REG-114494-10

LEGAL PROCESSING DIVISION
PUBLICATION & REGULATIONS
BRANCH

JUL 15 2010

PUBLIC SUBMISSION

As of: July 15, 2010
Received: July 14, 2010
Status: Posted
Posted: July 15, 2010
Tracking No. 80b18b36
Comments Due: August 11, 2010
Submission Type: Web

Docket: IRS-2010-0011
Group Health Plans and Health Insurance Issuers Providing Dependent Coverage of Children to Age 26 under the Patient Protection and Affordable Care Act

Comment On: IRS-2010-0011-0002
Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26, etc.

Document: IRS-2010-0011-0007
Comment on FR Doc # 2010-11391

Submitter Information

General Comment

Please see attached comments.

Attachments

IRS-2010-0011-0007.1: Comment on FR Doc # 2010-11391

Response to Request for Comments Regarding Section 2714 of the Public Health Service Act Prior to Rule-making

Submitted to the Department of Health and Human Services, Department of Treasury, and Department of Labor

Submitted by a FL-based Health Plan

Through the Federal eRulemaking Portal

Brief Background on Submitting Health Plan

The health plan making this submission is a FL-based Health Maintenance Organization with over 40,000 covered lives. Its large group and individual products are impacted by the health reform act changes. The preponderance of its covered lives is individual policyholders. Many of the benefit designs of the insurer are individual products with very low monthly premiums to attract individuals with very limited means who would otherwise be uninsured as they exceed Federal Poverty Income Thresholds for government programs. For example our comprehensive HMO coverage for children product is set as $75 per month per child. Our other individual comprehensive HMO coverage begins at $90 per month per individual.

General Comments

While we support the overall goals of health reform, as embodied in the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), the health plan cautions that a number of provisions could create instability in the insurance marketplace, especially as it relates to the individual market, and have unintended consequences that actually erode quality and cost effective health insurance coverage that is provided today. The same holds true for Section 2714, which requires dependent coverage of children to age 26. While we also support the intent of Section 2714, we believe the departments should approach this Section cautiously during the interim period of 2011 through 2014 before the individual and business mandates and subsidies begin.

Additional Comments Submitted

Since our initial comments, a number of issues have arisen that we do not believe have been addressed in the interim final regulations. We hope that these additional comments and questions can be reviewed before final regulations are published.

Up to age 26 coverage and out of state/out of network area issues

The age 26 requirement in PPACA requires a group or individual plan to allow a child up to age 26 to enroll with a limited exception for group plans before 1/1/14. However, many HMO plans (individual and group) require individuals to reside in the plan network's area as a condition of eligibility even if it covers individuals outside the network area in cases of emergencies, etc. While the PPACA requires dependent coverage to age 26 and limits the ability to define this coverage to age and relationship, we believe plans still have the ability to deny coverage due to the network eligibility requirement. That is, the plan would not be required to enroll the individual solely for emergency coverage outside of the network and certainly not for full coverage. We view the PPACA bar on residency and dependency rules as a bar on placing such rules with regard to the relationship between the parent and child only. We do not feel this should preclude the ability to have residency restrictions for eligibility as long as it is applied to all members in that restricted service area health plan or policy. While we do provide out-of-network and out-of-area emergency coverage for our

members, that constitutes a benefit (built into the approved rates) that we know will be utilized in only extreme circumstances due to the full-time, permanent residency requirement. Further, we also understand that our traditional underwriting (through 1/1/14) and other customary (universally applied) eligibility requirements can be followed.

Up to age 26 coverage and definition of relationship

Please confirm or address the following as relationship between the child and the participant or primary subscriber is not defined in the interim final regulations to the best of our knowledge.

