Murphy Anderson PLLC

Washington
1701 K Street NW, Suite 210
Washington, DC 20006
202.223.2620 Fax 202.223.8651

Boston
111 Devonshire Street, 5th Floor
Boston, MA 02109
617.227.5720 Fax 617.227.5767

Cincinnati
2406 Auburn Avenue
Cincinnati, OH 45219
513.784.1280 Fax 877.748.1449

www.murphypllc.com

Reply to Washington

August 25, 2010

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

Attn: RIN 1210-AB42

Re: Comments on Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections, Issued June 28, 2010, Fed. Reg. Vol. 75, No. 123

To Whom It May Concern:

I represent and work with Taft-Hartley welfare benefit funds that provide welfare benefits to tens of thousands of employees pursuant to collective bargaining agreements in the retail grocery and other industries.

I write to comment on the recently issued regulations enacting Section 2711 of the Public Health Service Act ("the PHS Act"), as added by the Patient Protection and Affordable Care Act ("the Act").

1. The Act prohibits "establishment"—not application—of lifetime and annual limits.

Section 1251 of the Act reflects Congress's intent to exempt existing health plans from the Act, with limited exceptions. One of those exceptions is Section 2711 of the PHS Act, added by Section 1001 of the Act, which provides:

(a) Prohibition.—
(1) In General. A group health plan and a health insurance issuer offering group or individual health insurance coverage may not *establish*—

> (A) Lifetime limits on the dollar value of benefits for any participant or beneficiary; or
> (B) Except as provided in paragraph (2), annual limits on the dollar value of benefits for any participant or beneficiary. (Emphasis added).

The common usage of the term "establish" is to put in place. One is generally understood to have established something, such as a college or a business, as of a particular date. The first definition of "establish" found in *The Merriam-Webster Dictionary* (2004 Ed.) is "to institute permanently," and the second is "to found," as in "to take the first steps in building." When we speak of something that has been "long established," it is understood that we are referring to something that happened in the past, and has continued into the present. Thus, the plain meaning of Section 2711 of the PHS Act is that a group health plan cannot put into place an annual or lifetime limit on benefits.

In Section 1251(a)(4)(A)(ii), Congress applied the lifetime limits provisions of Section 2711 to grandfathered plans, and in 1251(a)(4)(B)(i) of the Act, Congress applied the annual limit provisions of Section 2711 to grandfathered plans that are group health plans. Since Section 2711 says that lifetime and annual limits may not be "established," the most logical, straight-forward application of Section 2711 to grandfathered group health plans is that where they did not have annual or lifetime limits prior to enactment, they cannot establish them subsequently—meaning they cannot put them in place after enactment of the Act.

However, in drafting regulations to implement Section 2711, the Departments have interpreted it to mean that grandfathered group health plans may not *apply* annual or lifetime limits after the effective date of the Act. This interpretation is inconsistent with the statutory language of Section 2711.

The Departments state that Section 2711 provides that group health plans may not "impose" annual or lifetime limits. (*See, e.g.*, 75 Fed.Reg. No. 123, p. 37190 ("Section 2711 … generally prohibit group health plans … from *imposing* lifetime or annual limits on the dollar value of health benefits.") (Emphasis added.) This is incorrect. Section 2711 does not use the term "impose"—it uses the term "establish," both in subsection (a)(1) and in subsection (a)(2).[1]

---

[1] By contrast, Section 109 of the Affordable Health Care For Americans Act, H.R. 3962, which was not passed by the Senate, would have amended the PHS Act, and similar laws, to provide that group health plans and health insurance issuers "may not *impose* an aggregate dollar lifetime limit." (Emphasis added.) *See also* Section 222(a)(1)(3) of H.R. 3962, made applicable to existing employer-based group health plans via Section 202(b)(1)(A) ("essential benefits

By using the word "impose" rather than "establish," the Departments have changed the meaning of Section 2711. The main definition of "impose" is "to establish *or* apply by authority." *See* The Merriam-Webster Dictionary (2004 Ed.) (emphasis added). It is this second meaning of "impose" that the Departments have used in drafting the regulations under Section 2711, such that grandfathered plans may not apply lifetime and annual limits that were established prior to the Act. *See, e.g.*, 75 Fed. Reg. No. 123, p. 37191 ("a plan could not both *apply* a lifetime limit to a particular benefit ... and at the same time treat that particular benefit as an essential health benefit for purposes of applying the restricted annual limit") (emphasis added). Thus, the Departments have issued regulations requiring grandfathered plans to notify participants of the opportunity to re-enroll in coverage where they have already exceed the lifetime limits that "no longer *apply*." 75 Fed. Reg. No. 123, p. 37191-92; 29 CFR §2590.715-2711(e)(2)(i).

