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**Docket:** EBSA-2010-0014

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

**Comment On:** EBSA-2010-0014-0001

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

**Document:** EBSA-2010-0014-DRAFT-0017

Comment on FR Doc # N/A

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## General Comment

Attached is a comment letter filed on behalf of the American Benefits Council and the HR Policy Association regarding "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" (Document ID EBSA-2010-0014-0001).

Thank you for giving us the opportunity to comment on the Interim Final Rules and to highlight questions and issues from our employer members as they work toward compliance. We look forward to further clarification.

If we can be of further assistance, please contact Kathryn Wilber at 202-289-6700 or kwilber@abcstaff.org, or Marisa Milton at 202-789-8671 or mmilton@hrpolicy.org.

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## Attachments

**EBSA-2010-0014-DRAFT-0017.1:** Comment on FR Doc # N/A

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August 16, 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

Attention: RIN 1210-AB42

**Re: Interim Final Rules Regarding Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act**

Dear Sir or Madam:

We are writing on behalf of the American Benefits Council ("Council") and the HR Policy Association ("HR Policy") to comment on the Interim Final Rules and Proposed 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 (the "Interim Final Rules"). The Interim Final Rules were published by the Departments of Labor, Health and Human Services, and the Treasury (the "Agencies") on June 17, 2010 (75 Fed. Reg. 34,538). The Interim Final Rules address provisions of the Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act. It is our understanding that these comments will be shared with the Departments of the Treasury and Health and Human Services.

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans.

HR Policy represents the chief human resource officers of over 300 of the largest employers doing business in the United States. Representing every major industrial sector, HR Policy's members employ more than 18 million people worldwide and

collectively spend more than \$75 billion annually providing health insurance to millions of American employees, their dependents, and retirees.

We thank the Agencies for their continued efforts in issuing very important guidance for group health plans and issuers for purposes of implementing the insurance reform provisions of PPACA. This guidance is essential for employers and issuers as they work to comply with the new rules. Additionally, we very much appreciate the opportunity to comment with respect to the Interim Final Rules. Our joint comments are set forth below for your consideration.

### **CURRENT RULES ARE UNDULY RESTRICTIVE AND ARE LIKELY TO DRIVE PLANS AND ISSUERS TO SURRENDER GRANDFATHERED PLAN STATUS**

Section 1251 of PPACA provides a broad exemption from subtitles A and C for “a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act . . . .” The Interim Final Rules provide a restrictive interpretation of the grandfathering language in the statute and place significant restraints on the ability of employers to make adjustments to their existing plans that contain costs while maintaining the overall benefit structure and value for plan participants. Employers would like to have broader discretion to make limited benefit design changes beyond those that would be allowed under the Interim Final Rules in order to promote greater efficiency and enhance the value of the health plans that they sponsor for employees, their families, and retirees.

Large employers support the President’s goal that Americans should be able to keep the coverage they have. However, the Interim Final Rules are likely to have just the opposite impact. By imposing fairly strict limitations on what employers can do to manage the design of their benefit plans, many employers are likely to elect to forego grandfathered status. Although the preamble to the Interim Final Rules discussed other approaches that were ultimately rejected, we believe the Agencies should reconsider and adopt rules that provide more flexibility for employers to continue to offer current plans without losing their grandfathered status. (HR Policy will submit separate comments on an alternative approach for the Agencies to consider that takes into account the actuarial value of a health plan.)

### **INTERIM FINAL RULES INHIBIT USE OF VALUE-BASED INSURANCE DESIGN**

Employers often implement value-based insurance designs in the health plans that they sponsor to encourage the use of high-value care that takes into account the quality of care and its relative costs. These designs have been useful tools in helping employers manage the costs of their health plans and improving the health of their employees. Congress, in adding new section 2713 of the Public Health Service Act (“PHSA”), recognized the importance of value-based insurance design by authorizing the

Secretary of Health and Human Services to develop guidelines to permit health plans and health insurers to utilize these designs. Value-based designs employ financial incentives through differential copayments, deductibles, or coinsurance to encourage plan participants to seek cost-effective, high-quality, proven treatments and to discourage the overuse of costly and wasteful treatments. For example, an employer may reduce barriers to care for certain conditions to increase drug compliance and adherence by providing free coverage of cholesterol-lowering medications for beneficiaries with histories of diabetes or heart attacks. Employers may also set higher copayments, cost-sharing, or coinsurance for treatments and facilities that have been proven not to provide high-quality outcomes. The restrictive limitations under the Interim Final Rules restrain the ability of employers who have been successful in using value-based insurance design to drive improvements in cost and quality if they wish to retain grandfathered status.

