August 16, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

Re: OCIIO-991-IFC, The 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

These comments are submitted for the record to the Office of Consumer Information and Insurance Oversight (OCIIO) and other associated agencies on behalf of the National Federation of Independent Business (NFIB) and the NFIB Small Business Legal Center in response to the 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 (PPACA) published in the June 17, 2010, edition of the *Federal Register*.

NFIB is the nation's leading small business advocacy association, representing members in Washington, D.C., and all 50 state capitals. Founded in 1943 as a nonprofit, nonpartisan organization, NFIB's mission is to promote and protect the right of its members to own, operate, and grow their businesses. NFIB represents about 350,000 independent business owners who are located throughout the United States. The NFIB Small Business Legal Center is a nonprofit, public interest law firm established to provide legal resources and be the voice for small businesses in the nation's courts through representation on issues of public interest affecting small businesses.

NFIB is concerned that the Interim Final Rules provide small businesses with few options that will allow a business to keep the plan they like – and may well lead to an increase in the number of Americans without health coverage leading up to the 2014 requirement of mandated coverage. The Interim Final Rules appear to be based on an assumption that coverage choices should be narrowed in the run up to 2014. Nothing in the pertinent language of the PPACA supports that assumption. In fact, interpreting the PPACA so that it *narrows* the range of coverage choices is inconsistent with the spirit of the Act, as well as the letter of the law. Our concerns are addressed more substantively below.

Summary

NFIB is concerned that the Interim Final Rules are based on a misguided approach to interpreting the legislative language and purpose of the PPACA.

1. Congress conferred grandfathered health plan status on certain plans by statute, including insured and self-insured employer-sponsored plans providing employee coverage on the date of enactment. Grandfathered status increases a plan's chances of survival, especially through 2014, so that if the consumer likes the plan, the consumer can keep it. The Interim Final Rules are based on an assumption that Congress intended the agencies to decide whether and under what circumstances a plan meeting the statutory test should be stripped of its grandfathered status, thereby exposing it to a greater risk of extinction. The agencies have not identified any statutory language to support this assumption. Moreover, NFIB believes that the agencies' assumption is inconsistent with a straightforward reading of Section 1251 of the Act, which certainly does not appear to give anyone the authority to take statutory status as a grandfathered health plan away after the fact.

2. Moreover, the Interim Final Rules force employers to choose between the loss of statutorily-conferred grandfathered status or shouldering heavy regulatory burdens that are not even mentioned in the Act and which have no apparent connection with its purpose. The agencies do not identify any language in the statute justifying this regulatory approach. The agencies' decision to adopt this approach seems to be based on a belief that Congress intended the Executive Branch to limit consumers' freedom to keep the plans they liked. The agencies do not identify any basis for this belief in the language of the statute. To the contrary, the Preamble to the Interim Final Rules asserts that Congress left it to the Executive Branch to strike a "balance" between Congress's stated objectives and certain otherwise unidentified "policy goals." In NFIB's view, the Agencies' belief in this regard is both mistaken and unsustainable. Section 1251 of the Act confers grandfathered status on employer-sponsored group health plans with coverage in place on March 23, 2010, in order to protect consumer choice, including the choice to keep coverage that the consumer likes. In effect, the Preamble insinuates that the promise of consumer choice was little more than a smoke screen to secure passage of the Act and was never intended to be taken at face value, because Congress intended the Executive Branch to undercut that promise through post-enactment regulatory "balancing" that would discourage the continued existence of grandfathered plans.

3. Many provisions of the Interim Final Rules also run counter to the objectives of the PPACA. For example, they include regulations under which grandfathered health plan status is automatically and permanently lost because of a single, modest change in plan design, even if the change is necessary to preserve the plan's continued existence. The likely consequence of these rules will be to leave more Americans uninsured, especially during the run up to 2014—the very opposite effect from what the PPACA was intended to accomplish. Judging from the Preamble, the agencies apparently have chosen to believe that consumers do not make the best coverage choices, and therefore the agencies feel justified in issuing regulations promoting or hastening the extinction of grandfathered plans to "protect" consumers from being offered the opportunity to choose their existing coverage. The agencies' rationale in this regard is especially dubious because it leads to a conclusion that cannot be harmonized with the Act. The PPACA certainly

does not authorize the Executive Branch to develop a regulatory counterweight to Congress's own decision to preserve the right to choose.

4. Even if Congress had authorized the Executive Branch to issue regulations for the express purpose of discouraging the continued existence of grandfathered plans that the Executive Branch thinks might lead consumers to make what the agencies believe are "wrong" choices, the Interim Final Regulations represent dangerously wrong decisions about discouraging the continued existence of plans offered by the small business community. The burdens of compliance under the Interim Final Rules will weigh more heavily on small businesses than large businesses, often making it impossible for small businesses to continue to offer health coverage to employees. This is dangerous because of the staggering number of Americans who rely on small business plans for their health coverage, and must continue to rely on those plans until at least 2014 when new purchasing options for small business become available.

