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: CCD Comments on Interim Final Rules for Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections (File Codes OCIIO-9994-IFC, RIN 0991-AB69/ RIN 1210–AB43/REG–120399-10)

Dear Sir or Madam:

The Consortium for Citizens with Disabilities (CCD) appreciates the opportunity to comment on interim final rules that implement provisions of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA) regarding preexisting condition exclusions, lifetime and annual limits, rescissions, and patient protections. We applaud the issuance of these interim final rules by the Departments of Health and Human Services, Labor, and Treasury (collectively, the Departments), because their promulgation is an important step forward in protecting consumers against some of the most harmful practices within the private insurance market. We provide the following comments so that the Departments can strengthen the interim final rules.

CCD is a coalition of approximately 100 national disability organizations working together to advocate for national public policy that ensures the self determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society. Since 1973, the CCD has advocated on behalf of people of all ages with physical and mental disabilities and their families. CCD has worked to achieve federal legislation and regulations that assure that the 54 million children and adults with disabilities are fully integrated into the mainstream of society.

Prohibition of Preexisting Condition Exclusions

We strongly support interim final rules prohibiting preexisting condition exclusions.[1] These rules are, in a very real sense, the missing link of the Americans with Disabilities Act of 1990 (ADA), as they begin to implement the ACA's prohibition against discrimination based on health or disability status.[2] The ADA did little in the way of private insurance regulation and this was the great unfinished business for the disability community over the past twenty years. Although the interim final rules are important protections, we think the interim final rules could be improved in the following ways:

- We believe the definition of preexisting condition exclusions should be broadened to include additional forms of discrimination. We make the following recommendations.

    - Arbitrary restrictions on benefits, particularly in the area of rehabilitation and habilitation services and devices, should be considered a form of preexisting condition exclusion. In fact, coverage exclusions of, or arbitrary restrictions on, any benefits that are identified in the ACA statute as "essential health benefits"—as rehabilitation and habilitation services and devices are—should be considered a *de facto* preexisting condition exclusion and receive the same protections under the interim final rules.

    - The interim final rules do not provide necessary patient protections against new condition-based exclusions by health plans and health insurance issuers between now and 2014, when adults are protected against preexisting condition exclusions. For instance, to preemptively thwart the new rules on preexisting condition exclusions, health plans and health insurance issuers could simply eliminate coverage for certain benefits altogether. This could be viewed as a permissible condition-based exclusion of benefits, but would have the same effect as imposing a preexisting condition exclusion. Considering that Congress intended to ensure full access to coverage for individuals with preexisting conditions, CCD urges the Departments to take steps to protect patients against health plans and health insurance issuers that impose new condition-based exclusions. CCD suggests that until 2014, the interim final rules should require health plans and health insurance

[1] The interim final rules are set forth at 26 CFR 54.9815-2704T, 29 CFR 2590.715-2704, 45 CFR 147.108.
[2] The statutory prohibition is set forth at Sec. 2704 of the Public Health Service Act (PHS Act), which was added by section 1201 of the ACA. Section 2704 broadens current HIPAA provisions, which only apply to group health plans and group health coverage.

issuers to exercise "good faith efforts" in implementing condition-based exclusions. In this context, "good faith efforts" should be defined to prohibit plans from imposing condition-based exclusions if their effect is to subvert the intent of the new preexisting condition exclusions policy. In this instance, the Departments and state Insurance Commissioners should have the authority to nullify condition-based exclusions.

- Excessive waiting periods, which run more than 90 days, should fall within the definition of prohibited "exclusions."

- The Departments should use their regulatory authority to prohibit unreasonable premium increases for children receiving health coverage through the individual market. Currently, federal law prohibits group plans from charging higher premiums, but community rating restrictions in the individual market will not become effective until 2014. Accordingly, in the interim, children with preexisting conditions, who receive coverage through the individual market, may be charged excessive premiums. Such high premiums may defeat the purpose of prohibiting preexisting conditions exclusions, *i.e.*, expanding coverage to more children. One way to prevent such unreasonable premium increases may be to prohibit health plans and health insurance issuers from asking questions about the health status of children on health insurance applications, thereby minimizing the risk of discriminatory treatment of children. Further, the Secretary of Health and Human Services (HHS) and state Insurance Commissioners should monitor premiums for individual family policies with children to ensure that excessive premiums are not being imposed.

