AMERICAN ACADEMY of ACTUARIES

Aug. 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 Rule for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan

To Whom It May Concern –

On behalf of the American Academy of Actuaries'[1] Grandfathering Provisions Work Group, I appreciate the opportunity to provide the following comments to the Departments of Health and Human Services, the Treasury, and Labor on the recently released interim final rule on health insurance coverage in the group and individual markets regarding status as a grandfathered health plan.

Applicability of Regulations to Individual Health Insurance Coverage
The interim final rule (IFR) focuses on changes initiated by *plan sponsors* and *issuers*. The IFR does not address changes initiated by the purchaser of an individual insurance plan specifically. Often, individuals initiate changes to deductibles/coinsurance, add or delete dependents, or must be issued a new contract because they have moved to a different state.

> "As addressed earlier in this preamble, and further discussed below, these interim final regulations include rules for determining whether changes to the terms of a grandfathered health plan made by *issuers and plan sponsors* allow the plan or health insurance coverage to remain a grandfathered health plan." [Federal Register, June 17, p. 34546]

We recommend clarification on the requirements should an individual policyholder initiate a benefit or plan change. In such a situation, should the individual be treated the same as the plan sponsor/issuer?

[1] The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Applicability of Regulation to Plan Rolls
Under HIPAA (41 U.S.C.A. Sec. 300gg-42) as adopted by most states, issuers are allowed to uniformly discontinue coverage. This is often referred to as a "forms discontinuance" or "plan roll." Rolls are done on older contracts for a variety of reasons, including obsolescence, administrative efficiency, and compliance. We recommend clarification on whether such contract rolls automatically would cause the plan or coverage to cease to be a grandfathered health plan, provided that the contract roll is made without exceeding the standards established by Paragraph (g)(1).[2]

Maintenance of Grandfathered Status, Transitional Rules
Paragraph (g)(2)(ii)[3] addresses the ability of a group health plan or health insurance issuer that makes changes to the terms of a plan or health insurance coverage causing it to lose its grandfathered status to revoke or modify such changes to restore the coverage to acceptable grandfathered levels relative to the prior plan benefits. We believe incorporation of this type of transition rule is fair, given that the effective date for the determination of grandfathered status predates the release of this regulation and most people's notice of the provision's details. However, we have the following comments and observations regarding this provision:

- These rules do not address the ability of insured individuals, who make changes in their health plans, or health insurance issuers to take action to restore grandfathered status. There are certain advantages for some individuals to maintain grandfathered status, but the lack of availability of final regulations on a timely basis before such changes are made could result in them unintentionally losing this status.
- It would be inequitable to allow an employer sponsor of a group health plan or a health insurance issuer to revoke a change to restore its grandfathered status but not provide a similar ability to an individual.
- An individual may want to keep his/her current benefit plan, but his/her current health insurance provider may choose not to maintain the plan's grandfathered status. This appears to be at odds with comments made by administration officials that individuals should be able to keep their current coverage if they do not make a change.
- We also recognize serious administrative problems and potential increased risks to health insurance issuers associated with the ability of an individual to restore prior coverage levels. This may be addressed best by extending grandfathered status to individuals who made changes to their coverage before receiving notice of final grandfathered status rules without requiring the revocation of such changes. This would mean an extension of the transition period for only a short time relative to when the 2014 reforms become effective (the time when the differences between grandfathered and non-grandfathered business will become most pronounced).
- In the event that the health insurance issuer decides not to maintain grandfathered status for a health plan, an affected individual somehow should have the ability to

[2] 26 Code of Federal Regulations (CFR) 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140.
[3] Ibid.

maintain grandfathered status, if he/she wishes, without introducing an administrative burden on the health insurance issuer or health plan.

- The same may be true for small employers with fully insured health plans who have made changes to their plans before notice of the regulation. While they may be able to find a health plan similar to their prior plan, the regulation should address whether restoration of such a health plan needs to be with the same health insurance issuer on the same policy form. This could introduce certain availability and administrative problems, particularly if the preceding insurer no longer offers these policy forms or plan designs. We suggest you consider allowing the small employer to restore grandfathered status to a health plan when changing the plan back to an acceptably similar benefit design, irrespective of whether it is insured by the same health insurance issuer.

Documentation of Plan or Policy Terms on March 23, 2010
In Paragraph (a)(3) of 26 CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140 of the interim final regulation, it is unclear whether the issuer or the plan sponsor of a group plan is responsible for maintaining records.

> "To maintain status as a grandfathered health plan, a group health plan, or group or individual health insurance coverage, must, for as long as the plan or health insurance coverage takes the position that it is a grandfathered health plan –
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> (i) Maintain records documenting the terms of the plan or health insurance coverage in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan; and
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> (ii) Make such records available for examination upon request."

In many situations, the plan sponsor is the only entity with all the information necessary to confirm grandfathered status, including employee contribution levels and the existence of multiple plans with multiple issuers. If it is determined that the issuer is responsible for tracking grandfathered status for all group sizes, we recommend that the issuer be allowed to rely on the plan sponsor's representations that the plan's contribution levels have remained within the parameters of Paragraph (g)(1)(v) and its eligibility within the parameters of Paragraph (b)(2).

Responsibility of an Issuer to Preserve the Right to Maintain Existing Coverage
The IFR primarily addresses what health plans and health insurance issuers may and may not do regarding preservation of grandfathered status for a plan. It appears that there is no requirement that an issuer preserve grandfathered status of health plans. We note that the IFR does not appear to address an individual's right to maintain existing coverage, which appears to be the main focus of Sec. 1251 of the Affordable Care Act (ACA).

Consistent with permitted business activity, under the Public Health Service Act, health insurance issuers may make changes that could result in a loss of grandfathered status. As such, individuals who are enrolled in those plans inadvertently would lose the ability to maintain existing coverage. We suggest that the final regulation confirm the ability of a

health insurance issuer to choose not to maintain grandfathered status on any or all of its plans, and address alternative similar coverage that an individual can obtain to preserve grandfathered status in the event the grandfathered status of his/her current coverage is not preserved by the current health insurance issuer.

In addition to plan rolls (see earlier comment), situations such as an insurer exiting the comprehensive medical business market or an employer terminating its health plan raises a question of how the regulation addresses the ability of individuals covered under such plans to maintain rights of grandfathered status (e.g., the ability to maintain a plan with an actuarial value less than 60 percent) or whether there is no opportunity for them to do so under the circumstances.

Invited Comments

The departments have specifically invited comments on whether several changes should result in cessation of grandfathered health plan status for a plan or health insurance coverage:

(1) "changes to plan structure (such as switching from a health reimbursement arrangement to major medical coverage or from an insured product to a self-insured product);"

We recommend that the plan sponsor's choice of funding vehicles (fully insured, health reimbursement account (HRA), or self-funded) not affect grandfathering status. This is consistent with the remainder of the regulation, which focuses on benefits, cost sharing, and plan-sponsor contributions as opposed to how plan sponsors choose to fund their plans, provided that the change is made without exceeding the standards established by Paragraph (g)(1).[4] For example, a fully insured plan with a $500 deductible may move to a $2,500 deductible plan with an HRA that provides a $500 deductible to the employee and the same benefits as the fully insured plan.

(2) "changes in a network plan's provider network, and if so, what magnitude of changes would have to be made;"

As the stated purpose of this interim final regulation is to take into account reasonable changes routinely made by plans or issuers, we recommend that movements of providers into or out of a network have no effect on grandfathering status. Networks have many provider contracts and adding and terminating providers is a common occurrence. Providers are independent entities and may choose to leave a network for multiple reasons. A provider leaving a network should not jeopardize the grandfathered status of all of the network's participants.

Where an issuer provides a choice of networks, movement between networks similarly should not affect grandfather status, provided that the change is made without exceeding the standards established by Paragraph (g)(1).[5] The flexibility to change networks allows

[4] Ibid.
[5] Ibid.

individuals to take advantage of different providers and/or different discounts. In addition, an issuer may no longer offer a specific network, networks may merge, be acquired, or go out of business entirely. Thus, an issuer may need to replace an existing network arrangement with a similar network in the area.

(3) "changes to a prescription drug formulary, and if so, what magnitude of changes would have to be made;"

As the stated purpose of this interim final regulation is to take into account reasonable changes routinely made by plans or issuers, we recommend that changes in formularies not affect grandfathered status as long as an entire class of drugs is not removed from coverage. Formulary decisions, including tier placement, are based on clinical efficacy, safety, and the cost-effectiveness of the pharmaceuticals being reviewed. These changes are intended to encourage consumers to use the most cost- effective pharmaceuticals. When an expensive drug becomes generic, frequently these drugs are moved to separate tiers to encourage consumers to use more cost-effective alternatives.

(4) "any other substantial change to the overall benefit design."

We have no comments regarding any other substantial change to benefit design.

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We would welcome the opportunity to discuss any of these items with you at your convenience. If you have any questions or would like to discuss these items further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

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American Academy of Actuaries