



**BlueCross BlueShield
of Illinois, New Mexico, Oklahoma & Texas**

Submitted via the Federal Regulations Web Portal, <http://www.regulations.gov>

August 27, 2010

Hon. Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services

Hon. Hilda Solis, Secretary, U.S. Department of Labor

Hon. Timothy Geithner, Secretary, U.S. Department of Treasury

Attention: OCIO-9994-IFC

Room 445-G, Hubert H. Humphrey Building

200 Independence Avenue, S.W.

Washington, DC 20201

Re: Comments on Interim Final Rule on Preexisting Condition Exclusions for Children, Rescissions, and Patient Protections Relating to Emergency Services

Dear Secretaries Sebelius, Solis and Geithner:

Health Care Service Corporation, a Mutual Legal Reserve Company (“HCSC”), which operates Blue Cross and Blue Shield plans in Illinois, New Mexico, Oklahoma and Texas, appreciates the opportunity to offer the following comments in response to the Interim Final Rule on Preexisting Condition Exclusions for Children, Rescissions, and Patient Protections Relating to Emergency Services, 75 Fed. Reg. 37188 (June 28, 2010) (the “Interim Final Rule”) issued by the Department of Health and Human Services (“HHS”), the Department of Labor and the Department of the Treasury (collectively, the “Departments”).

HCSC is committed to implementing the Interim Final Rule and assisting the Departments in developing reasonable and administrable standards for PPACA implementation. Our comments include specific recommendations regarding suggested changes to the Interim Final Rule, as well as requests for clarification on particular areas of the Interim Final Rule.

1. Preexisting Condition Exclusions for Enrollees Under Age 19 – Enrollment Periods

HHS recently issued a clarification stating that the provision in the Interim Final Rule prohibiting pre-existing condition exclusions on children under 19 does not preclude issuers in the individual market from restricting enrollment to specific open enrollment periods, if permitted by state law. 45 C.F.R. § 144.103; HHS, Questions and Answers on Enrollment of Children under 19 under the New Policy that Prohibits Pre-Existing Condition Exclusions (July 27, 2010). HCSC commends the Departments for issuing this clarification and recognizing the concerns regarding adverse selection.

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Divisions of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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For the following reasons, HCSC believes that the dates of such open enrollment periods should be standardized for a particular market. One purpose of an open enrollment period is to address adverse selection resulting from persons adding coverage when medical care is needed and then dropping coverage after the needed services have been obtained. Such abusive practices increase the cost of coverage for other persons who maintain or seek coverage. If different insurers are able to establish open enrollment periods throughout the year so that coverage is available at different times during the year (on a guaranteed issue without a mandate basis), such practices would be facilitated to the detriment of other consumers.

Furthermore, HCSC recommends that the Departments permit a “quiet period” to allow issuers sufficient time to process applications and provide covered persons with appropriate information about their new coverage prior to the implementation date. Insurers will likely receive a large number of applications during the open enrollment period. Requiring a “quiet period” is standard practice in private health insurance and other federal health programs, such as Medicare Part D, for application processing and communications about coverage. In a report to the Chairman of the House Committee on Energy and Commerce, regarding implementation of Medicare Part D benefits, the General Accountability Office stated with the support of CMS that “Congress should consider authorizing the Secretary of Health and Human Services to amend the [Automatic Enrollment Period (AEP)] schedule to include a processing interval between the end of the AEP and the effective date of new coverage.” Report to the Chairman, Committee on Energy and Commerce, House of Representatives, Medicare Part D, Opportunities Exist for Improving Information Sent to Enrollees and Scheduling the Annual Election Period, United States Government Accountability Office (December 2008) <http://www.gao.gov/new.items/d094.pdf>. To provide adequate time for processing applications and communicating with new insureds, coverage should not be required to be effective until at least 15 days after the closing of the open enrollment period.

Recommendation:

HCSC recommends that the final rule specify that all insurers in the same market be required to use the same annual open enrollment period. In addition, coverage should not need to be effective until at least 15 days after the close of the annual open enrollment period.

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

The Interim Final Rule provides that a cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect. However, employers sponsoring group health plans routinely have an administrative lag in reporting an employee’s or dependent’s loss of eligibility for coverage to an administrator or health insurance issuer because the events triggering a loss of eligibility cannot always be foreseen and the enrollment data periodically transmitted by employers reflects eligibility changes that have already occurred. Furthermore, employers sometimes make inadvertent mistakes in providing information to administrators and issuers with respect to the enrollment of

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employees or their dependents in a plan. For instance, employers may transmit enrollment data that mistakenly includes an ineligible employee or dependent as an enrollee, or an employee may be late in notifying the employer of a family status change, such as a divorce, which impacts a dependent's eligibility for coverage. In fact, HCSC can report that, as a percentage of total coverage cancellations, a majority of cancellations for private employer groups are retroactive. HCSC can also report that it has experienced a similar volume of retroactive corrections in providing coverage through the Federal Employee Program.