Lifetime and Annual Limits

We applaud the interim final rules that prohibit health plans and health insurance issuers from imposing lifetime limits as well as unreasonable annual limits until 2014 when such limits are prohibited all together.[3] These restrictions on lifetime and annual limits only apply to "essential health benefits," a term that is defined in the Affordable Care Act to include ten general categories.[4] We believe the interim final rules could be improved in the following ways:

- Regulations regarding "essential health benefits" should be issued as soon as practicable. In the meantime, according to the preamble of the interim final rules, health plans and health insurance issuers may use "good faith efforts," to determine the meaning of "essential health benefits."[5] In 2014, large group and self-insured plans will continue to use good faith efforts to determine whether certain benefits are subject to the lifetime and annual limit restrictions. This may lead to significant variations in the set of benefits subject to the rule. Further, health plans and health insurance issuers may unduly narrow

[3] The interim final rules are set forth at 26 CFR 54.9815-2711T, 29 CFR 2590.715-2711, 45 CFR 147.126. The interim final rules implement the statutory provisions of Sec. 2711 of the PHS Act, which was added by Sec. 1001 of the ACA.
[4] ACA, § 1302.
[5] Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37188, 27191(June 28, 2010).

the scope of essential health benefits through the imposition of new coverage restrictions. And this may impact the federal government's definition of "essential health benefits" because this term will, in part, be based on a survey of what constitutes a "typical employer health plan." Therefore, the sooner the HHS Secretary can issue the essential health benefit regulations, the better.

- The rules should provide an objective definition of "good faith efforts" to comply with a reasonable interpretation of essential health benefits. CCD believes the Departments should provide examples of actions constituting "good faith efforts" for determining the meaning of essential health benefits. The Departments and insurance commissioners should have the authority to prohibit insurance plans from limiting coverage of benefits to subvert the intention of the ACA provisions on prohibiting lifetime and unreasonable annual limits on those benefits.

- The Departments should issue restrictions on benefit-specific limitations (*e.g.*, dollar or treatment frequency) that are imposed to subvert the intent of restrictions on lifetime and annual limitations. Different types of illnesses or injuries may require different levels of medical intervention, treatment, or care. Accordingly, it is important that health plans and health insurance issuers not sidestep restrictions on lifetime and annual limits by either imposing caps on costs related to a specific treatment, or by limiting treatment frequency. The Departments should require that health plans and health insurance issuers act in good faith and impose no restriction or limitation designed to subvert the intent of the annual and lifetime limit restrictions. Such a finding by the Departments or state Insurance Commissioners should render these types of limitations null and void.

- The imposition of restrictions on the use of annual and lifetime limits may have the unintended consequence of prompting health plans and health insurance issuers to impose "condition-based exclusions" of benefits in order to limit health expenditures in the future. The interim final rule explicitly permits "condition-based exclusions" of benefits. The rule states:

  > "The rules of this section do not prevent a group health plan, or a health insurance issuer offering group or individual health insurance coverage, from excluding all benefits for a condition."[6]

  CCD strongly urges the Secretaries to clarify that condition-based exclusions of benefits must not violate the requirements of the Americans with Disabilities Act of 1990, which prohibits "disability-based distinctions" in health insurance coverage. In fact, in issuing interim guidance on this issue in 1993, the Equal Opportunity Employment Commission (EEOC) stated the following:

  > "[H]ealth-related insurance distinctions that are based on disability may violate the ADA. A term or provision is "disability-based" if it singles out a particular disability (e.g., deafness, AIDS, schizophrenia), a discrete group of disabilities (e.g., cancer,

