



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

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

August 16, 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-9991-IFC

Room 445-G, Hubert H. Humphrey Building

200 Independence Avenue, S.W.

Washington, DC 20201

Re: Comments on the Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule

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 for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538 (June 17, 2010) (the “Interim Final Rule”) issued by the Department of Health and Human Services, the Department of Labor and the Department of the Treasury (collectively, the “Departments”).

It has been reported that certain insurers will not offer grandfathered plans. Even though administering fewer products may offer administrative efficiencies for HCSC, the company wants to provide its individual and group members with a full range of coverage options along with the opportunity to maintain their grandfathered product if they desire to do so. HCSC respectfully submits that certain clarifications are necessary to avoid unintended consequences for the Interim Final Rule that would severely limit the ability of many individuals and group health plans to retain the coverage they had in place when the Patient Protection and Affordable Care Act (“PPACA”) was enacted. In the absence of such clarification, very few health policies and plans, as a practical matter, will continue to qualify for grandfathered status. Because of the risk to an insurer that errs on the side of maintaining a grandfathered product that is later found not to be grandfathered, insurers may be forced to conclude that attempting to provide coverage through grandfathered products is not feasible. Those products will therefore need to be changed and modified to address all of the PPACA requirements, potentially resulting in cost increases for consumers. As a result, many individuals and groups may not be able to maintain their existing coverage, and the concept that Americans who like their existing health plan can keep it may not be fulfilled as is currently contemplated.

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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

Hon. Kathleen Sebelius
Hon. Hilda Solis
Hon. Timothy Geithner
August 16, 2010
Page 2 of 10

As a preliminary matter, we wholeheartedly support the comments made by the Blue Cross and Blue Shield Association. We also have the following additional comments:

1. Good Faith Compliance Period.

Issue:

The preamble to the Interim Final Rule establishes a good faith compliance period during which the Departments, for purposes of enforcement, will take into account good faith efforts to comply with a reasonable interpretation of the statutory requirements of PPACA and may disregard changes to plan and policy terms that only modestly exceed those changes described in the Interim Final Rule and that were adopted prior to the date the Interim Final Rule was issued. However, the good faith compliance period is applicable only for changes adopted before June 14, 2010. 75 Fed. Reg. at 24544. The possibility of changes to the requirements established in the Interim Final Rule as the result of comments submitted, including comments submitted at the request of the Departments, as well as the massive undertaking associated with implementation of PPACA in a relatively short period of time, make it difficult for insurers or health plans to have certainty as to applicable requirements of the regulations and how they will be interpreted. Moreover, many aspects of health insurance coverage are in a state of flux as insurers and health plans develop their procedures and practices to comply with the broad changes mandated by PPACA. Insured individuals should not be forced to lose their opportunity to maintain their existing coverage as a result of actions taken by the insurer or health plan in a good faith effort to comply with applicable requirements of the law and its implementing regulations. Accordingly, we believe that the good faith standard should be extended to changes after June 14, 2010 as well, and that a change made after June 14, 2010, in a good faith attempt to comply with applicable requirements of the statute and applicable regulations should not result in the loss of grandfathered status. To address any concerns that extending the period during which the good faith standard applies could result in a lack of uniformity in application of the Interim Final Rule, the Departments could, prior to publication of the final rule, issue additional guidance to resolve such questions. For example, following enactment of the American Recovery and Reinvestment Act of 2009, the Employee Benefits Security Administration of the Department of Labor issued FAQs and other guidance to assist insurers and others in their implementation of premium reductions for health benefits pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985. The Interim Final Rule also created a grace period within which changes can be revoked or modified where the changes might otherwise cause the plan or health insurance coverage to cease to be a grandfathered health plan. We recommend that the grace period also be extended to allow for revocation or modification of changes made prior to issuance of the final rule.

Recommendation:

HCSC recommends extension of the good faith standard at least until such time as final rules are made publicly available. The scope of the exception could be limited by additional guidance issued by the Departments prior to publication of the final rule. Similarly, a grace period should be established in the final rule similar to the grace period established in the Interim Final Rule

Hon. Kathleen Sebelius
Hon. Hilda Solis
Hon. Timothy Geithner
August 16, 2010
Page 3 of 10

that would allow individuals and plans to maintain their grandfathered status by revoking or modifying changes, that would otherwise result in the loss of grandfathered status, prior to the next plan or policy year after issuance of the final rule.