When there is an administrative lag in reporting eligibility changes or mistakes are detected either by the employer or the issuer, enrollment adjustments, including any return of premium, are made between the applicable issuer and the employer group. Retroactive corrections to group health plan enrollment where incorrect or non-eligible applications or premiums were received should not be regarded as rescissions. Furthermore, the final rule should state that retroactive corrections relating to administrative functions are not rescissions.

Moreover, an example in the preamble stating that "a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose" should not include adjustments made to correct enrollment mistakes. 75 Fed. Reg. at 37238. An individual covered as the result of a mistake is not "covered under the plan" as required under the Rule. 45 C.F.R. § 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." Moreover, payments made erroneously should not be considered the payment of "benefits." Enrollment mistakes involve administrative processes agreed to between an insurer and the employer as established in contracts between the two parties. Such processes should not result in the extension of coverage to otherwise ineligible individuals.

Treating retroactive corrections as rescissions would result in a conflict with ERISA's fiduciary rules and be inconsistent with COBRA eligibility. ERISA requires that a plan be administered in accordance with its terms and specifically directs that the fiduciary's duties be discharged "in accordance with the documents and instruments governing the plan." ERISA § 404(a)(1)(D). Providing coverage to ineligible individuals could also be inconsistent with the plan fiduciary's obligation 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." ERISA § 404(a)(1)(A). Furthermore, treating ineligible individuals as if they were covered could delay COBRA eligibility. An individual whose coverage is incorrectly continued beyond the date employment was terminated may not be eligible for COBRA. Preventing the correction of administrative errors may create uncertainty and confusion for employers and employees.

Recommendation:

HCSC recommends that the final rule clarify that retroactive corrections related to administrative functions and routine enrollment mistakes with respect to group health plans do not constitute rescissions of coverage.

3. Plans and Issuers Should Be Able to Hold Claims During the 30-Day Notice Period for Rescissions

Under the Interim Final Rule, a group health plan or health insurance issuer must provide at least 30 calendar days advance notice to an individual prior to rescission of the individual's coverage. 75 Fed. Reg. at 37193; 45 C.F.R. § 147.128(a)(1). A requirement that coverage be provided and claims paid during a 30-day notice period may cause a plan fiduciary or issuer to pay claims for an individual who was not eligible for coverage under the terms of the plan because the individual committed fraud or intentionally misrepresented material facts to the plan or issuer. Plans and issuers should not be required to provide coverage to ineligible individuals. To prevent claims from being improperly paid, plans and issuers should be permitted to hold claims during the pendency of the 30-day notice period.

Recommendation:

HCSC recommends that the Departments clarify that group health plans and issuers may pend claims during the 30-day notice period, as well as during any appeal period provided for rescissions to avoid payment of medical services for persons who, if a rescission is applied to that person, was never enrolled in such plan and therefore never eligible for payment of claims incurred.

4. Patient Protections – Out of Network Emergency Services: Anti-Assignment Provisions

Section 2719A of the PHSA requires a plan or health insurance coverage that provides out-of-network emergency services benefits in a hospital emergency department to provide coverage for such services just as cost-sharing would apply to emergency services provided in-network (without the need for prior authorization or a determination that the provider is a member of the plan's network). 75 Fed. Reg. at 37194; 45 C.F.R. § 147.128(b).

The cost-sharing provisions do not address how out-of-network emergency services rules impact anti-assignment provisions that may be contained in plan documents or insurance policies. Anti-assignment provisions prohibit the assignment of benefits of claims and can help to control medical costs and provide an incentive for providers to join provider networks. Requiring a plan or insurer to pay out-of-network providers directly, notwithstanding an anti-assignment provision, would be inconsistent with public policy promoting increased control of medical cost growth.

Recommendation:

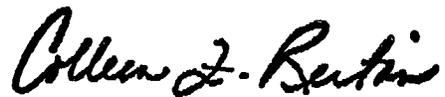
HCSC recommends that the Departments modify the final rule to provide that nothing in the rule shall be deemed to supersede, nullify, override, or invalidate a plan or policy's anti-assignment provision with respect to out-of-network providers.

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CONCLUSION

HCSC appreciates your consideration of our comments and recommendations on the Interim Final Rule. We look forward to continuing to work with the Departments on implementation issues related to PPACA.

Sincerely,

A handwritten signature in black ink that reads "Colleen J. Reitan". The signature is written in a cursive style with a large initial "C".

Colleen Reitan
Executive Vice President
Health Care Service Corporation,
A Mutual Legal Reserve Company