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Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

**Re: RIN 1210-AB42
Comments 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 75 Fed. Reg. 34538 (June 17, 2010)**

This letter responds to the request for comments by the U.S. Departments of Health and Human Services, Labor and the Treasury (Agencies) regarding the June 17, 2010, Interim Final Rules (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 (PPACA). These comments are submitted by the Society for Human Resource Management (SHRM).

SHRM is the world's largest association devoted to human resource (HR) management. Representing more than 250,000 members in over 140 countries, SHRM serves the needs of HR professionals and advances the interests of the HR profession. Founded in 1948, SHRM has more than 575 affiliated chapters within the United States and subsidiary offices in China and India.

SHRM members administer both insured and self-insured health care plans and have extensive knowledge and experience in trying to keep health care costs down while continuing to maintain a generous and meaningful benefit for their employees and beneficiaries. SHRM respectfully submits these comments in an effort to increase the Agencies' understanding of the challenges our members face in applying the Rules as they have been written. These comments are intended to assist the Agencies in revising the Rules in order to maintain consistency with the congressional intent of the grandfather rule added by the PPACA and to help ensure smooth implementation of the PPACA with little disruption to the participants and beneficiaries who enjoy robust health care coverage through their employer-provided plans.

SHRM respectfully submits these comments and suggested changes to the Rules in the following areas:

- Preservation of Right to Maintain Existing Coverage
- New Flexibility Recommended
- Need to Recognize the Employer Responsibility to Contain Health Care Costs
- Change in Insurance Carrier
- Involuntary Changes
- Annual Allowable Increase
- Provider Network and Prescription Drug Formulary Changes
- Record Maintenance
- Collectively Bargained Plans
- Small Entities
- Conclusion

I. Preservation of Right to Maintain Existing Coverage

The “grandfather rules” emanate from Section 1251 of the PPACA, entitled Preservation of Right to Maintain Existing Coverage. This language in the law originated in the Senate-passed health care reform bill, and places no time limits on the right to maintain existing coverage. Further, it does not stipulate any requirements that have to be satisfied to continue existing coverage.

The lack of qualifying language appears to reflect legislative intent. Throughout the legislative debate, congressional leaders and President Obama, himself, repeatedly stated that “if you like the coverage you have, you can keep it.” When the Rules were released, HHS Secretary Sebelius stated that the Rules “make good on President Obama’s promise that Americans who like their health plan can keep it.” SHRM shares these goals of the President and the Secretary.

Nevertheless, SHRM members are concerned that while the Rules technically allow an employer to maintain the coverage in existence as of March 23, 2010, the Agencies’ interpretation of the legislative language in the Rules goes too far, making it unlikely that existing coverage can be maintained for very long. The Agencies’ own statistics anticipate that many current plans will cease to retain grandfathered health plan status. The Agencies’ impact analysis states that by 2013, at the mid-range estimate, only 55% of large employers (compared to 82% in 2011) and 34% of small employers (compared to 70% in 2011) will retain grandfathered health plan status. The upper-range estimate is that 36% of large employers will retain grandfather status in 2013 and 20% of small employers will retain their grandfathered health plan status by 2013. These statistics demonstrate that the Rules will in fact substantially limit the ability of group health plans in existence on March 23, 2010, to preserve the right to maintain existing coverage. This is not consistent with the indefinite nature of the right enumerated in the statute. In addition, being too prescriptive of what is required to retain grandfathered status may have the unintended consequence of encouraging group health plans to forego grandfathered health plan status early or altogether, and make more substantial design changes which, though they will include all the law’s

new requirements, may result in lower employer-provided benefit values than the plans in existence on March 23, 2010.

As explained in the additional comments below, by broadening the construction of the Rules, many more employer-sponsored plans will be able to maintain their grandfathered health plan status in the future. This will allow employers to continue to provide the robust benefits that were highly praised by lawmakers as the standard for coverage that the new health reform law would make available to the rest of the American people.

