January 31, 2012

Submitted Via Email: EssentialHealthBenefits@cms.hhs.gov.

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on Essential Health Benefits Bulletin

Dear Secretary Sebelius:

The HR Policy Association (“HR Policy” or the “Association”) welcomes the opportunity to provide comments to the Department of Health and Human Services’ (HHS) Center for Consumer Information and Insurance Oversight’s (CCIIO) Essential Health Benefits Bulletin released December 16, 2011 that outlines the proposed regulatory approach to define EHBs under the Patient Protection and Affordable Care Act (PPACA).¹

HR Policy Association is a public policy advocacy organization representing chief human resource officers of major employers. The Association consists of more than 330 of the largest corporations doing business in the United States and globally, and these employers are represented in the organization by their most senior human resource executive. Collectively, their companies employ more than 10 million employees in the United States, nearly nine percent of the private sector workforce. Together the member companies spend more than $80 billion annually providing health insurance to tens of millions of American employees, their dependents, and retirees.

The Association appreciates the Agency’s confirmation that “self-insured employer plans, health insurance coverage offered in the large group market, and grandfathered plans do not have to provide essential health benefits.”² Nevertheless, the definitions of EHBs are critically important for large employer-sponsored health plans because almost all plans—including self-insured employer plans—are subject to PPACA’s restrictions on annual and lifetime dollar limits on “essential health benefits.”³ Thus, it appears that if HHS moves forward with its current proposal—without providing any exception or federal safe-harbor—employer-sponsored plans which currently provide coverage for over 100 million Americans would be subject to numerous different annual and lifetime limitation standards depending upon each particular state’s EHBs definition. This would create a significant obstacle for large employers in designing and administering health plans uniformly across the nation. Nationwide uniformity in benefit design and administration is extremely important because it promotes substantial efficiencies, and it significantly reduces health care costs to employers, employees, and dependents.

³ PHSA § 2711, as added by PPACA, Pub. No. 111-148, §§ 1001(5) and 10101(a) (2010).
HR Policy Association notes that the EHB Bulletin is rather limited in scope and “only relates to covered services” and that “plan cost sharing and the calculation of actuarial value are not addressed.” Indeed, HHS plans to provide guidance on these issues in the “near future.” Because the vast majority of the Association’s members sponsor self-insured health plans, these comments primarily target the problem that the planned approach—if not modified for large employer plans—will significantly interfere with employers’ ability to design and administer health plans uniformly across the nation. HR Policy’s goal is to strengthen and preserve the employer-based system of health care, while supporting health care reform that advances access to high quality, affordable coverage for all Americans. With that in mind, we respectfully express the following concerns and requests for clarification on issues raised herein.

“Essential Health Benefits” Under PPACA.

The Patient Protection and Affordable Care Act of 2010 (PPACA) requires non-grandfathered health benefit plans in the individual and small group markets, both inside and outside of the Exchange, and Medicaid plans to cover EHBs beginning in 2014. The ACA defines the ten broad categories of EHBs as: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. However, “self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered plans are not required to offer essential health benefits.” PPACA further requires HHS to define the services that must be provided within these benefit categories. These services will provide the minimum coverage required, but only for plans for those plans required to offer EHBs.


The “purpose of this bulletin is to provide information and solicit comments on the regulatory approach that the Department of Health and Human Services plans to propose to define essential health benefits.” The bulletin was not published in the Federal Register and it is not a typical notice and public comment rulemaking, which federal agencies use to propose a new regulation. HHS has indicated that at some future date it plans to issue final regulations in accordance with routine notice and public comment rulemaking procedures. HR Policy urges HHS to issue such guidance in a timely fashion as there is an ever growing concern among the members of the Association about whether PPACA’s impending deadlines regarding state and federal Health Insurance Exchanges can realistically be met. Final federal regulations on EHBs

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10 See CIIOO, Essential Health Benefits Bulletin, 1 fn. 1 (Dec. 16, 2011) (“Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered plans are not required to offer essential health benefits.”).
are essential to meeting the rapidly approaching Exchange deadlines; however, such regulations must not interfere with large employers’ ability to provide design and administer health plans with nationwide uniformity.

HHS’ planned approach pushes the decision on the definition of EHBs to the states. Under this early proposal each state will choose a “benchmark plan.” The “benefits and services included in the benchmark health insurance plan selected by the state will be the essential health benefits package.”13 States would have the option of selecting one of the following benchmark plans:

- The largest plan by enrollment in any of the three small group plans in the state;
- Any of the three largest (by enrollment) state employee health plans;
- Any of the three largest (by enrollment) federal employee health plan options; or
- The largest insured commercial non-Medicaid HMO plan offered in the state.14

States are to select a benchmark plan by September 30, 2012. If states do not choose a benchmark plan, the default benchmark will be the small group plan with the largest enrollment in the state.15 Presumably, federally facilitated Health Insurance Exchanges would use the default benchmark plan to define EHBs, although HHS should clarify this point.

PPACA requires that states must defray the costs of state-mandated coverage for services that exceeds the EHBs minimum required coverage if that coverage is purchased through the Exchange.16 However, HHS’ approach will allow states with more generous coverage mandates to select a benchmark plan—such as a small group market plan—that by law will include the state’s insurance mandates, which are often numerous and expensive. Permitting states to adopt such a course will allow them to continue to avoid paying for high cost mandates, which have contributed to rapidly rising health care costs.17 Currently, the states and District of Columbia collectively mandate more than 1,600 specific health services.18 However, HHS intends to revisit the state mandate issue by 2016. Meanwhile, the states will not have to defray the costs of mandates because they can define EHBs by selecting a benchmark plan that will include their mandates. This appears to have the effect of shifting the cost to consumers purchasing insurance through an Exchange.

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Annual and Lifetime Limits on Essential Health Benefits Prohibited.

As noted above, even though large group health plans—including self-insured plans—are not required to provide EHBs under PPACA, such plans are subject to the Act’s restrictions on annual and lifetime dollar limits on the value of “essential health benefits.” However, both lifetime and annual limits are allowed for benefits of services that are not EHBs. Since the HHS approach would allow each state to define EHBs in its own way, the Agency is effectively authorizing each state to determine the services and benefits that are subject to PPACA’s annual and lifetime restrictions for all plans including large employer plans which are not required to provide EHBs.

Because PPACA’s rules regarding lifetime and annual dollar limits took effect in 2010, and HHS had not specifically defined EHBs, there has been no way to determine exactly which services would be considered “essential” within the 10 broad statutory categories discussed above. Accordingly, HHS provided that until it issued final regulations defining EHBs, plan sponsors should use a “good faith” reasonable interpretation of EHBs in order to comply with restrictions on annual and lifetime limits. From 2010 through the present, large employers have generally been successful and comfortable in making a “good faith” comparison—often opting to err on the side of coverage for plan participants—between the services and benefits offered through their plans and the 10 categories of EHBs listed in the federal health care reform law. Indeed, these employers have been interpreting and applying their plans vis-à-vis PPACA’s EHBs categories on a nationwide basis and these plan sponsors—specifically through self-insured arrangements—have been providing health care coverage uniformly across the nation to millions of Americans.

Large Employer Health Plans Should Not Be Subject to State Definitions of Essential Health Benefits.

HR Policy Association has strong concerns about HHS’ planned approach because allowing each state to define EHBs is effectively a backdoor way of allowing the states to regulate which services and benefits are subject to PPACA’s annual and lifetime limits for all plans, including large group employer-sponsored plans. One of the Association’s chief concerns with the enactment and implementation of PPACA has been—and remains—that large multistate employers continue to have the ability to offer and administer health care benefits in a uniform manner. Indeed, the ability of large multistate employers who provide health care on a self-

19 See CIIOO, Essential Health Benefits Bulletin, 1 fn. 1 (Dec. 16, 2011) (“Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered plans are not required to offer essential health benefits.”).
20 PHSA § 2711, as added by PPACA, Pub. L. No. 111-148, §§ 1001(5) and 10101(a) (2010).
21 PHSA § 2711(b), as added by PPACA, Pub. L. No. 111-148, §§ 1001(5) and 10101(a) (2010); PHSA § 2711(a)(1)(A) restricts annual and lifetime limits on the “dollar value of benefits.” However, PHSA § 2711(b) expressly permits annual and lifetime “per beneficiary” limits on benefits “that are not essential health benefits.” See also Treas. Reg. § 54.9815-2711T(b)(1); DOL Reg. § 2590.715-2711(b)(1); HHS Reg. § 147.126(b)(2).
22 75 Fed. Reg. 37188 (June 28, 2010).
23 75 Fed. Reg. 37188, 37191 (June 28, 2010).
24 The Association has been encouraged by some of HHS’ regulatory proposals under consideration such as the current effort to “minimize[e] the burden on employers” by using a centralized uniform method—such as a central federal database or uniform templates—to facilitate the massive data exchange between employers, employees, Health Insurance Exchanges, and the federal government in order to verify eligibility for premium assistance.
insured basis to administer their programs uniformly across America has been a relative success in the otherwise flawed health care system in the United States. Their ability to do so is the result of the strong preemption provision under the Employee Retirement Income Security Act (ERISA).

