98,000, was not covered.

These limited benefit policies also increase the cost of premiums for those who buy comprehensive coverage: insurers assume that those who buy comprehensive coverage have higher medical costs than those who buy limited benefit policies and appear to price the premiums to drive most consumers to the limited benefit policies. Premium costs are not the only consideration: costs to consumers for necessary medical care that is not covered by limited benefit policies are also real costs to the health system and to the financial security of individuals.

In our negotiations with insurers here in California, we have been dismayed to discover that at least some of them intend to continue to offer hospital-only

policies and policies that cover only generic drugs, even if there is no therapeutic equivalent. The interim final rules state that insurers may place limits on specific benefits that are not essential health benefits as defined in Sec. 1302 (b) of the Patient Protection and Affordable Care Act. Policies that do not cover physician visits or that do not cover brand-name prescription drugs appear to us to plainly violate this rule. However, since insurers disagree, we seek clarity and ask that further guidance be given that such limited benefit policies violate the rule.

D. Rescissions

Sadly California has had considerable experience with rescissions. We are pleased that as a result of action at the state and federal levels rescissions have been reduced to a minimal number.

Any external review of a rescission must be a truly independent review by experts competent in both the legal and clinical issues. It is not an independent or external review if the insurer picks the reviewer and pays the reviewer: such a review is simply an extension of the internal review process of the insurer. To be independent, an external review must be conducted by an entity that is picked and paid by the regulator, not the insurer. The entity must face strict conflict of interest guidelines and have expertise in both legal and clinical issues. Also the entire review must be available at no cost to the consumer: otherwise consumers will be deterred from seeking reviews. Provision should be made for urgent review in those instances in which severe financial or clinical harm will occur if care is not provided promptly.

For over a decade, California has successfully implemented independent medical review regarding determinations of medical necessity using just such a system of independent review in which the regulator picks and pays the reviewing entity. The reviewers are subject to strict conflict of interest requirements. The entire process is available at no cost to consumers. Urgent reviews are available.

E. Patient Protections

1. Emergency Services:

a. Reasonable Person Standard

California law provides that health care service plans and health insurers: may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and *the enrollee reasonably should have known that an emergency did not exist* (emphasis added). Section 1371.4 of the Health and Safety Code

This provision is well settled law in California. It puts the burden on the insurer or plan to demonstrate that the insured should have known that an emergency did not exist. It does not put the burden on the consumer to make a clinical

determination of whether an emergency exists. The California standard does not require the consumer to be of “average knowledge”, a standard that is difficult to assess in a state with the diversity of culture and language that California faces. It does not require a consumer to behave with “average prudence”, something that many consumers are ill-equipped to do in the midst of a true emergency.

Existing California law does not prevent the application of the provisions of PPACA: it is well settled law in California.

b. Balance Billing

Existing California law regarding health care service plans prohibits balance billing. This case law does not prevent the application of the provisions of PPACA regarding access to emergency care.

Health Access is dismayed by the proposed interim final rule that would allow providers to charge consumer for the excess of the amount the out of network provider charges over the amount the plan or insurer is required to pay. With respect to health care service plans in California, this undercuts a California Supreme Court case that is directly on point to this consumer protection issue. Specifically, in *Prospect Medical Group v. Northridge Emergency Medical Group* (2009) 45 Cal. 4th 497, in a unanimous decision, the California Supreme Court found that:

For HMO members, it is always clear in advance who has to provide emergency services — any emergency room doctor to whom the member goes in an emergency — and who has to pay for those services — the HMO. The conflict arises when there is no advance agreement between the emergency room doctors and the HMO regarding the *amount* of the required payment... The resolution of such disputes can create difficult problems.

But the question of how to resolve disputes between the doctors and the HMO over the amount due for emergency care is not before us in this case. The issue here is narrow, although quite important for emergency room doctors, HMO's, and their members: When the HMO submits a payment lower than the amount billed, can the emergency room doctors directly bill the *patient* for the difference between the bill submitted and the payment received — i.e., engage in the practice called “balance billing”?

Interpreting the applicable statutory scheme as a whole — primarily the Knox-Keene Health Care Service Plan Act of 1975, Health and Safety Code section 1340 et seq. (Knox-Keene Act) — we conclude that billing disputes over emergency medical care must be resolved solely between the emergency room doctors, who are entitled to a reasonable payment for their services, and the HMO, which is obligated to make that payment. A patient who is a member of an HMO may not be injected into the dispute.

Emergency room doctors may not bill the patient for the disputed amount.

And further in their decision:

The only reasonable interpretation of a statutory scheme that (1) intends to transfer the financial risk of health care from patients to providers; (2) requires emergency care patients to agree to pay for the services or to supply insurance information; (3) requires HMO's to pay doctors for emergency services rendered to their subscribers; (4) prohibits balance billing when the HMO, and not the patient, is contractually required to pay; (5) requires adoption of mechanisms to resolve billing disputes between emergency room doctors and HMO's; and (6) permits emergency room doctors to sue HMO's directly to resolve billing disputes, is that emergency room doctors may not bill patients directly for amounts in dispute. Emergency room doctors must resolve their differences with HMO's and not inject patients into the dispute. Interpreting the statutory scheme as a whole, we conclude that the doctors may not bill a patient for emergency services that the HMO is obligated to pay. Balance billing is not permitted.

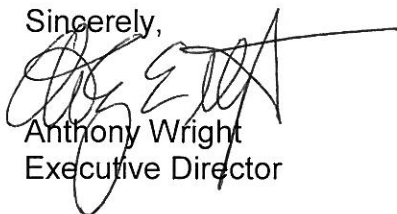
We seek provisions in the interim final rule that assure that state law regarding balance billing of consumers prevails if it is based on a specific statutory construct as is the case with respect to health care service plans in California.

2. Obstetrician-Gynecologist as Primary Provider

For over a decade, California law has provided that California consumers may rely upon their obstetrician and gynecologist as a primary care provider. While the precise language of the California statute is somewhat different since it takes into account the network requirements, from a consumer perspective the impact is similar.

We respectfully seek these changes and clarifications of the interim final rule.

Sincerely,



Anthony Wright
Executive Director