



SPAN
35 Halsey Street 4th Floor
Newark, NJ 07102
(973) 642-8100
(973) 642-8080 - Fax
E-Mail address: span@spannj.org
Website: www.spannj.org

Statewide Parent Advocacy Network, Inc.
Empowered Families: Educated, Engaged, Effective!

**Family Voices-NJ Comments on 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
Submitted August 6, 2010**

Thank you for the opportunity to comment on the status of “grandfathered” health plans under the interim rule pertaining to the Patient Protection and Affordable Care Act. Family Voices is a national network that advocates on behalf of children with special healthcare needs and works to “keep families at the center of children’s healthcare;” our NJ Chapter is housed at the Statewide Parent Advocacy Network (SPAN), NJ’s federally designated Parent Training and Information Center, and Family-to-Family Health Information Center. The NJ Coordinator also serves in a voluntary capacity as the NJ Caregiver Community Action Network representative for the National Family Caregivers Association for caregivers across the lifespan.

Supplementary Information
I. Background

We strongly support the definition of “group health plan” inclusive of both insured and self-insured plans under ERISA. We agree that exemptions can be made for small plans with less than two participants for both current employees as well as retiree-only plans that cover less than two participants. We agree that the PHS Act (Public Health Service Act) gives states the primary authority for both the group and individual market and that Health and Human Services will intervene only if the state “failed to substantially enforce” federal provisions, but recommend a robust federal review of the extent to which states are substantially enforcing federal provisions, including a clear, easy-to-use, and transparent complaint process. We also agree that the Affordable Care Act requirements can not be “construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement” of the Affordable Care Act. In NJ for example, we already have dependent coverage up to age 31, mental health parity, and guaranteed issue for preexisting conditions.

II. Overview of the Regulations: Preservation of Right to Maintain Existing Coverage

A. Introduction

We understand that for plans in existence as of March 23, 2010, these plans will be subject to only certain provisions of the Affordable Care Act and such plans will be known as “grandfathered health plans.” We also strongly support that “nothing in the Affordable Care Act requires an individual to terminate the coverage in which the individual was enrolled on March

23, 2010". We also agree that if an individual was enrolled on March 23, 2010, various requirements of the Act shall not apply "regardless of whether the individual renews..."

We strongly support that Congress required some "significant protections" for grandfathered health plans to ensure health care access. These protections include prohibition of rescissions and elimination of lifetime limits. However, we disagree that the grandfathered plans are not required to cover preventive health without cost sharing. Preventive health is not only cost effective but more importantly results in better health outcomes. Particularly for children, wellness initiatives such as immunizations and lead screening are especially important. For adults, prevention could include cancer screenings rather than waiting until the condition is more serious, costly, and results in higher morbidity and mortality. We strongly recommend for children that the Bright Futures guidelines, endorsed by the American Academy of Pediatrics, be utilized for children's wellness and prevention. For more information see <http://brightfutures.aap.org> .

We can appreciate that the statute balances "preserving the ability to maintain existing coverage with the goals of expanding access." Table 1 which summarizes to which requirements grandfathered plans must comply was extremely helpful. These requirements will be discussed in detail in later sections.

B. Definition of Grandfathered Health Plan Coverage

We understand that group or individual plans are grandfathered if individuals were enrolled March 23, 2010. We also understand that the plan doesn't cease to be grandfathered if "one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the ... coverage has continuously covered someone since March 23, 2010". We also agree that if an employer "enters into a new policy, certificate, or contract of insurance after March 23, 2010...is not a grandfathered plan." We also agree that "any policies sold in the group or individual health insurance markets to new entities or individuals after March 23, 2010 will not be grandfathered..."

We strongly agree with the requirement that to maintain status as a grandfathered plan there must be a "statement, in any plan materials provided to participants...describing the benefits...that the plan...believes that it is a grandfathered health plan..." We agree with providing contact information for questions or complaints. We also strongly support the requirement that to maintain grandfathered status, the plan must have "records documenting the terms of the plan...that were in effect on March 23, 2010." These records could include policies, certificates, contracts, summary plan descriptions, documentation of premiums, and employee contribution rates. We believe that the language needs to be strengthened and that the records "shall" (not could) include the aforementioned documentation, particularly in the area of premiums and cost sharing.

C. Adding New Employees

We agree that the grandfathered plans can maintain status with respect to new employees. However, we also agree that in order to prevent abuse that "if the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan." We also strongly support the second antiabuse requirement in which employees under grandfathered plans are transferred to another grandfathered plan. This will prevent "efforts to retain grandfather status by indirectly making changes that would result in loss of that status if those changes were made directly."

D. Applicability of Part A of Title XXVII of the PHS Act to Grandfathered Health Plans

We strongly agree that the “HIPAA portability and nondiscrimination requirements and the Genetic Information Nondiscrimination Act requirements applicable prior to the effective date of the Affordable Care Act continue to apply...” We also strongly agree that “mental health parity provisions, the Newborns’ and Mothers’ Health Protection Act provisions, the Women’s Health and Cancer Rights Act, and Michelle’s Law continue to apply to grandfathered health plans”.

Our comments on the aforementioned Table 1 are as follows:

We understand that the preexisting condition exclusion applies to grandfathered group plans. We disagree however that it should not apply to individual plans. We appreciate that the prohibition on excessive waiting periods applies to both group and individual plans. Regarding lifetime limits, we also appreciate that this applies to both group and individual plans. As far as annual limits, we are pleased that it applies to group plans. However, we disagree that it is not applicable to individual coverage. We strongly support the prohibition of rescissions for both group and individual plans. We also support dependent coverage until age 26 for both group and individual plans and understand this applies “only if the adult child is not eligible for other employer-sponsored health plan coverage”. Because New Jersey currently requires insurers to cover adult children up to age 31, we recommend specific language permitting and even encouraging states to require coverage above age 26, particularly although not exclusively for adult children with special healthcare needs even if those needs or their income levels do not qualify them for Medicaid.

E. Health Insurance Coverage Maintained Pursuant to a Collective Bargaining Agreement

We agree that if the collective bargaining agreement was ratified before March 23, 2010 that the “coverage is a grandfathered health plan at least until the date on which the last agreement relating to the coverage that was in effect on March 23, 2010 terminates ...even if there is a change in issuers...during the period of agreement.” It states that “The statutory language of the provision refers to ‘health insurance coverage’ and does not refer to a group health plan; therefore, these interim final regulations apply this provision only to insured plans maintained pursuant to a collective bargaining agreement and not to self-insured plans”. We disagree that this will not apply to self-insured plans because it will exempt 50-75% of plans due to ERISA. However, clarification is needed as on the next page it states, “However, the statutory language that applies only to collectively bargained plans, as signed into law as part of the Affordable Care Act, provides that insured collectively bargained plans in which the individuals were enrolled on the date of enactment are included in the definition of a grandfathered health plan. Therefore, collectively bargained plans (both insured and self-insured) that are grandfathered health plans are subject to the same requirements as other grandfathered health plans...”

F. Maintenance of Grandfathered Status

Overall, we recommend that the regulations limit the extent to which plans that do not contain all of the provisions of the new law can be grandfathered in.

We agree that there needs to be clarification on changes that would cause a plan to lose grandfathered status. We strongly support that benefit reduction would qualify. This would apply if a plan eliminates benefits for diagnosing or treating a condition so that it would cease to be a grandfathered plan. The example is given if the plan previously covered therapy and medication for a mental health condition but eliminated one of these, benefits have changed substantially and the plan would lose its status.

The second consideration would limit how much plans can increase the fixed-amount and percentage of cost-sharing. We agree that if plans exceed the amounts in these rules, they would lose their status. There are differences between coinsurance and fixed-amount cost sharing. We agree that coinsurance changes (e.g. patient pay increases from 20% to 30%) would significantly alter benefits and the plan would lose status. For fixed-amount cost-sharing such as copayments and deductibles, we agree that for anything greater than the maximum percentage increase (medical inflation plus 15 percentage points), the plan loses its status except for the case of copayments which could occur in the same case above or if the copayment exceeds “five dollars increased by medical inflation.”

Next, consideration is given to employer contributions. If the contribution rate (“amount of contributions made by an employer compared to the total cost of coverage, expressed as a percentage”) is based on cost of coverage, we agree that the plan would lose its status if the employer decreases its contribution rate “towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate on March 23, 2010”. For self-insured plans, contribution is calculated “by subtracting the employee contributions towards the total cost of coverage from the total cost of coverage.” Lastly, if the contribution rate is based on a formula (e.g. “hours worked or tons of coal mined”), the plan loses its status if the employer “decreases its contribution rate towards the cost of any tier of coverage...for similarly situated individuals...”

If a plan did not have an annual or lifetime limit on March 23, 2010, it will lose its status if it imposes an annual limit. If a plan previously had a lifetime but no annual limit, it will lose status if it adopts an annual limit. If a plan previously had an annual limit but decreases it, it will lose its status.

However, changes to premiums will not cause a plan to lose status. We strongly disagree with this as plans will merely transfer cost sharing prohibition requirements by increasing premiums. Indeed, we have seen double digit increases in premiums prior to enactment from corporations because “healthcare reform *might* happen” in backlash. We’ve also witnessed increased premiums, lower wages, no raises or bonuses, etc. in anticipation. We are hoping for monitoring and enforcement, including sanctions, for unreasonable premium increases as stated in the Act. We believe that unreasonable premium increases should cause a plan to lose its grandfathered status and urge tracking this prior to the changes in 2014.

We do agree with the good faith time period for transition, as plans make routine changes annually. We feel that if changes “only modestly exceed” the changes prior to June 14, 2010 they can be disregarded. We also feel that the grace period to revoke or modify changes adopted prior to June 14, 2010 until September 23, 2010 but again only if these changes “modestly exceed” regulations.

We urge the Department to add their suggestions on changes that would cause a plan to lose its status such as “switching from a health reimbursement arrangement to major medical coverage or from an insured product to a self insured product”; changes provider network; changes to prescription drug formularies; or any other changes that seek to circumvent the protections in the requirements.

III. Interim Final Regulations and Request for Comments

We strongly agree that the “six-month period between the enactment of the...Act and the applicability of many of the provisions affected by grandfathered status would not allow sufficient

time for the Departments to draft and publish proposed regulations, receive and consider comments, and draft and publish final regulations”. We also agree that the “Secretaries further find that issuance of proposed regulations would not be sufficient because the provisions of the...Act protect significant rights” and that “Proposed regulations are not binding...” In summary, we fully support the Department’s determination that “it is impracticable and contrary to the public interest to engage in full notice and comment rulemaking before putting these regulations into effect, and that it is in the public interest to promulgate interim final regulations.” However, we encourage widespread notice of the interim final regulations as soon as practicable and development of a process that allows for robust public input, including regional opportunities to hear concerns and recommendations from families and individuals.

IV. Economic Impact and Paperwork Burden

A. Overview

As stated above, we agree that clarification is needed on determining changes that would cause a plan to lose its grandfathered status.

B. Executive Order-Department of Labor and Department of Health and Human Services

We agree that this regulation is “economically significant” (...annual effect on the economy of \$100 million in any one year”).

1. Need for Regulatory Action

As stated above, we agree that the Department had to balance flexibility of plans to ease transition against “excessive flexibility that would conflict with the goal of permitting individuals who like their healthcare to keep it...” This would include changes that plans typically make on an annual basis. But again we strongly support that “allowing unfettered changes while retaining grandfather status would also be inconsistent with Congress’s intent to preserve coverage that was in effect on March 23, 2010”.

2. Regulatory Alternatives

We thank the Department for not allowing the original consideration for “looser cost-sharing”. We also thank the Department for considering and disallowing the possibility of an “annual allowance for cost-sharing increases above medical inflation, as opposed to the one-time allowance of 15 percent above medical inflation” as in the best interest of consumers. Although the Department rejected considerations of aggregate changes that over time would cumulatively “render the plan...substantially different”, we urge the Department to look at trend analysis to determine the extent to which this is occurring and if this violates the regulations on grandfathered status. We also agree that retaining actuarial status would not suffice to keep grandfathered status if it still allows for “fundamental changes to the benefit design”. We agree that requiring employers to contribute the same dollar amount would be insufficient monitoring due to other factors such as premiums. We agree that a “change in third party administrator by a self-insured plan” shouldn’t cause it to lose status, but only if benefits etc. remain the same.

