

August 25, 2010

Submitted electronically via the Federal Rulemaking portal @ [www.regulations.gov](http://www.regulations.gov)

Attention: RIN 1210-AB43  
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

Dear Sir or Madam:

Subject: Request for Comments Related to Patient Protection and Affordable Care Act (PPACA):  
Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections  
(RIN 1210-AB43)

Hewitt Associates (Hewitt) welcomes the opportunity to submit for consideration our comments relating to the interim final rules pertaining to preexisting condition exclusions, lifetime and annual limits, rescissions, and patient protections published in the *Federal Register* on June 28, 2010.

## Who We Are

Hewitt Associates (NYSE: HEW) provides leading organizations around the world with expert human resources consulting and outsourcing solutions to help them anticipate and solve their most complex benefits, talent, and related financial challenges. Hewitt works with companies to design, implement, communicate, and administer a wide range of human resources, retirement, investment management, health care, compensation, and talent management strategies. With a history of exceptional client service since 1940, Hewitt has offices in more than 30 countries and employs approximately 23,000 associates who are helping make the world a better place to work. For more information, please visit [www.hewitt.com](http://www.hewitt.com).

## Lifetime and Annual Limits

**A. Provide that stand-alone health reimbursement arrangements (HRAs) that are linked to the purchase of health insurance coverage in the individual market are not subject to the rules relating to annual limits.**

The interim final rules specifically requested comments on the application of Section 2711 relating to annual limits to stand-alone health reimbursement arrangements (HRAs) that are not retiree-only plans. The preamble clarifies that HRAs integrated with a group health plan and stand-alone HRAs that are limited to retirees are not subject to the rules related to annual limits. Further, the preamble states that where HRAs are integrated with a group health plan and the group health plan alone would comply with the provision, the fact that the benefits under the HRA are limited does not violate Section 2711 because the combined benefit satisfies the requirements.

Stand-alone HRAs are often used to purchase health insurance coverage in the individual market. In some cases, employers provide an annual contribution to employees through an HRA to pay premiums for coverage the employee purchases in the individual market. The employer may enlist the support of a

third-party insurance broker to help employees select among the available options that would best meet their needs. In this situation, even though the HRA is a stand-alone product, it is linked to health insurance coverage that must comply with the prohibition on annual and lifetime limits.

Hewitt requests that the final regulations provide that the rules related to annual limits do not apply to stand-alone HRAs that are linked to the purchase of health insurance coverage in the individual market, whether or not the HRA is established by an employer that makes an annual contribution that employees may use to pay for their health insurance premiums in the individual market. The health insurance policies to which the employee has access are individual products, licensed under state law, and will be required to comply with the prohibition on annual and lifetime limits. Therefore, the HRA is effectively linked to the purchase of health insurance coverage. In addition, from a policy perspective, applying annual limits to a stand-alone HRA will result in employers terminating such arrangements, which will adversely affect employees.

#### **B. Provide that annual and lifetime dollar limits can apply to out-of-network benefits**

The interim final regulations do not distinguish between in-network and out-of-network coverage when discussing the prohibition on lifetime and annual dollar limits. Plans and issuers negotiate allowable charges with in-network providers as a way to promote effective, efficient health care. Allowing a plan to impose limits on out-of-network coverage enables plans to encourage the use of in-network providers. Prohibiting employers from imposing limits on out-of-network coverage would constrain the ability of group health plans and health insurance issuers to contain costs, would result in higher premiums, and could reduce provider incentive to participate in insurer networks thereby decreasing participant access.

Further, provider networks are created to include providers that meet certain quality and performance standards. If plans are prohibited from imposing limits on out-of-network coverage, a plan's ability to ensure its participants are receiving coverage from the highest quality providers is limited. This point is clearly contemplated by the agencies. 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 here with respect to the annual and lifetime dollar limits. Therefore, Hewitt recommends that the final regulations allow annual and lifetime dollar limits to be imposed on out-of-network benefits.

#### **C. Clarify that non-dollar limits imposed by a plan are permitted, subject to compliance with other laws.**

The interim final rules are silent regarding the imposition of non-dollar limits, such as limits on the number of covered services or limits on the frequency of covered services. Hewitt requests 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.

