American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

August 14, 2020

The Honorable Charles P. Rettig
Commissioner
Internal Revenue Service
Department of the Treasury
1111 Constitution Avenue NW
Washington, DC 20224

The Honorable Preston Rutledge
Assistant Secretary
Employee Benefits Security Administration
Department of Labor
200 Constitution Ave NW
Washington, DC 20210

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid 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 Commissioner Rettig, Assistant Secretary Rutledge and Administrator Verma:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 90 that offer health plans, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, we appreciate the opportunity to comment on the proposed rule from the Departments of the Treasury, Labor and Health and Human Services that would allow certain grandfathered health plans to increase patient cost-sharing beyond current limits, without losing their grandfathered status.

At a time when access to health care is more critical than ever, we urge the departments not to finalize this rule, which could decrease patients' health care coverage.

The proposed rule would allow grandfathered plans more flexibility to increase fixed cost-sharing amounts (e.g., copays, deductibles and out-of-pocket maximums) without losing their grandfathered status. Under current policy, grandfathered health plans cannot increase copays annually by more than the greater of $5 (adjusted by medical inflation) or a maximum percentage increase set by the agencies. Non-copay fixed cost-sharing amounts (e.g., deductibles and out-of-pocket maximums) cannot increase beyond the maximum percentage increase set by the agencies. Currently, the maximum percentage increase is defined by medical inflation (from March 23, 2010) plus 15 percentage points. This proposal would change the definition of "maximum percentage increase" to the greater of medical inflation plus 15 percentage points, or the premium adjustment percentage plus 15 percentage points.

The AHA has previously expressed concerns about the growth rate of the premium adjustment percentage. Using the premium adjustment percentage for this calculation could lead to significant growth in cost-sharing amounts, leaving patients vulnerable to financial hardship.

The proposed rule also would allow grandfathered plans that are high-deductible health plans (HDHP) to increase their fixed-amount cost-sharing beyond the allowed amounts if doing so is necessary for compliance with the HDHP requirements established under section 223(c)(2) of the Internal Revenue Code. HDHPs must have annual deductibles above $1,400 for individual coverage or $2,800 for family coverage, which patients must pay before accessing coverage for most services.

The AHA has significant concerns about the financial burden these plans put on patients. A recent report found that almost half of consumers with employer-provided HDHPs report having less in savings than the amount of their deductible; two-thirds report that they would need to go into debt to afford their deductible. Similarly, the most recent Federal Reserve report on the economic well-being of U.S. households revealed that 40% of adults would not be able to afford a $400 emergency. Given the current economic crisis and rising unemployment, we expect that even fewer consumers will be able to meet their deductible amounts. As your departments note, this increased cost exposure could lead to an "increase in adverse health outcomes if a participant or beneficiary would forego treatment because the necessary services became unaffordable due to an increase in cost sharing."

Plans with such high cost exposure create financial barriers to care, leaving patients underinsured. This harms patients who may avoid accessing necessary care; it also has the added impact of undermining the financial stability of the hospitals and health systems that serve them. Hospitals and health systems report that more than 50% of charity care now goes toward supporting insured (or rather, underinsured) patients, rather than uninsured patients. At the same time, the increased financial pressure of

inadequate coverage challenges providers' ability to maintain access to a comprehensive scope of services. The COVID-19 crisis is taking a further toll on hospitals' finances.

Grandfathered health plans are not the right solution for patients. The AHA instead remains committed to expanding access to affordable, high-quality, comprehensive health coverage and looks forward to working with the federal government on this shared goal. In our previous comments to the Administration, we expressed support for solutions that would have the dual effect of lowering the cost of coverage while providing greater choice among plans. Among the concepts AHA supports are federal and state reinsurance programs that help reduce the cost of coverage and increasing outreach and enrollment assistance, since most uninsured individuals are already eligible for some form of subsidized coverage. These approaches retain vital consumer protections while supporting greater enrollment. They also reduce health care costs by bringing greater balance to marketplace risk pools.

We appreciate the opportunity to comment on this proposal. Please contact me if you have questions, or feel free to have a member of your team contact Ariel Levin, senior associate director of policy, at (202) 626-2335 or alevin@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy