ERIC

The ERISA Industry Committee

April 25, 2013

U.S. Department of Labor
U.S. Department of Health and Human Services
U.S. Treasury Department

RE: FAQs About Affordable Care Act Implementation (Part XII)

Ladies and Gentlemen:

The ERISA Industry Committee ("ERIC") is pleased to respond to the request of the U.S. Department of Labor, U.S. Department of Health and Human Services, and U.S. Treasury Department (collectively, the "Departments") for comments regarding guidance on annual cost-sharing limits under section 1302 of the Patient Protection and Affordable Care Act ("ACA"), which was published in FAQs About Affordable Care Act Implementation (Part XII) (the "FAQs").[1]

ERIC's Interest in the ACA

ERIC is a nonprofit association committed to the advancement of the employee retirement, health, and other welfare benefits of America's largest employers. ERIC's members sponsor some of the largest private group health plans in the country. These plans provide health care to millions of workers and their families.

ERIC's members devote considerable time and resources to their benefit plans. However, they must balance the desire to provide high quality, affordable health care with the need to contain the costs for these programs. The costs for medical benefits have been steadily rising. In the last 10 years, the average cost for family premiums in employer-sponsored health coverage has increased by 97%.[2] The U.S. Bureau of Labor Statistics found that large employers pay 80% of the cost for single medical care benefits and 77% of the cost for family coverage.[3] Any additional burdens placed on plans could adversely affect the ability of these employers to continue to provide generous benefits and could result in increased costs for participants.

[1] U.S. Dep't of Labor, U.S. Dep't of Health and Human Services, and U.S. Treasury Dep't, FAQs About Affordable Care Act Implementation (Part XII), available at http://www.dol.gov/ebsa/faqs/faq-aca12.html.
[2] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2012 Annual Survey (Sept. 2012), available at http://ehbs.kff.org/.
[3] William J. Wiatrowski, Employment-based health benefits in small and large private establishments, U.S. Bureau of Labor Statistics (Apr. 2013), available at http://www.bls.gov/opub/btn/volume-2/employment-based-health-benefits-in-small-and-large-private-establishments.htm.

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Summary of Comments

ERIC makes the following recommendations with respect to the FAQs:

- The Departments should provide greater flexibility and clarity with respect to the out-of-pocket rules. In particular, ERIC recommends that:
  - The out-of-pocket limits should apply only to essential health benefits, as determined in good faith by large employers.
  - The out-of-pocket limits should apply only to the employer's lowest cost coverage that provides minimum value (although an employer could elect to include the limits in other coverage options).
  - The Departments should affirm that the out-of-pocket limits do not apply to retiree health plans.
  - Additional charges to participants pursuant to a failure to adhere to a plan's cost management methodology should not be subject to the cost-sharing limits.
  - The transition rule should be expanded to cover related service-providers and extended for two years.
  - The transition rule should be clarified.
- The limitation on the amount for deductibles should apply only to health plans in the small group market.

Detailed Comments

I. The Departments should provide greater flexibility and clarity with respect to the out-of-pocket rules.

The ACA provides that health plans may not impose cost-sharing limits that exceed the dollar amounts for high deductible health plans for plan years beginning in 2014.[4] Under the ACA, the term "health plan" includes health insurance coverage and group health plans, but generally does not include self-insured group health plans unless specifically provided in the statute.[5] Section 2707(b) of the Public Health Service Act, as added by section 1201 of ACA, extends this requirement to self-insured plans.

The term "cost-sharing" includes "(i) deductibles, coinsurance, copayments, or similar charges; and (ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986)[6] with

[4] Pub. L. No. 111-148, § 1302(c) (2010).
[5] *Id*. at § 1301(b).
[6] All references are to the Internal Revenue Code of 1986, as amended, unless otherwise noted.

respect to essential health benefits covered under the plan."[7] Cost-sharing does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.[8] The ACA directs the Secretary of Health and Human Services to define the essential health benefits.[9]

A. The Departments should clarify that the out-of pocket limits should apply only to essential health benefits, as defined in good faith by the plan.

The ACA subjects the "essential health benefits" offered by large plans to two different limits. First, the ACA imposes restrictions with respect to annual and lifetime limits on essential health benefits for plan years beginning on or after September 23, 2010.[10] Second, the ACA limits the amount of cost-sharing that a plan may apply to essential health benefits.[11]

The ACA contains only a very broad definition of "essential health benefits."[12] The Departments did not provide final regulations interpreting this provision until February 2013, and even then, substantial questions remain for employer group health plans, since the guidance focuses on benefits to be provided through the Exchanges.[13]

Prior to the final regulations, group health plans had applied a good faith interpretation of the term "essential health benefits" for several years in complying with the restrictions on annual and lifetime limits. In the final regulations, the Department of Health and Human Services recognized this approach and stated "the Departments intend to work with those plans that make a good faith effort to apply an authorized definition of [essential health benefits ("EHB")] to ensure there are no annual or lifetime dollar limits on EHB."[14]

Plans in the large group market are not required to provide EHB. Instead, the plans must comply with ACA's restrictions on annual and lifetime limits and cost-sharing with respect to the EHB they choose to provide. Plan sponsors should be permitted to follow a good faith approach to determine which benefits within the ten broad categories defined in the statute are to be considered EHB and, thus, subject to the ACA restrictions. Plan sponsors are in the best position to design plans that are appropriate and effective for their populations: they determine which benefits will be provided, and they should also determine which benefits are to be considered "essential" for purposes of applying the ACA's annual and lifetime limits.

Although the preamble to the final EHB regulations endorses a good-faith approach to identifying EHB for purposes of the restrictions on annual and lifetime limits, it does not mention the

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[7] Pub. L. No. 111-148, § 1302(c).
[8] *Id.*
[9] *Id.* at § 1302(b) (specifying that the following categories must be included: (A) ambulatory patient services, (B) emergency services, (C) hospitalization, (D) maternity and newborn care, (E) mental health and substance use disorder services, including behavioral health treatment, (F) prescription drugs, (G) rehabilitative and habilitative services and devices, (H) laboratory services, (I) preventive and wellness services and chronic disease management, and (J) pediatric services, including oral and vision care).
[10] *Id*. at § 2711.
[11] Pub. L. No. 111-148, § 1302(c).
[12] *Id*. at § 1302(c).
[13] 78 Fed. Reg. 12834 (Feb. 25, 2013).
[14] *Id*. at 12835.

cost-sharing limits in connection with this approach. Plan sponsors should be permitted to use the same good-faith definition of EHB for purposes of applying the ACA's cost-sharing limits. To require the use of different definitions of EHB for the two ACA limits would lead to confusing and uncertain administrative interpretations that often would be acting at cross purposes. Two different interpretations would also be difficult to communicate to plan participants.

The definition of "essential health benefits" is important for both sets of limits, and plans should be permitted to use a good faith approach to define essential health benefits for purposes of applying the cost-sharing limits as well as for the restrictions on annual and lifetime maximums.

ERIC recommends that the Departments clarify that the cost-sharing limits are applied only to those benefits provided under large group health plans that the plan sponsors have determined in good faith are essential health benefits.

B. The out-of pocket limits should not apply to all options within a group health plan.

The ACA provides that group health plans may not impose cost-sharing limits that exceed certain dollar amounts.[15] The ACA does not specify whether these limits apply to all of the options provided under a group health plan (e.g., HMO, PPO, etc.).

Section 4980H provides that penalties apply if an employer does not offer coverage or if the coverage is not affordable or does not satisfy the minimum value requirements. An employer is not required to meet the affordability and minimum value tests with respect to every coverage option under the plan, however. Instead, in order to determine whether the coverage is affordable, the Internal Revenue Service examines the employee's contribution for "the employer's lowest cost coverage that provides minimum value".[16] ERIC believes that a similar approach should apply for purposes of evaluating a group health plan's compliance with the out-of-pocket limits.

By using an approach similar to the rule under section 4980H for the cost-sharing limits, the Departments could satisfy the objectives of the ACA while continuing to allow participants to have a variety of cost-effective choices in their group health plans. Applying the cost-sharing to the employer's lowest cost coverage that provides minimum value would ensure that all employees have access to an affordable, comprehensive coverage option that includes an out-of-pocket limit on EHB. This approach would satisfy ACA's requirement that every group health plan offer self-only coverage and family coverage that complies with the out-of-pocket limit. At the same time, however, employers would be able to offer other coverage options that did not incorporate the cost-sharing limits, but that might be better suited to the needs of an individual participant and his family. By adopting this approach, the Departments would encourage companies to give employees greater flexibility in their health plan options, so they can pick the one that is right for them.

ERIC urges the Departments to issue guidance that provides that the out-of-pocket limits are required to apply only to the employer's lowest cost coverage that provides minimum value. An

[15] Pub. L. No. 111-148, § 1302(c) (2010).
[16] 78 Fed. Reg. 218, 235 (Jan. 2, 2013).

employer could elect to include the limits in other coverage options, but would not be required to do so.

