National Association of Health Underwriters

America's Benefits Specialists

August 27, 2010

Via Electronic Transmission

The Honorable Kathleen Sebelius
Secretary, Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: File Code OCIIO-9994-IFC – Requirements for Group Health Plans and Health Insurance Issuers under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections

Dear Secretary Sebelius:

I am writing in on behalf of The National Association of Health Underwriters (NAHU), a professional trade association representing more than 100,000 licensed health insurance agents, brokers, consultants and employee benefit specialists nationally. We are pleased to offer comments on the Interim Final Rule (IFR) titled "Requirements for Group Health Plans and Health Insurance Issuers under the Patient Protection and Affordable Care Act (PPACA) Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections," as published in the *Federal Register* on June 28, 2010 (Volume 75, Number 123).

NAHU members work on a daily basis to help individuals and employers of all sizes purchase health insurance, use their coverage effectively and make sure they get the most out of the benefits they have purchased. They design benefit plans and solve problems that may occur once coverage is in place. Furthermore, most are small-business owners themselves. As such, our members are extremely concerned about ensuring adequate consumer protections within health insurance coverage plans. However, we also want to ensure that the application of such new consumer protections does not cause disruptions to the current health insurance marketplace. The unintended consequence could be a significant impact on coverage cost and/or availability. Furthermore, we seek clarification on a number of issues raised by the IFR so that our members can continue to advise their clients on benefit designs accurately and appropriately.

Preexisting Condition Requirements for Children

One part of the IFR that NAHU members are reporting is already impacting coverage availability is the preexisting condition requirements for children age 19 and under. The IFR establishes that, after September 23, 2010, in non-grandfathered individual plans and group plans, children under 19 may not be denied coverage through either a denial of enrollment or a denial of specific benefits based on a preexisting condition. Upon release of this IFR, many health insurance carriers expressed concern about

how the rule seemed to require guaranteed issuance of health coverage for children prior to the January 1, 2014, date that is clearly established in PPACA for the guaranteed issuance of other coverage. Health plans have indicated that the new guaranteed-issue requirement in the IFR might force them to cease offering child-only individual health insurance policies altogether. The concern articulated was that parents could elect to purchase child-only individual policies for their children only upon learning that their child was ill, with no insurance-related consequences. The resulting adverse selection would be so great and costly that many health insurance carriers could no longer afford to offer child-only individual coverage, thereby creating an enormous access issue in that marketplace.

To respond to these concerns, DHHS released guidance on its website in July stating, "To address concerns over adverse selection, issuers in the individual market may restrict enrollment of children under 19, whether in family or individual coverage, to specific open-enrollment periods if allowed under state law." While NAHU appreciates this clarification, our members in the field report to us that it has provided insufficient assurances to many health insurance carriers, and that a number of them still plan to cease offering child-only individual policies. NAHU is concerned that this requirement will inadvertently result in the complete loss of coverage options for many children in certain states. We respectfully request that DHHS reconsider its interpretation of PPACA's preexisting condition rules relative to child-only policies, at least during the transition years of 2010-2014, to prevent adverse selection and carrier withdrawal in this marketplace. At minimum, we feel that the adverse-selection prevention methodologies seemingly allowed by the July guidance, including open-enrollment options, should be expanded upon and explicitly included in any final regulation.

Annual Limit Requirements and HRAs

The IFR clearly indicated the Health Reimbursement Arrangements (HRAs) that are combined with high-deductible health insurance coverage are not subject to the annual limit requirements on essential benefits, provided that the other coverage provided meets the terms of the IFR. In addition, stand-alone HRA plans for early retirees are exempted from the requirements. However, we seek clarification about reimbursement arrangements an employer may have in conjunction with traditional group coverage that are similar to a HRA, but are not the same. For example, a pharmacy may not offer traditional prescription drug coverage, but instead allow employees to fulfill prescriptions gratis up to a certain dollar value amount. Are annual and/or lifetime limits permissible under such arrangements?

The IFR also seeks comment on how stand-alone HRA plans for current employees should be treated with respect to the annual limit rules. NAHU believes that an HRA is a financial arrangement between an employer and employee and should not be subject to the same terms as group health insurance coverage. Therefore, the annual limit rules should not apply. Application of such rules would severely constrain an employer's ability to set up stand-alone HRA plans, thereby limiting employee access to needed medical care services. Employers that choose to set up stand-alone HRAs generally do so because they cannot afford to provide traditional group coverage. If these employers are constrained in their ability to create HRAs, our members report that they will simply cease to offer their employees this benefit, not offer coverage that would meet the terms of the IFR. The result will be an immediate financial burden on individual employees, yet federal relief in the form of increased individual coverage options and subsidies will not be available to such individuals until 2014.

Other Provisions Regarding Annual Limits

NAHU appreciates the good-faith enforcement standard created by the IFR regarding the definition of essential benefits. As NAHU members help their employer clients design benefit plans for 2011 and

beyond, we look forward to obtaining additional guidance on the parameters of what exactly constitutes essential and non-essential benefits.

