



August 27, 2010

By Mail

U.S. Department of Labor
Office of Health Plan Standards
and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
Attn: RIN1210-AB43
200 Constitution Avenue NW
Washington, DC 20210

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attn: OCIIO-9994-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

Internal Revenue Service
CC:PA:LPD:PR (Reg-120399-10)
Room 5205
P.O. Box 7604
Ben Franklin Station
Washington DC 20004

To whom it may concern:

The American Cancer Society Cancer Action Network (“ACS CAN”) is the advocacy affiliate of the American Cancer Society (the “Society”). The Society is a nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service. The American Cancer Society, operating through its national office and 13 chartered, geographic division affiliates throughout the United States is the largest voluntary health organization in the United States.

ACS CAN appreciates the opportunity to provide comments to the U.S. Department of Labor, the Department of Health and Human Services and the Internal Revenue Service (the “Departments”) on the Interim Final Rules (the “Interim Rules”) published in the Federal Register on June 28, 2010. These rules implement

provisions of the Patient Protection and Affordable Care Act (the “PPACA”) relating to preexisting condition exclusions for children, lifetime and annual dollar limits on benefits, rescissions and patient protections.

ACS CAN is very pleased that the Interim Rules reflect a thoughtful and thorough implementation of key aspects of the PPACA. In general, we believe the Interim Rules are consistent with the broader policy objectives of the PPACA. Our comments are limited to several specific concerns relating to the structure of the rules on lifetime and annual limits.

Waiver of Restricted Annual Limits. The Interim Rules appropriately recognize the realities of the insurance marketplace by authorizing a program for the waiver of the restricted annual limits in circumstances where the application of the limits would result in a significant decrease in access to benefits or increase in premiums. However, we are concerned that the waiver program not be implemented in a way that provides an opportunity for plans and issuers to effect an end run around the restricted annual limits. This opportunity is particularly apparent in certain segments of the individual market, such as the limited benefit plans market, where consumers often face severely restrictive annual limits yet pay disproportionately high premiums for limited coverage. Accordingly, ACS CAN recommends that the authority to waive the restricted annual limits not result in a level that would be insufficient to provide adequate treatment for chronic conditions that are both common and costly to treat on an annual basis, such as cancer, heart disease or diabetes.

Non-Monetary Limits. ACS CAN recommends that the Interim Rules be revised to include an anti-abuse rule to prevent the use of non-monetary limits on plans benefits as a proxy for otherwise prohibited annual dollar limits on coverage. Although not specifically addressed by the Interim Rules, it is clear that insurers and employers may apply non-monetary limits to specific benefits, such as a limit on incidences of treatment or the number of days of care. For patients with chronic illnesses that require a high annual level of health care utilization, the imposition of annual non-monetary limits is as effective as the imposition of annual monetary limits in reducing the adequacy of their coverage. Accordingly, ACS CAN recommends that, for the period in which restricted annual limits are in effect, a plan or policy’s non-monetary limits applicable to essential health benefits should not be allowed to be lower than at the levels in effect on March 23, 2010, absent an express waiver from HHS. The waiver process applicable to non-monetary limits could easily be incorporated into the process already contemplated by the Interim Rules.

Definition of “Essential Health Benefits”. The definition of “essential health benefits” is crucial to the implementation of the rules relating to lifetime and annual limits. However, the Interim Rules defer a comprehensive definition of “essential health benefits” to the issuance of future guidance under PPACA

§1302(b), relying for an interim period on a cross-reference to the very general categories identified in the statute as essential health benefits. Prior to the issuance of guidance under PPACA §1302(b), the Interim Rules allow a plan or issuer to rely on a “good faith” reasonable interpretation of the term “essential health benefits”. ACS CAN believes that consumers will be significantly disadvantaged if plans and issuers are provided with the latitude to interpret the scope of the Interim Rules independent of comprehensive guidance. If this approach prevails, it is likely that consumers will be subject to disparate, and potentially adverse, treatment as plans and issuers reach different conclusions regarding which benefits are or are not essential. The statutory guidelines under PPACA §1302(b) are simply too general to provide plans and issuers with a basis for consistent interpretation of the term “essential health benefits.”

Pending the issuance of comprehensive guidance under PPACA §1302(b), ACS CAN recommends that any benefit provided under a plan or policy in effect as of March 23, 2010 be treated as an “essential health benefit” for purposes of applying the Interim Rules. Absent a bright-line test, it will be very difficult for both issuers and consumers to identify essential benefits with certainty, and the possibility that the Interim Rules will be applied incorrectly or with manipulative intent will be magnified. If the Departments decline to adopt a bright line test, ACS CAN recommends that the Interim Rule be revised to require plans and issuers to provide consumers with a comprehensive annual disclosure notice that identifies both the plan or policy’s essential health benefits and those benefits which the plan or issuers has determined are not essential and are subject to separate lifetime and/or annual limits. The disclosure notice should also be required to clearly state any change in the classification of a benefit as essential or non-essential as well as identify any non-monetary limits on any benefit(s) during the plan or policy year.

Reinstatement Rights under an Individual Policy. ACS CAN requests that the Departments clarify the application of the Interim Rules to an individual seeking reinstatement under an individual policy where the individual had previously reached a lifetime limit on benefits. Under the Interim Rules, a participant in a group health plan is eligible for reenrollment if they had reached the plan’s lifetime limit prior to the effective date of the Interim Rules even if they are no longer enrolled in the plan and no family member is currently enrolled in the plan. We are not clear as to why a similar rule is not applicable to a policy in the individual market. Instead, the preamble to the Interim Rules states at p. 37191 that “...this reinstatement opportunity does not apply to individuals who reached their lifetime limits on individual health insurance coverage ***if the contract is not renewed or otherwise is no longer in effect.***” (***emphasis added***) It is contrary to logic for a consumer to continue to renew an individual policy if they have reached a lifetime limit on benefits. Accordingly, if the referenced limit for individual policies is the overall limit on policy benefits, it is unlikely that any consumer will be able to take advantage of the reinstatement opportunity because such policies will no longer be in effect. Although the data in this area is sparse, it is likely that the highest incidence of

consumers who have reached a lifetime limit will be found in the individual market and, particularly, among purchasers of limited benefits policies. Yet, as drafted, the reinstatement opportunity for this group under the Interim Rules will be very limited. ACS CAN recommends that the reinstatement rule for individual policies be revised to create greater parity between the group and individual markets. This parity could be achieved by providing that an individual who did not renew or otherwise continue an individual policy should be eligible for reinstatement under the policy or any substantially similar policy then offered by the issuer if the subscriber or any insured under the policy reached a lifetime benefit limit and, thereafter, such policy was not renewed or otherwise continued during the plan year period ending September 23, 2010.

* * * * *

The elimination of lifetime and annual benefit limits is a cornerstone of PPACA reforms, enhancing the benefit security of millions of Americans who would otherwise be denied the opportunity to receive quality, affordable healthcare. We hope the Departments will consider our recommendations to help ensure that this significant reform is implemented on a consistent basis with the policy objectives of the PPACA.

Sincerely,

A handwritten signature in black ink, appearing to read "Chris Hansen", with a stylized flourish extending to the right.

Chris Hansen
President