#### **CURRENT RULES REGARDING MAINTENANCE OF GRANDFATHER STATUS NEED EXPANSION AND CLARIFICATION**

Paragraph (g)(1) of the Interim Final Rules provides the requirements regarding the ability of a plan to make substantive changes and maintain grandfathered plan status. The guidance provides a clear, enumerated list of changes, which, if undertaken by a plan, will cause the plan to cease to be a grandfathered plan. However, a host of questions and issues have arisen for which we request clarification in further guidance. In addition, as we discuss below, given the importance of grandfathered plan status to many of our members, we respectfully ask the Agencies to consider changes to the Interim Final Rules in several areas.

*Limitation on coinsurance is unduly restrictive and penalizes employers that voluntarily assumed a significant share of cost prior to the enactment of PPACA.* The Interim Final Rules provide that a grandfathered plan cannot be amended to increase the cost-sharing percentage (such as a coinsurance requirement) that applies to covered individuals. Specifically, paragraph (g)(1)(ii) provides that “[a]ny increase . . . in a percentage cost-sharing requirement . . . causes a group health plan or health insurance coverage to cease to be a grandfathered health plan.” Thus, it appears that an increase of even 1 percent in the coinsurance percentage can terminate grandfathered status.

Although we can understand the Agencies’ desire to limit to some extent an employer’s ability to shift to employees the costs associated with grandfathered plans, we find the above rule to be unduly restrictive. Sponsors of grandfathered plans should be allowed some flexibility to ensure that cost increases are shared by both employers and employees, regardless of how costs may have been shared previously. Additionally, the current rule penalizes employers who have been generous to date. Specifically, employers who have been willing to bear a significant amount of the costs associated with the plan through the imposition of low coinsurance rates will face the greatest difficulty in maintaining grandfathered status. In order for these employers to maintain

grandfathered plan status, they must remain willing to continue to shoulder the lion's share of the premium costs associated with the group coverage. Moreover, regardless of their willingness, some employers in light of today's economic climate or changed circumstances, generally, may be unable to maintain the prior coinsurance percentage. Accordingly, we request additional guidance which allows sponsors of grandfathered plans to increase the coinsurance percentage on an annual basis by some reasonable percentage, comparable to the permitted increases in deductibles and copayments, taking into consideration adjustments for medical inflation.

***Limitations on cost-sharing and coinsurance should allow for reasonable annual increases.*** With respect to cost-sharing, including deductibles and copayments (but excluding coinsurance as discussed above), the Interim Final Rules generally permit sponsors of grandfathered plans to increase a specific cost-sharing feature by 15 percent, *measured from date of enactment*, after adjusting for medical inflation.

The Council and HR Policy, along with our members, recognize the efforts of the Agencies to fashion a rule that provides sponsors of grandfathered plans with some degree of flexibility to adjust upward the cost-sharing features of a grandfathered plan. Without such a rule, most employers would have found it impossible to attempt to maintain grandfathered plan status. Nonetheless, the rule is not without significant drawbacks. Most notably, from the perspective of administering the rule, plans will need to constantly look back to the date of enactment for purposes of measuring any cost increases against the 15 percent maximum. This is unduly burdensome and is further complicated by having to adjust for applicable medical inflation, as measured from date of enactment.

Accordingly, we urge the Agencies to adopt a rule that permits plans to increase their cost-sharing features by a maximum percentage that is measured annually, after adjusting for medical inflation. Such a rule still comports with the policy considerations that gave rise to the rule as set forth in the Interim Final Rules but reduces the costs for sponsors in administering the rule and facilitates compliance with the rule.

***Instead of requiring that permissible maximums be applied to each cost-sharing feature separately, the Interim Final Rules should permit plans to use a holistic approach that looks at cost increases across a plan as a whole.*** In addition to our comments above, we urge the Agencies to reconsider issuing a rule that would allow plans to measure any changes to cost-sharing on a plan-wide basis rather than with respect to each type of cost-sharing (*e.g.*, with respect to deductibles only).

