



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

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August 27, 2010

Honorable Kathleen Sebelius
Secretary
U.S. Department of Health & Human Services

Honorable Hilda Solis
Secretary
U.S. Department of Labor

Honorable Timothy Geithner
Secretary
U.S. Department the of Treasury

Submitted via the Federal Rulemaking Portal: <http://www.regulations.gov>

**Re: Comments on Interim Final Rule Related to Preexisting Condition
Exclusions, Lifetime and Annual Limits, Rescissions, and Patient
Protections**

Dear Secretaries Sebelius, Solis, and Geithner:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments to the Departments of Health and Human Services ("HHS"), Labor, and the Treasury (collectively, the "Departments") regarding the Interim Final Rule (the "Rule") on Requirements for Group Health Plans and Health Insurance Issuers Under the Affordable Care Act ("ACA") Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections as issued in the *Federal Register* on June 28, 2010 (75 Fed. Reg. 37188).

BCBSA represents the 39 independent Blue Cross and Blue Shield Plans ("Plans") that provide health coverage to nearly 100 million – one in three – Americans. We offer coverage in every market and every zip code in America. As key stakeholders affected

by the Rule, the Plans are committed to implementing the Rule and to continuing to assist the Departments in developing reasonable and administrable standards for ACA implementation. Our comments include specific recommendations regarding suggested changes to the Rule, as well as requests for clarification on specific areas of the Rule.

I. Preexisting Condition Exclusions for Enrollees Under Age 19

Issue: HHS recently clarified that the Rule prohibiting preexisting condition exclusions applicable to enrollees under age 19 does not preclude issuers in the individual market from restricting enrollment to specific open enrollment periods, if permitted by state law. 45 CFR § 144.103; HHS, Questions and Answers on Enrollment of Children under 19 under the New Policy that Prohibits Preexisting Condition Exclusions (July 27, 2010).

Recommendation: BCBSA recommends that the final Rule include the July 27, 2010 Questions and Answers and we encourage HHS to work with states to ensure that open enrollment periods are held at uniform times to deter gaming by issuers and potential enrollees. BCBSA would like to work with HHS on additional guidance that would promote the availability of coverage under certain policies outside open enrollment periods.

II. Lifetime and Annual Limits on Benefits for Specific Conditions and Treatment Limits

Issue: Under the ACA, a group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish lifetime or annual limits on the dollar value of "essential benefits" for any participant or beneficiary. These restrictions are generally effective for plan or policy years beginning on or after September 23, 2010, but the ACA generally provides that the Departments may permit certain "restricted" annual limits on the dollar value of "essential benefits" for plan or policy years beginning before 2014.

Consistent with the statute, the Rule prohibits a group health plan, or a health insurance issuer offering group or individual coverage, from establishing any lifetime limit on the dollar amount of "essential benefits" for any individual. The Rule also prohibits all annual limits on the dollar amount of "essential benefits" for any individual beginning in 2014, but, as permitted by the ACA, provides guidance on certain "restricted" annual limits that are permitted for plan or policy years beginning before 2014. 45 CFR § 147.126(a)(2) and (d). The ACA and the Rule also provide that a group health plan or issuer may impose lifetime or annual dollar limits on specific covered benefits that are not "essential health benefits."

The Rule is helpful in that it clarifies that an exclusion of all benefits for a condition is not considered an annual or lifetime limit for a group health plan or issuer offering group health insurance. 45 CFR § 147.126(b)(2). In clarifying that an exclusion of all benefits for a condition is not considered an annual or lifetime limit, the Departments appear to recognize that group health plans and issuers of group coverage must be free to design

benefit plans and policies to include or exclude benefits as is most appropriate for individuals to be covered by the plan or policy. Additionally, retaining this flexibility helps ensure that the costs of offering plans and policies can be managed effectively so that coverage remains affordable, and therefore, accessible.

A plain reading of the statute clearly applies to “dollar limits” with no restrictions to specific treatment limits (e.g., day or visit limits). The Rule appears to be consistent with the statute on these restrictions. Treatment limits are an important method used by group health plans and issuers to manage costs consistent with appropriate clinical standards of care, which helps keep coverage affordable. Additionally, treatment limits are an appropriate medical management technique used to prevent fraud.

Recommendation: BCBSA recommends that the final Rule retain the provisions that a group health plan's or issuer's exclusion of all benefits for a condition is not considered an annual or lifetime limit. Additionally, the Rule should not expand the restrictions on lifetime or annual dollar limits to specific treatment limits (e.g., day or visit limits).

III. Specific Annual Limits

Issue: The ACA authorizes the Departments to permit certain "restricted" annual limits on the dollar value of “essential health benefits” for plan years beginning before 2014. The ACA provides that in defining restricted annual benefits, the Departments should ensure that "access to needed services is made available with a minimal impact on premiums." Applying this authority, the Rule provides for a three year phase-in of permitted annual limits on “essential benefits” for any individual, using the following schedule:

- \$750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011;
- \$1,250,000 for plan years beginning on or after September 23, 2011, but before September 23, 2012;
- \$2,000,000 for plan years beginning on or after September 23, 2012, but before January 1, 2014.

