Center on Budget and Policy Priorities

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August 10, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9991-IFC
P.O. Box 8016
Baltimore, Maryland 21244-1850

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
Attention: RIN1210-AB42

Internal Revenue Service
P.O. Box 7604 Ben Franklin Station
Washington, DC 20044
Attention: REG-118412-10

RE: File Code OCIIO-9991-IFC/RIN 1210-AB42/REG-118412-10. Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act

Dear Sir or Madam:

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, DC. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. We appreciate the opportunity to comment on the rules for maintaining status as a grandfathered health plan.

Overall, we strongly support the rules. We agree that they strike an appropriate balance between allowing many plans that existed as of enactment of the Affordable Care Act to continue without disruption, while also ensuring that when plans change significantly — particularly in ways that impact consumers' costs and coverage — they must conform to the requirements of the Affordable Care Act just like any other new plan. We are pleased that the rules allow a plan to retain grandfathered status only so long as it does not make substantial changes to benefits, cost-sharing charges, annual benefit limits, and employer contribution levels. The rules still leave employers and insurers with significant flexibility with regard to the coverage that they offer, including allowing them to retain

grandfathered status if they increase cost-sharing charges in order to keep up with medical inflation.

In a few areas, discussed below, we believe the rules should be modified to provide additional clarification when plan changes should cause a plan to no longer have grandfathered status.

Rules Should Specify What Changes to Plan Structure, Networks, and Formularies Cause a Plan to No Longer Have Grandfathered Status

The rules invite comments on whether changes to plan structure, provider networks and prescription drug formularies warrant a plan no longer having grandfathered status. In our view, certain changes in each of these areas would have a significant impact on enrollees' costs and coverage that should cause a plan to no longer have grandfathered status. Therefore, each of these areas should be subject to allowable thresholds for change, similar to the rules established for changes to benefits and cost-sharing charges.

Plan Structure: In our view, changes to plan structure, such as a switch from a PPO to an HMO or vice versa, are significant enough to warrant a loss of grandfathered status because they substantially alter access to providers. The rule also invites comment on whether a plan that switches from being fully insured to self-insured should be able to remain grandfathered. We do not think so. There is a serious risk that small firms, if permitted to do so, will increasingly move to self-insured status in order to avoid state regulation and certain requirements of the Affordable Care Act, such as the essential health benefits requirements. This is a change that could have a significant impact on consumers. Some small firms that would not otherwise risk being self-insured could switch but end up unable to pay the medical expenses of their workers, should they turn out to be unexpectedly high. And switching to self-insured status could increase the risk of adverse selection against more regulated fully-insured plans in the small-group market both inside and outside the exchange. In addition, self-insured plans are exempt from state regulations and oversight that help protect consumers. Becoming newly self-insured should lead a plan to no longer have grandfathered status.

The rule also invites comments on whether a plan that switches from a health reimbursement arrangement (HRA) to major medical coverage should be grandfathered. On this question, we believe it is important to consider whether an employer is offering an HRA on its own or paired with a health insurance plan. If an employer is offering major medical coverage for the first time, after providing only an HRA (and no related health insurance plan) to workers, the health plan should be viewed as an entirely new plan to the enrollees who did not have any major medical coverage offered previously, and thus it should not be considered grandfathered. If the employer has been offering a health plan paired with an HRA, and seeks to modify the health plan, then the same requirements for maintaining grandfathered status (pertaining to benefits and cost-sharing) should apply in determining whether the health plan can continue to be grandfathered.

Provider Network: Some changes to a plan's network of health care providers are reasonable — a physician might decide to leave a plan's network or a plan may negotiate better rates with a new set of physician groups in the same area. Such circumstances should not warrant a loss of grandfathered status. But certain substantial changes in this area would likely have such a significant, adverse impact on plan enrollees that the plan should not remain grandfathered. Such examples would include a plan dropping a significant portion of providers in a given geographic area from its network (including the primary hospital in the area serving a significant portion of all hospital

inpatient days in the area) or an insurer substantially scaling back the number of in-network providers in a particular specialty or subspecialty. The rules for maintaining grandfathered status should set an acceptable threshold for changes in provider network that ensures sufficient access for consumers.

