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Hon. Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services  
Hon. Hilda Solis, Secretary, U.S. Department of Labor  
Hon. Timothy Geithner, Secretary, U.S. Department of Treasury  
Attention: OCIO-9991-IFC  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

Submitted via the Federal Regulations Web Portal, <http://www.regulations.gov>

**Re: Comments on the Interim Final Rules Relating to "Grandfather" Status Under the Patient Protection and Affordable Care Act**

Dear Secretaries Sebelius, Solis, and Geithner:

Aetna appreciates the opportunity to respond to the request for comments issued by the Department of Health and Human Services ("HHS"), the Department of Labor ("DOL"), and the Department of Treasury (collectively, the "Agencies") 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") (the "IFR" or the "Regulation"), 75 Fed. Reg. 34538 (June 17, 2010).

Aetna is one of the nation's leading diversified health care benefits companies, providing members with information and resources to help them make better informed decisions about their health care. Our programs and services strive to improve the quality of health care while controlling rising employee benefits costs. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life, long-term care and disability plans and medical management capabilities.

As a key stakeholder affected by PPACA, Aetna is committed to working with the Agencies in developing reasonable standards for the implementation of PPACA. To that end, we are submitting these comments to the Agencies, recommending modification of the IFR in certain respects. Among other things, Aetna is concerned that the IFR may subject health insurance issuers to penalties for non-compliance with PPACA for unilateral actions that a plan sponsor may take without notifying the issuer. We therefore

recommend that the Agencies either eliminate or modify the IFR's rules regarding unilateral actions taken by a plan sponsor that could inadvertently cause an issuer to be liable for non-compliance with PPACA (such as a decrease in employer contributions by more than five percent).

Additionally, we are concerned that certain aspects of the IFR are unduly restrictive with respect to the substitution of new insurance coverage and benefit and cost-sharing changes that can be made without a loss of grandfather status. As detailed below, our comments include suggested modifications to the IFR that would address these concerns. Briefly, we recommend that the Agencies modify the Regulation to provide that the following actions will not cause the loss of grandfather status:

- Issuance of a new policy by an issuer to the same policyholder for bona fide business reasons, where the benefits under the new policy are substantially the same as the benefits under the prior policy;
- Voluntary decisions by an individual policyholder to reduce benefit coverage or increase cost-sharing;
- Changes to benefits that are adopted to comply with applicable federal or state law, even if such changes otherwise exceed the parameters established by the IFR;
- Modification of a HIPAA-compliant wellness program to alter incentives that may impact an employee's cost-sharing obligation;
- Changes to enrollee cost-sharing, including coinsurance, where the actuarial value of the cost-sharing provisions of the coverage remain within 15% of the original value as of the date of the PPACA's enactment;
- Changes to out-of-network cost-sharing, without restriction;
- Modification of prescription drug formularies and pharmacy networks;
- Changes to provider networks; and
- Modification of plan terms, such as dependent eligibility and treatment settings, where meaningful coverage for the benefit or condition is maintained.

Aetna's specific comments on the Regulation are set forth below.

**1. An Insurer Should Not Be Liable for Continuing to Offer a Grandfathered Policy to a Plan Sponsor That Has, Without Notice to the Insurer, Taken Unilateral Action to Defeat Grandfather Status**

Under the IFR, there are a number of actions that the sponsor of a grandfathered plan can take which could trigger the loss of grandfather status, about which the plan's insurer may have no notice or control. For example, employers determine how to

allocate the cost of health insurance coverage between themselves and their employees, typically on an annual basis. Insurers of group health plans do not know what an employer (or an employee organization) contributes to the cost of coverage, or whether the employer (or employee organization) may modify its contribution rate. Instead, insurers receive a monthly remittance from the employer which covers the monthly premium, and the remittance does not detail the contribution formula as between the employer and plan participants. Likewise, an employer could transfer employees from coverage under one plan to another, without notifying the insurer of the transferee plan of such action.

