ERIC

The ERISA Industry Committee

June 16, 2015

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Re: Maximum Out-of-Pocket Limits in Group Health Plans

Ladies and Gentlemen:

We are writing on behalf of The ERISA Industry Committee ("ERIC") to urge the Departments of Labor, Treasury, and Health and Human Services (the "Departments") to immediately retract the recent "clarification" of the rules applicable to cost-sharing limits in large group health plans.

The assertion that these plans are subject to the self-only limit when they provide coverage *other than* self-only coverage is not supported by the statute. The manner in which the Departments have created this new requirement is not consistent with the Administrative Procedure Act or with the most basic principles of fairness and good government. We ask the Departments to recognize that the requirement is unenforceable and to announce that it has been withdrawn.

The ERISA Industry Committee is the only national trade association advocating solely for the employee benefit and compensation interests of the country's largest employers. ERIC supports the ability of its large employer members to tailor health, retirement and compensation benefits for millions of employees, retirees and their families.

ERIC's members, which sponsor some of the largest private group health plans in the country, are committed to, and known for, providing high-quality, affordable health care. Our members expend considerable resources to maintain plans that cover many disparate populations across a wide range of geographic areas and that operate in all states and territories. These plans provide health care to millions of workers and their families with a high standard of cost containment, quality, and effectiveness.

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The Creation of the New Cost-Sharing Limit

Health and Human Services ("HHS") publishes annual notices of benefit and payment parameters applicable to health coverage in the individual and small group markets. In late November of 2014, HHS suggested in the preamble of the proposed benefit and payment parameters for 2016 that HHS might "clarify" that the annual cost-sharing limitation for self-only coverage "applies to all individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only." 79 *Fed. Reg.* at 70723 (Nov. 26, 2014). HHS did not propose any new regulation, or any modification of an existing regulation, to reflect this new rule.

When HHS published the final notice of benefit and payment parameters for 2016, HHS stated in the preamble that it was finalizing the proposal to apply the self-only limit to all coverage. 80 *Fed. Reg.* at 10824-25 (Feb. 27, 2015). This statement, too, appeared only in the preamble; the statement was not accompanied by any change in HHS's regulation describing the cost-sharing limits. The preamble acknowledged that some commenters had "raised concerns about whether this clarification was within the Congressional intent of the statute," but HHS did not respond to these concerns. Instead, HHS stated, "We believe that this clarification is an important consumer protection," without explaining by what authority HHS had created this consumer protection.

Because this new rule appeared in the preamble of a 129-page *Federal Register* notice dealing almost entirely with technical issues inapplicable to large group health plans, several months passed before most plan sponsors became aware of the change in the cost-sharing limits. When plan sponsors did become aware of the change, many of them assumed that the new rule applied only to individual and small group plans and did not affect large group health plans. This view was reinforced by the fact that neither the Labor Department nor the Treasury Department had endorsed the new cost-sharing limit, whereas these two agencies normally join with HHS in issuing Affordable Care Act (ACA) regulations applicable to large group health plans. Finally, on May 26, 2015, the Departments collectively issued informal guidance announcing their consensus view that HHS's earlier "clarification" applied to large group health plans. *See* ACA FAQ Part XXVII.

The Departments' Rule is Contrary to the Statute

Public Health Service (PHS) Act section 2707(b), as added by the Affordable Care Act, requires a group health plan to ensure that any annual cost-sharing limit imposed under the plan does not exceed the limits of section 1302(c)(1) of ACA.

Section 1302(c)(1) of ACA applies these cost-sharing, or out-of-pocket (OOP), limits to essential health benefits in non-grandfathered plans as follows:

> (c) REQUIREMENTS RELATING TO COST-SHARING.—
>
> (1) ANNUAL LIMITATION ON COST-SHARING.—
>
> (A) 2014.—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.
>
> (B) 2015 AND LATER.—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

> (i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and
>
> (ii) in the case of other coverage, twice the amount in effect under clause (i).
>
> If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

These limits are set at $6,850 for self-only coverage and $13,700 for family coverage in 2016. (Comparable limits are $6,600 for self-only coverage and $13,200 for family coverage in 2015.)

The statutory language states explicitly that the OOP limit for coverage other than self-only coverage (which we call "family" coverage for the sake of simplicity) is twice the limit applicable to self-only coverage. The statute does not impose any other OOP limit on family coverage. Nowhere does the statute suggest that family coverage is subject to two out-of-pocket limits: an umbrella limit for aggregate costs incurred by all family members, and an embedded individual limit, equal to the self-only limit, for costs incurred by any individual member of the family.