2. Group Unilateral Changes.

Issue:

Insurers providing group coverage may not have access to information to ascertain whether a covered group is eligible for, or continues to maintain eligibility for, a grandfathered plan. For example, under 45 C.F.R. § 147.140(g)(1)(v) of the Interim Final Rule, a five percent decrease in an employer's contribution rate may cause a plan or policy to lose grandfathered status. Health insurers, however, typically do not know the employer's contribution rate. Certain employers may not have the resources or sophistication to understand the requirements of PPACA and may not respond accurately or at all to the processes insurers may establish to determine if the group qualifies for grandfathered status. Similarly, an insurer may not know whether an employer has lost eligibility for grandfathered status because the employer violated an anti-abuse rule in 45 C.F.R. § 147.140(b)(2), such as through a merger or plan transfer. HCSC is the fourth largest health insurer in the United States and provides coverage to many thousands of groups of varying sizes. HCSC intends to establish a reasonable process to determine if its groups qualify for grandfathered status, but ultimately, HCSC should not be responsible for information to which it does not have access and cannot verify. Insurers should not be subject to penalties as the result of an action taken by an employer without the insurer's knowledge that causes a loss of eligibility for grandfathered status.

Recommendation:

HCSC recommends that a modification be made to the Interim Final Rule stating that an insurer will not be subject to penalties for violating PPACA if the insurer continues a grandfathered policy for an employer that has lost eligibility for the grandfathered policy due to an action taken by the employer without the insurer's knowledge.

3. Removal of a Benefit at the Election of the Insured.

Issue:

The Interim Final Rule suggests that removal of a benefit from an individual policy by the insured would cause the policy to lose grandfathered status. Grandfathered status could be lost even if the change was instigated by the insured for his or her own purposes, such as because the benefit is no longer needed or useful to the insured. *See*, 45 C.F.R. § 147.140(g)(1)(i). Maternity coverage, which is often offered as an additional benefit at an additional charge, is a good example of the type of benefit that might be removed by an individual because it is not needed. An insured female who no longer is of childbearing age or has a hysterectomy, or an insured male no longer with female dependents, would not benefit from maternity coverage. Such an insured has only two options: (i) pay for a coverage that will not provide any benefit; or

Hon. Kathleen Sebelius
Hon. Hilda Solis
Hon. Timothy Geithner
August 16, 2010
Page 4 of 10

(ii) remove the coverage, causing loss of grandfathered status. The cost to the insured to pay for coverage that is not desired or needed could make continued coverage unaffordable. The insured should be able to maintain the coverage the individual has and be able to make reasonable changes that reflect the individual's health coverage needs without loss of grandfathered status.

Recommendation:

HCSC recommends that the requirements in the Interim Final Rule be modified so that removal of a benefit at the instigation of the insured will not result in a loss of grandfathered status of an individual policy. This modification would permit an insured to maintain existing individual coverage that the insured finds advantageous, while still being able to eliminate benefits for which the individual no longer desires coverage and that increase the cost of insurance to the insured.

4. Disclosure Requirements.

Issue:

The Interim Final Rule provides for a detailed disclosure regarding grandfathered status in "any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage." See 45 C.F.R. § 417.140(a)(2). The Paperwork Reduction Act section of the preamble to the Interim Final Rule includes a discussion of this half-page disclosure that contemplates that it be included only in the plan document and summary plan description. 75 Fed. Reg. at 34554-55. Adding this extensive disclosure to all plan materials that might mention benefits, including notices to insureds and advertising materials, would be burdensome and is not necessary, so long as the disclosure is contained in the materials that the insured looks to for the description of benefits. In some cases, including the disclosure would be impractical and would not fit with the scope and purpose of the communication. An excessive application of the disclosure requirement could confuse insureds by interfering with and unnecessarily complicating such communications.

Recommendation:

HCSC recommends that the disclosure requirement specified in the final regulation be, consistent with the preamble to the Interim Final Rule, limited to requiring the prescribed disclosure in the plan document, the policy, the certificate of insurance, and the summary plan description. Under this approach, insureds would have the benefit of the disclosure, while excessive and unnecessary paperwork that increases administrative cost but does not provide a commensurate benefit to insureds would be avoided.

