GroupHealth

Group Health Cooperative
Public Policy / Government Relations
GHQ-E4N

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August 26, 2010

Department of Health and Human Services
Attention: OCIIO-9994-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

Re: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections Interim Final Rule
File Code OCIIO-9994-IFC

Submitted via eRulemaking Portal: www.regulations.gov

Dear Sir or Madam:

Group Health Cooperative (Group Health) appreciates the opportunity to provide comments on the Interim Final Rules on Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections under the Patient Protection and Affordable Care Act (PPACA). We agree with many of the comments offered by both Alliance of Community Health Plans (ACHP) and America's Health Insurance Plans (AHIP) on these topics, and will not repeat those comments here. However, we wish to provide additional comment on several aspects of the proposed rule that particularly affect organized, integrated group practice plans in the State of Washington; in particular, structured open enrollment periods for children under 19, lifetime and annual limit restrictions, and rescissions pertaining to group coverage. Reasonable modifications and clarifications within these areas are necessary to guarantee the timely and effective implementation of PPACA.

Group Health is one of America's oldest and largest non profit health care systems. Founded in Seattle in 1947, the organization is governed by consumers. It is a leader in integrated care, and an important voice for health care reform. We provide coverage and care to more than 628,000 residents in Washington State and Northern Idaho who are covered by our health plans and get their care from Group Health physicians and nurses in one of our medical centers or from our more than 9,000 contracted community providers.

1. Standardized Open Enrollment Periods for Children Under 19

Group Health is committed to expanding coverage to the uninsured, and fully supports early action to assure children's needs for affordable, quality care and coverage are addressed. We appreciate the Administration's recognition of potential "adverse selection" that may occur with the implementation of this particular PPACA requirement, and support the Department of Health and Human Service's (HHS) issuance of a

questions and answer document to allowing a standardized open enrollment period for children under the age of 19, if permitted under state law.[1]

In order to further protect against adverse selection, and continue offering quality affordable coverage to all members, we request a clarification to the IFR that designates one standardized open enrollment period for children under the age of 19 that is applicable to all health plans across the nation. In this situation, applicants will also be able to apply for coverage outside the standardized open enrollment period, but will then be subject to underwriting, as allowed by current state law.

Using the applicant's birthday month as the standardized open enrollment period is an easy way to designate a consistent, standardized open enrollment period. The open enrollment period would be the same for each applicant, regardless to which health plan the applicant applies. In addition, spreading out the open enrollment period over the course of the year, depending on the applicant's birthday month, will greatly decrease the administrative costs associated with offering an open enrollment month per year (for example, the month of January) that applies to all applicants.

Without one standardized open enrollment period for all applicants, as outlined above, applicants will have the opportunity of arbitrarily jumping from plan to plan or in and out of coverage, increasing the possibility of adverse selection. We believe that the proposed standardized open enrollment period will carry out the spirit of PPACA's requirement that pre-existing exclusions do not apply to applicants under the age of 19, while ensuring adverse selection does not substantially increase in the current individual health plan market.

2. Lifetime and Annual Limit Restrictions

Group Health agrees with the general PPACA requirements of restricted annual limits on essential benefits, as provided in the IFR. However, we request additional clarification to the IFR indicating that the "floor annual limits" for plan or policy years that begin prior to January 2014 apply to all essential benefits under the plan in the aggregate, and not to each specific essential benefit.[2] Applying the "floor annual limits" to each specific essential benefit would lead not only to consumer confusion, but increased administrative costs as well. Additionally, we suggest that the IFR clearly address whether specific annual and lifetime benefit limits for particular types of essential benefits are permissible under the IFR. We realize that HHS has not yet defined "essential benefits." However, there are a limited number of situations in which we feel some early clarity would be helpful. As a specific example, under what circumstances, if any, is it permissible for a plan to apply a separate annual or lifetime limit to organ transplantation benefits where such a limit is not applied to other services under the health plan? Ongoing conflicting interpretation across various parties involved in the implementation of PPACA on this issue is already resulting in a mixed interpretation throughout the nation and within states, and therefore a clarification to the IFR is extremely helpful for uniform implementation and clear consumer communication.

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[1] "Questions and Answers on Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions," July 27, 2010.

[2] The IFR establishes permissible annual limit restrictions of $750,000 for the first plan year on or after September 23, 2010, $1,250,000 for the next plan year, and $2,000,000 for the next plan year until January 1, 2014. 75 Fed. Reg. 37236 (June 28, 2010).

Furthermore, the IFR grants waiver authority to the Secretary of Health and Human Services to allow a group health plan or health insurance coverage to be exempt from the restricted annual limit requirements for plan or policy years beginning before January 1, 2014, should the requirements result in a "significant decrease in access to benefits under the plan or health insurance coverage or would significantly increase premiums for the plan or health insurance coverage."[3] Moreover, the preamble states that certain coverage could be exempt from the restricted annual limit requirements in order to preserve consumer access to medical services and to prevent significant premium increases to consumers. We believe the scope of the waiver provision should explicitly include state-mandated conversion policies that have annual limits that are below the required "floor annual limits" under the IFR, particularly since these conversion policies will remain in effect in the years leading up to 2014.

Washington state law, similar to other states, requires carriers who offer group health plans to also offer conversion plans that contain benefits with benefit annual limits and lifetime limits specifically prescribed by law. The majority of these limits are low dollar amounts, and are designed as a cost-containment mechanism to keep premiums affordable for the enrollees. Enrollees of these plans are frequently high risk, resulting in high utilization and premiums. In many cases, these plans serve as the only coverage option for high risk people who lost group coverage, as these high risk people will likely be denied coverage under an individual plan due to ongoing health issues. With the implementation of the PPACA guaranteed issue requirement for people of all ages in 2014, these plans will likely become obsolete due to their current benefit limitations and rising premiums. Any changes to the benefit limits, as currently prescribed in state law, will likely drastically increase premiums for members currently on these plans, making them no longer affordable for this high risk population. For these reasons, we support a clarification to the IFR that includes state-mandated group conversion health plans within the scope of the waiver provision contained in the restricted annual limits requirement.

3. Rescissions Pertaining to Group Coverage

Group Health supports the prohibition on rescissions of coverage. In the group health plan market, however, administrative adjustments are made daily to group health plans by the group employer, and these are very different from the types of rescissions that have been problematic in the individual market context. The IFR provides "A cancellation or discontinuance of coverage with only a prospective effect is not a rescission, and neither is a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage."[4] However, the IFR does not address the discontinuance of coverage under a group plan that is effective retroactively to the extent it is attributable to ineligibility. We believe these frequently occurring group health plan administration adjustments fall outside the definition of a "rescission" of coverage. As currently written, the IFR appears to prohibit group retroactive administrative corrections made to retroactively terminate an employee's coverage for ceasing to meet eligibility requirements. For example, it is very common for employers to pay premiums for group coverage a month or two in advance, and require that an employee's health coverage terminate after the last day of employment. In this situation, even though the employer

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[3] 75 Fed. Reg. 37236 (June 28, 2010).
[4] 75 Fed. Reg. 37192 (June 28, 2010).

may inform the carrier of the employee termination in a timely manner, the carrier will most likely retroactively cancel the employee's coverage back to the date of the employee's termination because notice to the carrier was given after the date of termination. Group Health supports a clarification to the IFR that enables flexibility for administrative corrections that occur in a group health plan environment on a daily basis.

We appreciate the opportunity to provide these comments for your consideration, and your willingness to consider these comments as you further develop clarifications on open enrollment periods for children under 19, lifetime and annual limit restrictions, and rescissions pertaining to group coverage.

Sincerely,

Megan Grover
Director, Regulatory Affairs
Group Health Cooperative