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

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

To Whom It May Concern:

The U.S. Chamber of Commerce (the “Chamber”) is submitting these comments 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 (“IFRs” or “regulations”), which were published in the Federal Register on June 17, 2010.¹ The IFRs provide guidance pursuant to the statutory language of the Patient Protection and Affordable Care Act (the “Affordable Care Act”) and the Health Care and Education Reconciliation Act (the “Reconciliation Act”). As with other guidance under these Acts, the IFRs were published jointly by the Department of the Treasury, the Department of Labor and the Department of Health and Human Services (the “Departments”).²

The Chamber is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. These comments have been developed with the input of member companies with an interest in improving the health care system.

¹ Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538–70 (June 17, 2010) (to be codified at 26 C.F.R. pts. 54 & 602; 29 C.F.R. pt. 2590; 45 C.F.R. pt. 147) [hereinafter Grandfathered Health Plans].

² Pursuant to the request in the IFRs, the Chamber is submitting these comments to one of the Departments - The Department of Labor, with the understanding that these comments will be shared with the Department of Health and Human Services and the Department of Treasury as well.

The Chamber recognizes the very difficult undertaking by the Departments in connection with the IFRs and supports the Departments' articulated general intentions and objectives, as stated in the preamble to the IFRs. However, the specific requirements delineated in the IFRs, as written, are inconsistent with the fundamental principles of health reform. Not only do the regulations frustrate the Administration's laudable promises to those covered by existing plans in the individual and group market, but they also undercut the admirable principles of health reform and far exceed the statutory language that authorizes their very promulgation.

Among our specific concerns are the IFRs' restrictions on changes in cost-sharing and changes in policy issuers. Our comments explain the critical importance of affording plans flexibility with regard to: financing changes; plan election structure; and, the incorporation of wellness programs. Finally, our specific comments elaborate on: the need for procedural clarifications as plans lose grandfathered plan status; the unnecessary imposition of a new disclosure requirement; nuances to be considered in the application of the anti-abuse provision; the importance of clarifying the definition of a plan; and the critical validation that the final regulations (when issued) will contain an exhaustive list of any and all prohibited plan changes that would result in the loss of grandfathered plan status. We also comment on particular topics pursuant to the IFRs' specific requests.

FUNDAMENTAL PRINCIPLES

Laudable Promises and Objectives:

We support the promise made by the Administration and the general objectives the Departments articulated in the regulations.

Most importantly, we appreciate the Departments' initial stated commitment to "provide rules that plan sponsors and issuers can use to determine which changes they can make to the terms of the plan or health insurance coverage while retaining their grandfathered status, thus... fulfilling a goal of the legislation, which is *to allow those that like their health care to keep it.*"³ This reiterates the goal that was clearly, consistently and repeatedly articulated by the Administration in the days leading up to, and immediately following, the passage of the Affordable Care Act and the Reconciliation Act.

This commitment is again asserted in the preamble: "[t]hese interim final regulations are *designed* to allow individuals who *wish to maintain their current health insurance plan to do so*, to reduce short term disruptions in the market, and to ease the transition to market reforms that phase in over time."⁴ We support and concur with the Departments' recognition "that many plan sponsors and issuers make changes to the terms of plans or health insurance coverage on an annual basis: Premiums fluctuate, provider networks and drug formularies change, employer and employee contributions and cost-shifting change, and covered items and services may vary. Without some ability to make some adjustments while retaining grandfathered status, the ability of individuals to maintain their current coverage would be frustrated."⁵ This clearly establishes a

³ Grandfathered Health Plans, 75 Fed. Reg. at 34,546 (emphasis added).

⁴ Id.

⁵ Id.

context for the “keep your plan” promise and appears to illustrate an understanding of, and appreciation for, the need for plan changes from year to year. Plans evolve constantly and if individuals want to keep the coverage that they have (and have had), then individuals will necessarily want their plans to be able to continue to evolve and adapt with the customary changes that plans typically make. The Departments are right to acknowledge the importance of this flexibility, which is a critical component to keeping the promise made to America both by Congress and the Administration. The Chamber supports these stated intentions and objectives.

Certainly, while we appreciate the Departments’ understanding that fluctuations and modifications are unavoidable and inevitable, we also understand the need for parameters. While change must be permitted to ensure the fulfillment of the promise, it also cannot be unlimited and unbridled. We understand that “allowing [plans to make] unfettered changes while retaining grandfathered status would be inconsistent with Congress’s intent to preserve coverage that was in effect on March 23, 2010.”⁶ The challenge is in balancing the need for moderate change while preserving the ability of individuals to keep existing plans. This is where we believe the approach taken by the Departments in the IFRs errs. In fact it appears, from the approach taken in the IFRs, the Departments have decided to scrap the promise, despite giving mention to it, in favor of overriding the statute.

