April 15, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Hilda Solis
Secretary
U.S. Department of Labor
200 Constitution Ave., N.W.
Washington, D.C. 20210

The Honorable Timothy Geithner
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

Re: Implementation of immediate insurance market reforms pursuant to the Patient Protection and Affordable Care Act of 2009 (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA)

Dear Secretaries Sebelius, Solis, and Geithner:

As organizations representing millions of patients, consumers and workers, we have engaged over the past 18 months in an unprecedented cooperative effort to enact meaningful health insurance reform to ensure that all Americans have access to affordable, meaningful coverage. We applaud this Administration for its historic achievement of enacting the Patient Protection and Affordable Care Act of 2009 (PPACA, as amended by the Health Care and Education Reconciliation Act of 2010), and stand ready to assist you in all possible ways to ensure the successful implementation of the new law.

To that end, we are writing to provide to you our recommendations to ensure that the regulations and/or other agency guidance issued to implement the "immediate" insurance market reform provisions of the PPACA will effectively protect consumers as intended under the legislation. We believe it is critical that the implementation of this new law be guided first and foremost by the needs of patients and consumers.

As you develop the rules and guidance necessary to make reform a reality, there are many areas that will demand particular vigilance to ensure that the new law lives up to its full promise to consumers. Below we provide specific suggestions to help ensure that the regulations and guidance from your respective agencies are as strong as possible.

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Enforcement

We recognize that the states have played a critical role in enforcing consumer protections in the insurance industry for many years. This law represents a new partnership between the federal government and state insurance regulators in coordinating activities to avoid duplication and assure that taxpayer dollars are used in the most efficient and cost effective manner, so that all Americans can access affordable, meaningful care.

To meet the full potential of the recently enacted insurance reforms for consumers and patients, there needs to be a robust enforcement mechanism. The PPACA provides federal authority to enforce the new rules for both nongroup and group coverage.[1] While these provisions defer to the states for enforcement of the law, in the absence of state capacity to enforce the immediate reforms, the federal government must step forward to make sure the requirements of the law are being met. The Departments of Labor and Treasury also have the legal authority to enforce the law against ERISA plans. The agencies, however, currently lack the capacity to enforce the reforms nationally, and it is critical that you make developing this capacity a priority.

Recommendation: We encourage you to revise the HIPAA enforcement regulation so that the federal government can verify effective enforcement of federal market standards by states and compliance by issuers. The federal government also must work closely with the states to develop monitoring and enforcement mechanisms to verify effective implementation of the federal market standards by states and compliance by issuers. These monitoring and reporting mechanisms must allow states to quickly address compliance issues with insurers or the federal government to help states that need assistance to quickly and effectively intervene to guarantee compliance with market rules that protect consumers.

[1] Patient Protection and Affordable Care Act of 2009 (PPACA) § 1321(c)(2), renumbering current Public Health Service Act (PHSA) § 2722 as §2736.

State insurance departments have regulations governing market conduct examinations of insurers and frequently work collaboratively to address compliance issues or business practices that involve more than one state. We hope the federal government will build on this regulatory practice and use it to monitor state enforcement of federal minimum standards and again assist states that need to expand their infrastructure to meet the requirements of the new law. Tracking compliance with the federal standards as well as state laws and regulations through market conduct examinations will allow both federal agencies and state insurance regulators to send a clear signal that they will intervene quickly if necessary to ensure adequate enforcement.

Finally, we urge you to move quickly to add the enforcement staff you need to meet the challenges before you.

Non-discrimination

The new law creates a ban on discrimination in health care.[2] Except as otherwise stated in the law, health care entities that receive federal financial assistance, including contracts of insurance, cannot discriminate on the basis of race, national origin, disability, age, or sex. Enforcement is linked to the enforcement proscribed in and available under other existing civil rights laws. This provision took effect immediately upon enactment.

Recommendation: Working with other relevant agencies, the Secretary should promptly issue regulations that delineate the types of discrimination prohibited by this law and procedures for enforcement.

