To: Ms. Karen Levin
Room 5205
Internal Revenue Service, Department of the Treasury
1111 Constitution Avenue, NW
Washington, DC 20224
Attention: CC:PA:LPD:PR (REC-118412-10)

Ms. Amy Turner
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
Attention: RIN 1210-AB42

Mr. Jim Mayhew
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
Attention: OCIIO-9991-IFC

Re: Comments on 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 (75 Fed Reg 34538-34570)

Date: August 16, 2010

Dear Ms Levin, Ms. Turner, and Mr. Mayhew,

Health Care for All (HCFA) and Community Catalyst (CC) greatly appreciate the opportunity to comment on the rules for grandfathered health plans and look forward to working with the Department of the Treasury, Department of Labor, and Department of Health and Human Services on this issue in the future.

Developing a definition of a "grandfathered" health plan is a critical step in implementing the Patient Protection and Affordable Care Act (ACA). We believe that it is paramount that these regulations strike the proper balance between allowing consumers to keep the health coverage they were enrolled in prior to March 23, 2010, if they wish to do so, and ensuring that all health coverage complies with the most significant protections enacted by the ACA.

HCFA and CC generally endorse the interim final rules for group health plans and health insurance coverage relating to status as a grandfathered health plan under the ACA. Overall, we

are pleased that the regulations will provide consumers with stronger protections, while allowing flexibility for people to keep their insurance if they like it. However, we have a few concerns about the regulations as they are currently drafted. Our recommendations regarding the rules for grandfathered health plans, in light of these concerns, are outlined below.

1. Mandatory Steps for Maintaining Grandfathered Status, Paragraph (a)(2)-(3)

We understand Paragraphs (a)(2)-(3) of the interim final regulations to require that a plan must take three steps in order to maintain status as a grandfathered health plan: include a statement, in plan materials, that the plan believes it is a grandfathered health plan; provide contact information for questions and complaints; and maintain, and make available for examination, records documenting the plan's terms.

Overall, we support the three requirements. The model disclosure language in Paragraph (a)(2)(ii), however, could be improved by requiring plans to explain which of the ACA consumer protections do not apply to grandfathered health plans. Many consumers are unaware of precisely what benefits and protections they give up by choosing a grandfathered plan. We fear that few consumers will take the additional suggested steps of accessing a government website or calling their plan administrator in order to access this information.

The disclosure should be required to include a clear, comprehensive list and concise description of the ACA benefits and consumer protections that do not apply to grandfathered plans. We understand that disclosure language included in plan materials may be considered part of a health plan's contract and that health plans will likely want substantial discretion over the wording of their contracts. However, the disclosure statement must be consumer-friendly in order to be meaningful. The disclosure should be included at the beginning of plan materials—not buried at the end of a document—so that consumers will see the disclosure, even if they only skim the materials. An eye-catching and easy-to-read format, like the warnings on cigarette boxes, would be helpful. A table (like the table available at http://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf) or bullet-point list would be ideal ways to convey the information in a consumer-friendly manner.

2. Constraints on the Maintenance of Grandfathered Status, Paragraph (g)

We support the clear limits that have been placed on the ability of plans to maintain grandfathered status, but would suggest making some of them even stronger. We recommend the following additional limitations to be added to this paragraph:

- Constraint on Reduction of Benefit Scope, (g)(1)(i): Under the interim final regulation, a plan ceases to be a grandfathered health plan if *all or substantially all* benefits to diagnose or treat a particular condition are eliminated. The elimination of benefits for *any necessary element* to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a condition.

  We think that this is an important restriction, but would like "necessary element" to be defined in such a way that it is clear *who* decides when an element is necessary—

preferably the doctor, rather than the insurer. If a doctor says a treatment is necessary for a particular patient, we believe it should be treated as such under these regulations.

In addition, we believe that a plan change that reduces access to physical therapy and occupational therapy—for example, by limiting the number of visits per patient—is a substantial constraint. However, the interim final regulations do not address this issue. We ask that they be revised to ensure that reductions of this kind constitute a substantial elimination of benefits, triggering loss of grandfathered status.

- Fixed-Amount Cost-Sharing Requirements Other than a Copay, (g)(1)(iii): The interim final regulation allows a plan's fixed amount cost-sharing requirements (other than copays) to increase by as much as the maximum percentage increase (medical inflation, from March 23, 2010, plus 15 percentage points), before the plan loses grandfathered status. We believe this allows cost-sharing requirements to increase too much. We ask that the rule only allow cost-sharing increases in keeping with medical inflation—rather than exceeding it by 15%.

- Fixed-Amount Copay, (g)(1)(iv): Similarly, the interim final regulation allows fixed-amount copays to increase by the greater of (A) the maximum percentage increase or (B) $5 increased by medical inflation, before a plan loses grandfathered status. For some, particularly the sick and the poor, even a slight increase in cost sharing can be a substantial financial burden.[1] For example, the Center for Studying Health System Change reports that as health plans have substantially increased prescription drug cost sharing over the last ten years, more Americans, especially those living with chronic conditions, are forgoing necessary prescription drugs due to cost issues.[2] The Kaiser Family Foundation reported that 13% of those with insurance have chosen not to fill a prescription because of cost.[3] Thus, we ask that the rule only allow grandfathered plans to increase copays in keeping with medical inflation.

- Constraints on Decreases in Employer Contributions, (g)(1)(v): Health care coverage is a financial burden on both employers and employees. It is reasonable to allow modest changes in the employer contribution. However, employees may find that their health plan has become unaffordable if their employer's contribution rate falls by 4-5%, as allowed by this interim final regulation. A contribution rate change of 4-5% would change a health plan in a very real way for consumers. We believe that *any* reduction in employer contribution rates should cause a plan to lose grandfathered status.

- The "Good Faith" and "Modestly Exceed" Exceptions: We understand the intent of the "good faith" and "modestly exceed" exceptions, included at the end of paragraph (g), however, the parameters appear overly flexible for the carriers.

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[1] *See* Jonathan Gruber, Kaiser Family Foundation, Report #7566, "The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond," 1 (2006), http://www.kff.org/insurance/upload/ 7566.pdf.

[2] "Impact of Copays on Vulnerable Populations," 12 AM. J. MANAGED CARE S359, S359 (2006), http://www.ajmc.com/media/pdf/A166_06NovImpactofS359to63.pdf.

[3] *Id*.

In recent months, many health plans have not demonstrated "good faith." For example, California's Anthem Blue Cross recently withdrew its request to raise individual health plan premiums by as much as 39% after "substantial errors" were found in its rate filing.[4]

We worry that these exceptions will create loopholes for health plans that are making calculated, self-interested changes to their plans with the intent of earning shareholders money rather than consumers. Therefore, we recommend further definition of these exceptions.

- Other changes: We are pleased that the above changes will result in loss of grandfathered status, but we think it is crucial that other changes be included in the constraints listed in (g)(1). For example:

    - Changes in plan structure: Significant changes to plan structure, like reducing the number of covered visits per year, should trigger loss of grandfathered status.

    - Changes in a network plan's provider network: While we recognize that there are always fluctuations within provider networks (as doctors relocate or change jobs), significant changes in a provider network (such as a switch to a limited-type network) should result in loss of grandfathered status. One way to regulate network changes could be by tying the standard into network adequacy standards like those established by Medicare.

    - Changes to a prescription drug formulary: Minimal changes to drug formularies are reasonable; however, we ask that plans lose grandfathered status if they make more significant changes to their prescription drug benefits. Changes such as cutting coverage for an entire class of drugs, or requiring people to fill prescriptions through the mail rather than at their local pharmacy, should result in health plans losing grandfathered status.

    - Changes to family coverage: Dropping coverage for a spouse or child or increasing costs beyond the limits outlined in the interim final rule should constitute changes to family coverage that trigger loss of grandfathered status.

    - Changes from fully-insured to self-insured: Because self-insured plans do not have to comply with a number of ACA's consumer protections, it is critical that plans that switch from fully-insured to self-insured should trigger the loss of grandfathered status.

Any changes to a health plan that *enhance* benefits without increasing costs for consumers, however, should not trigger loss of grandfathered status. For example, we would like

[4] Duke Helfand, Los Angeles Times, "New reviews of health insurance rate hikes in California due soon" (Jul. 15, 2010), http://latimesblogs.latimes.com/money_co/2010/07/new-reviews-of-health-insurance-rate-hikes-in-california-due-soon.html; Fran Matso Lysiak, "President of WellPoint's Anthem Blue in California Leaves Post" (Jul. 21, 2010), http://insurancenewsnet.com/article.aspx?id=209236.

grandfathered plans to be able to eliminate cost sharing requirements for preventive care without losing grandfathered status.

As always, we remain committed to making healthcare coverage affordable and accessible for all consumers. We thank the Departments of the Treasury, Labor, and Health and Human Services for their consideration and seek to be a resource as they tackle this issue. If you have any questions or concerns please contact Georgia Maheras at 617-275-2922 or gmaheras@hcfama.org or Christine Barber at 617-275-2914 or cbarber@communitycatalyst.org.

Sincerely,

Rob Restuccia
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Amy Whitcomb Slemmer
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