

August 16, 2010

Submitted electronically via the Federal Rulemaking portal @ www.regulations.gov

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

Dear Sir or Madam:

Subject: Comments on Retaining Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act (PPACA) (RIN 1545-BJ51 / RIN 1210-AB42 / RIN 0991-AB68)

Hewitt Associates (Hewitt) welcomes the opportunity to submit for consideration our comments on the interim final rules pertaining to the grandfathered health plan status of group health plans and health insurance coverage published in the *Federal Register* on June 17, 2010.

Who We Are

Hewitt Associates (NYSE: HEW) provides leading organizations around the world with expert human resources consulting and outsourcing solutions to help them anticipate and solve their most complex benefits, talent, and related financial challenges. Hewitt works with companies to design, implement, communicate, and administer a wide range of human resources, retirement, investment management, health care, compensation, and talent management strategies. With a history of exceptional client service since 1940, Hewitt has offices in more than 30 countries and employs approximately 23,000 associates who are helping make the world a better place to work. For more information, please visit www.hewitt.com.

Preservation of Right to Maintain Existing Coverage

The "grandfather rules" emanate from Section 1251 of 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.

That 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 interim final rules were released, Department of Health and Human Services (HHS) Secretary Sebelius stated that the interim final rules "make good on President Obama's promise that Americans who like their health plan can keep it." Hewitt shares these goals of the President and the Secretary.

Nevertheless, Hewitt is concerned that while the interim final rules technically allow an employer to maintain the coverage in existence as of March 23, 2010, the interpretation of the limited legislative language in the interim final 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. In addition, a recently released Hewitt survey of large employers found that nine out of ten large employers anticipate losing grandfathered health plan status by 2014, with the majority expecting to do so in the next two years.

These statistics demonstrate that the interim final 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, and is not consistent with the indefinite nature of the right laid down in the statute. In addition, being too prescriptive of what is required to retain grandfathered health plan 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 interim final rules, many more employer-sponsored plans will be able to maintain their grandfathered health plan status in the future and continue to provide the robust benefits so highly praised and set forth as the standard to which the new health reform law would extend coverage to the rest of the American people.

Additional Flexibility Recommended

One of the ways in which the interim final rules are lacking in flexibility has to do with the provisions relating to permissible changes in employer contributions and in employee cost sharing. The interim final rules set forth a very complex and administratively difficult series of formulas that 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, including the potential to fundamentally change a plan design but maintain the same actuarial value and the complexity in defining and determining actuarial value as well the necessity for the agencies to issue very prescriptive interim final rules. Hewitt would like to address these two objections.

- 1. Agency Concerns Over Fundamental Plan Design Changes:** The 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 interim final 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 interim final 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 health plan 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 interim final 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 interim final rules should address the concerns of the agencies, in our opinion.

- 2. Agency Concerns Over Complexity in Defining and Determining Actuarial Value:** In fact, 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, Hewitt 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 laid out in the interim final rules.

Need to Recognize the Employer Responsibility to Contain Health Care Costs

Hewitt recommends that the final rules more clearly establish that certain changes in group health plans intended to contain the costs of health insurance for employers and plan participants but that 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 the Employee Retirement Income Security Act (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 interim final 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 interim final rules can be improved to help allow for ways to contain costs consistent with the stated goals above.

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

There is language in the interim final rules described as an anti-abuse provision that unwittingly pulls in situations that, rather than being abusive, are standard business practices designed to get the best health care value with limited health care dollars. 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; and
- 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 for the remaining options 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 interim final 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 are decreased because the premium amount is much less than it would have been under the high-cost HMO option. Moreover, permitting this practice would be consistent with the administration's goal of providing better coverage for less cost.

Hewitt understands the agencies' concern that some plan sponsors may try to circumvent the interim final 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 interim final rules is not the driving force in the situation described above.

Hewitt 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 actuarially equivalent option, and/or if the employee has a choice of selecting other available plan options even if one of the technical grandfathered health plan rules, such as an increase in cost sharing, occurs when comparing the terminating plan with the remaining group health plans. In none of these situations are the employees forced to go into another plan. Absent such clarification, employers are confused and uncertain whether the elimination of a high-cost option, coupled with a review of changes in cost sharing, triggers a loss of grandfathered status for the remaining plan(s) under the interim final rules.

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 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 one child, employee plus one 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 who were paying the family rate because they covered more than just themselves but only covered a family of two versus a family of five.

The interim final 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 interim final rules do not address the type of change described above. In contrast, the Dependent Coverage of Children to Age 26 interim final rules imply that adding coverage tiers is an acceptable method of controlling costs (29 CFR 2590.715-2714(e), Example (2)).

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, Hewitt requests that the agencies allow insured and self-insured employer-sponsored health plans to add coverage tiers and, if necessary, apply a reasonable premium without losing grandfathered health plan status.

Change in Insurance Carrier

The interim final rules state that grandfathered health plan status is automatically lost if an employer-sponsored health plan changes insurance carriers. Hewitt believes that changing carriers should not per se trigger an inevitable loss of grandfathered health plan status if the terms of the benefit coverage remain similar but there is merely a different insurer involved. In addition, this suggested change could be applied in conjunction with the other rules to maintain grandfathered health plan status. 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.

Fully insured plans have to provide at least a minimum set of benefits in accordance with state insurance laws. Therefore, if the benefits are essentially the same and cost sharing is potentially lower because the plan sponsor found a better rate through another insurer, Hewitt 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. Hewitt 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.

Involuntary Changes

If the agencies are unwilling to make the recommended change in the above paragraph, Hewitt urges the agencies, at a minimum, to 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 initiated by the plan sponsor.

Hewitt requests that where the insurer initiates the termination and the 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, the benefit package is similar, and the cost sharing is also similar.

Definition of Benefit Package

The interim final rules state that the grandfather rules apply separately to each “benefit package” made available under a group health plan or health insurance coverage. Hewitt assumes that the term “benefit package” as used in the interim final rules means “benefit option,” such as an HMO, preferred provider organization (PPO), point of service (POS), or basic design within a group health plan. Because different groups of participants sometimes participate in one design, such as a PPO, with different premium subsidy levels, it would be helpful to employers to have the flexibility to determine grandfathered health plan status either by plan design and/or by plan design and premium subsidy level. Therefore, Hewitt requests that the agencies confirm the industries’ understanding of the term “benefit package” within the interim final rules.

Decrease in Contribution Rate by Employers and Employee Organizations

Some employer-sponsored plans utilize a capped dollar amount as the amount of contribution that the employer contributes toward a participant’s group health plan coverage. This capped dollar amount often is based on years of service. Based on the interim final rules, it appears that this type of “frozen” dollar contribution would be considered a “contribution rate based on a formula” as opposed to a “contribution rate based on cost of coverage.” Accordingly, if an employer does not reduce the capped dollar amount provided toward the cost of coverage by more than 5% below the contribution rate for the coverage period that includes March 23, 2010, it would appear that the benefit package will not lose grandfathered health plan status. Hewitt requests that the agencies provide an example in the final rules that confirms this interpretation.

Addition of Wellness Programs

Employer-sponsored plans are not only concerned about cost containment but are fully committed to ensuring that their workforce is and remains healthy. An unhealthy workforce or unhealthy family members can have a negative impact on both the employer and the employee and results in reduced productivity. One way of achieving a healthy workforce is through wellness programs. Wellness programs are one of the few areas for which there is broad bipartisan support, and they work hand-in-hand with prevention programs as a way to keep people healthy and help them to maintain productive lives.

As recognized in PPACA, financial incentives to participate in a wellness program are an effective means to incentivize employees and family members to maintain healthy lifestyles, such as not smoking and exercising, and as a way to help those with chronic conditions such as diabetes or heart disease to keep those diseases in check. Research has shown that wellness programs are more successful when employees are given a financial incentive to participate. Financial incentives in wellness programs create incentives by lowering the premiums for those individuals who participate in a program and conversely increasing premiums for those who do not participate.

Under the interim final regulations, if the employer contribution rate decreases by more than five percentage points below the contribution rate for the coverage period that includes March 23, 2010, grandfathered health plan status will be lost. A wellness program with financial incentives could result in an employer contribution rate decrease of more than five percentage points for an employee or beneficiary who chooses not to participate, such as in a smoking cessation program. However, the addition of a wellness program is a positive new benefit for employees and their families. Therefore, Hewitt requests that the agencies allow employer-sponsored plans to add wellness programs with financial incentives to their benefit packages without the threat of losing grandfathered health plan status.

