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## General Comment

See attached file.

## Attachments

**IRS-2010-0010-0941.1:** Comment on FR Doc # 2010-14488

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# COMMENTS ON "GRANDFATHER" INTERIM FINAL RULES

*Submitted by*

EMPLOYERS NETWORK FOR RESPONSIBLE OPTIONS, LAWS AND LEADERSHIP (ENROLL)
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August 16, 2010

# COMMENTS ON "GRANDFATHER" INTERIM FINAL RULES

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## INTRODUCTION

On June 17, 2010, 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. 34,538-34,570 (June 17, 2010) ("Grandfather Rules," "Interim Rules" or "Rules") were published pursuant to the Patient Protection and Affordable Care Act, Pub. L. No. 111–148 (March 23, 2010) ("Affordable Care Act" or "Act"), and the Health Care and Education Reconciliation Act, Pub. L. No. 111-152 (March 30, 2010) ("Reconciliation Act"). The Interim Rules were issued by the three agencies responsible for healthcare reform law rulemaking: the Internal Revenue Service in the United States Department of the Treasury ("IRS"), the Employee Benefits Security Administration in the United States Department of Labor ("DOL"), and the Office of Consumer Information and Insurance Oversight in the United States Department of Health and Human Services ("HHS") (together the "Departments"). The Interim Rules included a request for comments.

These comments[1] are submitted on behalf of the Employers Network for Responsible Options, Laws and Leadership ("ENROLL"), including the International Public Management Association for Human Resources ("IPMA-HR"), the College and University Professional Association for Human Resources ("CUPA-HR"), and the National Railway Labor Conference ("NRLC"). ENROLL consists of employers and associations that have a shared commitment to the responsible administration of healthcare benefit plans. In many respects, the Affordable Care Act and the Reconciliation Act (collectively "the Act") reinforce the role played by employers and employment relationships in national healthcare policy. As evidenced by the Interim Rules, responsibility for healthcare reform changes and costs will rest heavily on employers, and employers will play a central role in advancing the policies underlying healthcare reform. The employers and associations participating in ENROLL are identified in the Appendix.

The Interim Rules provide needed guidance concerning many aspects of Affordable Care Act Section 1251, captioned "Preservation of Right to Maintain Existing Coverage," which states:

> (a) NO CHANGES TO EXISTING COVERAGE –
> (1) IN GENERAL.–Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan

[1] Additional contributors to the these comments, on behalf of ENROLL and the associations identified in the text, include Morgan Lewis attorneys Ross H. Friedman, Sage Fattahian, Marianne Hogan, and Jessica R. Bernanke.

> or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.
>
> (2) CONTINUATION OF COVERAGE.–With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.
>
> (b) ALLOWANCE FOR FAMILY MEMBERS TO JOIN CURRENT COVERAGE.– With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act and which is renewed after such date, family members of such individual shall be permitted to enroll in such plan or coverage if such enrollment is permitted under the terms of the plan in effect as of such date of enactment.
>
> (c) ALLOWANCE FOR NEW EMPLOYEES TO JOIN CURRENT PLAN.– A group health plan that provides coverage on the date of enactment of this Act may provide for the enrolling of new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).
>
> (d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.– 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 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 relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this subtitle or subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.
>
> (e) DEFINITION.– In this title, the term "grandfathered health plan" means any group health plan or health insurance coverage to which this section applies.

Affordable Care Act § 1251(a)-(e).

There is boundless diversity among the employers, industries, unions, and benefit plans affected by the new healthcare reform laws. As reflected in the employers on whose behalf these comments are submitted, the new requirements profoundly affect healthcare benefits afforded to employees in railway transportation, trucking, integrated steel production, truck body production, biotechnology, chemical production, food product manufacturing, consumer packaging, publishing, broadcasting, heavy building materials, higher education, and municipal, state and federal governments. Based on the range of changes and costs associated with the new requirements, the "grandfathering" of existing health plans plays a central role in healthcare reform efforts. The concept of "grandfathering" provides the primary means by which employers throughout the country can formulate effective ways to implement the new mandates, which require extensive work by representatives of employers, unions, insurers, administrators and other parties involved in employer-provided healthcare arrangements.

In several important respects, the Interim Rules warrant modification to be consistent with statutory language, to advance the policies and purposes underlying the healthcare reform laws, and to avoid outcomes that are incongruous with other federal statutes, including the other benefits laws and the National Labor Relations Act ("NLRA"), 29 U.S.C. §§ 151 *et seq.* (2006), the Labor Management Relations Act ("LMRA"), 29 U.S.C. §§ 141 *et seq.* (2006), and the Railway Labor Act ("RLA"), 45 U.S.C. §§ 151 *et seq.* (2006).

## SUMMARY OF COMMENTS

1. **Immediate Mandate Cost.** The costs of the immediate mandates imposed by the Act are greater than the permissible range of cost changes permitted under the Grandfather Interim Final Rules and, hence, the maximum permissible modifications under the Interim Final Rules are set too low. *See* pages 5-9.
   - (a) **Dependent Coverage to Age 26.** The Dependent Rule itself constrains employer's ability to recover the cost of the Immediate Mandate and consumes over half of the permissible cost-sharing latitude permitted by the Grandfather Interim Final Rules. *See* pages 5-6.
   - (b) **Prohibition on Lifetime Limits.** The prohibition on Lifetime Limits will create financial uncertainty for employers and will have widely varying cost impacts that are not adequately recognized in the Grandfather Interim Final Rules. *See* pages 6-8.
   - (c) **Restricted Annual Limits.** The Interim Final Rules have widely disparate impacts on plans that currently contain annual limits and should be revised to permit plans to retain their current annual limits or end coverage for part-time, seasonal or low-wage workforces. *See* pages 6-8.
   - (d) **Prohibition on Rescission.** The Interim Final Rules impose unanticipated costs on standard plan administrative practices and are overbroad in relation to the perceived abuse in the traditional insurance market. *See* pages 8-9.
2. **Permissible Financial Changes Are Too Narrow.** The permissible range of financial changes outlined in the Grandfather Interim Final Rules is too narrow to reflect the cost of the immediate mandates. *See* pages 9-11.
   - (a) **Current Grandfather Rule Contains Too Little Leeway.** The limits reflected in the Grandfather Rule are totally insufficient to reflect the cost of the immediate mandates. *See* pages 9-11.
   - (b) **Prohibition on Cost Sharing for Preventive Care.** The cost of violating grandfather treatment, and adding in the grandfathered mandate of preventive services, adds even further cost to complying with the Act. *See* page 11.
3. **Collectively Bargained Plans.** The Interim Rules should not differentiate between collectively bargained self-insured plans and fully-insured plans, and should defer all healthcare reform mandates until the beginning of the plan year after termination of the last plan-related collective bargaining agreement. *See* pages 12-25.

(a) **Treatment of Collectively Bargained "Self-Insured" Plans.** Collectively bargained "self-insured" plans should be subject to the explicit collective bargaining agreement deferral language set forth in Affordable Care Act section 1251(d). *See* pages 12-19.

(b) **All Mandates Should be Deferred for Collectively Bargained Plans.** Consistent with the policies underlying the new healthcare reform laws, as well as other benefits laws and federal labor law requirements, the Departments should exercise their discretion to defer the effective date of all healthcare reform mandates for collectively bargained plans. *See* pages 19-24.

(c) **CBA Deferral Should Relate to the Relevant Plan Year.** The deferral of healthcare reform mandates for collectively bargained plans should continue at least until the commencement of the plan year after termination of the last plan-related collective bargaining agreement. *See* pages 24-25.

## DISCUSSION AND ANALYSIS

Consistent with promises made during the legislative process about the preservation of existing health plans, the Affordable Care Act confers "grandfathered" status on plans in effect as of March 23, 2010, with a requirement that at least one employee was enrolled in the plan as of March 23, 2010. The statute further provides that new employees and dependents may enroll going forward without compromising grandfather status.

However, the Interim Rules undermine, in important ways, the ability for employers to continue robust health care coverage. Employers are required to comply with a series of immediate costly mandates, including providing coverage to dependents up to age 26, the prohibition on lifetime limits, restricted annual limits and the prohibition on rescission (hereinafter referred to as the "immediate mandates"). Yet, if an employer makes any meaningful plan design changes, cost shifting modifications, or business restructuring to comply with immediate mandates, under the Interim Rules the employer's plan will lose its grandfather status, resulting in additional, more costly mandates (the "grandfathered mandates"). These immediate and grandfathered mandates are being imposed on employers who are already facing skyrocketing health care costs and who are experiencing significant financial challenges in the current economy.