Promises and Intent Frustrated By Approach

The regulatory approach taken by the Departments undermines the possibility of fulfilling the Administration’s promise and the stated intent of the regulations.

While we appreciate the importance of reading the Administration’s promise in context,⁷ the Chamber disagrees with the Departments’ next step. In defining permitted changes so prescriptively, the Departments’ approach not only goes beyond the intent of the statute, but makes the Administration’s promise impossible both for those offering coverage and those wishing to keep their current coverage. In the IFRs, the Departments choose to assess plans (and, by extension, the Departments’ commitments to the “keep your coverage” promise) using a “snapshot” perspective and comparing any fluctuations in a plan to the *precise* plan in existence on March 23, 2010. With this approach, the IFRs essentially ensure that all plans will lose grandfathered status within a couple of years.

The Departments’ approach, which will frustrate the stated design and purpose of the statutory provisions and the regulations that attempt to implement it, is confirmed in the preamble.

These interim final regulations are designed to *ease the transition* of the healthcare industry into the reforms established by the Affordable Care Act by

⁶Id.

⁷ Id. As the IFRs themselves specifically recognize, the relevant context is that coverage in effect on March 23, 2010 had previously evolved and must be expected to continue to develop further over time without ceasing to be your coverage. “Without some ability to make some adjustments while retaining grandfathered status, the ability of individuals to maintain their current coverage would be frustrated.”

allowing for *gradual implementation of reforms through a reasonable grandfathering rule.*⁸

Therefore it appears that, in the Departments' view, the grandfathered plan rule is to be merely a transition rule. In other words, "If you like your plan you can keep your plan, for a while." This is not what the Administration promised and is not what Congress intended. There is no basis for this position in the language of the statute.

Principles of Reform Undercut

The regulations threaten the laudable principles of health reform and, instead, may impede the goals of expanding coverage options, promoting competition, encouraging innovation and empowering American consumers.

Beyond undermining the intent and purpose of the specific provisions which these regulations are written to implement, the approach taken in these regulations frustrates even the general principles of the health reform law. The policy goals of health reform were to: expand coverage options; provide consumers with more power, information and choices; promote competition, and; encourage innovation both in the coverage and in the provision of health care services. These laudable policy goals are thwarted by the regulations which were designed to preserve current valuable coverage options available for Americans. These regulations instead lock individuals into their current choices, thereby limiting competition. By tightly prescribing the changes plans can make, the IFRs are instead anti-consumer and anti-innovation. The regulations effectively punish plans that attempt to adopt and incorporate medical advances, evidence-based medicine and value-based purchasing efforts.

To reconcile the worthy elements of reform while honoring the stated intent and promise, these regulations must instead preserve the ability of plans to change in a way that improves consumer choice, strengthens innovation and encourages competition. Just as the regulations permit grandfathered plans to voluntarily conform to insurance reform provisions without losing grandfathered plan status, it is equally important to permit grandfathered plans to incorporate other laudable elements of health reform. As touted and advocated for in health reform, practices that advance pro-consumer, pro-choice, pro-innovation principles and goals should be widely adopted. Grandfathered plans must be permitted to innovate by: incentivizing wellness activities; rewarding high quality health care providers; incorporating evidence-based medical treatments into benefit plans; and, responding to the needs and desires of plan participants and enrollees.

Far Exceeds Statutory Language

The prescriptive regulations exceed the more global and deferential language in the Statute.

The Affordable Care Act contains a very simple grandfathered plan rule essentially legislating the Administration's promise: "[n]othing in the Act shall be construed to require that an individual terminate coverage...in which such individual was enrolled on the date of

⁸ Grandfathered Health Plans, 75 Fed. Reg. at 34,541 (emphasis added).

enactment.”⁹ The provision specifies that the majority of the health insurance market reforms shall not apply to grandfathered plans and allows new family members and new employees to enroll in grandfathered plans.

