



August 27, 2010

VIA ELECTRONIC FILING – www.regulations.gov

The Honorable Kathleen Sebelius
Secretary
United States Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Hilda L. Solis
Secretary
United States Department of Labor
200 Constitution Ave., NW
Washington, DC 20210

The Honorable Timothy F. Geithner
Secretary
United States Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Re: Interim Final Rules; 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 Protection,
HHS File Code OCIIO-9994-IFC; DOL File No. RIN 1210-AB43;
IRS File No. REG-120399-10

Dear Secretaries Sebelius, Solis and Geithner:

The Council of Insurance Agents & Brokers (CIAB) appreciates this opportunity to provide comments on the Departments' Interim Final Rule (IFR) setting forth requirements relating to preexisting condition exclusions, lifetime and annual limits, rescissions, and patient protection under the Patient Protection and Affordable Care Act (PPACA).¹ CIAB is the premier association for commercial insurance and employee benefits intermediaries in the United States.

¹ Interim Final Rules; 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 Protection, 75 Fed. Reg. 37188 (June 28, 2010).

We represent leading commercial insurance agencies and brokerage firms, with members in over 3,000 locations placing more than \$90 billion of U.S. insurance products and services including group health insurance. Our members serve tens of thousands of employer-based health insurance plans covering millions of American workers, and seek to help employers to offer their employees the health coverage they need at a cost they can afford. As such, our membership has a thorough understanding of the group health insurance market, and has had a unique opportunity to observe the challenges group health plans have faced thus far in the PPACA implementation process.

Overview

Our comments on the IFR focus on the need for additional necessary guidance and for certain clarifications to better facilitate compliance and allow plans to meet the needs and expectations of the participants they serve. We are particularly concerned that the IFR has left the task of developing a detailed definition of “essential benefits” to future proceedings even though this concept is the foundation of the rules governing annual and lifetime limits. We urge the Departments to issue further guidance on the definition of essential benefits as quickly as possible. We recognize that this task is a sizable one. But our members are concerned that an extended period without regulatory guidance on this issue will increase the likelihood of confusion and difficulties for group plan participants arising from problems such as inconsistency in how various plans classify particular services. CIAB stands ready to assist the Departments in this process by providing any additional input on the definition of “essential benefits” that may be of use, given our members’ expertise in this area.

In the meantime, considering that plans are largely left on their own to navigate this uncharted territory, we request that the Departments provide an explicit safe harbor for plans that rely on established company or industry practice to help categorize benefits as essential or non-essential. We believe that the Departments’ commitment to consider plans’ good faith efforts to “comply with a reasonable interpretation of the term” is constructive. But plans that are making design decisions at the present moment and that are making an effort to utilize a rational basis for categorizing benefits, such their own past practice or that of the industry, should have more definitive assurance that their good faith efforts will not result in enforcement action.

Additionally, guidance is necessary on how plans can manage access to treatments and services that will be classified as essential benefits but traditionally have been covered based on a separate measurement – a particular number of visits or treatments. The most problematic category of essential benefits in this regard is “rehabilitative and habilitative services.” If unlimited dollar amounts are simply translated into an unlimited number of visits or treatments for chiropractic care, for example (assuming such care is considered an essential benefit), plan sponsors will quickly face a situation in which costs for such services will be unmanageable, which will not have a positive impact on the overall affordability of plans for employees. Therefore, we recommend that plans be permitted to use reasonable medical management techniques to determine coverage parameters for treatments and services that have been governed on a per visit or per service basis, just as plans have been permitted to do with respect to preventive services.

Definition of Essential Benefits

The restrictions on annual and lifetime limits apply to “essential benefits,” which makes the definition of “essential benefits” critically important. While PPACA sets forth categories of benefits considered essential, the language in the statute is just that – broad categories, rather than an enumeration of particular benefits that will not be subject to annual or lifetime limits.² The IFR has adopted these broad categories as the definition of essential benefits for purposes of the rules on annual and lifetime limits, with no additional detail.³ Thus, there is presently no definitive guidance for example, of how chiropractic treatment, or non-emergency use of hospital emergency room services, should be categorized.

CIAB members have received numerous *urgent* requests for information from plan sponsors who are attempting to comply with the annual and lifetime limits rules, but have questions about how to categorize particular services so that their plans can be structured accordingly. Among the most frequently asked questions are whether chiropractic services should be categorized as “rehabilitative and habilitative services,” and whether infertility treatment would be considered an essential benefit.