Rate Review

The new law provides that the Secretary of HHS, "in conjunction with the states" shall establish a process for annual review of "unreasonable" rate increases, effective with the 2010 plan year.[3] In implementing this provision, it is critical that federal and state regulators and the public have access to robust, specific and actionable information regarding the reasons for premium rate increases. Unfortunately, under the status quo, some insurance companies often successfully claim that much of the necessary data are proprietary.

Recommendation:

- States should require insurers to disclose justifications for all rate increases (not just those deemed "unreasonable"), and justifications should include a plain-language memorandum that describes how many people are impacted, the specific reasons for the rate increase (as they pertain to each category: medical claims, administrative costs, and profit/risk contribution), and describe all methods and factors used to determine the increase. Also, the memorandum must disclose the medical loss ratio and anticipated loss ratio for the rate increase period, and the rate increase history for the past 5-10 years and insurer profitability for the past 5-10 years.

[2] Ibid., § 1557.
[3] Patient Protection and Affordable Care Act of 2009 (PPACA), Sec. 1003, adding new Sec. 2794 to Public Health Service Act (PHSA).

- Any regulation or guidance on the rate review process should require health plan issuers to provide detailed data and justification for their rates, including contracted provider rates. The responsible agency should also have the authority to audit the data on both a prospective and retrospective basis. Further, all data and the justification for rate increases should be made available to the public in an accessible format.
- The definition of "unreasonable" should not solely be a matter of actuarial justification. Issues such as claims experience, contracted rates with providers, insurer solvency and affordability for consumers and employers should be factored into the definition. Specifically, regulators should consider the company's surplus level, historical (5-10 year) profitability of the specific line of business, as well as the historical profitability of the company as a whole, historical rate increases, and the amounts of dividends paid to shareholders or parent companies within the year since the last rate increase. Related to affordability, the regulators must consider whether the insurer has taken measures to control costs and the strength of those efforts, as well as whether the insurer has properly accounted for future savings from such efforts.
- Grants to states to assist in rate review should be linked to a clear set of standards for rate review. States should be required to show that the funds will be used to expand capacity for rate filing, review and audits, hiring or contracting with an actuary, and engage the public through hearings and other accessible forums on both the reasons for rate increases and any efforts to contain them. If a state declines the opportunity to implement this provision, or does so inadequately, HHS must step in and do so itself. HHS must immediately develop the capacity to do this if necessary.

Consumer Information

The new law provides grants to states to establish, expand or support offices of health insurance consumer assistance or health insurance ombudsman programs.[4] While it is critical that these new offices/ombudsmen are independent from the state insurance department, as required by the law, in order for them to be most helpful to consumers, there must be requirements for active, ongoing coordination between these agencies and both the federal government and state insurance regulators. We urge you also to consider as potential resources for consumer assistance, community-based consumer organizations that can be trusted and local sources of information on health care.. These groups will not only play a critical role in providing support to individuals through their consumer assistance programs, but they will be instrumental in ensuring that health reform in general is successfully implemented in their own states. Both ombudsmen and non-profit consumer groups can also serve a critical sentinel function by identifying problems as they arise and helping to resolve issues to make the insurance market reforms more responsive to consumer needs.

Recommendations: Grants to the states must be conditioned on meeting specified standards and the federal government should create a standardized reporting format and common definitions of terms (such as what constitutes a complaint) so that federal officials, states, and consumer advocates can effectively assess trends and respond to issues across states and regions. To best help consumers, these offices must:

[4] Ibid., §1001, PHSA § 2793.

- Have access to relevant data collected at other state agencies (e.g., complaints lodged with state attorneys general or the insurance department).
- Be empowered to direct people to coverage, take and respond to complaints, and advocate with regulators, health plan internal appeals panels, and external reviewers on consumers' behalf.
- Track and analyze complaints by health status, race, ethnicity, language and gender in order to identify any problems that particular populations are facing, and report the information to the public (brand new programs may need a short period of time to get their data analysis systems in place).
- Provide to the federal government the information necessary to help guide the necessary standards and rules for the reforms scheduled to take effect in 2014.
- Report to the federal government on how they are spending the grant dollars.