II. Additional Flexibility Recommended

As written, the Rules lack flexibility with regard to the provisions relating to permissible changes in employer contributions and employee cost sharing. The Rules set forth a very complex and administratively difficult series of formulas. These could be simplified by adding an alternative way of satisfying the employer contribution and cost sharing values, namely by considering actuarial equivalence in terms of the employer-provided value.

In the preamble, the Agencies explain why they dismissed use of an actuarial equivalency standard. First, the Agencies expressed concern about the potential to fundamentally change a plan design but maintain the same actuarial value. Second, the Agencies expressed concern about complexity in defining and determining actuarial value as well the necessity for very prescriptive rules. SHRM would like to address these two objections.

1. Agency Concerns over Fundamental Plan Design Changes: Use of employer-provided actuarial value to determine the permissible increases in employer contributions and cost sharing could be included as an option to the requirement already laid out in the Rules. When used alongside the other requirements to maintain grandfathered health plan status, actuarial equivalence would be used in a very limited way.

To illustrate how actuarial equivalence could be used, not as a substitute for what is now in the Rules, but as another option, consider the following example for an alternative cost sharing formula. Consider that a plan retains grandfathered health plan status as long as it maintains the relative employer-provided value of the coverage it provides on the date of enactment and after making legally required changes of grandfathered plans. This means that in future years, adjustments could be made in employee cost sharing to reflect the increase in health care costs without that causing a loss in grandfathered status.

Using this approach of allowing employer-provided actuarial value as an alternative test, the final rule could keep in place the other requirements in the Rules. For example, if a plan eliminates all or substantially all benefits to diagnose or treat a particular condition, although the actuarial value for cost sharing is the same, the plan would still lose grandfathered health plan status. Co-application of the other provisions in the Rules should address the concerns of the Agencies, in our opinion.

2. Agency Concerns over Complexity in Defining and Determining Actuarial Value: Determination of the employer-provided actuarial value of a benefit option is a straightforward calculation, commonly and frequently performed. In addition, its use has long precedent with other federal health programs under the jurisdiction of HHS. For example, the retiree drug subsidy under Medicare Part D uses a determination of actuarial value. It requires calculation and attestation by a qualified actuary and a member of the American Academy of Actuaries. Being a “qualified actuary” means the actuary needs years of experience in the health field. The attestation is included along with the application submitted by the plan sponsor for the retiree drug subsidy.

It would be quite easy to require a similar attestation to confirm that grandfathered health plan status of an employer-sponsored health plan is preserved. Such an attestation could be included as part of the notification to employees that the plan is a grandfathered health plan and also made available to the Agencies, perhaps with proactive notification to the Agencies if and when the actuary determines that the employer-provided value is no longer equivalent.

In short, SHRM recommends that the Agencies include more ways of allowing flexibility to employer-sponsored health plans in maintaining grandfathered health plan status, including the use of equivalent employer-provided actuarial value as an optional alternative test to the complex and prescriptive mathematical formulas in the Rules.

III. Need to Recognize the Employer Responsibility to Contain Health Care Costs

The final rules should more clearly establish that certain changes in group health plans intended to contain the costs of health insurance for employers and plan participants but maintain the value of the plans are consistent with the intent of the statute.

Sponsors of fully insured and self-insured employer group health plans governed by ERISA retain a fiduciary duty to act in the best interests of plan participants and beneficiaries. This duty includes getting the best price for the health care coverage provided to participants and beneficiaries. As noted on www.HealthCare.gov, “When employers pay more for insurance, they have less money to invest in the company and may be forced to pay lower wages or shift health care costs to their employees.” In addition, the fact sheet issued along with the Rules states that “[the rule] allows plans that existed on March 23, 2010 to innovate and contain costs by allowing insurers and employers to make routine changes without losing grandfather status.”

The following comments illustrate ways in which the Rules can be improved to help facilitate cost containment consistent with the stated goals above.

A. Allow Group Health Plans to Maintain Grandfathered Health Plan Status Even If They Eliminate a High-Cost Coverage Option

There is language in the Rules described as an anti-abuse provision that we believe unwittingly pulls in situations that are not at all abusive. Example 2 under 2590.715–1251(b)(2)(ii) states that if a high cost health plan is eliminated and the employees are transferred to another plan, and there is no bona fide employment-based reason to transfer the employees, then grandfathered health plan status is lost for the transferee plan. But consider the following: One of the ways that employer plan sponsors are able to contain costs is by eliminating a coverage option within the plan that is no longer competitively priced.

