

**America's Health  
Insurance Plans**

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August 16, 2010

Office of Health Plan Standards and Compliance Assistance  
Employee Benefits Security Administration  
Room N-5653  
U.S. Department of Labor  
200 Constitution Avenue, N.W.  
Washington D.C. 20210  
Attention: RIN 1210-AB42

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

Internal Revenue Service  
Room 5205  
P.O. Box 7604  
Ben Franklin Station  
Washington D.C. 20044  
Attention: REG-118412-10

*Re: Grandfathered Health Plan Interim Final Rule*

Submitted via eRulemaking Portal: [www.regulations.gov](http://www.regulations.gov)

Dear Sir or Madam:

I am writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the *Interim Final Rules (IFR) for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act* published in the *Federal Register* on June 17, 2010.<sup>1</sup> The IFR implements Section 1251 of the Patient Protection and Affordable Care Act<sup>2</sup> (the "Affordable Care Act"), which was signed into law on March 23, 2010.

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<sup>1</sup> 75 Fed. Reg. 34538.

<sup>2</sup> Pub. L. No. 111-148, as amended by Pub. L. No. 111-152.



AHIP is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and have demonstrated a strong commitment to participation in public programs. AHIP members remain committed to the successful implementation of the Affordable Care Act (ACA) and to working collaboratively with other stakeholders to make the process as seamless as possible for consumers. We appreciate the opportunity to comment on this regulatory proposal.

The ACA created a special category of coverage – called grandfathered health plans – to reduce disruption in the market and allow individuals, families, and employers to keep their current coverage. To be eligible for grandfathered status, the consumer or employer must have been enrolled in the coverage on or before the date of enactment of the ACA (March 23, 2010).

As noted in the IFR, “the statute balances its objective of preserving the ability to maintain existing coverage with the goals of expanding access to and improving the quality of health coverage. The statute does not, however, address at what point changes [to grandfathered coverage]...are significant enough to cause the plan or health insurance coverage to cease to be a grandfathered health plan, leaving that question to be addressed by regulatory guidance.”<sup>3</sup> The Departments of the Treasury, Labor, and Health and Human Services (Departments) jointly issued interim final rules in June 2010 providing guidance on how to maintain the grandfathered status of existing coverage.

AHIP members appreciate the allowance, noted in the IFR, for early and voluntary implementation efforts to come into compliance with the reforms established under the Affordable Care Act without impacting the grandfathered status of coverage. In addition, the guidance to states regarding the continued exemption for products that are classified as HIPAA “excepted benefits” is very helpful and will assist stakeholders as we work collaboratively to implement the new federal requirements.

For the reasons that follow, we encourage the Departments to reconsider the current guidance regarding permissible cost-sharing changes to provide individuals, families, and employers with additional flexibility to preserve their grandfathered plans as affordable coverage options. We believe this will be critical to help smooth the transition to the 2014 reformed environment – especially since consumers and employers are unable to make an informed-choice about maintaining their grandfathered coverage until the remaining reform components (e.g., the essential benefit package) are defined. Our members also suggest several areas for further technical clarification to lessen the potential for regulatory uncertainty and to minimize

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<sup>3</sup> 75 Fed. Reg. 34538, at 34540 - 34541.



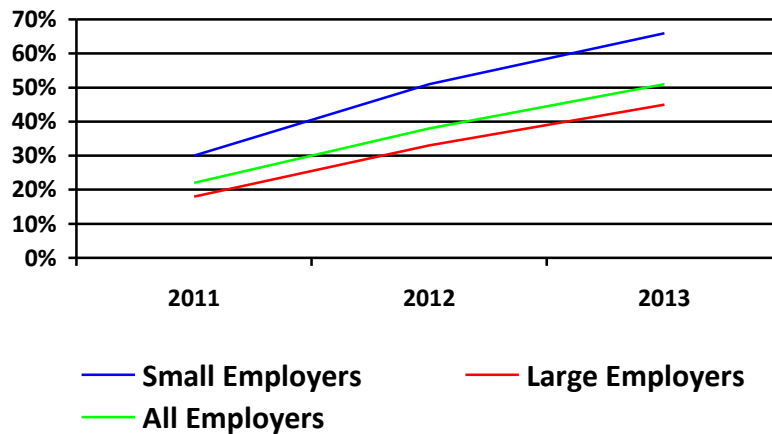
disruption for consumers with existing coverage. We welcome the opportunity to further discuss our concerns and recommendations.

**I. Suggestions to Further Safeguard the Stability of Existing Coverage for Consumers**

**A. Align Benchmarks with Rising Medical Costs and Current Market Trends**

We are concerned about the impact of the permissible cost-sharing changes established under the IFR for existing coverage. The estimates provided by the Departments demonstrate that the IFR's restrictions on changes to grandfathered plans effectively make the benefits associated with this ACA provision temporary, which does not appear to be the intent of this provision. The graph below highlights the data from the IFR – estimating that more than half of all employers, and two-thirds of all small employers, will relinquish their grandfathered coverage by the end of 2013.

