GROOM LAW GROUP

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June 2, 2010

Mr. Neil Trautwein
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National Retail Federation
325 7th Street, NW
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Mr. Paul Dennett
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American Benefits Council
1501 M Street, NW, Suite 600
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Ms. Sarah Arbes
Vice President, Government Affairs
Retail Industry Leaders Association
1700 N. Moore Street, Suite 2250
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Re: HHS Flexibility With Respect to Annual Limits and Limited Health Benefit Plans

Dear Mr. Trautwein, Ms. Arbes, and Mr. Dennett:

You asked whether the Patient Protection and Affordable Care Act ("PPACA") permits the Department of Health and Human Services ("HHS") to issue guidance providing that "limited health benefit plans" (also sometimes known as "mini-med plans") may maintain annual dollar limits on essential benefits for plan years beginning prior to January 1, 2014. As discussed below, PPACA grants the Secretary of HHS rulemaking authority with respect to the establishment of restricted annual limits, and it is clear that HHS could issue a special rule related to limited health benefit plans permitting them to maintain annual limits on essential benefits for plan years beginning prior to January 1, 2014.

I. Background

Public Health Service Act ("PHSA") § 2711 provides, in pertinent part, that effective for plan years beginning on or after September 23, 2010, a group health plan and a health insurance issuer offering group or individual coverage may not impose annual limits on the dollar value of essential benefits, *except* as permitted by the Secretary of HHS for plan years beginning prior to January 1, 2014. Annual dollar limits are prohibited altogether beginning in 2014. The restriction on annual limits applies to both new plans and grandfathered group health plans. *See* PPACA § 1251(a)(4)(B)(i).

You have indicated that approximately 1.4 million workers nationwide have group healthcare coverage under limited health benefit plans that cover accident- and sickness- related medical expenses and that these plans typically have an annual dollar cap on overall benefits and/or an annual dollar cap on specific services. The individuals covered by such plans typically work for employers on a part-time, seasonal, or temporary basis and are ineligible for coverage under the employer's regular group health plan, or are in an eligibility waiting period for an employer's regular health plan.

Unless HHS issues guidance permitting limited health benefit plans to establish annual dollar limits on essential benefits prior to 2014, these plans, as currently designed, could be effectively prohibited for plan years beginning on or after September 23, 2010, resulting in the loss of coverage for 1.4 million workers. These workers will not be eligible for guaranteed issue coverage in the individual market, or federal subsidies available through Exchanges, until 2014. Moreover, these workers will not be eligible for the temporary high-risk pool established by PPACA for at least six months following their loss of limited health benefit plan coverage given that such coverage is "creditable coverage." *See* PPACA § 1101(d)(2).

You asked whether HHS has the authority to issue a regulation which generally exempts grandfathered and new limited health benefit plans from the requirements of PHSA § 2711 until 2014. You asked whether such regulatory relief could be targeted just to limited health benefit plans issued as group coverage for existing and new employees who are part-time, temporary, or seasonal employees (and their dependents) or employees who are in an eligibility waiting period (and their dependents), and provided that such plans remain limited to these categories of workers. As described below, we believe that HHS has the authority to issue a special rule that would permit grandfathered and new limited benefit health plans to continue until 2014 with annual limits applying to essential health benefits based on HHS's authority under PHSA § 2711 to determine when restricted annual dollar limits are permissible.

II. Analysis

PPACA delegates rulemaking authority to HHS to determine permissible annual limits on the dollar value of essential benefits that group health plans and insurers may establish for plan years beginning prior to January 1, 2014. *See* PHSA § 2711(a)(2) (allowing group health plans and insurers to "to establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary . . . *as determined by the Secretary*") (emphasis added)). PHSA § 2711(a)(2) commands that, in defining the term "restricted annual limit," the Secretary "shall ensure that access to needed services is made available with a minimum impact on premiums." *Id.* HHS is also granted general rulemaking authority under PHSA § 2792, which extends to PPACA's restrictions on annual limits. *See* PHSA § 2792 (authorizing regulations under the

"title," which includes PHSA § 2711). This provision authorizes HHS to issue interim final rules, and already has been relied upon by HHS in issuing PPACA regulations.[1]