For example, if one of the coverage options offered to employees is an insured health maintenance organization (HMO) and that HMO option is overpriced relative to other HMOs in the market, it would not be prudent for the plan sponsor to maintain that particular HMO as a coverage option, especially where the same or similar benefits can be purchased at a lesser cost.

In this example, the rationale for dropping the HMO as an option may include:

- The HMO is priced so high that it is no longer competitive;
- Other coverage options provide similar benefits but cost less;
- The higher premiums for the overpriced option will reduce wages and also cause health care costs to increase unnecessarily.

If the plan sponsor eliminates the high-cost option, it should not trigger a loss of grandfathered health plan status if following the elimination of the high cost HMO (in our example), the plan sponsor allows its employees to choose among other coverage options that cost the same or less for similar coverage. In this example, employees are not forced into a lesser plan but rather are allowed to choose among the other coverage options available that would provide similar benefits to the eliminated HMO. In this situation, there is no abuse as contemplated by the Rules. In fact, dropping a high-cost coverage option that is not competitively priced is favorable for employees as they are free to select a plan in which benefits are similar and premiums or cost sharing is decreased because the premium amount is much less than it would have been under the high-cost HMO option.

SHRM understands the Agencies' concern that some plan sponsors may try to circumvent the Rules by forcing their employees out of a plan that provides rich benefits into a plan that only provides minimum benefits. However, a circumvention of the Rules is not the driving force in the situation described above.

SHRM requests that the final regulations clarify that eliminating a high-cost option does not trigger the anti-abuse rule and the loss of grandfathered health plan status for the remaining plan options if there are similar benefits available to the same employees through other options, or the option eliminated is replaced with an equivalent option, and/or if the employee has a choice of selecting other available plan options. These situations do not force employees into another plan. Absent such clarification, employers will be confused and uncertain whether the elimination of a

high-cost option by itself triggers a loss of grandfathered status for the remaining plan(s) under the Rules.

B. Allow Group Health Plans to Maintain Grandfathered Health Plan Status If It Adds Coverage Tiers to the Benefit Package

Another way that plan sponsors can help to contain health care costs is to provide for more coverage tiers within a plan. For example, a plan may move from two coverage tiers (employee only and family), to three or more coverage tiers (e.g., employee only, employee plus spouse, employee and spouse plus 1 child, employee plus 1 or more children, etc.). Each coverage tier would have a different premium rate attached to it. Adding more coverage tiers can have the effect of reducing premium costs for many employees such as those who were paying a full family rate to cover only themselves and a spouse.

The Rules state that a group health plan will lose its grandfathered health plan status if the employer contribution rate is decreased for any tier of coverage by more than five percentage points below the contribution rate in place on March 23, 2010. However, the Rules do not address the type of change described above.

SHRM recommends that the Agencies confirm that the addition of coverage tiers is a permissible change under the Rules. As stated above, the premium rate for many employees could be reduced by such a change thereby reducing their health care costs and increasing the value of the coverage provided to them. Therefore, SHRM requests that the Agencies allow insured and self-insured employer-sponsored health plans to add coverage tiers without losing grandfathered health plan status.

IV. Change in Insurance Carrier

The Rules state that grandfathered health plan status is automatically lost if an employer-sponsored health plan changes insurance carriers. SHRM believes that changing carriers should not per se trigger a loss of grandfathered health plan status if the terms of the benefit coverage remain similar but there is merely a different insurer involved. This may again be a situation where an employer is attempting to reduce the cost increases in health care coverage that would otherwise consume a greater portion of employees' wages and therefore the costs of employment and potentially employment levels. If the benefits are essentially the same and cost-sharing is potentially lower because the plan sponsor found a better rate through another insurer, SHRM believes that the plan sponsor is ensuring that participants and beneficiaries are able to keep the coverage that they like. Further, the Agencies should not be concerned about participants and beneficiaries losing their providers because most high quality providers are members of multiple insurance networks. SHRM therefore recommends that the final rules look at the surviving coverage for a determination of whether existing coverage is maintained, and not solely look at fact that the insurance carrier is different.