Taking these circumstances together, the predictable result of the immediate mandates will in many cases be the reduction or elimination of many benefits to accommodate the cost of the new healthcare reform mandates. This significant problem will undermine efforts to advance healthcare reform, and should be accommodated in more concrete ways by the Interim Rules.

Underlying the Interim Rules is a flawed assumption that the promise to "keep the coverage you have" requires that the level and type of coverage be frozen in time (as of March 23, 2010). All employees understand that employers frequently make annual modifications to benefits, increase copays, adjust fixed cost percentages, make other structural or business changes, and such adjustments are not regarded as an elimination of the preexisting employer-sponsored coverage.

By imposing the immediate mandates, the healthcare reform laws already provide for significant changes in the coverage available to employees, with substantial cost increases. To reflect this reality, the promise that employees will be able to keep their current coverage should permit plans to retain their grandfathered status, even if the employer implements plan changes to comply with the new mandates, or to address marketplace issues. Allowing employers greater latitude to adjust coverage and premiums should be regarded as an important tool permitting employers and grandfathered plans to bear the increased costs associated with immediate mandates. In turn, greater flexibility in the Interim Rules will translate into greater protection for ongoing coverage between now and January 1, 2014, thereby advancing the interests of healthcare reform. In 2014, if an employee is dissatisfied with the employer-sponsored coverage, the employee can enter the Exchange provided in the new laws, and employers themselves will face potential penalties if their coverage fails to meet minimum essential coverage standards that will then be required.

1. **Immediate Mandate Cost**. The costs of the immediate mandates imposed by the Act are greater than the permissible range of cost changes permitted under the Grandfather Interim Final Rules and, hence, the maximum permissible modifications under the Interim Final Rules are set too low.

The Act requires that all group health plans, regardless of their grandfather status, comply with the following, costly immediate mandates in the first plan year beginning on or after September 23, 2010 (which for many employer sponsored plans is January 1, 2011). The Departments recognize the significant cost of these immediate mandates but fail to permit sufficient latitude in the Interim Final Rules for employers to respond to these increased costs without, in turn, losing their grandfather status. Examples of these immediate mandates, and the costs drawn from the Department's own estimates, are as follows:

**(a) Dependent Coverage to Age 26.** The Dependent Rule itself constrains employer's ability to recover the cost of the Immediate Mandate and consumes over half of the permissible cost-sharing latitude permitted by the Grandfather Interim Final Rules.

As noted in the Dependent Rule, it is difficult to determine how many adult children will take this coverage, and/or how much it will cost to cover these children. But the Interim Rules do acknowledge that adverse self-selection will occur, such that adult children in fair or poor health will likely enroll in their parents' coverage, and the Departments' "mid range" assessment indicates that premiums will be increased over three years by 2.6%.

Even though the extension of dependent coverage to 26 will certainly increase the plan sponsor's health care costs, the Dependent Rule provides them with almost no ability to share the cost of this coverage with the adult dependents. Employers cannot require adult children to pay a higher percentage of the premium for their coverage or higher out-of-pocket expenses, or provide them with a more restrictive set of benefits. The only way for employers to recoup any of these costs is to raise the premiums for all dependents, which could be harmful to employee relations and make it more expensive for employees to cover their minor children. Moreover, in the context of collectively bargained plans, premiums cannot be raised mid-bargaining cycle.

This leaves employers not currently in negotiations with no opportunity to seek to recoup those costs at this time.

**(b) Prohibition on Lifetime Limits.** The prohibition on Lifetime Limits will create financial uncertainty for employers and will have widely varying cost impacts that are not adequately recognized in the Grandfather Interim Final Rules.

According to the data provided in the Patient Protections Rule, 45% of large employers have lifetime limits of $2 million or higher, and only 37% of large employers have no lifetime limits at all. The data also suggests that relatively few individuals actually hit their lifetime limits.

However, self-insured group plans that now have to eliminate their lifetime limits face financial uncertainty. The claims of one participant that are in excess of the current lifetime limit could have a significant negative impact on the health plan, including the possibility of bankrupting the plan. This is particularly true in the context of multi-employer plans, which in most cases are financed with limited employer contributions that are established in collective bargaining, and the investment income that is earned on such contributions. If a multi-employer plan has to cover health care claims that run into the millions of dollars for one participant, it is possible that plan will not be able to pay for the claims of other participants. And, this scenario is a serious proposition considering the limited investment income currently available to these plans. Moreover, in most instances there is a corresponding multi-employer defined benefit pension plan. Due to the market losses of 2008 and the application of the Pension Protection Act of 2006, the contribution increases required to fund many of these plans are projected to be 10% or more in each of the next five years. In the past, the collective bargaining parties have been able to reduce contributions to the multi-employer health fund and to contribute the difference to the multi-employer pension plan. Because of the current economic crisis, contributing employers will be required to shoulder the burden of increased pension costs at the same time the proposed regulations are imposing significant health plan increases. This double hit may cause many contributing employers to reduce employment levels. The Interim Rules do acknowledge that dropping lifetime limits will increases costs, and that the average increase will be .5% of premiums, but this statistic may be misleading because the average includes plans with high or no lifetime limits with plans that have low limits. It is anticipated that the cost increases for plans with lower lifetime limits will experience cost increases in excess of .5%.

**(c) Restricted Annual Limits.** The Interim Final Rules have widely disparate impacts on plans that currently contain annual limits and should be revised to permit plans to retain their current annual limits or end coverage for part-time, seasonal or low-wage workforces.

According to the data in the Patient Protections Rule, only 8.2% of large employers have annual limits. However, these statistics do not include multi-employer plans, which typically have annual limits. Moreover, it is likely that, during the transition period until 2014 during which annual limits are permitted but lifetime limits are not, certain plans will be converting their lifetime limits to annual limits. As such, it is likely that the 8.2% figure will rise substantially between now and 2014.

For the group health plans that have annual limits, they are an important cost control measure, and losing or greatly restricting those limits will impose a heavy burden on those plans. While the impact of dropping annual limits will vary by plan size, the smallest plans are expected to face a premium increase of 6.6% over time as they move to the unrestricted annual limit.

While the smallest plans will likely face significant premium increases, the restricted annual limits rule and lifetime limits prohibition will likely threaten the existence of limited health coverage options offered by many employers with significant part-time, seasonal, and low-wage workforces. For example, employers in the retail and supermarket industries commonly offer limited benefit plans to their part-time workers. This limited coverage provides important health coverage and has proven to be an important benefit for many of these participants. Application of the Act's annual limits rule and lifetime limits prohibition will endanger the continued existence of this important coverage and may leave many workers without health coverage for years until 2014, when Exchange coverage becomes available.

Limited benefit plans, including those offered to part-time retail and supermarket workers, typically involve significant waiting periods, offer expanded benefits over time,[2] and impose annual and lifetime limits that cap the employer's coverage liability and often offer employee-only coverage. While the coverage is "limited" in nature, it serves an important purpose. Limited benefit plans allow approximately 1.4 million workers access to affordable health coverage for a majority of key medical issues.

Without limited benefit plans, many workers will not have access to health coverage until 2014. Application of the restricted annual limits rule and lifetime limits prohibition to these plans will result in substantial costs increases for employers. Such cost increases could cause employers either to significantly raise premiums, rendering coverage unaffordable for many low-wage workers, or to drop coverage entirely. In either event, many workers may be left without health coverage.

Such a result was certainly not among the Act's intended consequences. President Obama and Congress have assured the public that the Act would not affect an individual's ability to retain health coverage that satisfied his or her needs. Indeed, both have explained that the Act, in general, and the grandfather rule, in particular, were intended to allow workers to keep employer-sponsored coverage with which they are satisfied. It would be counterproductive if the Act and the grandfather rules resulted in the loss of coverage for a significant number of workers rather than the preservation, improvement, and expansion of coverage, as was intended.

Moreover, although the statute does not explicitly address the application of the coverage mandates to part-time or limited benefit plans, it appears that Congress did not generally intend the Act's coverage mandates to apply to part-time plans that currently offer limited coverage. Conversely, the provisions regarding employer penalties related to Minimum Essential

[2] For example, a part-time employee may, after 90 days of employment, become eligible for vision coverage. After an additional 90 days, a part-time employee may become eligible for dental coverage. After an additional six months, the part-time employee becomes eligible for medical coverage.

Coverage, which become effective on January 1, 2014, do address part-time coverage. The statute makes clear that the penalties are not triggered by failure to provide health care coverage to part-time employees. The fact that employers will face no penalties for failing to offer coverage of any kind to part-time employees in 2014 combined with the huge cost increases that will result when the restricted annual limits rule and lifetime limit prohibition become effective will likely prompt employers to drop part-time coverage well before the Exchanges come on line in 2014. This will add to the ranks of the uninsured for at least the next three years.

