



Florida CHAIN

COMMUNITY HEALTH ACTION INFORMATION NETWORK

August 27, 2010

Mr. Jay Angoff
Director, Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9994-IFC
Mail Stop C4-26-05, 7500 Security Boulevard
Baltimore, MD 21244-1850.

RE: Comments on proposed final regulations pertaining to patient protections and insurer requirements under the Patient Protection and Affordable Care Act, File Code OCIIO-9994-IFC

Dear Mr. Angoff:

I am writing today on behalf of Florida CHAIN to submit comments on interim final temporary regulations implementing provisions of the Patient Protection and Affordable Care Act (PPACA). These provisions impose new requirements on certain health plans and insurers related to preexisting condition exclusions, lifetime and annual dollar limits on benefits, rescissions, and other patient protections.

Florida CHAIN is a statewide network working with and on behalf of uninsured and underinsured Floridians to ensure the continuous availability of quality, affordable health coverage. These rules constitute an important step towards realizing that goal through reforms in the private insurance market.

First, we strongly support the comments and echo the concerns submitted by Community Catalyst and Families USA.

Beyond this, **our most pressing concern pertains to the manner in which the regulations implement the prohibition on the imposition of annual limits for certain essential benefits**, pursuant to Section 2711 of the Public Health Service Act, as amended by the PPACA.

Specifically, 26 CFR 54.9815–2711(d)(3)T anticipates the **establishment of a temporary process by which HHS could waive the requirement on a case-by-case basis**, when compliance would result in “a significant decrease in access to benefits or a significant increase in premiums.” We are extremely concerned that such criteria, at least as stated without amplification in the regulations, are both hopelessly vague and seemingly contrary to the intent of the provisions of the PPACA that they are intended to operationalize.

While the premise underlying the provision of an opportunity for so-called “mini-meds” to obtain waivers from the requirement sounds reasonable at first blush, we fear that such exceptions would quickly swallow and utterly thwart the rule. **We strongly recommend against normalizing the use of any such waiver process.**

We further urge you to incorporate all of the following features into in any waiver application process you ultimately establish, preferably in the regulation itself, but at a minimum as part of any forthcoming guidance:



1. An assurance of transparency in the waiver evaluation process, including publicly posting the insurer's waiver application and allowing an opportunity for public comment. Such measures are justified because information received from the public might assist HHS with its evaluation, and because minimization of the number of unnecessary waivers from the new protections is a compelling public interest.
2. An operational definition of the term “significant” as applied to the evaluation of premium increases and benefit reductions that would purportedly result from compliance with the law. In particular, the definition should include absolute as well as relative components (e.g., a 50% reduction in a particular benefit cap amount should not be considered significant if the original cap amount was only the smallest fraction of what is available in full-benefit packages. **Any assertion that a plan should be exempted from a directive to significantly improve its coverage, simply because that coverage is so inadequate as to defy improvement without significant premium increases, is nonsensical.** Waivers should be used sparingly, and then only to protect patients, not insurers.
3. A requirement that insurers provide independent actuarial verification of their claims of significant premium increases and benefit reductions, and assurances that such changes are not the result of evasion or gaming the process.
4. Express clarification that only plans already in existence can qualify for a waiver. New plans cannot claim that the rules would result in any increase in premiums or reduction in benefits, because no policyholders are affected.

As a final note, we request that HHS also take steps to prevent gaming of the process by which plans may reach the minimum allowable aggregate annual limit on the value of essential benefits (26 CFR 54.9815–2711(d)(2)T). For example, insurers should not be permitted to increase benefits to meet the minimum thresholds while simultaneously blocking utilization to those benefits through extreme cost-sharing requirements.

Thank you for the opportunity to provide these comments pertaining to these important rules and the protections they will provide to millions of Floridians.

Sincerely,
Greg Mellowe
Policy Director