



UnitedHealth GroupSM

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

Submitted Via Federal Rulemaking Portal: <http://www.regulations.gov>

RE: Request for Comments Regarding the 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

Dear Sir or Madam:

UnitedHealth Group is pleased to provide the Departments of Health and Human Services, Labor and Treasury (“Agencies”) our comments regarding the Interim Final Rules (the “IFR”) relating to status as a grandfathered health plan (“grandfathered plan”) under the Patient Protection and Affordable Care Act (“PPACA” or the “Act”), 75 Fed. Reg. 34537.

UnitedHealth Group is dedicated to making our nation’s health care system work better. We serve 70 million Americans, funding and arranging health care on behalf of individuals, employers and governments, in partnership with more than 5,000 hospitals and 650,000 physicians, nurses and other health professionals. As America’s most diversified health and well-being company, we not only serve many of the country’s most respected employers, we are also the nation’s largest Medicare health plan — serving one in five seniors nationwide — and the largest Medicaid health plan, supporting underserved communities in 25 states and the District of Columbia. Recognized as America’s most innovative company in our industry by *Fortune* magazine, we bring innovative health care to scale to help create a modern health care system that is more accessible, affordable and personalized for all Americans.

It is this experience that is the basis upon which we offer the following comments and recommendations to ensure that affordability and quality continue to thrive in the health care marketplace. We welcome the opportunity for constructive dialogue regarding the grandfathered plan provision and its impact on the health care system and the chance to provide additional data and information supporting the comments set forth in this letter.

Summary of Recommendations and Discussions of Issues

Our recommendations stem from our assessment of the potential implications of implementing the IFR's requirements across diverse health care offerings and discussions with many of our customers about what the IFR's requirements would mean to them. To support our recommendations, we provide specific examples and information based on our experience. We believe these recommended changes are necessary to best serve consumers and reduce potential unintended consequences associated with the IFR in its current form.

Accordingly, we recommend the Final Rule for grandfathered plan status:

- Provide clearer direction on permissible changes versus policy or plan changes that will result in the loss of grandfathered plan status.
- Provide certainty to health insurance issuers ("issuers") and employer plan sponsors ("employers") that a loss of such status will be effective prospectively on the first plan year or policy year renewal date on or following the date the situation causing the loss occurs.
- Allow flexibility in making timely prescription drug formulary changes to help manage drug costs and promote the use of medications with the best health care value.
- Allow flexibility to make routine changes to the plan's provider network, so as to not inadvertently impact services designed to deliver higher quality and more effective care, whether by specialty services or performance measurement enhancements.
- Allow the addition of preventative care management programs to current plans without jeopardizing grandfathered plan status.
- Allow more flexibility in how the grandfathered plan disclosure notice is communicated to plan participants to minimize confusion and ensure the disclosure is meaningful.
- Provide more latitude in the transition rules for changes adopted prior to the publication of this interim final rule on June 17, 2010.
- Provide clarity that issuers are not responsible for changes that result in the loss of grandfathered plan status if the change was out of the issuer's control (i.e., issuer cannot be penalized if health insurance coverage or a plan loses grandfathered status because employer contributions are reduced, but the issuer is unaware of this fact and continues to operate as if the policy was a grandfathered plan).

Highlighted below are the primary concerns that drive these recommendations, focusing on the potential unintended consequences to consumers, as well as specific detailed recommendations for the modification of the IFR. We also include commentary upon items on which the Agencies solicited feedback in the IFR.

I. Maintaining Status as a Grandfathered Plan

(1) Provide Clarity Regarding Changes That Will Not Cause a Loss of Grandfathered Plan Status

The IFR outlines actions and changes that will cause a loss of grandfathered plan status, but does not explicitly state that this is the full list of changes. The IFR's preamble lists a number of possible plan or policy design changes that a grandfathered plan may adopt that will not result in the loss of grandfathered plan status and asserts that "changes other than the changes described

[in paragraph (g)(1) of the parallel regulations] will not cause a plan or coverage to cease to be a grandfathered health plan." While we are encouraged that the Agencies have provided these examples and assurances, it is vitally important to issuers and employers that the impact of a plan or policy change is clear. Further, issuers must have assurance that their reliance on Agency guidance when making plan and policy design decisions will achieve the intended result.