[6] Sections 26 CFR 54.9815-2711T(b)(2), 29 CFR 2590.715-2711(b)(2), 45 CFR 147.126(b)(2).

muscular dystrophies, kidney diseases), or disability in general (e.g., noncoverage of all conditions that substantially limit a major life activity)."[7]

- CCD believes that health plans and health insurance issuers may react to the elimination of lifetime limits by imposing new annual limits in benefits subject to the new dollar caps that are permissible until 2014 under the interim final rules. CCD believes that the Departments should promulgate a regulatory moratorium which would prohibit health plans and health insurance issuers from imposing new annual limits on essential health benefits. That is, no health plan or health insurance issuer should be permitted to impose an annual limit where none existed prior to enactment of the Affordable Care Act. Such a moratorium would supplement interim final regulations regarding "grandfathered health plans," which state that a health plan or health insurance issuer will lose grandfather status if it imposes annual limits on essential health benefits under any of the following situations:

  "(a) the plan, on March 23, 2010, did not impose an overall annual or lifetime limit, and now imposes an overall annual limit;
  (b) the plan, on March 23, 2010, imposed an overall lifetime limit, and now imposes an annual limit at a dollar value that is lower than the dollar value of the lifetime limit; or
  (c) the plan, on March 23, 2010, imposed an overall annual limit and now decreases the annual limit."[8]

- The rules should clarify how lifetime and annual limits will apply to large group and self-insured plans, because such plans will not be required to provide the essential health benefits package.

- The interim final rules allow the HHS Secretary to waive restrictions on annual limits if compliance would result in a significant decrease in access to benefits or a significant increase in premiums. Consumer protections should be included to ensure that waivers do not have a negative, disproportionate effect on specific patient populations, especially those based on diagnosis or health status. Indeed, the rules should allow the Secretary to rescind waivers if there is such a negative, disproportionate effect.

Prohibition on Rescissions

We applaud the interim final rules that prohibit health plans and health insurance issuers from rescinding coverage except for fraud or intentional misrepresentation of a material fact.[9] We believe the rules could be strengthened in the following ways:

[7] EEOC Interim Guidance on Application of ADA to Health Insurance, EEOC Compliance Manual, June 8, 1993.
[8] 26 CFR 54.9815–1251T(g)(vi), 29 CFR 2590.715–1251(g)(vi), and 45 CFR 147.140(g)(vi).
[9] The interim final rules are set forth at 26 CFR 54.9815-2712T, 29 CFR 2590.715-2712, 45 CFR 147.128. The interim final rules implement the statutory provisions of Sec. 2712 of the PHS Act, which was added by Sec. 1001 of the ACA.

- The rules now allow rescissions only in a limited set of circumstances. In those circumstances, consumers should be given the opportunity for independent, third-party review of any rescissions. Further, health plans and health insurance issuers should be required to continue coverage during the review and appeals process.

- The rules should provide a definition for the term "material fact." For example, the definition of "material fact" should require a *causal connection* linking an alleged omission and the condition that triggered the look back.

- Consumers should be given independent and clear "how-to" manuals which instruct how to fairly complete an insurance application. Applications should be standardized to avoid confusion and complexity.

Patient Protections

CCD also strongly supports the interim final rules regarding patient protections, which allow consumers greater choice in selecting in-network primary care providers and pediatricians.[10] Similarly, we applaud these interim final rules because they also prohibit mandatory referrals or prior authorizations for emergency care or obstetrical and gynecological care. These consumer access provisions were contained in more comprehensive patients' rights legislation proposed in 2001.[11] CCD strongly supported this patient rights legislation, but it was not enacted at the time. The promulgation, now, of a limited set of patients' rights is a positive development, but we urge the Departments to strengthen these consumer protections in the following ways:

- The Secretaries of the Departments should use their discretion to strengthen the definition of a "primary care provider," as used in the consumer protection rules. CCD believes that a "primary care provider" should be defined in *functional* terms, and not solely on the basis of *who* is providing care. In particular, we urge the Departments to adopt a multi-dimensional definition of primary care, as suggested by the Institute of Medicine (IOM):

