

**Response to Request for Comments Regarding Sections 2704, 2711, 2712 and 2719A of the Public Health Service Act
Prior to Rule-making**

Submitted to the Department of Health and Human Services, Department of Treasury, and Department of Labor

Submitted by a FL-based Health Plan

Through the Federal eRulemaking Portal

Brief Background on Submitting Health Plan

The health plan making this submission is a FL-based Health Maintenance Organization with over 40,000 covered lives. Its large group and individual products are impacted by the health reform act changes. The preponderance of its covered lives is individual policyholders. Many of the benefit designs of the insurer are individual products with very low monthly premiums to attract individuals with very limited means who would otherwise be uninsured as they exceed Federal Poverty Income Thresholds for government programs. For example our comprehensive HMO coverage for children product is set as \$75 per month per child. Our other individual comprehensive HMO coverage begins at \$90 per month per individual.

Section 2704

The comments on the interim regulations indicate that PPACA Section 2704 goes beyond HIPAA in that it not only bans an exclusion of coverage of specific benefits associated with a preexisting condition in the case of an enrollee, but a complete exclusion from such plan or coverage, if that exclusion is based on a preexisting condition. We are unsure what this means. Since guaranteed issue is part of another section of PPACA and not effective until 2014, we do not believe the intent of the act was to impact the underwriting process for individual policies at this time. Depending on the interpretation of the regulation, this well could impact the underwriting processes for insurers offering individual policies. Will the departments be issuing additional guidance on what constitutes exclusion from a plan based on a preexisting condition under PPACA and how that is or is not different from guaranteed issue? Implementing the regulation as is if were a guaranteed issue for children under age 19 will have major repercussions in the marketplace through 2014 and could lead to some insurers declining to participate in issuing coverage for this age group. Further, since grandfathered individual health plans are exempt from the provision, is it the case that neither the ban on denying coverage due solely to a preexisting condition nor establishing a preexisting condition exclusion applies. We ask because new dependents may join a grandfathered individual plan.

The interim final regulations do not change the HIPAA rule that an exclusion of benefits for a condition under a plan or policy is not a preexisting condition exclusion if the exclusion applies regardless of when the condition arose relative to the effective date of coverage. To confirm, if our individual policies exclude pregnancy coverage universally for a certain period of time or entirely, this is allowable as long as we do not exclude enrollment of a female in the plan simply because she is pregnant? Even if this is allowable under Section 2704, will the departments view an exclusion of pregnancy coverage for a period of time as a disallowable waiting period as of 2014 pursuant to Section 2708?

Section 2711

The interim final regulations guidance is clear. We appreciate the departments attempt to address the issue of allowing annual limits for policies beginning after 9/23/10 by having plans employ good faith efforts before regulations for 1302(b) are established. Plans are in the process of amending policies and rates with state insurance regulators for implementation beginning 9/23/10.

We think some consideration should be made to allowing somewhat lower annual limits before 1/1/14. We do support the concept of a phaseout given the underlying law.

We understand that both lifetime and annual limits can be placed on non-essential benefits. We view this as applying to all grandfathered (group and individual) and all non-grandfathered (group and individual) plans. The annual limit on

essential benefits applies to all non-grandfathered plans and group grandfathered plans. Thus, as we see it for non-grandfathered plans and group grandfathered plans you can set an annual limit on essential benefits and then separate annual and lifetime limits on non-essential benefits. We interpret the statute and regulations as to say these non-essential benefit limits can be on various benefit categories and do not have to be overall aggregate limits. However, on grandfathered individual policies, there is some confusion. Grandfathered individual policies can have annual limits within certain parameters per the interim final regulations pertaining to Section 1251. We view this annual limit as being on all benefits (as is customary in most plans). Would the grandfathered individual plan still be free to establish subset lifetime and annual limits on non-essential benefits? Or, would the annual limit then apply only to essential benefits?

With regard to a grandfathered group plan, Section 2711's provision with regard to annual limits is applicable. This would imply that a \$750,000 annual limit is the most a grandfathered group plan could impose as of policies beginning on or after 9/23/10. However, the interim final regulations published with regard to Section 1251 indicate various possible limits for annual limits that would not jeopardize the grandfather status. In some regard, the two interim final regulations would appear to conflict. Isn't it the case, however, that if a grandfather plan could impose a higher than \$750,000 annual limit pursuant to the Section 1251 regulations that it still cannot impose one higher than \$750,000 because Section 2711 in fact applies to grandfathered group plans.

With regard to annual limits for what the departments term as "limited benefit plans" and "mini-med plans," the interim final regulations note that the HHS Secretary may waive the restrictions on annual limits if compliance with the interim final regulations would result in either: (1) a "significant" decrease in access or benefits or (2) a "significant" increase in premiums. The preamble indicates that HHS will be issuing guidance "regarding the scope and process for applying a waiver" in the near future. We feel strongly that annual limits should be waived prior to 1/1/14 for such plans. The products we offer pursuant to a state pilot program offer preventive coverage only for those up to 300% of the federal poverty level. These plans generally have low annual limits (below \$100,000) but provide important health care coverage for people of limited means but above the threshold for government programs. These premiums often are below \$50 per month. While they generally do not include inpatient coverage, they do provide comprehensive access to preventive and other health care services. Significantly increasing such annual limits beyond established limits would increase premiums and likely lead to the erosion of such vital coverage in the marketplace through 2014.

Further, do all the PPACA provisions apply to such plans and similar products? Also, if an insurer offers a state pilot program meant to encourage low-cost insurance alternatives, would this product be subject to the grandfather vs. non-grandfather rules and the various PPACA mandates in general?

In separate comments on Section 1251, we have made suggestions on the treatment of annual limits for grandfather plans.

Section 2712

The interim final regulations guidance is clear. The distinction between cancellation and rescission is critical. Further, the ability to cancel a policy retroactively for non-payment of premiums or cost-sharing is important.

Section 2719A

The interim final regulations provide that, in the case of out of network emergency care, a health plan may not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers. We believe that this proposal may need to be amended for the following reasons:

- Network group and individual products often serve limited geographic areas. In the case of out of network emergency care, we require a member or someone on the member's behalf to contact the health plan when a member can be transferred to a participating provider. In general, this is when the person has been stabilized, is no longer in an emergent situation, and when transfer does not risk significant and unreasonable risk to the

patient. Further, coverage through an out of network provider is not a covered benefit when the emergency has ceased. Thus, notification and the need for a transfer are important and are clearly spelled out in our contracts with groups and individuals. We believe this practice is critical to cost control and should not be deemed an additional administrative requirement because the emergency situation has concluded.

- Because network plans do not have relationships with providers in and outside of a plan's service area, we make it incumbent on the covered person to furnish, at the member's expense if there is one, complete medical and administrative records and itemized bills for out of network emergency care that was undertaken. Again, we do not believe this should be deemed an additional administrative requirement because the emergency situation has concluded and it is the member's responsibility to facilitate payment for such non-network providers. We believe it was not the intent of PPACA to bar this type of requirement on the individual, especially since balance billing is permitted. Indeed, the coordination by the member will help ensure a quick resolution to outstanding claims by the out of network providers and appropriate balance billing, if any.