#### **Essential Health Benefits**

The interim final rules state that the prohibition on lifetime and annual dollar limits applies only to "essential health benefits." Although the PPACA sets forth the general categories, and items and services within those categories that are considered "essential health benefits," it is up to the agencies to further define that term. The agencies provide that until regulations are issued on this topic, good faith efforts to comply with a reasonable interpretation of the term will be allowed. Hewitt commends the agencies for providing good faith compliance. However, Hewitt also encourages the agencies to issue regulations defining "essential health benefits" as soon as possible in order to provide clarity.

As enumerated in the PPACA, “essential health benefits” include ambulatory patient services; emergency services; hospitalization; maternity and newborn; mental health or substance use disorder (MH/SUD), including behavioral health treatments; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including pediatric oral and vision care). Hewitt urges the agencies to clarify that “essential health benefits” mean *medically necessary* services as defined by the terms of the health plan and not to expand this definition beyond its original intent. Hewitt reminds the agencies that the PPACA requires the scope of the definition of “essential health benefits” “to be equal to the scope of benefits provided under a typical employer plan.” The definition also must be submitted to Congress with a certification from the Chief Actuary of the Centers for Medicare and Medicaid Services that the definition is equal to the typical employer plan.

Today, employer plans typically exclude certain benefits or place dollar limits on certain benefits if, for example, the services are discretionary or the limits are designed to manage costs and quality or risk to the patient. Common examples of the benefits subject to the types of limits described include bariatric surgery, chiropractic and fertility treatments, and cosmetic or Lasik surgery. Hewitt recommends that the final regulations also clarify that prescription drugs associated with a non-essential health benefit are excluded from the requirements on lifetime and annual dollar limits. While such items and services may be highly valued by the plan participants who receive them, the cost impact could be substantial if the agencies determine these to be “essential.” This would then likely lead the plan sponsor to adjust other terms of the plan to help offset the cost increase associated with covering such services or to exclude such benefits from coverage altogether.

In addition, Hewitt urges the agencies to exclude from the definition of “essential health benefits” certain supplemental benefits that may or may not be considered “excepted” benefits as defined in Part 7 of the Employee Retirement Income Security Act of 1974 (ERISA). For example, some employers may offer benefit plans for employees who have children with physical or developmental disabilities. These plans typically impose a lifetime cap. If the agencies deem these supplemental benefit plans to be essential and thus prohibiting annual and lifetime dollar limits, it will likely cause employers, though reluctantly, to discontinue these beneficial plans.

Finally, Hewitt requests that the agencies allow employer-sponsored plans the flexibility to provide essential health benefits through value-based plan designs that encourage the use of high quality health care providers. This could include allowing employers and health plans to impose limits on essential health benefits that are delivered through lower quality health care providers.

## **Rescissions**

The interim final rules define a rescission as a cancellation or discontinuance of coverage that has retroactive effect. The only exception allowed for a retroactive termination is for the non-payment of premiums or contributions for coverage. This definition appears to be overly broad and does not contemplate many of the most common situations where an employer-sponsored group health plan must terminate coverage on a retroactive basis. The prohibition on rescissions was aimed at preventing the egregious actions by some insurers in the individual market that do not occur in the group market. However, the statute and these interim final rules apply to both individual and group health plans. Therefore, to address the circumstances in the group market where a retroactive termination is a necessary and equitable result for all participants, Hewitt requests that the final regulations either create exceptions from the rescission rules or in the alternative exempt these circumstances from the definition of a rescission.

**A. Allow an employer to retroactively terminate coverage if a dependent is found to be ineligible for the plan based on a dependent audit.**

At the time of enrollment, many employer-sponsored plans require a participant to agree to a declaration regarding dependent eligibility for coverage under the group health plan, including agreeing to provide proof of eligibility when requested. When enrolling electronically through an intranet Web site, the participant must check a box stating that he/she “agrees” to the affirmative statements. Otherwise, the participant is not allowed to proceed with enrollment. When enrolling over the phone, the participant must reply affirmatively to each statement read to them before the service center representative may proceed with enrollment. Typically, the declaration contains the following statements:

- I understand the rules that define who is eligible under the plan.
- I represent that the dependent I am enrolling is eligible under the plan.
- I acknowledge that I may be asked to provide proof of my dependent’s eligibility.
- I agree to provide proof, if requested.
- I agree to timely notify the plan if my dependent becomes ineligible for the plan.

