



August 16, 2010

Office of Consumer Information and Insurance Oversight  
Department of Health and Human Services  
Attention: OCIO—9991-IFC  
P.O. Box 8016, Baltimore, MD 21244-1850

Re: **OCIO-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 Director Angoff:

The Alliance of Community Health Plans (ACHP) is pleased to submit comments in response to the Interim Final Rule with Comment (IFR) on Section 1251 of the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148). Section 1251 specifies that certain plans or coverage existing as of the date of enactment (March 23, 2010) are only subject to certain provisions of the Act. These plans, which may be either insured or self-insured group health plans or health insurance coverage purchased from health insurers by individuals or groups, are referred to as grandfathered health plans.

ACHP is a national leadership organization representing community-based and regional health plans and provider organizations that collectively provide health care and coverage for approximately 18 million Americans, predominantly in the individual and small and mid-sized group markets. ACHP members also have a significant presence in the Medicare Advantage market and some contract with their states to provide coverage to Medicaid beneficiaries. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems. Member plans share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality.

ACHP appreciates the challenges presented to the Departments in implementing Section 1251. The regulations must reflect the intent of Congress in writing PPACA to ensure that Americans who are satisfied with their existing coverage are able to retain it, while also reflecting the intent to spread important reforms in the private insurance market. In the regulations for grandfathered plan status, as well as in other regulations, the Department should strive to provide bright lines that promote understanding and consistent implementation and facilitate interactions among health plans, employers and other plan sponsors, and consumers. At the same time, the Department should establish a process for the consideration of exceptions that do not fit the norm.

#### *Maintenance of Grandfathered Plan Status*

The Interim Final Rule sets forth a number of criteria that will be used to determine whether a health plan maintains or loses grandfathered status. These criteria are expressed in terms of changes that directly affect enrollees – i.e., elimination of benefits to diagnose or treat a particular condition, increases in cost-sharing requirements, increases in fixed amount copayments, decreases in employer or

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employee organization contribution rate, and changes in annual or lifetime limits. ACHP believes that the impact on enrollees of changes related to benefits, as determined by the thresholds established in the IFR – rather than changes that relate to plan administration or source of funding – should guide decisions on grandfathered status.

Accordingly, we recommend that a plan should not lose grandfathered status simply because a new policy, certificate, or contract has been issued, or technical changes made to an employer's plan certificate. Our member plans typically re-issue policies, certificates, and contracts in the ordinary course of business, often on an annual basis. If these actions have no significant impact on member benefits – that is, they stay within the thresholds established in the IFR – then these administrative changes should not trigger loss of grandfathered status.

Similarly, we encourage the Department to reconsider whether an employer plan that changes insurance carriers, while retaining the same level of benefits, should lose grandfathered status. The potential loss of grandfathered status if an employer changes carriers may well act as a disincentive for employers to search for and contract with another carrier that would provide the same or better benefits or service but at lower cost. Allowing employers to maintain grandfathered status if they are only switching carriers but maintaining benefits would likely spur competition among carriers for that business, leading to the possibility of an overall reduction in costs. As above, we think the assessment should turn on the impact on employee benefits determined according to the thresholds set forth in the IFR, not the administrative or funding arrangements of the plan.

The Department has invited comments on what other changes, if any, should cause loss of grandfathered status. Possibilities include: (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); (2) changes in a network plan's provider network, and if so, what magnitude of changes would have to be made; (3) changes to a prescription drug formulary, and if so, what magnitude of changes would have to be made; or (4) any other substantial change to the overall benefit design. We offer the following comments on these questions:

Changes in a plan's provider network – ACHP believes that routine changes in a plan's provider network to add new providers, drop providers who have failed to meet plan contracting requirements or drop providers who fail to meet plan quality standards should not trigger loss of grandfather status. Nor should routine changes to update the provider network to reflect the movement of providers in and out of a plan's service area. We believe that the only reason why a network change should result in the loss of grandfathered plan status is if the change significantly reduces timely and appropriate access to plan providers or significantly reduces the value/quality of plan benefits. We also believe that any regulation in this area should establish a process that allows plans the opportunity to demonstrate that the network change was necessary due to extenuating circumstances.

Changes to plan structure – As noted above, given the intent of the President and lawmakers to preserve coverage that was available as of March 23, 2010, ACHP believes that the major test for retaining grandfathered plan status is that the benefits provided by that coverage continue as is and do not erode over time. Changes in plan structure or funding should not cause loss of grandfathered status if benefit changes remain within the thresholds established by the IFR. For example, an employer plan that shifts from a high deductible health plan with an HRA to the same high deductible plan with a health

savings account should not lose its grandfathered status so long as enrollees are kept whole in terms of their benefits (including the amount of employer contributions to their tax-favored accounts) under the thresholds set out in the IFR. We also believe that a change from fully-funded to self-funded coverage should be considered an administrative change and not trigger loss of grandfathered status if benefit changes are within the thresholds.

Changes to a plan's prescription drug formulary – ACHP believes that plans should retain the flexibility to make changes to their formularies without losing grandfathered status because such changes are warranted for reasons of clinical effectiveness, patient safety, and keeping formularies current with the availability of new products, both branded and generic. If the Departments decide, however, to include formulary changes as a reason for a plan's loss of grandfathered plan status, we urge that these changes be limited to those that result in reducing the generosity (actuarial value) of the drug benefit for the plan's participants, beneficiaries or subscribers. Changes to improve quality, the effectiveness of the plan's drug benefit, or the safety of its covered drugs, however, should not trigger loss of grandfather status. For example, formulary changes to enable a plan to remove a drug that is determined by the Food and Drug Administration to be unsafe or because a generic alternative has become available should not trigger a change in status. Additional exceptions may also be warranted because a plan might want to move one or more types of medication from a lower to a higher cost-sharing tier or vice versa as a way of encouraging use of the more clinically effective alternative. On the other hand, elimination of coverage for all branded drugs would constitute a significant change that merits loss of grandfather status.

#### *Definition of Grandfathered Health Plan Coverage—Model Language for Disclosure Requirement*

Under the IFR, a plan or health insurance coverage must include a statement, in any plan materials provided to participants or beneficiaries (in the individual market, primary subscribers), describing the benefits provided under the plan or health insurance coverage, and stating that the plan or health insurance coverage believes that it is a grandfathered health plan within the meaning of section 1251 of the ACA. The plan must provide contact information for questions and complaints. Model language is provided that can be used to satisfy this disclosure requirement. Comments are invited on possible improvements to the model language of grandfathered health plan status.

ACHP appreciates the intent of the Departments in including the model language, which is not included in the statute, and recognizes the model language is not a requirement. We believe, however, that the notice, as presented in the Model language, is more likely to confuse individuals with fully-insured and self-funded coverage. It is the employers who choose to retain grandfathered status, not the members. Notifying members that their coverage is grandfathered will likely lead members to call their health plan to inquire what this means, when the member should really be talking with their employer. The model language should better explain the employer's involvement in making that decision. Further, there are two different situations that may confront enrollees in employment-based plans. If the employer offers only one option, and retains grandfathered status, the notice to the employee would reflect that. However, if the employer offers multiple options, some of which are grandfathered and some of which are not, the notice to the enrollees in the grandfathered plans would presumably be different to reflect the options available.

Additionally, the Model notice states that being grandfathered means the member's coverage may not include, for example, preventive health services without cost sharing. Many of our member's plans, however, already are leaders in covering preventive health services without cost sharing. Thus, the notice may cause enrollees' unwarranted concerns. If plans are to be required to notify members that their covered is grandfathered and to state what benefits or protections they might not have because of that status, health plans should be able to customize the notice.

Thank you for your consideration of our views. Please let me know if you have any questions about these recommendations or require additional information.

Sincerely,

A handwritten signature in cursive script that reads "Patricia P. Smith".

Patricia P. Smith  
President & CEO