Health plans should also be required to provide, in all consumer materials, contact information for the office the consumer should call if he or she has any problems.

We encourage you to look at programs such as Connecticut's Office of the Healthcare Advocate and the consumer assistance programs run by Health Care for All in Massachusetts (the HelpLine) and the Community Service Society of New York as proven models of providing consumers with assistance on health insurance issues.

Grandfathered Plans

The PPACA exempts individual and group health insurance coverage in effect on or before the law's date of enactment from many of the new insurance market reforms, and allows for unlimited renewal of that coverage.[5] Allowing some plans but not others to avoid the consumer protections provided under the new law could create significant confusion and risks for consumers. State and federal regulators will need to set strong standards for what plans can remain grandfathered, and be vigilant in guarding against plans that use the differences in the rules to "game" the system.

Recommendations: To ensure that the maximum number of consumers will benefit from the law's new protections, the federal rules on grandfathered coverage should, to the extent consistent with PPACA:

- Require the Department of Labor (DoL) to establish a registry to track all ERISA employers offering grandfathered coverage, and the state insurance regulators to maintain a list of fully insured plans that are currently grandfathered or subject to the new protections, so that enrollees have easy access to information on the status of their plan. The certificates of creditable coverage that insurers already are required to issue to consumers would provide the information necessary for such tracking if also furnished to federal and state regulators.

[5] Ibid., §§ 1251, 10103(d); Health Care and Education Reconciliation Act of 2010 (HCERA), § 2301). Coverage is defined further in § 2791 of the PHSA to mean benefits "under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance contract offered by a health insurance issuer."

- Require employers to tell their employees if their health coverage is grandfathered, or subject to the new protections.
- Set clear criteria for when coverage is modified to be considered a "new" plan and thus subject to the full range of market reforms. Under the PHSA definition, for example, a change in a policy, contract, or certificate (other than simple renewal or adding family members or employees) terminates grandfathered status. An increase in member cost-sharing, for example, should end grandfathering.

Temporary Reinsurance for Early Retirees

The bill appropriates $5 billion for the establishment of a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare.[6] It is crucial that consumers and retirees see tangible benefits from this significant investment of taxpayer dollars. To help ensure this, the federal government needs to clearly define "actual cost" of the claim being reimbursed and collect data on costs, claims submissions and payments, and should require plans to provide the Department of Labor and the Internal Revenue Service (IRS) with documentation and certification to show that the funds are used to lower plan costs. The federal government should issue a public report on the use of these funds.

Cost-sharing for Out-of-network Emergency Room Visits

The new law requires equivalent cost-sharing for network and non-network emergency department providers.[7]

Recommendations: The rule should ensure that no higher deductible, copayments or coinsurance applies if people receive out-of-network emergency services. We recognize that health plans cannot require emergency room providers to enter into contracts with them, but we encourage the Secretary, states, and plans to determine reasonable payment arrangements and dispute resolution systems for plans and providers to use in these situations to better protect consumers from balance billing for emergency services. Currently, balance billing occurs when non-network providers' charges are significantly higher than the negotiated rate with a network provider, and the consumer's cost-sharing may still be different even if the health plan pays the same percentage of the cost. For example, 80% of a network provider's allowable charge will be lower than 80% of the non-participating provider's charge. In many states, providers are permitted to bill the patient for this difference. However, some states either require the plan to pay a particular rate in those circumstances, or require an arbitration process that holds the consumer harmless. If balance billing is allowable under the new law, at a minimum the rule should require clear information to consumers about the cost implications of receiving out-of-network emergency services.

Careful attention needs to be taken in defining all out-of-pocket costs, coinsurance, co-payments, deductibles, and balanced billing so that the cost implications are transparent to consumers.

[6] Ibid., § 1101.
[7] Ibid., § 10101(h), PHSA § 2719A).