Neither Section 1251, nor any other provision of the Affordable Care Act, discusses the loss of grandfathered plan status. In previous legislative reforms, when Congress intended grandfathered status to be terminable, that intention was clearly stated in the law. As an example, deferred compensation reform legislation specifically included language describing when a grandfathered plan would lose grandfathered status. Specifically, in October 2004, Internal Revenue Code Section 409A was enacted to reform the tax treatment of nonqualified deferred compensation paid to employees and independent contractors by entities to which they provided services. The statutory language which permitted existing deferred compensation plans to be grandfathered also specifically stated that this grandfathered plan status would continue unless the plan was materially changed.¹⁰ Significantly, before the Affordable Care Act and the Reconciliation Act were passed, ***other health reform legislation considered by Congress included far more prescriptive grandfathering provisions*** and limited the duration of grandfathered plan status to a definitive period of time. ***This approach was specifically rejected by Congress.***¹¹

Based solely on the statute, the absence of a provision describing ***how*** grandfathered status may be lost suggests one of three possibilities: (1) grandfathered status may never be lost; (2) any change to a grandfathered plan other than the two specifically mentioned in the statute (enrolling new family members or new employees) will cause a loss of grandfathered status; or (3) a plan will retain grandfathered status unless it is terminated, or modified in such a way that it is effectively no longer the same plan that was in effect on March 23, 2010. Because the first of these alternatives would make significant portions of health reform inapplicable to any existing plan (something that we could expect to be much more clearly stated, if it were the case) and the second alternative would make the administration’s “keep your coverage” commitment wholly illusory, the third alternative is the appropriate way to apply the grandfathered plan concept.

Instead, through regulations, the Departments have designed a complex approach that looks at each plan change in isolation. This approach (despite acknowledgement in the preamble to the contrary) fails to consider: the typical kinds of changes that have been made in the past; the overall impact of the plan changes (some of which may be beneficial) on participants; or the reasons for the changes. It is incongruous that these nuances are not considered, particularly

⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1251(a), 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 2301(a), 124 Stat. 1029 (2010).

¹⁰ See American Jobs Creation Act of 2004, Pub. L. No. 108-357, § 885(d)(2), 118 Stat. 1418 (2004) (providing Section 409A does not apply to compensation deferred on or before December 31, 2004, unless “the plan under which the deferral is made is materially modified. . .”).

¹¹ See Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, H.R. 3962, 111th Cong. §202(a)(1)–(3) (2010). As passed by the House of Representatives, H.R. 3962 designated that grandfathered plan status would be lost for insured arrangements if: new enrollees (other than dependents of existing enrollees) entered the plan; or if plan provisions “including benefits and cost-sharing” changed. Employment based plans could only be grandfathered for a five year “grace period.” After five years, grandfathered plans would then be required to “meet the same requirements as apply to a qualified health benefits plan under section 201, including the essential benefit package requirement under Section 221.”

given that each of these important elements contributes significantly to the appropriate maintenance of a plan in the face of usual changes and advances.

We appreciate and support the laudable promise of the Administration and the overarching objectives of health reform. Our general concern remains that these regulations, which purport to implement this promise as legislated in statute, negate it entirely instead. The regulations go far beyond the statute and, in doing so, destroy the very protection it created for people who want to keep their current plan. In addition to highlighting our overall concern with the impact the regulations will have on crucial shared policy goals and promises, our comments will also highlight specific nuanced concerns on precise points.

SPECIFIC CONCERNS

Our specific comments not only reiterate the disparity between the commitment made by the Administration and the Departments' approach in the IFRs, but also target more precise elements that must be changed or clarified if the Departments' current approach is to be followed. Grandfathered plans *must* be permitted to make certain changes to ensure their fiscal solvency as they comply with the new insurance requirements. The following are our specific concerns:

1. Changes in Cost-Sharing. Grandfathered plans *must* be permitted to make necessary and appropriate changes in cost-sharing, provided the fundamental underlying coverage remains intact. By so severely restricting changes in cost-sharing, the regulations will effectively force plans to lose grandfathered status in order to remain solvent (as utilization and costs increase) and innovative (as treatment and technology advance). There are four fundamental problems with the cost-sharing provisions in the regulations. First, the regulations fail to consider the historical context and basic methodology and purpose behind the imposition of cost-sharing. Second, the regulations use a snapshot approach and compare all changes to the plan's cost-sharing structure in effect on March 23, 2010 without appropriately accounting for year to year cumulative plan cost changes. Third, the regulations use an inappropriate benchmark which fails to incorporate the increases in the cost of the plan. Fourth, the regulations rely on this inappropriate benchmark to prohibit increases in percentage coinsurance changes. Because of the regulations' approach on the issue of changes in cost-sharing, plans will be eventually forced to choose between fiscal solvency and retaining grandfathered plan status.