To preserve until 2014 the important health care benefits that 1.4 million workers enjoy under limited benefit plans, such plans should be exempted entirely from the immediate mandates, particularly the restricted annual limits rule and the lifetime limits prohibition. This exemption would be consistent with Congress's apparent intention to apply the Act's 2014 rules only to full-time employee coverage. If a complete exemption is not permitted, then the waiver program, contemplated in the Patient Protection Rule, should be implemented with no restrictions on the annual limits that these limited benefit plans can impose. Under the waiver program, plans seeking a waiver will have to show that compliance with the restricted annual limits would either significantly diminish benefits access or cause significant premium increases for the limited benefit coverage. The Departments should ensure that the burden of seeking a waiver is not so great that employers choose to discontinue limited benefits coverage rather than seek a waiver.

**(d) Prohibition on Rescission.** The Interim Final Rules impose unanticipated costs on standard plan administrative practices and are overbroad in relation to the perceived abuse in the traditional insurance market.

Many employers anticipated that the prohibition on rescission would protect individuals from the insurance market practice of rescinding coverage retroactively based on arguably false or unfair bases. Because participants in group health plans are protected by ERISA, including the portability and nondiscrimination provisions in Part 7, as a general matter employers did not regard the prohibition on rescissions as imposing a substantial burden on healthcare plans.

However, the Patient Protection Rule takes a very expansive view of this prohibition, and includes instances in which group health plans revoke health care coverage retroactively when an employee's coverage is mistakenly continued. For example, if an individual is moved from full-time to part-time employment, but continues to receive full-time health benefits, or if an individual is terminated, but, due to ministerial error, his health coverage is not timely discontinued. This raises a quandary for group health plans because, if an ineligible employee's coverage is mistakenly continued, it is the plan's ERISA obligation to ensure that mistake is fixed in a fashion that does not waste plan assets. In the normal course, the health plan would terminate the individual's coverage retroactively back to the proper date, and, as required, offer the participant COBRA continuation coverage. It is unclear whether that procedure would still be permissible under the new rescission rules. But, if not, the cost of covering these ineligible individuals will be another additional cost foisted on the employer.

Further, these costs will likely be unaffordable to multi-employer plans that do not have "general assets" available to cover unexpected costs. Moreover, in the multi-employer context,

the only way that the plan would know if an employee has been terminated or moved to part-time status is if the employer timely informs the plan. In many instances multi-employer plans do not receive information on whether an employee worked during a given month until midway or later through the following month. So, in summary, multi-employer plans will be responsible for covering ineligible employees when their employers fail to timely or correctly notify of the employee's termination or change to part-time status; and, arguably, this is a violation of ERISA because plan funds will be used to cover ineligible employees. The Departments were unable to estimate the cost impact of ending rescissions.

The immediate mandates detailed above change the coverage that was available to employees as of March 23, 2010, and significantly increase the employers' cost of providing such coverage. For some employers, the cost of the immediate mandate will be at least 9.7% of premiums. However, the grandfather rule does not provide employers with the necessary financial and design tools to integrate these mandated changes into their current coverage in a cost efficient manner. This obvious imbalance will cause many plans to lose their grandfather status in short order, as they will be required to increase the employee's share of the total premium beyond the limited 5% provision in the grandfather rule. Once that occurs, employers will be burdened with the additional grandfathered mandates described below, which will likely result in unanticipated reductions in or elimination of employer sponsored coverage prior to January 1, 2014.

2. **Permissible financial changes are too narrow.** The permissible range of financial changes outlined in the Grandfather Interim Final Rules is too narrow to reflect the cost of the immediate mandates.

The grandfather interim final rules contain unnecessarily narrow restrictions on the permissible changes that employers can make to their plans and still retain grandfathered status. When coupled with the cost of the immediate mandates, the Interim Final Rules make it extraordinarily difficult to retain grandfathered status for any period of time.

**(a) Current Grandfather Rule contains too little leeway**. The limits reflected in the Grandfather Rule are totally insufficient to reflect the cost of the immediate mandates.

The grandfather rule greatly limits the financial tools available to plan sponsors by causing group health plans to lose their grandfather status if they: (1) increase at all the employee's percentage of a fixed amount (such as co-insurance); (2) increase a fixed copay by an amount that is greater than (i) an amount equal to $5 increased by "medical inflation" or (ii) the "maximum percentage increase;"[3] (3) increase a fixed amount cost sharing requirement other than a copay (such as deductible or out of pocket expense) if the total percentage increase after March 23, 2010 exceeds the "maximum percentage increase;" and (4) if the employer or employee organization decreases its contribution to the plan by more than 5% below its March 23, 2010 contribution rate. Recognizing that employers and plan sponsors routinely contain costs and deflect medical inflation by increasing copays or other out of pocket expenses, or by

[3] "Maximum Percentage Increase" is defined as "medical inflation" expressed as a percentage plus 15 percentage points.

decreasing their share of the cost of coverage, the grandfather rule allows for very limited modifications as noted above. However, those permissible levels are totally insufficient. Also, in the normal course, employers may decide to adjust the co-insurance amounts for the same reasons, but the grandfather rule allows for no such adjustment. Employees generally understand these types of adjustments are necessary for the employer to continue to provide its health care coverage, and these types of changes are not viewed as "changing" the benefits available.

Although the Departments may need to set some limits on the financial tools described above, those limits should, at a minimum, reflect the actual increases of approximately 10% that employers and plans will experience due to implementing the immediate mandates, as well as anticipated (and true) medical inflation. The language of the Act contains no such restrictions, the current limits in the grandfather rule fall far short of reflecting the true increases in cost created by the Act, and there is nothing in the grandfather rule that indicates that the Departments considered setting limits that would permit the employers to shift some meaningful portion of the increased costs associated with the immediate mandates.

The grandfather rule does allow employers or plan sponsors to increase premiums without losing grandfather status, but that does not provide employers with sufficient tools to counter the costs of implementing the immediate mandates. Many employers believe it is far more of an imposition on employees to raise their premiums than copays and other out of pocket expenses. Premium increases apply across the board, while increases in copays and out of pocket expenses shift the costs to employees who actually use medical services, and therefore, encourage efficient and smart use of medical services. Further, as collectively bargained plans do not have the option to increase health care premiums outside of the bargaining cycle, they cannot even use this option to recoup the costs associated with the immediate mandates.

With regard to vendors, plans may switch third party administrators without losing grandfather status, but entering a new policy, certificate or insurance contract will cause a loss of grandfather status. These rules once again leave employers with little leeway to manage the increased costs of the immediate mandates. Allowing self-insured plans to switch third party administrators provides little relief when, as is the case here, the plans can make no meaningful changes to their financial structure. And, there is seemingly no legitimate policy reason to require a loss of grandfather status due to the issuance of a new insurance policy, particularly if the new policy offers substantially the same benefits as the original policy. It makes far more sense to connect grandfather status to the level of coverage, and not the provider of such coverage.

Lastly, the grandfather rule restrains employers from consolidating or restructuring their group health plans to move new employees into a grandfathered plan. The "anti-abuse" rules preclude employers from: (1) entering a merger, acquisition or business restructuring that has the purpose of covering new employees in a grandfathered plan, or (2) transferring employees into another, existing health plan (transferee plan) if the plan from which the employees were transferred would lose grandfather status if it were amended to reflect the transferee plan. However, these rules are contrary to the statute, which permits grandfathered plans to enroll new employees and their family members into a grandfathered plan without affecting their grandfather status. And, these rules, which are nowhere in the statute, deprive employers of

important business tools by through which they could continue to offer their health plan coverage and contain the costs imposed by the immediate mandates.

If a plan sponsor needs to make plan design changes or adjust its financial burden beyond what is permitted by the Grandfather Rule (as described above), it will lose its grandfather status, and then have to comply with additional, expensive grandfathered mandates described below. The imposition of these additional mandates, on top of the immediate mandates, is likely to cause certain employers to reduce or eliminate their group health plan benefits.

**(b) Prohibition on Cost Sharing for Preventive Care.** The cost of violating grandfather treatment, and adding in the grandfathered mandate of preventive services, adds even further cost to complying with the Act.

The Preventive Care Rule explains how increased use of preventive care should reduce health care costs due to a healthier population, and therefore, it is reasonable to give participants an incentive to seek preventive care by making that care free to them. But the Rule also acknowledges that "free" preventive services will result in an uptick in the use of such services, and it is the plan sponsors who are going to have to pay for those services without the benefit of any cost-sharing. While the Preventive Care Rule acknowledges that the data related to the costs of these services is uncertain, it posits that, based on the current cost of providing preventive care services, the full cost of providing such services for free will result in a 1.5% increase in premiums.