Appeals Processes

The bill requires a mechanism for internal appeals and external review of plan decisions.[8] These appeals provide critical due process for consumers. Under current ERISA law and many state laws, consumers have rights of appeal, but the existing standards often lead to a lengthy and discouraging process, a particular challenge for patients who are battling a serious illness or condition while also trying to obtain the coverage they need and deserve. ERISA rules, the current National Association of Insurance Commissioners (NAIC) model, and many state laws require that multiple levels of internal review be exhausted before a consumer can access an independent external review process, a process that can take many months. Further, ERISA allows for extra "voluntary appeals," which can be confusing for consumers.

The PPACA is also silent on critical questions regarding whether state and federal remedies would be preserved, whether the requirements are privately enforceable, and whether any discretionary clause would be binding on the reviewer. Any regulation promulgated to implement these provisions must address these issues.

Recommendations: The rule must ensure that:

- No more than one level of internal review is required before the consumer can access an independent external review.
- The entire review process, from initial denial to external review resolution, takes place in a timely fashion, i.e., no more than two months for non-urgent claims, one week for urgent claims.
- The consumer can access external review based on any denial for any reason, including disputes over eligibility, pre-existing condition exclusions and improper filing of claims, not just medical necessity denials.
- An appropriate decision-maker is involved for the issues at hand. For some types of appeals, such as rescissions, an evidentiary hearing with a judge is more appropriate than a review by a panel of medical experts.
- Existing federal and state judicial remedies are preserved, and that contracts must comply with existing federal and state law.
- Consumer assistance offices or ombudsman programs are required to assist consumers throughout the appeals process.
- Any external review is *de novo*.

Pre-existing Condition Exclusions

The new law bans any pre-existing condition exclusions for children under 19.[9] In implementing this provision, it is critical to ensure that parents don't face unaffordable rate increases, or other inappropriate restrictions in order to get their children covered.

[8] Ibid., §§ 1001, 10101(g), PHSA § 2719.
[9] Ibid., § 10103(e), PHSA § 2704.

Recommendations: The rule must ensure that:

- Consistent with Congressional intent, pre-existing condition exclusions should be defined to include all the forms of discrimination that a child may face because of their condition, including denial of coverage, the exclusion of their specific condition from coverage, and excessive waiting periods.
- Annual rate submissions should include documentation about rate increases (if any) that are applied to policies that cover children subject to the new protections.
- Rate filings and market conduct examinations should include standardized reporting about changes in underwriting actions and policies, and the number of children under 19 that were added to the subscriber's coverage as a result of the new law.

Extension of Dependent Coverage

The new law requires plans to allow parents to keep dependents up to age 26 on their policy.[10] This policy is critical to helping young adults access affordable, meaningful coverage at a time when they are just launching their careers and do not receive an offer of employer-sponsored coverage. However, if not implemented well, many families could face insurmountable barriers to accessing the coverage they need.

Recommendations: The rule implementing these provisions must:

- Define an adult dependent as a biological, adopted, or step child who otherwise does not have access to a group insurance plan. The definition should not be tied to the IRS meaning of the term (i.e., the presence or absence of parental income support should not be a factor).
- Specify that more protective state laws are not preempted. For example, in New Jersey, adult dependents up to age 30 can remain on their parents' policy.
- Allow for this new option to be considered a "qualifying enrollment" event so that adult dependents that have graduated or otherwise lost family coverage can quickly get back on their parents' plan. This special enrollment period should be a minimum of 90 days to allow for public education and give families sufficient time to understand their options and make educated decisions.
- Require that employers and insurers give families adequate and timely notice of this new option.
- Allow for maintenance of COBRA rights, so that when the adult dependent ages out of dependent coverage, COBRA continues to be an option.
- Bar any re-underwriting in the individual market.
- Bar any imposition of pre-existing condition exclusions or waiting periods if there has been a gap in coverage.
- Require insurers to document and report on the young adults they cover on their parents' policies and whether consumer notices were sent as required.

[10] Ibid., § 1001, PHSA § 2714; HCERA §§ 1004(d)(3)(b), 2301(a)-(b)).

