received 8/19/10

MurphyAnderson PLLC

Washington
1701 K Street NW, Suite 210
Washington DC 20006
202.223.2620 Fax 202.223.8651

Boston
111 Devonshire Street, 5th Floor
Boston MA 02109
617.227.5720 Fax 617.227.5767

Cincinnati
2406 Auburn Avenue
Cincinnati, OH 45219
513.784.1280 Fax 877.748.1449

www.murphypllc.com

Reply to Washington

August 13, 2010

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

Attn: RIN 1210-AB42

Re: Comments on Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act
Issued June 17, 2010, Fed. Reg. Vol. 75, No. 116

To Whom It May Concern:

I represent and work with Taft-Hartley welfare benefit funds that provide welfare benefits to tens of thousands of employees pursuant to collective bargaining agreements in the retail grocery and other industries.

I write to comment on the recently issued regulations enacting Section 1251 of the Patient Protection and Affordable Care Act ("the Act").

1. <u>Section 2590.715-1251(f) should reflect the deferred effective date for collectively-bargained health coverage intend by Congress in Section 1251(d).</u>

Section 1251, entitled, "Preservation of Right to Maintain Existing Coverage," was included in the first draft of the Senate health care reform bill. Throughout the legislative process, Subparagraphs (b), (c), (d) and (e) remained exactly the same—their language was never changed. Only Subparagraph (a) was changed, first to add subsection (3) via the amendments to the Senate bill, and second to add subsection (4) via the House reconciliation bill.

Subparagraph 1251(a), entitled "No Changes To Existing Coverage," provides that nothing in the Act requires a person to drop the health insurance coverage or group health plan he had at the date of enactment, and that the provisions of Subtitle A and C do not apply to group health plans and health insurance coverage in existence at the time of enactment, except as set forth in subsections (3) and (4). Subsections (3) and (4) delineate which specific provisions of the Act apply, and when, to "grandfathered health plans," as defined in subparagraph 1251(e).

By contrast, Subparagraph 1251(d), entitled "Effect on Collective Bargaining Agreements," provides in relevant part:

> In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this Act, ***the provisions of this subtitle [Subtitle C] and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements to the coverage terminates***.

(Emphasis supplied.)

The Departments have interpreted the above language to mean that there is no deferred effective date for collectively-bargained coverage: instead, the provisions of Section 1251(a) apply to collectively-bargained coverage the same as for all other grandfathered plans, with the only effect of a collective bargaining agreement's expiration date being to provide a date on which a determination must be made as to whether the collectively-bargained coverage's grandfathered status has been lost due to changes made in the interim. Under this reading, despite the express language that the Act "***shall not apply until***" the last existing collective bargaining agreement terminates, the Departments have interpreted Section 1251(d) to mean that the Act ***does*** apply ***before*** the last collective bargaining agreement terminates. This interpretation is manifestly contrary to the language of the statute.

The Departments' interpretation is based on their determination that collectively-bargained coverage is included in the definition of "grandfathered health plans." *See* 75 Fed. Reg. No. 116, p. 34543. That is undoubtedly the case, but it does not end the inquiry. Rather, the Departments must go further to determine the meaning of the language in Section 1251(d) that the Act shall not apply to collectively-bargained coverage until after the last collective bargaining agreement terminates.

The most logical, straight-forward way to read Section 1251(d) in harmony with the other provisions of Section 1251 and giving effect to the language of them all, is to interpret Section 1251(d) as carving out a subset of grandfathered health coverage that is collectively bargained, and setting an effective date for this subset that differs from that contained in subparagraph (a). That is, once the last underlying collective bargaining agreement terminates, those provisions of the Act otherwise applicable to grandfathered coverage also apply to collectively-bargained grandfathered coverage; if after the last underlying collective bargaining agreement terminates the collectively-bargained coverage loses its grandfathered status, then the Act applies to it as it does for all other non-grandfathered coverage. This interpretation of Section 1251(d) is just as reasonable as the one given to it by the Departments, and far more plausible in light of the policy considerations discussed below.