By placing these examples and assurances in the preamble to the IFR, rather than in the text of the IFR itself, we are concerned that this guidance may be ambiguous and not clearly establish to issuers what the particular impact of a change will be. This uncertainty may cause issuers to not fully rely upon this guidance, which could result in an unlevel playing field in the market. We are specifically concerned that placing these provisions in the preamble will hamper effective and innovative plan design, and ultimately increase consumer cost while limiting consumer benefits.

Impact on Consumers: Without the certainty that would arise from the assurance and the examples of permitted plan changes being in the text of the IFR, employers and issuers may be reluctant to make effective and innovative plan design changes, which may increase consumer cost while limiting consumer benefits. It may also lead to different outcomes for different issuers under the same set of circumstances.

Recommendation: Amend paragraph (g)(1) by adding the following sentence at the end of the introductory paragraph:

"(g) Maintenance of grandfather status – (1) Changes causing cessation of grandfather status. Subject to paragraph (g)(2) of this section, the rules of this paragraph (g)(1) describe situations in which a group health plan or health insurance coverage ceases to be a grandfathered health plan. Changes other than the changes described in paragraph (g)(1) will not cause a plan or coverage to cease to be a grandfathered health plan."

Amend paragraph (g)(4) to include specific examples that illustrate changes in premiums, changes to comply with Federal or State legal requirements, changes to voluntarily comply with PPACA provisions, and/or changes of third-party administrators by self-funded plans, as situations that do not cause loss of grandfathered plan status.

(2) Provide Clarity Regarding Effective Date for Loss of Grandfathered Plan Status

The IFR is unclear as to when a loss of grandfathered plan status becomes effective. We believe it is important to provide certainty to issuers and employers that a loss of such status will be effective prospectively on the next plan year or policy year renewal date on or following the date the situation causing the loss occurs.

Impact on Consumers: Without clarifying in the text of the IFR when a loss of grandfathered plan status will impact an employer and issuer, sponsors and issuers may be reluctant to make effective and innovative plan design changes, which may increase consumer cost while limiting consumer benefits.

Recommendation: Amend paragraph (g)(1) as follows by adding a last sentence at the end of the introductory paragraph:

“(g) Maintenance of grandfather status – (1) Changes causing cessation of grandfather status. Subject to paragraph (g)(2) of this section, the rules of this paragraph (g)(1) describe situations in which a group health plan or health insurance coverage ceases to be a grandfathered health plan. Changes other than the changes described in paragraph (g)(1) will not cause a plan or coverage to cease to be a grandfathered health plan. The loss of grandfather status under this paragraph shall be effective as of the first day of the next plan or policy year renewal date that is on or after the date of the change causing the loss.”

(3) Allow Changes to Prescription Drug Formularies to Promote the Use of Medications with the Best Health Care Value

The Agencies have asked for comments on whether changes to prescription drug formularies should result in cessation of grandfathered plan status and if so, what magnitude of changes would need to be made. Prescription drug formularies change for a number of reasons, from replacements of one drug for another in a therapeutic category, a response to drug recalls, to clinical determinations of unsuitability of a drug for treatment by the expert panel of physicians. We believe that, in order to ensure consumers receive health care that is most appropriate for their needs, while also maintaining a plan formulary that has the flexibility to operate within the constructs of a grandfathered status, formulary changes made in the normal course of clinical formulary management should qualify as “reasonable changes made by employers or issuers.”

For example, a plan often reviews a category of drugs available on the formulary, and frequently makes modifications such as: (1) recognizing which clinical needs are already met, and then reducing the drugs listed on a formulary; (2) including newly developed drugs on the formulary; or (3) determining when two (or more) equally effective drugs are listed on the formulary, and eliminating one drug to alleviate the cost of competing products. Also, when new drugs come to market, they are reviewed to determine whether they should be placed in a more favorable copayment tier. If a brand drug becomes available in a generic form, often the generic is placed in a lower copayment tier while the brand moves to a higher copayment tier to incent the use of the more cost-effective option. If new safety or other clinical information (such as treatment guideline updates) becomes available, a product may move to a lower or higher copayment tier depending on whether the new evidence is positive or negative.

In addition, the Final Rule should provide an exception for formulary changes made as a result of mandates issued by the Food and Drug Administration (FDA). For example, a plan may remove a drug from the formulary when the product has been recalled or withdrawn from distribution by the FDA; or a plan may limit the availability of a drug or product (i.e., no new patients may commence treatment, nor be allowed to re-start treatment if it was previously discontinued) due to a newly imposed restriction on market availability/distribution by the FDA.