The Departments' Rule is Contrary to HHS's Own Regulation

HHS's regulation at 45 C.F.R. § 156.130 interprets the ACA cost-sharing limits. This regulation was published in 2013, and HHS has not changed it in any relevant respect since then. The regulation states:

> (a) *Annual limitation on cost sharing.*
>
> (1) For a plan year beginning in the calendar year 2014, cost sharing may not exceed the following:
>
> (i) For self-only coverage—the annual dollar limit as described in section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986 as amended, for self-only coverage that that is in effect for 2014; or
>
> (ii) For other than self-only coverage—the annual dollar limit in section 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986 as amended, for non-self-only coverage that is in effect for 2014.
>
> (2) For a plan year beginning in a calendar year after 2014, cost sharing may not exceed the following:
>
> (i) For self-only coverage—the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage, as defined in paragraph (e) of this section.
>
> (ii) For other than self-only coverage—twice the dollar limit for self- only coverage described in paragraph (a)(2)(i) of this section.

Like the statute, the regulation clearly states that the cost-sharing limit for coverage other than self-only coverage is twice the limit for self-only coverage. The regulation does not state, or even suggest, that any other limit applies to family coverage.

HHS confirmed in the preamble of the 2013 regulation that the cost-sharing limit for family coverage is twice the limit for self-only coverage:

> Proposed paragraph (a)(1)(i) would address the limitation for self-only coverage and proposed paragraph (a)(1)(ii) would address the limitation for coverage other than self-only coverage; *the practical effect for coverage other than self-only coverage would be that the annual limitation would be double the limitation applicable to self-only coverage.*

78 *Fed. Reg.* at 12847 (emphasis added).

HHS announced the new embedded self-only limit two years later, in the preamble of a different regulation. It is unfair to portray the new limit as a "clarification" of HHS's regulation setting forth the cost-sharing limit for family coverage. No one reading the statute or HHS's regulation would guess that family coverage is subject to an embedded self-only limit applicable to each family member.

Because HHS has never amended the regulation to set forth its new cost-sharing requirement, group health plan sponsors and other interested parties reading the regulation in the future will reach the same conclusion that they reached in the past, the only conclusion one *can* reach from the wording of the regulation: that the sole out-of-pocket limit for family coverage is an umbrella limit that is twice as high as the self-only limit. HHS cannot expect those who seek to understand the cost-sharing limits in the future to read the preamble of every rule HHS has issued since 2013 to discover whether HHS has created a new cost-sharing limit that is not reflected in its regulation. Announcing a new rule in the preamble of an unrelated regulation, and pretending that the new rule is a "clarification" of a regulation that clearly and unambiguously states a different rule, is not an appropriate exercise of HHS's rulemaking authority.

The Departments' Rule is Contrary to Treasury's Interpretation of IRC § 223

Both the statute and HHS's regulation incorporate by reference the OOP expense limits applicable to high-deductible health plans under section 223(c)(2) of the Internal Revenue Code (Code). Code section 223(c)(2)(A)(ii) specifies the dollar limit on OOP expenses for self-only coverage. Like the ACA cost-sharing statute, Code section 223(c)(2)(A)(ii) states that the limit for family coverage is *twice* the limit for self-only coverage.

In the twelve years since Code section 223 was enacted, the Treasury Department has never suggested that a high-deductible health plan must apply the self-only OOP limit to each individual with family coverage; nor could the Treasury Department plausibly adopt this interpretation of Code section 223(c)(2). We are at a loss to understand how the Departments can take the position that the OOP limit for family coverage in Code section 223(c)(2)(A)(ii) has one meaning when applied to high-deductible health plans, and has an entirely different meaning when incorporated in ACA's OOP limits. Congress clearly stated that the ACA limit for family coverage was to be *the same as* the limit under Code section 223(c)(2)(A)(ii).

The Departments' Rulemaking Procedure is Contrary to the Administrative Procedure Act

Thus, the Departments' new cost-sharing limit is not an interpretation—still less is it a clarification—of existing law. Instead, it is an entirely new rule, unsupported by the statute and existing regulations. We do not think HHS has authority to apply the self-only limit to family coverage when Congress has stated clearly that the only applicable limit is *twice* the limit for self-only coverage. Even if HHS did have authority to promulgate a new cost-sharing limit, however, it must follow federal rulemaking procedures in order to do so.

Under section 553 of the Administrative Procedure Act, 5 U.S.C. § 553, a federal agency that wishes to create a substantive rule must publish the proposed rule in the *Federal Register*; must refer to the legal authority under which the rule is proposed; must give interested persons an opportunity to comment on the proposed rule; and must publish the rule in final form at least 30 days before its effective date. HHS has done none of these things.

