



College and University Professional
Association for Human Resources

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VIA ELECTRONIC MAIL: <http://www.regulations.gov>

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

**Re: RIN 1210-AB43
Comments Re: Interim Final Rules Relating to Preexisting Condition Exclusions,
Lifetime and Annual Limits, Rescissions, and Patient Protections Under the Patient
Protection and Affordable Care Act (PPACA) 75 Fed. Reg. 37188 (June 28, 2010)**

This letter responds to the request for comments by the U.S. Departments of Health and Human Services, Labor and the Treasury (Agencies) regarding the June 28, 2010, Interim Final Rules (Rules) relating to preexisting condition exclusions, lifetime and annual dollar limits, rescissions, and patient protections under the Patient Protection and Affordable Care Act (PPACA). These comments are submitted jointly by the Society for Human Resource Management (SHRM) and the College and University Professional Association for Human Resources (CUPA-HR).

SHRM is the world's largest association devoted to human resource (HR) management. Representing more than 250,000 members in over 140 countries, SHRM serves the needs of HR professionals and advances the interests of the HR profession. Founded in 1948, SHRM has more than 575 affiliated chapters within the United States and subsidiary offices in China and India.

CUPA-HR serves as the voice of human resources in higher education, representing more than 12,000 HR professionals at over 1,700 colleges and universities across the country, including close to 90 percent of all U.S. doctoral institutions, 70 percent of all master's institutions, more than half of all bachelor's institutions and almost 500 two-year and specialized institutions. Higher education employs 3.3 million workers nationwide, with colleges and universities in all 50 states.

Both SHRM and CUPA-HR members have experience with both insured and self-insured health care plans and have extensive knowledge and experience in trying to keep health care costs down while continuing to maintain a generous and meaningful benefit for their employees and beneficiaries.

SHRM and CUPA-HR respectfully submit these comments and suggested changes to the Rules in the following areas:

- Lifetime and Annual Dollar Limits
- Rescissions
- Mini-Med Waiver Program
- Small Entities

I. Lifetime and Annual Limits on the Dollar Value of Health Benefits

A. Clarify that Annual and Lifetime Dollar Limits Can Apply to Out-of-Network Benefits

The Rules are silent on whether the prohibition on annual and lifetime dollar limits apply to both in-network and out-of-network benefits or just to in-network benefits. Plans and issuers negotiate allowable charges with in-network providers as a way to promote effective, efficient health care, contain costs and premiums and increase access to high quality providers that meet certain quality and performance standards. Prohibiting both out-of-network and in-network plans from applying annual or lifetime dollar limits will discourage employee use of in-network providers and reduce the incentive for providers to join the network, thus defeating the purpose of having a network. For this reason, SHRM and CUPA-HR strongly recommend that the prohibition on annual and lifetime dollar limits be applicable to in-network benefits only. The interim final regulations on preventive services, “permit plans and issuers to implement designs that seek to foster better quality and efficiency by allowing cost-sharing for recommended preventive services delivered on an out-of-network basis while eliminating cost-sharing for recommended preventive health services delivered on an in-network basis.” The same logic and policy analysis applies to the annual and lifetime dollar limits.

B. Clarify that Non-Dollar Limits are Permitted, Subject to Compliance with Other Laws

We also recommend reading the statute as permitting the use of non-dollar limits on services, e.g., those limits relating to frequency and duration of the covered service. The Rules do not address whether the imposition of non-dollar limits, such as limits on the number of covered services or limits on the frequency of covered services are allowable. SHRM and CUPA-HR request that the final regulations clarify that non-dollar limits imposed by a plan are permitted to the extent the limits comply with other federal and state laws as applicable, such as the Mental Health Parity and Addiction Equity Act.