Prescription drug coverage is a highly utilized benefit and increasing prescription drug costs are a major driver in the high cost of health coverage. We believe it is important that issuers and employers continue to have flexibility in making timely prescription drug formulary changes to help manage drug costs and promote the use of medications with the best health care value. Restricting changes to prescription drug formularies in order to maintain grandfathered plan status will impair issuers’ and employers’ ability to respond to market changes and align incentives better to enhance overall health care value (including health care quality and

affordability). Ultimately, consumers would pay increased costs resulting from unmanaged prescription drug formularies.

Recommendation: We urge the Agencies not to limit the flexibility of employers or issuers to make periodic changes to the drug formularies covered under their benefit plans that they believe are necessary, and not to add this item to the list of plan changes that will impair grandfathered plan status. Should the Final Rule not allow formulary changes to be permissible, we recommend that there should be certain exceptions to the rules, including one for formulary changes made as a result of mandates issued by the FDA.

(4) Allow Changes to Health Care Provider Networks Given Ongoing Network Composition Updates

The Agencies have asked for comment on what changes may be made to health care provider networks without forfeiting grandfathered plan status. As a general matter, network composition changes daily, with providers joining the network (new providers, providers new to the area, etc.) and providers leaving the network (providers relocating to a new area, providers with credentialing issues, circumstances where the provider and carrier no longer wish to have a contract, etc.). These types of ongoing, continuous updates should not cause a plan to lose its grandfathered plan status.

In addition, many plans rely upon a vendor for specialty network services, such as pharmacy, behavioral health, transplants, chiropractic, physical therapy/occupational therapy, and dental. The same general network composition changes also occur within these specialty networks, and such networks also have centers of excellence accreditation criteria which new providers may meet or existing providers may lose over time. Changes in the vendor providing the specialty network also should not cause a plan to lose grandfathered plan status.

Finally, changes in network tiering or reimbursement based on quality, efficiency and other performance measures should be exempted. This will promote the continued or more frequent use of higher quality, more efficient alternatives. Restricting changes in network providers as a condition of preserving grandfathered plan status is inconsistent with the routine changes that are commonplace and will limit the ability of employers and issuers to make needed changes to manage health care quality and affordability.

Recommendation: We urge the Agencies not to limit the flexibility of employers or issuers to make periodic changes to the network providers covered under their benefit plans. Such limitations could negatively impact services designed to deliver more personalized care, whether by specialty services or performance measurement enhancements. Network provider changes should be permissible under the final regulations.

(5) Allow the Addition of Preventative Care Management Programs

The Agencies have asked for comments on what other plan changes may be made without forfeiting grandfathered plan status. Another area that should not impact grandfathered plan status is the addition of preventative care management programs (i.e., wellness, health care decision support, disease management, care management, complex condition management, employee assistance programs, mental health screenings, etc.) to a plan. These programs may

provide enhanced benefits, premium discounts, or contributions to an HRA/HSA for meeting certain biometric targets and/or completing certain activities. For example, a program could provide enhanced benefits to pre-diabetics and diabetics who complete certain compliance requirements (i.e. having certain lab tests, physician office visits, etc.). If participants fail to meet the criteria in any given year, they revert back to a base plan that covers the rest of the employee population. Other programs could provide premium or employee contribution discounts or credits for meeting certain biometric targets and completing certain health actions (i.e. having a mammogram, etc.). These programs meet the requirements of the federal wellness regulations, to the extent applicable. We believe these preventative care management programs are important to the health care system in encouraging healthy behavior and holding down cost, and employers and issuers should have flexibility to add them to their health plans without fear of losing grandfathered plan status.

Recommendation: We urge the Agencies to provide flexibility to employers and issuers to add these types of preventative care management programs without risking the loss of grandfathered plan status. These changes should be permissible under the final regulations.

(6) Ensure Meaningful Disclosures

The IFR sought comments on the model disclosure language in the regulation and whether improvements are recommended for the language. The IFR requires that plans and health insurance coverage claiming grandfathered plan status include a statement in any benefit materials provided to participants or subscribers that the plan or issuer believes it is a grandfathered plan.

We are concerned that including this disclosure requirement in consumer materials may be confusing to covered persons and may not have the intended benefit. The explanation that the plan or coverage complies with some but not all of the PPACA consumer protections may not be easily understood by consumers, and may lead to numerous questions that may be difficult to answer for employers' HR departments and issuers' and third party administrators' customer service representatives. We believe it may be more appropriate to include the applicable consumer protections of PPACA in the employer plan documents or insurance coverage documents, rather than in the separate disclosure document under the IFR.

