UPMC HEALTH PLAN

August 16, 2010

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

Re: 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/Madam:

UPMC Health Plan is pleased to submit the following comments in response to the Interim Final Rule on Status as a Grandfathered Health Plan, implementing Section 1251 of the Patient Protection and Affordable Care Act ("PPACA" or "the Act").

Introduction

The purpose of the Interim Final Rule regarding grandfathered plans ("IFR") is "to ease the transition of the healthcare industry into the reforms established by the Act by allowing for gradual implementation of reforms through a reasonable grandfathering rule...." As stated in the IFR's preamble, by providing that some but not all rules apply to grandfathered coverage, the statute seeks to balance the goals of preserving the right to maintain existing coverage with those of expanding access to and improving the quality of health coverage. Accordingly, consideration as to which changes should result in a loss of grandfathered status must be carefully considered with these basic principles in mind.

1. Change in Carrier

The purpose of Section 1251 is to preserve the ability of individuals to maintain their existing coverage while pursuing the goal of ensuring access to affordable essential coverage and improving quality. We do not believe that a change in insurance carrier should by itself force a Plan to forfeit is grandfathered status; changing carriers and maintaining existing coverage are not mutually exclusive. We believe that, if a Plan is dissatisfied with its existing carrier for reasons of cost, customer service, quality, or countless other reasons, it should be permitted to change carriers and maintain grandfather status, provided that the benefit design, level of coverage and quality remains the same (or improves). It is our fervent belief that the quality of the benefits and not the means by which covered individuals access that coverage is what should be protected. A rule to the contrary could run afoul of PPACA's stated goal to improve the quality of services offered to individuals; it would arguably force a Plan to stay with a sub-standard carrier simply to maintain grandfather status. We do not believe that this is the intent of the Act.

Moreover, while we agree that covered-individuals should be permitted to maintain the health benefits with which they are satisfied as contemplated by the Act, we do not believe concurrently locking those

individuals to their current carriers is the intent of the Act. Plans should be permitted to seek out those carriers that offer the most cost effective, clinically sound, and actuarially similar coverage for their covered-individuals. We believe that allowing carrier change will allow grandfathered Plans much-needed flexibility in their choice of coverage without destroying the principal purposes of the grandfathering provision in general.

Finally, we note that, for the reasons set forth above, changes to plan structure (e.g. fully insured to a self-funded arrangement) that do not result in a reduction of benefits to covered individuals should likewise not result in a loss of grandfathered status.

2. Network Changes

While we acknowledge the importance of maintaining prescribed boundaries within which grandfathered Plans may makes changes, we do not believe that a Plan's provider network is an appropriate target for limits, and certainly not for strict limits.
Provider networks are generally vetted and reviewed by the State for adequate access, and changes are most often made in response to Fraud, Waste and Abuse concerns or to increase access. Certainly a strict prohibition against network changes would severely threaten a Plan's ability to reduce costly fraud and abuse, which would run squarely foul of the Act's primary goals. It may also harm rather than help covered individuals, as, presumably, even network changes made to expand a network's breadth or quality could trigger loss of grandfather status; limiting loss of grandfather status to those actions taken by Plans for reasons other than expanding or improving the network would place overseers in the difficult position of having to judge which changes were improving and which harming network quality.

A strict prohibition against network change will run afoul of the stated purpose of PPACA in other ways. It has been well documented that changes to the manner in which health care is delivered in the United States are necessary. It is expected that, both directly and indirectly, PPACA will reform (and perhaps revolutionize) the manner in which care is provided, including through accountable care organizations. Changes of this nature will be severely thwarted by any prohibition against network change; this is clearly contrary to the very intent of the Act.

Even conditioning loss of grandfather status only to "material changes" to a provider network is of concern and is arguably unnecessary. First, mechanisms already exist at the State levels to discourage such changes; Plans must maintain network adequacy or risk loss of ongoing licensure. Moreover, one would assume that only material changes made for reasons other than to improve network adequacy would be targeted. This, of course, would present potentially unworkable administrative and practical challenges and beg the question "who decides" the reason for which a change is made? Federal monitoring of provider networks would be administratively cumbersome and, given the ability of States to intervene in network matters, duplicative. For all these reasons we request that the Departments refrain from conditioning grandfather status on network change.

3. Formulary Changes

Similar to our position above with regard to provider networks, we do not believe that a drug formulary is an appropriate target upon which to condition grandfather status. Drug formulary management is a critical tool in managing clinical efficacy as well as costs for any Plan that offers prescription drug benefits. We acknowledge the importance of protecting consumers from any attempt by a Plan to arbitrarily use formulary management as a means by which to cut meaningful benefits purely for money-saving purposes. That said, we believe that conditioning grandfather status

on a strictly static formulary would be harmful to all stakeholders. New and better drugs (brand and generic) enter the market on an ongoing basis and evidence-based information relative to post-launch drug use, surveillance and efficacy is ever evolving. Prohibiting formulary-change may harm more than help covered-individuals by reducing the quality and clinical adequacy of the drugs contained thereon.

Moreover, limiting loss of grandfather status only to formulary-changes made for reasons other than to improve the scope or quality of drugs offered would present significant administrative and practical challenges. Accordingly, we hope that the Departments will refrain from conditioning grandfather status on the absence of formulary change.

4. Benefit Changes

The IFR provides that loss of grandfather status will result from "the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits." As written, grandfather status arguably would be lost if a Plan eliminated coverage for a single treatment of a condition though countless other (perhaps more effective) treatments remained covered. Because clinical recommendations surrounding new treatments and information on the efficacy of existing treatments is constantly evolving, we do not feel that equating "any" with "all" is in the clinical best interests of covered-individuals. Such a prohibition would discourage Plans from wisely limiting diagnostic and treatment modalities to only those most effective for fear of losing their grandfathered status. Moreover, a concession by the Department that grandfather status would only be lost if the elimination of a benefit was made for reasons other than for clinical efficacy would be administratively and practically unworkable and would potentially impair a Plan's ability to effectively manage care.

We note as well that, before a prohibition of the elimination of "any necessary element" to diagnose or treat a condition should result in the loss of grandfather status by a Plan, further clarification as to what is meant by "any necessary element" would be necessary.

Having shared our concerns, please understand that we do agree with the importance of the rule in prohibiting the elimination of "all benefits" to diagnose or treat a single condition. We believe that this may be a workable standard, which would not present the administrative and practical challenges posed by the more restrictive approach set forth above. We would argue, however, that Plan discretion as to which "conditions "are capable of a meaningful response to medical intervention should remain intact.

5. Cost-Sharing Limits.

The IFR limits permissible cost-sharing changes with respect to deductibles and out-of-pocket maximums to 15% plus the annual cost of medical inflation. The medical component of the Consumer Price Index (Medical CPI) measures the inflationary component of prices charged for a fixed group of medical services. It does not, however, consider or include any of the other factors driving increases in health care spending. For example, it is not unreasonable to assume that some of the changes required by PPACA will result in increased utilization of medical services, which may drive up the costs associated with providing medical care. Likewise, the aging population and the development of new medical technologies may similarly result in increased costs. Accordingly, we respectfully submit that the Medical CPI is an inadequate measure of the cost of providing health benefits to covered-individuals.

Conclusion

For the reasons set forth above, we respectfully request that you consider our comments in formulating final regulations. We thank you in advance for your time and consideration in these regards.

Daniel Vukmer
Vice President & General Counsel