It is reasonable to assume that once an employer no longer has the incentive of maintaining grandfather status, it will further increase the premiums to take into account the cost of the Immediate and grandfathered mandates, which, for some employers, will be as high as 11.2% of premiums. Significantly, collectively bargained plans will not have the ability to raise premiums until the parties' next bargaining cycle. As such, collectively bargained plans, including multi-employer plans with contractually limited resources, may not be able to offset these increased costs for a number of years. In the meantime, these plans, many of which are already in serious financial condition, likely will experience even more severe financial hardship until the controlling collective bargaining agreements are renegotiated, at which time there will be enormous pressure on employers to require substantial contribution increases.

Because the limits contained in the current Grandfather Interim Final Rules are so restrictive, and the cost of immediate mandates so high (not to mention the additional cost of grandfathered mandates if grandfather treatment is lost), the Departments should give serious consideration to revising the Rules to provide for all current grandfather limits to be tripled. This additional room will allow employers to adequately reflect the cost of the immediate mandates and, where necessary due to economic circumstances or collective bargaining restraints, pass the increased cost along to their employees without losing grandfather status. This expansion will allow the Interim Final rules to reflect the spirit of President Obama's pledge and reflect the unconstrained language of the Act.

3. **Collectively Bargained Plans**. The Interim Rules should not differentiate between collectively bargained self-insured plans and fully-insured plans, and should defer all healthcare reform mandates until the beginning of the plan year after termination of the last plan-related collective bargaining agreement.

Section 1251(d) of the Affordable Care Act makes grandfathered mandates inapplicable to collectively bargained health insurance coverage until, at the earliest, the termination of the last collective bargaining agreement ("CBA") relating to the coverage. However, the Interim Final Rules indicate that this language (hereinafter referred to as "CBA deferral" language) has no impact on collectively bargained self-insured plans. Moreover, the Interim Rules also indicate that the CBA deferral language has no effect on the immediate mandates. Although collectively bargained fully-insured health plans are covered by Section 1251(d)'s CBA deferral language, the Interim Rules still make the immediate mandates applicable to such plans.

For the reasons noted below, the Departments should modify these aspects of the Interim Rules, which pertain to collectively bargained plans.

(a) **Treatment of Collectively Bargained "Self-Insured" Plans**. Collectively bargained "self-insured" plans should be subject to the explicit collective bargaining agreement deferral language set forth in Affordable Care Act section 1251(d).

Section 1251(d) of the Affordable Care Act states that the non-grandfathered healthcare reform mandates (set forth in subtitles A and C of Title I of the Act) do not apply to certain healthcare plans until the termination of the last plan-related CBA (*i.e.*, the last collective bargaining agreement relating to the coverage in question). Thus, Section 1251(d) states:

> (d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.– 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 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 relating to the coverage terminates*. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this subtitle or subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.

Affordable Care Act § 1251(d) (emphasis added).

The Interim Rules, as explained by the Departments, would substantially narrow the above language by excluding self-insured healthcare plans from any CBA deferral. Here, the Interim Rules incorporate the statutory language almost verbatim, and add a sentence indicating that, after the termination of the last plan-related CBA, "the determination of whether health insurance coverage . . . is grandfathered health plan coverage is made under the [other] rules of this section . . . and, for any changes in insurance coverage after the termination of the collective bargaining agreement, under the rules of paragraph (a)(1)(ii) of this section." 75 Fed. Reg. at

34,559 (interim 26 CFR § 54.9815–1251T(f)), 34,564 (interim 29 CFR § 2590.715–1251(f)), 34,568 (interim 42 CFR § 147.140(f)).

However, the preamble accompanying the Interim Rules indicates that the Departments intend to exclude self-insured health plans from Section 1251's CBA deferral. The Departments state:

> The statutory language of the provision *refers solely to "health insurance coverage"* and *does not refer to a group health plan*; therefore, these interim final regulations *apply this provision only to insured plans* maintained pursuant to a collective bargaining agreement *and not to self-insured plans.*

75 Fed. Reg. at 34,542 (emphasis added). The importance attached to the phrase, "group health plan," which is absent from section 1251, is explained elsewhere in the preamble in a footnote reading:

> The term "group health plan" is used in title XXVII of the [Public Health Service] Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term "health plan", as used in other provisions of title I of the Affordable Care Act. The term "health plan" does not include self-insured group health plans.

75 Fed. Reg. § 34,539 n.1. *Cf.* Affordable Care Act § 1301(b)(1)(A) ("The term 'health plan' means health insurance coverage and a group health plan"); § 1301(b)(1)(B) ("the term 'health plan" shall not include a group health plan . . . not subject to State insurance regulation under [ERISA] section 514"); § 1301(b)(2) (defining "health insurance coverage" by reference to Public Health Service Act § 2791(b)); § 1301(b)(3) (defining "group health plan" by reference to Public Health Service Act § 2791(a)).

For several reasons, the Departments should reconsider the status of self-insured collectively bargained health plans, and conclude that self-insured plans – like fully-insured plans – are subject to the CBA deferral provision in Affordable Care Act section 1251(d).

(1) *Section 1251's Plain Language.* The language of section 1251 does not support making a distinction between "self-insured" and "fully-insured" healthcare plans for purposes of the CBA deferral. Nor does the Affordable Care Act's legislative history establish that Congress intentionally used the phrase "health insurance coverage" (rather than "group health plan") to exclude self-insured health plans from the CBA deferral.[4] Several aspects of section 1251's construction support a more expansive application of the CBA deferral to self-insured (as well as fully-insured) health plans:

- The title of section 1251(d), "Effect on Collective Bargaining Agreements," suggests that the subject matter of the section relates to collective bargaining agreements

[4] As noted on page 24 below, the courts refrain from drawing conclusions about Congressional intent from the omission of a particular statutory term when the outcome would be contrary to other provisions, legal requirements and/or the policies underlying the statute.

generally, and nowhere in section 1251 is there any explicit distinction made between self-insured and fully-insured medical plans.

- The concept of "insurance" is clearly evident in "fully-insured" *and* "self-insured" health plans because the term "insured" is used when referring to both types of plans. Likewise, the "insurance" concept underlying self-insured plans is not materially different from fully-insured plans. Both types of plans involve the balancing of benefit utilization, claims, costs and premiums across a group of participants.

- The proliferation of different "health plan" concepts – some of which include and others which exclude self-insured benefits – precludes any reasonable inference that Congress intended to exclude self-insured plans when using the phrase "health insurance coverage" in section 1251(d). In fact, the conflicting and inconsistent "health plan" terms in section 1251, ERISA and the Public Health Service ("PHS") Act, combined with a dearth of legislative history on this point, renders implausible any conclusion that the single use of the word "insurance" in section 1251(d) means Congress thereby intended to exclude all "self-insured" health plans.[5]

- Many group health plans include insured *and* self-insured benefits. For example, it is not unusual to have a fully-insured medical plan but a self insured prescription drug, dental and vision plan. Collectively bargained plans that combine insured and self-insured benefits face the exact same collective bargaining obligations that are the reason for treating collectively bargained plans under separate grandfathering rules. Clearly Congress did not intend to draw distinctions between fully-insured, partially insured and self-insured collectively bargained plans.

- The one thing that is clear from section 1251(d) is that Congress recognized that collectively bargained healthcare benefits were sufficiently distinct from other types of benefits to warrant an exemption, at least from the grandfathered mandates, until the termination of plan-related collective bargaining agreements. This exemption should not be narrowed – or, for a significant category of collectively bargained benefits, extinguished – without a clear and unambiguous indication that such an outcome was intended. It is incongruous to believe that Congress with one hand, in a statutory provision captioned "Effect on Collective Bargaining Agreements," would create a broad deferral for collectively bargained health plans and with the other hand

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[5] As just one example of the confusing "health plan" references that now exist, the generic phrase "health plan" would normally be considered *broader* than "group health plan," since the term "group" (in the phrase "group health plan") clearly operates as a word of limitation. Paradoxically, "health plan" as defined in the PHS Act and ERISA is actually given a *narrower* technical definition than "group health plan" because self-insured plans are only included in the latter. *See* 75 Fed. Reg. at 34,539 n.1. Along similar lines, Affordable Care Act section 1251(e) takes the term "health plan" (which, as noted above, has a technical definition that *excludes* self-insured plans) and makes it part of the phrase, "grandfathered health plan," which is then defined as encompassing any "group health plan," thereby *including* self-insured plans. In the same way, even the Interim Rules conflate the term "health insurance coverage" (which, according to the Departments, *excludes* self-insured plans) and the term "grandfathered health plan" (which, as defined in Affordable Care Act § 1251(e), *includes* self-insured plans as part of the term "group health plan"). *See, e.g.*, 75 Fed. Reg. at 34,559 (interim 26 CFR § 54.9815–1251T(f)) (referring to "the determination of whether health insurance coverage . . . is grandfathered health plan coverage"). *See also* 75 Fed. Reg. at 34,564 (interim 29 CFR § 2590.715–1251(f)), 34,568 (interim 42 CFR § 147.140(f)).

would make such a deferral unavailable for a large number of collectively bargained plans.

