BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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August 11, 2010

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

The Honorable Hilda Solis, Secretary, U.S. Department of Labor

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

Attention: OCIIO-9991-IFC
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Via Regulations.gov, RIN 1210-AB41

RE: Comments on the Interim Final Rules Relating to Dependent Coverage of Children to Age 26 under the Patient Protection and Affordable Care Act

Dear Secretaries Sebelius, Solis, and Geithner:

The Blue Cross and Blue Shield Association ("BCBSA"), which represents the 39 independent, community-based and locally operated Blue Cross and Blue Shield Plans ("Plans"), is pleased to submit comments on the interim final rule (the "Rule") for dependent coverage to age 26 under the Affordable Care Act ("ACA"), as published in the *Federal Register* on May 13, 2010 (75 Fed. Reg. 27122), to the Departments of Health and Human Services, Labor, and the Treasury (the "Departments").

Blue Cross and Blue Shield Plans collectively provide healthcare coverage for nearly 100 million people, or one-in-three Americans, in all 50 states, the District of Columbia, and Puerto Rico, and in all markets, including the individual, small group, large employer, and national account markets. Plans also participate in

government programs, such as Medicare, Medicare Advantage, Part D, and the Federal Employees Health Benefits Program.

Recognizing that many young people could lose their coverage because of their age, student status, graduation from school or other factors prior to this provision going into effect, BCBS Plans voluntarily agreed to offer coverage to adults under age 26 on health insurance policies their parents purchased through the individual market, effective June 1, 2010. Our Plans also offered the early extension to their employer accounts.

We look forward to continuing to work with the Administration on implementation of this provision and offer the following three recommendations:

1. Clarify the Definition of "Child"

Issue: Prior to ACA, health benefits were not taxable for dependents who were considered "qualified children" or "qualified relatives" under Internal Revenue Code ("IRC") § 152. A "qualified child" was defined as a legal child, foster child, or stepchild up to age 24 (where a full-time student), and a "qualified relative" was any other person, regardless of age, for whom the employee provided over one-half of his or her support. Based on these definitions, many Plans had required that a dependent child either be a "qualified child" or be a tax dependent of the subscriber or the subscriber's spouse so that the Plan did not have to impute income on benefits for these dependent children.

The Rule requires that, to the extent a Plan covers a "child," it must do so to age 26, without further conditions such as tax dependency. This could discourage some Plans from covering additional classes of children because the tax treatment of children within the group would be inconsistent and potentially confusing. The Rule does not define "child," so there is some uncertainty as to how broadly this term should be applied. Following the enactment of ACA, the IRS issued new guidance (IRS Notice 2010-38), that increased the age for a "qualified child" up to age 27, but did not address other relationships that could entitle a dependent to coverage (*e.g.,* legal guardianship, qualifying grandchildren, domestic partners' children). This means that the term "child" could be read broadly so that when a Plan voluntarily covers a "child," and that "child" does not meet the "qualified child" definition under IRC § 152(f), the Plan may not be able to require tax dependency. This in turn means that the Plan will have to impute income where these children are not qualified relatives.

This issue may also be viewed from an underwriting perspective. If insurers are not permitted to consider the relationship between an insured and an individual who is a grandchild, ward, etc., they may no longer extend coverage to these individuals. This result is contrary to the goal of ACA to increase the number of insured individuals.

Recommendation: The final rule should provide that the requirement to cover a dependent child to age 26, without additional conditions, only applies to a "child" as used in the "qualified child" definition in IRC § 152(f). This reading would be consistent with the express carve-out in the statute and regulation providing that a Plan does not have to extend coverage to grandchildren, who are not "qualified children" under IRC § 152(f). The final rule should clarify that if a Plan voluntarily chooses to extend coverage to other classes of dependent children outside of the definition of "qualified child" in IRC § 152(f), the Plan may impose additional conditions (such as tax dependency) with respect to these individuals.

2. Allow Age-Appropriate Benefits

Issue: Plans often offer and deliver different types of benefits or screenings based on various demographic characteristics, including gender or age, according to medical standards. For example, well-child screening (also known as well-baby visits) and certain immunizations may be covered based on the age of the individual, or certain copayments may be eliminated for children under age 19 to encourage the use of certain services (*e.g.,* primary care physician visits). The Rule provides that a plan or issuer cannot vary benefits based on age. Plans should be permitted to continue to administer and pay for benefits using evidence-based standards where medically necessary, including those based on the age of the covered individual.

Recommendation: The final rule should clarify that, while a Plan may not vary eligibility for a certain benefit plan based on a dependent child's age, a Plan may administer benefits using evidence-based standards that vary based on age.

3. Clarify that Individual Market Premiums Can Vary by Age

Issue: The Rule prohibits premium increases based on the age of the child, but allows premium changes based on classifications such as "self-plus-one, self-plus-two," etc., 29 C.F.R. § 2590.715-2714(e). The examples in the Rule are oriented toward group coverage where participants and dependents do not pay different rates that vary by their ages and the examples are not specific to coverage offered in the individual market.

In the individual market, premiums frequently are based on the ages of the family members covered under a family policy. If the Rule were read to prohibit age rating with respect to children in the individual market, it would be a major change given that the practice currently is permitted in almost all states. Furthermore, ACA sets forth the permissible age variations that will apply to individual market premiums effective January 1, 2014. Public Health Service Act § 2701.

Recommendation: The final rule should clarify that insurers can vary individual market premiums by age, as otherwise permitted by law, as long as the insurer applies the same age rating rule uniformly regardless of an individual's status as a dependent.

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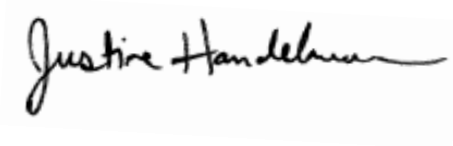
We appreciate your consideration of our comments and recommendations on the adult child coverage extension Rule. We look forward to continuing to work with the Departments on implementation issues related to the ACA. If you have any questions, please contact Kris Haltmeyer at (202) 626-4814 or at kris.haltmeyer@bcbsa.com.

Sincerely,



Justine Handelman
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Blue Cross Blue Shield Association