



AMERICAN BENEFITS

COUNCIL

January 31, 2012

Submitted electronically via EssentialHealthBenefits@cms.hhs.gov

The Honorable Kathleen Sebelius
Department of Health and Human Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments - Essential Health Benefits Bulletin

Secretary Sebelius:

We write to provide comments on behalf of the American Benefits Council (“Council”) in response to the Essential Health Benefits Bulletin (“Bulletin”) issued by the Department of Health and Human Services (“Department”) on December 16, 2011. 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 to define what constitutes an essential health benefit, including benefits in at least 10 categories specified by statute.

The Bulletin is intended to provide information and solicit comments on the Department’s intended regulatory approach to define essential health benefits. As discussed below, however, the Bulletin could cause confusion for some plan sponsors

and issuers. This is because the Bulletin does not expressly reaffirm, with respect to section 2711 of the Public Health Service Act (“PHSA”), that insured large group health plans and self-insured group health plans may continue to utilize a good faith effort to comply with a reasonable interpretation of the term “essential health benefits” as provided in interim final regulations issued in June 2010.¹ To avoid any confusion, we request, as reiterated below, that the Department issue clarifying guidance that reaffirms that plan sponsors and issuers may continue to use a good faith effort to comply with a reasonable interpretation of the term “essential health benefits.”

FUTURE GUIDANCE SHOULD REAFFIRM THAT THE GOOD FAITH STANDARD APPLIES IN DETERMINING ESSENTIAL HEALTH BENEFITS FOR PURPOSES OF RESTRICTIONS ON ANNUAL AND LIFETIME LIMITS

As noted above, beginning in 2014, the Affordable Care Act will require certain types of plans to offer coverage for essential health benefits; however, per the statute, large group health plans and self-insured group health plans will not be required to offer such coverage. The Department affirmatively states in the Bulletin that neither insured large group health plans nor self-insured group health plans are required to provide coverage for essential health benefits in order to qualify as minimum essential coverage. We urge the Department to include such a statement in future regulations.

Although large group health plans and self-insured plans are not required to cover essential health benefits, a significant compliance concern arises with respect to the many large and self-insured plans that in fact cover benefits that could be classified as essential health benefits. Pursuant to PHSA section 2711, if a large group health plan or a self-insured plan voluntarily provides coverage for essential health benefits, then such plan is required – with respect to those benefits that are essential health benefits – to comply with the restrictions regarding the use of certain lifetime and annual dollar limits.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.

Pursuant to interim final regulations issued with respect to PHSA section 2711, plans are permitted to use a good faith effort to comply with a reasonable interpretation of the term “essential health benefits” for plan years beginning before final regulations defining the term are issued.³ Many of the Council’s member plan sponsors have relied

¹ Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. at 37,191 (June 28, 2010).

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

³ 75 Fed. Reg. at 37,191.

on, and continue to rely on, this good faith standard in determining which of their covered benefits are subject to the restrictions on annual and lifetime dollar limits.⁴

According to the Bulletin, 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. The benefits and services included in the selected benchmark plan would be the required essential health benefits for that state.

While the flexibility afforded by the rule for purposes of individual and small group plans may be desirable, any such rule should make clear that it applies only to qualified health plans and not to large group and self-insured health plans. This is because allowing each state to develop its own definition of essential health benefits would provide an unworkable standard for large group health plans and self-insured plans for purposes of complying with PHSA section 2711. Theoretically, if the intended rule were to apply to large group or self-insured health plans, then such plans could be required to structure themselves to comply with up to 50 different definitions of essential health benefits, which simply would not be possible. This is because such a plan – especially a self-insured plan – may cover individuals residing in many, if not all, of the 50 states.

Accordingly, we request that the Department state in future regulations that the intended rule will apply to qualified health plans and not to large group and self-insured health plans. In addition, in the interest of eliminating any confusion, we recommend that the Department reiterate that large group and self-insured health plans are permitted to continue to use a good faith effort to comply with a reasonable interpretation of the term “essential health benefits” for plan years beginning before any final regulations that provide a definition of “essential health benefits” explicitly applicable to large and self-insured health plans for purposes of PHSA section 2711 are issued. In developing any such regulations, we encourage the Department to also consider establishment of a safe harbor for large and self-insured health plans. Such a safe harbor rule – if properly designed to take account of the unique realities of self-funded and large group coverage – would be welcomed by those employers that seek certainty in complying with their obligations under PHSA section 2711.

⁴ PHSA section 2711 prohibits plans and issuers from imposing annual or lifetime limits on the *dollar* value of essential health benefits. The interim final regulation does not provide that annual or lifetime limits apply to specific treatment limits, including day, visit or per-procedure dollar limits, and thus it appears that the restrictions on annual and lifetime dollar limits are not extended to such treatment limits. The Council requested in a comment letter on the interim final regulations that any final regulations affirm that such non-dollar limits are not the types of limits considered to be annual or lifetime limits on the dollar value of essential benefits. We reiterate our request that the Department confirm this reading in future guidance. See Council and HR Policy Association Letter dated August 27, 2010, available at http://www.americanbenefitscouncil.org/documents/hcr_omni-comments-abc-hrpa082710.pdf.

THE DEPARTMENT SHOULD NOT IMPOSE A SPECIFIC MINIMUM VALUE TEST

The Bulletin states that it only relates to covered services and that it does not address plan cost sharing and the calculation of actuarial value. The Bulletin further states that the Department plans to release guidance on calculating actuarial value and the provision of minimum value by employer-sponsored coverage in the near future.

Pursuant to section 4980H of the Internal Revenue Code of 1986, as amended (“IRC”), certain large employers could be subject to a penalty if any full-time employee is certified to receive an applicable premium tax credit or cost-sharing reduction and either (1) the employer does not offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan,⁵ or (2) the employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage that either is unaffordable within the meaning of IRC section 36(B)(c)(2)(C)(i) *or does not provide minimum value within the meaning of IRC section 36(B)(c)(2)(C)(ii).*⁶

IRC section 36B(c)(2)(C)(ii) states that an eligible employer-sponsored plan generally provides minimum value if the plan’s share of the total allowed costs of benefits provided under the plan is at least 60% of those costs. Specifically, the statute provides:

Except as provided in clause (iii) [relating to actual coverage under an eligible employer-sponsored plan], an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in [IRC] section 5000A(f)(2)) and the plan’s share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

We read this language to permit employers broad flexibility in fashioning their plan benefits and to provide that employers are not subject to specific benefit mandates so long as the plan’s share of total allowed costs is at least 60%.

As we noted in a prior comment letter submitted to the Department of the Treasury in connection with proposed regulations implementing the health insurance premium tax credit under IRC section 36B, the agencies, according to the regulation’s preamble are “contemplating whether to provide appropriate transition relief with respect to the minimum value requirement for employers currently offering health care coverage.”⁷ Although unclear, this language appears to signal an intention by the agencies to issue

⁵ See IRC section 4980H(a).

⁶ See IRC section 4980H(b).

⁷ See Council Letter dated October 31, 2011, available at http://www.americanbenefitscouncil.org/documents/hcr_premium-tax-credit_comments103111.pdf.

future rules that would articulate and impose a certain benefit value test on employer-sponsored plans, subject to a transition period.

It is important that any future guidance on the “minimum value” of employer-sponsored coverage both acknowledge and stay within the bounds of the express statutory language. We do not believe that Congress intended, or that the text of IRC section 36B(c)(2)(C)(ii) permits, the agencies to impose a certain minimum value test on employer-sponsored plans. As explained in our prior comment letter, we do not believe that the statutory language permits using the essential health benefits requirement to essentially bootstrap such a result.

We are concerned that such an approach would not only increase the cost and complexity for employers of providing coverage to employees, but also lead to some employers exiting the system altogether. Moreover, large employers have a significant interest in providing comprehensive benefits that will best keep their workforces healthy. For these reasons, we strongly urge the Department to not impose a specific minimum value test as part of any guidance issued regarding minimum value.

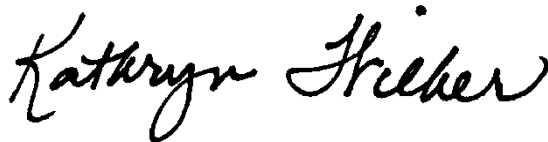
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We appreciate the opportunity to provide comments regarding the Bulletin. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,



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