(2) *The perspective of employees.* Another reason that section 1251's CBA deferral should be available for self-insured plans stems from the lack of any rational reason that self-insured plans, for purposes of the new healthcare reform mandates, should be treated differently from fully-insured plans. Self-insured plans are indistinguishable from fully-insured plans as to the process by which benefits are negotiated. There is no difference between the two types of plans as to the level or types of benefits offered. The ERISA requirements pertaining to welfare plans, and the flexibility afforded to employers under such plans, apply equally to self-insured and fully-insured health plans. Indeed, employers can (and many have) transitioned from maintaining self-insured health plans to arranging for fully-insured coverage (and vice versa) based on the coverage, just as employers often change insurance carriers without making modifications in the underlying plan. For employees and other plan participants, the salient feature that characterizes collectively bargained health plans – whether or not they are self-insured – is the origination and maintenance of such plans in bargaining between one or more unions and one or more employers.

Cases dealing with collective bargaining – which is the central focus of section 1251(d) – emphasize that bargaining-related issues should be governed by the impact on employees. For example, in *Fall River Dyeing & Finishing Corp. v. NLRB*,[6] the Supreme Court stressed that the National Labor Relations Board ("NLRB") must evaluate whether and how any changes affected employees. The Supreme Court in *Fall River Dyeing* stated:

> The Board keeps in mind the question whether "those employees who have been retained will understandably view their job situations as essentially unaltered." . . . *This emphasis on the employees' perspective furthers the Act's policy of industrial peace.* If the employees find themselves in essentially the same jobs after the employer transition and if their legitimate expectations in continued representation by their union are thwarted, their dissatisfaction may lead to labor unrest.[7]

To the same effect, the Court of Appeals for the D.C. Circuit in *UFCW Local 152 v. NLRB*[8] criticized the Board for attributing significance to changes that could *not* reasonably have affected employees' attitudes concerning union representation.[9] The court asserted that the "essential inquiry is whether operations, *as they impinge on union members*, remain essentially the same after the transfer of ownership."[10] The court concluded: "The focus of the analysis, in

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[6] 482 U.S. 27 (1987).

[7] *Id.* at 43-44 (emphasis added), *quoting Golden State Bottling Co.*, 414 U.S. 168, 184 (1973); *NLRB v. Jeffries Lithograph Co.*, 752 F.2d 459, 464 (9th Cir. 1985).

[8] 768 F.2d 1463 (D.C. Cir. 1985).

[9] For example, the Board relied on the new employer's disposition of four different facilities that had been acquired from the predecessor, the reduction from a two-shift to a one-shift operation, and comparable changes.

[10] 768 F.2d at 1470, *quoting International Union of Electrical Workers v. NLRB*, 604 F.2d 689, 694 (D.C. Cir. 1979), *citing NLRB v. Zayre Corp.*, 424 F.2d 1159, 1162 (5th Cir. 1970).

other words, is . . . on the particular operations of the business *as they affect the members of the relevant bargaining unit.*"[11] *See also Nephi Rubber Products Corp. v. NLRB*, 976 F.2d 1361 (1992), *enforcing* 303 N.L.R.B. 151 (1991), *supplemented*, 312 N.L.R.B. 297 (1993) ("the key to the successor analysis is the perspective of the employees").

Employees and other plan participants are treated in precisely the same manner by self-insured and fully-insured health plans alike. For this reason as well, the Interim Rules should not differentiate between self-insured and fully-insured plans for purposes of section 1251(d)'s CBA deferral provision.

(3) *Healthcare reform mandates are generally considered a mandatory subject of bargaining, irrespective of whether health plans are self-insured.* Evaluation of the healthcare reform mandates from a different perspective – that is, considering the other federal labor obligations imposed on employers and unions – further supports a broad-based application of the section 1251(d)'s CBA deferral language to include self-insured plans. Regardless of whether an employer's health plan is fully-insured or self-insured, changes like those required by the healthcare reform mandates in various contexts have been deemed mandatory subjects of bargaining for purposes of federal labor law.[12]

For example, Sections 8(a)(5) and 8(b)(3) of the NLRA *require* employers and unions to bargain collectively with one another. 29 U.S.C. § 158(a)(5), (b)(3). *See also* NLRA section 8(d), 29 U.S.C. § 158(d) (defining the duty to bargain collectively as "the performance of the mutual obligation of the employer and the representative of the employees to meet at reasonable times and confer in good faith with respect to wages, hours, and other terms and conditions of employment"). The NLRB and the courts have long made a distinction between "mandatory" bargaining subjects and "permissive" bargaining subjects, with "mandatory" subjects defined as those subjects over which employers and unions are compelled by law to bargain. *See, e.g., NLRB v. Borg Warner Corp., Wooster Div.*, 356 U.S. 342 (1958). Employers are barred from taking unilateral action with respect to mandatory subjects. *NLRB v. Katz*, 369 U.S. 736 (1962). Consequently, employers are generally prohibited, without bargaining, from making changes concerning mandatory bargaining subjects – whether favorable or unfavorable – without violating the NLRA. *Provena Hosp.*, 350 NLRB 808 (2007).

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[11] 768 F.2d at 1470 (emphasis added).

[12] Because the new healthcare reform mandates were enacted so recently, and become effective in stages (with various mandates and plans being afforded "grandfathered" status), no NLRA or RLA rulings deal with bargaining obligations pertaining to the healthcare reform mandates. As noted in the text, substantial case law indicates various types of benefits changes are generally deemed mandatory bargaining subjects. At the same time, NLRA and RLA case law regarding bargaining obligations establishes that determinations concerning any employer's obligations in particular cases depend on a highly fact-specific inquiry frequently involving questions about impact, specific contract language, negotiating history, past practice, and the potential waiver of bargaining rights, among other things. Consequently, notwithstanding the general labor law principles summarized in the text, nothing in these comments should be regarded as any suggestion or indication concerning how future bargaining-related issues pertaining to healthcare reform mandates should be resolved. Of course, the significant variables that govern these types of bargaining determinations only add to the considerations, described in the text, which warrant the deferral of healthcare reform mandates for collectively bargained plans.

The Railway Labor Act similarly imposes a broad duty on carriers and employees in the railroad and airline industries, to "exert every reasonable effort to make and maintain agreements concerning rates of pay, rules, and working conditions." 45 U.S.C. § 152 First. This obligation is central to the purpose of the RLA, which is to avoid "any interruption to commerce" resulting from labor disputes in the airline and railroad industries, industries that serve vital transportation functions in the national economy. Therefore, the Supreme Court has held that the duty to bargain collectively under the RLA is not merely a "statement of policy or exhortation to the parties; rather, it was designed to be a legal obligation, enforceable by whatever appropriate means might be developed on a case-by-case basis." *Chicago & North Western Ry. Co. v. United Transp. Union*, 402 U.S. 570, 577 (1971). This obligation is the "heart of the Railway Labor Act." *Brotherhood of R.R. Trainmen v. Jacksonville Terminal Co.*, 394 U.S. 369, 377-78 (1969).

For railway and airline employers governed by the RLA, bargaining plays the same essential role as it does under the NLRA – *i.e.*, required bargaining permits employers and unions to work out the resolution of challenges involving wage and benefits issues, among other things. *International Ass'n of Machinists v. Northeast Airlines, Inc.*, 473 F.2d 549, 554-57 (1st Cir.), *cert. denied*, 409 U.S. 845 (1972) (bargaining issues under RLA resolved based by reference to NLRA principles and legal decisions); *Elgin, Joliet & Eastern Ry. v. Bhd. of R.R. Trainmen*, 302 F.2d 540 (7th Cir. 1962) (pension plans are a mandatory subject of bargaining under the RLA). *Cf. First Nat'l Maintenance Corp. v. NLRB*, 452 U.S. 666, 682-83 and n.20 (1981) (citation of RLA case law involving bargaining issues in Supreme Court decision involving NLRA bargaining obligations).