*Mid-Range Estimates of Cumulative Percent of Employer Plans Relinquishing Grandfathered Status<sup>4</sup>*



The Departments also estimate that the percentage of individual market policies losing grandfathered status in a given year will likely exceed the 40 to 67 percent range. As such, the structure of the grandfathered IFR could cause disruptions for employers who are struggling to provide coverage to their workers and for individuals and families who wish to keep their existing coverage.

Our members are also concerned that the selected benchmark – the medical component of the Consumer Price Index (Medical CPI) – simply measures the

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<sup>4</sup> 75 Fed. Reg. 34553.



inflationary component of prices charged for a defined group of services. It does not include other major factors that drive increases in health care spending, such as increased utilization, the needs of an aging population, and the development of new medical technologies and prescription drugs. As a result of these other factors, the cost of providing health benefits increases significantly above Medical CPI.

Finally, we note that the proposed benchmark represents a significant departure from market trends regarding voluntary employer changes to a plan's cost-sharing features to maintain affordability of coverage in response to rising medical costs. Data from the Kaiser Family Foundation demonstrate that the percentage change in average deductible levels have, over time, increased at rates much higher than allowed under the IFR (a cumulative 15 percentage points plus Medical CPI). In addition, coinsurance obligations have been on the rise, at a much slower pace, under employer plans over the course of the last five years. Consumers in the individual market similarly adjust plan cost-sharing features to keep their premiums stable.

The following tables examine the application of the permissible cost-sharing changes to the data from the Kaiser Family Foundation for average deductible and coinsurance (for hospital admissions) changes to employer Preferred Provider Organization (PPO) plans from 2004 – 2008.

*Average Deductible Changes – Employer PPO Plans<sup>5</sup>*

	<b>Small Employer Average Deductible</b>	<b>Estimated Allowable Change under IFR</b>	<b>Percent Difference – Average vs. Estimate</b>
2004	\$420	-	-
2005	\$469	\$482	3%
2006	\$673	\$517	-23%
2007	\$667	\$532	-20%
2008	\$917	\$553	-40%

	<b>Large Employer Average Deductible</b>	<b>Estimated Allowable Change under IFR</b>	<b>Percent Difference – Average vs. Estimate</b>
2004	\$232	-	-
2005	\$254	\$264	4%
2006	\$375	\$286	-24%
2007	\$382	\$294	-23%
2008	\$413	\$305	-26%

<sup>5</sup> Kaiser Family Foundation Employer Health Benefits Annual Survey (2004 – 2008), as available on the internet, accessed on August 12, 2010, at <http://ehbs.kff.org/>



*Average Coinsurance Changes for Hospital Admissions – Employer PPO Plans<sup>6</sup>*

	<b>All Employers Average Coinsurance</b>	<b>Estimated Allowable Change under IFR</b>	<b>Percent Difference – Average vs. Estimate</b>
2004	16%	-	-
2005	16%	None	0%
2006	17%	None	-1%
2007	17%	None	-1%
2008	17%	None	-1%

**Recommendation: We therefore request reconsideration of the selected benchmark and accompanying standards for permissible cost-sharing changes to allow consumers to preserve their existing grandfathered plan as an affordable coverage option.**

**B. Allow Changes to Prescription Drug Formularies and Provider Networks**

The availability of new prescription drugs, newly available generics, advances in medical knowledge and research regarding drug therapies, and opportunities for improving patient safety necessarily requires regular changes to prescription drug formularies. Modifications should be allowed, without impacting the grandfathered status of coverage, to ensure the provision of high-quality, low-cost prescription drug coverage.

Similarly, the maintenance of provider networks should be allowed without relinquishing the grandfathered status of coverage. Changes are made to networks on a regular basis to expand the network to include additional providers, improve quality, and address other changes (e.g., provider's relocation outside the service area, change in practice, or retirement). Individuals and families benefit from the establishment of provider networks that promote quality and patient safety, along with access to a broad selection of health care professionals at a contractually-discounted reimbursement rate.

**Recommendation: We suggest the Departments clarify that such changes made to prescription drug formularies and provider networks continue to be allowed, without impacting the grandfathered status of coverage, to ensure the provision of high-quality, low-cost coverage.**

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<sup>6</sup> Ibid.



## **II. Additional Technical Comments for Consideration**

### **A. Clarify the Scope of the Grandfathered Plan ACA Requirements**

Our members greatly appreciate the discussion in the preamble of the IFR regarding the scope of the new federal requirements – the application of the ACA market reforms to comprehensive, major medical insurance only and not to products that are classified as “excepted benefits” under subsection 2791(c) of the Public Health Service Act.

**Recommendation: We ask that the same recognition also be incorporated in the text of the grandfathered health plan regulations.**

### **B. Protect Grandfathered Status of Coverage for Administrative Changes**

The IFR includes a specific invitation for comments from the Departments on whether certain changes should result in the loss of grandfathered status of coverage. This included changes in a provider network and prescription drug formulary – we refer to our above comments and suggestion that these types of changes should not impact grandfathered status – as well as changes to plan structure (such as switching from an insured to self-funded financing arrangement).