- Generally, is relationship defined as natural born or adopted child?
- Are there any circumstances in state or other federal law where a person would qualify for dependent coverage outside of PPACA? The interim final regulations appear to rule out coverage based on other criteria through age 26, but what if other federal laws or state laws may allow such people to qualify as dependents and therefore be covered under another's health insurance? Can the existing state or federal laws be used as qualifying events even though PPACA rules them out? (We understand at a minimum we will use the federal definition for up to age 26 if the individual is a natural-born or adopted child. For example, if a person is the guardian of an individual (who is under 18 or who may be over 18 and is disabled), could other criteria be applied if the child is under age 26 to determine eligibility?

Up to age 26 dependent coverage and children of other than primary insureds

Please confirm or address.

It appears that for group plans a step child (that is the son or daughter of a spouse who is a secondary insured) would in fact be eligible to enroll for up to age 26 coverage. Would the dependent child be eligible if the spouse was not enrolled as a secondary insured?

At the same time, for individual products, the interim final regulations appear to tie relationship to the primary subscriber and, thus, a step child would not be eligible for an individual policy if the spouse was a secondary insured. Please confirm this understanding for group and individual policies.

Further, with regard to the group coverage issue if the answer is step children must be covered, if a divorce degree requires the other spouse to provide health insurance, could that be grounds for denial of enrollment of the age 26 dependent in a plan.

Individual policies and allowances to enroll in different plans

The interim final regulations appear to mandate that children and thus, parents, in group plans must be offered the opportunity to switch to other benefit packages. Please confirm this is not applicable to the individual market. That is, even if a plan has multiple benefit packages, that a primary subscriber and child are only entitled to enroll in the benefit design that the primary subscriber was underwritten for. If the conclusion is different, please confirm that any switch is subject to new underwriting and higher premiums could apply. Can the plan change premiums and underwrite? Please confirm for before and after 2014.

Group plans and allowances to enroll in different plans

Notwithstanding the need to treat a child as a special enrollee and offer all the benefit packages of similarly situated individuals, confirm it is the case that the proposed rule on dependent coverage does not force a business or insurer to have an individual and dependent child in different benefit packages. Meaning, the insurer and business can mandate that the parent and child be in the same benefit package.

Up to age 26 dependent coverage and uniformity and comparability of benefits

The interim final regulations in both the group and individual sections state: "Uniformity irrespective of age. The term of the plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older.)" This would appear to cover both group and individual plans. Is this the case because the examples given only discuss group health plans (or is this for consistency as the first interim final regulation applies only to group plans)? If the provision does apply to individual, is it the case that *no surcharges or additional premiums* can be applied based on age up to age 26 or can the plan charge surcharges, change premiums and underwrite? Please comment on before and after 2014.

The interim final regulations later state in all parts that any child enrolling in a group plan must be treated as a special enrollee as provided under the rules of 54.9801-6(d). It says that the child must be offered all the benefit packages available to similarly situated individuals who do not lose coverage ... It also notes that any difference in benefits or cost-sharing requirements constitutes a different benefit package. It also states that the child cannot be required to pay more for coverage than similarly situated individuals who do not lose coverage ... *If the general provision does impact* the individual marketplace, what is the difference between the general provision above that seems to impact individual and group plans and this provision impacting only group plans?

Recognized periodicity schedules and other evidence-based practices and how they are impacted by uniformity/comparability mandates

A number of outside entities have introduced nationally recognized recommendations on periodicity of primary care and other visits, immunization schedules, and other recommendations that health insurers have adopted. For example, recognized standards for well child visits include multiple visits under age 1, periodic visits in early childhood and less frequent visits later in life. Plans have built benefits and made financial assumptions around these periodicity and other standards. Are these periodicity and other standards impacted by the general requirements and *specific group* requirements outlined in the section immediately above. For example, can plans have benefits that cover nationally recognized well child visits based on age even if that allows more primary care well-child visits earlier in life than later? Indeed, the elements listed in Section 2713, which bars cost-sharing for certain evidence-based primary prevention recommendations, have considerations based on age and periodicity. How would this section comport with the uniformity/comparability mandates?