The IFR provides that a group health plan or health insurance coverage ceases to be a grandfathered plan if an employer (or employee organization) decreases its contribution rate "towards the cost of any tier of coverage for any class of similarly situated individuals . . . by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010." 45 C.F.R. § 147.140(g)(1)(v). And, the IFR sets forth two "anti-abuse" rules, which provide, in pertinent part, that a plan will lose grandfather status if:

1. The principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered plan; or
2. Employees are transferred into a plan or health insurance coverage (the transferee plan) from a plan or health insurance coverage under which employees were covered on March 23, 2010 (the transferor plan), and: (a) comparing the transferee plan to the transferor plan would cause a loss of grandfather status; and (b) there was no *bona fide* employment-based reason for the transfer. 45 C.F.R. § 147.140(b)(2).

However, the IFR does not address how these rules apply in the context of an insurer of a grandfathered group health plan where the insurer has no notice as to whether an employer has decreased its contribution rate toward coverage, undergone a business restructuring, or transferred employees from one plan to the plan for which the insurer is providing health insurance coverage. Without clarification in the final regulation, an insurer could be deemed non-compliant with PPACA (and therefore subject to penalties under the Public Health Services Act as well as lawsuits under ERISA for not providing all of the PPACA required benefits for non-grandfathered plans) for continuing to offer a grandfathered policy to an employer that has unilaterally taken action that could trigger loss of grandfather status, even if the insurer had no notice of the employer's action.

Accordingly, Aetna requests that the Agencies adopt a final regulation which clarifies that, with respect to the period of March 23, 2010 until September 23, 2010, a health insurance issuer will not be treated as non-compliant with PPACA where, without notifying the insurer, an employer (or employee organization) has taken action that could cause the health insurance coverage to cease to be a grandfathered plan, such as decreasing the sponsor's contribution rate by more than five percent measured from March 23, 2010 or transferring employees to the grandfathered coverage without a *bona fide* employment-based reason.

And, for plan years beginning on or after September 23, 2010, we request that the final regulation clarify that the Agencies will not treat a health insurance issuer as non-compliant with PPACA if it continues to offer a grandfathered policy to an employer or employee organization that has taken action that could cause the coverage to cease to be a grandfathered plan (such as decreasing the sponsor's contribution rate by more than five percent measured from March 23, 2010 or transferring employees to the grandfathered coverage without a *bona fide* employment-based reason), where: (a) the insurer has taken steps to require that an employer (or employee organization) disclose any actions by the employer (or employee organization) that could cause the loss of grandfather status under the IFR; and (b) the employer or employee organization fails to do so notwithstanding the insurer's requirement. In such circumstances, we respectfully submit that the Agencies should treat the insurer's efforts to obtain notice of the employer's actions as good faith compliance with the regulation.

**2. An Insurer Should Be Able to Issue a New Policy To a Policyholder With Grandfathered Coverage, Without Loss of Grandfather Status, Where the Benefits Under the New Policy Are Identical Or Substantially the Same as the Benefits Under the Prior Policy**

Insurers commonly issue new policies or certificates of insurance to policyholders which are substantially the same as a previously issued policy or certificate for *bona fide* business reasons. For example, an insurer may consolidate duplicate policy forms into a smaller number of substantially similar policy forms for purposes of simplifying the insurer's administration. In such cases, a new policy or certificate is issued by the same insurer to the same policyholder, which details the new policy or certificate number, but the benefits under the new policy or certificate are nearly the same as the benefits offered under the previous policy or certificate.

The IFR defines a grandfathered health plan as "coverage provided by a group health plan, or a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010 (for so long as it maintains that status under the rules [of the IFR])." 45 C.F.R. § 147.140(a). The IFR also provides that "if an employer or employee organization enters into a new policy, certificate, or contract of insurance after March 23, 2010 (because, for example, any previous policy, certificate, or contract of insurance is not being renewed), then that policy, certificate, or contract of insurance is not a grandfathered health plan with respect to the individuals in that group health plan." 45 C.F.R. § 147.140(b)(2). The IFR includes a special anti-abuse rule that effectively permits a group health plan and health insurance coverage to retain its grandfathered status where (1) employees are transferred into existing coverage, (2) comparing the transferee plan to the transferor plan would not cause the loss of grandfathered plan status, and (3) there is a bona fide employment based reason for the transfer. 45 C.F.R. § 147.140(a)(ii).

