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Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201
Attn: OCIIO-9994-IFC

RE: Interim Final Rules for Group Health Plans and Health Insurance Coverage Regarding Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections under the Patient Protection and Affordable Care Act

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") is submitting these comments in response to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Regarding Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections under the Patient Protection and Affordable Care Act ("IFRs" or "regulations"), which were published in the Federal Register on June 28, 2010.[1] The IFRs provide guidance pursuant to the statutory language of the Patient Protection and Affordable Care Act (the "Affordable Care Act") and the Health Care and Education Reconciliation Act (the "Reconciliation Act"). As with other guidance under these Acts, the IFRs were published jointly by the Department of the Treasury, the Department of Labor and the Department of Health and Human Services (the "Departments").[2]

The Chamber is the world's largest business federation, representing the interest of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. These comments have been developed with the input of member companies with an interest in improving the health care system.

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[1] Group Health Plans and Health Insurance Coverage Regarding Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 37,188–37,241 (June 28, 2010) (to be codified at 26 C.F.R. pts. 54 & 602; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 144, 146 and 147) [hereinafter Preexisting Condition Exclusion, et al].

[2] Pursuant to the request in the IFRs, the Chamber is submitting these comments to one of the Departments - The Department of Health and Human Services - with the understanding that these comments will be shared with the Department of Labor and the Department of Treasury, as well.

OVERVIEW

These Interim Final Regulations implement four separate health reform provisions of the Affordable Care Act. In §1201, the Affordable Care Act amends the Public Health Service Act (PHSA) to include §2704 which prohibits preexisting condition exclusions. The Affordable Care Act's §1001 amends the PHSA to include §2711 which bans the impositions of annual and lifetime limits, §2712 which prohibits rescissions, and §2719A which creates new patient protections.

The U.S. Chamber of Commerce has long advocated for targeted health reform, including expanded health care coverage and improved access to care so that individuals can obtain health care in the appropriate delivery setting, at the proper time. However, flexibility is critical to foster innovation and competition in the delivery and coverage of health care services. As the Departments have repeatedly stated during this regulatory process,[3] the challenge remains in balancing the needs of clarity and flexibility. We are encouraged by some efforts to date, particularly regarding the details of these statutory provisions, which demonstrated a commitment to advancing the principles of health reform.

- After the law was enacted, insurers voluntarily agreed to go beyond the letter of the law and comply with the intent of the prohibition of preexisting condition exclusions for children.[4]
- Employers highlighted the negative repercussions that annual and lifetime limit restrictions would have on the ability of certain health plans to provide coverage without decreasing access to benefits and significantly increasing premiums. In response, the Departments swiftly addressed these concerns in the interim final regulations by providing a waiver program to be established by the Secretary which would allow these plans to continue to exist until 2014.[5]

[3] Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,546 (June 17, 2010) (to be codified at 26 C.F.R. pts. 54 & 602; 29 C.F.R. pt. 2590; 45 C.F.R. pt. 147) [hereinafter Grandfathered Health Plans].

[4] Technically, the law bans insurers from denying certain services for children with preexisting conditions, who are already insured, beginning with plan years after September 23, 2010 (i.e., if a plan currently covering a child does not pay for that child's treatments of a preexisting heart condition, this plan would have to drop this exclusion (and cover treatments for this preexisting condition) when the plan year renews after September 23, 2010). The law was intended (as these regulations clarify) to also prohibit plans from denying coverage entirely for children based on a preexisting condition. The President also repeatedly stated that the law immediately bans insurance companies from denying children with preexisting conditions from buying new insurance plans. On March 30, 2010, AHIP announced that insurers would immediately stop denying children with preexisting conditions from getting new insurance plans. In this instance, insurers voluntarily elect to comply with overall reform intent, although not required to by statute.

[5] Restricting or prohibiting limited health benefit plans from establishing annual limits could effectively outlaw such plans resulting in the 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. Per the regulations, these annual and lifetime limit prohibitions were designed to ensure that individuals have access to needed services with a minimal impact on premiums. In this instance, the Departments appropriately preserve flexibility to ensure the overall reform intent is met.

