December 26, 2012

Submitted electronically via http://www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9980-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Proposed Rule Regarding Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation (CMS-9980-P)

Dear Sir/Madam:

We write on behalf of the American Benefits Council ("Council") to provide comment regarding the proposed rule entitled "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation," 77 Fed. Reg. 70,644 (Nov. 26, 2012). The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans.

Beginning in 2014, section 1311(d) of the Patient Protection and Affordable Care Act ("Affordable Care Act") will require in part that non-grandfathered plans in the individual and small group markets cover essential health benefits. Neither plans in the large group market nor self-insured plans will be required to offer essential health benefits (but may voluntarily do so). Section 1302(b) of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (the "Department") to define what constitutes an essential health benefit, including benefits in at least 10 categories specified by statute.

1501 M Street NW Suite 600 Washington, DC 20005 202-289-6700 Facsimile 202-289-4582 www.americanbenefitscouncil.org

We appreciate the guidance issued to date, and request that the Department consider issuing guidance related to the following as part of its finalization of the proposed rule.

CLARIFICATION IS NEEDED REGARDING WHAT CONSTITUTES AN ESSENTIAL HEALTH BENEFIT SUBJECT TO THE ANNUAL AND LIFETIME DOLLAR LIMITS FOR LARGE GROUP HEALTH PLANS AND SELF-INSURED GROUP HEALTH PLANS

We appreciate that the preamble to the proposed rule clearly states, as set forth in the statute, that large group health plans and self-insured group health plans are not required to provide the full suite of essential health benefits. However, as we previously stated in a comment letter regarding the Department's bulletin on essential health benefits (issued on December 16, 2011), a concern arises with respect to the many large group health plans and self-insured group health plans that cover benefits that could be classified as essential health benefits (even though they are under no general legal obligation to do so).[1]

Pursuant to Public Health Service Act ("PHSA") section 2711, if a large group health plan or a self-insured group health plan voluntarily provides coverage for essential health benefits, then such plan is required to comply with the restrictions regarding the use of certain lifetime and annual dollar limits with respect to those benefits that are essential health benefits.[2] This rule took effect for plan years beginning on or after September 23, 2010. Accordingly, the sponsor of such a group health plan must be able to determine with certainty whether any of the benefits offered under its plan constitute essential health benefits and thus are subject to the restrictions on the use of lifetime and annual dollar limits.

The proposed rule indicates that the Department intends to permit each state to define essential health benefits for coverage offered in such state pursuant to a benchmark plan selected by the state. While the flexibility provided by such a rule may be helpful for purposes of the individual and small group market, such a standard is unworkable for large group health plans and self-insured group health plans for purposes of complying with PHSA section 2711. This is because, under such a rule, a large group health plan or a self-insured group health plan could be required to be structured to comply with up to 50 different definitions of essential health benefits (depending on the number of states in which the plan provides coverage), which would be impossible to do.

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[1] *See* Council Letter dated January 31, 2012, *available at* http://www.americanbenefitscouncil.org/documents2012/hcr_ehb_council-hhs-letter013112.pdf.

[2] The term "essential health benefits" is defined by cross-reference to section 1302(b) of the Affordable Care Act.

Following issuance of the December 16, 2011 bulletin regarding essential health benefits, the Department released a set of Frequently Asked Questions regarding essential health benefits.[3] FAQ #10 addresses how employers sponsoring large group health plans or self-insured group health plans would determine which benefits are essential health benefits when they offer coverage to employees residing in more than one state.

In its response to FAQ #10, the Department initially states that self-insured group health plans, large group market health plans, and grandfathered health plans are not required to offer essential health benefits. It goes on to state that a self-insured group health plan or a large group health plan will be considered to have used a permissible definition of the term essential health benefits if the definition is one that is authorized by the Secretary of the Department (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories). The response to FAQ #10 goes on to state that the Department of Health and Human Services, the Department of the Treasury, and the Department of Labor intend to use their enforcement discretion and work with those plans that make a good faith effort to apply an authorized definition of essential health benefits to ensure there are no annual or lifetime dollar limits on essential health benefits.

The Council and its members very much appreciated the issuance of FAQ #10. Specifically, we appreciated the statement included therein that "self-insured group health plans, large group market health plans, and grandfathered health plans are not required to offer [essential health benefits]." We also appreciated the statements contained in FAQ #10 that a self-insured group health plan or a large group health plan will be considered to have used a permissible definition of essential health benefits if "the definition is one that is authorized by the Secretary of HHS." The Council has read FAQ #10 to provide that a self-insured group health plan or a large group health plan can select from any of the approved essential health benefit packages among the various states. However, the language in FAQ #10 is not entirely clear and could be read to suggest that the Secretary of the Department will be issuing a specific list of essential health benefits that must be used by self-insured group health plans and large group health plans.

We had hoped that the proposed rule would include a restatement of FAQ #10, as well as a clarification that employers may pick from any of the approved essential health benefit packages among the various states for purposes of applying the essential health benefit requirements to self-insured group health plans and large group health plans. Given the difficulties of applying a state-by-state determination of essential health benefits, and further given that many large and self-insured plans are administered by issuers that are resident in specific states (and thus will be familiar

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[3] *See* Frequently Asked Questions on Essential Health Benefits Bulletin, *available at* http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

with the essential health benefits packages allowed by those specific states), we urge the Department to include as part of a final rule a clarification that employers will be permitted to choose from any of the approved essential health benefit packages among the state, and that the Secretary of the Department will not promulgate a single list that must be used by self-insured and large group health plans.

