

August 16, 2010

Delivered Via Email

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
Attention: RIN 1210-AB42

RE: An Alternative Actuarial Equivalence Model Under Interim Final Rules Regarding Grandfathered Health Plans under the Patient Protection and Affordable Care Act

Dear Sir or Madame:

HR Policy Association (“HR Policy”) is submitting this comment letter on 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 (P.L. 111-148). The Interim Final Rules were issued by the Departments of Labor, Health and Human Services, and Treasury (the “Agencies”) on June 17, 2010 (75 Fed. Reg. 34538). HR Policy represents the chief human resource officers of over 300 of the largest employers doing business in the United States. Representing every major industrial sector, HR Policy’s members employ more than 18 million people worldwide and collectively spend more than \$75 billion annually providing health insurance to millions of American employees, their dependents and retirees. It is our understanding that these comments will be shared with the Departments of Health and Human Services and Treasury.

Section 1251 of PPACA provides exemptions from some of the mandates under subtitles A and C for grandfathered health plans. The statute defines grandfathered health plans as “a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act...” The provision regarding grandfathered health plans is drafted very broadly. Yet, the Interim Final Rules adopt an unnecessarily restrictive approach and the statute simply does not demand such a narrow interpretation.

HR Policy supports the President’s objective that under health care reform Americans should be able to maintain coverage under the health plans they currently have if they so desire. However, the proposed regulations will have just the opposite impact. The Agencies’ interpretation will place significant restraints on an employer’s ability to make adjustments that contain costs and to maintain the overall benefit structure and value for plan participants. By imposing strict limitations on discrete elements of what employers can do to manage the design of their benefit plans, many employers will likely forego grandfathering status all together.

Accordingly, HR Policy recommends that the Agencies refine some of the rules in the Interim Final Rules regarding the maintenance of grandfathered status. For example, limitations on grandfathered plans should only be limited to in-network benefits and plan sponsors should be permitted to provide financial incentives for the use of high value and quality benefit designs through co-insurance differentials. Moreover, the Agencies should adopt an “actuarial equivalence” approach to permit plan sponsors to continue to innovate for use of quality providers of care, promote greater efficiency and better decision-making by beneficiaries in employer-sponsored plans. This flexibility for innovation has delivered greater value to populations covered by employers in terms of clinical outcomes and affordability for

employees and companies, as well as introduced many new approaches broadly adopted in the healthcare marketplace.

Thus, plan sponsors would have two methods that enable them to maintain grandfathered status – actuarial equivalency, or a rules-based approach set forth in the Interim Final Rules which may be more appealing to smaller employers in particular. These recommendations are discussed more fully below.

The Interim Final Rules

Under the Interim Final Rules, employers lose their grandfathered status if they make any changes described below:

- eliminate benefits for a particular condition or benefits to diagnose or treat a particular condition
- impose any increase in percentage cost sharing (co-insurance)
- increase fixed amount cost-sharing (*e.g.*, deductible or out-of-pocket limit) exceeding medical inflation plus 15 percent
- increase in fixed-amount copayment that exceeds the greater of \$5 or medical inflation plus 15 percent
- decrease employer contribution rate (% of total premium) for employee or family coverage by more than 5 percent
- restructure a business with principal purpose to cover more individuals under a grandfathered plan

Application of Grandfathering Limitations to In-network Benefits Only

The Interim Final Rules regarding maintenance of grandfathered status should only apply to "in-network" benefits, as there should be no limitations on benefits related to providers not under contract. In interim final rules relating to coverage of preventive services under PPACA that were released this year, the Agencies recognized the principle of value-based insurance design by permitting plans to allow cost-sharing for recommended preventive services delivered out-of-network. This approach is also consistent with existing regulations around HSA-qualified High Deductible Health Plans which do permit restrictions on benefits provided out-of-network. Similarly, state regulatory bodies do not mandate levels of out-of-network benefits, but rather focus on adequate access to coverage in-network. However, emergency room benefits should not be considered "out-of-network" for these purposes.