Historically, employers have voluntarily paid an overwhelming portion of health care expenses.¹² Reimbursement methodologies and mechanisms have evolved to educate and engage consumers as they become more involved in making health care decisions and treatment choices. Plans revise formularies, and consequently cost-sharing rates and mechanisms, to reflect the availability of new less expensive generic pharmaceuticals, new treatment options and technological developments. Plans must be permitted to make changes that incorporate outcome-supported scientific or technological developments, as well as changes that improve

¹² For 2009, on average, employers paid 83% of the cost of employee-only coverage and 73% of the cost of family coverage. The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2009 Summary of Findings*, at 1 (2009) (available at <http://ehbs.kff.org/>) [hereinafter KAISER AND HRET]. The overall percentage paid by employers was virtually unchanged over the 1999-2009 period (with employers paying 73.4% in 1999 and 73.8% in 2009).

health care quality or desired utilization (e.g., a desire to incentivize the use of high-performing providers). Cost-sharing methodologies must be permitted to continue to evolve, allowing consumers and employers to explore different approaches to ensure more effective use of their funds to pay for health care. The regulations, as they are written, effectively reward a plan that avoids incorporating outcome-supported treatments, new evidence-based medicine, or cost-cutting measures. To deny grandfathered plans the ability to make such changes contradicts the very intent of health reform generally and the goals of this statutory provision, specifically. Congress and the Administration recognize that these are key elements in the effort to hold down health care costs and improve the quality of care. Forward-thinking plans should not risk losing grandfathered status or be forced to balance that status against sound plan design considerations.

Although the regulations highlight the importance of flexibility,¹³ the Departments adopt an isolated “snapshot” approach to analyzing future cost-sharing changes. Instead, the IFRs should employ an overall cost-sharing approach that assesses whether “your coverage” is still intact. Changes in cost-sharing must be evaluated on a multi-year basis, looking at average annual percentage changes over a number of years, to take into account the manner in which plans have typically changed over time. The Affordable Care Act did not mandate a reference back to the costs in effect on the date of enactment.

Restricting permissible cost-sharing increases to medical inflation (as defined in the regulation) plus 15% is not workable.¹⁴ Simply, medical inflation is not a measure of the increases in plan costs.¹⁵ Medical inflation does not reflect the utilization of services by persons enrolled in a plan, or plan “intensity” (which is a measure of the degree to which certain lower-cost services are replaced by similar but more expensive services). By comparing all cost-sharing increases to the plan’s cost-sharing structure as in place on March 23, 2010, the troublesome affect of this inappropriate benchmark is compounded. It seems that the IFRs are redefining cost-sharing. Cost-sharing, both flat dollar copayments and percentage co-insurance rates, is just that – cost-sharing; it must inherently reflect and be tied to the costs of coverage. Premiums increase at nearly 10% a year in the large employer market; to tie cost-sharing to medical inflation plus 15% fulfills the fundamental troubling assertion in the regulations that grandfathered status will be fleeting. This is not only contrary to the Administration’s promise but contradicts the language in the statute. The Affordable Care Act did not mandate a reference back to the medical inflation in effect on the date of enactment.

¹³ Grandfathered Health Plans, 75 Fed. Reg. at 34,546 (“These interim final regulations are designed to take into account reasonable changes routinely made by plan sponsors or issuers without the plan or health insurance coverage relinquishing its grandfathered status.”).

¹⁴ Grandfathered Health Plans, 75 Fed. Reg. at 34,561 (to be codified at 26 C.F.R. § 54.9815-1251T(g)(3)(i)) (“Medical Inflation means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982-1984 base of 100.”).

¹⁵ Over the 1999-2009 period, the average annual health insurance premiums for employer-sponsored coverage, which equates with plan costs, increased 131%. KAISER AND HRET, *supra* note 12, at 1. This is approximately a 9% compounded annual growth rate. Over the same period, the Medical Care Component of the CPI increased approximately 50%, which equates to a compounded annual growth rate of around 4%. See Consumer Price Index, Buck Consultants (2010) (available at http://www.buckconsultants.com/buckconsultants/Portals/0/documents/publications/newsletters/key_indicators/cpi.pdf).

We also disagree with the reasoning in the regulations that led the Departments to conclude that co-insurance increases should not be permitted.¹⁶ Co-insurance, a cost-sharing methodology that is based on a percentage of the cost of a health care service or good, must be permitted to change to reflect the changes in the cost of a plan. The cost of a plan does not increase solely due to medical inflation but based on utilization and other factors; percentage cost-sharing or co-insurance must reflect the actual increases in the plan's costs. Co-insurance values will reflect the change in the value of a dollar (i.e. medical inflation), but this will not reflect changes in the cost of the plan. For this reason, it is critical that plans be permitted to change co-insurance amounts and percentages as well.

2. Changes in Policies and Plan Financing. All plans should be permitted to change policies and issuers. This change is necessary to ensure that plan fiduciaries can continue to discharge their duties under ERISA; the primary focus must continue to be on the benefits provided to participants. Locking employers and consumers into staying with policy issuers in order to maintain grandfathered status is inconsistent with the clear support of Congress and the Administration for grandfathered plan status. Instead, this creates a situation in which plans must choose between paying increased premiums without shopping for alternative coverage, or losing grandfathered plan status. It eliminates the downward pressure on costs that results from the ability of businesses to consider switching insurers. Insured plans should not be treated any differently than self-insured plans; the identity of the policy issuer (insurance company) is no more important to most participants than the identity of the third party administrator (TPA) in a self-insured plan. Similarly, the financial structure of a plan should not affect grandfathered status. Coverage, as experienced by the enrollee and participant, may be identical regardless of whether the plan is insured or self-insured. The direct impact on the consumer is negligible and, in fact, in many instances, these types of changes are necessary to preserve the ability of individuals to keep the plan they have, if they want to.

3. Changes to Benefit Election Tier Structures. Plans must be permitted to make some structural changes without losing grandfathered plan status to ensure plan solvency as plans comply with the new insurance requirements. The interim final rules issued on the coverage of adult children up to age 26 clarified that plans cannot charge adult children a different amount than that charged for coverage of non-adult children.¹⁷ In order to comply with the new requirement to cover adult children up to age 26, plans offering dependent coverage will need to appropriately align the premiums paid with the number of people covered. To do this, many plans will need to change coverage tiers. Instead of the previously offered election options where employees could choose between coverage for an employee, or an employee-plus-spouse, or an employee-plus-family, plans are likely to move to coverage election options that are simply based on number of dependents – employee-plus-one, employee-plus-two, etc. This change will be necessary to help plans continue to survive given the new coverage requirements; as the regulations say, plans may “comply with these new provisions” without losing grandfathered plan status. It would run counter to the intent of both the grandfathered regulations¹⁸ and the

¹⁶ Grandfathered Health Plans, 75 Fed. Reg. at 34,543 (“Coinsurance automatically rises with medical inflation.”).

¹⁷ Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 27,134 (May 13, 2010) (to be codified at 26 C.F.R. § 54.9815-2714T(d)).

¹⁸ That is - to ease the transition of the health care industry into the reforms established by the Affordable Care Act. Grandfathered Health Plans, 75 Fed. Reg. at 34,541.

adult child coverage regulation, to penalize plans with the loss of grandfathered plan status for incorporating such necessary structural election option changes. In order to reconcile two very important policies of reform (covering adult children and maintaining grandfathered status), plans must be permitted to revise coverage tiers without risking grandfathered status.

4. Wellness Programs. Given health reform's recognition of the importance of wellness programs and the policy choice to permit employers to increase incentives in rewarding employee participation,¹⁹ the IFRs need to specify that implementing enhanced wellness programs and increasing the permissible reward or penalty will not affect a plan's grandfathered status.

Effective for plan years beginning on or after January 1, 2014, employers may vary premiums by as much as 30% for employee participation in certain health promotion and disease prevention programs.²⁰ It should be clarified in the final regulations that any premium variation made by the employer in compliance with this provision will not result in the loss of grandfathered plan status.

5. Procedural Considerations; Losing Grandfathered Status

a. The IFRs need to specify how a plan or issuer will be notified of the loss of grandfathered plan status. There must also be a remediation opportunity for plans to: reverse a change that caused the loss of grandfathered plan status; or come into compliance with the additional provisions of health reform. The new changes and restrictions placed on plans are complicated and confusing. Plans must be afforded an opportunity to correct changes which may have significant and long lasting ramifications.

b. The IFRs also must clarify when a plan, after losing grandfathered status, must come into compliance with the insurance reform provisions from which it had previously been exempt. To avoid disruption to vendors and participants as well as to ensure compliance, plans losing grandfathered status should be afforded the longer of six months or the period until the beginning of the next plan year to comply with the new insurance reform requirements.

c. Finally, the IFRs need to delineate details regarding the burden of proof in assessing whether grandfathered status is lost. If an enrollee, or one of the Departments, maintains that a plan is no longer grandfathered, the burden of proof should be on the party arguing against grandfathered status and there should be a rebuttable presumption that grandfathered status is retained. If a sponsor or plan reasonably believes that the plan is grandfathered, but the party challenging grandfathered status prevails, the period allowed for compliance (as described in b., above) should not begin until the plan is notified of the definitive loss of grandfathered status.