The IFR does not address whether a grandfathered health plan will cease to be treated as such where a new policy or certificate of insurance is issued by the same insurer to the same policyholder for *bona fide* business reasons, and the coverage is substantially the same as was in force on March 23, 2010. We note, however, that in

other circumstances, the DOL has recognized that non-substantive changes to policy terms should not disqualify an insurance policy from grandfather status. *See* DOL Adv. Op. 2000-12A (October 4, 2000) (amendments to group annuity contracts to accommodate changes in a plan sponsor's corporate structure are not material, and will not disqualify such policies from their status as "transition policies" under DOL regulation issued pursuant to ERISA § 401(c)(1)).

Aetna therefore requests that the final regulation clarify that a new policy or certificate will be considered as a grandfathered health plan where: (a) the new policy or certificate is issued by a health insurance issuer to the same policyholder for *bona fide* business reasons; and (b) the coverage under the new policy, when compared to the coverage under the old policy, would not cause the loss of grandfathered status under the provisions of section (g)(1) of the IFR. In these circumstances, the new policy or certificate will be considered as continuing in force the same insurance coverage that was in effect on March 23, 2010.

### **3. Voluntary Decisions By An Individual Policyholder to Reduce Benefits Should Not Cause a Loss of Grandfather Status**

Policyholders in the individual market frequently make voluntary requests to decrease benefits by eliminating coverage for certain conditions, or to increase the policyholder's deductible, out-of-pocket maximum, coinsurance, or copayments. Individual policyholders make these requests for reduced coverage to reduce their premiums, and they commonly do so following the loss of a job or another significant change in the policyholder's financial situation or family status.

The IFR provides that a plan or policy will lose grandfathered status if, among other things, there is:

- a. The elimination of all (or substantially all) benefits to diagnose or treat a particular condition;
- b. An increase in copayment above the level in effect on March 23, 2010;
- c. An increase in deductible, out-of-pocket maximum, or other fixed-amount cost-sharing that is more than medical inflation plus 15 percent (measured from March 23, 2010); or
- d. An increase in copayment in an amount greater than \$5 increased by medical inflation, or medical inflation plus 15 % (measured from March 23, 2010).

45 C.F.R. § 147.140(g)(1)(i)-(iv). The IFR, however, does not address whether a benefit change that is voluntarily requested *by a policyholder* in the individual market, which would otherwise exceed the IFR's limits, may cause a loss of grandfather status. If a voluntary reduction in coverage causes the loss of grandfather status, the policyholder would be required to either drop coverage entirely (which is contrary to PPACA's goal of expanding coverage), or to buy a new policy that is subject to all of PPACA's insurance

market reforms, which will be more expensive and likely beyond the means of the policyholder who has experienced a job loss or change in financial status. Additionally, these policyholders will not be eligible for the temporary high-risk pool established by PPACA for at least six months following their loss of coverage, *see* PPACA § 1101(d)(2), and they will not be eligible for federal subsidies available through the Exchanges until 2014.

Accordingly, in the final regulation, the Agencies should clarify that an individual insurance policy that is grandfathered will continue to remain so notwithstanding the individual policyholder's voluntary decision to decrease benefits by eliminating coverage for certain conditions or increasing the policyholder's deductible, out-of-pocket maximum, coinsurance or copayments.

#### **4. Changes to Comply with Mental Health Parity and Other Laws Should Not Cause a Loss of Grandfather Status**

Between the promulgation of the Mental Health Parity and Addiction Equity Act ("MHPAEA") regulations in February 2010 (which became applicable as of July 1, 2010) and the issuance of the grandfather IFR on June 14, 2010, many plans and issuers adopted benefit and cost-sharing changes for mental health/substance use and medical/surgical benefits. These changes were adopted for purposes of satisfying the MHPAEA regulation's "predominant/substantially all" test.

