March 26, 2019

Steven Mnuchin
Secretary, Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

Alexander Acosta
Secretary, Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Alex M. Azar II
Secretary, Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: CMS–9923–NC
Request for Information Regarding Grandfathered Group Health Plans and Grandfathered Group Health Insurance Coverage

Dear Secretaries Mnuchin, Acosta, and Azar:

The National Health Law Program (NHeLP) is a public interest organization working to advance access to quality health care and protect the legal rights of low-income and under-served people. NHeLP appreciates the opportunity to provide comments in response to the Request for Information ("RFI") regarding grandfathered group health plans from the Internal Revenue Service (IRS), Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, and the Department of Health and Human Services (HHS).

Our comments will broadly address the questions posed in the RFI. We believe the underlying premise of the RFI, that roadblocks to retaining grandfathered status are too stringent, is fundamentally flawed. Congress authorized grandfathered plans to ease the transition to coverage requirements and consumer protections provided under the Affordable Care Act (ACA).

Extending and expanding grandfathered plans is not only contrary to congressional intent, it would also destabilize the health insurance marketplace and harm health care consumers.

1. Grandfathered plans should be phased out, not expanded

The ACA extends health care coverage to millions of previously uninsured individuals, establishes important consumer protections including those for persons with pre-existing conditions, and makes health care more affordable through subsidies and other benefits. However, Congress recognized that such sweeping changes could disrupt the health insurance market. Therefore, Congress expressly granted "grandfathered" status to plans in existence on March 23, 2010, the day the ACA was signed into law.[1]

In accordance with the ACA, a trifecta of federal departments (Labor, Treasury, and HHS) established the strict requirements for maintaining grandfathered status. To retain grandfathered status, a plan must not substantially deviate from its benefits and pricing as those parameters existed on March 23, 2010, including:

- not eliminating or substantially eliminating benefits for a particular condition;
- not increasing co-insurance percentages;
- not adding or reducing an annual limit;
- not lowering employer contribution rate by more than five percent;
- providing a notice of grandfathered status in participant communications.[2]

Once a plan loses grandfathered status, it cannot cure the defect and regain grandfathered status.[3]

The departments established this high bar for retaining grandfathered status "to reduce short term disruptions in the market, and to ease the transition to market reforms."[4] The Internal Revenue Service guidance from 2013 noted that the "grandfathering provision is only transitional in effect."[5] Under the ACA, these noncompliant plans were not intended to continue

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[1] 42 U.S.C. § 18011. Grandfathered plans must comply with some ACA provisions, such as eliminating annual and lifetime caps for certain benefits, requiring the option of dependent coverage to age 26, prohibitions on rescissions, and prohibitions on excessive waiting periods. However, grandfathered plans are expressly exempt from other key ACA provisions, including coverage of preventive services (including contraceptive services) without cost sharing, coverage of essential health benefits, annual limitations on cost sharing, and certain appeal rights.

[2] 45 C.F.R. § 147.140.

[3] 45 C.F.R. § 147.140(g).

[4] Dept. of Treasury, Dept. of Labor, Dept. of Health and Human Srvs., *Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act*, 75 Fed. Reg. 34537, 34546 (June 17, 2010).

[5] Dept. of Treasury, Dept. of Labor, Dept. of Health and Human Srvs., *Coverage of Certain Preventive Services Under the Affordable Care Act*, 78 Fed. Reg. 39869, 39887, n. 49 (July 2, 2013).

indefinitely. This administration's proposal to ease restrictions on grandfathered plans contradicts congressional intent and existing administrative guidance.[6]

The number of individuals enrolled in grandfathered plans through their employer has decreased significantly. According to a study by the Kaiser Family Foundation, 56% of enrollees in small group coverage (e.g., small employer plans) were enrolled in grandfathered plans in 2011; by 2018 that number was just 16%.[7] Currently, only 20% of employers now offering noncompliant plans.[8]

The RFI suggests the administration is considering extending and expanding grandfathered status under the guise of "minimiz[ing] the unwarranted economic and regulatory burdens of the [Affordable Care Act]." Such action, consistent with other administration efforts to undermine ACA protections, would contravene congressional intent.[9]

2. The extension of grandfathered plans destabilizes the health insurance market and decreases issuer participation

The proliferation of noncompliant plans, without the ACA's robust coverage standards and consumer protections, destabilizes health insurance markets. If the administration proceeds with this apparent effort to extend and expand grandfathered plans, the result will be higher premiums, poorer coverage, and less consumer choice with fewer issuers participating in the ACA marketplaces. To see how grandfathered group health plans increase premiums and decrease issuer participation, one must look no further than Iowa.

Iowa regulators and politicians have made a series of decisions to promote non-compliant plans, including upholding grandfathered plans, extending grandmothered plans, and

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[6] By contrast, the Obama administration temporarily exempted from ACA requirements "grandmothered plans" issued between March 23, 2010 and December 2013, which would terminate in 2017. CMS "Insurance Standards Bulletin Series – INFORMATION – Extension of Transitional Policy through Calendar Year 2017" (Feb. 29, 2016), https://www.cms.gov/CCIIO/Resources/Regulations-andGuidance/Downloads/final-transition-bulletin-2-29-16.pdf. The current administration, however, extended grandmothered plans. CMS, "Insurance Standards Bulletin Series – INFORMATION – Extension of Transitional Policy through 2019" (Apr. 9, 2018), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Extension-Transitional-Policy-Through-CY2019.pdf.