The Importance of an Actuarial Equivalence Alternative

HR Policy recommends that the Agencies adopt an alternate actuarial equivalence approach for employers and allow them to choose between such an approach or the rule-based one set forth in the Interim Final Rule. In other words, plan sponsors should have the option to maintain grandfathered status by adhering to the rules outlined above or by maintaining an actuarial value that is equal to or greater than the value that would be allowed under the above rules. The alternate approach enables employers to continue to innovate and advance value in terms of clinical outcomes, cost and practices which would not be possible under the Interim Final Rules. It imposes no cost to any plan sponsor that is not willing voluntarily to assume that cost and the actuarial equivalence methods are readily available in the marketplace.

Rather than codifying stagnant benefit designs, this approach would allow for innovations to promote usage in medical homes and accountable care organizations, providers of best clinical outcomes, improve consumer engagement, and advance the efficient delivery of recommended clinical preventive services, chronic care management and care coordination. Indeed, this flexibility is what enabled employers to create and adopt the many components of what have become known as "value-based insurance design."

The preamble to the Interim Final Rules noted that the Agencies considered some form of an actuarial equivalency approach but rejected it for two reasons: 1) because the Agencies believed such an approach would allow “a plan could make fundamental changes to the benefit design, potentially conflicting with the goal of allowing those who like their healthcare to keep it, and still retain grandfather status;” and 2) because of the Agencies’ concerns about the complexity involved in defining and determining actuarial value for these purposes, the need for very detailed prescriptive rules, and the costs of administering and ensuring compliance with such rules. However, the Association believes that the same concerns expressed by the Agencies about an actuarial equivalence approach apply to the approach taken in the Interim Final Rules.

An actuarial equivalence standard has been used successfully for other government regulated medical benefits. For example, under the Medicare Modernization Act, the federal government established a retiree drug subsidy for employers who continued to offer prescription drug benefits to retirees after creation of the Medicare Part D program. To be eligible for the subsidy, employers had to demonstrate that the drug benefit that they provide to retirees is actuarially equivalent or better than the Medicare Part D prescription drug plan. This requires that plans reimburse at least the "same percentage" overall as the standard Medicare Part D benefit. The actuarial equivalency standard has been effective at preserving private innovation of a highly successful social insurance health benefit and has created no undue burden to employers who subsidize Medicare prescription drug coverage and opted for the subsidy approach. In fact, the flexibility and success of the Medicare Part D approach has enabled employers continue to subsidize drug coverage and pursue value-based insurance designs.

Moreover, the actuarial equivalency approach was adopted by Congress in PPACA for determining the different types of plans offered through the state insurance exchanges. PPACA defines plans under these exchanges as Platinum, Gold, Silver or Bronze based on their aggregate "value." Without dictating specific design elements other than requiring coverage of essential benefits, a bronze level plan provides benefits that are *actuarially equivalent* to 60 percent of the full actuarial value of the benefits provided under the plan. Platinum, gold, and silver are similarly defined as actuarially equivalent to 90%, 80% and 70% coverage, respectively. Therefore, it is difficult to discern why an actuarial equivalence model is not suitable for the grandfathering rules under PPACA.

Most employer-based plans in existence today provide a richer benefit than those provided under a bronze plan and employers that preserve at least the same actuarial value of benefits should be able to maintain their grandfathering status, while enabling thoughtful redesign and innovation within those benefit structures. The actuarial equivalence alternate pathway, allowing for medical inflation, would preserve the value intended in the regulations provided that the group health plan offered provides coverage that is equal to or greater than the actuarial value of the current plans.

Application of "Actuarial Equivalence" by Specific Category of Medical Benefits

To avoid substantial changes to any specific category of medical benefits, "actuarial equivalence" could be required for each specific medical benefit category as an alternative to a “plan wide” actuarial equivalence test. This would ensure no significant reduction in the aggregate value of the benefits for any specific category of benefits. There are multiple ways in which categories could be defined, for example the category definitions used in the mental health parity regulations. As another example, the categories could be: office visits, other medical, inpatient hospital, emergency room, preventive care, and prescription drugs.

"Actuarially Equivalent" Plan Design - Following Year

Below are benefit provisions of the illustrative plan for the following plan year that are "actuarially equivalent" in each of the major benefit categories to the Permitted Provisions above. Calculations demonstrating actuarial equivalence are provided in the next section.