- Allow young adults enrolled in student health plans that drop them from coverage during periods they are not in school (i.e., during the summer) to rejoin their parents' plan during those periods.

Rescissions

The law places restrictions on plans' ability to rescind coverage for enrollees.[11] This provision is critical to ensuring that consumers can trust that the coverage they have purchased will be there when they get sick, but strong regulatory language is essential to ensure that there are no loopholes that will result in consumers continuing to lose the coverage they need and have paid for. For example, policies could be cancelled going forward without rescinding them as of the effective date.

Recommendation: The rule should:

- Require insurers to report to state regulators when a post-claims investigation of eligibility is initiated, what triggered it, and the disposition of the investigation.
- Require third-party external review before a rescission can occur for groups or individuals.
- Require claims to be paid while a case is being reviewed.
- Clearly define the fraud standard and apply it equally to any misrepresentations allegedly made in the context of employer wellness programs.
- Include model advance notices. These notices should explain consumers' rights to challenge rescissions that they believe are wrong.

Medical Loss Ratios

The new law requires health plans to report on the proportion of premium dollars spent on clinical services, quality and other costs, and provide rebates to consumers if the amount of the premium spent on clinical services and activities that improve health care quality is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets.[12] In order to honor both the spirit and the letter of the law, it is absolutely essential to establish clear definitions and uniform standards for determining medical lost ratios.

Recommendations: The rule should:

- Provide clear and consistent definitions and a methodology to be used by insurers that will allow unambiguous and transparent allocation of expenses to the categories recognized by the rule. In particular "activities that improve health quality" must be clearly defined so as to exclude general administrative expenses, like claims processing.
- Provide for prospective and retrospective audits of health plans to verify that the standard definitions and methodology were used and assure that expenses are being reported accurately.

[11] Ibid., §§ 1001, 10101(f), PHSA § 2718.
[12] Ibid., §§ 1001, 10101(f), PHSA § 2718.

- Outline the procedures for insurers to provide rebates to consumers and state oversight to define the forms those rebates can take, and ensure that rebates are provided in the appropriate amounts and that they are furnished on a timely basis.

In implementing this policy, HHS should take care not to create unintended disincentives for insurers to reduce their investment in evidence-based preventive services, disease management, case management, and quality improvement programs that may currently be considered administrative or medical costs, depending on the legal structure of the health plan and the product.

No Lifetime Limits and Restricted Annual Limits

The new law bans global lifetime limits or lifetime limits on "essential benefits"[13] and restricts annual limits on essential benefits.[14] These are critical consumer protections, but over time will need to be refined to reflect the items and services in the minimum essential benefit package, which will be defined by the Secretary of HHS.

Recommendations: All health plans should be prohibited from any lifetime limits. And issuers should be prohibited from offering a "new plan" that has annual limits that are less generous than any of its existing grandfathered plans. The rule should also require insurers to clearly disclose any approved annual limits to consumers at the start of each plan year, and provide consumers advance notice when they are close to reaching the defined annual limit.

Transparency/Disclosure

The new law imposes significant new reporting and transparency requirements on most health plans, with even greater requirements imposed on Exchange-participating health plans, such as reporting on claims payment policies, enrollment, disenrollment, and number of claims denied.[15] Transparency in health insurance will make it easier for consumers to understand coverage and for regulators to detect when coverage is not working as it should.

Recommendation: The rules for disclosure must:

- Ensure that disclosures are understandable and actionable for consumers.
- Allow consumers to get a complete picture of their estimated total annual costs.
- Ensure that all information provided to consumers is easily accessible and understandable to consumers at all levels of health literacy, as well as those with limited English proficiency. We recommend that consumer and patient advocacy groups consult in the establishment of standard disclosure formats and the website to help Americans identify health coverage options.[16] These standards should also go through focus group testing, with the testing results publicly reported.

[13] Ibid., §§ 1001, 10101(a), PHSA § 2711; HCERA § 2301(a).
[14] Ibid., §§ 1001, 10101(a), PHSA § 2711.
[15] Ibid., § 10101(c), PHSA § 2715A.
[16] Ibid., § 1103.