Under both the NLRA and RLA, health and welfare benefits for more than six decades have been considered a mandatory subject of bargaining. *See, e.g., Allied Chem. & Alkali Workers v. Pittsburgh Plate Glass Co.*, 404 U.S. 157 (1971); *W.W. Cross & Co. v. NLRB*, 174 F.2d 875 (1st Cir. 1949); *Standard Oil Co.*, 92 NLRB 227 (1950). During the same period, the NLRB and the courts have repeatedly held that employers have violated federal law if they made unilateral changes to benefit plans.[13]

The driving purpose underlying federal labor policy is the notion that employers, unions and employees mutually benefit from the opportunity *to work together and resolve important issues as a result of negotiation.* As formulated by Congress in LMRA section 201(a):

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[13] *See W.W. Cross & Co. v. NLRB*, 174 F.2d 875 (1st Cir. 1949) ("wages" as used in the Act embraces a group program providing "a financial cushion in the event of illness or injury . . . at less cost than such a cushion could be obtained . . . individually"); *Beverly California Corp.*, 310 N.L.R.B. 222 (1993), *enforced in part sub nom. Torrington Extend-A-Care Employee Ass'n v. NLRB*, 17 F.2d 580 (2d Cir. 1994) (unlawful for employer to unilaterally impose consultation and screening requirement prior to surgery or hospital stay exceeding 24 hours); *Garrett Flexible Products*, 276 N.L.R.B. 704 (1985) (unlawful for employer to unilaterally require employee contributions for insurance contrary to past practice); *Bastian-Blessing v. NLRB*, 474 F.2d 49 (6th Cir. 1973) (unlawful unilateral change in carrier affecting benefits coverage); *Carpenter Sprinkler Corp.*, 238 N.L.R.B. 974 (1978), *enforced in part*, 605 F.2d 60 (2d Cir. 2979) (unlawful for employer to substitute its own health and welfare benefits for those provided under expired contract). *Accord: Loral Defense Sys.*, 320 NLRB 755, 756 (1996); *United Hosp. Med. Ctr.*, 317 NLRB 1279 (1995); *Master Slack Corp.*, 230 N.L.R.B. 1054 (1977), *enforced*, 618 F.2d 6 (6th Cir. 1980).

> [S]ound and stable industrial peace and the advancement of the general welfare, health, and safety of the Nation and of *the best interest of employers and employees can most satisfactorily be secured by the settlement of issues between employers and employees through the processes of conference and collective bargaining between employers and representatives of their employees.*

29 U.S.C. § 171(a) (emphasis added).

In unionized work settings, the federal labor policies favoring bargaining stem from the importance of permitting the employers and unions to mutually address challenges, with a view towards fashioning better solutions than could be formulated by either party unilaterally. As the Supreme Court stated in *NLRB v. Insurance Agents' International Union*, 361 U.S. 477, 488 (1960), the NLRA's the legislative history reveals that Congress favored bargaining not only to promote "the over-all design of achieving industrial peace" but also that "Congress intended that the parties should have wide latitude in their negotiations, unrestricted by any governmental power to regulate *the substantive solution of their differences*." *Id.* at 488 (emphasis added; citation omitted).

Self-insured health plans present issues that are more important, for several reasons, than fully-insured health plans when it comes to bargaining over the new healthcare reform law's mandates:

- Because the employer maintaining a self-insured health plan directly bears the financial costs and risks associated with the plan's healthcare claims, collective bargaining provides the opportunity for the employer and union to formulate a wide array of potential arrangements to address new or increased costs, with the possible options ranging from adjustments in wages, other benefits, work practices, management restrictions, other aspects of plan design, working conditions and all other potential subjects of bargaining.
- The direct financial impact of new healthcare reform mandates on the employers who maintain self-insured plans, creates a shared interest – more so than would exist with fully-insured plans – among the employer, its union(s) and, and its employees to address and formulate mutually acceptable ways to deal with changes in costs, coverage, plan design, and other variables.
- Most important, if the section 1251 CBA deferral is unavailable to unionized employers that maintain self-insured plans – thereby denying employers the time and opportunity afforded by section 1251 to consider and negotiate different ways to address healthcare reform mandates – employers will face costs and risks ranging from potential legal challenges to the denial of opportunities to adequately prepare for the new mandates. These risks, in combination, especially cause injury to the employers who maintain self-insured health plans, because increased employment-related costs imposed directly on the employer predictably will cause decreased employment and potential layoffs. Thus, the outcome will be to reduce the availability of employer-provided healthcare coverage for union-represented employees, which directly undercuts the policies underlying our new healthcare

reform laws, and which poorly serves the interests of employers, unions, employees and other plan participants.

For all of the above reasons, the Departments should conclude that the section 1251 CBA deferral is equally available to self-insured health plans in addition to fully-insured plans.

**(b) All Mandates Should be Deferred for Collectively Bargained Plans.** Consistent with the policies underlying the new healthcare reform laws, as well as other benefits laws and federal labor law requirements, the Departments should exercise their discretion to defer the effective date of all healthcare reform mandates for collectively bargained plans.

For many reasons relevant to the CBA deferral's applicability to collectively bargained self-insured plans (see pages 12-19 above), the Departments should exercise their discretion, for collectively bargained plans, to defer the effective date of all healthcare reform mandates, even those that would otherwise apply to grandfathered plans.[14] As discussed in subpart (c) (pages 24-25 below), the healthcare reform mandates should be deferred for collectively bargained plans at least until the beginning of the plan year following termination of the last collective bargaining agreement relating to health plan coverage (or, if later, until the loss of grandfather status based on the final grandfather rules adopted by the Departments).

Preliminarily, there is ample precedent and authority for the Departments, as a general proposition, to defer enforcing grandfathered and non-grandfathered healthcare reform mandates for collectively bargained plans as described above. As noted in the Interim Rules, ERISA and the PHS Act authorize the Departments to promulgate rules addressing their respective enforcement responsibilities. *See* 75 Fed. Reg. at 34,545.

The Interim Rules also recognize the authority of the Departments, as a discretionary matter, to refrain from enforcing certain requirements under the healthcare reform laws and related statutes. *See, e.g.*, 75 Fed. Reg. at 34,540 (noting that, in the interest of avoiding "confusion with respect to the obligations of issuers," certain enforcement authority will not be exercised, stating that States having "primary authority" to enforce particular PHS Act provisions are being encouraged "not to apply" certain provisions, and explaining that no citations will be issued against the States for "failing to substantially enforce" the provisions in question).

Several considerations in particular warrant the exercise of discretion by the Departments to refrain from enforcing any healthcare reform mandates for collectively bargained benefits until after existing agreements expire.

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[14] The exemptions associated with grandfathered status do not automatically eliminate every mandate associated with the healthcare reform laws. *See* Interim Rules Table 1, 75 Fed. Reg. at 34,542 ("List of the New Health Reform Provisions of Part A of Title XXVII of the PHS Act that Apply to Grandfathered Health Plans"). In these comments, the phrase "immediate mandates" is used to describe those healthcare reform requirements that remain potentially applicable to grandfathered plans, including grandfathered collectively bargained plans. As noted more fully in the text, we believe the policies underlying the healthcare reform laws, federal labor law and the interests of employers, unions, employees and other plan participants warrant the Departments' exercise of their discretion to defer enforcement of *all* mandates for collectively bargained plans.

(1) *Federal labor law generally prohibits mid-term unilateral benefit changes.* As noted previously, it has long been established that employers are generally prohibited from making mid-term changes in wages, working conditions, and benefits without satisfying bargaining obligations imposed by federal law. This prohibition against unilateral changes has been deemed applicable *even if the changes involve mandates imposed under other federal laws.*[15] Thus, in *Winn-Dixie Texas, Inc.*, 234 N.L.R.B. 72 (1978), the employer was found to have violated the NLRA even though its actions were based on constraints imposed by the Internal Revenue Code. In reference to the "mandate of the Internal Revenue Code," the Board concluded that the employer's obligation to engage in bargaining was not "minimized or obviated" by the "mandate and requirements of other Federal statutes." *Id.* at 77.

Even two months ago, current members of the NLRB, upholding an administrative law judge's findings, reaffirmed that "requirements of complying with other Federal statutes" are *not* automatically considered an "extraordinary event" permitting "immediate action" without bargaining. *San Miguel Hospital Corp.*, 355 N.L.R.B. No. 43, slip op. at 8 (June 11, 2010). *See also* Quality House of Graphics, Inc., 336 N.L.R.B. 497, 498 (2001) (unilateral action not permitted notwithstanding the "necessity to alter terms and conditions of employment to meet the requirements of other federal statutes").

(2) *Unique aspects of collectively bargained plans.* Collectively bargained plans in a multitude of ways are unusually situated for purposes of healthcare reform compliance. For many reasons similar to those raised previously (see pages 16-19 above), these unique aspects of collectively bargained health plans warrant a meaningful deferral of all healthcare reform mandates. This is not a case of favoring delay for delay's sake. Rather, for collectively bargained plans, the deferral of healthcare reform mandates centers around (i) fundamental constraints, (ii) unique needs, and (iii) competing federal policies that conflict with the immediate implementation of healthcare reform changes:

- Nothing in the Affordable Care Act repeals, rescinds or limits the contractual commitments of the parties under existing collective bargaining agreements. *See*

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[15] Unlike other statutes, the Affordable Care Act contains no provision reconciling its requirements with the competing obligations imposed under collective bargaining agreements or other federal laws. *Compare* Worker Adjustment and Retraining Notification Act §§ 6, 9, 29 U.S.C. §§ 2105, 2108 (2006) (provisions in federal WARN notice statute stating statutory notice "shall run concurrently with any period of notification required by contract or by any other statute" and that the "giving of notice . . . in good faith . . . shall not constitute a violation of the National Labor Relations Act"). Although longstanding case law indicates that changes in healthcare benefit plans are considered mandatory subjects of bargaining, which results in a general prohibition against unilateral changes, some cases have held (in different contexts) that employers can be permitted to comply with new statutory requirements without bargaining to an impasse or agreement if the new requirements involve no employer discretion. *See, e.g., Long Island Day Care Services*, 303 N.L.R.B. 112 (1991) (involving federal grant mandates); *United Telephone*, Case No. 16-CA-14505 (NLRB Gen. Counsel Advice Mem. Jan. 31, 1991) (involving drug testing requirements imposed by U.S. Department of Transportation); *Cf. Standard Candy Co.*, 147 N.L.R.B. 1070, 1073 (1964) (unilateral wage adjustments exceeding new minimum wage rate required under Fair Labor Standard Act deemed unlawful except for adjustment of wages that previously were lower than the new minimum wage). As indicated in note 12 above, these comments should not be regarded as any suggestion or indication concerning how future bargaining-related issues pertaining to healthcare reform mandates should be resolved, given the many variables which relate to bargaining determinations in individual cases. *Id.*

*Retail Clerks Local 455 v. NLRB*, 510 F.2d 802, 807 n.20 (D.C. Cir. 1975) (integrity of collective bargaining agreements is "a most basic policy of the national labor law"). Without a reasonable deferral of healthcare reform mandates, a requirement of immediate implementation will expose employers and unions to significant liability under existing contracts and federal labor law. Most collective bargaining agreements have multiple-year terms, commonly spanning three years, and frequently specifying a term of five years or longer. Under the NLRA, the existence of a collective bargaining agreement suspends, for the agreement's duration, any party's obligation to renegotiate commitments expressed in the agreement. *See* NLRA § 8(d), 29 U.S.C. § 158(d) (making it unlawful for any party to insist on a mid-term "modification" of any provision contained in a CBA); *Mead Corp.*, 318 N.L.R.B. 201 (1995) (contractual "zipper clause" eliminates obligation to bargain during term of CBA).

- In the railroad and airline industries, collective bargaining agreements continue indefinitely until changed, but become amendable at certain dates determined by the parties. The process of amending a collective bargaining agreement is subject to an extensive process of negotiation and mandatory mediation under the Railway Labor Act. *See* 45 U.S.C. § 156; *Detroit & Toledo Shore Line R. R. v. United Transp. Union*, 396 U.S. 142, 149 (1969). Any changes to existing collective bargaining agreements to implement the healthcare reform mandates will be subject to this lengthy, federally regulated process under the auspices of the National Mediation Board. Moreover, to the extent that implementation of the healthcare reform mandates raise questions concerning the interpretation of existing provisions of collective bargaining agreements, those disputes are subject to mandatory, binding arbitration under the Railway Labor Act. *See Conrail v. Railway Labor Executives' Ass'n*, 491 U.S. 299, 303-04 (1989).

- Imposing mid-term healthcare reform mandates on collectively bargained plans will predictably distort the complex assortment of tradeoffs, concessions, and compromises that constitute the quid pro quo underlying every collective bargaining agreement. *See Shaw's Supermarkets*, 343 NLRB 963, 969 (2004) (collective bargaining inherently "involves a party giving up a right in one area in exchange for concessions in another area"). Thus, the healthcare reform mandates are likely to cause severe inequities – for employers, unions, and/or employee-participants – with no available relief until the agreement's expiration. As the court stated in *NLRB v. United States Postal Service*, 8 F.3d 832, 836 (D.C. Cir. 1993): "[N]either the Board nor the courts may abrogate a lawful agreement merely because one of the bargaining parties is unhappy with a term of the contract and would prefer to negotiate a better arrangement. . . . [T]he courts are bound to enforce lawful labor agreements as written."

- As noted previously, it has long been established that employers are required to provide the opportunity for bargaining over changes in healthcare plans, medical benefits, premium and contribution amounts, and related matters. Under the NLRA, such bargaining generally entails an array of subsidiary obligations, including the duty to provide relevant information and documentation upon request, the right to

meet at reasonable times, and a prohibition against implementation unless and until negotiations result in a new agreement or impasse. *Bottom Line Enterprises*, 302 N.L.R.B. 373 (1991), *enforced*, 15 F.3d 1087 (9th Cir. 1994); *RBE Electronics of S.D., Inc.*, 320 N.L.R.B. 80 (1995). Again, unlike other statutes, the Affordable Care Act contains no provisions negating or limiting notice and bargaining obligations. *See* note 15 above. Consequently, it is important for the Departments to reconcile these competing obligations by deferring healthcare reform mandates until after the expiration of existing plan-related collective bargaining agreements.

- Applying the immediate healthcare reform mandates on collectively bargained plans, before the parties have the opportunity for bargaining, may substantially undermine the likelihood that employers and unions in bargaining can reach a mutually acceptable resolution of healthcare benefit issues. In most if not all cases, employers and unions have already worked for years on efforts to preserve healthcare benefits to the extent possible while attempting to cope with substantial ongoing increases in healthcare costs. Imposing the immediate mandates *before* employers and unions next have the chance to negotiate healthcare issues may overwhelm parties who, in the next round of bargaining, will be confronted by immense backward- *and* forward-looking healthcare benefit challenges.

- In the case of multi-employer collective bargaining agreements, such as the national rail freight agreements, healthcare benefits involve an even greater proliferation of potential obstacles to the immediate application of healthcare reform mandates. If a preexisting agreement does not preclude bargaining, even more time for bargaining is required based on the participation of employer and multi-employer association representatives, the participation of international and local union representatives, and the frequent need for separate follow up bargaining with other industry employers (and local unions) that may independently adopt the "pattern" established by multi-employer agreements, with yet additional bargaining over company-specific issues.

- In many cases, union-negotiated health and welfare funds are responsible for single- and multi-employer healthcare arrangements, and escalating healthcare costs have placed those funds in financial distress to the point of insolvency. Without the deferral of new mandates until after existing agreements expire – thereby permitting new negotiations concerning funding, contributions, plan design and related measures – the new healthcare reform requirements may cause health plan benefits to be reduced or unavailable altogether. Such outcomes obviously would undermine, rather than advance, the policies underlying the healthcare reform laws.

(3) *Preexisting recognition of healthcare reform burdens.* Reinforcing the above considerations is the acknowledgement – already incorporated into the healthcare reform laws, and reflected in the Interim Rules – that new healthcare mandates create substantial challenges for union *and* nonunion employers. As noted previously, the Affordable Care Act itself recognizes the need at least to defer grandfathered mandates for collectively bargained health plans. *See* pages 12-19 above.

The Departments' own description of the insufficient time available for rulemaking bears a striking resemblance to the variables and requirements applicable to mandated bargaining over healthcare changes. The Departments concluded that the healthcare reform timetable renders "impractical" and "contrary to the public interest" the normal 60-day notice of rulemaking usually associated with new regulations (75 Fed. Reg. at 34,545). The factors responsible for bypassing conventional rulemaking bear witness to the obstacles facing employers, unions, and employees if new mandates are not deferred for collectively bargained health plans. The Interim Rules recognize that group plans, especially if not grandfathered, "must make significant changes in their provisions to comply"; that "plans and issuers considering other modifications . . . need to know whether those modifications will affect their status"; and that compliance and enforcement activities are "needed well in advance of the effective date of the requirements of the Affordable Care Act." *Id.* As noted by the Departments: "The six-month period between the enactment of the Affordable Care Act and the applicability of many of the provisions affected by grandfather status *would not allow sufficient time for the Departments to draft and publish proposed regulations, receive and consider comments, and draft and publish final regulations.*" *Id.* (emphasis added).

For similar reasons, collectively bargained health plans – and employers, unions, employees and other participants – face enormous challenges that render "impractical" and "contrary to the public interest" the implementation of healthcare reform mandates prior to the termination of all plan-related CBAs. *Id.* Consequently, the Interim Rules should defer all mandates, including the immediate mandates, for collectively bargained plans.