C. Provide that the Prohibition on Lifetime and Annual Dollar Limits Do Not Apply to Stand-Alone HRAs

The Agencies specifically requested comments on the application of Section 2711 prohibiting annual and lifetime dollar limits to stand-alone health reimbursement arrangements (HRAs) that are not limited to retirees. According to the preamble, the prohibition on annual and lifetime dollar limits do not apply to HRAs that are integrated with a group health plan or to stand-alone HRAs that are limited to retirees. Regarding HRAs that are integrated with a group health plan, the preamble states that because the group health plan alone would have to comply with the prohibition on annual and lifetime dollar limits, the combined benefit satisfies the requirements of Section 2711. Therefore the HRA does not also have to meet the requirements on its own.

Stand-alone HRAs are frequently used to enable employees to purchase health insurance coverage but in the individual market, and sometimes employers provide an annual contribution to employees through an HRA to cover those premiums. Similar to the group health plan situation described in the preamble, even though the HRA is a stand-alone product, it is linked to individual health insurance coverage that must comply with the prohibition on annual and lifetime dollar limits. Therefore, SHRM and CUPA-HR request that the final regulations provide that the prohibition on annual and lifetime dollar limits under Section 2711 does not apply to stand-alone HRAs that are linked to the purchase of health insurance coverage in the individual market, through an employer contribution or otherwise.

D. Define Essential Health Benefits as “Medically Necessary”

The Rules state that the prohibition on lifetime and annual dollar limits applies only to “essential health benefits.” The PPACA defines “essential health benefits” as including at least the statutorily enumerated general categories and the items and services covered within those categories. The Agencies are tasked with further defining the term. According to the preamble, until regulations are issued, good faith efforts to comply with a reasonable interpretation of the term will be considered. SHRM and CUPA-HR members support the Agencies’ decision to allow good faith compliance but encourage the Agencies to issue regulations defining “essential health benefits” as soon as possible to provide more clarity.

In particular, we encourage the Agencies to define essential health benefits as *medically necessary* services as defined by the terms of the health plan. In addition, we urge the Agencies to reject any expansion of the definition beyond what is essential and medically necessary. It is important to note that the PPACA requires that the scope of the essential health benefits definition is equal to the scope of benefits provided under a typical employer-sponsored plan and that the scope is certified by the CMS Chief Actuary upon submission to Congress.

For example, employer plans today may exclude certain benefits or place dollar limits on them if, for example, the services are discretionary or the limits help manage costs, quality, or the risk to the patient. It is not unusual to find limits on bariatric surgery, chiropractic services, or

fertility treatments, for example. Other common examples include cosmetic or Lasik surgery. While such services may be highly valued by the plan participants who receive them, if the Agencies were to take the position that such services are considered “essential,” the cost impact to employer-sponsored plans could be substantial. In addition, including these services in the definition would likely lead the plan sponsor to adjust other terms of the plan to help offset the cost increase from covering such services.

Similarly, we request that the Agencies exclude certain supplemental benefits from the definition of essential health benefits that may or may not be considered “excepted benefits.” For example, some employers may offer benefit plans to help employees who have children with physical or developmental disabilities, and those plans usually have a lifetime cap. If these types of benefits are deemed to be essential and annual and lifetime dollar limits are prohibited, then employers are likely, albeit reluctantly, to discontinue these beneficial plans.

II. Rescissions

The Rules state that a cancellation or discontinuance of coverage is not a rescission if it either has only a prospective effect or is retroactive to the extent attributable to a failure to timely pay premiums or contributions. We are concerned that the definition of a rescission in the Rules is overly broad and that the proposed Rules do not take into consideration a number of very common situations in the group market where a retroactive termination of coverage is necessary but does not meet the level of a rescission that was intended in the statute. For example, when Congress was considering the PPACA, there was a great deal of concern over rescissions that were occurring in the individual market. In these situations, people who purchased coverage in the individual market had their policies terminated retroactive to the date of enrollment for allegedly not disclosing a condition for which they later sought coverage. This type of behavior, however, occurs solely in the individual market, not in the group market. Despite this, the Rules apply to both the individual and group markets. As written the Rules do not take into account certain situations that are very common in the group market in which a retroactive termination is necessary and equitable for all plan participants. We urge the Agencies to either create exceptions from the rescission rules for these situations described below, or in the alternative, exempt these situations from the definition of a rescission.