C. The Departments should affirm that the ACA out-of pocket limits do not apply to retiree-only health plans.

The preamble to the interim final regulations on grandfathered plans indicates that certain provisions of the ACA do not apply to retiree-only health plans.[17] Among the provisions singled out as not applying to retiree-only plans are the cost sharing limits of the ACA.

While we believe it is clear that the out-of-pocket limits do not apply to essential health benefits offered by retiree-only plans, ERIC requests that the Departments affirm that the limit does not apply to plans with fewer than two participants who are current employees.

D. Additional charges to participants pursuant to a failure to adhere to a plan's cost management methodology should not be subject to the cost-sharing limits.

The ACA is designed to expand the number of Americans with comprehensive health coverage. For the most part, however, the ACA does little to reduce costs; the prime movers in this sphere have been employers, who have used cost control mechanisms to try to limit the rising cost of health care. One common approach chosen by employers is to charge employees a smaller amount, through differential cost sharing and by other means, to encourage employees to use less costly forms of medical care and services. The Departments should not apply the out-of-pocket limits in a way that interferes with employers' effective cost-control mechanisms.

The ACA provides that the term "cost-sharing" includes "(i) deductibles, coinsurance, copayments, or similar charges; and (ii) any other expenditure required of an insured individual which is a qualified medical expense…with respect to essential health benefits covered under the plan."[18] It also states that cost-sharing does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.[19]

In the essential health benefits regulation, the Department of Health and Human Services provides that out-of-network expenses generally will not be treated as cost-sharing.[20] The preamble explains, "[W]e have decided to apply cost-sharing limits to in-network visits only to promote health plan affordability."[21] The Department also eliminated a proposed rule prohibiting discriminatory cost sharing "in response to comments about the protection of a health plan's ability to control costs through the use of utilization management . . . ."[22]

The rationale behind the exemption from the cost-sharing rules for out-of-network charges should apply equally to other situations where participants may either choose a low-cost option or

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[17] 75 Fed. Reg. 34538, 34539 (Jun. 17, 2010).
[18] Pub. L. No. 111-148, § 1302(c).
[19] *Id.*
[20] 45 C.F.R. §§ 156.130, 156.150 (published at 78 Fed. Reg. 12834 (Feb. 25, 2013)).
[21] 78 Fed. Reg. 12834, 12848 (Feb. 25, 2013).
[22] *Id.*

pay a higher amount for a medical service that is more expensive. For instance, plans may give participants an option to pay a lesser amount for a generic drug or to pay more for a higher-cost brand-name prescription drug. Some plans require the use of mail order for prescriptions in order to minimize plan costs and charge participants higher costs if they do not order prescriptions by mail. Some plans also use reference-based pricing, where the plan pays up to the average price of a procedure in a region. Plans may also apply a fee if the participant does not get preauthorization for services, such as for certain hospital visits.

These higher costs that result from the participant's electing not to use the most cost-efficient options should not be subject to the limit on cost-sharing. Instead, the cost-sharing limits should apply only to the lowest-cost version of an essential health benefit that is available to a participant. This approach is cost effective for both plan sponsors and participants: it gives all participants access to essential health benefits with limited cost-sharing, while it preserves plan sponsors' ability to control costs and gives participants the flexibility to choose a more expensive option. Under this suggested approach, however, the participant choosing the more expensive option will bear the added cost, and not the other plan participants.

ERIC urges the Departments to distinguish clearly between those medical costs and services that are properly subject to the out-of-pocket limits, and additional expenses attributable to a plan's cost-management approach, which should not be subject to these limits.

E. The transition rule should be expanded to cover related service-providers and extended for two years.

The Departments have recognized in the FAQs and in the final regulations defining essential health benefits that it will be challenging for plans to coordinate out-of-pocket expenses among various service providers.

The FAQs state, "The Departments recognize that plans may utilize multiple service providers to help administer benefits . . . . Separate plan service providers may impose different levels of out-of-pocket limitations and may utilize different methods for crediting participants' expenses against any out-of-pocket maximums."[23]

The Department of Health and Human Services stated in the preamble to the final regulations for essential health benefits that "We agree with comments noting that coordination between medical and dental issuers would be administratively complex and accordingly could result in higher premiums for consumers. We therefore allow for a separate out-of-pocket maximum for stand-alone dental issuers."[24]

The FAQs provide an exception to the out-of pocket limits for the first plan year beginning on or after January 1, 2014 (the "transition rule"). To qualify for this exception, a plan must: (1) use more than one service provider to administer benefits that are subject to the out-of-pocket limits; (2) comply with the out-of-pocket limit with respect to its major medical coverage; and (3) not

[23] U.S. Dep't of Labor, U.S. Dep't of Health and Human Services, and U.S. Treasury Dep't, *FAQs About Affordable Care Act Implementation (Part XII)* (Feb. 20, 2013).
[24] 78 Fed. Reg. at 12852.

include any other out-of-pocket limit (such as for prescription drug coverage) that exceeds the applicable dollar amounts.

