



AMERICAN BENEFITS COUNCIL

April 22, 2013

Submitted via email to e.ohpsca-2707.ebsa@dol.gov

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Ave., NW
Washington, DC 20210

Re: Limitations on Cost-Sharing Under the Affordable Care Act

Sir or Madam:

We write on behalf of the American Benefits Council (“Council”) to provide comment in connection with the FAQs About Affordable Care Act Implementation (Part XII) (“FAQs”) issued by the Departments of Labor, Health and Human Services, and the Treasury (collectively, the “Departments”) on February 20, 2013. The FAQs provide subregulatory guidance regarding, among other issues, certain limitations on cost-sharing and deductibles imposed by the Patient Protection and Affordable Care Act (“ACA”). Public Health Service Act (“PHS Act”) Section 2707(b), as added by the ACA, provides that a group health plan must comply with cost-sharing limitations imposed by ACA Section 1302(c)(1). ACA Section 1302(c)(2) provides certain limitations on deductibles for plans in the small group market. We write to provide our views with respect to the guidance provided in the FAQs regarding the cost-sharing and deductible limitations.

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.

DEDUCTIBLE LIMITATIONS UNDER PHS ACT SECTION 2707(B)

The Council agrees with the conclusion set forth by the Departments in the FAQs that the deductible limitations apply only to non-grandfathered health insurance coverage and qualified health plans in the small group market and do not apply to large group insurance and self-funded employer-sponsored coverage. The Council supports the Departments' decision to expressly set forth this conclusion as part of its future rulemaking. We note that the Departments' conclusion is supported by the express statutory language. Specifically, ACA Section 1302(c)(2) provides that certain limitations on the amount of permitted deductibles apply "[i]n the case of a health plan offered in the small group market"; no reference is made to self-insured or large group health plans.

OUT-OF-POCKET LIMITATIONS UNDER PHS ACT SECTION 2707(B)

According to Q2 of the FAQs, the Departments read PHS Act Section 2707(b) as requiring all non-grandfathered group health plans to comply with the annual limitations on out-of-pocket ("OOP") maximums described in 1302(c)(1) of the ACA.

The FAQs provide much needed transition relief with respect to the cost-sharing limitations. The transition relief provides that, only for the first plan year beginning on or after January 1, 2014, a group health plan or group health insurance issuer that utilizes more than one service provider to administer benefits that are subject to the cost-sharing limitations will be considered to have satisfied the limitations if (i) the plan complies with the requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage), and (ii) to the extent the plan or any health insurance coverage includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage, such out-of-pocket maximum does not exceed the cost-sharing limitations.

We appreciate that the Departments have provided the aforementioned transition relief. As noted in the FAQs, in situations in which a plan utilizes multiple service providers to administer various benefits, such service providers will need to develop and adopt significant systems changes and procedures in order to coordinate the cost-sharing limitations across all benefits. In the absence of the transition rule, it would be very difficult, if not impossible, for plans to come into compliance with the cost-sharing limitations in the short lead time before the effective date of the limitations.

Additional Transition Relief

Notwithstanding our appreciation for the existing transition rule, we urge the Departments to provide additional transition relief for plans that do not utilize multiple providers but may nonetheless be unable to provide for a coordinated out-of-pocket

maximum limitation across all benefits under the plan for the 2014 plan year. This is especially the case where a plan is utilizing noncoordinated out-of-pocket limitations on certain categories of benefits.

We are concerned that many of these types of plans exist and that they may not be able to come into full compliance with the rules because their existing administrative-services-only (“ASO”) provider (or the plan itself if self-administered) may not have the necessary systems in place to allow for the application of a coordinated out-of-pocket maximum limitation across all benefits under the plan.

Accordingly, we request additional transition relief, for at least 2014, that would permit such plans to utilize noncoordinated out-of-pocket maximum limitations so long as the sum of all such limitations in the aggregate does not exceed the statutory maximum limitation as set forth in Internal Revenue Code Section 223, as incorporated by ACA Section 1302(c)(1). Thus, for example, with respect to family coverage in 2014, a plan would be permitted to impose one out-of-pocket limitation on pharmacy benefits of \$X so long as the second, noncoordinated limitation that applies to all other benefits under the plan does not exceed an amount equal to \$12,500-\$X. Such a rule would enable plans to comply with the new rule for the 2014 plan year, while ensuring that participants enjoy coverage that protects them against excessive out-of-pocket expenses.