CLARIFICATION IS NEEDED THAT A PLAN'S MINIMUM VALUE IS DETERMINED BASED ON ALL BENEFITS UNDER THE RELEVANT BENCHMARK DATA SET RATHER THAN ONLY ESSENTIAL HEALTH BENEFITS

The proposed rule appears to base the determination of minimum value only on essential health benefits offered under a plan, rather than on all benefits offered under the benchmark data set.

The proposed rule contemplates that the minimum value of a plan would be determined using one of the methodologies set forth in Treasury Notice 2012-31. Treasury Notice 2012-31 provides that minimum value for employer-sponsored self-insured plans and insured large group plans "would be determined in the same manner as actuarial value" applied to qualified health plans, but with appropriate modifications.

Since actuarial value is determined with respect to plans that are required to offer all of the required essential health benefits (and is based upon a data set regarding the same types of plans), the actuarial value mechanism would not be appropriate for employer-sponsored self-insured plans and insured large group plans, absent significant modifications. This is because such plans are not required to provide coverage for essential health benefits as defined under the Affordable Care Act and implementing guidance.

Accordingly, we urge the Department to apply appropriate modifications and clarify that the determination of a plan's minimum value is determined based on all benefits offered by the plan, rather than only the essential health benefits (if any) offered by the plan.

THE DATA SET USED TO DETERMINE MINIMUM VALUE SHOULD BE BASED ON WHAT EMPLOYERS ARE DOING FOR THE MOST RECENT YEAR FOR WHICH THERE IS DATA

In formulating the data set used in determining the minimum value of an employer-sponsored group health plan, we urge the Department to utilize the most recent data available for this purpose. We are concerned that many of the costs of complying with the Affordable Care Act are yet to arise or will not be fully reflected in any existing data set. As a result, we urge the Department to (i) update any currently existing data set

with 2014 data as soon as possible, and, (ii) more generally, ensure that the data set is always updated to reflect the most recent data available.

EMPLOYERS SHOULD BE ABLE TO CHOOSE AMONG ALL AVAILABLE TOOLS FOR DETERMINING MINIMUM VALUE

Guidance issued to date by the Department of Health and Human Services and the Department of the Treasury indicates that three tools are available to sponsors to use, in their discretion, in determining minimum value. The tools available are a calculator, a checklist, and an actuarial certification. The proposed rule appears to limit use of the actuarial certification to situations in which neither the checklist nor the calculator is applicable. We encourage the Department to consider making the actuarial certification tool available to all plans regardless of whether a plan could also use the calculator or checklist tool. This will ensure that employers have all means available to them to best determine minimum value with respect to their plan offerings.

CLARIFICATION AND CONFIRMATION REGARDING APPLICATION OF DEDUCTIBLE LIMITATIONS AND OUT-OF-POCKET LIMITATIONS TO LARGE GROUP HEALTH PLANS AND SELF-INSURED PLANS

The proposed rule provides that the deductible limitations of Affordable Care Act section 1302(c)(2) ($2,000 self only/ $4,000 other plans) "apply only to plans and issuers in the small group market and do not apply to self-insured plans or health insurance issuers offering health insurance coverage in the large group market." We appreciate the confirmation that the deductible limitations do not apply to large group health plans and self-insured plans. The preamble to the proposed rule, however, is silent with respect to the application of the out-of-pocket limitations set forth in Affordable Care Act section 1302(c)(1) that are linked to the limits set for health savings accounts ("HSAs") under Internal Revenue Code section 223. We urge the Department to clarify in final regulations (or in regulations implementing PHSA section 2707) whether the out-of-pocket limitations apply to large group and self-funded plans.

TREATMENT OF HSAS AND HRAS IN CALCULATING MINIMUM VALUE

The proposed rule provides that annual contributions to HSAs and amounts newly made available under health reimbursement arrangements ("HRAs") will be taken into account for purposes of determining actuarial value.

The Council appreciates this guidance, and urges the Department to make clear in final regulations that, for purposes of determining minimum value, a plan may take into account all contributions an employer makes to an HSA in the year in which

contributed, without regard to whether such employer contributions can be rolled over from one year to the next in the event they are not used in the year of contribution. Similarly, with respect to amounts first made available under an HRA, we urge the Department to make clear in final regulations that, for purposes of determining minimum value, a plan may take into account all amounts made available under the HRA in the first year in which they are made available. Taking into account any lesser amount of employer contributions to an HSA or amounts made available under an HRA could discourage employers from offering such benefits, ultimately making health coverage more expensive for employees.

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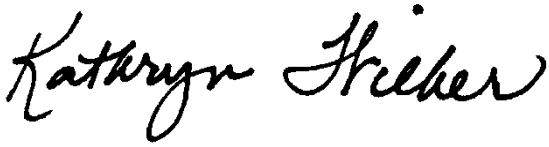
Thank you for considering these comments related to the proposed rule entitled "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation." If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,



Paul W. Dennett
Senior Vice President,
Health Care Reform

Kathryn Wilber
Senior Counsel,
Health Policy