[7] Kaiser Family Foundation, *Section 13: Grandfathered Health Plans* (Oct. 3, 2018), https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-13-grandfathered-health-plans/.

[8] *Id.*

[9] *E.g.,* CMS cut funding for consumer enrollment outreach and assistance through the Navigator program more than 80%. *See* CMS, *Grants Awarded for the Federally-Facilitated Exchange Navigator Program* (Sep. 12, 2018), https://www.cms.gov/newsroom/press-releases/grants-awarded-federally-facilitated-exchange-navigator-program. *See also* Center on Budget and Policy Priorities, *Sabotage Watch: Tracking Efforts to Undermine the ACA* (last updated Jan. 28, 2019), https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca.

authorizing unregulated plans.[10] The results have been devastating for the state's insurance market and consumers.

The number of Iowans enrolled in the grandfathered, transitional, and other non-compliant plans was significantly higher than the national average. Approximately 60% of Iowans eligible for the ACA Marketplace enrolled in non-compliant plans, over 85,000 individuals.[11] By 2018, just one group plan issuer, Medica, offered ACA-compliant plans in Iowa, down from 2015, when there were four issuers participating in the marketplace.[12] Marketplace premiums in Iowa ballooned to the second highest in the country, with the average annual marketplace plan premium in excess of $10,000 annually.[13] Iowa's per capita health costs are near the national median, so the average Marketplace premium in Iowa has disproportionately increased when compared with other states.[14]

Allowing noncompliant plans causes risk pool stratification.[15] Enrollees with relatively fewer health care needs often select noncompliant plans, which are less expensive and have fewer benefits, while individuals with relatively higher health needs select ACA-compliant plans with more robust benefits and protections, which better address their health care needs.[16] Issuers of ACA-compliant plans then increase premiums to cover those increased needs. This decreases enrollment and discourages issuer participation.

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[10] Sabrina Corlette and Kevin Lucia, *The Road Not Traveled How Policy, Business Decisions in Iowa Led to Higher Premiums*, The Commonwealth Fund (June 28, 2018), https://www.commonwealthfund.org/blog/2018/policy-decisions-iowa; Doug Ommen, Insurance Commissioner, State of Iowa, Bulletin 18-01, CMS allows extension for transition policies through 2019 (April 19, 2018), https://iid.iowa.gov/documents/extension-of-transitional-policies-through-2019; Amy Goldstein, *Iowa tries another end run around the Affordable Care Act*, WASHINGTON POST (April 2, 2018), https://www.washingtonpost.com/national/health-science/iowa-tries-another-end-run-around-the-affordable-care-act/2018/04/01/cd25baec-3429-11e8-94fa-32d48460b955_story.html?utm_term=.92ea7eb2a416.

[11] Nationwide, the percentage of enrollees who are enrolled in non-ACA compliant plans is 11.8% as of 2017. *See* Kaiser Family Foundation, Data Note: Changes in Enrollment in the Individual Health Insurance Market (July 31, 2018), https://www.kff.org/health-reform/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market/.

[12] Corlette & Lucia, *supra* note 10.

[13] Center for Medicare & Medicaid Services, 2018 OEP State-Level Public Use File, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Downloads/2018_OE_State.zip.

[14] Iowa was 25 among the 50 states and D.C. with $8,200 spent per capita on health. Kaiser Family Foundation, Health Care Expenditures per Capita by State of Residence (2014), https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[15] Mark A. Hall & Michael J. McCue, The Commonwealth Fund: *To The Point, How Do Noncompliant Health Plans Affect the Market?* (Nov. 14, 2017), https://www.commonwealthfund.org/blog/2017/how-do-noncompliant-health-plans-affect-market.

[16] *Id*. In the small group market, noncompliant plans were 6% less expensive and members made 9% less medical claims per month when compared to compliant plans.

The harm of noncompliant plans, including grandfathered plans, is completely avoidable. The Wakely Consulting Group found that if Iowa sunsets its grandfathered plans, premiums in the Iowa marketplace would fall by as much as 18%, and enrollment would be increased by between 55,000 and 85,000.[17]

The administration should not replicate nationwide Iowa's self-inflicted health insurance debacle of lower coverage standards, skewed risk pools, and higher premiums. Instead of extending grandfathered plans, the administration should uphold ACA coverage standards and protections.