The Departments' interpretation of Section 2711 is contradicted by the unambiguous, plain language of the statute: Section 2711 does not say that group health plans may not *apply* annual and lifetime limits—it says they may not *establish* them. [2]

I respectfully request that regulations be drafted in line with the actual language of the Act, which is that grandfathered plans that did not have lifetime or annual limits in place before the Act may not put them into place afterward. This will require deleting the regulations that give participants who already exceed the pre-Act lifetime limits the opportunity to re-enroll. It will also require changes to the regulations on whether applying annual limits will cause loss of grandfathered status, as well as changes to the model notice grandfathered plans must provide to participants with respect to not being able to apply annual and lifetime limits.

2. Rescissions should not include retroactive cancellation of coverage where contributions not paid due to ineligibility for coverage or individual not otherwise eligible for coverage.

Section 2712 of the PHS Act, as added by Section 1001 of the Act, provides that group health plans may not "rescind" such plan or coverage with respect to a person

---

package" "does not *impose* any annual or lifetime limit on the coverage of covered health care items and services.") (Emphasis added.)

[2] Notably, Section 2711(b) uses the term "placing" when providing that nothing in the Act prohibits a group health plan from "placing" annual or lifetime benefits on specific covered benefits that are not essential health benefits. The plain meaning of placing is consistent with "establish" as meaning "to put into place," not "to apply."

covered by the plan except where the person performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact. "Rescind" is not defined by the Act.

"Rescission" is widely understood to be a practice used by health insurance companies in the private market whereby they retroactively cancel coverage of policy-holders who incur substantial medical claims, often because of a purported failure to disclose a preexisting condition. While Section 2717 now prohibits group health plans from engaging in "rescission" as well, in drafting regulations under Section 2717, the Departments must be mindful of the differences between group health plans, especially multiemployer group health plans, and insurers in the private market, so as to not unduly create burdens on group health plans to continue coverage for persons who would not otherwise be eligible for coverage.

One major difference between coverage under multiemployer health plans and coverage in the private market is that participants and their dependents in multiemployer health plans are eligible for coverage solely on the basis of their employment with contributing employers; they do not apply for coverage as a policy-holder does in the private market. As a result, when they become eligible for coverage, they are not required to provide any information as to their health status or prior claims history.

Another major difference between coverage under multiemployer health plans and coverage in the private market is that often participants are eligible for coverage under multiemployer health plans only upon working a certain number of hours in a month or over a period of time, and coverage ends when the employee's employment with a contributing employer ends (or at the end of the month in which the employment ends). Typically there is a separate "hours worked" requirement for full-time coverage and part-time coverage, with corresponding contribution rates to be paid by contributing employers.

Multiemployer health plans do not have access to employer records; they rely upon the contributing employers to report the hours worked and the termination dates. Typically the hours worked are reported when the contributions are due, and often contributions are not due until the month after the hours worked (for example, contributions for hours worked in January are due by February 15). Thus, where a participant has not worked sufficient hours in a month to be eligible for coverage, the multiemployer plan does not learn about it until after-the-fact.

If retroactive termination of coverage in these situations is included in the definition of "rescission," multiemployer plans will be required to provide coverage for periods of time when employees are ineligible for coverage under the terms of the plan,

and without any supporting contribution due from employers, as employers are not required to pay contributions for ineligible employees. Indeed, Example 2 in the regulations, 29 CFR 2590.715-2712(a)(3), seems to contemplate this very scenario, except that in the example, the employer mistakenly paid contributions during a period of ineligibility. Under the terms of most plans I have worked with, in Example 2 the employer would be able to have the mistakenly paid contributions restored to him or credited against future contributions, with the result being that the health plan would have to provide the coverage to an ineligible employee for a period of several months without supporting contributions, thereby depleting the assets of the plan available to provide coverage for other eligible employees. This is unreasonable and not a true "rescission" as that practice is widely understood.

A fair and reasonable way to address the situation is to modify Section 2590.715-2712(a)(2)(ii) to read as follows:

> The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to an absence of payment of premiums or contributions towards the cost of coverage.

This makes clear that rescission does not include retroactive cancellation of coverage for nonpayment of premiums or contributions regardless of whether the employee or the employer was responsible to pay, and where contributions are not "required" because the employee was not eligible.