Moreover, creating rules that will selectively promote the extinction for health plans sponsored by small business is a disastrous policy choice. Under any given set of market conditions, the plans maintained by a small business are most likely to reflect the most manageable combination of quality and affordability available in that very limited marketplace, before, on, and after the date of enactment of the PPACA. Thus, of all the plans on which Congress conferred grandfathered health plan status, the plans maintained by a small business on the date of enactment are the plans that most need the flexibility to remain in existence.

Background: How Small Business Responds to Increases in Healthcare Costs

The small business community is all too familiar with the impact of high healthcare costs. With about 15 million employees accessing their health insurance through their employer in firms with less than 100 employees, small business employers are well aware of how the high cost of health insurance affects the men and women who work with them every day.[1] For more than two decades, research has reinforced what small business owners across the country tell us every day: the most significant obstacle to gaining access to health insurance is the prohibitive cost of coverage. NFIB remains concerned that the Interim Final Rules, as issued, will leave small businesses with even less choice and flexibility. Instead, they will be faced with the difficult choice of paying more to maintain grandfathered coverage, shopping for a new (and more expensive) plan, or possibly dropping employer-sponsored coverage entirely.

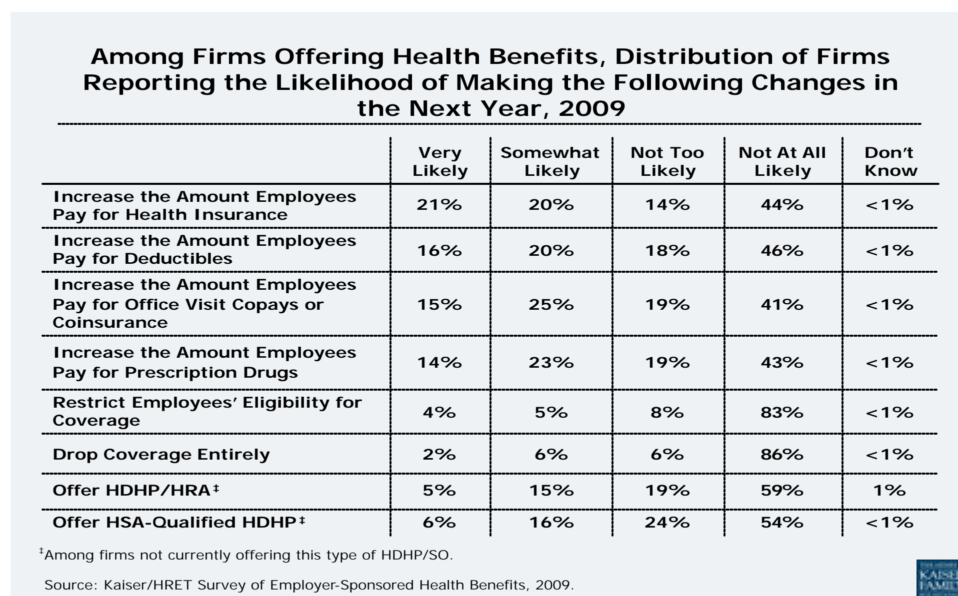
For small business the problem is obvious: health insurance is and remains one of the fastest growing and most unpredictable costs of doing business. According to the Kaiser Family Foundation, health insurance premiums (family coverage) for small firms with 3-199 employees increased 123 percent since 1999.

Paramount to achieving more affordable coverage is creating an environment that provides employers with the flexibility necessary to adapt to changing insurance costs – and for small business that typically means that they need flexibility to deal with cost increases. Currently, when small business owners are faced with premium increases – often in the double digits – they

[1] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2009 Medical Expenditure Panel Survey-Insurance Component.

are forced to evaluate their budget and their employees' needs to determine how they can best adapt to this increased cost.

As noted in the chart included below by the Kaiser Family Foundation, the Foundation's 2009 survey data suggests that in the face of premium increases employers look at a variety of options – changes in deductibles, co-pays, coinsurance – all the things they do before they do what scores lowest on the list – having to drop coverage entirely. However, as drafted, the Interim Final Rules severely restrict the ability of an employer to utilize any of the options outlined in the chart as a way of meaningfully helping to offset, adjust or minimize the overall increase in their health insurance policy.



Among Firms Offering Health Benefits, Distribution of Firms Reporting the Likelihood of Making the Following Changes in the Next Year, 2009

	Very Likely	Somewhat Likely	Not Too Likely	Not At All Likely	Don't Know
Increase the Amount Employees Pay for Health Insurance	21%	20%	14%	44%	<1%
Increase the Amount Employees Pay for Deductibles	16%	20%	18%	46%	<1%
Increase the Amount Employees Pay for Office Visit Copays or Coinsurance	15%	25%	19%	41%	<1%
Increase the Amount Employees Pay for Prescription Drugs	14%	23%	19%	43%	<1%
Restrict Employees' Eligibility for Coverage	4%	5%	8%	83%	<1%
Drop Coverage Entirely	2%	6%	6%	86%	<1%
Offer HDHP/HRA‡	5%	15%	19%	59%	1%
Offer HSA-Qualified HDHP‡	6%	16%	24%	54%	<1%

‡Among firms not currently offering this type of HDHP/SO.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009.

For instance, consider a small business owner who, faced with increased costs, chooses to make a modest adjustment such as increasing a copayment from $30 to $45. As far as NFIB is aware, employers, employees, nor any other stakeholder would seriously consider a change that small as the basis for concluding that the plan in existence on the date of enactment was transformed out of existence. Members of the small business community certainly would not reach that mistaken conclusion; they know better because they have been confronted year-in and year-out by the stark choice between terminating a plan completely or modifying its cost structure to preserve its continued existence. Yet, even though every rational employee and employer would agree that a modest copayment increase is a better alternative than having no plan at all, the Interim Final Rules limit flexibility so severely that it creates a stronger likelihood that an employer will drop coverage altogether.

The consequence of maintaining the overly restrictive guidelines outlined in the Interim Final Rules may well have the opposite effect of what the legislation was intended to achieve. Instead of fewer uninsured, we may well see more uninsured. The staggered timeline for implementation will leave any newly uninsured searching for coverage at a time when none of the new insurance rating reforms are in place, when no exchanges are open and when there is a greater likelihood that those who once had guaranteed coverage in the employer-based system

find themselves denied for insurance in the individual market because of a pre-existing condition.

We have recently heard from hundreds of our members who have altered various pieces of their health insurance plan in the last year. In response to cost increases that threaten their continued ability to make coverage available to their employees, our members have increased co-pays, eliminated a specific service, increased employee contributions, and/or added co-pays for prescription drug coverage. These practices mirror the data from the 2009 Kaiser Employee Health Benefits survey, which shows that 21 percent of small firms reduced the scope of health benefits or increased cost sharing in the last year. See below.

Among Firms Offering Health Benefits, Percentage of Firms That Report They Made the Following Changes as a Result of the Economic Downturn, by Firm Size and Region, 2009

	Reduced Scope of Health Benefits or Increased Cost Sharing	Increased the Worker's Share of the Premium
FIRM SIZE		
200-999 Workers	23%	22%*
1,000-4,999 Workers	19%	21%
5,000 or More Workers	21%	19%
All Small Firms (3-199 Workers)	**21%**	**15%***
All Large Firms (200 or More Workers)	**22%**	**22%***
REGION		
Northeast	31%	15%
Midwest	22%	18%
South	22%	16%
West	10%*	12%
ALL FIRMS	**21%**	**15%**

* Estimate is statistically different from estimate for all other firms not in the indicated size or region ($p<.05$).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009.

NFIB opposes implementing any restrictions on how plans can currently be changed or modified by employers and employees between now and 2014 when the healthcare law and its consumer options are fully implemented. If employers and employees make the determination to make adjustments to their plan so that "if you like your plan, you can keep it," then they ought to have that freedom. Some might argue that freedom may lead to rate shocks in 2014 when new rating reforms are fully implemented. While employers and employees ought to be aware of the potential for rate shock, the spending and coverage decisions they make in an effort to maintain coverage today should not be restricted by arbitrary regulations imposed by the federal

government. This is particularly true given that until 2014, employers and employees will not have Exchange-based coverage to fall back on. Forcing the small business community to walk yet another regulatory tightrope is bad enough; forcing them to walk that tightrope before there is a safety net for employees is unjustifiable.

While the most preferred solution would be to suspend in its entirety these severely restrictive practices, at the very least the final rules and regulations ought to reflect the primary challenge facing the small group market: cost. Small employers pay about 18 percent more for health insurance than their larger counterparts for the same group of services. Such data suggests that small employers either pay more for the same services or receive less (in terms of services) for their health insurance. Understanding that small employers are in a far more volatile marketplace, at the very least, NFIB suggests that the Administration increase the parameters for changes that employers can make to fixed-amount and percentage cost-sharing requirements to more appropriately reflect the premium increases in the small group market and still retain their grandfathered status. As a foundation for determining those parameters the agencies ought to consider the average premium increases in the small group market over a 10-year period and then construct a formula that reflects those costs in some sort of combination with medical inflation.

Congress Did Not Authorize the Agencies to Devise Rules for Terminating the Grandfathered Status of Group Health Plans on Which Such Status Was Conferred by Statute

Throughout the legislative debate, small business owners called on Congress to address the rising cost of healthcare coverage, citing it as the most significant impediment to finding, accessing and maintaining health insurance. As small business enters the regulatory phase of implementation, we remain deeply concerned about the impact that rules and regulation will have on healthcare costs, particularly since there are few if any options if employers cannot maintain an offering of coverage prior to 2014. Based on a sensitivity analysis conducted by the Administration and featured in the Interim Final Rules, the government's own analysis confirms what many small businesses fear most, that upwards of 80 percent of small employers could lose the plan they have today by 2013.

The small business community is particularly concerned by the provisions of the Interim Final Rules that create circumstances under which grandfathered status conferred by the statute purportedly can be lost based on regulations.

As many have observed, neither PPACA Section 1251 nor any other provisions of the Act authorize or even contemplates post-enactment loss of grandfathered health plan status by a group health plan or employer-sponsored health insurance coverage that satisfied the requirements of Section 1251 on the date of enactment. Thus, insofar as they might be construed as a basis for applying the provisions of Subtitles A and C of the PPACA to apply prematurely to such plans or coverage based on post-enactment events, 45 C.F.R. § 147.140(g) and (a)(2) lack any apparent statutory basis. This observation about the text of the Act is confirmed in the next-to-last paragraph of Section II.A of the preamble to the Interim Final Rules. That paragraph makes essentially the same finding regarding the statutory facts. However, it draws the

unwarranted conclusion from those facts that there is a "question" regarding "at what point changes to a group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010, are significant enough to cause the plan or health insurance coverage to cease to be a grandfathered health plan," and then bootstraps from that conclusion to decide that the statute "leav[es] that question to be addressed by regulatory guidance." ***See also Section II.F (failing to cite any section of the Act but describing 45 C.F.R. § 147.140(g) as the regulatory answer to "[q]uestions [that] have arisen").***

Naturally, NFIB agrees about the objective legislative fact; the PPACA is completely silent on the subject matter addressed by 45 C.F.R. § 147.140(g) and (a)(2). However, NFIB believes that the conclusion drawn by the agencies from this fact is erroneous. The legislative silence on the subject matter addressed by 45 C.F.R. § 147.140(g) and (a)(2) does not raise a "question" regarding "at what point changes to a group health plan . . . are significant enough to cause the plan . . . to cease to be a grandfathered health plan." To the contrary, PPACA § 1251(e) defines the term "grandfathered health plan" with respect to criteria that must be satisfied as of March 23, 2010, and Section 1251 as a whole does not even mention "changes to a group health plan," much less any distinction between "significant" changes and other changes, and it certainly does not mention or allude to any relationship between the "significance" of a post-enactment plan amendment and a loss of grandfathered status. Indeed, it does not mention or even allude to <u>any</u> possibility of loss of grandfathered health plan status, much less of "ceas[ing] to be a grandfathered health plan."

Nor can the existence of any such "question" be inferred without at least implicitly contradicting the language of the Act. A straightforward interpretation of the actual terms of PPACA § 1251(c) shows that the provisions of Subtitles A and C of the PPACA from which a group health plan is exempt as a grandfathered health plan *never* become applicable to a group health plan described in that section.

Finally, NFIB has grave reservations about the very concept on which the agencies seem to have based 45 C.F.R. § 147.140(g) and (a)(2). The agencies appear to have concluded as a general principle that a statute's failure to mention a topic automatically raises a "question" regarding how that topic should be addressed in regulations. NFIB cannot agree that legislative silence on any given topic always raises a question regarding that topic. To the contrary, that belief often would lead to outlandish and absurd conclusions. For example, there is no mention of a general sunset date for the Internal Revenue Code of 1986 as a whole, and the legislative silence on this topic is fully explained by Congress's decision that the Code as a whole would not "expire" in some future taxable year. The legislative silence cannot be interpreted rationally as a basis for Treasury regulations regarding how to determine the Code's expiration date.

Moreover, even if a statute's complete failure to mention a topic could raise a question regarding a legal norm applicable to that topic, there is no basis to treat a statute's complete silence on a topic as a delegation of regulatory authority to the Executive Branch. To the contrary, if a statute is silent on a topic, then by definition it does not articulate the "intelligible standards" necessary to delegate rule-making power regarding the topic. *See, e.g., Touby v. United States*, 500 U.S. 160 (1991).

The Rules Are Based on the Erroneous Assumption of a Conflict Between Congressional Objectives and Policy Goals

In Section IV.B.1 of the Preamble, HHS and the Department of Labor state that in drafting the Interim Final Rules, "the Departments attempted to balance a number of competing interests." This section of the Preamble illustrates the Departments' attempted balancing with one example. Interestingly, the example of departmental "balancing" involves an issue that is not mentioned anywhere in the PPACA itself, namely providing "adequate flexibility" to ease an otherwise-unidentified "transition" while at the same time "avoiding excessive flexibility" that the Departments inexplicably state "would conflict with the general goal of permitting individuals who like their healthcare to keep it."

As explained above, NFIB agrees with the traditional view of the relationship among the branches of government. According to this view, the task of striking a balance among "competing interests" is regarded as the exclusive job of the legislative branch. The Departments' example of how it balanced or re-balanced competing interests after the PPACA was enacted does nothing to alter NFIB's adherence to the mainstream, conventional principles of the separation of powers. That example is not evidence that the Executive Branch does a better job of balancing competing interests than Congress does. If anything, the particulars disclosed in the Preamble confirm the wisdom of the conventional view. Those particulars convince us the balancing act attempted by the Departments was fundamentally flawed.