The Departments have based their interpretation on the fact that other, rejected, versions of the health care reform law expressly provided for a deferred effective date for collectively-bargained coverage, whereas in their view, Section 1251(d) does not. *See* 75 Fed. Reg. No. 116, p. 34542-43. But what can the phrase "shall not apply until" in Section 1251(d) reasonably mean other than a deferred effective date? While Section 1251(d)'s language may differ from other rejected versions of the health care reform law, the Departments' interpretation distorts that key phrase into nearly meaningless surplusage.

Further, the Departments' interpretation leads to illogical and absurd results and manifest unfairness. Traditionally when enacting changes to health care laws, Congress has provided deferred effective dates for collectively-bargained health coverage. The reason for this is inherent in the nature of collectively-bargained coverage, which generally have limited flexibility to respond to the new law during the life of the underlying collective bargaining agreements. These benefit plans are locked into particular benefit schemes and funding sources during the life of the underlying collective bargaining agreements, and generally cannot adjust their terms and funding sources until those agreements are renegotiated to account for the costs and burdens associated with the new legal scheme. For this reason, Congress provided deferred effective dates for collectively-bargained health coverage when enacting ERISA, HIPAA, and most recently MHPAEA.

With the Act, Congress made sweeping changes to how existing health coverage must operate, and there is no logical reason to think that Section 1251(d) was not intended to enact a deferred effective date for collectively-bargained coverage as Congress has traditionally done when enacting other, less sweeping changes to health

care laws.[1] Yet despite language indicating a deferred effective date, as reflected by the phrase "shall not apply until," the Departments have ignored Congress's intent and imposed the costs and burdens of complying with the Act on collectively-bargained plans coverage before the underlying collective bargaining agreements expire and can be renegotiated. This makes no sense and is manifestly unfair.

Finally, the deferred effective date for collectively-bargained coverage should apply to all collectively-bargained coverage, not just fully-insured collectively-bargained coverage. The Departments have noted that Section 1251(d) refers only to "health insurance coverage" and not to group health plans, and thus have determined that Congress did not mean to include self-insured collectively-bargained plans. *See* 75 Fed.Reg. No. 116, p. 34542. Thus, they drafted the regulations to apply only to fully insured collectively-bargained coverage. *See, e.g.*, 29 CFR § 2590.715-1251(f)

As many commentators have noted, the language of Section 1251(d) differs significantly from other deferred effective date provisions Congress has enacted for collectively-bargained plans in the past. However, it does not make sense to read "health insurance coverage" to reflect an actual intent to exclude self-funded collectively-bargained plans. The only time Section 1251(d) was discussed on the floor of either the Senate or the House, it was clearly intended to apply to all collectively-bargained health coverage:

---

1 In issuing regulations governing the provision of preventive care pursuant to Section 2713 of the Public Health Service Act, added by Section 1001 of the Act, the Departments resolved ambiguous statutory language without hesitating to consider unstated policy considerations:

> Section 2713(b)(1) refers to an interval between "the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement descried in subsection (a) is effective with respect to the service described in such recommendation or guideline. While the first part of this statement does not mention guidelines under subsection (a)(4), ***it would make no sense*** to treat the services covered under (a)(4) any differently than those in (a)(1), (a)(2) and (a)(3). ... ***there is no plausible policy rationale*** for treating them differently.

75 Fed. Reg. No. 137, p. 41729, ft. 4 (emphasis supplied). Here, it makes no sense and there is no plausible policy rationale to treat Section 1251(d) as doing anything other than giving a deferred effective date for collectively-bargained plans as has been traditionally enacted by Congress in other legislation affecting group health plans.