As noted above, the Interim Final Rules generally require that grandfathered plans measure cost increases with respect to a given cost-sharing feature. Although such a rule may make some intuitive sense, it encourages plan sponsors to perhaps make changes to their plan's cost-sharing features based simply on cost rather than on effective medical management techniques. For example, a plan sponsor of a

grandfathered plan might want to increase a deductible, but finds that it has already hit the 15 percent threshold. Thus, the plan sponsor cannot increase the deductible. To the extent the plan sponsor has little to no ability to assume additional cost increases associated with the grandfathered plan, the plan sponsor may be compelled to increase other cost-sharing features to the extent permitted under the Interim Final Rules, such as with respect to copayments for specific benefits; the end result being that the plan unintentionally imposes disproportionately higher cost-sharing on some small percentage of plan participants.

For the reasons discussed above, we urge the Agencies to modify the Interim Final Rules to allow plans to measure any changes to cost-sharing on a plan-wide basis rather than with respect to each type of cost-sharing (*e.g.*, with respect to deductibles only). Such a rule would allow plan sponsors to increase cost-sharing with respect to their grandfathered plans in a well-reasoned manner that ensures the continued delivery of high-quality care.

***Confirmation is requested that a plan may take advantage of the PPACA wellness plan provisions without jeopardizing grandfathered plan status.*** In addition to the suggested clarifications above with respect to cost-sharing, there are several other clarifications that, if issued, would be very helpful to our members. One such clarification pertains to the ability of grandfathered plans to take advantage of the various provisions contained in PPACA with respect to wellness programs.

As you know, the PPACA includes multiple provisions regarding wellness programs. These include provisions intended to encourage plans to adopt wellness programs (PPACA section 10408), and provisions designed to allow for increased rewards and incentives (PPACA section 1201, which added new PHSA section 2705). The Interim Final Rules do not currently address how the grandfathered plan rules apply to these new provisions. We note that this is perhaps not surprising given the format of paragraph (g) of the Interim Final Rules, which is drafted to provide an enumerated list of actions that, if undertaken by a sponsor of a grandfathered plan, will result in a loss of grandfathered status. Nonetheless, given the importance of grandfathered status to many of our members, and the absence of any statement in the Interim Final Rules regarding plans' voluntary compliance with PPACA provisions, including the wellness provisions, our members are understandably hesitant to make certain changes to their plans where the Interim Final Rules are simply silent. Accordingly, the Council, along with HR Policy, would greatly appreciate written confirmation that a plan does not lose grandfathered status by voluntarily subjecting itself to the provisions contained in PPACA, including with respect to the provisions related to wellness programs referenced above.

***Confirmation is requested that a grandfathered plan may increase or decrease the number of premium tiers.*** Questions within our membership have arisen regarding the extent to which a plan sponsor may add additional premium tiers (*e.g.*, instead of

having two premium tiers comprised of self-only and family coverage, the plan seeks to have three premium tiers comprised of self-only coverage, employee-plus-one, and employee-plus-two-or-more). As noted above, based on the structure of the Interim Final Rules, it appears to us that a plan may be amended to increase or decrease the number of premium tiers without jeopardizing grandfathered plan status. However, given the importance of grandfathered status to certain of our members, written confirmation of this fact would be appreciated.

*Clarification is needed regarding the ability of grandfathered plans to add or modify annual limits with respect to non-essential health benefits.* Per PPACA section 1001 (which added new PHSA section 2711), and the interim final rules that were issued by the Agencies on June 28, 2010, plans generally are prohibited from imposing annual and lifetime limits on the dollar value of essential health benefits. The statute and regulations provide for a special transition rule pre-2014, during which a plan may impose certain “restricted” annual limits on essential benefits (generally \$750,000 for plan years beginning on or after September 23, 2010 and before September 23, 2011; \$1.25 million for plan years beginning on or after September 23, 2011 and before September 23, 2012; and \$2 million for plan years beginning on or after September 23, 2012 and before January 1, 2014).

Many questions have arisen with respect to the ability of a grandfathered plan (i) to add or decrease an annual limit with respect to non-essential health benefits generally; and (ii) to take advantage of the special pre-2014 period during which a plan may impose restricted annual limits on essential health benefits.