It appears that the Departments determined their task involved striking a balance between allowing "adequate flexibility" and permitting flexibility that the Departments regard as "excessive" insofar as that flexibility would "conflict with the general goal of permitting individuals who like their healthcare to keep it." This conclusion strikes us as unsound because it assumes that there is a conflict between employers' flexibility and employees' ability to keep healthcare that they like. Section 1251 of the Act does not assume the existence of any such "conflict." Quite the opposite is the case, based on the language and structure of Section 1251. Section 1251(a)(1) was intended to express an individual's right to keep a plan that he or she likes, and it reflects the frequently-repeated promise of an individual's right to choose that was politically essential to the adoption of the Act. Sections 1251(a)(2) and (c) require the continued existence of the employer-sponsored plans under which coverage choices are offered. Congress clearly understood that if employer-sponsored group health plans were not protected, the individual right to choose coverage under those plans could not be effectively exercised.

Thus, the statutory provisions that require maximizing employer's flexibility to adapt existing plans to ensure their continued survival and the statutory provisions guaranteeing the individual right to choose are <u>not</u> mutually inconsistent. It is inherently unlikely that when dealing with a matter of this importance, Congress would fail to notice if there were "conflicting goals" in different parts of the very same section of the Act or that Congress would simply pass over any such "conflict" in silence and leave it to the Departments to sort things out afterwards. Contrary to what the Departments appear to have assumed about the legislation, two statutory objectives spelled out in Section 1251 are halves of the same whole. By allowing the Interim Final Rules to be forged based on the assumption that Congress not only created a conflict with the individual right to choose but then also delegated the resolution of that conflict to the Executive Branch is

not only unfounded, it reflects a willingness to believe that, in the last analysis, the Act's passage was procured by a cleverly-worded but an utterly insincere promise. Since the Departments have not presented evidence to substantiate that belief, NFIB believes the regulatory results of endorsing it are presumptively unsound.

Rather Than Preserving the Individual Right to Maintain the Coverage the Consumer Prefers, the Rules Adopt the Position That Individuals Should Not Be Permitted to Make That Choice

Furthermore, the "balance" struck by the Departments manifestly is not based on preserving an individual's right to maintain coverage on the basis of his or her own preference for that coverage. Instead, it is based on what can only be called an invidious stereotype about American employees, according to which their express preferences are likely to be "wrong" and therefore are not only unworthy of preserving, but should not even be permitted to be made. According to Section IV.B.4 of the preamble,

> Decisions by plan sponsors and issuers may be significantly affected by the preferences and behavior of the enrollees, especially a tendency among many towards inertia and resistance to change. There is limited research that has directly examined what drives this tendency – whether individuals remain with health plans because of simple inertia and procrastination, a lack of relevant information, or because they want to avoid risk associated with switching to new plans. One study that examined the extent to which premium changes influenced plan switching determined that younger low-risk employees were the most price-sensitive to premium changes; older, high-risk employees were the least price-sensitive. This finding suggests that, in particular, individuals with substantial health needs may be more apt to remain with a plan because of inertia as such or uncertainties associated with plan switching rather than quality per se – a phenomenon some behavioral economists have called "status quo bias," which can be found when people stick with the status quo even though a change would have higher expected value.
>
> Even when an enrollee could reap an economic or other advantage from changing plans, that enrollee may not make the change because of inertia, a lack of relevant information, or because of the cost and effort involved in examining new options and uncertainty about the alternatives. Consistent with well-known findings in behavioral economics, studies of private insurance demonstrate the substantial effect of inertia in the behavior of the insured. One survey found that approximately 83 percent of privately insured individuals stuck with their plans in the year prior to the survey. Among those who did change plans, well over half sought the same type of plan they had before. Those who switched plans also tended to do so for reasons other than preferring their new plans. For example, many switched because they changed jobs or their employer changed insurance offerings, compelling them to switch.

Emphasis added, footnotes omitted.

The underscored language indicates that the Departments' analysis depends on a very unflattering generalization about consumers' motivation, ability and confidence to make their own choices wisely. NFIB does not share the pessimistic view reflected in the broad stereotype of the American consumer on which the Departments chose to rely. Moreover, NFIB does not believe that sweeping and invidious generalizations of this type should have any role to play in formulating regulations under the Act.

Plans Sponsored by Small Businesses are the Grandfathered Plans Most Deserving of Preservation as Grandfathered Plans

When it comes to plans sponsored by small businesses, there is certainly no place for the Department's apparent conclusion that it has a mandate to take choices away from American employees to prevent the possibility of what practitioners of "behavioral economics," academics, survey takers, and others may regard as sub-optimal choices. For obvious economic reasons, the plans offered by the small business community are likely to represent the optimum selection from among any available alternatives. This is so for two reasons.

First, small businesses cannot survive unless they are smart shoppers who systematically seek out the best ratio of value to cost with respect to virtually every good or service they pay for, from cleaning supplies to health coverage. It is completely illogical to believe that a small business owner would spend countless hours after the regular business day is over comparison shopping for miniscule differences in the cost of office supplies, only to select its health plan on a random or heedless basis. This is particularly unlikely to be true when one considers that the vast majority of entrepreneurs are owner-employees. They want to make the best coverage choice possible under prevailing circumstances, not only for the sake of their employees, but for their own sake and the sake of their families as well.