6. Disclosure Requirement and Model Language. While it may be appropriate for an employer to declare that its plan will retain grandfathered plan status, ERISA's disclosure requirements are already sufficient to explain to employees what their coverage is (and, by

¹⁹ Patient Protection and Affordable Care Act § 1201(2)(a) (amending Public Health Service Act § 2705(j), 42 U.S.C. § 300gg et. seq. (1996)).

²⁰ Patient Protection and Affordable Care Act § 1201(2)(a) (amending Public Health Service Act § 2705(j), 42 U.S.C. § 300gg et. seq. (1996)).

implication, what their coverage is not). Communicating to enrollees that there are other benefits that they *could have had*, if their employers chose to relinquish their grandfathered plan status, is unnecessary. Further, to the extent the Departments continue to require that some disclosure is necessary, the model language is inappropriate and must be revised. A simple statement that the plan is subject to the grandfathered rules under the Affordable Care Act is sufficient.²¹

7. Anti-Abuse and Bona Fide Business Purpose. We appreciate the examples included in the regulations but would request additional clarifications on a few other scenarios. For example, when an employer with **three** benefit packages all of which are grandfathered plans eliminates the richest plan for bona fide business purposes, the remaining **two** less rich plans should remain grandfathered. The mere fact that the richer plan is eliminated should not impact the status of the other two plans provided the elimination is based on a bona fide business purpose. This clarification expands on the scenario detailed in Example 2, which explores a situation where an employer offers two packages and then eliminates one of them for a bona fide business purpose.²² Also, in connection with these rules, the Departments need to detail how these rules impact the bona fide restructuring of a company with a grandfathered health plan. Specifically, if an organization with a grandfathered health plan is divided into two new organizations for a valid business purpose (e.g., pursuant to a sale of a factory or industry line or spinoff of a part of the business to shareholders), both organizations should continue to be permitted to offer coverage to employees under the grandfathered health plan (in effect, under a successor piece of the pre-transaction grandfathered plan), until such time as that grandfathered successor loses grandfathered status under the regulation's loss-of-status rules. When a company's restructuring is pursuant to a bona fide business purpose and employees are not being forced into a different/new plan package (i.e., when they are keeping their coverage), employees should be dealt a similar outcome as that described in one of the Examples illustrating the impact of bona fide business changes.²³

8. Definition of Plans. While the IFRs state that each benefit package will be considered separately for grandfathered purposes,²⁴ the IFRs should clarify that each benefit offering (e.g., PPO, POS and HMO) will be considered separately, even if these offerings are filed on the same IRS Form 5500.

9. Exhaustive List of Actions. The IFRs need to make clear that no other plan changes, other than those enumerated, could cause a plan to lose its grandfathered status.

COMMENTS SOLICITED

Below are our recommendations on areas that the Departments invited comments. We have discussed many of these areas above, as they relate to our areas of concern, but below provide comments on these areas to the extent the Departments inquired.

²¹ Based on the model language in the IFRs, if there is a disclosure requirement, it should be sufficient to say "This [plan or issuer] believes this [plan or coverage] is a 'grandfathered health plan' under the Patient Protection and Affordable Care Act."

²² Grandfathered Health Plans, 75 Fed. Reg. at 34,559 (to be codified at 26 C.F.R. § 54.9815-1251T(b)(3)).

²³ Id.

²⁴ Grandfathered Health Plans, 75 Fed. Reg. at 34,541.

10. Possible improvements to the model language.²⁵ We have articulated our general concerns on the disclosure requirements earlier on page 7, item 6 entitled “Disclosure Requirement and Model Language.” To reiterate, if there is model language, our recommendation is that it read as follows:

This [plan or issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act.

