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**Elizabeth P. Hall**
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Submitted via Federal e-Rulemaking Portal: www.regulations.gov

August 27, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

ATTENTION: OCIIO-9994-IFC

**RE: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections**

Dear Secretary Sebelius:

WellPoint Inc. (WellPoint) appreciates the opportunity to respond to the "Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections," published June 28, 2010. WellPoint is committed to ensuring the delivery of high quality, safe and effective care for our members. We look forward to working with the Departments of Health and Human Services (HHS), Labor (DOL) and Treasury (Treasury) to successfully implement these reforms.

WellPoint is the largest publicly traded commercial health benefits company, in terms of membership, in the United States with 33.8 million medical members as of March 31, 2010, and 1.1 million Medicare enrollees. WellPoint is an independent licensee of the Blue Cross Blue Shield Association and serves its members as the Blue Cross licensee for California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as Blue Cross Blue Shield in 10 New York City metropolitan counties and as Blue Cross or Blue Cross Blue Shield in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), and Wisconsin; and UniCare Life and Health nationwide.

Our specific comments on the interim final rule (IFR) are below.

***Prohibition of Preexisting Condition Exclusions***

*Under 19 Enrollment*

WellPoint agrees that ensuring that children and young adults have access to affordable, quality health insurance coverage is important. As such, we applaud HHS's clarification to this IFR issued July 27, 2010, that allows for the establishment of open enrollment periods for children under 19, whether for family or individual coverage, pursuant to applicable State law, for plan years beginning on or after September 23, 2010. This clarification will help protect against adverse selection and will promote a viable and stable market for children and their families alike. We believe that additional guidance regarding sales outside of the open enrollment period would be warranted.

***Lifetime and Annual Limits***

The ACA and this IFR generally prohibit the application of lifetime and annual dollar limits. Our specific comments on issues surrounding lifetime and annual dollar limits are below.

*Restricted Annual Limits*

WellPoint appreciates that HHS, DOL, and Treasury have granted flexibility to employers and plans by providing a 3-year transition period during which plans may continue to apply annual limits as long as they comply with minimum amounts set by the IFR. However, even with the transition period, the potential for market disruption is significant due to the high minimum limits required. Actuarially, raising a plan's annual limit from an amount that is significantly lower than the new requirement (e.g., $100,000) to $750,000 is no different than eliminating the annual limit and will therefore have a significant impact on premiums and offered benefits.

*Waiver Program*

The IFR outlines a waiver program associated with the restricted annual limits requirements to be established by the Secretary of Health and Human Services in order to prevent coverage losses or considerable premium increases. WellPoint appreciates the Secretary's acknowledgement of the challenges employers and plans will face to bring low annual limit plans and limited benefit plans into compliance with the statue, and thus encourages the quick and expedient distribution of scope and process information related to the waiver program. In addition, we respectfully request that the Secretary grant safe harbor to retain affected group and individual market plans prior to receiving guidance on the waiver program.

*Essential Health Benefits*

The IFR makes clear that restricted annual limits are permitted with respect to "essential health benefits" for plans or policies issued on or before January 1, 2014. In addition, only "essential health benefits" may be taken into account for calculating the minimum annual limits. However, the Departments have not yet issued regulations more precisely defining the included benefits. While the IFR states that the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" prior to the issuance of regulation, further clarification is requested. WellPoint encourages the Secretary to issue the regulations defining "essential health benefits" as soon as possible.

*Notice of Enrollment and Reinstatement Opportunity Requirements*

The regulation lays out requirements that health plans and issuers must follow to provide notification of an individual's right to reinstate or enroll for eligible benefits. WellPoint would like to highlight the challenges associated with notice requirements in the group market. As currently written, the IFR states that the plan and the issuer are required to give the individual written notice that the lifetime limit on the dollar value of all benefits no longer applies and that the individual is once again eligible for benefits under the plan. However, a health insurance issuer in the group market can communicate with current subscribers only. Issuers are not empowered to independently fulfill the obligation to notify eligible but not enrolled individuals; the issuer relies on timely communication from the employer group to relay employee eligibility. WellPoint believes it is appropriate for health insurance issuers to support the group plan in its efforts to contact relevant individuals, but to not have independent responsibility for directly contacting individuals.

***Prohibition on Rescissions***

WellPoint announced earlier this year that it would implement federal requirements regarding individual market rescissions early, effective May 1, well ahead of the effective date. WellPoint was the first insurer to announce it would follow these provisions. The standard contained in the federal legislation requires insurers not to rescind policies except in cases of fraud or intentional misrepresentation of material fact. Rescissions, while rarely used, are one process insurers employ to reduce fraud and protect members.

As part of our normal business practices, WellPoint monitors claims for a variety of things, from indications of potential fraud to potential opportunities to improve quality and better coordinate care. In response to public concern over the practice of rescissions, WellPoint in 2006 undertook a thorough review of our policies and procedures. Following that review, WellPoint was the first insurer to announce the establishment of a variety of changes to our rescission practices in an effort to ensure that rescissions are handled as accurately and appropriately as possible. These changes include: 1) creating a new Application Review Committee which includes a physician that makes rescission decisions, 2) establishing a single point of contact for members undergoing a rescission investigation, and 3) establishing an appeal process for applicants who disagree with our original determination, which includes a review by an Application Review Committee not involved in the initial decision. In addition, WellPoint was the first insurer to commit to the utilization of an independent external review for rescission decisions.