In addition, group health plans commonly conduct a dependent audit to determine if there are any ineligible dependents enrolled in the plan. This is done, in part, to comply with a plan administrator’s fiduciary duty under ERISA to pay plan benefits only to *eligible* employees and dependents (emphasis added). Additionally, in the case of a self-insured health plan funded through a voluntary employee beneficiary association (VEBA) under Internal Revenue Code section 501(c)(9), paying claims for ineligible dependents could be viewed as a misuse of plan assets. VEBAs often are created by employers that have a union population where the union wants assurances that their benefits will be paid.

The interim final rules at 54.9815–2712T(a)(3) include an example of an employer that mistakenly fails to terminate an employee’s group health plan coverage when 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 employment reassignment because there was no fraud or intentional misrepresentation of material fact. This example appears to assume that the employee notified the plan of his/her part-time status. However, the interim final rules do not address the situation where the plan is not notified of a dependent’s eligibility status change and cannot know such information unless the participant notifies the plan or an audit is conducted.

If a dependent is found to be ineligible for coverage after a dependent audit, Hewitt urges the final regulations to allow the coverage to be retroactively terminated to the date of ineligibility and to be considered an exception to the rescission rules. If coverage in this situation cannot be terminated retroactively, employees who do not self-report would be rewarded by being allowed to keep their dependents in coverage longer than those who properly report a change in eligibility. This creates a perverse incentive to not report a change in eligibility to the plan. In addition, payment of claims during the period the dependent was ineligible would be an ERISA fiduciary violation.

In the alternative, based on the affirmative declaration described above, if an individual fails to provide proof of dependent status within a reasonable time provided by the plan, Hewitt urges the agencies to consider this failure to respond to be the equivalent of an intentional misrepresentation of material fact since the participant knowingly refused to provide requested information.

Hewitt also recommends that the final regulations include an example of this situation, such as the following:

**Facts:** M and S are employees of company X. M has a daughter, C. S has a son, T. M and S enroll C and T to X's plan, respectively. At the time that C and T are enrolled, M and S each agree to affirmative statements that declare their understanding of dependent eligibility and the requirement to notify the plan if dependent eligibility changes.

C becomes ineligible for coverage on January 31, 2011. M follows the plan rules and reports C's ineligibility to the plan on January 29, 2011. The plan removes C from coverage effective February 1, 2011.

T also becomes ineligible for coverage on January 31, 2011. However, S does not report T's ineligibility to the plan and continues him in coverage. A dependent audit performed by the plan on June 30, 2011 reveals that T could be an ineligible dependent. The plan requests S to provide proof of eligibility within 30 days, but S fails to do so.

**Alternative Conclusion 1:** X may retroactively terminate T's coverage effective February 1, 2011. In this example, T was ineligible for coverage beginning January 31, 2011, yet the plan continued to pay benefits to T through July. Because T was ineligible for coverage, terminating coverage back to the date of ineligibility (January 31, 2011) is not a rescission. Further, X would face a breach of fiduciary duty claim under ERISA for paying plan benefits to ineligible beneficiaries and potentially for a misuse of plan assets.

**Alternative Conclusion 2:** X may rescind T's coverage effective February 1, 2011. Because S affirmed the declarative statements at enrollment and refused to provide information when requested, S made an intentional misrepresentation of material fact by not notifying the plan of T's ineligibility for coverage and for refusing to provide the information requested.

Alternative Conclusion 1 is consistent with the exception in the interim final rules permitting retroactive termination of coverage when a participant fails to timely pay premiums. The plan can neither control if a participant will timely pay premiums nor whether a participant will timely notify the plan of ineligibility.

**B. Clarify that an employer may cancel health coverage as of an employee's employment termination date (or some later date provided in the plan), even if there is a lag between the employment termination date and the coverage termination date.**

The interim final rules at 54.9815-2712T(2) provide, in part, that a rescission does not include a cancellation or discontinuance if it has only a prospective effect. Generally, when an employee is terminated, his/her coverage ends the day of termination (or shortly thereafter as provided in the plan). All communications to the employee, including the summary plan description and Consolidated Omnibus Budget Reconciliation Act (COBRA) election notice indicate that coverage terminates as of the employment termination date (or shortly thereafter as provided in the plan).

