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To: [E-OHPSCA1251.EBSA](#)
Subject: Comment, interim final rule on status as grandfathered health plan
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The interim final regulations on grandfathered health plans go into some detail on the impact on grandfathered status on changes in cost-sharing, including fixed payment deductibles or co-pays and percentage coinsurances.

One area not addressed by the interim final regulations is the impact on covered persons obtaining services from non-network providers if the health plan reduces the allowable charge payable to network providers.

For the purposes of this comment, an allowable charge is the amount agreed upon between the health plan and a network provider as payment in full, subject to any co-insurance, deductibles, or co-payments.

Many health plans provide either that the amount payable (subject to any co-insurance, deductibles, or co-payments) for services when obtained from a non-network provider will be a percentage of the allowable charge when services are obtained from a network provider. Others may provide for the same amount payable (subject to any co-insurance, deductibles, or co-payments) to non-network providers as the allowable charge for network providers, but may have other provisions, such as not allowing assignment of benefits to non-network providers. In all cases, non-network providers are not constrained by the health plan allowances or payments and may bill covered persons for balances beyond simply co-insurance, deductibles or co-payments.

If a health plan reduces the allowable charge for a service, the effect on a covered person obtaining services from a network provider may be neutral (in the case of fixed-cost co-payments or deductibles) or even beneficial (in the case of co-insurance). On the other hand, for a covered person who obtains services from a non-network provider, the effect would be adverse, except in the unlikely circumstance that the non-network provider lowered its charge to the new (reduced) allowable charge amount.

For health plans with very high provider network participation for the particular service involved, the net impact on covered persons of reducing an allowable charge should be sufficiently beneficial that the increased cost to a covered person obtaining services from a non-network provider should be disregarded and grandfather of a health plan should not be affected. For most covered persons, direct cost changes will be neutral or beneficial, and the cost-containment impact of a reduced allowable charger should be reflected in premiums, benefiting all persons covered by the health plan. If, however, a health plan had such low provider network participation for the particular service (e.g., a health plan might have high levels of provider participation by most kinds of professionals or institutions) that large numbers of enrollees obtained services from non-network providers, there might be significant additional costs to many participants. Even in such a case, however, such a plan should nonetheless continue to be grandfathered. First, a plan with very low participation by a particular type of provider might well be found under some relevant state law to have an inadequate provider network, a situation capable of remediation under those laws. Second, low levels of participation by a particular type of provider may be indicative of inappropriate agreements among such providers rather than a fault of the health plan. Finally, the health

plan may deliberately seek a highly limited provider panel as a matter of fostering competition among health care providers, with beneficial effects on the market for health coverage. Parsing the reasons for low levels of network participation and making case-by-case decisions in each circumstance of a reduction in allowed charges would seem likely to pose insurmountable regulatory challenges.

I would suggest that the interim final rule be clarified to indicate that a reduction by a health plan in the allowable charge for a covered service having the result of higher cost to plan participants who obtain services from a non-network provider will not result in such a plan failing to be a grandfathered plan. Such a clarification is desirable to avoid hesitation on the part of health plans in pursuing cost-reduction strategies and equally to avoid inappropriate pressure, by non-network providers in particular, encouraging a determination that such plans would no longer be grandfathered as a tactic to prevent any such changes in allowable charges. A finding that such a plan is not grandfathered would not benefit such non-network providers, of course, but it is the threat of finding such a plan not to be grandfathered that might be used inappropriately.

Retaining grandfathered status was plainly an element Congress recognized as important to health plans, and this minor but potentially problematic issue should be addressed by the agency.

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