Second, small business tends to attract employees who are very good at making the best decisions possible in response to rapidly-changing circumstances. The same tendency means that the employees of small businesses are more likely to "vote with their feet" if they find that their employer's compensation and benefits package is no longer suited to their individual needs. Thus, over time, employees of small businesses are more likely to align themselves with employers whose plan design decisions, however they are made, best fit employees' perceptions of their overall best interests.

Loss of Grandfather Status Subjects Small Business to New Rules and Regulations That Increase Costs

A concern that has been raised upon reviewing the proposed grandfathering regulations is the economic impact that will be placed on those four out of five small employers who are unable to maintain their grandfathered status. In the event that an employer is forced to transition to a new plan, that employer will also become subject to a new set of requirements that are put upon those who are not considered grandfathered. This has both short-term and long-term cost implications for the employer and employee.

In stark contrast to much of the rhetoric supplied in talking points, fact sheets and press releases, the economic impact on small employers who are forced to surrender their grandfather status is significant. In addition to other requirements that will be placed on all plans – regardless of grandfathering status – plans that lose grandfathered status will immediately pick up two new coverage requirements: coverage of recommended prevention services with no cost sharing; and patient protections such as access to OB-GYNs and pediatricians without a referral by a separate primary care provider. But, those two new requirements are just the beginning. The most significant impact is the plethora of new requirements that these same small employers will be subjected to as the overall healthcare law is fully implemented. As outlined in PPACA, although the final essential benefits package remains to be determined by the regulatory process, PPACA notes that the "Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories: (A) Ambulatory patient services, (B) Emergency services, (C) Hospitalization, (D) Maternity and newborn care, (E) Mental health and substance use disorder services, including behavioral health treatment, (F) Prescription drugs, (G) Rehabilitative and habilitative services and devices, (H) Laboratory services, (I) Preventive and wellness services and chronic disease management and (J) Pediatric services, including oral and vision care."[2]

The effect of these new requirements, in combination with the other requirements that will befall all plans, is certain to have an impact on the cost of those plans. As noted in a June 23 *Wall Street Journal* article, "The U.S. Chamber of Commerce estimates that 20 or so new rules [in PPACA] could raise companies' health bills by 1 percent to 3 percent each." [3]

Although the examination of the essential benefits package will be discussed in future regulatory processes, its composition, and the breadth of requirements outlined in the PPACA will directly affect those losing grandfathered status today because they will become a part of the non-grandfathered population subject too all of these new requirements. While small employers might have some of these requirements in some states, all of the new benefit requirements along with all of these additional changes – minimum loss ratios, capped deductibles in the small group market, and changes to lifetime and annual limits, etc., will have an effect on the overall cost of small employer coverage. As passed, it is highly likely that these combinations of cost factors will result in plans that are more expensive than what small employers are currently purchasing today.

Research by the Council for Affordable Health Insurance (CAHI), reaffirms that cost increases can result from the imposition of new insurance mandates. Consider the following from CAHI's 2009 report on the cost of mandates to the states.

"CAHI's independent Actuarial Working Group on State Mandated Benefits analyzed company data and their experience and provided cost-range estimates — less than 1 percent, 1-3 percent, 3-5 percent and 5-10 percent — if the mandate were added to a policy that did not include the coverage. These estimates are based on real health insurance policies and are not based on theory or modeling. However, mandate legislation differs from bill to bill and from state to state.

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[2] USC18022 Section 1302 (b)(1) pp. 163-164

[3] http://online.wsj.com/article/SB10001424052748703513604575311013340405940.html? "Firms Find Changing Insurance Is Trickier" (Johnson, 2010)

For example, one state may require insurance to cover a limited number of chiropractor visits per year, while another state may require chiropractors to be covered equally with medical doctors. The second will have a greater impact on the cost of a health insurance policy than the first. It would be impossible to make a detailed assessment of the cost of each state's mandates without evaluating each piece of legislation…Although most mandates only increase the cost of a policy by less than 1 percent, 40 such mandates will price many people out of the market. It is the accumulated impact of dozens of mandates, not just one that makes health insurance unaffordable."[4]

For small employers who generally purchase fully-insured health coverage for their employees (as opposed to larger employers who are more able to self-insure their group health plans and thus have more control over what changes are made to their plans), the health insurance providers will be the "actors" making changes to the plans. Therefore, there is a greater likelihood that because health insurers will be under greater pressure to conform their plans or policies to the reform provisions in PPACA, small employers will have little choice but to watch the plan "they like" lose its grandfathered status.

We have heard from many of our members who have already been told that they will lose the plan they have today – meaning they will lose their grandfathered status. The employers are not consciously deciding to give up these plans. Rather, they are being told by insurers that the plan they have and know will no longer be available.