Drug Formulary: A health plan's decisions about what drugs are covered and what cost-sharing amounts beneficiaries must pay for drugs represent another important area for the grandfathering rules to address. It would be reasonable for plans to remain grandfathered if they remove particular drugs from a formulary that are found to be dangerous or ineffective. Similarly, insurers and employers should have flexibility to maintain a plan's grandfathered status if a drug is added or removed from a preferred formulary (or moved to a different formulary tier with different cost-sharing) due to the latest clinical evidence or as part of negotiations for lower drug prices that are expected to benefit plan enrollees. But some formulary changes that would likely negatively impact beneficiaries should trigger a loss of grandfathered status. For example, if an insurance plan adds a new tier with higher cost-sharing charges or otherwise restructures its formulary in ways that impose substantially higher costs than plan enrollees had been paying, grandfathered status should end. This would include cases when a plan creates a new tier for "specialty" drugs, which typically requires enrollees to pay a cost-sharing percentage rather than the copayments commonly charged in other tiers. Also, if a plan moves all or most of a class of drugs, or drugs used to treat or control a particular illness, into a formulary tier that requires enrollees to pay higher cost-sharing, grandfathering status should end.

Rules Should Clarify that Changes to Annual Benefit-Specific Limits Prevent Plans from Maintaining Grandfathered Status

The rules outline several changes related to annual and lifetime dollar limits on benefits that would trigger a loss of grandfathered status. The rules refer to "overall" annual and lifetime benefit limits that apply to total medical costs covered by the plan, but the rules are unclear about how changes to limits imposed on *specific* benefits would affect a plan's grandfathered status.

For example, the rules state that a plan would lose grandfathered status if it imposes an "overall annual limit on the dollar value of benefits" when the plan did not have an "overall annual or lifetime limit on the dollar value of all benefits" on or before March 23, 2010. We believe the rules should clarify that this would also prevent a plan that lacked an annual or lifetime limit on the value of all benefits as of March 23, 2010 from maintaining grandfathered status if, for example, it imposes a new annual dollar limit on a particular benefit, such as prescription drug coverage. In addition, we think that any plan that imposes a new dollar-value limit on a specific benefit — regardless of whether the plan had annual or lifetime limits in place prior to enactment of the Affordable Care Act — should be prohibited from maintaining grandfathered status. A plan would also lose grandfathered status if it previously imposed an annual dollar limit on a benefit like prescription drugs but then subsequently lowers that limit. This issue is particularly important because grandfathered individual-market plans (in contrast to other grandfathered plans) are not subject to the Affordable Care Act's restrictions on applying annual dollar-value limits to essential health benefits. Such limits could constitute a significant change in coverage for enrollees, and plans that impose them should not be permitted to maintain grandfathered status.

Changes in Availability and Cost of Out-of-Network Coverage Should Prevent a Plan from Maintaining Grandfathered Status

The rule does not clearly specify whether the rules related to cost-sharing changes apply equally to both in-network and out-of-network benefits. We believe they should be applied equally because the availability and cost of out-of-network benefits are a key element of coverage for many enrollees, and significant changes in this area should warrant a plan no longer having grandfathered status. If a plan such as a PPO or point-of-service HMO provided out-of-network coverage as of enactment of the Affordable Care Act, enrollees should be able to have the same coverage if their plans are to remain grandfathered plans.

Conclusion

Thank you for the opportunity to comment. If you have any questions, please do not hesitate to contact Edwin Park (park@cbpp.org) or Sarah Lueck (lueck@cbpp.org).

Sincerely,

Edwin Park
Co-Director of Health Policy

Sarah Lueck
Health Policy Analyst