The IFR's Preamble provides that "group health plans and health insurance issuers will not cease to be considered grandfathered if the plan sponsor or issuer makes changes to comply with Federal or State legal requirements[.]" 75 Fed. Reg. at 34544. The IFR, however, does not address whether changes to benefits or cost-sharing that were adopted to comply with federal or state law may cause the loss of grandfather status, where such changes exceed the IFR's limits of permissible benefit or cost-sharing changes. Nor does the IFR address whether such changes may be covered under the good faith compliance period.

To clarify this issue, Aetna recommends that the final regulation expressly provide that changes to a plan or policy's cost sharing provisions that affect medical/surgical benefits or mental health/substance use benefits – which were adopted between March 23 and June 14, 2010 for purposes of coming into compliance with the MHPAEA regulations – will not cause the loss of grandfather status. The Agencies could issue this clarification by advising that coverage will not lose its grandfathered status where the plan or issuer made the benefit modification in a good faith effort to comply with law between March 23, 2010 and June 14, 2010, even if the modification altered benefits or cost sharing in a manner that exceeded the limits in the IFR.

We also recommend that the final regulation clarify that where a federal or state law provides a plan sponsor or issuer with *options* as to how to comply with the law, a grandfathered plan will not lose such status based upon the sponsor or issuer's election of an option that is permitted by law, even if such option exceeds the parameters of the IFR.

**5. The Modification of HIPAA-Compliant Wellness Programs That Offer Incentives That May Impact Employee Cost-Sharing Should Not Cause a Loss of Grandfather Status**

Wellness programs are dynamic benefits which are subject to frequent change. Among other things, insurers and sponsors may change wellness providers to improve the delivery of benefits, and they frequently modify a wellness program's incentives to encourage greater participation in the program and to provide greater incentives for participants to make important lifestyle changes, such as quitting smoking or losing weight. Wellness programs are often offered by separate vendors and sometimes are offered outside of a group health plan or group health insurance coverage.

Under HIPAA, wellness programs are permitted to provide rewards based on health status, provided that the reward is limited to 20 percent of the cost of coverage. For example, as expressly permitted by the HIPAA regulation, a wellness program may provide a premium holiday or deductible credit of a limited amount for employees who do not smoke or who have a favorable cholesterol level. By definition, wellness rewards tend to be temporary, given that they are provided only for as long as the employee is compliant with the program (within the parameters established by the HIPAA regulation), and they are subject to frequent modification to incentivize changes in behavior.

The IFR provides, in pertinent part, that:

The elimination of all or substantially all benefits to diagnose or treat a particular condition causes a group health plan or health insurance coverage to cease to be a grandfathered health plan. For this purpose, the elimination of benefits for any necessary *element* to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition.

45 C.F.R. § 147.140(g)(1)(i) (emphasis added). And, the IFR provides that a change in deductible or out-of-pocket maximum that is greater than medical inflation plus 15 percent (measured from March 23, 2010), or a change in copayment that is greater than (a) medical inflation plus 15 percent, or (b) \$5 plus medical inflation (measured from March 23, 2010) will cause the plan to lose grandfather status.

The IFR does not address, however, whether changes to a wellness program could cause the loss of grandfather status. Considering that the incentives and benefits offered by wellness programs frequently change to address the medical conditions and lifestyles of plan participants, a broad interpretation of the IFR could stifle the innovation of wellness programs, especially if changes to a wellness program's incentives may trigger the loss of grandfather status for the *entire* plan. Such an interpretation of the IFR would be contrary to clear Congressional intent.

