REG-120399-10

LEGAL PROCESSING DIVISION
PUBLICATION & REGULATIONS
BRANCH

SEP 1 2010

PUBLIC SUBMISSION

As of: September 01, 2010
Received: August 27, 2010
Status: Posted
Posted: September 01, 2010
Tracking No. 80b3d464
Comments Due: August 27, 2010
Submission Type: Web

Docket: IRS-2010-0015
Requirements for Group Health Plans and Health Insurance Issuers under the Patient Protection and Affordable Care Act

Comment On: IRS-2010-0015-0002
Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and PatientProtections

Document: IRS-2010-0015-0024
Comment on FR Doc # 2010-15278

Submitter Information

Name: Anthony Barrueta
Address:
Oakland, CA,
Organization: Kaiser Permanente

General Comment

Re: Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to PreExisitng Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections Under the Patient Protection and Affordable Care Act

Attachments

IRS-2010-0015-0024.1: Comment on FR Doc # 2010-15278

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Kaiser Foundation Health Plan, Inc.

August 27, 2010

Submitted Electronically: *http://www.regulations.gov*

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-4150-IFC
Baltimore Maryland 21244-1850

Re: *Interim Final Rule for Group Health Plans and Health Insurance Coverage Relating to PreExisitng Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections Under the Patient Protection and Affordable Care Act*

Dear Sir or Madam:

Kaiser Permanente offers the following comments in response to the above-captioned Interim Final Rule ("IFR"), issued in the *Federal Register* on June 28th. Kaiser Permanente is the largest private integrated healthcare delivery system in the U.S., delivering health care to approximately 8.7 million members in nine states and the District of Columbia. Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals which operates 36 hospitals and over 400 other clinical facilities; and the Permanente Medical Groups, independent physician group practices that contract with Kaiser Foundation Health Plan to meet the health needs of Kaiser Permanente's members. Most pharmacy, diagnostic, and laboratory services delivered to Kaiser Permanente members are performed within Kaiser Permanente.

Kaiser Permanente believes the Patient Protection and Affordable Care Act (PPACA) has the potential to represent an important step towards achieving universal coverage in the United States and towards establishing reasonable market rules that will allow plans to compete on quality and cost rather than on risk avoidance. It is in this context that we offer comments on the aforementioned rule.

PreExisting Condition Exclusions

Guaranteed Issue in the Absence of a Mandate

The IFR issued on June 28th clarifies that under the new PHS section 2704, the prohibition of preexisting condition exclusions for children under 19 "prohibits not just an exclusion of coverage of specific benefits associated with the preexisting condition, but a complete exclusion from such plan or coverage, if that exclusion is based on a preexisting condition." With this interpretation, carriers are required to issue coverage on a guaranteed issue basis to all children under 19, irrespective of any preexisting condition. (p. 37190) While Kaiser

Legal and Government Relations
One Kaiser Plaza, 27th Floor
Oakland, CA 94612

Permanente has long supported universal access to care, a guaranteed issue requirement on health insurers should be accompanied by an individual mandate to purchase coverage with subsidies for those in need. In the absence of such a mandate, individuals have a financial incentive to remain uninsured when they are healthy, and buy coverage only when they are sick. As a result, individual health coverage in a guarantee issue market is less "insurance" than pay-as-you go health care on demand. Guaranteed issue without an individual mandate will raise costs for all individuals. We are very concerned that the impact of this provision will increase costs substantially for all children and severely undermine the stability of this market. We suggest steps below to partially mitigate these problems, but emphasize the difficulty of retaining a broadly accessible and affordable market under these conditions. The most effective way to retain a strong, stable and affordable individual market when insurers are required to accept all children is to require all to purchase and maintain coverage through an enforceable individual mandate.

Uniform Open Enrollment Period

Given the new guaranteed issue requirements, there is a very real possibility that children without access to employer-sponsored or other subsidized coverage will only purchase coverage when they are sick and drop coverage once they receive the services they need. Given these market rules and expected consumer behavior, there is also a strong incentive for insurers to exit the individual market for children altogether or to avoid enrolling high risk children by charging premiums substantially higher than other possible options.

On July 28th, HHS released a Q & A allowing carriers in the individual market to restrict enrollment of children under 19, whether in family or child only coverage, to specific open enrollment periods if otherwise allowed under State law to "address concerns over adverse selection". While we agree that a properly structured open enrollment period will partially mitigate adverse selection concerns, we believe it would only be effective if all carriers follow the enrollment rules. However, the HHS Q & A is not so specific as prevent each carrier from separately determining the number, time and length of open enrollment periods for children under 19, families and adults. Kaiser Permanente is concerned that allowing each carrier to establish its own open enrollment period will result in substantial disruption of the individual market and broad confusion among consumers as to when and from whom they can purchase coverage. In addition, if at any time one carrier is the only "open" carrier, that carrier is in effect the only option for children with immediate health care needs. Permitting each carrier to set its own open enrollment period provides an incentive to be open late and a disincentive to be open early. For example, carriers which schedule shorter or later enrollment periods could expect that most high risk children would enroll with their competitors.

For these reasons, we strongly recommend HHS establish a uniform annual open enrollment period accompanied by reasonable rating rules and a penalty for individuals who wait to purchase coverage or drop in and out of the market depending on need.