5. March 23, 2010 as the Baseline for Benefits in Grandfathering Determinations.

Issue:

Because PPACA's grandfathering provision is intended to permit a group or individual to maintain coverage in effect on March 23, 2010, we believe that March 23, 2010 should be used

Hon. Kathleen Sebelius
Hon. Hilda Solis
Hon. Timothy Geithner
August 16, 2010
Page 5 of 10

as the baseline for benefits considered for purposes of determining eligibility for grandfathered status. For example, a benefit may have been added after March 23, 2010, and then may be removed after that date. The benefits provided as of March 23, 2010, would still be covered: only benefits added after that date would be removed. In such a scenario, so long as the benefits are no less than those in effect on March 23, the plan should still be grandfathered. In 45 C.F.R. § 147.140(g)(1)(ii) and (iii), the Interim Final Rule provides that cost-sharing changes that might impact grandfathered status should be measured from March 23, 2010. Benefit changes should be subject to a similar measurement.

Recommendation:

For the forgoing reasons, consistent with sections 45 C.F.R. § 147.140(g)(1)(ii) and (iii) relating to cost-sharing requirements, HCSC recommends that the Departments clarify that the baseline for benefits should be “measured from March 23, 2010.” This clarification would enable insureds to retain the coverage they had in effect on the effective date of PPACA, even if certain benefits were added (and subsequently removed) after PPACA’s enactment.

6. Selection of Different Deductible/Copayment/Coinsurance Levels by the Insured or Group.

Issue:

The preamble to the Interim Final Rule notes that routine changes are made by health plans and health insurance issuers from year to year. *See* 75 Fed. Reg. at 34544. Many plan designs offer a choice of deductibles, coinsurance, and copayment levels that permit the insured or group to exercise options in the level of coverage, for example by offsetting a premium increase by increasing the copayment amount. The exercise of these options is generally considered a routine change and is an important method for individuals and groups to control costs. However, under the Interim Final Rule, an insured or group that makes one of these routine changes may cause the policy or plan to lose grandfathered status, and the insured or group would no longer be permitted to keep the plan they have. The Interim Final Rule allows for only minimal changes to cost-sharing requirements and other limits without loss of grandfathered status. 47 C.F.R. §§ 147.140(g)(1). The narrow band of changes permitted in that section without loss of grandfathered status is inconsistent with generally available product designs. For example, a typical HCSC product may offer choices of deductible limits of \$250, \$500, \$750 or \$1,000. Such product designs are generally well-established and typically were in place prior to adoption of PPACA. For current HCSC products, the cost savings for changing to the next deductible level is approximately 5 percent. The measures in Section g(1) such as “[a]n amount equal to \$5 plus medical inflation” are inconsistent with existing product designs and do not provide individuals or groups any meaningful flexibility. *Id.* Due to the narrow bands created by the Interim Final Rule, an individual or group would not be able to move to the next available deductible level without triggering loss in grandfathered status. As a result, the individual or group would lose an important method to keep their coverage affordable. Permitting such routine changes benefits consumers by allowing them to take steps to control costs. If a formula is used, HCSC respectfully recommends that an alternative formula be developed based on

Hon. Kathleen Sebelius
Hon. Hilda Solis
Hon. Timothy Geithner
August 16, 2010
Page 6 of 10

recommendations the Departments could request from the American Academy of Actuaries that would provide individuals and groups with meaningful flexibility. HCSC recognizes that over time some individuals and groups will transition to ungrandfathered plans and coverage will be available through the exchanges in 2014. However, we believe that increasing the level of cost-sharing without ungrandfathering coverage will be beneficial to our customers and facilitate the transition. Permitting movement to the next established deductible level without loss of grandfathered status would ease the administrative burden of establishing new benefit designs and facilitate an orderly transition to ungrandfathered products.

Recommendation:

HCSC recommends that individuals and group health plans be permitted to change to the next higher deductible, co-payment or coinsurance level that was available on March 23, 2010, on a one-time basis, without losing grandfathered status.

7. Changes in Cost-Sharing Methodology.

Issue:

The Interim Final Rule does not address whether changes in cost-sharing methodology (*e.g.*, changes from copayment to coinsurance) would cause a plan or insured's coverage to lose grandfathered status. Certain methodology changes may cause changes in how a service is classified, such as a change from a routine laboratory charge with a copayment to one that is not routine where coinsurance would be required. Moreover, providers may charge differently for similar services. For example, some hospitals may provide services on an in-patient basis or that others provide on an out-patient basis, which could affect how the services are reimbursed. In addition, ICD-10 mapping that is currently underway may result in the reclassification of claims.

Recommendation:

HCSC recommends that the Departments clarify that a change in claims methodology from copayment to coinsurance or vice versa should not result in loss of grandfathered status to the extent the estimated economic impact to the covered person is within the scope of changes permitted under the rule. This approach would be consistent with the provisions in the Interim Final Rule that permit a plan to retain grandfathered status while changing cost-sharing provisions within established parameters.