The ACA and this IFR state that all plans and issuers in the group and individual markets cannot rescind coverage unless an individual was involved in fraud or made an intentional misrepresentation of material fact, or failed to pay premiums after sufficient notice from the insurer. In describing the standards for rescissions, the IFR states that the rules prohibiting rescissions extend to representations made by the individual or person seeking coverage on behalf of the individual. WellPoint requests further clarification that the reference to 'person seeking coverage on behalf of an individual' refers to those persons legally permitted to do so, such as when a parent/legal guardian seeks coverage for a dependent. In all other circumstances, WellPoint considers a contract not signed by the person seeking coverage to be void – as it was never a legally executed contract – and therefore requests that HHS not consider this a rescission.

The regulation calls for the group plan or the issuer to provide advance notice of at least 30 calendar days to an individual whose policy is being rescinded. WellPoint would like to suggest that a notice declaring a rescission investigation is underway and inquiring about discrepancies, with a 30 day response window to supply the requested information, is compliant with the requirement to provide 30 days notice.

The IFR further defines a rescission as a cancellation or discontinuance of coverage that has a retroactive effect, which is distinct from a cancellation that is conducted either prospectively, or retrospectively, in the case of a failure to pay premiums. WellPoint would like to suggest that the regulations be modified to afford insurers more flexibility for special situations where end of coverage may not be known in advance by plans/issuers and when retrospective cancellations are appropriate. For instance, employers typically have a grace period of 30-45 days to notify issuers that an employee has terminated employment or had a change in status, and cancellation of coverage is effective retrospectively as of the last day of employment or eligibility. As the regulation is currently written, insurers would have to notify employers that cancellations for terminated employees or employees with a change in status can only be done prospectively. However, employers may not always be able to comply, such as when an employee does not give advance notice of employment termination or change in status (e.g., divorce). In these cases the employer and/or the issuer will have to bear the costs associated with the employee who is no longer eligible and no longer making premium contributions. Therefore, WellPoint requests that retroactive cancellations be permitted in such circumstances and not be considered rescissions.

Similarly, under COBRA rules, plans can carry a terminated employee forward under the assumption that the employee will elect COBRA coverage (since the employee has 63 days to do so and get retroactive coverage). In the event the employee does not pay the COBRA premium, then the plan will cancel the policy for failure to pay premiums. This would be done retroactively to the employee's termination date, since the plan was carrying the employee forward. This too should not be considered a rescission.

***Patient Protections***

*Choice of Health Care Professional*

The regulation specifies that, for plans that require the designation of a primary care provider, enrollees have the right to designate the primary care provider of their choice, as long as that primary care provider is in network and accepting patients. While WellPoint supports the intent of this provision, we need to have flexibility to step in and designate providers to ensure the convenience, safety, and well-being of enrollees. As such, WellPoint recommends that language be added permitting exceptions to this rule for cause.

*Emergency Services*

WellPoint supports the legislative intent of the ACA's emergency services provisions as a means of protecting members in cases of true medical emergencies where choice in the setting of care is not reasonable. The regulations also impose member cost-sharing and plan reimbursement requirements related to emergency services rendered by out-of-network providers. We support these cost-sharing and plan reimbursement requirements for clearly demarcated emergencies, as defined. Below, we offer select, specific comments on the relevant definitions and plan reimbursement requirements put forth in the regulation.

*Definition of Provider and Emergency Services*

The regulation uses the term "provider" broadly, and with respect to emergency services, WellPoint would like to see the term defined so as to prevent overutilization and charging for services outside of the scope of the emergency services provisions of the ACA. In addition, we note that the regulation is consistent with most state laws that impose a prudent layperson standard in determining an emergency medical condition for which coverage must be afforded. However, administrative complications arise when a patient comes through the emergency room and ultimately is admitted as an inpatient. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires both a medical screening examination and, to the extent necessary, stabilization of the patient; it was not designed to be definitional with diagnosis and procedure codes. Thus, it is very difficult to determine without medical records the point in time at which emergency services end and inpatient services begin. Administrative simplification will greatly assist plans and issuers in demarcating emergency services from additional services.

*Median Amount*

The IFR requires plans to reimburse out-of-network providers for emergency services at the maximum of one of three amounts. One of those amounts is the median of in-network reimbursement rates. This will pose operational difficulties because not all providers are paid on the basis of a fee schedule. For example, in-network reimbursement rates are often based on a percent of charges. The variation in payment methodology will make it difficult to calculate a median amount. In addition, we suggest that the reimbursement amounts be calculated on a per year basis.

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WellPoint appreciates this opportunity to offer our suggestions for implementation of the pre-existing condition exclusions, lifetime and annual limits, rescissions, and patient protections regulation. Should you have any questions or wish to discuss our comments further, please contact Jennifer Boyer at 202-628-7831 or Jennifer.Boyer@WellPoint.com.

Sincerely,

Elizabeth P. Hall
Vice President, Public Policy