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Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-1850

Attention: OCIIO-9994-IFC

Comments on CFR 75 27171 submitted electronically at http://www.regulations.gov

Ladies and Gentlemen:

On behalf of the 3.2 million members of the National Education Association, I am pleased to provide comments on the Final Rule and Proposed Rule for Group Health Plans and Health Insurance Issuers Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed Reg. 37188-37241, (June 28, 2010).

NEA has long supported health care reform efforts that would provide access to affordable and comprehensive health care coverage for all Americans while, at the same time, working towards improving the U.S. health care system. NEA greatly values and appreciates the hard work of the Departments of the Treasury, Labor, and, Health and Human Services in drafting and finalizing these and other regulations related to the new health care law.

The following are the NEA's comments on 75 Fed Reg. 37188-37241, Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets:

§ 147.126, No lifetime or annual limits,

1) In-network and out-of-network services. The interim final rule (IFR) does not specify whether the "No lifetime or annual limits" provision applies to both in- and out-of-network services. Given the way health plans function in practice, NEA believes that the "no lifetime or annual limit" provisions should apply to covered health care services provided by both in-network and out-of-network providers.

In many situations, patients need to use out-of-network facilities or providers. Health benefit plans and policies often negotiate favorable reimbursement rates with providers who agree to participate in a network in exchange for, among other things, a guarantee of patients with health insurance and prompt reimbursement of claims. Many physicians and hospitals, however, do not participate in provider networks.

Entire specialty groups are often missing from network panels (e.g., many pediatric specialists, neurosurgeons, and anesthesiologists are often absent from networks). As a result, patients who need certain types of specialty care must sometimes use an out-of-network provider.

In addition, even when a patient receives services from an in-network hospital or outpatient facility, non-network providers often provide some of the care and later bill the patient at the non-network rate. In the case of emergency or urgent care, the patient may not have had the ability at the time of service to determine if a facility or provider was in their network. Furthermore, many in-network primary care physicians have stopped accepting new patients on a short- or long-term basis, forcing the patient to seek care out-of-network. In these situations the patient is usually left with exorbitant out-of-pocket costs. Patients should not be financially penalized even further with lifetime or annual limits.

2) Benefit-specific lifetime limits. The IFR does not specify if it would be permissible for plans/policies to establish benefit-specific lifetime limits. NEA believes that lifetime benefit-specific limits for essential benefits should be prohibited for all health plans and policies.

Many plans limit the number of inpatient hospital days allowed or the number of certain outpatient treatments available over the course of an enrollee's lifetime. Lifetime treatment limits fail to address the particular health needs of patients for whom such a limit could be devastating or, worse, fatal (e.g., a one organ transplant lifetime limit). Further, a benefit plan could, in theory, completely undermine the goals of the health care reform law by replacing an overall lifetime limit with a series of benefit-specific lifetime limits. Benefit-specific limits would also discriminate against the sick, causing irreparable damage to the sickest of patients and undermining the purpose of this reform provision.

3) One overall annual limit. The IFR does not specify if a plan/policy would be permitted to establish only one overall annual limit during the restricted annual limit period or if a plan/policy could establish separate limits on a benefit-specific basis that would then add up to the total allowed restricted annual limit. Many plans/policies have already indicated that they plan to establish limits on a benefit-specific basis, during this time period, for high-cost benefits.

NEA believes that plans/policies should include at most one overall annual limit and not be permitted to break out the limit on a per-benefit basis during the restricted annual limit period. We believe that this practice penalizes patients who need certain essential services, discriminates against the sickest patients, and undermines the purpose of this reform provision.

4) Waiver from annual limits. The IFR indicates that group health plans/policies may receive a waiver from the restricted annual limits prior to 2014 if compliance would result in a significant decrease in access to benefits under the plan/policy or would significantly increase premiums for the plan or health insurance coverage.

NEA requests the establishment of parameters that will be utilized to measure what a "significant" decrease in access and/or increase in premium would be for purposes of receiving a waiver so that consumers and plan stakeholders can review and provide comments.

§ 147.38 Patient Protections.

5) Coverage of emergency services. The law requires that plans/policies cover emergency services without prior authorization and regardless of whether they are provided in- or out-of-network. The IFR refers to "benefits with respect to services in an emergency department of a hospital." Please clarify whether the rule also applies to emergency care provided at urgent care centers, in an air, land or water ambulance, and other settings.

NEA believes that the prior authorization for emergency services should apply to settings and providers other than just the "emergency department of a hospital." For example, other approved emergency settings, modes of emergency response, and emergency transportation should also be included. People living in many parts of the United States do not live near a hospital. Also, people in remote areas of the country in need of emergency care must depend on whatever emergency response team is available, whether or not services are provided in a hospital setting.

Thank you again for all the hard work and for clarifying the issues that have come up for NEA members and their health plans. We anxiously await your responses to these comments.

Yours truly,

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