(4) *Past benefits laws have consistently deferred their application for collectively bargained plans.* The litany of prior benefits laws that have deferred implementation of new requirements for collectively bargained plans provides additional compelling evidence that Congress has recognized the need to defer new requirements until compliance issues can be resolved in bargaining. Relevant examples include the following:

- Employee Retirement Income Security Act of 1974 (ERISA): General effective date: plan years beginning after September 2, 1974; Effective date for collectively bargained plans: *Earlier of the date on which the last CBA expires or plan years beginning after December 31, 1980.*
- Health Insurance Portability and Accountability Act of 1996 (HIPAA): General effective date: plan years beginning after June 30, 1997; Effective date for collectively bargained plans: *Later of June 30, 1997 or the date on which the last CBA terminates.*
- Economic Growth and Tax Relief Reconciliation Act of 2001: General effective date: plan years beginning after *December 31, 2001*; Effective date for collectively bargained plans: *Earlier of January 1, 2006 or later of January 1, 2002 or expiration of the CBA with a termination date on or after May 26, 2001.*
- The Pension Protection Act of 2006 (PPA): General effective date: plan years beginning after December 31, 2007; *Effective date for collectively bargained plans: Earlier of January 1, 2010 or date the last CBA terminates.*

- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): General effective date: plan years beginning after one year following the date of enactment of the statute; *Effective date for collectively bargained plans: the later of (i) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or (ii) January 1, 2010.*

A broad-based deferral of healthcare mandates for collectively bargained plans is not rendered inappropriate based on the absence of an unqualified CBA deferral provision in the Affordable Care Act. As noted previously, section 1251(d) in the Affordable Care Act *does* contain a broad-based deferral applicable to collectively bargained plans. *See* pages 12-19 above. Although section 1251 does not provide for the automatic deferral of immediate mandates for collectively bargained plans, the absence of explicit statutory language is *not* controlling especially when a particular interpretation is supported by the statute's underlying policies and objectives, and/or additional legal requirements imposed under other laws. As the court indicated in *E.F. Hutton Group, Inc. v. United States*, 811 F.2d 581, 586 (Fed. Cir. 1987), "While the intention of the legislature must be ascertained from the words used to express it, the manifest reason and obvious purpose of the law should not be sacrificed to a literal interpretation of such words" (citations omitted). *See also* 2A SUTHERLAND STATUTORY CONSTRUCTION § 46:7 (Singer & Singer eds. 7th ed. 2007) (same); *United States v. Brumbaugh*, 909 F.2d 289, 289-91 (7th Cir. 1990) (absence of statutory reference held not to preclude interpretation based on "structure and language of the statute" and where "legislative history does not address the deletion"); *United States v. Truong Dinh Hung*, 629 F.2d 908, 924 (4th Cir. 1980) (absence of explicit mention of intent held not to eliminate intent as statutory requirement); *In re Casper*, 154 B.R. 243, 247 (N.D. Ill. 1993) (absence of phrase statutory language held immaterial where contrary reading would produce anomalous results).

For all the above reasons, the Interim Rules should defer all mandates until the commencement of the new plan year following termination of such CBAs (or, if later, until grandfather status is lost based on other requirements set forth in final grandfather rules adopted by the Departments).

**(c) CBA Deferral Should Relate to the Relevant Plan Year.** The deferral of healthcare reform mandates for collectively bargained plans should continue at least until the commencement of the plan year after termination of the last plan-related collective bargaining agreement.

The deferral of healthcare reform mandates for collectively bargained plans should continue at least until the beginning of the new plan year following termination of the last collective bargaining agreement relating to health plan coverage (or, if later, until the loss of grandfather status based on the final grandfather rules adopted by the Departments).

The CBA deferral language in Affordable Care Act section 1251(d) would defer various mandates until "the date on which the last of the collective bargaining agreements relating to the coverage terminates." However, based on several considerations, the Departments should

continue deferral at least until the commencement of the new plan year after the last plan-related collective bargaining agreement terminates.

First, the mid-year imposition of healthcare reform mandates will result in substantial costs which, in turn, will detract from the ability of each plan to deal with other mandate-related cost increases. Additionally, the wide variety of different healthcare arrangements prevents any certainty concerning who will ultimately bear such mid-plan-year costs, which may end up being imposed on the plan, the employer, the union, employees, and/or other plan participants. Especially in the aggregate, such mid-year costs will be enormous, and the interests of all parties will be advanced, along with healthcare reform policies in general, by avoiding such costs.

Second, more burdens will result from the extensive multi-party coordination needed to deal with the mid-plan-year imposition of healthcare reform changes. For example, such changes will require significant out-of-cycle work between employer and union representatives, officials associated with union health and welfare funds, possible third party insurers, third party administrators, outside actuaries, consultants, and/or inhouse or outside counsel. In addition to requiring coordination among these various parties, duplicative coordination among many or all of the same parties predictably will need to occur again upon when the next plan year commences following expiration of the last plan-related collective bargaining agreement.

Third, adding to the complexity of mid-plan-year changes is the time lag that invariably exists between the receipt of medical services by healthcare plan participants and the time that the participant's claim is received by and/or processed by the plan. Focusing on CBA expiration dates also would create unmanageable problems for employers that had multiple unionized locations, each with separate expiring collective bargaining agreements. Such employers could face a gauntlet of successive out-of-cycle benefits changes that could persist for years, which clearly would degrade the benefits and/or assistance otherwise available to employees and other plan participants.

Fourth, because open enrollment periods are timed in coordination with the relevant plan year, the required implementation of mid-plan-year mandates, with corresponding costs and changes in plan design, could dramatically affect – for better and worse – enrollment elections made by employees and other participants. Such changes predictably would also cause substantial unnecessary confusion for employees and other participants (as well as employer and union representatives, third party insurers or administrators and others), all of which are accustomed to addressing benefits issues on a plan year basis.

No party will experience any long-term disadvantage by extending the deferral of mandates for collectively bargained plans until the new plan year's commencement after termination of the last plan-related CBA. If such a modest additional deferral caused a delay in mandated benefit improvements or protection, this disadvantage would clearly be offset entirely by the increased costs, confusion and potential prejudice caused by materially altering the consequences of the employee's prior open enrollment choices.

## CONCLUSION

We hope that the Departments will consider the comments set forth above and incorporate them in the Final Grandfather Rules, consistent with the Affordable Care Act, the Reconciliation Act, and the interests of employers, employees and other healthcare benefit plan participants. We remain available to meet and consult with representatives of the Departments and to provide any other assistance that will facilitate development of the final regulations.

Respectfully submitted,

EMPLOYERS NETWORK FOR RESPONSIBLE OPTIONS, LAWS AND LEADERSHIP

INTERNATIONAL PUBLIC MANAGEMENT ASSOCIATION FOR HUMAN RESOURCES

COLLEGE AND UNIVERSITY PROFESSIONAL ASSOCIATION FOR HUMAN RESOURCES

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The Employers Network for Responsible Options, Laws and Leadership (ENROLL) consists of companies and associations that have a shared commitment to the responsible administration of healthcare benefit plans in the context of new requirements imposed under the Patient Protection and Affordable Care Act, Pub. L. No. 111–148 (March 23, 2010) and the Health Care and Education Reconciliation Act, Pub. L. No. 111-152 (March 30, 2010) ("Reconciliation Act"). ENROLL participants include the International Public Management Association for Human Resources, the College and University Professional Association for Human Resources, the National Railway Labor Conference, United States Steel Corporation, ArcelorMittal, Tribune Company, Trucking Management Inc., Lehigh Hanson, Inc., Bemis Company, Inc., Pactiv Corporation, Eppendorf, Inc., M&G Polymers USA, LLC, The Knapheide Manufacturing Company, McCain Foods USA, Inc., and other employers.

The International Public Management Association for Human Resources (IPMA-HR) is an organization that represents the interests of human resource professionals at the federal, state and local levels of government. IPMA-HR includes more than 5,500 federal, state and local human resource professionals throughout the United States.

The College and University Professional Association for Human Resources (CUPA-HR) is devoted to the higher education human resources profession and the higher education community, and consists of more than 12,000 higher education human resources professionals at more than 1,700 colleges, universities and other institutions associated with higher education. The participants in CUPA-HR encompass approximately 90 percent of the doctoral institutions, 70 percent of the master's institutions, 50 percent of the bachelor's institutions and close to 500 two-year and specialized institutions throughout the United States.

The National Railway Labor Conference (NRLC) represents member railroads throughout the United States in collective bargaining, labor relations, health and welfare benefits, and other employment-related matters. The NRLC dates back to 1963, resulting from the merger of three separate regional carriers conference committees which previously represented railway carriers in the Eastern, Western and Southeastern United States. Organized within the NRLC is the National Carriers' Conference Committee (NCCC), one of the two components of the joint plan committee which serves as a fiduciary and administrator of the Railroad Employees National Health & Welfare Plan.

**APPENDIX**