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Group Health Plans and Health Insurance Coverage: Interim Final Rules for Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act

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General Comment

See attached file(s)

Attachments

IRS-2010-0010-0484.1: Comment on FR Doc # 2010-14488

August 10, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
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P.O. Box 8016
Baltimore, MD 21244–1850

Re: Interim Final Rule for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act

Below are our comments regarding the Interim Final Rule for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act (PPACA).

We believe that every effort should be made to increase the number of individuals covered by PPACA, especially as of January 1, 2014 when most of the reform components (Insurance Exchanges, Subsidies, Tax Credits, etc.) come into play.

The Rule provides the seven triggers that would revoke the grandfathered status of a group health plan:

- Mergers or acquisitions with the sole intention of maintaining grandfather status
- Elimination of substantially all benefits to treat a particular condition
- Elimination of benefits for any element necessary to eliminate or diagnose a condition
- Any change to coinsurance level
- Fixed-amount cost-sharing (Deductibles/OOP) Inflation +15%
- Co-payments (Medical Inflation +15% or $5 adjusted for medical inflation)
- Employer contribution (> 5% reduction in Employer Contribution)

While relatively straightforward, these guidelines may still result in some confusion to the marketplace in their application. For example, if an employer raised the copayment level beyond the maximum in one area (i.e. outpatient services) but retained the copayment level for primary care doctor visits, does that mean a loss of grandfather status? Clarity will be critical both for the employer and the employee.

The average consumer has a broad definition of "benefits." Consumers view their health plan beyond the covered benefits, cost sharing, and the contribution levels associated with the plan. Other components of health care services can have a significant impact on the individual employee, which can result in a change to their plan including:

- *A "substantial change" to the provider network*

  Consumers believe their provider and the provider network associated with any plan is an integral part of the health care benefits provided by the employer. A termination of a

hospital system or specific provider group sometimes has significant impact on the employee population and should be viewed as a substantial change to the plan itself. As a guideline, we would suggest any change in the provider network impacting over 50% of the employee population (nationally or locally) should result in a loss of the grandfather status.

- *Change in issuer or third-party administrator (TPA) (including moving from fully-insured to self-funded)*

  Even if the benefit structure of a group health plan remains largely the same, a change in administration of the plan requires new communication, new processes, and new requirements on the part of an employee and the employer. Moving from a fully-insured to a self-funded status or changing administrators requires new processes and legal agreements for the group health plan. These transitions are not daily or regular events and should be considered a change in the group health plan.

- *Significant change in care management/authorization requirements*

  The processes consumers need to follow to receive care are a significant component of their perceptions of their health benefits plan. Changing notification requirements, requiring referrals, or other care management strategies involved in the delivery of care should also be considered as a change to the plan. This may prevent group health plans from maintaining their grandfather status by not necessarily eliminating a benefit, but making it difficult to receive by changing the care management process around it.

Even by the most optimistic estimates, a substantial portion of the employee population will remain outside the PPACA as of January 2014 based on the current rules. While we understand the difficulty involved in making change, creating another large sub-population of excluded individuals will only add to costs, increase confusion, and mitigate the potential impact of the legislation. This only adds to the uncertainty surrounding the $143 billion in deficit reduction projected by the Congressional Budget Office (CBO) when the process began.

We believe that any changes related to the areas listed above should also result in a loss of grandfather status as these are changes that heavily impact a patient's healthcare benefits. The Rule needs to be clear, reasonable, and with no ambiguities involved in determining whether a group health plan is "in or out." The decisions we make today will determine the outcomes for tomorrow. We may need to make some difficult decisions to create a sustainable health care system that will support a growing economy in the future. That means getting as many citizens across the country participating at the beginning to make it work and delivering on its promises to retain their support.

Thank you for the opportunity to comment on this regulation.

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