Specifically, Congress *encouraged* the establishment of wellness programs in PPACA. For example, PPACA permits plan sponsors and issuers to increase the value of a wellness program reward from 20 percent to 30 percent of the cost of employee

coverage, which can be increased up to *50 percent* at the discretion of the Agencies. PHSA § 2705(j)(3)(A). PPACA also establishes a grant program to assist employers in establishing and evaluating workplace wellness programs. PPACA § 10408. And, Congress established reporting requirements for certain plans and insurers that implement wellness and health promotion activities. PHSA § 2717. Given the clear Congressional intent to encourage the continued development of effective wellness programs, Aetna recommends that the Agencies modify the Regulation to expressly provide that changes to wellness program providers or incentives will not cause a loss of grandfather status.

## **6. The Regulation Should Permit Greater Flexibility With Respect to Cost-Sharing**

The IFR imposes significant restrictions upon a plan sponsor or issuer's ability to modify cost-sharing provisions in the plan without triggering a loss of grandfather status. These restrictions apparently apply regardless of whether the cost-sharing change is imposed with respect to services rendered by in-network or out-of-network providers, and without regard to whether the cost-sharing applies to "essential benefits" or "non-essential" benefits.

Specifically, the IFR provides, in pertinent part, that a plan or policy will lose its grandfathered status if the sponsor or issuer makes any of the following changes to cost-sharing:

- Increases coinsurance (or another percentage cost-sharing requirement) above the level at which it set on March 23, 2010;
- Increases fixed-amount cost-sharing requirements *other* than copayments, such as a deductible or an out-of-pocket limit, by a total percentage (measured from March 23, 2010) that is more than the sum of medical inflation plus 15 percent; or
- Increases copayments above the level in effect on March 23, 2010 by an amount that exceeds the greater of (a) the sum of medical inflation plus 15%, or (b) \$5 increased by medical inflation.

45 C.F.R. § 147.140(g)(1)(ii)-(iv). The Agencies, in the IFR's Preamble, appear to recognize the importance of ensuring that plans and issuers have flexibility with respect to cost-sharing, noting that:

[M]any plan sponsors and issuers make changes to the terms of plans or health insurance coverage on an annual basis: Premiums fluctuate, provider networks and drug formularies change, employer and employee contributions and cost-sharing change, and covered items and services may vary. Without some ability to make some adjustments while retaining grandfather status, the ability of individuals to maintain their current coverage would be frustrated, because most plans or health insurance coverage would quickly cease to be regarded as the same group health plan or health insurance coverage in existence on March 23, 2010.



75 Fed. Reg. at 34546. We respectfully submit, however, that the IFR adopts undue restrictive limits to cost-sharing which (a) severely limit a plan sponsor's ability to utilize value-based insurance design as a means of improving the quality and efficiency of the delivery of medical care, and (b) do not accurately reflect the factors that plan sponsors and issuers take into account when designing benefit plans.

a. The Regulation Should Establish Limits On Changes to Cost-Sharing Only for Services Delivered In-Network

The IFR appears to provide that any change to cost-sharing that exceeds the limits established by the IFR will cause a loss of grandfather status, without regard to whether the cost-sharing change applies to in-network or out-of-network benefits. We recommend that the Agencies modify the Regulation to provide that only changes to cost-sharing for benefits delivered on an *in-network* basis should be subject to limits that may impact grandfather status, thereby preserving plan sponsors' flexibility with respect to out-of-network cost-sharing. This distinction between in-network and out-of-network cost-sharing is entirely consistent with the distinction that the Agencies themselves recognized in the IFR addressing preventive services. 75 Fed. Reg. 41726 (July 19, 2010).

Specifically, the Preamble to the preventive services IFR notes that PPACA authorizes the Agencies to develop guidelines to permit a plan or insurer to utilize "value-based insurance designs," which "include[s] the provision of information and *incentives for consumers that promote access to and use of higher value providers, treatments and services.*" 75 Fed. Reg. at 41729 (emphasis added). Recognizing that the establishment of differential cost-sharing levels with respect to in-network and out-of-network benefits is a critical component of a value-based design, the Agencies expressly *permitted* plans and issuers "to implement designs that seek to foster better quality and efficiency by allowing cost-sharing for recommended preventive services delivered on an out-of-network basis while eliminating cost-sharing for recommended preventive health services delivered on an in-network basis." *Id.*

