



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

DRAFT

August 26, 2010

Mr. Jim Mayhew
Office of Consumer Information and Oversight
Department of Health and Human Services
Attention: OCIO-9994-IFC
P.O. Box 8016
Baltimore Maryland 21244-1850

Re: CCD Comments on Interim Final Rules for Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections

Dear Mr. Mayhew:

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, 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 federal government could 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. 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. 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 pre-existing condition exclusions should be broadened to include additional forms of discrimination. We make the following two recommendations.
 - Arbitrary restrictions on benefits, particularly in the area of rehabilitation and habilitation services and devices, should be considered a form of pre-existing condition exclusion. In fact, coverage exclusions of, or arbitrary restrictions on, any benefits that are identified in the ACA statute as "essential benefits"—as rehabilitation and habilitation services and devices are—should be considered arbitrary limitations.
 - Excessive waiting periods, which run more than 90 days, should fall within the definition of prohibited "exclusions."
- The Secretary of Health and Human Services (HHS) should use her inherent 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 pre-existing 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 from asking questions about the health status of children on health insurance applications.

Lifetime and Annual Limits

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

- Regulations regarding "essential benefits" should be issued as soon as practicable. According to the preamble of the interim final rules, health plans may use "good faith efforts," to determine the meaning of "essential benefits." See 75 FR 37188, 37191. This may lead to significant variations in the set of benefits subject to the rule. Further, health plans may unduly narrow the scope of essential benefits. And this may be problematic because the federal government's definition of "essential benefits" is, in part, to be based on a survey of what constitutes a typical employer health plan.

- The rules should provide an objective definition of “good faith efforts.” CCD believes it may be helpful for the rules to provide illustrating examples of actions constituting “good faith efforts” for determining the meaning of essential benefits.
- The rules should clarify how lifetime and annual limits would 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. For example, 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 from rescinding coverage except for fraud or intentional misrepresentation of a material fact. We believe the rules could be strengthened in the following ways:

- 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 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.

Consumer Protections

CCD also strongly supports the interim final rules allowing consumers greater choice in selecting in-network primary care providers and pediatricians. Similarly, we applaud the interim final rules prohibiting referrals or authorizations for emergency care or obstetrical and gynecological care. These consumer access provisions were contained in more comprehensive patients’ rights legislation proposed in 2001.¹ The promulgation of a limited set of patients’ rights is a positive development, but we urge the HHS Secretary to strengthen these consumer protections in the following ways:

¹ 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.

- The HHS Secretary should use her discretion to include provisions that would allow patients with disabilities and chronic conditions to have better access to specialty care without prior authorization from a primary care “gatekeeper.” This is a critical protection in health plans that use a network of providers that are only accessible through a primary care case manager. For many people with disabilities and chronic conditions who know their condition well and are active participants in managing their condition, direct access to a specialist is efficient, less costly to the plan, and leads to better, more timely care. It is for these reasons that CCD believes the HHS Secretary should permit enrollees with disabilities and chronic conditions to select a willing specialist to serve as a case manager or primary care “gatekeeper” in plans that employ this delivery model.
- 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:

CCD Health Task Force Members: