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VIA EMAIL (E-OHPSCA715.EBSA@dol.gov)
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration, Room N-5653
U.S. Department of Labor
Attention RIN 1210-AB43
200 Constitution Avenue, NW.
Washington D.C., 20210

Re: Department of Labor-Employee Benefits Security Administration
29 CFR Chapter XXV
Part 2590-Rules and Regulations for Group Health Plans
§2590.715-2711 No lifetime or annual limits
RIN 1210-AB43

To Whom It May Concern:

We request clarification on the application of the annual limits restrictions to out-of-network benefits. It is our interpretation that the prohibition on annual limits would apply to an annual cap on out-of-network benefits when they qualify as "essential health benefits." Section 2590.715-2711(a)(2) of the regulations states the general rule for annual limits is "a group plan, or health insurance issuer offering group coverage, may not establish any annual limit on the dollar amount of benefits for any individual." The regulations go on to state that there may be annual limits for benefits that are not essential health benefits. §2590.715-2711(a)(2)(b). For plans beginning prior to January 1, 2013, carriers are permitted to have restricted annual limits on essential health benefits. §2590.715-2711(a)(2)(d).

It is currently unclear whether the new annual limits section applies to out-of-network essential health benefits. "Essential health benefits" has yet to be defined and perhaps the future

regulations will clarify any ambiguity in this section. The recently released regulations address the in and out-of-network issue with respect to emergency services. Section 54.9815-2719AT(b) provides that the services provided on an emergency basis by an out-of-network provider are covered under the section. Guidance is also required as to the in and out-of-network issue with respect to limits on essential health benefits.

Currently in New Jersey, insurance carriers are limiting patient out of network benefits by putting annual caps on services provided by ambulatory surgical centers. Attached for your reference are riders approved by the New Jersey Department of Banking and Insurance which allow for caps of $2,000.00 on services provided at out-of-network ambulatory surgical centers and the questions and answers involving limits on benefits from the New Jersey Department of Banking and Insurance website describing the annual cap. The riders also limit coverage of out-of-network laboratory services, out-of-network therapy services, home health care visits and durable medical equipment. These annual limits result in higher out of pocket costs for patients who are paying more in premiums for out-of-network benefits, which appears contrary to the intent of the annual limits reform.

For example, if yearly colonoscopies are determined to be an essential health care benefit a health insurer may only apply a restricted annual limit to this procedure. If a patient has out-of-network benefits, this procedure should be an essential health care benefit that can only have restricted annual limits whether it is performed at an in-network facility or an out-of-network facility. The facility charge, whether it be an ambulatory surgical center or a hospital, is an integral part of the procedure. An average facility fee charge for a colonoscopy ranges from $3,000.00 to $4,500.00, pending on what is actually performed. The procedure can be for screening purposes or polyps can be removed during the procedure, the latter being more expensive. If the patient has a policy which contains the $2,000.00 cap on services provided at an out-of-network ambulatory surgical center, the patient will meet his or her cap for the year by having one procedure done. The patient will then be left with a balance of $1,000.00 to $2,500.00. This scenario does not appear to fit within the intent of the law. Patients are paying extra for the ability to use out-of-network facilities and are not getting the protection of the regulation when using these providers for essential health benefits.

The summary accompanying the annual limits regulations suggests that the main focus of the annual limits regulations is: if the insurance carrier provides a benefit, it must comply with the regulations in seeking to limit the benefit. The regulations should clarify that if a service is defined as an essential health benefit, the restricted annual limits apply whether that service is provided in network or out of network (if out of network benefits for that service are provided under the plan). We are therefore requesting guidance clarifying that carriers are prohibited from placing an annual cap on out-of-network benefits that qualify as essential health benefits.

Very truly yours,

NEIL L. PRUPIS