Preventive Coverage

The new law requires health plans to cover certain preventive items and services without any cost-sharing imposed on the enrollee.[17] HHS will need to translate this requirement into coverage specifications that ensure patients have the access they need to appropriate, evidence-based preventive items and services, and to understand what benefits they will and will not have to pay for.

Recommendations: The rule should include:

- The regulation should make it clear that the United States Preventive Services Task Force (USPSTF), Health Resource and Services Administration (HRSA) and Advisory Committee on Immunization Practices (ACIP) guidelines are a floor, not a ceiling, for preventive services. Plans should be encouraged to consider more expansive guidelines as the basis for coverage.
- A mechanism to ensure that the decision and justification for what constitutes a covered preventive service is in a central location accessible to the general public. This mechanism should provide details needed by consumers, such as how frequently a service can be obtained and still be free of charge (i.e., once a year or once every three years). Limitations on free preventive coverage based on patient characteristics (such as minimum age) should also be clear to consumers.

Small Business Tax Credits

The new law provides tax credits for eligible small employers to assist them with providing health coverage to their employees.[18] Prior to 2014, the maximum tax credit is based on the average premium in a rating area's small group market as determined by the Secretary of HHS. However, in states that have not yet banned age or gender rating in their small group market, the average premium – and thus the tax credit – will not be as helpful to small employers with workforces that are older, and/or predominantly female. To avoid a similar issue for such employers under the high-cost plan excise tax, the law allows an adjustment based on workforce composition for those affected employers.[19]

Recommendations: To ensure that the calculation of the small business tax credit is done equitably, regulations should allow for an adjustment to the average small group premium for employers located in states that have not yet banned gender and/or age rating in their small group markets, and that have workforces that are older and/or have a higher percentage of female employees. This could be modeled on the adjustment provided for in the high-cost excise tax.

Self-Insured Plans

Finally, an overarching issue that must be addressed to ensure the sustainability of the consumer protections in PPACA is the definition of "self-insured" plan. The PPACA distinguishes between

[17] Ibid., § 1001, PHSA § 2713.
[18] Internal Revenue Code (IRC), § 45R (as added by PPACA § 1421).
[19] HCERA § 1401(a)(2)(C), amending § 4980I of the IRC.

self-insured and insured plans but nowhere defines “self-insured.” Court rulings on this issue have been confusing and permissive. As a result, some insurers are currently marketing "self-insured" plans to employers with as few as 10 employees, along with significant stop-loss coverage.

We believe a federal definition of “self-insured” plans will be needed by 2014. As you know, self-insured plans need not cover the essential benefits that non group and small group plans must cover. And the PPACA allows "self-insured" plans in effect on or before enactment to claim indefinite grandfathered status, even when the insurers that administer them and provide them with stop-loss coverage change. This could create an unlevel playing field that will undermine the success of federal health insurance reform.

At a minimum, we recommend:

- Any federal definition needs to limit self-insured plans to those where the plan itself bears substantial risk.
- All self-insured plans need to be clearly labeled as such in all consumer materials.
- Policies need to discourage employers from shifting from the self-insured to fully insured market and back again, depending on where they can get a better “deal.”

We thank you for your continued leadership and commitment to meaningful health insurance reform, and we are grateful for your efforts to ensure the new law is implemented so that consumers accrue real and sustainable benefits. We stand ready to assist you to ensure that we meet our shared goal of comprehensive, affordable health coverage for all Americans. If you have any questions, please contact Sabrina Corlette at (202) 986-2600 or scorlette@nationalpartnership.org.

Sincerely,

Organizations
American Cancer Society Cancer Action Network
American Diabetes Association
American Federation of State, County and Municipal Employees (AFSCME)
American Heart Association
Community Catalyst
Consumers Union
Families USA
National Partnership for Women & Families
National Women’s Health Network
National Women’s Law Center
Progressive States Network
Raising Women’s Voices for the Health Care We Need
SEIU
Young Invincibles

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