45 CFR § 147.126(d)(1). According to the Preamble to the Rule, the Departments adopted the three-year phase-in approach "[i]n order to mitigate the potential for premium increases...while at the same time ensuring access to essential health benefits." 75 Fed. Reg. at 37191.

These limits apply on an individual basis, so an overall annual dollar limit collectively applied to families is not allowable as a basis to deny a covered individual the minimum annual benefit for the plan or policy year. 45 CFR § 147.126(a)(2). Further, plans and issuers may take into account only "essential benefits" in applying the minimum limits. The Preamble notes that these limits are minimum amounts and that plans or issuers may use higher annual limits or impose no limits. 75 Fed. Reg. at 37191. There remains some uncertainty, however, as to whether specific annual benefit limits (e.g.,

\$200,000 for physical therapy) are prohibited under the Rule even if the plan would otherwise cover aggregate claims above the specified amount.

Recommendation: BCBSA recommends that the Departments clarify in the final Rule whether benefit specific annual limits (e.g., \$200,000 for physical therapy) are prohibited, even if the plan would otherwise cover aggregate claims above the specified amount.

IV. Rescissions and Routine Administrative Enrollment Functions with Respect to Group Health Plans

Issue: The Rule prohibits rescissions except in the case of fraud or an intentional misrepresentation of a material fact. BCBSA seeks a clarification that routine enrollment adjustments and corrections of routine enrollment errors for non-eligible persons, with respect to group health plans, do not constitute a rescission of coverage

There are various situations where these adjustments occur, whether due to administrative mistakes by human resource departments or plan service providers such as insurers and third party administrators, or a failure of an employee or dependent to provide information concerning their eligibility status. For example, an employee may be late in notifying the employer of a family status change which impacts a dependent's eligibility for coverage. In other cases, an employee could lose group health plan eligibility for failing to return to work after a leave of absence. It is quite common for the employer to have 30 days (or some other reasonable time period) to notify their carrier of a dependent status change or of an employee termination. When such mistakes are detected either by the employer or the issuer, enrollment adjustments, including any return of premium, are made between the issuer and the employer group. The Rule should clarify that correcting group health plan enrollment errors where incorrect or non-eligible applications or premiums were received are not rescissions for purposes of the Rule. Our request for this clarification is premised on two considerations.

First, correcting these types of enrollment adjustments does not operate as a rescission of coverage under the plain language of the Rule because the individual is not "covered under the plan" as required under the Rule. 45 CFR § 147.128(a)(1). Group health plans generally require that an individual be *eligible* for coverage before an individual will be "covered under the plan." The enrollment adjustments described above are administrative processes agreed to between an insurer and the employer as established in contracts between the two parties and do not operate to extend coverage to otherwise ineligible individuals.

Second, clarifying that these types of enrollment mistakes do not operate as rescissions would harmonize the Rule with ERISA's fiduciary rules. If a group health plan is required to treat correction of an ineligible person or enrollment as a rescission (including issuing the advance notice of rescission), plan fiduciaries that administer group health plans would be required to provide coverage to an individual who is not eligible for coverage under the terms of the plan. ERISA § 404(a)(1)(D) requires that a plan be administered in accordance with its terms and specifically directs the fiduciary to

discharge his or her duties "in accordance with the documents and instruments governing the plan." If forced to provide coverage to ineligible individuals, plan fiduciaries could be breaching their fiduciary duties, including their duty under ERISA § 404(a)(1)(A) to "discharge . . . duties with respect to a plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries." *Hartsfield, Titus & Donnelly, LLC v. Loomis Co.*, 2010 WL 596466 (D.N.J. Feb. 17, 2010).

Additionally, in the group market cancellations can occur for reasons of noncompliance. For example, upon a group's renewal date the group must provide appropriate paperwork to continue coverage. In Florida, state law provides for a 30-day window in which groups are able to provide the documentation needed for coverage. In this timeframe, insurers may receive premium payments from individuals under the group plan and individuals may seek health services. If the group does not supply the necessary documentation to renew its coverage within the state-mandated 30-day window, the group plan policy is cancelled retroactive to the renewal date. In effect, if the group does not provide the necessary documents, there is no coverage.

Recommendation: BCBSA recommends that the final Rule clarify that routine enrollment adjustments and corrections of routine enrollment errors for non-eligible persons, with respect to group health plans, do not constitute a rescission of coverage. In addition, cancellation of a group health plan for reasons of noncompliance with applicable state law concerning renewal documentation should not constitute a rescission of coverage.

V. Patient Protections – Designation of Primary Care Provider

Issue: Under the Rule, if a group health plan with a network of providers or a health insurance issuer offering group health insurance coverage through a network of providers requires or provides for the designation of a primary care provider by a member, then the plan or issuer must permit each member to designate any participating primary care provider who is available to accept the member. 45 CFR § 147.138(a)(1). If a Plan or issuer requires or provides for the designation of a primary care physician for a child, the plan must permit a physician who specializes in pediatrics to be designated as the primary care physician. 45 CFR § 147.138(a)(2).