V. Involuntary Changes

If the Agencies are unwilling to make the recommended change in IV above, SHRM urges that the Agencies, at a minimum, allow plans to maintain grandfathered health plan status when a change in insurers is an involuntary decision by the plan sponsor. In some instances, an insurance company of a fully insured group health plan will, for example, exit the market or discontinue offering the product. In these situations, the plan sponsor is forced to find a new insurance product due to circumstances beyond the plan sponsor's control. In these situations, the group health plan is still intact and merely the provider has changed; however, the change was not a voluntary act by the plan sponsor.

SHRM requests that where a plan sponsor is involuntarily forced to make a change, the Agencies allow that plan to maintain grandfathered health plan status if the plan sponsor ensures minimal disruption to participants and beneficiaries and the benefit package and cost-sharing are similar.

VI. Annual Allowable Increase

The Rules present a complicated mathematical formula that must be calculated to determine the allowable increase for each year with respect to employer contributions and cost sharing. The Rules define the term "medical inflation" as the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the U.S. Department of Labor using the 1982–1984 base of 100. For this purpose, the increase in the overall medical care component is computed by subtracting 387.142 (the overall medical care component of the CPI-U (unadjusted) published by the U.S. Department of Labor for March 2010, using the 1982–1984 base of 100) from the index amount for any month in the 12 months before the new change is to take effect and then dividing that amount by 387.142.

To reduce the administrative burden of every group health plan and insurer having to conduct these calculations, SHRM requests that the Agencies annually publish the medical inflation rate to be used for these Rules in the Federal Register or other publication. This will help ensure that every group health plan and insurer is using the correct medical inflation rate each year and are not caught off guard by an incorrect calculation that would then cause them to lose grandfathered health plan status. This should not be an additional burden since the Agencies will likely make this mathematical calculation to determine the allowable increase for each year to ensure that plan changes fall within the stated requirements.

VII. Provider Network and Prescription Drug Formulary Changes

The Agencies specifically requested comments regarding changes to provider networks and to prescription drug formularies and their potential effect on grandfathered health plan status.

Plan provider networks can vary somewhat from year to year, depending on a number of circumstances. Sometimes a provider will be dropped from the network because he/she has either moved out of the service area or otherwise chose not to participate in the network any longer. A provider may be added if he/she has gained a medical license and has joined a practice that is part of a plan's network. Other times, the provider may be dropped from a network because of poor performance ratings. Overall, however, provider networks do not change significantly. Therefore, SHRM recommends that routine provider network changes that naturally occur should not cause a plan to lose its grandfathered health plan status.

Similarly, prescription drug formulary changes are made for many reasons, such as a beneficial new drug becomes available, a drug becomes available in generic form, certain drugs in a drug class are deemed more effective at treating a particular disease than another, or an FDA change regarding the safety or efficacy of a drug. The routine changes made to a prescription drug formulary generally do not have a significant negative impact on participant and beneficiary access to necessary treatments and any such changes are made with participant safety and access in mind. Therefore, unless a plan or issuer makes such a significant change in the formulary as to eliminate coverage for an entire class or classes of drugs that would deny access to life saving and/or medically necessary treatments, SHRM believes that routine formulary changes should be allowed without the loss of grandfathered health plan status.

VIII. Record Maintenance

A. Requiring Plans to Maintain Records as Long as Grandfathered Health Plan Status is Held is Unduly Excessive

The Rules state that to maintain grandfathered status, a group health plan or group health insurance coverage must, for as long as the plan or coverage takes the position that it is grandfathered, maintain records documenting the terms of the plan or coverage in connection with the coverage in effect on March 23, 2010. According to the Rules, these records must be maintained along with any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan. The preamble states that such documents could include intervening and current plan documents, health insurance policies, certificates or contracts of insurance, summary plan descriptions, documentation of premiums or the cost of coverage, and documentation of required employee contribution rates. The preamble further states that the Agencies assume that most of the documents required to be retained to satisfy the PPACA's recordkeeping requirement already are retained by plans for tax purposes, to satisfy ERISA's record retention and statute of limitations requirements, and for other business reasons.

To minimize the administrative burden on employers and given the preamble's recognition of current ERISA document retention requirements, SHRM requests that the Rules limit the document retention requirement to match the six year document retention requirement of ERISA. This period of time will give participants, beneficiaries and the Agencies ample time to review the documents and confirm grandfathered health plan status. In addition, the Agencies could require

any allowable plan changes under the Rules to be retained for six years from the time a change is made to the plan instead of requiring all prior documents to be retained in perpetuity even though they are no longer relevant.

B. Plans Need Clarification on Who Can Examine Records, Fees and Frequency of Requests

The Rules include a second requirement for plans to make their records available for examination upon request. However, unlike in the preamble, there is no limitation on who can examine these records. Further, the Rules do not address whether a plan could charge a fee for the request or address the frequency in which such requests can be made. There may also be competitive or proprietary reasons to limit the disclosure of information to health plan enrollees only, and there should be reasonable frequency and timing limits permitted to help manage the costs of this requirement.

The preamble anticipates that a participant, beneficiary, individual policy subscriber, or State or Federal agency official would be able to inspect the documents. However, the construction of the regulatory text places no limits on who can request the documents. SHRM requests that the Agencies include in the final regulation the categories of persons who will be able to request an examination of the documents. In addition, SHRM does not believe that a State official has any need to see the documents of a self-insured group health plan. Therefore, SHRM requests that the Rules further clarify that State officials could request an examination of documents only with respect to insurance policies sold in the individual market.

With respect to fees and frequency, SHRM requests that the Agencies allow a plan to charge photocopying fees plus a reasonable administrative charge and that a request for examination be limited to once per plan year per requestor.

IX. Collectively Bargained Plans

For insured collectively bargained plans, the statute and the Rules state that grandfathered health plan status is determined after the date on which the last of the collective bargaining agreements related to the coverage in existence on March 23, 2010 terminates. SHRM recommends that the Agencies interpret the statute to mean that if grandfathered health plan status is lost, it will be lost at the end of the plan year in which the agreement expires in order to avoid mid-year plan changes that will be both confusing and disruptive to plan participants and beneficiaries.

X. Small Entities

According to the preamble, because the Rules are exempt from the Administrative Procedures Act, the Regulatory Flexibility Act does not apply and the Agencies are not required to either certify that the regulations would not have a significant economic impact on a substantial number of small entities or conduct a regulatory flexibility analysis. However, the Agencies

encourage public comments that suggest alternative rules that accomplish the stated purpose of section 1251 of the PPACA and minimize the impact on small entities.

SHRM appreciates the Agencies' recognition that small entities can be significantly affected by law changes that may not similarly affect larger entities. SHRM notes, however, that small employers may not have the resources to engage in this undertaking at the same time that they are also trying to absorb and understand the many changes made by the PPACA as well as the regulations that have been issued to date implementing the new law. SHRM therefore suggests that the Agencies consider other ways of encouraging small entities to provide input and a reasonable time frame in which to do so, which may be longer than would be required for larger entities.

XI. Conclusion

SHRM and its members recognize, appreciate and commend the Agencies' Herculean efforts to release the Rules on such a timely basis, given the rapidly approaching implementation date. We urge the Agencies to reconsider, however, whether the many single actions in the Rules that could cause a loss of grandfathered status can be tempered to allow greater flexibility to accommodate changes in the health care marketplace without losing the right to maintain existing coverage. SHRM is concerned that the narrow scope of the Rules effectively makes section 1251 a short transition rule rather than allowing the current coverage to remain in place indefinitely as the legislative language intends. This is especially true in the employer-sponsored large group market where the Agencies recognize that many, if not most, of the patient protections enacted by the law are already in place.

We appreciate the opportunity to assist the Agencies in continuing to develop guidance on this important issue.

Respectfully submitted,



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