COST-SHARING RELATED TO OUT-OF-NETWORK SERVICES SHOULD NOT BE TAKEN INTO ACCOUNT IN APPLYING THE COST-SHARING LIMITATIONS.

The final rule regarding essential health benefits provided guidance regarding the application of the cost-sharing limitations to services provided by an out-of-network provider. The final rule¹ stated that cost-sharing requirements for benefits from a provider outside of a plan’s network would not count toward the annual limitations on cost-sharing. We support this view, which applies to qualified health plans and health insurance coverage offered in the small group market. We urge the Departments to similarly provide that cost-sharing requirements for benefits from a provider outside of a plan’s network would not count toward the annual limitations on cost-sharing for self-insured and large group health plans.

¹ Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834 (Feb. 25, 2013).

COST-SHARING RELATED TO NON-PREFERRED DRUGS SHOULD NOT BE TAKEN INTO ACCOUNT IN APPLYING THE COST-SHARING LIMITATIONS.

We encourage the Departments to also exclude from the limitations cost-sharing for non-preferred prescription drugs so long as a plan's formulary includes preferred drugs in each clinical category. Given the substantial costs of non-preferred drugs to both plans and enrollees, the cost-sharing limitations could be fully consumed by the purchase of non-preferred drugs. In situations in which a plan has negotiated rates with respect to preferred drugs, a plan and its participants should not be penalized because an enrollee chooses to purchase a comparable, and more expensive, non-preferred drug.

Lastly, we note that a contrary rule could have adverse implications for enrollees' health since enrollees could find themselves moving from a preferred drug to a non-preferred drug, and back to a preferred drug based on the application of cost-sharing. For example, a contrary rule could result in some enrollees utilizing a preferred drug until the out-of-pocket maximum is met, then moving to a non-preferred drug for the remainder of the plan year, only to move back to the preferred drug as of the start of the next plan year, when the plan's cost-sharing limitations restart. The Council and its members are concerned that allowing for this behavior could result in adverse health consequences to enrollees as a result of cycling among preferred and non-preferred drugs over the course of a plan year for reasons unrelated to medical necessity.

Accordingly, we request that the Departments issue guidance clarifying that the cost-sharing limitations do not apply to non-preferred drugs so long as a plan's formulary includes preferred drugs in each clinical category.

CLARIFICATION REQUESTED REGARDING DEFINITION OF "COST-SHARING".

ACA Section 1302(c)(3) provides a definition of "cost-sharing" for purposes of applying the limitations related thereto. The term is defined to mean:

- (i) deductibles, coinsurance, copayments, or similar charges; and
- (ii) any other expenditure required of an insured individual which is a qualified medical expense . . . *with respect to essential health benefits covered under the plan*

(emphasis added). It is not entirely clear based on the text of ACA Section 1302(c)(3) (defining "cost-sharing") how the Departments are interpreting the reference to "essential health benefits" as contained in ACA Section 1302(c)(3)(A)(ii). More specifically, questions have arisen regarding whether the term "cost-sharing" only includes "deductibles, coinsurance, copayments, or similar charges" with respect to essential health benefits or whether it includes "deductibles, coinsurance, copayments,

or similar charges” regardless of whether the relevant benefits are essential health benefits. Similarly, clarification is needed regarding whether “any other expenditure of an insured individual which is a qualified medical expense,” as referenced in ACA Section 1302(c)(3)(A)(ii), only constitutes cost-sharing for purposes of PHS Act Section 2707(b) if the relevant benefit is an essential health benefit. We urge the Department to issue guidance providing clarity with respect to these questions.

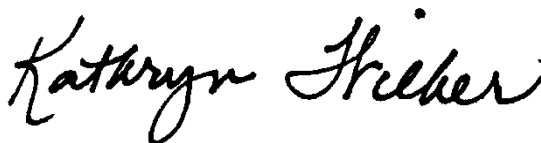
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Thank you for considering these comments submitted with regard to the FAQs. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,



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