



August 16, 2010

The Honorable Hilda L. Solis
Secretary
U.S. Department of Labor
Employee Benefits Security Administration
Office of Health Plan Standards and Compliance Assistance
Attention: RIN 1210-AB42
200 Constitution Avenue, N.W.
Room N-5653
Washington, DC 20210

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Attention: OCIO-9991-IFC
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445G
Washington, DC 20201

The Honorable Timothy F. Geithner
Secretary
U.S. Department of the Treasury
Attention: REG-118412-10
Internal Revenue Service
1111 Constitution Avenue, N.W.
Room 5205
Washington, DC 20224

Re: 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 (Affordable Care Act)

Dear Secretaries Solis, Sebelius, and Geithner:

The National Business Group on Health appreciates the opportunity to comment on the proposed Interim Final Rules relating to grandfathered status of plans in existence on March 23, 2010, the date of enactment of the historic Patient Protection and Affordable Care Act of 2010 (The Affordable Care Act). We commend your efforts to implement the rules for maintaining grandfathered status, which is intended to assure that employers may continue to offer and

employees may continue to be covered by plans they had before the law's enactment. The intent of our comments is to enhance that assurance for both employees and employers, so that plans that wish to maintain grandfathered status can easily do so. Our employer members are very concerned about the current "triggers" that could significantly inhibit employer plans as a source of innovations to help our country move toward more affordable, sustainable, effective and efficient health care.

The National Business Group on Health represents approximately 294, primarily large, employers (including 64 of the Fortune 100) who voluntarily provide health benefits and other health programs to over 50 million American employees, retirees, and their families.

The National Business Group on Health's concerns include:

- 1) The rules may inhibit plan changes that enhance the quality, affordability (both to employers and employees) and value of employer-sponsored benefits;
- 2) By outlining six very specific "triggers", any of which by themselves could result in the loss of grandfathered status, the proposed rules overlook the possibility that plan changes in the aggregate may maintain or even increase the overall value of plan benefits;
- 3) Changes beyond the control of plans, particularly in those areas such as changes in formularies and provider networks (areas that the Departments requested comment on to potentially add to the list of additional plan changes) may "trigger" the loss of grandfathered status through no decision or fault of plans;
- 4) The Departments have not made it clear that plan changes required to comply with other laws, such as the Mental Health Parity and Addictions Equity Act of 2008 (MHPAEA), will not by themselves "trigger" the loss of grandfathered status;
- 5) The Departments have not made it clear that plans may drop outmoded treatments without jeopardizing grandfathered status;
- 6) Because of the above concerns and our recommended solutions, we recommend that the Departments not consider adding any additional "triggers" based on specific plan changes; and
- 7) Employers need flexibility to keep up with rapidly rising costs and changing conditions and needs. If the Departments allowed actuarial equivalence, to maintain grandfathered status, employers could continue providing comprehensive, quality health benefit plans, while remaining affordable to employers and employees.

The Departments Should Permit Plan Changes that Are Proven to Enhance the Value of Employer-Sponsored Health Benefits without Jeopardizing Grandfathered Plan Status

Recommendation: The Departments should continue to permit plans to consider and adopt proven, evidence-based plan changes that enhance the quality and value of

employer-sponsored benefits without jeopardizing grandfathered status, so that employer plans can continue to be a source of innovative solutions.

Early each year, employers who sponsor health plans for employees routinely review and consider many changes to plans, taking into consideration a multitude of data and criteria, including quality, financial, economic, labor market, business and government requirements, before settling on plan changes for the coming year. Employers' ultimate goal is to maintain health benefits packages and options that help attract and retain talent, boost employee health and productivity, and remain affordable.

The rules outlining the parameters beyond which plans lose grandfathered status mean that, for the first time, as employers consider their annual, routine plan changes, those wishing to maintain grandfathered status must take a significant number of tools off the table and only consider a narrower set of plan changes. This represents a sea change from the past where employers could consider any plan changes that fostered the goals for the coming year. This ability to consider any and all changes, made possible in large part by the Employee Retirement Income Security Act (ERISA), means that employer plans have adopted and initiated innovative practices to improve employees' wellness, address chronic diseases, reward high performing health care providers and many other vitally important strategies that directly translate into better health care for employees and their families. Many of these same programs have also "bent the cost curve" and helped employer plans lower their overall trend in health care costs.

Unfortunately, the unintended consequences of the proposed rules may also mean that plans wishing to maintain grandfathered status may no longer consider some of these innovations if they would jeopardize grandfathered plan status. For example, plans may no longer consider adding HIPAA-allowed wellness incentives such as premium discounts, which studies have shown significantly increase participation, for targeted wellness activities such as exercise and weight management, if they fear that the overall employee premium impact may "trigger" the loss of grandfathered status because of its potential to change relative premium contributions beyond the 5 percentage points permitted in the Interim Final Rules. Furthermore, the rules limit of a \$5 copayment differential (plus medical inflation from March 23, 2010) prohibits employers from providing virtually any incentive for employees to use higher value provider networks. In another example, plans may no longer consider adding new consumer-directed plans, which by definition would be non-grandfathered, if it would "trigger" the loss of grandfathered status of their other previously offered options even though it would be voluntary and employees may still select the other plans. Moreover, with significant upfront employer contributions and generous preventive coverage, consumer-directed plans help employees better access health care services. In addition, the introduction of new pharmacy benefits such as mandatory mail order or mandatory generics to lower both employers' and employees' costs would also "trigger" the loss of plans' grandfathered status. All of these examples raise significant uncertainties—if and how wellness incentives would be factored into the "triggers" (we recommend that they do not) and the effect of adding new plan options or benefits on the status of existing options that may leave many innovations off the table and reduce the ability of employer-sponsored plans to be forces for promoting more effective and efficient health care delivery.

The Departments Should Consider an Aggregate Standard as a “Trigger” instead of the Six Individual “Triggers”

Recommendation: We believe that an aggregate standard would better serve the intent to preserve current plan options for employers and employees who prefer to maintain them. We recommend a standard whereby plans could make changes but maintain their grandfathered status as long as the actuarial value of the plan does not change beyond 5%.

Recommendation: We do not recommend that the Departments add any additional plan changes that would “trigger” the loss of grandfathered status and strongly recommend reconsidering the Interim Final Rules, which currently are too inflexible and will stifle innovation.

Unfortunately, with the current draft of the rules, plan changes that go beyond the permitted parameters **of a single “trigger”** would cause plans to lose grandfathered status. Using this approach can mean that even if employers increase overall percentage plan contributions but shift from copayments to coinsurance for example, possibly for even just one service, they may lose grandfathered status. Similarly, employer plans shifting from copayments to coinsurance but maintaining the same estimated percentage employee cost-sharing would lose grandfathered status as well. We do not believe that this individual approach, without looking at the overall totality of the effect of plan changes, best serves the intent of the law.

The Departments Should Exempt Plan Changes not under Plan Control from Jeopardizing Grandfathered Status

Recommendation: Plan changes that arise because of, or as adjustments to, market conditions or other factors beyond plan control should not jeopardize grandfathered plan status.

The Departments ask for comment on what other changes including changes in plan structure, provider networks, prescription drug formularies, and other substantial changes in benefits should “trigger” the loss of grandfathered status. We are concerned that a number of changes in these areas may not be under plans’ control (discussed here) or they include employers’ efforts to improve health care quality, such as adopting centers of excellence, mandatory use of generics or incentives for using high performance provider networks (discussed above) and should be permitted without loss of grandfathered status.

The following are just a few examples of changes beyond plans’ control. Individual employer plans often do not have much leverage with some providers who may present contract terms that plans cannot afford or decline to participate in plan networks. Similarly, formularies constantly change as medications go off patent, generic competitors enter the market, and new brand medications come on the market. Formularies change to reflect changing market conditions. Recently a Pharmacy Benefit Manager (PBM) announced, but later rescinded, a decision that it would no longer be dealing with one drug store chain. Employer plans using that PBM would have been forced to either switch PBMs or keep the PBM but no longer permit plan participants

to fill prescriptions through the affected chain drug stores. We do not believe that any of these changes beyond plan control should jeopardize grandfathered plan status.

Additionally, if the Departments did adopt a trigger based on provider network changes, it would likely inhibit the ability for plans to negotiate lower rates for fear of triggering provider network changes, leading to uncontrollable premium increases.

The Departments Should Clarify that Plan Changes to Comply with Other Laws Will not “Trigger” Loss of Grandfathered Status

Recommendation: The Departments Should clarify that compliance with another law does not jeopardize grandfathered status even if it results in “triggering” one of the six items in the interim final rules.

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires plans that voluntarily offer mental health and substance abuse treatment benefits to examine and potentially make changes in copayments, coinsurance and other factors that can affect some of the specific “triggers” in the proposed regulation. Though the Interim Final Rules clarify that grandfathered plans must comply with MHPAEA and other applicable laws, the proposed rules add unclear and potentially ambiguous language stating that they must comply “except to the extent supplanted by changes made by the Affordable Care Act.” For example, it is unclear whether plans adjusting copayments or coinsurance to comply with MHPAEA would remain grandfathered plans if the necessitated changes required plans to go beyond one of the specific “trigger” in the proposed rule. We believe that the intent of the PPACA is not to create a situation where in complying with one law, in this case the MHPAEA, plans unfairly lose grandfathered status.

The Departments Should Clarify that Plans May Drop Outmoded Treatments Without Jeopardizing Grandfathered Status

Recommendation: The Departments should exempt plans from losing grandfathered status if they eliminate coverage for services or treatments recognized to be ineffective or outmoded by the relevant medical professional societies, the relevant federal government entities (Food and Drug Administration (FDA), National Institutes of Health (NIH), Centers for Disease Control (CDC), etc.) or the consensus of medical research.

Recommendation: The Departments should exempt plans from losing grandfathered status if they eliminate coverage of services or treatments that are outmoded or underutilized services, which are not defined as “essential benefits”.

As you know, medicine continues to evolve and researchers announce new clinical evidence daily, including new evidence about existing treatments. Plans strive to stay current as do providers by assuring that covered benefits match the latest clinical evidence. This raises potential concerns that plans may lose grandfathered status by “triggering” the prohibition on eliminating benefits to diagnose or treat specific conditions, particularly the elimination of benefits for any necessary elements to diagnose or treat the conditions. In some cases, people

may find only one provider who claims that a particular service, test, or treatment is necessary even if the relevant medical professional society has reached a consensus that a particular service or treatment is not effective and is outmoded or peer-reviewed medical literature has reached the same conclusion.

In addition, under the new law, the Secretary of Health and Human Services will define the “essential health benefits” for the exchange plans that are “equal to the scope of benefits provided under a typical employer plan”. Accordingly, plans should not lose their grandfathered status for eliminating underutilized services that the federal government itself does not recognize as “essential health benefits” for “qualified” health plans.

Thank you, again, for the opportunity to provide comments and assist you in this vital work to drive reform in our health care delivery system and improve the health of our country.

Please contact me or Steve Wojcik, Vice President of Public Policy, at 202.585.1812 if you have questions or would like to discuss this feedback in further detail.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Helen Darling'.

Helen Darling
President

cc: The Honorable Phyllis C. Borzi, Assistant Secretary, Employee Benefits and Security Administration
Mr. Jay Angoff, Director, Office of Consumer and Insurance Oversight
The Honorable Douglas H. Shulman, Commissioner, Internal Revenue Service
Ms. Nancy Ann DeParle, Director, White House Office of Health Reform