Changes in Plan Eligibility

Sometimes in reviewing dependent coverage under an employer-sponsored health plan, the plan will make a change to the eligibility rules whereby a spouse who is eligible for other health care coverage will not be

eligible for the employer-sponsored health plan. For example, where both spouses work for different employers and their respective employers offer health care coverage, the plan of one spouse may exclude the other from the plan because of his/her eligibility to participate in his/her own employer-sponsored health plan.

This change in eligibility rules is a legitimate plan design change that does not violate any of the rules set forth in the interim final regulations that would cause a plan to lose grandfathered health plan status. There is no elimination of benefits to treat or diagnose a particular condition nor is there any change in any of the cost-sharing requirements. Furthermore, the spouse would no longer be eligible for the plan only if he/she is eligible for other coverage, so the plan is relying on the participant to make that determination when they enroll in the plan.

Therefore, Hewitt recommends that the agencies clarify in the final regulations that changes to plan eligibility requirements will not cause a loss of grandfathered health plan status.

In-Network Versus Out-of-Network Changes

In setting forth the allowable changes a plan can make without losing grandfathered health plan status, the interim final regulations do not make a distinction between in-network and out-of-network coverage. Plans and issuers negotiate allowable charges with in-network providers as a way to promote effective, efficient health care, and allowing differences in cost sharing in-network and out-of-network enables plans to encourage the use of in-network providers. Restricting employers from changing out-of-network benefits and contributions outside of the grandfather rules would constrain the ability of grandfathered health plans to contain costs, would result in higher premiums, and could reduce provider incentive to participate in insurer networks thereby decreasing participant access.

If the agencies determine that the prescriptive rules set forth will be maintained in the final regulation, Hewitt recommends that the restrictions be limited to in-network changes only.

Annual Allowable Increase

The interim final 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 interim final 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 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 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, Hewitt requests that the agencies annually publish the medical inflation rate to be used for these interim final rules in the *Federal Register* or other publication. This will help ensure that all group health plans and insurers are 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. In addition, the agencies will probably be making this mathematical calculation anyway to determine the allowable increase for each year so that the agencies can ensure that plan changes fall within the stated requirements.

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.

Provider Networks

Plan provider networks can vary somewhat from year to year in the normal course of business, 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, Hewitt recommends that routine provider network changes that naturally occur should not cause a plan to lose its grandfathered health plan status.

Prescription Drug Formularies

Similarly, prescription drug formulary changes are made for many reasons, such as a beneficial new drug becoming available, a drug becoming available in generic form, certain drugs in a drug class being deemed more effective at treating a particular disease than another, or a Food and Drug Administration (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, Hewitt believes that routine formulary changes should be allowed without the loss of grandfathered health plan status.

Record Maintenance

Requiring Plans to Maintain Records as Long as Grandfathered Health Plan Status Is Held Is Unduly Excessive

The interim final rules state that to maintain status as a grandfathered health plan, a group health plan, or group health insurance coverage, must, for as long as the plan or health insurance coverage takes the position that it is a grandfathered health plan maintain records documenting the terms of the plan or health insurance coverage in connection with the coverage in effect on March 23, 2010, and 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 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. ERISA's required documentation retention is six years.

To minimize the administrative burden on employers and given the preamble's recognition of current ERISA document retention requirements, Hewitt requests that the final rules similarly limit the document retention requirement to six years. 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 final 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.

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

The interim final 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, there is no indication regarding whether a plan could charge a fee for the request and the frequency with 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. Hewitt 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, Hewitt does not believe that a state official has any need to see the documents of a self-insured group health plan. Therefore, Hewitt requests that the final 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, Hewitt 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.

Collectively Bargained Plans

For insured collectively bargained plans, the statute and the interim final 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. Hewitt 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.

Model Language to Satisfy Participant Disclosure Requirement

The agencies invited comments on the model language provided in the interim final regulations that can be used to satisfy the participant disclosure requirement. Hewitt is very pleased with the model language developed by the agencies and believes that it is ideally suited to its purpose. The model language strikes the correct balance in providing enough information to participants and beneficiaries without overburdening them with too much information that would create confusion. Therefore, Hewitt recommends that the agencies maintain the current model language that appears in the interim final regulations.

Closing

If you have any questions or comments, please contact the undersigned at the telephone number or e-mail address provided below.

Sincerely,

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