Specifically we recommend the following:

- All carriers follow an initial open enrollment period from October 1, 2010 through November 30th 2010, with an effective date of coverage January 1, 2011.
- Subsequent open enrollment periods would occur once a year, on the child's birth month.
- Carriers may apply a risk-based rating factor of no more than 2 times the rate charged for a child of the same age of a standard health risk.
- Children may enroll throughout the year following a qualifying event, provided the child submits an application within 30 days.
- Outside of the annual open enrollment periods (based on children's birth month or qualifying event) individuals can apply for coverage at any time. However, applicants of any age are subject to medical underwriting standards, if allowed under state law.
- For those who enroll after the initial open enrollment period, a late enrollment surcharge of 20% of the premium will be levied on applicants who have been uninsured for more than the prior 90 days, unless enrolling through a qualifying event.

Medical Underwriting Outside Open Enrollment
It has been argued that medical underwriting should continue outside the open enrollment periods. Under this structure, children would have year round access to coverage unless they failed medical underwriting and did not enter through a qualifying event. If a child fails medical underwriting their coverage would be effective at the next open enrollment period. This structure would preserve the stability of the current market, retain greater access to affordable coverage for all children and incentivize maintenance of coverage, while allowing high risk children the opportunity to enroll in coverage at a reasonable rate during annual open enrollment periods. We would recommend that HHS clarify that medical underwriting is permissible outside open enrollment periods.

Lifetime and Annual Limits

Definition of Essential Benefits In the Context of Annual and Lifetime Limits
PPACA requires the elimination of lifetime limits and allows restricted annual limits with respect to essential health benefits for plan years beginning before January 1, 2014. The IFR defines "essential health benefits" by cross reference to section 1302 (b) of PPACA. Under this section essential health benefits are defined to "include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management ; and pediatric services, including oral and vision care." The IFR does not provide further specifics regarding the items and services that fall within these categories. Kaiser Permanente assumes that DME and organ transplants would both be considered items and services included in these categories and thus subject to these mandated limits, but seeks clarification of this issue.

Day and visit limits
Section 2711 of the PHS Act and the IFR released June 28th, prohibit group plans and insurance issuers offering group or individual health insurance coverage from imposing lifetime limits and establish a restricted annual limit on the dollar value of health benefits. However, the regulation

is silent on the issue of whether reasonable day and visit limits on specified benefits are permissible as long as they are within the permitted overall annual limit on the dollar value of those benefits. We seek clarification of this issue.

Application of annual and lifetime limits to out-of-network benefits
As stated above, the IFR establishes restricted annual limits on the dollar value of essential health benefits. However, it is unclear whether both the annual and lifetime limits are applicable for in-network benefits only or whether they also extend to out-of-network benefits. In the case of the newly established requirements for preventive services, HHS clarified that the zero cost sharing restrictions pertain to in-network benefits only. We believe HHS should adopt the same rule here. In addition, it would be helpful to clarify that all plans, including plans that differentiate coverage based on provider status (whether in a HMO, PPO or POS plan) must provide at least one tier of coverage in which the restrictions on annual and lifetime limits apply. For example, Kaiser Permanente as an integrated system with a limited geography sometimes offers out of area PPO plans for employers with staff outside of Kaiser's service area. For employees enrolled in the out of area PPO, the restrictions would apply to the contracted preferred providers in the areas, but not to non-preferred providers. In a multi-tier plan in our service area, the restriction on limits would apply to our HMO provider network, but not to a secondary PPO or POS providers. We think this approach best offers patients the benefit of the new rules and promotes affordability of coverage.

Annual internal/sub-limits and Annual cumulative limits
To avoid gaming and excessive application of dollar limits, HHS should clarify that the new regulations on annual and lifetime limits do not permit internal sub-limits that are lower than the overall limit. If HHS intends to permit internal sub-limits, it should provide more specific guidance, and not simply permit plans to establish lower sub-limits with a cumulative limit of $750,000.

Recognizing Good Faith Efforts and Hold Harmless Provisions
Given the clarifications requested above, Kaiser Permanente requests that HHS acknowledge an issuer's good faith efforts to comply with the regulations. We recommend a safe harbor be granted such that issuers would be required to amend plans on a prospective basis only for the following plan year, once further guidance has been issued.

Patient Protections

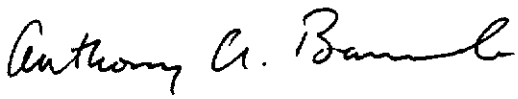
Coverage of Emergency Services

Prohibition against balance billing by providers for emergency services is an important protection for patients. Kaiser Permanente assumes that the new regulation does not seek to preempt existing state laws that limit the ability of providers to balance bill for emergency services. We also interpret the new regulation relating to the amount a group health plan or health insurance issuer must pay to emergency service providers to apply in states regardless of whether the state has prohibited providers from balance billing for emergency medical

services. Such limits prevent providers from charging beyond the usual and customary community rate for emergency medical services and help to support affordable premiums for health benefits coverage.

We appreciate the opportunity to comment on this IFR. If you have questions or concerns, please contact me at 510.271.6385 (email: anthony.barrueta@kp.org).

Sincerely,



Anthony Barrueta
Senior Vice President, Government Relations
Kaiser Permanente