August 16, 2010

The Honorable Kathleen Sebelius
Secretary, Department of Health and Human Services
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: File Code OCIIO-9991-IFC; Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act.

Dear Secretary Sebelius:

The Coalition for Affordable Health Coverage (CAHC) welcomes the opportunity to provide our comments on the Interim Final Rule ("IFR") relating to Grandfathered Health Plan Status under the Patient Protection and Affordable Care Act (PPACA), as published in the Federal Register on June 17, 2010 (Volume 75, Number 116). To inform CAHC's comments on the IFR, we conducted a survey through the National Association for the Self Employed. The survey was conducted over the past two weeks and represents the very real concerns of small employers regarding the potential negative impact of the rule on this population. The results of the survey are attached.

We hope these comments provide insight into the significant negative impact the rule will have, particularly on small businesses and that it will prompt you to make appropriate changes to the rule to help ensure consumers can keep the coverage they have if they like it. We also urge you to make changes to ensure sufficient choice and flexibility for small businesses and individuals.

CAHC is a broad-based group with a diverse membership including organizations representing consumers, physicians, small businesses, large employers, insurers, brokers and agents. The Coalition maintains a singular focus: making health coverage more affordable for all, whether they have private insurance or access health services through a public program.

One of the most publicized and often repeated arguments in favor of the health care reform law was that if you liked your current health coverage, you would be able to keep it. This argument was partially codified in the new health care reform law through Section 1251 of PPACA, as modified by section 10103 of the Reconciliation Act. These sections state that nothing in the bill should be construed to require an individual to terminate their current health coverage, and limit certain provisions of PPACA to health insurance coverage or health plans in which an individual was enrolled on March 23, 2010.

CAHC strongly supports the idea of allowing people to maintain their current coverage through the grandfathered health plan status, not only because we believe choice is important,

but, as HHS has stated in the rule, grandfathered plans will likely be less expensive and thus more affordable.

Therefore, we are concerned that in its current form, the IFR will not preserve this opportunity and will instead drive most people out of their current health insurance plans by 2014. In fact, the estimates provided in the IFR demonstrate that by 2013 as many as 69% of all employer plans and 80% of small businesses, will relinquish their grandfathered status. We believe that in order to assure most plans will not lose their grandfathered status the Secretary should consider the following suggestions to promote choice, flexibility and more affordable coverage.

1. Promote competition by allowing employers to change insurance carriers without losing grandfather status.

2. Enhance flexibility for individuals and employers, including in network and formulary design and changes to promote competition, drive down costs and better reflect medical advances.

3. Better reflect changes in medical costs by revising the baseline for calculating fixed dollar cost sharing.

4. Promote innovation by allowing value based benefit design to promote wellness and reduce costs.

5. Promote market certainty by ensuring the changes outlined in the rule are the only changes that will trigger a loss of grandfathered status.

6. Ensure consumers are notified when the status of their plan changes and are given unbiased information on the benefits of grandfathered plans.

1. Promote Competition

The IFR sets a number of restrictions and requirements which we believe may make it extremely difficult for grandfathered plans to adapt to increased costs and changing business needs. Restrictions on changing policies or issuers and prohibitions of certain plan changes will have a dramatic anti-competitive effect if HHS does not allow for more flexibility.

Under the IFR, in order to preserve grandfathered status, a plan that is not maintained pursuant to a collective bargaining agreement is prohibited from changing issuers or policies. This means fully insured group health plans making such a change would relinquish their health plan status even if they did not change coverage under the plan, their level of contribution to the plan or any cost sharing aspects of the plan itself. Many individuals and small businesses change health issuers for a variety of reasons. Plan purchasers shop for their coverage based partially on the cost of their coverage, particularly in the small employer market. Securing a better deal from another plan should not trigger a loss of grandfather plan status if the plan provides for essentially equivalent coverage as the previous plan.

As we stated above, the CAHC conducted a survey through the National Association for the Self Employed. These are very small employers who are most price sensitive and who often struggle to provide coverage for themselves and their employees. According to the survey:

- 46 percent of the survey respondents shopped for a new plan at least every other year.

- Just 37 percent of those surveyed have kept the same insurance carrier since starting their business.

- 63 percent of respondents have switched insurers once or more. 36 percent switched carriers two times or more.

- 58 percent have changed insurance carriers in the past three years to get a better deal or to lower health plan costs.

These small businesses are struggling to keep their businesses open, create jobs and provide health coverage. They do this partially by shopping for a better deal, and yet the HHS rule would require them to relinquish grandfather status if they seek to obtain a lower cost plan, even if the plan provides the same level of benefits. It is hard to understand how this anti-competitive, anti-cost containment and anti-choice aspect of the rule would benefit these small employers who are trying to provide jobs and coverage for themselves and their families.

CAHC believes grandfathered health plans should have the flexibility to change policies or issuers without triggering the loss of their grandfathered status. HHS should allow for an actuarial value equivalency test, designed to permit plans some ability to change issuers and policies if certain requirements are met. For example, if the original grandfathered plan has an actuarial value of 55 percent and the employer switches to a plan with a value of 55 percent or greater, the grandfathered status should be maintained.

Recommendation: Allow purchasers to obtain essentially equivalent coverage from another plan and not relinquish grandfathered plan status if an actuarial equivalence test is met.

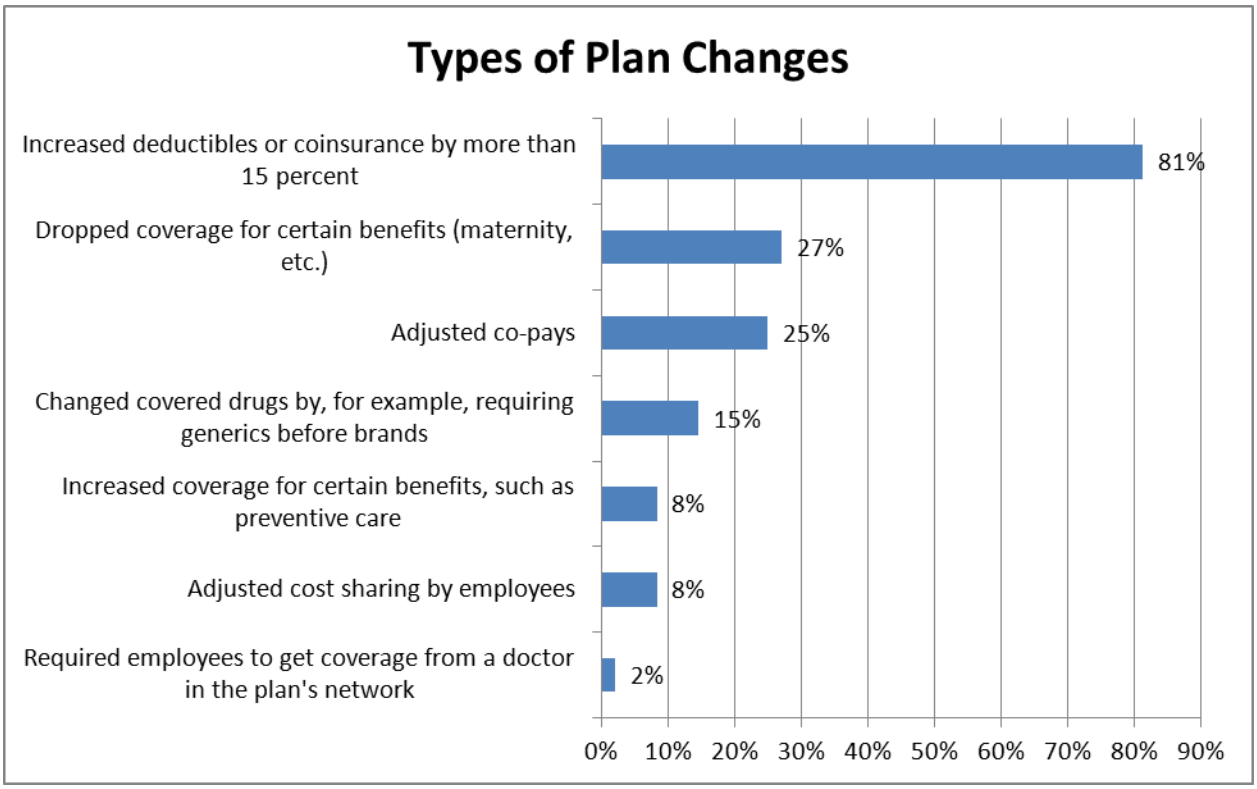
2. Enhance Flexibility

In the preamble to the rule, HHS is specifically seeking comment on permissible changes to provider networks and plan formularies. Individuals and employers choose plan changes for a variety of reasons. In our survey small businesses changed insurers for a variety of reasons, including:

- 58 percent – get a better deal/lower costs
- 8.2 percent – obtain better service
- 3.0 percent – needed to change benefits

- 1.5 percent – to obtain more or different choice of doctors
- 3.7 percent – desired a different plan

Of those respondents who kept their current plan, 23.5 percent changed benefits, copayments, deductibles or cost sharing requirements in the past year. The following specific changes were made by survey respondents:



Employers made these changes to their existing plans in order to be able to keep the coverage they have. In many instances, these changes are driven by cost concerns and to keep coverage affordable. As demonstrated in the graph above, many of the modifications that small employers made involved some adjustment in the cost-sharing requirements. In the preamble to the IFR HHS notes that the limitations on cost-sharing increases imposed by the rule "could result in the cost of some grandfathered health plans increasing more (or decreasing less) than they otherwise would)." Without more flexibility for plan changes, many employers will face increased costs and little ability to relieve those burdens.

As a result of the inflexibility in permissible changes and the cost increases HHS admits will follow, employers, especially small businesses, may choose to forgo offering coverage altogether. This result will not only negatively impact hardworking individuals and their families, but it could further strain an already stretched health system. The IFR notes that if employers continue coverage through grandfathering, it would have the effect of "potentially reducing new Medicaid enrollment and spending and lowering the number of uninsured

individuals." It is important that HHS allow more flexibility in permissible changes to provider networks and plan formularies to let employers continue to offer affordable coverage to their employees, which keeps more people insured and off of the Medicaid program.

Recommendation: HHS should allow plan formularies to reflect ongoing negotiations on behalf of consumers. Changes within tiers or across tiers should not be treated as an event that would cause loss of grandfathered status. Likewise, routine changes to a plan's provider network that allows for better prices for consumers should not trigger a loss of grandfathered status.

3. Better Reflect Medical Costs

On June 15, 2010, you stated "If you like the plan you have, you can keep it…And we've carefully written these rules to make sure grandfathered plans still have the flexibility they need to make reasonable changes to their benefits packages." The purpose of the rule, however, is to ensure that if you like your plan, you will not be able to keep it over time. The IFR provides that a group health plan or health insurance coverage would no longer be considered a grandfathered plan if increases in fixed amount cost-sharing other than copayments (deductibles, out-of-pocket limits) are more than medical inflation plus 15 percentage points *measured from March 23, 2010.* Increases in copayments by an amount that exceeds the greater of: (1) a total percentage *measured from March 23, 2010,* that is more than the sum of medical inflation plus 15 percentage points, or (2) $5 increased by medical inflation *measured from March 23, 2010.*

This will eventually lead to all plans relinquishing their grandfathered status. If businesses are faced with increasing costs to maintain a grandfathered health plans but have no avenues to lower the burden through negotiations or adjustments to plan benefits or cost sharing, it is more likely that the business will drop coverage altogether. If this happens, millions of Americans who were happy with their coverage, may find themselves moved to a higher cost plan or become uninsured.

Recommendation: HHS should eliminate the March 23, 2010 static baseline because it will cause most plans to relinquish their grandfather status over time. HHS should allow grandfather plans to change fixed dollar cost sharing requirements by medical inflation on a year-to-year basis rather than the medical inflation plus 15 percent or $5 increased by medical inflation measured from March 23, 2010.

4. Value Based Benefit Design

Under the IFR, if a plan sponsor or issuer increases a percentage cost sharing requirement such as coinsurance above the level it was set on March 23, 2010, the plan will no longer be considered a grandfathered plan. We appreciate the desire to protect consumers from increases in cost sharing, but also appreciate HHS' recognition that value based benefit designs can incent healthy behavior and use of most clinically appropriate services. In the Interim Final Rule on preventive care requirements enacted by PPACA, HHS states:

"The Departments recognize the important role that value-based insurance design can play in promoting the use of appropriate preventive services. These interim final regulations, for example, permit plans and issuers to implement designs that seek to foster better quality and efficiency by allowing cost-sharing for recommended preventive services delivered on an out-of-network basis while eliminating cost-sharing for recommended preventive health services delivered on an in-network basis. The Departments are developing additional guidelines regarding the utilization of value-based insurance designs by group health plans and health insurance issuers with respect to preventive benefits."

According to the University of Michigan Center for Value-Based Insurance Design:

1. Value equals the clinical benefit for the money spent.
2. Value-based benefit packages adjust patients' out-of-pocket costs for health services on an assessment of the clinical benefit to the individual patient, based on population studies.
3. Thus, the more clinically beneficial the therapy for the patient, the lower that patient's cost share will be. Higher cost sharing will apply to interventions with little or no proven benefit.

The value of these innovative benefit designs are being implemented in the market today by a number of companies. The IFR would require grandfathered plans to relinquish their status if VBBD were implemented to discourage the use of interventions with little or no proven benefit. Considering the VBBD approach would provide incentives to keep people well and to discourage services with little or no evidence of clinical benefit, thereby saving dollars for inappropriate care, we believe HHS should encourage value based benefit design.

Recommendation: HHS should allow grandfathered plans to adopt value based benefit design changes without relinquishing their grandfathered status to promote wellness and to hold down health costs.

5. Promote Certainty

While the IFR specifically details a number of changes that result in plans losing their grandfathered status, it does not indicate whether that list is exclusive. To provide certainty to both consumers and payers, HHS should clarify that the list included in the IFR is an exclusive list. In addition, changes made by a plan sponsor or health insurance issuer in response to the guidance provided by HHS on mental health parity should not trigger changes to grandfathered status. The interim final rule became effective on April 5, 2010, after the effective date of the grandfathered status baseline, and thus should not trigger loss of status under this rule.

Recommendation: HHS should make clear that only those changes specifically delineated in the rule should cause loss of grandfather status. Changes as a result of the mental health parity guidance should not trigger loss of grandfathered status.

6. Consumer Notification and Correction

The IFR requires disclosure of grandfather status to plan participants or beneficiaries. HHS included in the IFR model disclosure language that would be sufficient to fulfill this requirement. We believe that this disclosure language may lead to misleading or biased information being provided to the consumer. Information should be included in the disclosure form describing that while the grandfathered plan may not include all of the features included in the Affordable Care Act, the plan may be less expensive than alternatives. Furthermore, a statement should be included detailing the grandfathered plan's policies in the areas where the plan may not specifically meet the Affordable Care Act requirements. It is important that consumers be afforded the opportunity to fully assess the benefits and shortfalls of both the new plans under the Affordable Care Act and the grandfathered plans.

In addition, the IFR includes a transitional rule that allows certain plan changes to be implemented after the March 23, 2010 deadline as long as the changes were contracted, filed, or adopted prior to that deadline. Furthermore, a temporary grace period is provided to employers and issuers to revoke or modify any changes to plans adopted after enactment of the health care reform legislation and prior to publication of the rule. While CAHC recognizes the importance of these temporary transitional measures, it is important that notification and correction procedures be included for the long term.

The IFR does not include any specifications on how plans or purchasers of health coverage will be notified that, due to impermissible changes, they will lose their grandfathered status. Furthermore, no procedures for correcting impermissible changes, outside of the temporary transitional measures, are included. We believe that this omission could potentially lead to some unknowingly relinquishing their grandfathered status without the possibility of taking corrective actions. We believe that a notification process should be spelled out by HHS and that plans and purchasers should be given a reasonable amount of time, upon being notified, to revoke or correct the action that has put their grandfathered status in jeopardy.

In our survey, 91.7 percent of respondents believe the self-employed and small business owners should receive a notice from their insurer or from the Federal government about whether their plan qualifies as a grandfathered plan. This overwhelming response reflects what we know intuitively – consumers want information about their plans to make informed decisions.

Recommendation: HHS should improve the model disclosure form to better inform consumers about the benefits of grandfathered plans to promote informed choice and decision making. HHS should establish a process for loss of grandfathered status.

Once again, thank you for the opportunity to provide comments on the Interim Final Rule relating to grandfathered health plan status under the Patient Protection and Affordable Care Act. We urge you to consider the issues and recommendations raised in this comment letter and to ensure that the millions of Americans who are happy with their current coverage will be able to maintain that coverage. Furthermore, it is vital, especially during difficult economic times, that businesses have the choice and flexibility to keep health insurance costs low and adapt to an

ever-changing business environment. We look forward to continuing to work with you throughout the implementation of the health care reform law.

Sincerely,

American Osteopathic Association
Communicating for America
International Franchise Association
National Association for the Self Employed
National Association of Health Underwriters
National Association of Manufacturers
National Retail Federation
U.S. Chamber of Commerce

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