3. Discussion of Regulatory Provisions

Again as stated earlier, we agree that the plan would lose status if it eliminates benefits for diagnosis or treatment, increases a percentage cost-sharing above previous levels, increases fixed-amount cost-sharing (other than copayments) above previous levels, increases

copayments in excess of the sum of medical inflation plus 15% or \$5 increased by medical inflation, and changes in lifetime and/or annual limits.

4. Discussion of Economic Impacts of Retaining or Relinquishing Grandfather Status

Plans have the option of limited changes, changes which cause loss of status, or ceasing to offer any plans. We agree that in the group market, individuals do not often switch plans and this is particularly true for those with substantial health needs. We also agree that for those in individual plans, changes occur more often and are usually related to employment status. We understand that with changes in 2014, there will be limits on premium rates. We also understand that this will depend on the number of employees covered and agree this will be up to 100 employees, though states may limit this to 50 until 2016. We understand that the Act rating rules will not apply but that grandfathered plans must comply with state rating rules; however it appears that no rating rules will apply to grandfathered plans with 51-100 employees. This means premiums can vary widely beginning in 2014. This could encourage plans to retain grandfathered status; conversely plans that cover high risk groups may relinquish their status so that “group would be folded into the larger, lower-risk non-grandfathered pool.” We also agree with the Department’s decision to allow greater flexibility at onset and less over time (“cumulative increase in copayments... compared to a maximum percentage...that doesn’t increase annually”) which will help “mitigate adverse selection.”

5. Estimates of Number of Plans and Employees Affected

We agree with the current estimates of 72,000 ERISA plans and 2.8 million small group plans (97 million in large plans, 40.9 million in small plans); 126,000 governmental plans (36.1 million in large and 2.3 million in small plans); and 16.7 million under age 65 in individual plans.

a. Methodology for Analyzing Plan Changes Over Time in the Group Market

We support the Department looking into when a plan loses status, if it “could have achieved the same cost control... with a smaller change”. For example if a plan lost status due to a large increase in its deductible, perhaps it could have had smaller change in deductible but added changes in copayments, out-of-pocket maximums, and employer contribution to premiums. However, we also urge the Department to monitor this closely for potential circumvention of the requirements to retain status.

b. Impacts on the Group Market Resulting from Changes From 2008 to 2009

We disagree that these changes were made primarily due to the economic climate. We feel that employers were anticipating health care reform and made changes at that time that they would no longer be able to make post March 23, 2010 and retain grandfathered status.

c. Sensitivity Analysis: Assuming That Employers Will Be Willing to Absorb a Premium Increase in Order to Remain Grandfathered

We agree with estimates that 14% of small employers and 11% of large employers would relinquish their status if they made the same changes as 2009.

d. Sensitivity Analysis: Incomplete Flexibility to Substitute One Cost-Sharing Mechanism for Another

As stated previously, we understand analyzing if plans have alternate means to remain grandfathered using cost-sharing flexibility. We do think however that the high end estimate of

plans relinquishing status in 2011 (42% small employers, and 29% large employers) is much too high.

e. Estimates for 2011-2013

We feel that the mid range estimates regarding 66% of small and 45% of large plans relinquishing status before the changes in 2014 is still too high.

f. Impacts on the Individual Market

Although we disagree with some of the estimates above, we do agree that the numbers for the individual market will be higher than the group market. However, 40% relinquishment of status for individual plans still seems high.

g. Application to Extension of Dependent Coverage to Age 26

We agree that there may be an increase of relinquishing grandfathered status for plans due to dependent care coverage. The Department estimates that there were 5.3 million young adults ages 19-25 covered (and 480,000 uninsured) by an employer sponsored plan but that only 20% would have parents on non-grandfathered plans. The young adults would compare the cost of their employer sponsored plan vs. their parent's plan. It is estimated that 25% would switch to their parent's plan if not grandfathered. It is also estimated that 15% of the uninsured young adults would switch to their parent's plan. In 2011 it is estimated that 414,000 young adults (of whom 14,000 are uninsured) will be covered in their parent's non-grandfathered plans; by 2013 an additional 698,000 (of whom 36,000 were uninsured) would be on their parent's plan.

6. Grandfathered Health Plan Document Retention and Disclosure Requirements

The Department estimates a one time cost regarding disclosure to be \$39.6 million. It is also estimated that record retention will be a one-time cost of \$32.2 million. However we disagree with the labor rates (see IV. E. 1. a. below).

C. Regulatory Flexibility Act-Department of Labor and Department of Health and Human Services

We agree that because the Department "made a good cause finding that a general notice of proposed rulemaking is not necessary" they are not required to "either certify that the regulations would not have a significant impact on a substantial number of small entities or conduct a regulatory flexibility analysis." Although we do feel that there will be a likely impact on small entities due to the data in 6. above, we do not have any suggestions at this time on minimizing this impact.

D. Special Analyses – Department of the Treasury

We agree that "this Treasury decision is not a significant regulatory action" and that therefore "a regulatory assessment is not required."

E. Paperwork Reduction Act

1. Department of Labor and Department of Treasury: Affordable Care Act Grandfathered Plan Disclosures and Record Retention Requirements

We again support the requirements that there must be a statement in any plan materials describing benefits and also with the requirements to maintain records in connection with coverage that was in effect March 23, 2010. We also agree with minimizing the burden by allowing plans to use electronic submission of responses to these requirements as long as there is verification of receipt of the same.

a. Grandfathered Health Plan Disclosure

Current estimates are that 2.2 million ERISA plans will have to notify 56.3 million policyholders of grandfathered status. However the estimated costs (\$36.6 million for disclosure even with 38% delivered electronically) seem extraordinarily high with clerical rates at \$26.14/hour and human resources rates at \$89.12/hour. For the record keeping requirement, we again disagree with the estimate of \$30.7 million with clerical rates at \$26.14/hour and legal professionals at \$119.03/hour. We would also request confirmation of receipt for any electronic communications on disclosure or record keeping.

2. Department of Health and Human Services: Affordable Care Act Grandfathered Plan Disclosure and Record Retention Requirements

a. Grandfathered Health Plan Disclosures

Current estimates are that 98,000 governmental plans will need to notify 16.2 million policyholders of grandfathered status. We again disagree with the estimate of \$1.8 million based on the clerical and human resource rates in 1.a. above.

b. Record-Keeping Requirement

For these plans, we also disagree with the estimate of \$1.5 million based on the clerical and legal rates listed in 1.a. above.

F. Congressional Review Act

We agree that these interim final regulations are “subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act.

G. Unfunded Mandates Reform Act

We agree that these rules are not subject to the Unfunded Mandates Reform Act because they are being issued as interim final regulations.

H. Federalism Statement

We agree these rules have federalism implications because it directly affects “States, the relationship between the national government and the States, or on the distribution of power and responsibilities among various levels of government”. However this is mitigated by the fact that most states “will enact laws or take other appropriate action resulting in their meeting or exceeding the Federal standard.”

V. Statutory Authority

Lastly, the Department requested comments on the model language notice on disclosure. We would modify it as follows:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. A grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform . This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

As the Family to Family Health Information Center (F2F HIC) in NJ, we work with families and professionals to help them collaborate to improve health care access and quality for children with special healthcare needs. Thank you again for the opportunity to comment on the status of grandfathered health plans under the Patient Protection and Affordable Care Act.

Sincerely,

Lauren Agoratus, M.A.-parent
NJ Coordinator- Family Voices at the Statewide Parent Advocacy Network
35 Halsey St., 4th Fl.
Newark, N.J. 07102
(800) 654-SPAN ext. 110
Email familyvoices@spannj.org
Website www.spannj.org

Our Mission: To empower families and inform and involve professionals and other individuals interested in the healthy development and educational rights of children, to enable all children to become fully participating and contributing members of our communities and society.