Network providers generally are grouped by geographic region so that the availability of a primary care physician, including a pediatrician, is generally limited to the geographic region in which the patient resides. Plans also have to assure states of access to providers within defined standards (e.g., 30 minutes) and for these reasons generally limit selections of primary care providers to reasonable distances from the member's residence.

Recommendation: BCBSA recommends that the Departments modify the Rule to provide clarification that plans and issuers may establish geographic limits regarding available providers with respect to the designation of a primary care physician, including a pediatrician.

VI. Patient Protections – Emergency Services

Issue: As noted above, a plan or issuer that provides benefits with respect to emergency services in an emergency department of a hospital must follow the specific payment rules set forth in the Rule. Requirements regarding out-of-network provider payments for covered emergency services are satisfied only if the plan provides payments to the out-of-network providers in an amount at the greatest of:

- A. The amount negotiated with in-network providers for the emergency service furnished. If there is more than one amount negotiated, then the payment is the median amount.
- B. The amount calculated using the same method the plan generally uses to determine payment for out-of-network services but uses the in-network cost-sharing provision for out-of-network care without reduction for out-of-network cost-sharing that generally applies; or
- C. The amount that would be paid by Medicare.

75 Fed. Reg. at 37194; 45 CFR § 147.138(b)(3)(i)(A)-(C).

BCBSA is concerned that the Rule's requirement to use the "median" amount as described in A with respect to negotiated rates for in-network providers underestimates the complexity and difficulty of determining such amount. Although the Rule provides examples of how to determine the median amount, those examples do not reflect the complexity of implementing such a calculation:

- First, the examples include only a small number of negotiated amounts for in-network providers (nine amounts in one example, and 10 amounts in another). Some Blue Plans have hundreds of negotiated amounts for in-network providers. That number increases substantially if negotiated amounts across Blue Plans are included for an account that serves a national employer group. The number of negotiated amounts for in-network providers changes regularly because of the addition of new in-network providers, and revisions to provider agreements that occur throughout the year. Moreover, the examples provided do not state whether those amounts are based on negotiated amounts applicable as of the date the individual receives the out-of-network services, or some other date.
- Second, the examples provided assume the simplest type of contractual pricing where for every in-network provider there is a negotiated rate for each emergency service furnished. Some Blue Plans have a number of different contractual approaches to paying in-network providers: some in-network providers are paid for every line item that makes up an emergency service, based on revenue codes; some are paid on the basis of "whole claim pricing," where providers bill using

condition codes that apply to the whole claim, which may include multiple services furnished in addition to the particular emergency procedures to stabilize the patient.

- Third, the examples provided do not reflect the variations in in-network rates depending on such factors as: (1) the type of hospital where the out-of-network emergency room physicians practice (e.g., higher rates for tertiary care, lower rates for small, community hospitals); (2) the type of product in which the patient is enrolled (e.g., HMO or PPO); (3) the geographic location of the provider (high-cost MSAs versus low-cost non-MSA rural areas; and (4) the specialty of the provider. Some Plans pay different specialties a rate negotiated for a particular procedure regardless of whether that procedure is rendered in an ER or in another setting. In addition, Plans are likely to pay, for example, a nurse practitioner a lower rate than a physician for performing certain simple procedures, like a routine suturing of a laceration.
- Fourth, the examples provided do not reflect the way in which hospitals bill health plans when a patient is admitted to the hospital from the emergency room. Hospitals often or are mandated to follow Medicare's methodology for billing, which requires that if a patient is admitted to the hospital within one to three days of the emergency room visit for the same condition, then the emergency room visit is included in the inpatient hospital care charges, not charged separately.

A median amount that does not take these complexities into account, that lumps together all types of hospitals, all types of products, all types of geographies, all types of specialties, all types of contracts, and all types of billing arrangements will lead to gross overpayments to some providers and underpayments to others (with higher balance billing resulting for patients), and will encourage gaming by providers to maximize reimbursement.

Recommendation: We recommend that the Departments modify the Rule to provide that a plan may use a reasonable good faith methodology to estimate a median amount for purposes of paying for out-of-network emergency services, and such a calculation may be done on an annual basis. Such a methodology should allow a plan to estimate separate median amounts based on different categories of hospitals, or insurance products, or geographic areas, or specialties of types of providers; and estimate separate median amounts for each category as needed.

We also recommend that the Departments modify the Rule as it applies specifically to situations where a patient is admitted to the hospital after visiting the emergency room and the emergency room visit is not charged separately. We recommend that the Rule provide that a plan may pay the hospital using the same method the plan generally uses to determine payments for out-of-network inpatient services, so long as the plan applies the appropriate cost-sharing to the estimated portion attributable to emergency services (these patients would not be included in estimating the general median rate).

* * *

We appreciate your consideration of our comments on the Rule and our suggested recommendations. We look forward to continuing to work with the Departments on implementation issues related to the ACA. If you have any questions, please contact Kris Haltmeyer at (202) 626-4814 or at kris.haltmeyer@bcbsa.com.

Sincerely,

A handwritten signature in cursive script that reads "Alissa Fox".

Alissa Fox
Senior Vice President
Blue Cross and Blue Shield Association