Just as the Agencies permit cost-sharing for preventive services delivered on an out-of-network basis, so too should the Agencies allow plan sponsors and issuers to retain flexibility with respect to out-of-network cost-sharing. Differential cost-sharing for services delivered in-network or out-of-network is an important component of value-based design, given that such differentials enhance utilization of credentialed network providers. To ensure that innovation with respect to value-based design is not inadvertently stifled, we recommend that the final regulation establish limits as to permissible changes only with respect to cost-sharing for in-network services.

b. The Regulation's Limits on Changes to Cost-Sharing Should Only Apply to Essential Benefits

We also recommend that the IFR be modified to provide that changes to cost-sharing with respect to *non-essential* benefits will not trigger a loss of grandfather status. In enacting PPACA, Congress was clearly focused on ensuring that participants had

access to coverage for essential benefits, as defined by PPACA § 1302. Given that non-essential benefits were not a subject of Congressional concern due to the incidental nature of such benefits, the Regulation should not treat cost-sharing changes for non-essential benefits as implicating the plan's grandfather status.

c. The Agencies Should Adopt an Actuarial Equivalence Standard With Respect to Cost-Sharing for Essential Benefits Delivered In-Network

The IFR's limits to changes to cost-sharing do not reflect critical factors that plans and issuers take into account when designing plans. For example, the IFR's limits on changes to cost-sharing are all based upon the rate of medical inflation. The rate of medical inflation, however, does not take into account the full scope of medical cost trend, or utilization and demographic changes that may significantly increase a plan's costs above the rate of medical inflation—especially when measured from March 23, 2010, as the Regulation requires, rather than annually.

Accordingly, Aetna recommends that the final regulation modify the IFR, to eliminate the prohibition on any changes to coinsurance, and the IFR's prohibition on changes to deductibles, out-of-pocket maximums, or copayments above the limits established by the IFR. We instead recommend that the Agencies adopt an actuarial equivalence standard which would assure that typical year-to-year changes in cost-sharing would be permitted. Our recommended standard would allow plans and issuers flexibility to adopt changes to in-network coinsurance, copayments, deductibles, and out-of-pocket maximums, provided that the actuarial value remains within 15% of the plan's original value as of March 23, 2010.

The Preamble to the IFR indicates that the Agencies rejected an actuarial equivalence standard, finding that such a standard could permit a plan "[to] make fundamental changes to the benefit design." 75 Fed. Reg. at 34547. We note, however, that the final regulation could limit modifications based on actuarial value only with respect to a plan's *cost-sharing* provisions, rather than permitting wholesale changes to plan benefits. Aetna would be pleased to work with the Agencies in developing such a standard.

**7. Changes to Prescription Drug Formularies and Prescription Drug Benefits Should Not Trigger Loss of Grandfather Status**

Responding to the IFR's request for comments regarding whether changes to a plan's prescription drug formulary should trigger a loss of grandfather status, 75 Fed. Reg. at 34544, Aetna respectfully submits that such changes should not cause a loss of grandfather status. In drafting the IFR, the Agencies appropriately preserved a plan sponsor's flexibility with respect to the design of prescription drug formularies and pharmacy benefit programs. Issuing a final regulation that would limit this flexibility would significantly restrict the sponsor's ability to adapt to constantly changing industry developments, and severely restrict a critical tool that helps control spiraling health care costs.

Pharmacy benefit programs are especially dynamic and are subject to frequent modifications that reflect constant changes in the industry and the needs of plan participants. Among other things, new drugs are continuously introduced to the market while other drugs become obsolete or less favored, lower cost generic drugs regularly become available, and therapeutic equivalents are introduced. Moreover, prescription drug formularies and pharmacy benefit programs vary widely among plan sponsors to reflect the unique characteristics and needs of plan participants. For example, many plans have adopted multi-tier formularies to reflect differences in drug efficacy and pricing. In virtually all instances, however, plans maintain at least one drug within each therapeutic class within its top (most preferred) tier of benefits. Although specific drugs or cost-sharing within a benefit tier may change based on factors such as drug safety, efficacy, and the availability of generic substitutes, plan participants are assured preferred coverage within each therapeutic class. So long as a plan continues to adhere to this standard, its grandfather status should not be threatened based on changes in the designated drugs or cost-sharing within the formulary tiers.