In-Network

- Office Visits - 15% copay for primary care, 25% for specialty care
- Other Medical Services - 80% after \$400 deductible (Health Reimbursement Accounts (HRA) Incentives up to \$200 for healthy behaviors)
- Hospital Inpatient - 100% (no copay) if utilize high value network,
- 100% after \$750 copay per admission outside of high value network
- Emergency Room - \$120 copay
- Prescription Drugs - Generic Drugs, Preferred Maintenance Drugs - 20% coinsurance
Other Preferred Brand Drugs - 30% coinsurance
Non-Preferred Brand Drugs - 45% coinsurance

Out-of-pocket maximum (excluding deductible and copays) = \$2,400

Out-of-Network

- All services - 60% after \$1,200 deductible
- Out-of-pocket maximum (excluding deductible) = \$5,000

Calculation of Actuarial Equivalence by Benefit Category

The following provides an illustration of the actuarial equivalence determination for each of the major benefit categories. In each case, actuarial equivalence is established by showing that average expected member cost sharing is greater than or equal to that under the Permitted plan design, using current utilization and cost assumptions.

Office Visits

- Specialty Care = 3/5 of office visits based on past history
- Average Primary Care Visit is \$100, \$30 copay=30% of in-network charges
- Average Specialty Care Visit is \$150, \$30 copay=20% of in-network charges
- Overall average visit copay expressed as a percentage = $\frac{3}{5} (30\%) + \frac{2}{5} (20\%) = 24.0\%$
- Average visit coinsurance percentage under the "actuarially equivalent" plan design
= $\frac{3}{5} (20\%) + \frac{2}{5} (25\%) = 23.0\%$ √ **Actuarially Equivalent**

In the above example, because members are on average required to pay less in cost sharing under the Actuarially Equivalent plan than under the Permitted plan (23% vs 24%, respectively), the Office Visit benefits are considered actuarially equivalent.

Other Medical Services

- Average value of \$200 HRA Incentives based on past history of health behaviors = \$110
- Average value of Deductible under Actuarially Equivalent plan after HRA Incentives = \$400-\$110= \$290
√ **Actuarially Equivalent**

In the above example, since the average expected deductible net of HRA incentives is \$290, less than the \$300 under the Permitted plan (which has no HRA incentives), the Other Medical Services benefits are considered actuarially equivalent.

Hospital Inpatient

- Admissions in high value network are 1/5 of admissions based on past history
- Average hospital copay under Actuarially Equivalent plan = $\frac{1}{5} (\$0) + \frac{4}{5} (\$750) = \$600$
√ Actuarially Equivalent

In the above example, since the \$600 is equal to the \$600 required under the Permitted plan, the Inpatient Hospital benefits are considered actuarially equivalent.

Emergency Room

These benefits are the same under both the Permitted plan and the Actuarially Equivalent plan, so they necessarily pass the actuarial equivalence test.

√ Actuarially Equivalent

Prescription Drug

- Costs based on past history are split 1/5 generics, 1/5 preferred maintenance brand, 2/5 other preferred brand, 1/5 non-preferred brand
- Average cost of generic drug = \$25; \$15 copay=60% of charges
- Average cost of preferred brand name drug (maintenance & other) = \$120; \$30 copay=25% of charges
- Average cost of non-preferred brand name drug = \$165; \$45 copay= 37% of charges
- Average prescription copay under Permitted plan as % of cost = $\frac{1}{5}(60\%)+\frac{2}{5}(25\%)+\frac{1}{5}(37\%)=33.4\%$
- Average prescription coinsurance percentage under Actuarially Equivalent plan
= $\frac{1}{5}(20\%)+\frac{1}{5}(20\%)+\frac{3}{5}(30\%)+\frac{1}{5}(45\%)=29\%$

√ Actuarially Equivalent

In the above example, since 29% is less than 33.4%, the prescription drug benefits are considered actuarially equivalent.

Out-of-Network

√ No Requirement

Conclusion

The actuarial equivalence approach described above will allow for continued innovation and design encouraging greater personal engagement, and value based activities while helping to preserve the generous level of benefits that most employers offer today. We respectfully urge the Agencies to consider permitting plan sponsors to maintain grandfathered status under an actuarial equivalence alternative to the Interim Final Rules.

We appreciate the opportunity to comment on the Interim Final Rules. If you have any questions, please contact Marisa Milton at mmilton@hrpolicy.org or (202) 789-8671.

Sincerely,



Vice President, Health Care Policy
& Government Relations
HR Policy Association