Additionally, as an issuer of fully insured employer health plans, we usually have no knowledge of the employer's contributions toward the cost of coverage, and would be unable to state our belief on whether grandfathered plan status had been maintained on that ground. Thus, we do not believe this disclosure requirement can be placed on an issuer for its insured group health plan business.

Alternatively, we recommend that flexibility be allowed for the notice to appear either in annual open enrollment materials or in other plan materials. The requirement to include it in "any plan materials provided to a participant" could be read to state it must be included in multiple participant communications, such as explanations of benefits and claim appeal notifications.

Recommendation: Either delete the disclosure requirement from the rule or modify it as follows in paragraph (a)(2)(i) and (ii):

“(2) Disclosure of grandfather status – (i) To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, either in ~~any~~ annual open enrollment materials or some other plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act...”

(ii) The following model language can be used to satisfy this disclosure requirement: This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.”

II. Transition Rules

In the IFR, the Agencies have given some assurances to employers and issuers that certain changes made prior to March 23, 2010, but put into effect after that date, do not forfeit grandfathered plan status. Paragraph (g)(2)(i) includes three such circumstances as changes effective after March 23, 2010 pursuant to a legally binding contract entered into, State Insurance Department filing made, or written plan amendments adopted on or before March 23, 2010. While we applaud the Agencies for including these transition rules in the IFR, we believe they could be broadened to include the situation where an employer made the decision to change its group health plan on or before March 23, 2010 but did not enter into a written contract or amend its plan in writing until after that date. In many cases this decision will have been communicated to participants and the issuer or third party administrator less formally prior to March 23, 2010. If the employer can document its decision to change its plan on or before this date, we believe its plan should be a grandfathered plan. We believe expanding the transition rules in this manner is consistent with the policy considerations behind the grandfathered plan provision.

In addition, we note that the IFR, published on June 17, 2010, outlined potential plan changes that could affect grandfathered status and which may not have been anticipated by employers. We suggest that the Agencies consider modifying the transition rules to permit plan changes effective on or before June 17, 2010.

Recommendation: Amend paragraph (g)(2)(i) by adding a new (D) as follows: “(D) Changes effective after March 23, 2010 pursuant to a decision documented in writing to change the plan or insurance coverage on or before June 17, 2010.”

III. Loss of Grandfathered Plan Status Due to Employer Plan Design Decisions

The consequence to losing grandfathered plan status is that a policy or plan must comply with additional requirements. However, there are penalties for failing to comply with the insurance market reform requirements (the requirements listed in subtitles A and C of PPACA). As a

result, if a plan or policy loses grandfathered plan status and does not comply with the above requirements, the plan or policy could be penalized. It is also possible that if the plan or policy was part of an ERISA plan participants could sue for failure to comply with the requirements.

Some of the changes that trigger a loss in grandfathered plan status of insured group health plans are the sole result of employer actions, which issuers will not be aware of and, therefore, will not be able to adequately respond. For example, a loss of grandfathered plan status caused by an employer's decreasing its contribution toward the cost of coverage is something an issuer is very unlikely to know and is generally beyond the issuer's control. We believe the IFR should make clear that issuers cannot be penalized for failing to comply with the insurance market reform requirements in the event that a plan or policy loses grandfathered plan status as a result of employer action.

Impact on Consumers: Penalties on issuers will likely increase the cost of coverage to consumers, particularly where issuers were not aware and could not have avoided the penalty, due to employers' actions that result in loss of grandfathered plan status.

Recommendation: Amend the IFR to state that issuers cannot be penalized for failing to comply with the insurance market reform requirements in the event that group health insurance coverage loses grandfathered plan status as a result of employer action, and results in non-compliance with PPACA.

Summary of Recommendations & Conclusion

We believe the recommendations highlighted in this letter support the goals of the Act and the IFR to balance the objective of preserving the ability of individuals to maintain their existing health insurance coverage with the objectives of ensuring access to affordable, essential health care coverage and improving the quality of coverage. On behalf of the 70 million consumers of UnitedHealth Group, we thank you for your thoughtful consideration of these recommendations and the discussion of the issues and concerns underlying them.

UnitedHealth Group appreciates the opportunity to provide you with our comments on the IFR for grandfathered plan status under PPACA. Should you have any questions regarding the information set forth in this letter please do not hesitate to contact me.

Thank you again for your time and thoughtful consideration of the enclosed comments.

Sincerely,



Gail K. Boudreaux
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and President,
UnitedHealthcare