Many plans have also established, or are considering, step-therapy protocols as a means of providing the most effective treatment for participants at the least out-of-pocket cost. Step-therapy protocols encourage safe and cost-effective medication use by providing coverage for front-line medications (usually generic), with access to back up drugs (such as higher copay brand name drugs) should the front-line treatment prove ineffective. The final regulation should not restrict a plan sponsor or issuer's ability to introduce or modify step-therapy protocols; doing so would have the counterproductive effect of increasing plan and participant costs, with no appreciable benefit to participants.

Additionally, many plans require, or are considering, the use of mail order pharmacies for maintenance medications, or require that such medications be dispensed in larger quantities, such as 60 day supplies. Requiring use of mail order pharmacies or specifying a minimum day supply for prescription drug medications does not restrict a participant's access to prescription drug benefits. Accordingly, adding or modifying a mail order requirement or a quantity standard should not trigger a loss of grandfather status.

We also encourage the Agencies to recognize that a change to a plan's pharmacy network should not cause a loss of grandfather status. Plans switch provider networks for a variety of reasons: plans may seek a network that provides more geographically convenient access to plan participants, or may switch to a network that has comparable geographical access, but more favorable reimbursement rates. We note, however, that in considering changes to a pharmacy network, plans have an inherent incentive to ensure that participants have convenient access to network pharmacies, given the plan's desire to steer a greater percentage of participants to contracted providers. Accordingly, the Agencies should recognize in the Regulation that a change to a pharmacy network will not cause a loss of grandfather status.

**8. Changes to Provider Networks Should Not Trigger Loss of Grandfather Status**

In response to the Agencies request for comments regarding changes to a plan's provider network, 75 Fed. Reg. at 34544, we submit that such changes should not cause the loss of grandfather status. As noted above, plan sponsors and issuers have an inherent incentive to maintain stable provider networks that provide participants with convenient access to health care providers and health care services. Nevertheless, some change in the composition of a network is inevitable, given that institutional providers merge, change the services they provide, or exit particular markets. Likewise, physicians and other professionals may close their practices, retire, or relocate. Even in the absence of these changes, providers may not agree to continue participation in a particular network. These routine changes do not impact a participant's ability to access health care providers or services. As such, the Agencies should recognize that routine changes to a provider network should not trigger a loss of grandfather status.

Likewise, a plan should not lose grandfather status as a result of switching its network provider. As described above in connection with pharmacy benefits, plans switch provider networks for a number of reasons: a geographically significant provider may discontinue its participation in the network, forcing the plan to seek an alternate network that can provide services to participants; or a plan may negotiate more favorable reimbursement rates with a new network that will result in cost-savings for the plan and participants, in the form of lower premiums and cost-sharing. But as is the case with pharmacy networks, plans have an incentive to ensure that participants have convenient access to network providers, given that a failure to provide such access would defeat the plan's attempt to steer a greater percentage of participants to network providers. Accordingly, Aetna submits that changes to a provider network should not cause the loss of grandfather status, where the network change does not alter an enrollee's access to comparable providers in the same geographic area.

**9. Changes to Plan Terms that Do Not Eliminate Benefits Should Not Trigger a Loss of Grandfather Status**

Aetna also recommends that the Agencies modify the Regulation to clarify that changes to a plan's eligibility criteria or plan terms which do not eliminate all (or substantially all) benefits to treat a particular condition will not cause the plan to lose grandfather status. For example, a plan or issuer may alter its dependent eligibility criteria under group or individual health plans, including the addition of a "tier" structure (*i.e.*, moving from "employee" to "employee +1" "employee + 2", etc.). Additionally, plans and issuers routinely make changes to a plan's definition of medical necessity and experimental/investigational procedures, and may modify coverage terms to reflect appropriate treatment settings (*e.g.*, providing coverage for certain minor procedures if performed at a physician's office rather than an inpatient setting). Assuming that meaningful coverage for a condition that was covered on March 23, 2010 is maintained, none of these changes should be deemed to eliminate all (or substantially all) benefits to treat a particular condition, or otherwise implicate limitations set forth in the final regulation.