From an administrative standpoint, however, the actual cancellation of coverage with the insurance carrier may not occur until several weeks after the employment termination date. This is because it takes time for a termination to be processed in the employer's human resources department, and then communicated to the third-party administrator and insurance provider. In addition, there is nothing in the regulations 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.

Accordingly, Hewitt requests that the final regulations clarify that the back end time required to communicate the employment termination between the employer, third-party administrator, and insurance provider in order to cancel coverage retroactive to the employment termination date does not constitute a rescission. In the alternative, Hewitt requests that this situation be considered an exception to the rescission rules because the terminated employee is no longer eligible for coverage as of the employment termination date.

**C. Clarify that an employer may retroactively terminate coverage for a participant-initiated midyear change-in-status event (i.e., marriage, divorce) that is reported after the event and results in a cancellation of health coverage as of the event date.**

Generally, when an employee experiences a participant-initiated midyear change-in-status event that permits a revocation of an election under the Cafeteria Plan Regulations Section 1.125-4(c), the participant's coverage ends as of the date of the event (e.g., divorce or marriage). This is the case even if the event is reported by the employee within in a certain time period after the event occurs (e.g., 30 days). All communications to the employee, including the summary plan description indicate that if coverage is terminated, the termination is effective as of the event date (or shortly thereafter).

Hewitt recommends that the final regulations clarify that it is not a rescission if a participant initiates a midyear change-in-status event resulting in a cancellation of health coverage as of the event date (i.e., marriage, divorce) (or some later date provided under the plan) that is not reported until after the event occurs. Without this clarification, an employee may be forced to continue and pay for coverage for a longer period than required before the interim final regulations became effective. In the alternative, Hewitt requests that the agencies consider this to be an exception to the rescission rules because the participant is requesting the termination of coverage.

An example of the situation described is as follows: Joe is married on July 31. Joe calls the plan on August 15 to report the marriage (change-in-status event) and to request that his coverage be terminated as of August 1 because he will be added to his spouse's coverage as of July 31.

Prior to these interim final rules, Joe would have been permitted to drop his coverage retroactive to August 1. However, following the interim final rules as drafted, terminating Joe's coverage retroactively to July 31 would be considered a rescission. Therefore, the employer could only terminate Joe's coverage as of August 15—the date of Joe's call—which would require Joe to pay premiums for coverage from August 1–August 15, even though he does not need to or want to do so.

**D. Provide that in the event of an inadvertent administrative error, the plan sponsor may cancel coverage retroactively to the date coverage should have ended provided the error is corrected within a reasonable time of first occurring.**

Hewitt believes that employers should be given some latitude to correct administrative errors that are corrected within a reasonable period of time (e.g., 90 days). Employers and administrators handle thousands of records each day and mistakes happen without any intent to deprive employees and dependents of their coverage rights. In fact, in some instances, it is in the best interest of the participant to retroactively cancel coverage when an error is discovered.

For example, if an ineligible employee pays for coverage and incurs no claims during the period of ineligibility, it would be in the best interest of the employee to terminate coverage retroactively, and be reimbursed the employee-paid premiums. The interim final rules as currently written would prohibit this

Attention: RIN 1210-AB43

Page 7

August 25, 2010

scenario. Accordingly, Hewitt recommends that the final regulations permit employers to cancel coverage retroactively to the date coverage should have been cancelled provided the error was inadvertent and occurred within 90 days of the correction.

### **Mini-Med Waiver Program**

The interim final rules state that for plan years beginning before 2014, the Department of Health and Human Services (HHS) may establish a waiver program for mini-med plans where the prohibition on restricted annual dollar limits would significantly increase premiums under the plan or insurance coverage or would result in a loss of access to coverage. Hewitt applauds the agencies for recognizing the significant negative impact the restricted annual dollar limits would have on employees who participate in mini-med plans.

Hewitt is aware that the agencies are working on guidance regarding the waiver process and urges the agencies to issue the guidance as soon as possible since plan sponsors are currently finalizing their plan designs for 2011 and will need to understand the waiver process. Hewitt would be pleased to provide further input if needed.

### **Closing**

If you have any questions or comments, please contact the undersigned at the telephone number or e-mail address provided below.

Sincerely,

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