National Retail Federation®
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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

Submitted Electronically

Re: **OCIIO–9991–IFC**, 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 or Madam:

The National Retail Federation (NRF) represents the greater retail industry, employers of one of every five employees in the American economy. As the world's largest retail trade association and the voice of retail worldwide, NRF's global membership includes retailers of all sizes, formats and channels of distribution as well as chain restaurants and industry partners from the U.S. and more than 45 countries abroad. In the U.S., NRF represents the breadth and diversity of an industry with more than 1.6 million American companies that employ nearly 25 million workers.

Our members are strong supporters of employer-based health coverage and thus are vitally interested in the degree of flexibility and continuity provided by the interim final regulations addressing grandfathered status. In our view, these regulations fail to provide sufficient flexibility and thus will undercut the all-important continuity of employer-based coverage in the critical interim between now and 2014, when health insurance exchanges and individual tax subsidies will become available. We will also seek to address the four additional issues raised in the preamble that the agencies sought comment on.

NRF has also joined in separate coalition comments submitted by the Small Business Coalition for Affordable Healthcare and the Coalition for Affordable Health Coverage. We recognize and appreciate that these comments will also be shared with the Department of Labor and the Internal Revenue Service.

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Continuity

The Patient Protection and Affordable Care Act (PPACA) is a complex law, designed to be phased in between now and 2018. Many significant provisions – including new purchasing options through Health Insurance Exchanges and individual subsidies to assist in purchasing – are not effective until 2014. The interval between enactment in 2010 and key affordability provisions in 2014 will be difficult for employers and employees alike. One of NRF's greatest objections to PPACA was its failure to provide both short and longer term relief from rising health care costs.

Congress sought in PPACA to build from the existing base of the employer-based system, especially between 2010 and 2014. Thus, Section 1251 of PPACA (as modified by Section 10103 of the Reconciliation Act) attempts to provide for continuity of coverage for both employees and employers through "grandfathered plan" status. With limited statutory provisions, Congress sought to hold in place coverage at date of enactment: March 23, 2010.

The interim final regulation (IFR) has gone beyond Congress' intent, making it very difficult to maintain grandfathered status. In fact, the IFR's own estimates[1] are that a majority of employers will lose grandfathered plan status by 2013. Unless the IFR is changed and improved to provide greater necessary flexibility, Congress' goal of ensuring continuity of coverage will be frustrated. More individuals will lose coverage without a reasonable marketplace alternative available in advance of 2014.

Grandfathered Plan Status

The following summarizes our understanding of the IFR:

Generally

- Plans must assert grandfathered status based on coverage in existence as of March 23, 2010.
- There is a limited grace period to revoke non-conforming changes before September 23, 210.

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[1] Agencies estimate that between 39% and 69% of all employer plans will have relinquished grandfathered plan status by 2013.

- **2011** – Low-end estimate: small 20%, large 13%, all 15%. 2011 – Mid-range estimate: small 30%, large 18%, all 22%. 2011 – High-end estimate: small 42%, large 29%, all 33%.
- **2012** – Low-end estimate: small 36%, large 24%, all 28%. 2012 – Mid-range estimate: small 51%, large 33%, all 38%. 2012 High-end estimate: small 66%, large 50%, all 5%.
- **2013** – Low-end estimate: small 49%, large 34%, all 39%. 2013 – Mid-range estimate: small 66%, large 45%, all 51%. 2013 – High-end estimate: small 80%, large 64%, all 69%.

- "Good-Faith" compliance standard – "only modestly exceed" permitted changes.
- Regulation specifies the type of notice required in summary plan descriptions. Plans must retain documentation.
- Collectively-bargained plans that are grandfathered retain that status until the collectively bargained agreement (CBA) terminates.

Not applicable to Grandfathered plans in 2014

- Comprehensive insurance coverage (essential benefits).
- Prohibit discrimination based on health status.
- No cost sharing for prevention and wellness benefits.
- Prohibition on discrimination in favor of highly compensated individuals.
- Appeals (external and internal) process.

Applicable with or without Grandfathered Status in 2014

- Employer mandate penalties.
- Prohibition on waiting periods more than 90 days.
- No preexisting condition exclusions.
- Extension of dependent coverage to age 26.
- No Lifetime limits (plan years after October 2010).
- No annual limits (restricted after October 2010).
- Prohibition on recessions.
- Application of medical loss ratio standards (fully insured).

Prohibited changes

- Elimination of a particular benefit.
- Elimination of all or substantially all benefits (or necessary elements) to diagnose or treat a particular condition.
- Increase in coinsurance by any amount beyond that in effect on March 23, 2010.
- Increase in deductible or out-of-pocket maximum by more than the maximum percentage increase (medical inflation [March 23, 2010] plus 15 percent).
- Decrease employer contribution rates for any similarly situated class of employees by more than five percent.
- Change in insurance carrier (fully-insured).

Allowable changes

- Voluntary changes to increase benefits or to conform with required federal or state law changes or to voluntarily adopt PPACA changes in advance.
- Add new employees and dependents.
- Increase cost-sharing requirements by less than the maximum percentage increase (medical inflation [March 23, 2010] plus 15 percent).

- Change employer contribution rates for any similarly situated class of employees by five percent or less.
- Changes to a plan's third party administrator (TPA).

Lack of Flexibility

Our concern is that the IFR's rigid, trip-wire rules make it entirely too possible (if not probable) that a plan that elects grandfathered plan status will not be able to maintain that status for long. Many plans may not even bother to elect grandfathered plan status. In order to maintain the continuity of coverage Congress sought to provide, we recommend the following steps to improve the IFR:

1. Allow employers to change insurance carriers without losing grandfathered status provided that:

    - The coverage is actuarially equivalent or better, and that
    - Provider networks are substantially equivalent.
    - Prohibiting a change in carriers will needlessly inhibit competition bases on price and quality of service.

2. Allow for improvements in prescription drug formularies and provider networks without jeopardizing grandfathered plan status.

    - New drugs come onto the market with great regularity and medical practice changes quickly. Formulary changes in the interest of plan beneficiaries are appropriate and necessary.
    - Provider networks require regular maintenance to allow for retirements, addition of new providers and to maintain network quality. Reasonable changes that do not compromise ongoing treatment should be allowed.

3. Provide greater flexibility to manage future medical inflation.

    - Changes in fixed dollar cost sharing should be made on a year-to-year basis rather than be based on March 23, 2010 and percentage increases from that.

Additional Agency Questions

The IFR sough comments on whether four specific changes[2] ought to result in loss of grandfathered plan status. We have addressed two of these questions (e.g.

[2] The changes in question included: changes to plan structure (switching from a health reimbursement arrangement to major medical coverage or from an insured product to a self-insured product); changes in

changes in formulary and provider networks) above. Our concerns in that area were to provide for reasonable plan improvement and evolution so long as beneficiary interests were preserved. Requiring actuarially equivalent coverage or better should protect beneficiary interest and allow for changes in benefits or plan structure. In addition, provider networks must be maintained and prescription drug formularies must reflect new medications and changes in medical thought and practice.

Conclusion

Thank you for allowing NRF to comment on the IFR concerning grandfathered rule status. We again urge you to improve the flexibility allowed to employers to continue coverage in the interim between now and 2014 in particular. We look forward to continuing to work with you in the months and years ahead as PPACA phases in.

Sincerely,

E. Neil Trautwein
Vice President
Employee Benefits Policy Counsel

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a network plan's provider network and what magnitude of change would be involved; changes to a prescription drug formulary; and changes to overall benefit design.