**10. The Elimination of a Benefit That Is No Longer Required By Applicable State Law Should Not Trigger Loss of Grandfather Status**

The IFR provides that "[t]he elimination of all or substantially all benefits to diagnose or treat a particular condition causes a group health plan or health insurance coverage to cease to be a grandfathered health plan." 45 C.F.R. § 147.140(g)(1)(i). We note, however, that just as states frequently mandate that insurers (and other plans subject to state law) provide coverage for particular items or procedures, so too do states *revoke* such mandates. In such circumstances, the state is affirmatively authorizing insurers and other plans to drop coverage for the particular items or procedures, and a plan should not lose its grandfather status based on a decision to eliminate coverage for that item or service. Accordingly, we request that the final regulation be modified to provide that a grandfathered health plan will not lose such status based on a decision to eliminate benefits for items or services that are no longer mandated under state law.

**11. The IFR's Transition Rules Should Be Modified**

The IFR provides specific "transition rules" which, if applicable, will prevent a plan from losing grandfather status as a consequence of a benefit or cost-sharing change that was adopted prior to June 14, 2010 which exceeds the parameters established by the IFR. The availability of the IFR's transitional relief depends on when the benefit or cost-sharing change was adopted, and the magnitude of the change.

The first transition rule provides that a policy or plan will not lose grandfather status based on benefit or cost-sharing changes that exceed the IFR's limits, if the changes were adopted *before* March 23, 2010 (even if they take effect after March 23, 2010) so long as such changes were adopted pursuant to "a legally binding contract entered into on or before March 23, 2010," "a filing on or before March 23, 2010 with a State insurance department," or "written amendments to a plan that were adopted on or before March 23, 2010." 45 C.F.R. § 147.140(g)(2)(i). With respect to filings with a state insurance department, the IFR does not address whether the insurance department had to approve the filing on or before March 23, 2010 as a condition of maintaining grandfather status. We therefore recommend that the Agencies clarify that so long as the benefit or cost-sharing change was filed with a state insurance regulator before March 23, 2010, the change will not trigger loss of grandfather status, even if an insurance regulator approves the filing after such date.

The IFR also provides plan sponsors and insurers an opportunity to revoke amendments that would cause the loss of grandfathered status that were adopted after March 23, 2010 and before June 14, 2010. The Preamble to the Regulation also provides that for plan changes adopted during this period that "only modestly exceed" the Regulation's parameters, the Agencies will "take into account good-faith efforts to comply" with PPACA, which is a very narrow standard. 75 Fed. Reg. at 34544. For more "significant" changes adopted after March 23, 2010 – but before June 14, 2010 – the only option is to revoke the change or lose grandfathered status.

Plan sponsors and insurers must make changes year-round to address changes in federal and state laws, and those changes are implemented when policies renew. As noted above, many insurers and plans have already made changes to comply with MHPAEA that were required by July 1, 2010. And many insurers filed amendments with state insurance commissioners on a myriad of benefit or cost-sharing issues shortly after March 23, 2010, when they had no notice as to the scope of the IFR or its restrictiveness with respect to changes to benefits and cost-sharing. We therefore recommend that the Agencies withdraw this transitional relief/good faith compliance standard, and apply the Regulation only to changes made by plans and insurers after the publication of the IFR on June 14, 2010.

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Aetna is pleased to have the opportunity to provide comments regarding the grandfather IFR, and we thank you for consideration of our comments. Should you have any questions, please feel free to contact me.

Sincerely,



Steven B. Kelmar