Federation of American Hospitals®

Charles N. Kahn III
President and CEO

August 10, 2020

The Honorable Alex Azar
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

**Re: Grandfathered Group Health Plans and Grandfathered Group Health Insurance Coverage (RIN 1210-AB89)**

Dear Secretary Azar,

The Federation of American Hospitals (FAH) is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural America. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. The FAH appreciates the opportunity to submit comments to the Departments of Health and Human Services, Labor, and Treasury (the Departments) regarding the proposed Grandfathered Group Health Plans and Grandfathered Group Health Insurance Coverage.

Grandfathered health plans are plans that were offered before enactment of the Affordable Care Act (ACA). Under the ACA, those health plans are exempt from some of the law's rules and consumer protections, so long as they continuously provide coverage and the terms of coverage remain unchanged. Employers and individuals were permitted to maintain the noncompliant health plans in order to help smooth the transition to a minimum essential benefit level and to incorporate other standards for health plans.

Under the ACA's exemption, grandfathered health plans are not required to offer essential health benefits nor provide preventive care without cost-sharing. They do not need to comply with certain coverage guarantees or rating rules. They can still impose annual dollar limits and are not subject to a number of patient protections and consumer safeguards including appeals rights and certain non-discrimination rules. As anticipated, the number of grandfathered

plans has naturally declined each year since the ACA's enactment. In 2011, 72 percent of employers offered employees at least one grandfathered group health plan. In 2019, that declined to 22 percent, covering 13 percent of covered workers.[1]

The proposed rule would amend the 2015 regulations in two ways. First, group health coverage and group insurance plans would be permitted to raise deductibles and fixed amount copayments by an amount that the Departments estimate would be 3 percentage points (by 2026) higher than the increases permitted under existing rules. It would do this by incorporating an alternative inflation adjustment into the maximum percentage increase permitted for those fixed cost sharing amounts. The Departments state the alternative inflation adjustment would more accurately account for the changes in costs of health insurance coverage over time. Second, the Departments would clarify that high deductible health plans may retain grandfathered status when implementing the maximum annual cost-sharing adjustments permitted by those plans under Internal Revenue Service (IRS) rules even if those amounts exceed the maximum annual changes permitted under these proposed rules.

**The FAH does not support the proposed changes and urges the Departments not to finalize this rule. More specifically, we have serious concerns about impacts of the proposed rule on our patients and the downstream impacts to hospitals and other providers. If implemented, the proposed rule would permit already non-compliant health plans to increase copayments and deductibles beyond the levels permitted under existing rules and would shift more the plans' costs onto consumers - making insurance less affordable and jeopardizing access to care.**

**There could not be a more unfortunate time for regulatory changes encouraging group health insurers and group health plans to shift more of their costs onto consumers. Eroding the coverage under grandfathered plans – plans that are already permitted to provide fewer health care benefits – at a time when the US is facing an unprecedented public health crisis while tens of millions of individuals are confronting job and income losses is unacceptable.** We remain concerned that the increased cost sharing may make it difficult for consumers, particularly those in low- and moderate-income families, to access the health care services covered under their plans. In addition, consumers are likely to find themselves unable to pay their increased cost sharing obligations, leading to increased uncompensated care for hospitals and other providers.

The shift of health care costs from group health insurers and group health plans to consumers and health care providers seems especially untimely as the current public health crisis is having a major impact on those same consumers and providers while insurer medical expenses plummet. A considerable amount of reporting has described how many large insurers are facing lower costs because their beneficiaries have cancelled or postponed elective medical care during the public health emergency period.[2]

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[1] Kaiser Family Foundation, 2019 Employer Health Benefits Survey, https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/.

[2] See for example S. Livingston, "Large health insurers appear immune to COVID-19", *Modern Healthcare*, May 9, 2020, https://www.modernhealthcare.com/insurance/large-health-insurers-appear-immune-covid-19; and J. Appleby and S. Findley, Health insurers prosper as COVID-19 deflates demand for elective treatments", *Kaiser Health News*,

This rule is intended to lengthen the amount of time that group health plans can continue to provide coverage that does not meet ACA standards for basic health insurance. By loosening the test for determining if coverage has remained unchanged, this rule would enable substandard insurance to continue to exist far longer than was envisioned with the passage of the ACA in 2010.

In contrast, we believe the existing rules are working precisely as intended. Over time, the number of such non-compliant plans was expected to decline as health plans naturally turn over, or their benefits or terms are updated. We oppose policies that would slow the decline in grandfathered plans that is already underway because that decline represents the natural transition to health coverage that meets statutory minimum standards for coverage and consumer protections.

In light of these concerns, we urge you not to finalize these proposed regulatory changes that would shift costs to consumers, especially during a time of economic hardship under the COVID-19 pandemic, or could leave providers, who are experiencing the greatest challenges they've faced in decades, with higher uncompensated care.

Please feel free to contact me or any member of my staff to discuss further these important matters at (202) 624-1534.

Sincerely

April 28, 2020, https://www.fiercehealthcare.com/payer/health-insurers-prosper-as-covid-19-deflates-demand-for-elective-treatments.