As the Departments complete the final regulations implementing these provisions, we urge the Departments to continue to incorporate flexibility. Plans must not be forced to comply with reform provisions and regulations at the expense of fiscal solvency. Additionally, as the reform law is implemented, we must minimize any unintended consequences that inadvertently run contrary to either statutory intent or the overall principles of health reform. With this in mind, there are a number of details that must be clarified. There are also several nuances that the Chamber would like to highlight for the Departments' consideration.

PREEXISTING CONDITION EXCLUSION

Nuanced Scenarios

Since the intent of this statutory provision, as well as the overarching principle of health reform, is to ensure and improve individual access to needed medical services, we ask for flexibility in the application of this prohibition in the following instances.

Some health plans generously provide extended coverage to enrollees who become disabled while covered under the plan, often for as long as they remain disabled, which may be decades. For example, a child covered at the age of 5 became a quadriplegic due to a car accident while covered under the plan. So long as the employee parent remains with the employer sponsoring the plan, the plan agreed to cover the child above and beyond the age of 26 for all health-related coverage. A plan offering coverage on a *preferential* basis *because of* a pre-existing condition must be permitted.

ANNUAL AND LIFETIME LIMITS

Waiver Program

We appreciate the Departments' swift response to concerns regarding the detrimental short-term effect of restricted annual limits on specific plans and the regulatory incorporation of a waiver program. To further ensure the priorities of flexibility and clarity, we recommend several additional modifications be included in the final regulations.

As the Departments clarified in the preamble, "restricted annual limits are designed to ensure that individuals would have access to needed services with a minimal impact on premiums."[6] This laudable goal, however, would have been significantly undercut in many instances, if it weren't for the Department's appropriate and responsive incorporation of a waiver program in these regulations. The statutory language[7] provides for the delegation of authority to the Secretary of Health and Human Services (HHS) to establish a waiver program in order to ensure access to needed services with minimal impact on premiums.[8] The waiver authority provision in

[6] Preexisting Condition Exclusions et al; 75 Fed. Reg. at 37,191.

[7] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001(1) , 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 10101(a), 124 Stat. 1029 (2010). "Sec. 2711. No Lifetime or Annual Limits. (a)(2) …In defining the term 'restricted annual limit,'…the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums."

[8] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1001(5), 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, §10101(a), 124 Stat. 1029 (2010) "§2711(a)(2)... In defining the term 'restricted annual limit'…, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums."

the regulations appropriately reflects the language and intent of the statute and the principles of health reform.

> These requirements relating to annual limits may be waived (for such a period as is specified by the Secretary of Health and Human Services) for a group health plan or health insurance coverage that has an annual dollar limit on benefits below the restricted annual limits, if compliance would result in a significant decrease in access to benefits under the plan or health insurance coverage or would significantly increase premiums for the plan or health insurance coverage.[9]

This waiver program will ensure that individuals in an array of situations will be able to continue to receive coverage, when the only alternative (if compliance was required) would be the loss of coverage.

As guidance for this waiver process is developed, we urge the Secretary of Health and Human Services provide flexibility to plans and employers so that coverage can continue to be offered prior to 2014. We also implore the Secretary to act promptly to ensure that waiver guidance is released within the next few weeks. As the majority of employers finalize their 2011 plan design, vendor interface and employee communications over the next couple of weeks in anticipation of the Open Enrollment season (which typically starts mid-October and end mid-November), employers will need to know more definitively about these waivers. We are concerned that unless this information is made available in the next two or three weeks, employers will need to assume they will not be available and will NOT offer related plans for the 2011 calendar year.

Procedurally, we recommend that waivers be granted for a full three year period until 2014 to reduce the administrative burden that would accompany a yearly application requirement. Additionally, the Chamber suggests that the process permit insurers to apply for waivers for their products. Allowing insurers to obtain these waivers for their products and extending the waiver to employer plans that purchase this insurance would simplify the process and result in HHS having to review and process far fewer waivers. Alternatively, we recommend that the regulation state that the requirements "shall" be waived, rather than "may" be waived, in certain circumstances.

<u>Essential Health Benefits –Clarifications</u>

The Chamber requests that the Departments clarify that, when a plan or policy has in-network or out-of-network providers, annual and lifetime limit prohibitions should apply only to the non-essential health services provided by in-network providers. Additionally, we request that, prior to the effective date of final regulations defining Essential Health Services, the Departments adopt a good faith compliance approach where plans and employers are presumed to apply the restrictive annual limits to non-essential health benefit services in good faith.

[9] Preexisting Condition Exclusions et al; 75 Fed. Reg. 37,236 (to be codified at §147.126(d) (3)).

The Affordable Care Act specifically states that plans may only establish a restricted annual limit on the dollar value of essential health benefits.[10] We request that the Departments clarify that these limits apply to the dollar value of essential health services delivered by in-network providers. It would be contrary to the intent of the statute or previously issued regulations to prohibit plans from imposing annual or lifetime limits on essential benefits offered by out-of-network providers. Previously published regulations articulated support for provider networks. The regulations published on §2713 Coverage of Preventive Health Services, as added by §1001 of the Affordable Care Act to the Public Health Service Act, specifically provide "that nothing precludes a plan or issuer that has a network of providers from imposing cost sharing requirements for items or services [described in the regulations as preventive health services] that are delivered by an out of network provider."[11] As the Departments specifically acknowledged, "plans and issuers negotiate allowed charges with in-network providers as a way to promote effective, efficient health care, and allowing differences in cost sharing in- and out-of-network enables plans to encourage use of in-network providers."[12] Similarly, in this instance, preserving a distinction between in-network and out-of-network providers is "the appropriate option to preserve choice of providers for individuals" and to curb the likelihood of higher premiums.[13]

As the regulations mention, the regulatory definition of "essential health benefits" has not yet been issued.[14] We appreciate the Departments commitment "to take into account good faith efforts to comply with a reasonable interpretation of [this] term."[15] The Chamber respectfully requests that the Final Regulations incorporate this good faith compliance provision and, in doing so, also delineate important details regarding the burden of proof in assessing good faith compliance. If an enrollee, or one of the Departments, maintains that a plan is not in compliance with the a good faith interpretation of "essential health services," the burden of proof must be placed on the party arguing against the plan's good faith interpretation. There must be a rebuttable presumption that the plan's (or issuer's) interpretation, prior to the issuance of a final regulatory definition of essential health services, constitutes good faith compliance.

Notification Requirement

The Chamber recommends that the Departments deem timely delivered Summary Plan Descriptions to satisfy statutory and regulatory notice requirements when required information

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[10] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1001(5), 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, §10101(a), 124 Stat. 1029 (2010) "§2711(a)(2) Annual limits prior to 2014. - With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under Section 1302 (b) of the Patient Protection Act, as determined by the Secretary."

[11] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41,759 (July 19, 2010) (to be codified at §147.130(a)(3) [hereinafter Coverage of Preventive Services].

[12] Coverage of Preventive Services, 75 Fed. Reg. 41,739.

[13] Id.

[14] Preexisting Condition Exclusions et al, 75 Fed. Reg. 37,191.

[15] Id.

is incorporated in these materials. We also urge the Departments to adopt a good faith effort standard in requiring plans, issuers and employers to notify prior enrollees of new eligibility.

The Chamber understands the importance of notifying enrollees of critical coverage details, particularly in light of the tremendous changes made by the Affordable Care Act. We also support the intent of the Departments and Congress to simplify the information provided to enrollees. To advance both priorities, we believe that information currently provided to enrollees through Summary Plan Descriptions can fulfill these goals. We recommend that Summary Plan Descriptions (SPDs) be deemed to satisfy the notice requirements, provided these SPDs incorporate the required information as stipulated by the regulations and statute. For individual insurance policies and the few group insurance plans that are not subject to ERISA's summary plan description requirements, we suggest that the Departments permit notification be made by documents that would substantially comply with the summary plan description requirements, if these requirements were applicable to them.

The regulations require plans to notify individuals who are no longer enrolled in the plan, when those individuals exceeded lifetime limits prior to effective date of these regulations, but are otherwise still eligible.[16] In notifying such individuals that the lifetime limits no longer applies, the Chamber requests that a similar good faith effort standard be applied when the individual is no longer employed by the plan sponsor. For plans and employers that offer retiree health care, it can be exceedingly difficult to track down prior enrollees – particularly after they have been terminated from coverage which in many cases may be the only remaining connection between the employer and the former employee.

<u>Less Traditional Plans - Clarification Requested</u>

Additionally, many companies offer less traditional medical plans – either in addition to, or instead of, traditional health insurance. For example, some plans offer executive physical programs or extend medical coverage to employee injured while traveling on business. We ask that the Departments clarify that these plans will not be required to meet the annual and lifetime limit requirements delineated in the regulations. The treatment of these plans must be more in line with that of other benefit specific plans – such as dental and vision plans.

RESCISSION

It is our understanding that the goal of this provision and the regulations implementing it is to prevent rescissions that would, in essence, retroactively pull coverage out from under an enrollee, without his/her knowledge. However, we believe the regulations go beyond protecting enrollees to penalizing plans and employers by creating an entitlement to mistaken coverage or benefits, even when the enrollee had neither a reasonable expectation of coverage, nor a right to coverage, under plan or contract terms. We request that the Department make further distinctions and clarify that, in certain circumstances, coverage terminated retroactively will not be deemed a rescission as prohibited under the Affordable Care Act.

[16] Preexisting Condition Exclusions et al, 45 Fed. Reg. 37,191-37192 and 37,236 (to be codified at §147.126 (e)(2)).

Legal Concerns

The Chamber is extremely concerned about the scope of the regulations with regard to rescissions, particularly due to the approach taken in defining a rescission. According to the initial definition in the statute," a rescission is a cancelation or discontinuance of coverage that has a retroactive effect."[17] A critical element of the definition of rescission is "coverage." However, the regulations not only fail to define coverage but also inappropriately modify the definition of rescission to avoid this element entirely. As a result, circumstances that under legal precedent would not constitute a rescission are determined, by the regulations, to be a rescission and are thereby inappropriately prohibited.

While the proper meaning of rescission is initially stated in the regulations, subsequent clarifications transforms the term, permitting the regulations to promulgate results unintended by Congress. The statutory clarifications begin to transform the definition by stating, "for example, a cancellation that ***treats*** a policy as void from the time of the individual's or group's enrollment, is a rescission.[18] This "clarification" relies on the word "treats" and thereby removes the critical element, of coverage, from the definition. The fundamental question remains – was there a health insurance policy (or health care coverage) legally in place at the time of cancelation or not? If not, the cancellation is not a rescission, since there was no legal right to, or obligation to provide, coverage. Further, the regulations state, "as another example, a cancelation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose." Again, the notion of whether there is a health insurance policy or contract that is legally enforceable at the time of cancelation is omitted.

We understand the goal of protecting individual enrollees from having coverage pulled out from under them on a retroactive basis. However, in instances where there is no coverage, this need for protection dissipates. When errors or mistakes are made in other business dealings, corrections are made, particularly when there is no legal standing to permit a party to benefit from the error. When money is mistakenly deposited in the wrong checking account, that checking account owner does not have a legal right to keep the money.

Plan's Failure to Properly Cancel Policy After Coverage Terminated

For these reasons, we believe that the example included in the regulations, stating that an employer cannot correct an error in administratively cancelling a policy after the enrollee's legal right to coverage has terminated, must be removed from the regulations.[19] In the example provided, an employer had the information necessary[20] to properly terminate a policy and failed to do so. We understand the Department's general policy goal of protecting the individual in instances where a policy remains active because of an employer's failure to properly cancel coverage. However, this policy fails to address the critical fact of the legal right to coverage.

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[17] Preexisting Condition Exclusions et al, 45 Fed. Reg. 37,238 (to be codified at 14.128 (a)(2)

[18] Preexisting Condition Exclusions et al, 45 Fed. Reg. 37,238 (to be codified at 14.128 (1)(2

[19] Preexisting Condition Exclusions et al, 45 Fed. Reg. 37,238 (to be codified at §147.128(a) (3) (Example 2).

[20] Preexisting Condition Exclusions et al, 45 Fed. Reg. 37,238 (to be codified at §147.128(a) (3) (Example 2). "An employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Employee has coverage under the plan as a full time employee. The employer reassigns the employee to a part time position where he no longer works 30 hours a week and is therefore no longer eligible for coverage."

In the scenario described in the example, coverage was predicated on the employee working at least 30 hours a week. Therefore, the legal right to coverage terminated when the employee was re-assigned to a part time position. With the right to coverage terminated, a correction to remediate the employer's failure to administratively cancel the policy does not constitute a rescission. Certainly, a purely administrative correction to cancel coverage retroactively, as expected by the employee and intended by the employer, must be permitted.

Secondly, from an administrative standpoint, there are many instances when an employer or plan may not have access to necessary information, and instead must rely on an employee for notice, that a terminating event has occurred. In these instances, a broader reading of the specific provisions regarding intentional misrepresentation or omission[21] is necessary and warrants a different determination. In several situations, an insurer or plan sponsor is dependent on enrollees for timely notice of events or change in circumstance that will have coverage ramifications, e.g. a birth of a child, a divorce, etc. It is incumbent on employees to provide necessary documentation with the birth of child to obtain coverage for the newborn retroactively to the qualifying event. The same should be required and provided in the case of terminating events. The COBRA regulations deny COBRA coverage to enrollees who fail to provide timely notice of such events. Similarly, the rescission prohibition should not prevent an insurer or plan sponsor from retroactively cancelling coverage if the enrollee or other appropriate family member has failed to provide advance notice of the coverage terminating event and the issuer or plan sponsor could not reasonably have timely cancelled coverage without such notice.
In both instances, timely action can only be taken by the employer after notification from an employee. To do otherwise implicitly encourages employees to "subvert the rules" where they stand to benefit with improper extension of coverage.

To address these concerns, we request that the Departments continue to implement these provisions of the law in a manner consistent with the statutory intent by incorporating the following clarifications in the final regulations:

1. When a right to coverage has been terminated, but there is an administrative failure to cancel, coverage termination must be permitted to have a retroactive effective date that reflects the date that the legal right to coverage terminated.
   When an event (clearly identified as a terminating event) occurs that causes the legal right to coverage under the plan to end, and the individual knows (or should know) that coverage has ended as a result of the terminating event, the coverage may be administratively terminated retroactively.

2. Intentional omission of terminating event must not preclude retroactive cancelation:
   Failure to provide required notice of an event within a plan's reasonable notice period constitutes a rebuttable presumption of fraud which the individual must disprove. Cancelation may be made retroactively to the date when the individual was required to provide notice of the terminating event.

[21] Preexisting Condition Exclusions et al, 45 Fed. Reg. 37,238 (to be codified at §147.128(a) (1).

PATIENT PROTECTIONS

The Chamber supports the simplification provided by the general rules protecting the choice of primary care provider, pediatrician and access to obstetrical and gynecological care. As mentioned previously in these comments on page 5, we recommend that the Departments deem Summary Plan Descriptions to satisfy statutory and regulatory notice requirements when required information as stipulated in incorporated in these materials.

CONCLUSION

While we recognize the need for certain targeted kinds of health reform, we are concerned by some critical elements of the Interim Final Rules implementing the particular provisions prohibiting annual and lifetime limits and rescissions. To reconcile the worthy elements of reform, these regulations must preserve the ability of plans to operate in a way that will allow fiscal solvency as they comply with these provisions. We hope that with our comments and examples, the Departments will make the necessary changes, as we have suggested, to ensure that inadvertent consequences do not result. We look forward to working with you to protect the fundamental goals of health reform that we jointly support. We appreciate the opportunity to comment on the IFRs and are available to discuss any of our comments informally or by way of testimony in hearings conducted by the Departments.

Sincerely,

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