8. Changes Mandated by State or Federal Law.

Issue:

The preamble to the Interim Final Rule identifies plan or policy changes made to comply with state or federal law as examples of changes that would not cause a plan or policy to cease to be a grandfathered health plan; however, no exemption applies to these changes under the Interim Final Rule as currently drafted. 75 Fed. Reg. at 34544. Accordingly, changes made to comply with state or federal law would, if they meet the criteria set forth in 45 C.F.R. § 147.140(g)(1),

Hon. Kathleen Sebelius
Hon. Hilda Solis
Hon. Timothy Geithner
August 16, 2010
Page 7 of 10

result in loss of grandfathered status. As a result, an insurer or plan may not be able to continue to provide grandfathered coverage because changes that are mandated by a new state or federal statute or regulation would cause the plan to cease being grandfathered. State and federal law with respect to health insurance changes frequently, for example, adding mandated benefits and other provisions. Of particular significance are the Mental Health Parity and Addiction Equity Act and related regulations, which require changes to cost-sharing for mental health and medical benefits. If changes in a plan or policy that are required by law cause a plan to lose grandfathered status, then few plans or policies will remain grandfathered for long, thus eliminating the ability of insureds to retain their current coverage in effect when PPACA was enacted.

Recommendation:

HCSC recommends that the Final Rule include a provision in the body of the rule itself providing that a change made in a plan or policy to comply with state or federal law not result in a loss of grandfathered status, even if the change is one of the changes listed in 45 C.F.R. § 147-140(g)(2).

9. Effective Date of Loss of Grandfathered Status.

Issue:

The Interim Final Rule identifies those changes that will cause a plan or policy to cease being grandfathered, but it does not identify when the loss of grandfathered status becomes effective. 45 C.F.R. § 417.140(g)(1). Once a plan or policy that does not meet the PPACA requirements loses its grandfathered status, it can no longer be provided and must be terminated or modified. For example, if an employer decreases the contribution rate as provided in section 45 C.F.R. § 417.140(g)(1)(v), and the plan or policy is no longer grandfathered, the insurer would need to modify the policy to conform to PPACA. Making such changes in mid-policy year (or retroactively if the employer gives late notice of the change in contribution rate) would be administratively burdensome and would also disrupt coverage for the insureds. Anti-abuse provisions could be adopted to address any concern that groups may make a contribution or similar change early in a plan year and maintain grandfathering until the end of that plan year.

Recommendation:

To avoid these consequences, HCSC recommends that any loss of grandfathered status become effective at the end of the policy or plan year.

10. Changes in Eligibility.

Issue:

The anti-abuse provisions in the Interim Final Rule address the loss of grandfathered health plan status when employees are transferred into a plan or health insurance coverage from a plan or health insurance coverage under which the employees were covered on March 23, 2010, where the terms of the transferee plan, if it was amending the transferee plan, would not support

Hon. Kathleen Sebelius
Hon. Hilda Solis
Hon. Timothy Geithner
August 16, 2010
Page 8 of 10

grandfathered status and when there is no bona fide employment-based reason to transfer the employees into the transferee plan. 47 C.F.R. § 147.140(g)(ii). The Interim Final Rule does not, however, address whether eligibility changes would result in the loss of grandfathered status, such as through elimination or freezing a class of employees or retirees for coverage, except in the case of transfer of employees to another plan. HCSC believes that certain changes in eligibility, if made for bona fide employment based reasons, should not result in the loss of grandfathered status.

Recommendation:

HCSC recommends that the final rule clarify that a change in the eligibility criteria for coverage under a plan should not affect the grandfathered status of the plan so long as the change was made for a bona fide employment-based reason.

11. Return to Grandfathered Plan.

Issue:

Outside of the transition rules available for a limited period of time and in limited circumstances, the Interim Final Rule does not provide sufficient flexibility for covered small groups and individuals to consider their options regarding maintaining grandfathered status or changing to a plan with PPACA benefits. HCSC, as required by state law, offers individuals who purchase policies subject to such laws a limited “free look” period during which an insured can examine the policy and, if not happy with the terms, return it for full refund. *See, e.g.*, 50 Ill. Adm. Code 5421.110 (Requirements for Group Contracts, Evidences of Coverage and Individual Contracts); 50 Ill. Adm. Code 2007.80 (Required Disclosure Provisions); NMSA 1978, § 59A-46-8(C) (Requirements for HMO group contract, individual contract and evidence of coverage); Oklahoma Administrative Code 365:10-5-6 (a) (7); Texas Insurance Code 1201.058 (Notification that Policy is Returnable; Effect of Return). Upon reviewing the terms in detail during that period, an individual may determine that the previous grandfathered policy better served the individual’s needs. Such periods provide valuable consumer protections under existing state consumer protection laws. In the absence of clarification to the Interim Final Rule, insureds in those circumstances would not have the ability to go back to their grandfathered plan. Individuals and small groups should have the opportunity for a limited time to return to a grandfathered plan.

