



**National
Business
Group on
Health**

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

August 27, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Attention: RIN 0991-AB69
OCHIO-9994-IFC
REG-120399-10
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445G
Washington, DC 20201

The Honorable Hilda L. Solis
Secretary
U.S. Department of Labor
Employee Benefits Security Administration
Office of Health Plan Standards and Compliance Assistance
Attention: RIN 1210-AB43
200 Constitution Avenue, N.W.
Room N-5653
Washington, DC 20210

The Honorable Timothy F. Geithner
Secretary
U.S. Department of the Treasury
Attention: RIN 1545-BJ61
REG-120399-10
OMB Number: 1210-0143; 1545-2179
Internal Revenue Service
1111 Constitution Avenue, N.W.
Room 5205
Washington, DC 20224

Re: Interim Final Rules for group health plans and health insurance coverage in the group and individual markets under provisions of the Patient Protection and Affordable Care Act (Affordable Care Act) regarding preexisting condition exclusions, lifetime and annual dollar limits on benefits, rescissions, and patient protections.

Dear Secretaries Sebelius, Solis, and Geithner:

The National Business Group on Health (Business Group) appreciates the opportunity to submit comments on the Interim Final Rules for group health plans and health insurance coverage in the group and individual markets under the Affordable Care Act regarding preexisting condition exclusions, lifetime and annual dollar limits on benefits, rescissions, and patient protections. We hope that our recommendations will assist you to allow group health plans and insurance providers to continue to provide affordable, high-quality coverage, particularly with respect to “mini-med” or limited benefit medical plans that frequently cover part-time, seasonal, contract and temporary employees until they can obtain access to coverage in the state health care exchanges in 2014.

The National Business Group on Health represents approximately 296, primarily large, employers (including 64 of the Fortune 100) who voluntarily provide health benefits and other health programs to over 55 million American employees, retirees, and their families.

We applaud the Department of Health and Human Services’ (HHS) consideration of an exemption or waiver for “min-med” plans from the Affordable Care Act’s prohibition on annual benefit limits until the exchanges begin in 2014 (or beyond). Because most limited benefit plans have lower annual limits to keep premiums affordable, exempting these plans or establishing a process for waiving these requirements is critical for the 1.4 million people and their families who depend on them as a source of coverage. It is also critical for employers who want to continue to offer coverage to employees currently in these plans.

According to Mercer’s National Survey of Employer-Sponsored Health Plans (2009), 7% of large employers offer “mini-med” or limited benefit plans with over 49% enrollment for employers with 50-499 employees. Employees covered by limited benefit plans include those in the manufacturing, wholesale (51%), retail services (49%), grocery, waste management, transportation, restaurant and hospitality industries, often as a bridge or transition to more comprehensive coverage.

“Mini-med” or “mini-medical” plans, also known as limited medical benefit plans, offer a viable, affordable, alternative to expensive, comprehensive major medical insurance frequently for part-time, but also for full-time employees. These plans are COBRA compliant, reduce turnover, decrease absenteeism and increase the attraction and retention of employees.

Employers may use limited medical benefit plans as either primary insurance or supplemental coverage. Unlike comprehensive major medical insurance, many limited medical benefit plan designs do not base their benefits on actual charges incurred and actually pay based on a fixed benefit indemnity amount when various health care services are utilized. Many employers and employees, and individuals prefer limited medical benefit plans because they carry a first dollar benefit. The typical limited medical plan includes doctor’s office visits, prescription drugs, wellness, outpatient diagnostic lab and

X-Ray, emergency room for accident, hospital and surgical coverage. Sometimes, limited medical benefit plans are offered with deductibles or co-payments and have annual limits on benefits and maximums. Plans may even include Preferred Provider Organization (PPO) networks, dental, vision, prescription drug coverage, a nurse line for the purpose of reducing visits to health care providers, lab programs and Flex 125 participation.

In order to assist you with the administration of the Interim Final Rules, we make the following recommendations, which reflect the suggestions and concerns of our member companies:

- I. Exempt Limited Benefit or “Mini-Med” Plans from the Annual Limit Restrictions until 2014;**
 - II. Establish an Annual Waiver Process for “Mini-Med” Plans from the Annual Limit Restrictions until 2014 as a Secondary Option;**
 - III. Clarify that Plans may Maintain Annual Dollar Limits on Out-of-Network Benefits; and**
 - III. Exempt Stand-Alone Health Reimbursement Arrangements (HRAs) from the Annual Limit Restrictions.**
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- I. Exempt Limited Medical Benefit or “Mini-Med” Plans from the Annual Limit Restrictions until 2014**

Recommendation: The Departments should exempt grandfathered limited medical benefit (“mini-med”) plans from the restrictions on annual limits until participants can access the state exchanges in 2014 (or beyond).

Recommendation: The exemption should last until: (a) the last date of plan year ending on or after January 1, 2014; (b) the last date of plan year in the year when exchanges are operational in a given State; or (c) the last date of plan year in year when subsidies for comprehensive coverage are available, whichever occurs last.

Because most limited benefit plans have lower annual limits, exempting these plans from the annual limit restriction is critical for employers who offer them to continue to so. If the Departments do not exempt “mini-med” plans from this requirement it would result in much higher premiums, less access and possibly abruptly end this coverage for 1.4 million primarily part-time, seasonal and temporary employees and their families beginning later this year. In fact, a majority of this population would likely be without coverage until 2014.