The embedded self-only cost-sharing limit for family coverage has never been published in proposed or final form. Neither the proposed nor the final version of this new rule appears anywhere in the Code of Federal Regulations: instead, the rule is mentioned exclusively in the preambles of regulations that primarily address technical payment parameters for the individual and small group markets. The preambles do not say whether the new rule applies to large group health plans. The preambles do not state what the effective date of the proposed "clarification" is intended to be. The preambles do not explain what legal authority empowers HHS to create a rule contrary to the statute. In these circumstances, interested parties have never had an opportunity to comment on the proposal: HHS adopted the proposed rule before the sponsors of large group health plans were aware that it even applied to their plans.

These are not mere technical deficiencies. The purpose of the notice-and-comment rulemaking procedure is to inform the agency concerning the consequences of substantive rules that it proposes to adopt. When a proposed rule would impose new and unanticipated costs on private parties, it is especially important that the parties have a full and fair opportunity to be heard. As we explain below, the Departments' new cost-sharing limit will have significant and adverse effects on large group health plans. Because the Departments did not follow the rulemaking procedure prescribed by the Administrative Procedure Act when they adopted this new substantive rule, the rule is unenforceable. *See, e.g., Chamber of Commerce v. Occupational Health and Safety Administration,* 636 F.2d 464, 471-72 (D.C. Cir. 1980) (Bazelon, J., concurring) (federal agency must comply with the Administrative Procedure Act when it "effectively enunciates a new requirement heretofore nonexistent"); *Credit Union National Ass'n v. National Credit Union Administration Board,* 573 F. Supp. 586, 591 (D.D.C. 1983) (a substantive rule's nature cannot be "disguised by the simple semantic maneuver of claiming it 'clarifies or explains'").

The Departments' New Cost-Sharing Limit Would Adversely Affect Group Health Plans

The embedded self-only cost-sharing limit would have a significant impact on large employers. For any alteration of this magnitude, plan sponsors need sufficient time to be able to understand and implement the necessary modifications within their companies and with their third-party administrators ("TPAs") and carriers as well as to prepare their employees for a significant departure from the current rules.

ERIC recently polled its members on the impact of the new cost-sharing limit for family coverage. More than half of our members completed the poll. Of those who responded, 70% said that they

would be moderately or significantly affected by this new rule. Almost 95% of respondents identified their high-deductible health plans as the plans that would be affected.

As we have explained, Code section 223(c)(2) currently requires employers to apply only an umbrella out-of-pocket limit to their high-deductible health plans: no separate limit applies to the expense incurred by individual family members. The Departments' new rule would require these plans also to apply a self-only limit to each individual with family coverage. The new cost-sharing limit shifts medical costs to employers for individuals who have not reached, and might never reach, the umbrella limit under Code section 223(c)(3). Many employers face a major plan design change or revision to the pricing structure to accommodate the additional cost.

Almost more important, though, is that the rule change in many cases would be extremely disruptive to the plan operations of ERIC members. Those affected would face a huge time commitment to determine what design revisions would be necessary and how they should be implemented; most ERIC members by this point in the year have already settled on at least a preliminary pricing structure, including employee contributions, for 2016.

Many ERIC members do not know if their TPAs or carriers are capable of complying with the new limits on cost-sharing, let alone how much it would cost and what change in the price structure would be necessary to accommodate the increase. For instance, some ERIC members use pharmacy benefit managers ("PBMs") for their self-insured plans, and it is not clear if these PBMs would be able to administer an "embedded" OOP limit for a high-deductible health plan that has a shared medical/drug deductible. Other ERIC members have heard that their current vendors may not be able to handle the new rules within their current platforms; some have said that they must change the deductible limits if the OOP limits are changed.

Once the plan design changes are decided upon, significant systems and operations modifications would be required to implement the new cost-sharing limits. After that, our members would face the considerable task of changing all of their open enrollment material for 2016 and, of course, communicating with their employees and their families would be both complicated and time-consuming.

ERIC's recommendation: The Departments' "clarification" of the ACA cost-sharing limits must be withdrawn immediately. We believe that the rule is unenforceable in any event, but the Departments' recent assertion in FAQ Part XXVII that they intend to enforce the rule starting in 2016 has created concern that employers will be targeted with enforcement activity that is expensive and disruptive even if it is ultimately unsuccessful.

Immediate withdrawal is imperative as plan sponsors are literally in the midst of finalizing their benefits for the 2016 plan year; it is essential that they know very, very quickly that they will be able to finalize their plan designs and operations for 2016 without having to accommodate this wholly unexpected and unjustified policy change.

If the Departments wish to promulgate a new substantive rule of this magnitude, they must follow the rulemaking procedure prescribed by the Administrative Procedure Act, and they must identify the source of their authority to create the rule. They must give employers and other affected parties

adequate notice and sufficient time to comment. Any substantive rule the Departments ultimately adopt must give employers time to understand and implement the new requirement.

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Thank you for your consideration of these comments. We would be pleased to discuss this letter with you if you have any questions.

Sincerely,

Annette Guarisco Fildes
President & CEO
The ERISA Industry Committee