

From: [Anne Lennan](#)
To: [E-OHPSCA715.EBSA](#)
Subject: RIN 1210-AB43
Date: Friday, August 27, 2010 1:51:16 PM

August 26, 2010

Office of Health Plan Standards and Compliance Assistance
EBSA

Room N-5653

Department of Labor

200 Constitution Avenue, NW

Washington, DC 20210

ATTN: RIN 1210AB43

Comments on Interim Final Rules on Patient Protections under P.L. No. 111-148

These comments are submitted on behalf of the Society of Professional Benefit Administrators (SPBA).

SPBA is the national association of Third Party Administration (TPA) firms that are hired by employers and employee benefit plans to provide outside professional management of their employee benefit plans. It is estimated that 55% of US workers in non-federal health coverage are in plans administered by some form of TPA. The clients of TPA firms include every size and format of employment, including large and small employers, state/county/city plans, union, non-union, collectively bargained multiemployer plans, as well as plans representing religious entities.

Section 2590.715-2711 No Lifetime or Annual Limits

Moratorium Needed

Plan sponsors need to have a clear understanding of the definition of essential health benefits in order to design plans that comply with the new prohibitions on lifetime and annual limits. The prohibition on lifetime and annual limits represents a major, major change for group health plans. At minimum, plans need a six-month lead time before the beginning of the plan year to redesign their plans after the agencies issue a detailed explanation of what constitutes essential health benefits. Plan sponsors and their advisors are not able to draft compliant plans because the most important guidance on the definition of essential health benefits has not been provided. Given that this guidance has not been issued by late August, we request a one-year moratorium on the rule prohibiting lifetime and annual limits, or a waiver of penalties for noncompliance. A full year is needed to match the annual cycle workers and employers must have to make choices and changes.

Dental and Vision

Are non-pediatric dental and vision benefits that are a part of the major medical plan subject to the prohibition on lifetime and annual limits? While the interim final rules state that only essential health benefits are to be taken into account in determining whether an individual has received benefits that meet or exceed the restricted annual limits, plan sponsors and third party administrators are not certain whether dental and vision benefits that are a part of a major medical plan are considered essential health benefits.

Excepted Benefits

It is our understanding that self-funded indemnity plans meeting the conditions in Section 2590.732(c)(4) are excepted benefits and therefore are not subject to the prohibition on

lifetime and annual limits. Section 2590.732(c)(4) sets forth a number of conditions for indemnity insurance; one of which is that the benefits are provided under a separate policy, certificate, or contract of insurance. We seek clarification that this condition does not exclude self-funded indemnity plans. While the term policy is often associated with fully-insured plans, it could also apply to a self-funded arrangement.

Transitional Rules for Individuals whose Coverage or Benefits Ended by Reason of Reaching a Lifetime Limit

Please clarify whether the transitional rules apply to individuals who elected COBRA coverage and then dropped their coverage because they reached their lifetime limit. Further, if these individuals have been without coverage for 63 days or more, may the plan impose a pre-existing condition on them (with the exception for those under the age of 19)?

Do the transitional rules apply to individuals who exhausted their lifetime maximum and subsequently terminated employment, but did not elect COBRA because their benefits ended? If so, how far back must eligibility be checked on these prior participants?

Section 290.715-2712 - Rescissions

The interim final rules prohibit plans from rescinding coverage unless an individual was involved in fraud or made an intentional misrepresentation of material fact. This extremely narrow exception is unworkable and fails to take into account all the situations where individuals are responsible for informing the plan and voluntarily choose not to do so. For example: 1) A plan participant divorces and informs the plan 8 months after the fact that the ex-spouse should not have been covered under the plan; 2) A young adult dependent becomes covered under non-parent employer-sponsored coverage and does not inform the plan of this coverage. In both these examples, the plan clearly states in the plan document and the SPD the participants obligation to inform the plan of these changes.

The current exception to the prohibition on rescissions must be expanded to include all those situations where the participant is required under the terms of the plan to notify the plan of a change impacting eligibility and fails to notify.

Section 2590.715-2719A - Patient Protections

Coverage of Emergency Services

The interim final rule sets forth requirements for covering emergency services in an emergency department. SPBA members find these rules to be very confusing.

Please clarify that the interim final rule applies to outpatient emergency room services only and not emergency admissions. Many plans require pre-certification for emergency admission (within 48 hours after emergency admission). Clarification that pre-certification for emergency admission is still permitted would be appreciated.

The section on cost-sharing requirements needs another subheading to distinguish between copayments/coinsurance and the requirement to pay a reasonable amount to out-of-network providers. These are different requirements and should be presented as such to avoid confusion.

To many readers, the interim final rule appears to impose a mandate on out-of-network emergency services that is more stringent than the requirement on in-network emergency services. According to the interim final rule, out-of network emergency services must be provided without regard to any terms or conditions of coverage, other than the exclusion of

or coordination of benefits, an affiliation or waiting period, or applicable cost-sharing requirements. This has given readers the misimpression that plans are required to cover ALL emergency room visits if out-of-network, when such visits would not be covered if in-network.

For example: A plan excludes work-related injuries from coverage. A plan member suffers a work-related injury and seeks treatment at the emergency department of an out-of-network hospital. Is the plan required to cover these emergency services?

Adding an example such as the one above and explaining that the plan is not required to cover emergency services that are excluded under the terms of the plan would be appreciated.

We request clarification that plans may still impose penalties, such as reducing benefits, for participants who use the emergency services of a hospital for non-emergency situations.

Thank you for considering these comments.

--

Anne C. Lennan
Vice President
SPBA
Two Wisconsin Circle, Suite 670
Chevy Chase, MD 20815
301-718-7722
anne@spbatpa.org