Recommendation:

HCSC recommends that an individual exercising a free look provision of a new individual policy consistent with state law have the option to move back to and keep the previous grandfathered policy within the applicable free look time period. The purpose of the free look period is to give the insured a full opportunity to make a considered decision on keeping the new coverage, which is fulfilled if the insured retains the choice to go back to the grandfathered plan during this limited period. Small group policy holders should have a similar opportunity to evaluate their options and return to their grandfathered policy.

12. Response to Request for Comments.

In the Interim Final Rule, the Departments solicit comments on whether certain types of changes should be added to the list of changes that result in loss of grandfathered status. HCSC has the following comments and recommendations:

- *Routine Coverage Changes.* HCSC recommends that in the final rule, the Departments establish a standard such that changes to a plan's eligibility criteria or plan terms that do not eliminate all or substantially all benefits to treat a particular condition will not cause the plan to lose grandfathered status. For example, plans and issuers should be permitted to alter their dependent eligibility criteria, make changes to definitions of medical necessity and experimental or investigational procedures, and modify coverage to reflect appropriate treatment settings as medical practice evolves. HCSC recommends that so long as appropriate coverage for a condition that was covered on March 23, 2010, is maintained, such changes should not be deemed to eliminate all (or substantially all) benefits to treat a particular condition, triggering a loss of grandfathered status.
- *Change in plan structure.* A change in plan structure, such as a shift from self-funded to insured (and vice versa) should not affect grandfathered status to the extent the same plan structure is maintained. Under such circumstances, a change in plan structure does not affect the coverage being provided to the covered individuals, and is more akin to changes in premium (which do not affect grandfathered status) than a change to the plan. Permitting changes in funding could permit employers to retain coverage that satisfies the needs of employees, while finding the most cost-effective method of doing so. Similarly, employers should be able to change carriers or plan structure without loss of grandfathered status so long as benefits do not change beyond the level of permitted changes if the coverage continued under the original carrier or structure. Permitting changes in carriers or structure benefit consumers by allowing insurers and insurance administrators to compete for customers. Limiting such changes has the anti-competitive effect of locking customers into their existing carriers or structure to maintain grandfathered status.
- *Network Changes.* Network changes should not cause a loss of grandfathered status so long as the network continues to meet state insurance law or other applicable standards. Provider contracts are regularly negotiated and re-negotiated, and providers are added or removed from the network for a wide variety of reasons, such as new providers entering the service area, providers' economic circumstances, retirement of providers, and quality control issues. Health insurance issuers and plans should not be discouraged from employing innovative reimbursement mechanisms because they might cause a change in the network providers. In addition, insurers and plans should be encouraged to implement quality improvement programs and initiatives, such as utilization of centers of excellence. Such programs and initiatives could result in changes to provider networks. If network changes cause the loss of grandfathered status, it is unlikely that grandfathered status could be maintained for any plan. Existing standards for network adequacy

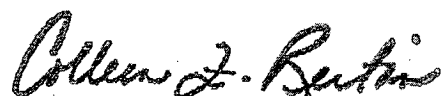
Hon. Kathleen Sebelius
Hon. Hilda Solis
Hon. Timothy Geithner
August 16, 2010
Page 10 of 10

provide assurance that appropriate coverage is maintained and changes in the specific providers included in a network should not result in loss of grandfathered status.

- *Formulary Changes:* Formulary changes should not cause a loss of grandfathered status. Medications go on and off formularies throughout a policy period based on a variety of factors including evolving standards of medical care and treatment. Such changes do not materially affect coverage. If a therapeutic equivalent, such as a generic, is available to a covered person, then coverage is not eliminated or diminished. Furthermore, the grandfathering rule should not provide a disincentive for providing the most appropriate care for covered persons, such as discontinuing coverage for contraindicated drugs and allowing for step therapy, where medically appropriate. Similarly, other formulary changes, such as those in response to drugs moving from prescription only to over-the-counter status, should not cause a loss in grandfathered status.

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

Sincerely,



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