For example, one Business Group member company stated that they want to continue to offer coverage to all of their employees, but if their “mini-med” plans were forced to change they would have almost 9,600 employees who may not be able to afford this coverage on January 1, 2011. In addition, the company cannot absorb the increases to these plans and would need to increase premiums on their employees which would also increase adverse selection against the plans and continue to increase their costs to provide coverage to their employees. The company’s only other option would be to drop the plans

completely and not offer health care coverage to 34,000 part-time employees and reduce the health care options available to their full-time employees as well. Clearly, it was not the intention of the Congress or the Administration to increase the number of uninsured by eliminating the ability of employers to offer “mini-med” plans to their primarily part-time employees before they are eligible for exchange coverage in 2014.

II. Establish an Annual Waiver Process for “Mini-Med” Plans from the Annual Limit Restrictions until 2014 as a Secondary Option;

Recommendation: The Departments should establish an annual waiver process from the restrictions on annual limits for grandfathered limited medical benefit (“mini-med”) plans until participants can access the state exchanges in 2014 (or beyond).

As a secondary option to exemption from the annual limit restriction, establishing a process at HHS for plans to obtain annual waivers is a logical step towards complying with Section 1255 of the new health care law that guarantees people’s ability to maintain their current levels of coverage.

Recommendation: HHS’ waiver process should allow insurance carriers and/or third party administrators to apply for waivers from the restrictions on annual limits by product on behalf of employer sponsors. Using this approach, the carriers could apply for 1 waiver for all group plans under that particular limited medical product.

Allowing insurance carriers to apply for 1 waiver for all group plans under a particular limited medical product would:

- 1) Minimize the number of waivers that need to be applied for on behalf of plan sponsors/employers; and
- 2) Also minimize the work load on HHS’ end, since there would be fewer waivers to approve.

Allowing TPAs or insurers of employer plans to provide information for the waivers on behalf of employers would facilitate the efficient information flow between HHS and plans and reduce the administrative costs for employer plans—many of whom use the same administrators and carriers to provide this coverage to their employees. If the plan is self-insured, the plan sponsor/employer may need to apply for the waiver directly.

Recommendation: The HHS Secretary’s waiver program should define a “significant decrease in access to benefits” as the change in total cost of the plan by more than 20% or if employees’ average premiums are more than 9.5% of individual employees’ average weekly wage. We recommend defining a “significant increase in premiums” as an increase in anticipated premium of greater than Medical Inflation plus 15% or alternatively, an increase in anticipated premium of 50% or more. For limited benefit plans that self-insure, a significant increase in

premiums should be interpreted as a significant increase in employer or employee contributions.

We believe 20% is a reasonable threshold to measure a significant decrease in access to benefits. Using 9.5% of average weekly wages as a measure that results in unaffordable weekly health care premiums would be consistent with other parts of the law that define unaffordable using a similar percentage of income.

Recommendation: The Departments should design an internet application to process the applications for the “mini-med” waivers (with a defined review period (i.e. within 2 business days), updates, certification and the anticipated cost to employers and employees if waivers are not approved) similar to the Medicare Part D Retiree Drug Subsidy Application and the recent Retiree Reinsurance Program.

An internet application for the waiver process would allow for continuous updates as to when the waiver process would conclude, immediate notification when the application would be approved/denied and changes that denied plans would need to make in order to appeal and come into compliance.

Recommendation: The Departments should also include a process whereby “mini-med” plans denied waivers may have an opportunity to appeal and modify their applications to comply with the requirements of the waiver.

III. Clarify that Plans may Maintain Annual Dollar Limits on Out-of-Network Benefits;

Recommendation: The Departments should clarify that plans may maintain annual dollar limits on out-of network benefits.

Employers use their flexibility under the Employee Retirement Income Security Act (ERISA) to “bend the cost curve” by paying providers higher or lower payments based on the relative quality and cost of care provided to their employees and by negotiating lower rates for providers who meet plan standards and agree to accept in-network rates. In the recent Interim Final Rules, the Departments allowed plans to maintain cost sharing requirements when plan participants receive preventive care services out-of-network. Accordingly, we recommend the Departments ensure consistency and apply that same principle in this case. Because the interim regulations are ambiguous on this point, we recommend that the Departments clarify that employers and health plans may maintain annual dollar limits on out-of-network benefits. This clarification will help plans encourage plan participants to go to higher quality providers, improve the quality of care for employees, and keep plan costs more affordable.

IV. Exempt Stand-Alone Health Reimbursement Arrangements (HRAs) from the Annual Limit Restrictions

Recommendation: The Departments should preserve stand-alone HRAs by exempting these plans from the annual limit restrictions.

Based on the Interim Final Regulations, it appears that stand-alone HRAs with typical annual limits will not satisfy the prohibition. HRAs are entirely employer-paid health care accounts where employees can make tax-free withdrawals for qualified medical expenses. They do not provide health benefits, but are dollar accounts used to help pay for medical expenses. Subjecting them to annual benefit limit requirements therefore, does not make sense.

Employers use HRAs (both stand alone and together with high-deductible health plans (HDHPs)) to help employees afford their health care expenses. Some employers rely upon stand-alone HRAs for employees because that is all they can afford to help offset employees' health care costs. If stand-alone HRAs do not receive an exemption from the annual limit requirements, some employers may cease to offer these benefits, leaving employees with higher out-of-pocket costs and no employer assistance. We believe that this result runs counter to the intentions of the President and the Congress in the new health care law to help people to maintain their current coverage.

Thank you for considering our comments and recommendations. We look forward to continuing to work with you as you implement the various provisions of the new law. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 585-1812, if you would like to discuss our comments in more detail.

Sincerely,



Helen Darling
President

cc: The Honorable Phyllis C. Borzi, Assistant Secretary, Employee Benefits and Security Administration
Mr. Jay Angoff, Director, Office of Consumer and Insurance Oversight
The Honorable Douglas H. Shulman, Commissioner, Internal Revenue Service