3. Grandfathered plans lack of coverage of essential health benefits harms health care consumers

The ACA requires most health plans to provide essential health benefits (EHB), including important preventive services and screenings.[18] The EHBs help ensure people have access to basic health care services like ambulatory patient services, hospitalization, laboratory services, preventive services, and prescription drugs. Prior to the ACA, federal law did not require minimum coverage standards, and consumers often did not have coverage for services like maternity care or mental health and substance use disorder (SUD) services. An analysis of individual market coverage before EHBs were required found that 75% of non-group market plans did not cover maternity care (delivery/inpatient care), and 45% did not cover inpatient/outpatient SUD services.[19]

Congress also recognized that even small investments in preventive screenings and services can yield significant cost savings and improve health outcomes. Accordingly, the ACA requires most health plans to provide certain preventive screenings and services with no cost sharing for consumers. Eliminating co-pays and other out-of-pocket expenditures for preventive care increases access to these important services, particularly for low-income persons for whom cost is often a barrier to accessing needed preventive services and care.

However, grandfathered plans are not required to meet coverage standards for essential health benefits or provide no-cost preventive services.[20] Continued or expanded enrollment in grandfathered or other noncompliant plans may decrease access to important health care services and enrollees may not be able to afford necessary preventive screenings and services. Studies show that increased coverage in through the ACA has led to higher rates of preventive health care visits and testing for diabetes, HIV, cholesterol, and various forms of

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[17] Wakely Consulting Group, The Commonwealth Fund, *Analysis of Alternative Policy Decisions in Iowa's Individual Market* (May 25, 2019), https://www.commonwealthfund.org/sites/default/files/2018-06/Alternative_Scenarios_for_Iowa_5_25_18_final.pdf.
[18] 42 U.S.C. § 18022, 42 U.S.C. § 300gg–13; 29 C.F.R. §§ 2590.715-2713; 45 C.F.R. § 147.130.
[19] Gary Claxton et al., *Would States Eliminate Key Benefits if AHCA Waivers are Enacted?,* Kaiser Family Foundation (June 14, 2017), https://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/.
[20] 42 U.S.C. § 18022.

cancer.[21] Preliminary results also found that increased screening for breast cancer under ACA-compliant plans' preventive services requirement may have a significant positive impact on patient outcomes and decrease racial/ethnic disparities in outcomes.[22]

Moreover, continued support or expansion of grandfathered plans will restrict access to critical reproductive and contraceptive health services, which will have serious, real-life consequences.[23] The preventive services coverage requirement in the ACA has been successful in improving access to contraceptives. A study by the Guttmacher institute in 2014 showed that the proportion of privately insured women with no out-of-pocket costs for a number of contraceptive services increased dramatically.[24] As noncompliant plans decreased, access to contraceptives increased.[25] A report from the IMS Institute for Healthcare Informatics found that 24.4 million more prescriptions for oral contraceptives with no copayment were filled in 2013 than in 2012.[26] Removing this coverage requirement creates a greater risk of medical complications and increases the risk of unintended pregnancy.

Limiting access to essential health benefits and preventive screenings and services will invariably lead to worse health outcomes and higher health care costs.

Conclusion

Strict requirements to retain grandfathered status are consistent with the congressional intent and existing guidance that such plans are transitional. We urge this administration to bring grandfathered plans into compliance with the ACA, which has helped millions of people

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[21] Benjamin D. Sommers et al., Changes in utilization and health among low-income adults after Medicaid expansion or expanded private insurance, 176 JAMA INTERNAL MED. 1501-1509 (2016); Kosali Simon et al., The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the First Two Years of the ACA Medicaid Expansions, 36 J. OF POLICY ANALYSIS AND MGMT. 390-417 (2017); Katherine Baicker et al., The Oregon Experiment – Effects of Medicaid on Clinical Outcomes, 368 NEW ENGLAND J. MED. 1713-1722 (2013) (showing fifteen percent increase in rate of cholesterol screening and fifteen to thirty percent increase in rates of screening for cervical, prostate, and breast cancer).

[22] Abigail Silva et al., *Potential impact of the Affordable Care Act's preventive services provision on breast cancer stage: A preliminary assessment*, 49 CANCER EPIDEMIOLOGY, 108-11 (2017).

[23] *See* Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725 (Feb. 15, 2012); Coverage of Certain Preventive Services under the Affordable Care Act, 78 Fed. Reg. 8456 (proposed Feb. 6, 2013) (to be codified at 29 C.F.R. pt. 2590; 45 C.F.R. pts. 147, 148, 156) (regulations regarding religious exemptions to these requirements); *See also* National Health Law Program, *Medical Management and Access to Contraception* (Mar. 15, 2016), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/09/Medical_Management_and_Access_to_Contraception.pdf.

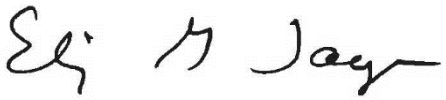
[24] Adam Sonfield et al., *Impact of the Federal Contraceptive Coverage Guarantee on Out-of-Pocket Payments for Contraceptives: 2014 Update*, 91 CONTRACEPTION 44, 44-45 (2014).

[25] *Id.*

[26] IMS Inst. For Healthcare Informatics, *Medicine Use and the Shifting Costs of Healthcare: A Review of the Use of Medicines in the United States in 2013* (2014).

affordable coverage that meets their health care needs. If you have further questions, please contact Senior Attorney Wayne Turner at turner@healthlaw.org.

Sincerely,



Elizabeth G. Taylor
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