ERIC appreciates the Departments' granting of the transition rule. Coordination among service providers is challenging for many plans, whether it is between medical and dental issuers or for other types of benefits, such as for prescription drug or mental health benefits. Companies will need to build complex systems to achieve the necessary coordination, which will result in a significant investment of both time and money.

Additionally, some major medical claims administrators and pharmacy benefit managers may share common ownership or constitute separate legal divisions of a single legal entity, but nevertheless operate as separate service providers to group health plans. A plan's use of one or more service providers of this type, owned by one company but providing services independently to their clients, should also be entitled to the transition relief provided for service providers that are independently owned.

ERIC thus requests that the Departments expand the transition rule to encompass service providers that operate independently but that are subject to a common ownership.

ERIC also urges the Departments to give employers additional time to make the necessary systems and administrative changes to conform to these new rules. We request that the proposed transition rule, as clarified, be extended for an additional two years.

F. The Departments should clarify the transition rule.

The transition rule contained in the FAQs has been the subject of some confusion and would benefit from clarification. We believe that the following examples illustrate the way in which the transition rule is intended to operate.

A group health plan includes major medical coverage with an out-of-pocket limit of $6,000. The plan also includes a prescription drug benefit that has a separate out-of-pocket limit of $5,000. The major medical coverage and prescription drug benefit are administered by different service providers. ERIC understands that this group health plan would be able to rely on the transition rule because the out-of-pocket limits for major medical coverage and the prescription drug benefit each independently satisfies the ACA requirement.

A different group health plan includes major medical coverage with an out-of-pocket limit of $6,000. The plan also includes a prescription drug benefit that has no out-of-pocket limit. The major medical coverage and prescription drug benefit are administered by different service providers. ERIC understands that this group health plan would also be able to rely on the transition rule because the out-of-pocket limit for major medical coverage satisfies the ACA requirement and the prescription drug benefit does not include a separate out-of-pocket limit and therefore is not subject to the ACA requirement during the transition period.

ERIC requests that the Departments issue guidance that clarifies that the transition rule applies in each of these situations.

II. The limitation on the amount for deductibles should apply only to health plans in the small group market.

The ACA limits the amount of deductibles for health plans offered in the small group market.[25] The ACA provides in section 1201 (amending section 2707 of the Public Health Service Act) that "[a] group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c)."[26] Section 1302 then explains how each of these provisions applies. For example, section 1302(c)(1) applies to "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 . . . ." Section 1302(c)(2) applies "[i]n the case of a health plan offered in the small group market . . ."[27] Section 1304 of the ACA defines the term "small group market" as "the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by . . . a small employer (as defined in subsection (b)(2)), respectively."[28]

In the preamble to the essential health benefits regulation, the Department of Health and Human Services indicates that there are multiple ways to read this language.[29] We agree with the Department that "the annual limitation on deductibles in section 1302(c)(2) applies only to 'health plan[s] offered in the small group market,' and so under this interpretation that limitation would apply only to insured small group market health plans."[30] As a result, we do not think it is necessary for the Department to rely on the second interpretation, which considers the actuarial valuation of the plan.

The FAQs state also that the Departments believe that only plans and issuers in the small group market are required to comply with this requirement.[31] The Departments note that they expect future rulemaking on this issue and state that until then, "a self-insured or large group health plan can rely on the Departments' stated intention to apply the deductible limits imposed by section 1302(c)(2) of the Affordable Care Act only on plans and issuers in the small group market."[32]

ERIC strongly encourages the Departments to retain the rule provided in the preamble to the essential health benefits regulation and the FAQs regarding the limit on the amount of deductibles.

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[25] Pub. L. No. 111-148, § 1302(c) (2010).
[26] *Id.* at 1301.
[27] *Id*. at 1302(c)(2).
[28] *Id*. at 1304(a)(3).
[29] 78 Fed. Reg. at 12837.
[30] *Id.*
[31] U.S. Dep't of Labor, U.S. Dep't of Health and Human Services, and U.S. Treasury Dep't, *FAQs About Affordable Care Act Implementation (Part XII)* Q&A-1 (Feb. 20, 2013).
[32] *Id.*

ERIC appreciates the opportunity to provide comments on the FAQs. If the Departments have any questions concerning our comments, or if we can be of further assistance, please contact us at (202) 789-1400.

Sincerely,

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