Absence of a small employer perspective is analogous to leaving the largest sector of job creators without representation. In previous years, there has been a movement in Congress to increase awareness about the "one-size fits all" approach to legislating. In response, the Regulatory Flexibility Act, as amended by the Small Business Regulatory Enforcement Fairness Act (SBREFA) was passed so that Congress can more closely examine the impact of regulation on smaller entities. Specifically, under Section 609 (b) procedures are set forth so that "covered agencies" (OSHA and EPA) can convene a Small Business Advocacy Review Panel prior to the agency proposing a rule that will "significantly impact a substantial number of small entities." We recommend that all agencies with jurisdiction over grandfathering regulations conduct some form of a Small Business Advocacy Review Panel prior to the agency finalizing the rules so that it can determine whether these regulations will "significantly impact a substantial number of small entities." Acquiring this small business input is critical to understanding the impact on small business and the best way to mitigate any unintended consequences. If the impact is found to be significant, we further recommend that the agencies halt all rules until alternative arrangements can be proposed, examined and finalized so that small employers will not be adversely and disproportionately harmed.

Regulations Fail to Treat All Members of the Employer Community Equally

Throughout the legislative processes, many accommodations were made to meet the needs or demands of various entities and political interests. One such accommodation was a special rule for grandfathered status for group health plans established pursuant to one or more collective

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[4] http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf "Health Insurance Mandates in the States 2009" Council for Affordable Health Insurance (Bunce and Wieske, 2009).

bargaining arrangement ("CBA"). Section 1251(d) allows such plans to maintain grandfathered status "automatically" until after the last CBA terminates to determine if the plan has lost its grandfathered status. As a result, throughout the life of the CBA, the plan is free to change its terms (as much as it wants) and will not lose its grandfathered status until the last CBA terminates, at the earliest.

NFIB believes that if it was appropriate for the agencies to "balance" policy concerns in formulating the Interim Final Rules, one of the most important policies to be applied should have been fairness, which would have resulted in more even-handed treatment of plans sponsored by small businesses and plans established by collective bargaining agreements. Instead, the Interim Final Rules force an employer sponsoring a non-collectively-bargained plan to choose almost immediately between the extraordinary burdens of regulatory compliance, including the loss of flexibility regarding plan design, or giving up grandfathered status. Collectively bargained plans would not be forced to make that choice until the expiration of the last CBA pursuant to which the plan is maintained. Yet both categories of plans will be exposed to the same market conditions in the years ahead, and neither has a better ability than the other to predict what will happen in that market between now and 2014.

Thus, the disparate treatment of these two categories of plans cannot be justified on the basis of any realistic difference between them. That is why the different treatment of these two categories of plans is one of NFIB's greatest areas of concern.

The ability for small employers to shop for coverage as a response to premium increases is critical to maintaining the offer of employer-sponsored coverage in the small business community. Small employers, like others who offer employer-based coverage, often/frequently shop around for new coverage options and opportunities. According to the Kaiser Family Foundation, 63 percent of small firms (3–199 workers) have shopped for coverage in the past year. Among firms that shopped, 31 percent of small firms have changed the type of health plan. Further, they shop in response to cost pressures. A national survey of small employers found that 45 percent of small employers who shopped for health insurance in the last three years did so in an effort to lower premium costs.

The necessity for employers in the small business community to have maximum flexibility has also been acknowledged by the Administration. A press release issued by the Department of Health and Human Services, notes that small employers "typically buy commercial insurance and frequently make changes in insurers and coverage." The same press release goes on to note that "Limited purchasing power and high overhead often force a trade-off between dramatic changes in benefits and cost sharing and affordable premiums." However, despite the government's acknowledgement of this common practice by employers trapped in such a volatile marketplace, small employers do not retain such freedom or flexibility under the proposed Interim Final Rules.[5]

Small businesses need flexibility and a reduction of regulatory burdens at least as much if not more than large unions and industry groups. In the small business segment of the employment

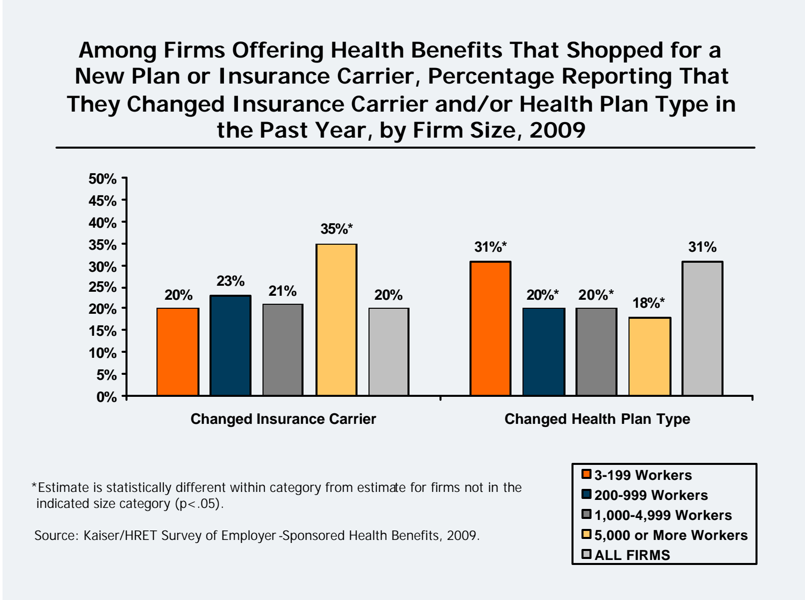
[5] http://www.hhs.gov/news/press/2010pres/06/20100614e.html "U.S. Departments of Health and Human Services, Labor, and Treasury Issue Regulation on 'Grandfathered' Health Plans under the Affordable Care Act" (2010)

arena, the flexibility to make changes between the date of enactment of PPACA and the date that the exchanges are set up in 2014 is especially crucial to maintaining the offer of employer-sponsored coverage in the small business community. NFIB suggests that small employers retain the same opportunity to shop for and switch plans that CBA has under the Interim Final Rule. Like CBA plans, small employers should have the right to exercise this much-needed flexibility without being forced by the government to relinquish their grandfathered status.

Comments Requested to Other Topics for Which Rules Were Not Issued

In its Interim Final Rules, the government specifically asked for interested parties to provide comments on whether four specific changes ought to result in cessation of grandfather status. Those specific changes included: (1) changes to plan structure (switching from a health reimbursement arrangement to major medical coverage, or from an insured product to a self-insured product); (2) changes in a network plan's provider network and what magnitude of changes would have to be made; (3) changes to a prescription drug formulary; and (4) changes to overall benefit design. NFIB offers the following thoughts on two of the categories outlined above.

(1) Changes to plan structure and (2) Changes in a network plan's provider network.
When confronted with increased healthcare costs, small businesses often respond by changing plans and carriers. As depicted in the Kaiser Family Foundation 2009 employer survey, 31 percent of small business owners who offer health benefits and have shopped for a new plan or insurance carrier in the last year changed the type of health plan they offered to their employees. Only 18 percent of the largest employers made these same changes. In regards to changing insurance carriers, 20 percent of small business owners who offer health insurance and have shopped have changed insurance carriers, while 35 percent of the largest insurance carriers have done this.



Changes such as these can often result in a change of networks and providers. When asked, small employers indicated that in the last year they have made changes that have resulted in going to new or different hospitals or doctors to obtain their medical services. The changes outlined in this section only reinforce what we've long heard from employers – increasing, rather than decreasing flexibility and options are critical to maintaining the ability of a small business to offer employer-based coverage. When asked, members have told us that cost is a main reason for their decision to both shop, and in some cases to cease offering coverage to their employees.

For those firms who are still able to offer coverage, the limitations imposed by the grandfathering regulations will likely cause even more business owners to cease offering coverage. Therefore, NFIB strongly recommends against taking additional steps to limit the ever-shrinking amount of options that employers have to adjust costs and still maintain grandfather status. Adopting tighter restrictions on the categories listed above would, in fact, limit those options.

Conclusion

For more than a decade NFIB has been a constructive participant in seeking to develop solutions that bring about lower costs, more choices and greater competition for private insurance. Unfortunately, as drafted, the rules are overly restrictive and create an even stronger likelihood that small businesses faced with unsustainable premium increases may choose to drop their plans prior to 2014. Instead of lowering the number of uninsured Americans, these rules may very likely increase the number of uninsured before the law is fully enacted. Specifically, NFIB remains concerned that the Interim Final Rules:

- Overstep the boundaries of the PPACA and assume that the agencies have been vested with more authority than provided by Congress and the PPACA (Sec. 1251);
- Fail to acknowledge that the Interim Final Rules, as drafted, will increase, rather than decrease cost for small businesses;
- Fail to conduct appropriate research and analysis to evaluate the affect that the Interim Final Rules will have on the small group market where about 15 million employees access coverage today;
- Give preferential treatment to CBA plans by allowing them to switch plans until their final CBA terminates, but doesn't allow small businesses the same flexibility;
- Will force small employers, their employees and families out of the small group market where they are guaranteed an offer of coverage and into the individual marketplace where they can be denied insurance;
- Will force those employers into a new marketplace (created by the PPACA) where they will be exposed to a more expensive insurance marketplace, a greater set of requirements and more expansive regulations; and
- Will increase the uninsured population because there will not be exchanges, insurance reforms or other safety net options so that employers, employees and their families can effectively "bridge" to 2014 when those reforms become available.

Most importantly, neither the PPACA nor these Interim Final Rules address the core problem facing small businesses – the rising costs of healthcare. Instead, the rule does the opposite. It strips small employers of the ability to exercise realistic flexibility to adjust to cost increases in a meaningful way so they can maintain their current plan. The Interim Final Rules should allow for more flexibility to keep more plans in grandfathered status. As written, the rules run counter to the spirit of the law on which they should be based.

Thank you for your time and consideration. Should you require further information, please contact Michelle Dimarob at 202-314-2091.

Sincerely,

Susan Eckerly
Senior Vice President
Public Policy