Furthermore, to continue to assist employers in designing affordable health coverage plans that help to constrain rising medical costs, NAHU seeks clarification on non-dollar utilization limits. While the IFR provides clear examples regarding prohibitions on dollar limits on benefits, it appears that plans may still limit, for example, the number of visits a participant may make to a doctor's office or, generally, other non-dollar utilization limits. As such limits are a common component of plan design for cost-containment purposes, we request clarification that utilization limits are indeed still permissible.

Waiver for Limited Medical Benefit Plans

NAHU appreciates the IFR's provisions that specify that certain benefit plans, including limited benefit plans, may seek a waiver to the annual limit requirements if compliance will result in a significant decrease in access to benefits or a significant increase in premiums. It is estimated that more than 2 million Americans currently have coverage under limited medical benefit plans that are not considered to be excepted benefits under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and that the cost of this coverage could triple or quadruple in absence of a waiver. In addition, many college students who obtain coverage through similar limited benefit plans offered by universities across the country could be affected in the same way. We appreciate that the waiver process will allow these coverage options to continue because sometimes a limited benefit policy is the best match for an individual or family's budget and health insurance needs. Particularly in these trying economic times, a limited benefit policy may be the best and most affordable way for a consumer to ensure continuous and HIPAA-creditable coverage.

As employers and individuals are currently working with our members to review their plan options for the coming year, we look forward to the near-term issuance of additional guidance regarding the terms of such a waiver and the application process. We anticipate that there are many plan options now that will need to complete the waiver process immediately in order to be able to continue to offer permissible coverage to consumers by the IFR's January 1, 2011, effective date. For calendar-year plan renewals, this information will be needed by early September 2010.

Furthermore, when the guidance is issued, we request that it allows for a single, self-executing waiver that will be applicable through the 2014 plan years. A single plan waiver, as long as there are no substantive changes in coverage, will be the simplest way to ensure coverage on a continuous basis until other more robust and subsidized alternatives are offered following January 1, 2014.

Conflict between COBRA Rules and Rescission Requirements

A final concern that NAHU members have identified with the IFR is the confusion the requirements banning rescissions of coverage create relative to individuals who are eligible for continued group coverage as per the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). There appears to be conflicts between the IFR and existing COBRA rules and, as an association of benefit professionals who are engaged in assisting millions of employers with administering their COBRA benefits, we seek both clarification and a good-faith enforcement standard for employers that may have inadvertently mishandled coverage.

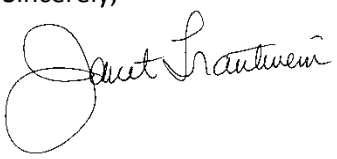
The IFR clearly defines a rescission as a retroactive termination of coverage except in the case of fraud or the individual's intentional representation of a material fact, as prohibited by the plan terms. In addition, a group health plan must provide at least 30 days advance written notice to each participant

who would be affected before any coverage may be rescinded. A group health plan may also cancel coverage, even retroactively, if the termination of coverage is due to a failure to pay required premiums or contributions toward the cost of coverage on a timely basis. NAHU seeks clarification as to how these requirements interact with existing COBRA rules that clearly allow for retroactive termination of coverage under certain circumstances for individuals in their 60-day COBRA election period. According to current COBRA rules, if the plan allows retroactive reinstatement, it can terminate the qualified beneficiary's coverage during the election period and reinstate coverage following an election and the receipt of any applicable premium payment. Claims incurred prior to the election and payment do not have to be paid. If the plan decides to provide continuous coverage to beneficiaries during their election period, it is allowed to cancel the coverage retroactively if COBRA coverage is not elected or the premium is not paid on time. Does the IFR continue to permit retroactive terminations of coverage if a COBRA election is never made? If so, do the new notice requirements apply, do COBRA notification requirements, or both?

Another confusing area is how, or whether or not, a plan is allowed to terminate coverage retroactively in cases that would normally be considered a COBRA qualifying event. The IFR gives an example of someone who inadvertently was offered coverage inappropriately because his or her employee status changed from full-time to part-time. The example concluded that the individual's coverage could not be retroactively terminated because the coverage had been continued inadvertently. However, the example does not address that such a change in status would normally be a COBRA qualifying event and, consequently, subject to existing federal rules on coverage. Does new example in the IFR override existing COBRA principles that would allow the plan administrator to retroactively terminate coverage if a COBRA election is not made? If so, then is the plan at least allowed to credit the period of inadvertent coverage toward satisfying its COBRA obligations to provide up to 18, 29 or 36 months of coverage from the qualifying event date?

NAHU sincerely appreciates this opportunity to provide comments on the IFR, and we look forward to working with you as implementation of PPACA moves forward. If you would like more information from NAHU, or if we can be of further assistance, please feel free to contact me at either (703) 276-3806 or jtrautwein@nahu.org.

Sincerely,



Janet Trautwein, Executive Vice President and CEO
National Association of Health Underwriters