11. Is the list of changes appropriate?²⁶ No. As we articulated in our comments on page 4 under the heading “Far Exceeds Statutory Language”, there are no provisions in the statute that mention the loss of grandfathered status or describe (even broadly) how or why a plan would lose grandfathered status. The regulations far exceed the statutory intent by prescribing permitted and prohibited changes that plans must comply with in order to retain grandfathered status. We strongly disagree with the assertion in the IFRs that the statute’s *silence* on what changes lead to the loss of grandfathered status provides the Departments with the authority to elaborate on this in regulations.²⁷ Although there are numerous provisions in the statute that provide for clarification through future regulation,²⁸ there is nothing in this provision in the statute delegating this authority or power to the regulators.

12. Changes to plan structure.²⁹ Please see our comments on this issue under items 2, 3, 4, and 8, on pages 6–8. Grandfathered plans must be permitted to make (at the very least) changes to preserve fiscal solvency as they comply with new insurance reform requirements.

13. Permissible Network Changes.³⁰ Consistent with our other recommendations, the approach here must permit plans to promote centers of excellence, as well as high value and high quality providers. The focus must be on the overall impact felt by participants. There are consumer protections in many states that require plans comply with basic network adequacy requirements on all plans. Specifically, plans must comply with particular geo-access standards; these standards permit plans flexibility in managing provider networks, while ensuring appropriate provider access for enrollees. No more stringent requirements on network changes are necessary. Changes that are made by plans to networks, provided they comply with these existing requirements, must be permitted.

14. Prescription Drug Formulary Changes.³¹ Prescription formularies are perhaps the most frequently revised and developed areas of plan design. Perhaps no other area of health care delivery is subject to such frequent change, based on medical effectiveness, changes in costs, innovative new products and treatments, and technological advancements. Therefore, it is important that maximum flexibility be permitted with regard to formularies.

²⁵ Grandfathered Health Plans, 75 Fed. Reg. at 34,541 (requesting comments on the model language).

²⁶ Grandfathered Health Plans, 75 Fed. Reg. at 34,544 (requesting comments on additional restrictions on changes).

²⁷ Grandfathered Health Plans, 75 Fed. Reg. at 34,540.

²⁸ Copeland, Curtis W., Regulations Pursuant to the Patient Protection and Affordable Care Act (PL 111-148), U.S. Cong. Res. Serv. (April 13, 2010). A CRS report written by Curtis W. Copeland identified 41 provisions requiring future regulations while the U.S. Chamber of Commerce has identified an additional 60 provisions that will likely result in future regulations and guidance.

²⁹ Grandfathered Health Plans, 75 Fed. Reg. at 34,540.

³⁰ Id.

³¹ Id.

Finally, prescription formulary changes must be permitted to encourage the pursuit of lower cost treatment alternatives that do not sacrifice outcomes. For a reform law to advocate comparative effectiveness and then penalize plans for similarly adopting outcome-based treatment options as they become available is duplicitous. Plans must be permitted to revise formularies and cost-sharing structures when generic alternatives become available, provided the plan continues to provide a similarly appropriate alternative as afforded under the prior formulary. For example, if a brand name drug is offered at a lower cost-sharing tier when no generic is available, a plan must be permitted to move this brand name drug to a higher (or the highest) cost-sharing tier of a formulary when a generic alternative becomes available. Plans should be permitted to revise the formulary and cost-sharing status of the brand name drug, as it would have prior to reform. In fact, permitting the plan to make this change is permitting the enrollee to keep the plan he/she has. Additionally, we concur with the interim final regulations that a change in the Pharmacy Benefit Manager (PBM) is not relevant to grandfathered status. A change in PBM is similar to a change in TPA. Provided the general plan remains consistent, this change in outsourcing and administration should be permitted.

15. Substantial Changes to Overall Benefits Design.³² We believe that, in evaluating substantial changes to the overall benefit design, the assessment must focus on the changes that each particular plan has made historically. The purpose of the provision and this regulation, as repeatedly stated, is to ensure that “individuals can keep the plan they have” while preserving plan flexibility to make changes, provided there are some controls on the changes permitted.

16. Specific standards on benefits, cost-sharing, and employer contributions?³³ We do believe that standards should be drawn differently in light of the changes made by the reform law and the impact they will have on plan practices. For a more complete discussion on why this is critical, please refer to our comments regarding the fundamental principles on pages 2-5. We have addressed specific issues with the establishment of these standards in the remaining pages of our comments, pages 5-9.

17. Additional Guidance or More Restrictive Final Regulations.³⁴ The Chamber is concerned by the suggestion that the Departments may “issue as appropriate, additional administrative guidance other than in the form of regulations to clarify or interpret the rules contained in these interim final regulations for maintaining grandfathered health plan status prior to the issuance of final regulations.”³⁵ While we appreciate the desire to provide clarity, we remain alarmed that further interpretation of these regulations (which we already believe to be overreaching) may be done without notice and comment. Even more worrisome, given the prescriptive nature of the requirements in the IFR is the additional statement that “any new standards published in the final regulations that are more restrictive than these IFRs would only apply prospectively to change to plans after the publication of the final rules.”³⁶ The arduous requirements that the Interim Final Regulations suggest are beyond the scope of what was

³² Id.

³³ Id.

³⁴ Grandfathered Health plans, 75 Fed. Reg. at 34,545.

³⁵ Id.

³⁶ Grandfathered Health Plans, 75 Fed. Reg. 34,545.

contemplated by Congress in the statute or the Administration in its promise to the American people. To suggest that there may be more restrictive requirements published in the Final Regulations is extremely troubling, regardless of the prospective application.

18. Assessment and conclusions of the potential costs, benefits and transfers associated with these interim final regulations.³⁷

As required by OMB Circular A-4, the Departments evaluated the potential costs, benefits and transfers of the IFRs and concluded that there are many potential benefits to the regulations, including continuity of coverage, slower rates of premium growth, incentives to employers to continue offering coverage, and greater certainty for employers. In the view of the Departments, these potential benefits outweigh the potential costs (greater increases in premiums or lesser decreases in premiums for some grandfathered plans and higher premiums for the exchanges when they come on line in 2014). The Departments also conclude that some transfers (of wealth, from non-grandfathered plans to grandfathered plans) will occur.

In the discussion of costs, benefits and transfers, the Departments heavily emphasize that there is sufficient flexibility for employers to avoid losing grandfathered status. This seems to be contradicted by statistics included in the regulations, themselves which assert forecast potentially two-thirds of small employer plans and one-half of large employer plans will lose grandfathered status in 2011.³⁸ The Departments assert that this “sufficient flexibility” is afforded to plans based on the way the regulations permit cost-sharing changes. The regulations assert that plans can make “smaller increases in deductibles while raising copayments, out of pocket expenses and employer contributions to the premiums or cost of coverage at a greater rate to achieve the same cost control objectives” and retain grandfathered status.³⁹ But, this particular reasoning demonstrates the inappropriate orientation and focus of the IFR’s. Most importantly, the same cost control objectives would not be met, even if the overall cost savings for the plan would be the same. The regulation’s inaccurate terminology here highlights the very reason that flexibility is critical. To support the important goals that motivated health care reform in the first place, plans must be permitted to make strategic changes to plan design to incent appropriate utilization and reward high quality providers. Plans should not be forced to jerry-rig important plan design changes in order to comply with regulatory restrictions. Instead, as health reform principle’s dictate, plans should be encouraged to explore ways to incent enrollees to seek the appropriate medical treatment from the appropriate health care provider at the appropriate time.

So, we find the Departments’ analysis in this area to significantly underestimate the cost impact of the IFRs. Moreover, according to Rand, as more plans lose grandfathered plan status, overall government spending will increase:

³⁷ Grandfathered Health Plans, 75 Fed. Reg. at 34,546.

³⁸ This estimate was formulated by extrapolating cost-sharing change data from 2008-09. Grandfathered Health Plans, 75 Fed. Reg. at 34,551.

³⁹ Grandfathered Health Plans, 75 Fed. Reg. at 34,550.

[W]hen the grandfathered market is eliminated, ESI [employer sponsored insurance] enrollment falls, Medicaid enrollment and subsidized exchange policies increases, government spending increases.⁴⁰

CONCLUSION

We appreciate the opportunity to comment on the IFRs and are available to discuss any of our comments informally, or by way of testimony in hearings conducted by the Departments. While we support the general principles of health reform and applaud the Administration's promise to the American people that nothing will require an existing plan to terminate coverage, we are concerned by some critical elements of the Interim Final Rules implementing the Grandfathered Status provisions. We hope that with our comments and examples, the Departments will make the necessary changes, as we have suggested, ensuring that inadvertent consequences do not result. We look forward to working with you to protect the fundamental goals of health reform that we jointly support.

Sincerely,



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U.S. Chamber of Commerce



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⁴⁰ Christine Eibner et. al., *Grandfathering in the Small Group Market Under the Patient Protection and Affordable Care Act: Effects on Offer rates, Premiums and Coverage*, POLICY INSIGHTS, Rand (2010).