As noted in the IFR, the ACA was intended to allow individual consumers and employers the flexibility to preserve their existing coverage. We suggest that administrative changes made to a plan that do not otherwise impact the underlying benefits should not impact the grandfathered status of the coverage. Specifically, we encourage the Departments to allow changes to: (1) the contractual structure of the plan (e.g., movement from a medical policy with a dental rider to a medical policy with a separate dental policy), (2) to the selection and utilization of third-party vendors (e.g., wellness, behavioral health organizations, pharmacy benefit managers, and rental network vendors); and (3) the financing arrangement for coverage (e.g., movement from self-funded to fully-insured coverage and vice versa).

**Recommendation: To promote flexibility for consumers and continued innovation in the market, we suggest that the above noted types of administrative changes should not result in the loss of grandfathered status, so long as the modifications do not impact the underlying benefits or otherwise exceed the permissible thresholds established under the IFR.**



C. Issue Further Clarification to Minimize Disruption for Consumers with Existing Coverage

The Departments can further minimize the potential for disruption to existing coverage by minimizing the litigation and enforcement risks associated with the complex grandfathered health plan regulations. This can be accomplished through issuance of further clarification. We encourage consideration of all of the following topics as areas to provide more regulatory certainty:

- only require prospective (not retrospective) changes to grandfathered plans when a plan sponsor or health insurance issuer, acting in good faith, is challenged on its modification to the coverage or benefit structure of the grandfathered plan;
- clarify that only those changes specifically proscribed by the IFR would cause a loss of grandfathered status;
- confirm that changes made by a plan sponsor or health insurance issuer in response to federal or state guidance (e.g., the guidance issued by the U.S. Department of Labor on implementation of the mental health parity rule) will not impact the grandfathered status of coverage;
- provide parity in the treatment of annual limit requirements under the grandfathered IFR with the ACA restrictions on annual limits with a clarification that the IFR guidelines on “changes in annual limits” do not apply to such limits for non-essential benefits<sup>7</sup>;
- acknowledge that changes made to rewards or other incentives used in connection with bona fide wellness programs will not cause the loss of grandfathered status; and
- clarify that the transitional rules established under the IFR<sup>8</sup> protect existing contractual rights in the individual market (e.g., premium affordability features that allows consumers to increase cost-sharing in order to maintain stable premiums) and allow the consumer to exercise those rights without impacting the grandfathered status of the plan.

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<sup>7</sup> The “changes in annual limit” requirements are established under 54 CFR §54.9815-1251T(g)(1)(vi), 29 CFR §2590.175-1251(g)(1)(vi), and 45 CFR §147.140(g)(1)(vi).

<sup>8</sup> The transitional rules are established under 54 CFR §54.9815-1251T(g)(2)(ii), 29 CFR §2590.175-1251(g)(2)(ii), and 45 CFR §147.140(g)(2)(ii).



**Recommendation: To preserve the availability of existing insurance and promote additional choices of affordable coverage options for individuals, families, and employers, we request the issuance of further clarification to address the above items to enhance the current guidance and provide more regulatory certainty for the implementation process.**

*D. Promote the Uniform and Consistent Application of the Grandfathered Plan Provisions*

Finally, we suggest that the Departments consider issuing additional guidance to promote the uniform and consistent application of the grandfathered plan provisions. The uniform application of these provisions can help ensure that all consumers receive the same level of protections with respect to the right to preserve existing coverage options, regardless of the consumer's residence. Guidance from the Departments also can help alleviate the administrative burdens and associated costs with multiple, potentially overlapping and conflicting, state-specific requirements.

**Recommendation: We suggest issuance of guidance on the following topics: (1) plan sponsors and health insurance issuers are permitted to provide coverage with different benefits under a single policy form so long as the differences are directly attributable to the grandfathered status of coverage; and (2) the date for determining the grandfathered status of coverage purchased through an association or trust is the date that the individual consumer or employer secured coverage (not when the association or trust health arrangement or insurance is established).**

**In addition, we also support our employer-consumers in asking the Departments to reconsider the scope of the safe-harbor provided to collective-bargaining arrangements (CBA) to provide parity in the treatment of self-funded and fully-insured plans by allowing CBAs ratified before March 23, 2010, to qualify as grandfathered coverage until the CBA terminates.**

AHIP members support granting employers, individual consumers, and families stronger protections to maintain their existing plan and provide greater stability of coverage. We therefore encourage the Departments to consider the above suggestions for clarifying the ACA grandfathered health plan protections.



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Our members remain committed to our continued collaboration and dialogue with other stakeholders and interested parties throughout the implementation process. We welcome the opportunity to meet with you to discuss our concerns and recommendations in more detail. Thank you for the opportunity to comment on this regulatory proposal.

Sincerely,

A handwritten signature in black ink, which appears to read "Jeffery L. Gabardi". The signature is written in a cursive, flowing style.

Jeffery L. Gabardi  
Senior Vice President, State Affairs