In addition, it would be helpful if the Departments clarified what constitutes an "omission that constitutes fraud" in Section 2590.715-2712(a)(1), and specifically, whether that can include a failure to timely inform the plan of events that would trigger loss of eligibility, such as divorce for dependent spouses, which is a recurring problem for my multiemployer plan clients. The marital status of a dependent spouse is undoubtedly material, but the question is whether the failure to inform the plan of changes in marital status is deemed to be intentional or inadvertent, such that it constitutes fraud. In either case, though, the plan is required to continue coverage for a person who clearly was not eligible for coverage.

This distinguishes this scenario from that given in Example 1 of Section 2590.715-2712(a)(3), which addresses an inadvertent failure to disclose long-ago medical treatment. Since enrollees in multiemployer plans do not disclose any medical history or health status, as it is irrelevant to whether they are eligible or coverage, it seems a clearer distinction in the regulations itself is in order to address situations where enrollees are required to but fail to inform the plan of events that trigger loss of eligibility for coverage. I urge the Departments to draft regulations indicating that a failure to report a

divorce or other event that would trigger loss of eligibility is the type of omission that would constitute fraud for purposes of rescission.

3. Medicare rates should not be part of formula in determining payment of out-of-network emergency services.

Section 2719A(b)(1)(C) of the PHS Act, as added by Section 1001 of the Act, provides that where non-grandfathered group health plans and health insurance issuers cover emergency services, they must cover them when provided by out-of-network service providers without any limitation on coverage that is more restrictive than the limitations applicable to in-network service providers, and without imposing any additional cost-sharing requirements for participants than those that would apply if the services were provided in-network.

In issuing regulations under this provision, the Departments believe it is necessary to protect participants from excessive "balance billing" by imposing a requirement that a "reasonable amount" be paid to the service provider before a participant may be "balanced billed." *See* 75 Fed.Reg. No. 123, p. 37194. Such reasonable amount must be the greater of the following: (a) the amount negotiated with in-network providers for the emergency services furnished; (b) the amount for the emergency service calculated using the method applicable to out-of-network services, but substituting the in-network cost-sharing provisions for any out-of-network cost-sharing provisions; or (c) the amount that would be paid by Medicare. *Id.*; *see also* 29 CFR § 2590.715-2719A(b)(3)(i). The first two amounts make sense, but the third amount will do little to protect participants from excessive balance billing, but will increase the administrative burdens of health plans, and should be discarded.

The danger of excessive balanced billing is more a function of what out-of-network providers charge than what health plans pay.[3] Health plans have no control over the fees charged by out-of-network providers. Their ability to exert a modicum of control is limited to enacting plan terms providing that the plan will pay only the "usual, customary and reasonable fee" ("UCR") for any service provided. A participant or provider (standing in the shoes of the participant through an assignment of benefits) may challenge the health plan's determination of UCR through the plan's claims appeal process. Yet while paying UCR protects health plans from exorbitant billings from out-

[3] Typically, in exchange for being included in the network, providers agree to accept the negotiated rates and forego balance billing the participants for any difference between their standard rates and the network rate, and so there is no balance billing when in-network providers are used.

of-network providers, plans have no ability to prevent out-of-network providers from balance billing a participant for the difference between a reasonable fee paid either to in-network providers or the UCR rates for comparable services, and whatever exorbitant fee the provider may seek to charge.

Similarly, requiring plans to pay Medicare rates to out-of-network providers does nothing to protect participants from excessive balance billing, as the plans have no control over how much above Medicare rates out-of-network providers choose to bill the plans. However, unlike when paying UCR, plans have no control over what Medicare rates are, and so they have even less ability to control costs than when paying based on UCR.

On the other hand, to a large extent, Medicare rates are completely irrelevant to the operation of health plans that cover active employees eligible for Medicare (as the plan pays primary in these situations), as well as for plans that do not offer retiree health care benefit. Requiring plans to check the Medicare rates before paying any claim for out-of-network emergency service adds to the administrative costs and burdens of the plan. Far from providing a comprehensive list of rates for emergency services, the website referenced in the regulations links the viewer to a 24-page document explaining general rules for Medicare payments for all services, not just emergency services, and without any list of rates for out-of-network emergency service. Wherever the list is located, it will add a needless work to require plans to check the most recent version in order to determine how much to pay a claim for out-of-network emergency services, when they will readily have information available to them to calculate the amounts under (a) and (b), and paying the greater of those will protect participants from unfair balance billing.

The burden of requiring plans to pay the Medicare rates far outweighs any benefit to participants. I respectfully request that the Departments delete subparagraph (c) to 29 CFR § 2590.715-2719A(b)(3)(i) and the corresponding regulations.

I appreciate your consideration of these issues. Thank you.

Very truly yours,

Joni Jacobs

Joni S. Jacobs

JSJ:oc