> But I would want to point out page 100 of the Senate bill[2]. You know, why were the unions so happy to jump on this? You know, unions are beginning to look at their health insurance policies as—some of them are—as a massive debt, and they'd like to get rid of it, and we know that they'd be unable to do this under the bill. But people will be glad to know, people who are in unions who are retired and have union health insurance, they'll be glad to know that ***they won't lose their union-negotiated health care, at least not until the date on which the last of the collective bargaining agreements relating to the coverage terminates.***
>
> So people will be able to keep, if you're in a union, or, Madam Speaker, people are in a union or they have retired and they have union health care, ***they can be assured they do not lose their health care—at least not until the date on which the last of the collective bargaining agreements relating to the coverage terminates.*** And then, of course, once a new union contract has to be negotiated, all bets are off.
>
> So that should provide some comfort ***if there is a year or two left on a collective bargaining agreement, then, they can be comforted.*** They have got that insurance if they like it, and they can keep it until the collective bargaining agreement terminates.

156 Cong. Rec., H1513 (daily ed. March 16, 2010) (statement of Rep. Gohmert, emphasis added). Rep. Gohmert used the terms "health insurance" and "health care" interchangeably, indicating that he understood Section 1251(d) to apply to ***all*** union-negotiated health care—not just fully-insured union-negotiated health care. (His remarks also indicate that he believed Section 1251(d) granted a deferred effective date to collectively-bargained health care, which as explained above, is the most straightforward reading of it.)

Further, reading Section 1251(d) to apply only to fully-insured plans leads to absurd and unfair results. Because fully-insured plans pay premiums, rather than benefit claims, the costs of operating the plans are more stable and such plans have more flexibility to respond to new legislation that imposes additional costs and burdens on the plan. Insurance policies typically set a premium rate for one year, followed by specified percentage increases to the rate for any subsequent years of the policy, and contain provisions that allow the premium rates to be renegotiated when new legal obligations materially change the performance obligations of the insurer. Where the policy does not

---

[2] Page 100 of the Senate bill published by the GPO, the only version that would have been available at the time of these remarks, included Section 1251(d).

contain such a provision, the insurer, not the plan, bears the costs of complying with new legislation. In either case, even where contribution rates are locked in during the life of the underlying collective bargaining agreements, there is less risk that new legislation will threaten the financial security of a fully-insured collectively-bargained plan.

By contrast, self-insured collectively-bargained plans have less flexibility to respond to new legislation, and face a greater risk that such legislation will financially devastate the plan. The increased costs and burdens imposed by new legislation are borne solely by them until the underlying collective bargaining agreements can be renegotiated—they cannot be shifted to contributing employers by increasing contribution rates, and they cannot be shifted to employees by reducing benefit levels or increasing coinsurance, co-pays and other cost-shifting mechanisms. The reserves of the plans are quickly drained, risking insolvency and termination of the plan all together. If anything, self-insured collectively-bargained plans are *more* in need of deferred effective dates than fully-insured collectively-bargained plans.

If the goal of the Act was to extend health coverage to more Americans, while allowing everyone to keep the coverage they currently have, it makes no sense to interpret Section 1251(d) in a way that it threatens existing coverage for millions of employees covered by self-insured collectively-bargained plans.[3]

I respectfully request that the Departments redraft the regulations, especially 29 CFR § 2590.715-1251(f) and the corresponding regulation in the IRS and DHHS regulations, so as to implement what Congress intended and what makes the most sense policy-wise: a deferred effective date for all collectively-bargained coverage, whether self-insured or fully-insured.

2. Section 2590.715-1251(g) is overbroad and needlessly complex.

It cannot be gainsaid that in extolling the virtues of the Act, various members of Congress, the White House, and even the regulators themselves, made repeated statements indicating that Americans who were happy with their coverage would be able

[3] According to The Kaiser Family Foundation and Health Research & Educational Trust, 57% of employees receive their health coverage through self-insured plans in 2009. *Employer Health Benefits Annual Survey*, Section 10, Plan Funding (KFF/HRET 2009). According to the U.S. Department of Health and Human Services, Agency for Health Care Research and Quality's Medical Expenditure Panel Survey of 2009, where there is a union presence employers are far more likely to offer health coverage through self-funded plans rather than fully-insured plans (70.7% vs. 29.3%). This data indicates that a large percentage of employees get their health care coverage through self-insured collectively-bargained plans.

to keep it under the new law. Section 1251 reflects Congress's intent to exempt existing health plans from the Act, with limited exceptions, and is silent on whether, or in what circumstances, a plan in existence on the date of enactment would ever become subject to the other provisions of the Act.

Yet the Departments have adopted a complex regulatory scheme for determining how and when "grandfathered status" is lost. The need to monitor whether such status has been lost, in and of itself, will significantly increase the administrative expenses of a plan, especially a plan that (like most) offers different benefit levels for various groups of employees (for example, full-time versus part-time coverage, or single versus family coverage). Changes to the benefits offered or costs of the plan to employees alone can cause loss of grandfathered status, even if those changes are not significant.[4] The practical result will be that most, if not all, health plans will become subject to the full Act in a few years. This contradicts the many public statements of Administration officials that the Act would allow Americans to keep the coverage they already had. Indeed, a recent study by Hewitt Associates indicates that nine out of 10 companies expect to lose grandfathered status for their plans by 2014. Fifty-one percent of self-insured plans expect to lose it in 2011, and another 21 percent of self-insured plans expect to lose it in 2012.

A further, perhaps unintended consequence, of this complex regulatory scheme will be that many existing health plans could terminate rather than take on the costs and burdens of complying with the Act. For example, one self-insured plan I work with is considering dropping coverage for part-time employees all together. Under the regulations as drafted, a plan loses its grandfathered status if it increases an individual's coinsurance requirement, no matter how modest the increase [29 CFR § 2590.715-1251(g)(1)(ii)], yet under other regulations issued by the Departments, plans that currently set lifetime or annual limits on benefits may no longer apply them. (*See*, *e.g.*, 29 CFR § 2590.714-211.)

This particular plan currently offers limited health benefits to part-time employees with a modest monthly premium, a fairly standard 80-20 coinsurance, and standard copayments, but with an annual limit of $50,000. In the last plan year, less than 1% of participants exceeded the annual limit. The plan sponsor does not believe it can afford to absorb the cost of providing unlimited coverage to part-time employees without being able to shift at least some of the increased cost to employees. Even if the employees were

---

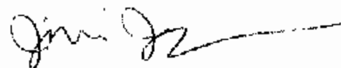
[4] For example, elimination of coverage for a specific condition, no matter how obscure or how little utilized such coverage has been in the past, will cause a loss of grandfathered status. *See* Section 2590.715-1251(g)(1)(i).

willing to accept a modest increase in the coinsurance, the plan sponsor cannot make this change without losing the grandfathered status for the part-time plan, which it is not willing to do until there is a clearer picture of what that will mean as far as increased administrative burdens and costs, and whether it could obtain a waiver of the annual limit restrictions for this coverage under still-to-be-issued regulations. Therefore, this plan sponsor is considering terminating part-time coverage, all because it is not able to continue to offer the coverage it has offered to this point. The plan sponsor is not worried about its ability to continue to attract qualified part-time employees without offering health benefits, because unemployment is so high and few of its competitors offer much in the way of health insurance to part-time employees. The plan sponsor's dilemma may have been alleviated had the regulations on how and when grandfathered status is lost been drafted so as to give more flexibility to redesign the plan in order to respond to the few provisions of the Act that apply to the existing plan without becoming subject to all the other applicable provisions of the Act.

At a minimum, grandfathered status should not be lost unless significant changes to the plan are made, with the standard for what is "significant" being a change that affects more than a specified percentage of participants, deceases their access to health care by more than a specified percentage, or increases their overall costs of being covered by more than a specified percentage above medical inflation. On this last point, the determination of whether the employee's cost of being covered has increased too much should be based on the aggregate of all changes to monthly premiums, coinsurance and copayments, rather than a change in any single cost-sharing item.

I appreciate your consideration of these issues. Thank you.

Very truly yours,



Joni S. Jacobs

JSJ:oc