Nationwide Uniform Plan Administration Is Necessary for Large Multistate Employers. The ERISA preemption clause prohibits state and local governments from imposing requirements on self-insured employer-sponsored plans that would interfere with the ability of these companies to design and maintain health care plans that meet their unique needs. Nationwide uniformity in benefit design and administration is extremely important because it promotes substantial efficiencies, and it significantly reduces health care costs to employers, employees, and dependents. In addition, it streamlines communications and promotes better understanding of coverage options by allowing employers to offer a standard set of benefits across the country. Further, it allows employers to obtain better pricing with national or regional healthcare providers by allowing them to negotiate contracts on a national basis. Finally, uniformity permits companies to provide similar benefits to their workers (regardless of where they reside), which promotes equity and the ability of employees and retirees to freely move from state to state and city to city without concern for benefit changes.

In view of the above, the Association is concerned with a state-by-state approach to defining EHBs to the extent it undermines the ability of multistate employers to uniformly design and administer health benefits. This could subject such employers to numerous sets of operating requirements, a change that would be administratively burdensome and costly for them. If states are allowed to directly regulate the design of self-insured plans—such as defining which benefits are subject to annual and lifetime limits—some aggressive states will undoubtedly try to impose additional regulations, mandates, and burdensome reporting requirements. At some point such state interference will make it unworkable for large multistate employers to continue providing employer-sponsored benefits.

HR Policy recommends that HHS provide clear guidance that state definitions of EHBs will not apply to large group health plans in any respect, including annual and lifetime limits. A workable effective federal standard or safe-harbor providing flexibility for large group plans with respect to identifying restrictions on annual and lifetime limits is much more preferable than a state-by-state approach. Meanwhile, HHS should maintain its position that plan sponsors should use a “good faith” reasonable interpretation of EHBs in order to comply with PPACA’s restrictions on annual and lifetime limits.25 The Association further urges that HHS provide regulatory guidance clearly explaining that state efforts in connection with any aspect of PPACA implementation should not interfere with the ability of multistate employers to uniformly design and administer health plans and that such state efforts would be preempted by ERISA.

HHS Should Reaffirm that Lifetime Limits Do Not Apply to Secondary Supplemental Plans. On October 29, 2010, HHS (along with the Department of Labor and Department of Treasury) issued a sub-regulatory FAQ adopting a non-enforcement policy and finding that the “good faith” interpretation standard applies with respect to secondary enhanced benefit plans that “reimburse expenses for special treatment and therapy of eligible employees’ children with


physical, mental, or developmental disabilities.” Reimbursements include treatment and therapy related to day or residential special care facilities, special education facilities for learning-disabled children, or special devices. Such treatment or therapy is not covered the employer’s primary health plan. These benefit plans are self-insured and operate separately from the employers’ primary health plans and are offered in addition to the primary medical plans. Moreover, employees who are otherwise eligible may participate in the plan without participating in those primary medical plans. While these secondary benefit plans do have a dollar limit on the total benefits provided for each eligible child, these plans were in place long before PPACA’s enactment. Most critically, however, these plans provide important benefits to a particularly vulnerable population of children. While these plan sponsors offer very rich benefit coverage through their primary health plans, they choose to offer these benefits in order to assist, enable and empower children with disabilities. The dollar limits on these benefits provided under these plans should not be considered to fall within PPACA’s restrictions on annual or lifetime limits. Indeed, Congress certainly could not have foreseen nor intended to disrupt or otherwise interfere with these plans and deprive children with physical and mental disabilities of important benefits. Yet, it is unclear how states would define EHBs and how these plans would be treated. Without clear guidance from HHS that state definitions of EHBs will not apply to self-insured health plans (including these plans) or without an effective federal standard or safe-harbor providing flexibility for these plans, the plan sponsors will either most likely have to substantially change the plans or possible terminate them.

Moreover, HR Policy Association urges the Agencies to maintain their position that sponsors of such plans have “a reasonable good faith interpretation” that the “plan does not violate the prohibition…on imposing a lifetime dollar limit on ‘essential health benefits.’” In addition, the Agencies should maintain their position that “in the case of plans described above…[that] the imposition by such plans of such a limit will not result in an enforcement action by the Departments against such plans under PHS Act section 2711.”

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27 Id.
28 Id.
29 Id.
30 Id.
31 Id.
32 Id.
33 Id.
34 Id.
Thank you for the opportunity to comment on the Essential Health Benefits Bulletin and for considering our suggested recommendations. If the Association can be of further assistance, please contact Michael Peterson at 202-789-8659 or mpeterson@hrpolicy.org.

Sincerely,

Michael Peterson
Vice President, Benefits & Employment Policy
Associate General Counsel
HR Policy Association