  > "Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[12]

  CCD believes this definition would remove unnecessarily sharp distinctions between generalists and specialists, at least when it comes to the provision of care to people with chronic conditions and disabilities. Consequently, adoption of this concept of primary care may allow patients, particularly those with disabilities and chronic conditions, to

[10] The interim final rules are set forth at 26 CFR 54.9815-2719AT, 29 CFR 2590.715-2719A, 45 CFR 147.138. The interim final rules implement the statutory provisions of Sec. 2719A of the PHS Act, which was added by Sec. 1001 of the ACA.

[11] See the Bipartisan Patient Protection Act, S. 1052 and H.R. 2563 (as introduced) from the 107th Congress. Sections 112, 115, 116 contain provisions for access to primary care, obstetrical and gynecological care, and pediatric care, respectively.

[12] Institute of Medicine, Committee on the Future of Primary Care, *Primary Care: America's Health in a New Era* (Washington: National Academy Press, 1996), p. 31.

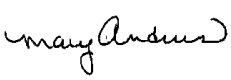
have better access to specialty care without prior authorization from a primary care "gatekeeper" who is a generalist. This would be a critical protection in health plans that use a network of providers that are only accessible through a primary care coordinator. Many people with disabilities and chronic conditions know their condition well and are active participants in managing their health care. In these instances, direct access to a specialist is often more efficient, less costly to the plan, and may lead to better, more timely care. In fact, in many instances, specialists already serve as *de facto* care coordinators for persons with disabilities. CCD believes that the Secretaries of the Departments should exercise their discretion to ensure that the final rules permit enrollees with disabilities and chronic conditions the option of selecting a willing specialist to serve as a care coordinator in plans that employ a network delivery model that utilizes the care coordinator concept.

- The provisions for emergency care should be expanded. Notably, the current rule protects patients from undue cost-sharing and administrative burdens if they receive out-of-network emergency care without prior authorization, but there are no explicit similar provisions for in-network care obtained without prior authorization.

CCD believes the interim final rules are a significant step forward for persons with disabilities and chronic conditions. Nonetheless, we believe that the rules could be further strengthened in significant ways. If you have any questions, please feel free to contact any of the Health Task Force Co-Chairs listed below. Thank you for your consideration of our comments.

Sincerely:

CCD Health Task Force Co-Chairs:



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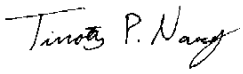

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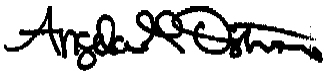

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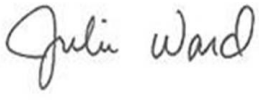

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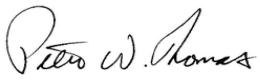

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CCD Health Task Force Members:

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American Academy of Physical Medicine and Rehabilitation
American Association of People with Disabilities
American Association on Health and Disability
American Counseling Association
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Network of Community Options and Resources
American Occupational Therapy Association
American Physical Therapy Association
American Speech Language Hearing Association
American Therapeutic Recreation Association
Association of University Centers on Disabilities
Autism National Committee
Autism Society
Autism Speaks
Bazelon Center for Mental Health Law
Brain Injury Association of America
Burton Blatt Institute
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Community Access National Network
Dialysis Patient Citizens
Disability Rights Education and Defense Fund
Easter Seals
Epilepsy Foundation
Mental Health America
National Alliance on Mental Illness
National Association of Councils on Developmental Disabilities
National Association of County Behavioral Health and Developmental Disability Directors
National Association of State Head Injury Administrators
National Association for the Advancement of Orthotics and Prosthetics
National Council for Community Behavioral Healthcare
National Council on Independent Living
National Disability Rights Network
National Down Syndrome Congress
National Multiple Sclerosis Society
National Spinal Cord Injury Association
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United Spinal Association