CIAB believes plans are making good faith efforts to categorize treatments and services to the best of their ability in light of the present absence of regulatory guidance. But we urge the Departments to issue more detailed guidance on the definition of essential benefits as quickly as possible, particularly since the majority of plans have January 1 renewal dates and are currently in the process of attempting to structure their benefits to comply with PPACA starting January 1, 2011 as the statute requires. We recognize that the enumeration of specific treatments and services that fall within the “essential” category represents a sizable task for the Departments. However, the longer the wait for guidance, the greater the chance of difficulties that all wish to avoid, such as inconsistencies in how various plans categorize particular services, and confusion on the part of employees about which services are subject to limits.

In the interim, our members believe that reference to established company or industry practice, where such practices exist, is one way to make rational and informed classifications of services. Thus, for example, many employer-sponsored plans do not cover infertility treatment (unless required by state law).⁴ Plans may infer from this fact that such treatment would not be

² The categories of “essential benefits” listed in Section 1302(b) of PPACA are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

³ IFR, 75 Fed. Reg. at 37191.

⁴ For example, New Jersey and Massachusetts require group health plans that provide pregnancy-related coverage (but not self-insured plans) to cover a broad range of infertility treatments.

considered an essential benefit (in addition to the observation that this treatment does not appear to fit within the categories identified in the statute). CIAB further suggests that where plans classify treatments and services based on established practices, plans should have the advantage of an explicit safe harbor from enforcement actions based on those classifications, in addition to the Departments' existing commitment to take into account good faith efforts to comply.⁵

The Role of Reasonable Medical Management Techniques

The CIAB also requests guidance on managing access to treatments and services that will be classified as essential benefits but have traditionally been administered on a per visit or per treatment basis. For example, many plans cover chiropractic care through a certain number of visits per year. If a plan classifies chiropractic care as "rehabilitative and habilitative services," chiropractic care, as an essential benefit, will be subject to the rules on annual and lifetime limits. But unlimited dollar amounts should not simply be translated into an unlimited number of visits or treatments for chiropractic care. Otherwise, sponsors will quickly face a situation in which costs for such services will be unmanageable, which can adversely impact premiums for employees and perhaps even availability of coverage.

The Departments addressed an analogous problem in its Interim Final Rule on free preventive services.⁶ In that context, the Departments recognized that reliance on established guidelines was necessary to outline reasonable parameters for such services. More specifically, where guidelines from relevant regulatory or expert bodies address the frequency, method, treatment, or setting for the provision of a particular service (e.g., the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention), plans must follow those guidelines. Where such guidelines do not address the frequency, method, treatment, or setting for a covered item, plans are allowed to use "reasonable medical management techniques to determine any coverage limitations."⁷

A similar standard should be applied here to those services that traditionally are covered on a per visit or per treatment basis. Thus, while no dollar limits would be placed on such essential benefits, plans would be permitted to use "reasonable medical management techniques" – a known standard – to determine parameters for the frequency, method, treatment, or setting for these services.

Relatedly, we also seek clarification of plans' obligations where the essential benefits and preventive services rules overlap. For example, questions have been raised about annual

⁵ Of course, good faith compliance efforts should be taken into account for all classification decisions made by a plan, whether or not the plan is able to identify an established practice to rely upon for guidance.

⁶ Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41726 (July 19, 2010).

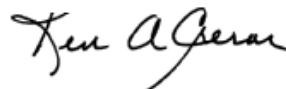
⁷ *Id.* at 41729.

physical exams, which may be classified under the “preventive and wellness services” category of essential benefits and thus subject to no annual or lifetime limits, but which also fall under the preventive services rule and would be subject to first dollar coverage by non-grandfathered plans. The combined effect of these rules should not be that plans are required to provide first dollar coverage of an unlimited number of routine physical exams each year, or here again, costs will quickly become unmanageable. Rather, the rule on annual and lifetime limits should specify that use of reasonable medical management techniques (where permitted), does not trigger an annual or lifetime limit analysis.

Conclusion

The CIAB appreciates this opportunity to comment on the Departments’ IFR concerning annual and lifetime limits. The Council and its members continue to work diligently in assisting employers in their efforts to comply with PPACA and related regulations. However, we encourage the Departments to clarify the various issues discussed here to better facilitate compliance, and to help plans manage access to services in a manner that will ensure that costs and premiums remain affordable to participants. The CIAB stands ready to provide any additional assistance that may be helpful.

Respectfully submitted,



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