Courts have held that "[t]he power of an administrative agency to administer a congressionally created . . . program necessarily requires the formulation of policy and the making of any rules to fill any gap left, implicitly or explicitly, by Congress." *Chevron U.S.A., Inc. v. Natural Resources Defenses Council*, 467 U.S. 837, 843 (1984). *See also Nat'l Cable & Telecommunications Ass'n v. Brand X Internet Services*, 545 U.S. 967, 980 (2005) (agency's subsequent interpretation of an ambiguous statute is binding on courts, notwithstanding a court's earlier, contrary, interpretation); *School Dist. of the City of Pontiac v. Sec'y of U.S. Dep't of Education*, 584 F.3d 253, 272 (6th Cir. 2009) ("agencies generally have broad power to interpret and administer law[.]"). And where, as in the case of PHSA § 2711(a)(2), "Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation. Such legislative regulations are given *controlling weight* unless they are arbitrary, capricious, or manifestly contrary to the statute." *Chevron*, 467 U.S. at 843-44 (emphasis added), *quoting Morton v. Ruiz*, 415 U.S. 199, 231 (1974). Indeed, where a statute expressly commits the definition of a term to an agency, the agency's "construction and application of this [definition] should not be overturned by a reviewing court simply because it may prefer another interpretation of the statute"). *INS v. Jong Ha Wang*, 450 US. 139, 144 (1981). *See also Johnson v. Buckley*, 356 F.3d 1067, 1074 (9th Cir. 2004) (given that Congress expressly delegated the power to define the term "hour of service" to the Department of Labor for purposes of ERISA, "the court must defer to the agency's regulation unless it is arbitrary, capricious, or manifestly contrary to the statute").

When reviewing an agency's actions, there are two steps courts consider. The first step is to determine whether Congress has "directly spoken to the precise question at issue." *Chevron*, 467 U.S. at 842. If so, "that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id.* at 842-43. But where the statute is silent or ambiguous, "the reviewing court must defer to the agency's construction of the statute, so long as it is reasonable." *Mineral Policy Center v. Norton*, 292 F. Supp. 2d 30, 37 (D.D.C. 2003).

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[1] HHS has taken the position that its authority under PHSA § 2792 is so broad that it is not required to comply with the Administrative Procedure Act's ("APA") general requirement that agencies specify "good cause," *see* 5 U.S.C. § 553(b), when deciding to issue an interim final rule rather than a proposed rule under the APA's traditional notice and comment process. *See* 75 Fed. Reg. 27122, 27125-26 (May 13, 2010) (Preamble discussion of Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act).

In enacting PHSA § 2711(a)(2), Congress delegated authority to HHS to "determine" what annual limits may be established by group health plans and insurers prior to 2014, and given this express delegation, HHS's determination of such permissible annual limits should be given "controlling weight," unless the regulation is arbitrary, capricious, or manifestly contrary to the statute. *Chevron*, 467 U.S. at 843-44. Overcoming the presumptively controlling weight of HHS's determination would be difficult, given that PHSA § 2711(a)(2) authorizes HHS to define "restricted annual limits," and directs HHS to "ensure access to needed services is made available with a minimal impact on premiums."

Issuing a rule that allows limited benefit plans to continue until 2014 is entirely consistent with this statutory directive to ensure that individuals can maintain their coverage without significant premium hikes. We think HHS regulations could provide a special rule for limited health benefit plans that permitted the general use of annual limits as part of a larger regulation that implements PHSA § 2711 for traditional group health plans and group and individual insurance coverage. Such a rule could be justified on the grounds that restricting or prohibiting limited health benefit plans from establishing annual limits could effectively outlaw such plans as of plan years beginning on or after September 23, 2010, resulting in a loss of coverage for approximately 1.4 million people who do not have access to other group coverage, and who will not have access to subsidized coverage until 2014. If the limits imbedded in these plans were lifted, the associated premiums would skyrocket. Such a result would clearly conflict with the direction Congress gave to the Secretary to "ensure access to needed services is made available with a minimal impact on premiums" in issuing guidance under PHSA § 2711.

Given the rulemaking authority delegated to HHS under PHSA § 2711(a)(2), and its command that HHS "ensure access to needed services is made available with a minimal impact on premiums," HHS clearly has discretion to adopt a regulation that permits grandfathered and new limited benefit plans to establish annual limits prior to 2014. In connection with such a rule, we also believe that HHS could target relief to just those limited benefit plans which are issued as group coverage for existing and new employees that are part-time, temporary or seasonal employees (and their dependents), or employees who are in an eligibility waiting period (and their dependents). *See Chevron*, 467 U.S. at 843-44; *Jong Ha Wang*, 450 U.S. at 144 (where Congress delegates authority to define a term, a court must defer to the agency's definition, and the policy choices reflected in such definition). As discussed above, such a rule would be supported by the negative impact that PHSA § 2711 would otherwise have on such plans' coverage and premiums, and would be consistent with the statute's command that the

Secretary "shall ensure that access to needed services is made available with a minimum impact on premiums." PHSA § 2711(a)(2).

I would be pleased to respond to any further questions you may have.

Sincerely,

Jon W. Breyfogle