- A. Permit employers to cancel coverage retroactively if a dependent is found to be ineligible for coverage through a dependent audit.

Prior to completing enrollment in a group health plan, many employer-sponsored plans require a participant to affirm certain statements regarding dependent eligibility for coverage. The plan also requires that the participant agree to provide proof of dependent eligibility upon request as a condition of participation in the plan. In addition, later in the plan year, a group health plan may conduct an audit to determine if there are any ineligible dependents enrolled in the plan. These audits are done in accordance with a plan administrator’s fiduciary duty under the Employee Retirement Income Security Act of 1974 (ERISA) to pay plan benefits only to *eligible* employees

and dependents (emphasis added), and to avoid payment of claims for ineligible dependents that could be viewed as a misuse of plan assets.

SHRM and CUPA-HR recommend that if a dependent is found to be ineligible for coverage as a result of a dependent audit, that the final regulations allow the coverage to be terminated retroactively to the date of ineligibility and be considered an exception to the rescission rules. Prohibiting a group health plan from retroactively terminating coverage creates an inequity with participants who properly report a change in dependent eligibility. Under this scenario, the participant who properly reported a change in eligibility to the plan would have their dependent's coverage terminated at the beginning of the following month while the participant who did not report a change would continue to have his/her dependent covered by the plan until the time of the audit. Because the termination could be prospective only, there is a potential ERISA fiduciary violation. In addition, the situation creates the unintended consequence of providing an incentive to fail to report an eligibility change to the plan.

In the alternative, if the Agencies consider this situation to be a rescission, we urge the final regulations to provide that if proof of dependent status is requested but not provided by the participant within a reasonable period of time provided by the plan, this failure to respond be considered the equivalent of an intentional misrepresentation of material fact.

B. Allow employers to retroactively terminate coverage as of an employee's employment termination date (or some later date provided in the plan) even though the actual cancellation occurs after the employment termination date.

Generally, when an employee is terminated, his/her coverage ends on the date of termination (or shortly thereafter as provided in the plan). All communications to the employee prior to termination, including the summary plan description and COBRA election notice typically indicate that coverage terminates as of the employment termination date (or shortly thereafter as provided in the plan).

However, in administering the employment termination, the coverage termination with the insurance carrier may not actually occur until several weeks after the employment termination date. This can occur because of the time it takes for the human resource department to process the employment termination and for the communication to occur with the third-party administrator and insurance provider.

We request, therefore, that the final regulations clarify that the time required to communicate the employment termination between the employer, third party administrator and insurance provider does not constitute a rescission. For example, if an employee's employment is terminated on September 14, but it takes until October 31 for the insurance provider to cancel coverage and the terminated employee submits claims after the termination date of September 14, it should not be considered a rescission. In addition, there is nothing in the Rules or the PPACA that modifies the COBRA rules related to the ability of a plan to terminate coverage retroactively in

the event the qualified beneficiary does not elect continuation coverage. In the alternative, SHRM and CUPA-HR recommend that this be made an exception to the rescission rules because the terminated employee becomes ineligible for coverage as of the employment termination date (or shortly thereafter as provided in the plan).

- C. Allow retroactive coverage termination for a mid-year change in status event requested by the participant after the date of the event.

If a participant experiences a change in status event, such as a marriage or divorce that permits a revocation of an election under the Cafeteria Plan Regulations at Section 1.125-4(c), the participant's coverage ends as of the date of the event. This is true even if the employee reports the event within a certain period after the event occurs (e.g., 30 days) as provided by the plan. All plan communications to the employee, including the summary plan description state that the coverage terminates as of the date of the event (or shortly thereafter as provided by the plan).

If a participant reports a mid-year status change within the period specified in the plan, and cancellation of coverage is requested and is effective back to the date of the event, we urge the Agencies to exclude this situation from the definition of a rescission and allow the plan to retroactively terminate coverage as of the event date. Otherwise, the employee will be forced to continue to pay for coverage for a longer period than desired by the participant. In the alternative, we recommend that this situation be considered an exception to the rescission rules because the participant is requesting the termination of coverage.

To illustrate the point, consider the following example: Anna gets married on September 1. As required by the plan, Anna notifies the plan on September 20 of the marriage (change in status event). Anna also requests that her coverage be terminated as of September 1 because she will be enrolling in her spouse's coverage effective September 1. Under the Rules as currently drafted, the plan could only terminate her coverage on a prospective basis (i.e., as of September 20, the date of her call). This would require Anna to pay premiums to the plan from September 1 through September 20 although she requested a cancellation of coverage as of September 1. In addition, Anna's spouse would have to pay the additional premium for Anna, effectively forcing them to pay for double coverage.

- D. Allow a reasonable time for plan sponsors to correct administrative errors.

The Rules at 54.9815-2712T(a)(3) include an example of an employer who mistakenly fails to terminate an employee's group health plan coverage when the employee is reassigned from full-time to part-time employment. The example concludes that the plan is prohibited from rescinding the employee's coverage retroactive to the date of the employment reassignment because there was no fraud or an intentional misrepresentation of material fact.

Employers and plan administrators make mistakes that are not intended to deprive employees and dependents of their coverage rights. Recognizing this, SHRM and CUPA-HR hope

that the Agencies will provide employers with a reasonable correction period for inadvertent errors, e.g., 90 days. This correction period could serve the best interest of employees and employers. For example, an employee who is ineligible for coverage and has filed no claims could have that coverage terminated retroactively. In this situation, the employee-paid premiums are reimbursed to the employee and additional costs to the health plan are avoided and attributable only to eligible employees. It would also prevent penalizing an employer for an inadvertent error that is caught within a reasonable period of time

III. Mini-Med Waiver Program

The Rules state that for plan years beginning before 2014, HHS may establish a waiver program for mini-med plans where the restricted annual dollar limits would significantly increase premiums under the plan or insurance coverage or result in a loss of access to coverage. SHRM and CUPA-HR applaud the Agencies for recognizing the significant negative impact the restricted annual dollar limits would have on employees who participate in mini-med plans.

We understand that guidance on the waiver process is forthcoming and urges the Agencies to issue guidance as soon as possible. Plan sponsors are finalizing their plan designs for 2011 and need to understand the rules regarding the new waiver provision and the process for seeking and obtaining it. SHRM and CUPA-HR would be pleased to provide further input if needed.

IV. Small Entities

According to the preamble, because the Rules are exempt from the Administrative Procedures Act, the Regulatory Flexibility Act does not apply and the Agencies are not required to either certify that the regulations would not have a significant economic impact on a substantial number of small entities or conduct a regulatory flexibility analysis. However, the Agencies encourage public comments that suggest alternative rules that accomplish the stated purpose of section 1251 of the PPACA and minimize the impact on small entities.

We appreciate the Agencies' recognition that small entities can be significantly affected by law changes that may not similarly affect larger entities. We note, however, that small employers may not have the resources to engage in this undertaking at the same time that they are also trying to absorb and understand the many changes made by the PPACA as well as the regulations that have been issued to date implementing the new law. We therefore suggests that the Agencies consider other ways of encouraging small entities to provide input and a reasonable time frame in which to do so, which may be longer than would be required for larger entities.

V. Conclusion

SHRM, CUPA-HR, and their members recognize, appreciate and commend the Agencies' efforts to release the Rules on such a timely basis, given the rapidly approaching implementation date. We hope that the Agencies will seriously consider our comments and recommendations,

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which in our opinion would address many of the situations that occur in group health plans today without violating the intent of the law and continuing to provide protections equitably and efficiently to the millions of consumers enrolled in employer-sponsored group health plans.

We appreciate the opportunity to assist the Agencies in continuing to develop guidance on this important issue. If we can be of further assistance on this rule or the mini-med waiver program guidance, we would be happy to do so.

Respectfully submitted,



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