With respect to the first issue, questions have arisen in large part because the Interim Final Rules state that a grandfathered plan may not add or decrease an annual limit with respect to “all benefits.” The reference to “all benefits” versus only “essential health benefits” appears to preclude a grandfathered plan from adding and/or decreasing annual limits, not just with respect to essential benefits, but also with respect to non-essential health benefits. It is our hope that this is not in fact the case, as such a rule would seem to greatly hinder the ability of grandfathered plans to control costs through the use of reasonable annual limits on non-essential health benefits, with the likely result being that participants in such plans will be subject to premium increases that could lead some to decide to forego coverage.

With respect to the second issue, the Interim Final Rules appear to prohibit a grandfathered plan from utilizing “restricted” annual limits on essential health benefits prior to 2014. As noted above, PHSA section 2711 generally allows plans to impose “restricted” annual limits on essential health benefits for plan years beginning on or before January 1, 2014. The ability of plans to impose “restricted” annual limits on essential health benefits is critical, given that until 2014 there are no federal premium subsidies to assist individuals in affording the cost of coverage. Absent this ability, many plans will likely need to increase premiums, which is likely to lead lower-income

individuals, among others, to forego coverage. Obviously, this would be a very unfortunate result both for plan sponsors and their employees, and also from a policy perspective. Accordingly, the Council and HR Policy urge the Agencies to consider issuing a rule that allows grandfathered plans, like non-grandfathered plans, to take full advantage of the important pre-2014 transition rule that permits the use of “restricted” annual limits on essential health benefits.

***Changes to provider networks and prescription drug formularies should not result in a loss of grandfathered status.*** Your office, along with the Departments of the Treasury and Health and Human Services, has requested comments regarding whether a grandfathered plan should be permitted to make changes to provider networks and prescription drug formularies without losing grandfathered status. Employers seek to design their benefit programs to ensure that their employees, families, and retirees have access to the most cost-effective, clinically appropriate drug therapies available. As such, they often establish drug formularies that encourage the use of generic drugs by requiring plan participants to pay a higher fee for brand-name drugs as generics become available. Plan sponsors also frequently change drug formularies as new medical evidence and treatment alternatives become available. Similarly, as medical evidence becomes available on certain drugs, it often becomes apparent that one is superior to others in the same line. As a result, plan sponsors frequently increase coinsurance for non-preferred brand drugs while the coinsurance for preferred brand drugs remains constant. In addition, employers work with insurers and their plan administrators to design provider networks that deliver quality, high-value care. It is the opinion of the Council and HR Policy that grandfathered plans should be permitted to make changes to formularies and provider networks in order to ensure that their plan participants receive sound and efficient medical care.

Moreover, any restriction on changes to drug formularies or provider networks could have the unintended consequence of inhibiting competition. Employers of self-insured plans use their leverage to negotiate for cost-effective benefits for their employees. If rules bar employers who want to retain grandfathered status from switching providers or drug formularies, those entities may be less likely to offer competitive pricing to grandfathered plan sponsors. Thus, the Council and HR Policy request guidance clarifying that a plan may make changes to provider networks and/or drug formularies without jeopardizing grandfathered status, provided that such changes do not result in the elimination of all, or substantially all, services needed to treat a covered benefit under the plan.

***Changes in plan financing also should not result in a loss of grandfathered status.*** Your office, along with the Departments of the Treasury and Health and Human Services, has also requested comments regarding whether a plan should be permitted to “switch” from an insured product to a self-insured product, without negatively affecting a plan’s grandfathered status. The Council and HR Policy believe strongly that plans should not lose grandfathered status merely by changing the manner in

which a plan is financed. Plan financing is largely unrelated to a plan participant's "consumer" experience. In fact, unless a participant has read the disclosure in the plan's "summary plan description" indicating whether the plan is insured and/or self-insured, it is our understanding that most participants are unlikely to know about and/or give much attention to a plan's financing. Accordingly, plan sponsors should be permitted to make changes to a grandfathered plan's underlying financing without jeopardizing grandfathered status.

#### **CLARIFICATION NEEDED REGARDING CERTAIN SELF-INSURED LIMITED EXCEPTED BENEFITS**

Although the Interim Final Rules specifically relate to the status of grandfathered health plans, the preamble also addresses coverage that is generally exempt from having to comply with various provisions of the PPACA, including its insurance reforms. Specifically, the preamble makes clear that very small plans (generally, plans with less than two active employees) and certain retiree-only plans are exempt. Additionally, the preamble makes clear that coverage that qualifies as an "excepted benefit" under the Health Insurance Portability and Accountability Act ("HIPAA") is also exempt.

As noted in the preamble to the Interim Final Rules, the definition of HIPAA "excepted benefits" is set forth in the statute and related regulations. Generally, for coverage to qualify as a HIPAA "excepted benefit," it must provide for certain ancillary health coverage, *i.e.*, it cannot be major medical coverage, and it must be offered under a separate stand-alone insurance policy, except in the case of self-insured dental and/or vision coverage, in which case it may be self-insured so long as it is not an integral part of a major medical plan.

Many of our members provide important self-insured coverage in addition to major medical coverage. In a great many instances, these types of coverage, to the extent they were fully insured, would qualify as HIPAA "excepted benefits" and thus would not be subject to certain PPACA provisions, including the insurance reforms. As set forth below, unless additional guidance is issued clarifying that the types of coverage outlined below may be treated as HIPAA "excepted benefits" for purposes of PPACA, employers may have to terminate coverage (because the cost of providing the coverage through third-party insurance outweighs the benefits), or otherwise force employees to pay for coverage currently paid for by the employer (as in the case of certain self-insured dental and vision coverage). Accordingly, the Council and HR Policy request clarification that plans offered by employers such as those described below are HIPAA-excepted benefits that are not subject to PPACA's insurance reform requirements.

***Regarding self-insured supplemental coverage generally.*** As noted above, many of our members self-insure ancillary health coverage that is offered in conjunction with their self-insured major medical coverage. These types of coverage generally provide supplemental benefits (that would appear not to qualify as essential benefits under

existing administrative guidance) to employees and/or their family members, including those with special needs such as autism or Down syndrome. In many instances, these types of coverage would qualify as HIPAA “excepted benefits” except for the fact that they are self-insured.

For example, we have members who provide to their employees coverage for some medical expenses related to a child with autism. This type of coverage is typically offered in addition to major medical insurance and provides benefits to a greater extent than provided for under the major medical plan. For example, the plan may cover enhanced prescription drug coverage, habilitative and rehabilitative care, tutoring, and other benefits up to a lifetime maximum of \$50,000.

By self-insuring the supplemental coverage, our member employers are able to provide the coverage at a reasonable cost (either to the employer where employer-paid or to the employee in the form of reduced premiums). Absent the requested guidance, some of our members who offer these plans will have to consider either fully insuring the coverage or ceasing to offer the coverage altogether. Although our members who provide these benefits want to continue offering this type of coverage, they are concerned that, if they are required to fully insure these benefits or offer them without annual or lifetime limits, the increased costs associated with the coverage will be too expensive. The likely result would be that families may be left without important health coverage upon which they currently rely.

*Regarding self-insured dental and vision coverage.* A related issue pertains to self-insured dental and vision coverage. As noted above, under existing administrative guidance, the term HIPAA “excepted benefits” also includes self-insured dental and vision coverage so long as the coverage is not an integral part of a major medical plan.

Under applicable regulations, it appears that two conditions must be satisfied for self-insured dental and/or vision coverage to be deemed not an integral part of a major medical plan. First, individuals must have a separate election right with respect to the vision and dental coverage, (*i.e.*, they must be able to elect major medical coverage without corresponding dental or vision coverage and vice-versa). Second, individuals must pay a premium contribution towards the cost of the dental or vision coverage.

Many of our members, in an effort to keep health costs low for their employees, have chosen to self-insure their dental and/or vision coverage, in addition to their major medical coverage. Moreover, by reason of related collective bargaining agreements or employer practice, it is not uncommon for participants to be provided with bundled self-insured coverage that includes medical, dental, and vision coverage together. Additionally, it is not uncommon for self-insured dental and/or vision coverage to be fully employer-paid, at least with respect to self-only coverage (with covered employees having to pay a premium contribution for spouse or dependent coverage). Thus, it is not uncommon for employers to bundle dental and/or vision coverage with major

medical coverage and/or fully pay for the premium cost associated with the self-insured dental and vision coverage.

Unless additional guidance is issued clarifying that self-insured dental and vision coverage qualifies as a HIPAA “excepted benefit” at least for purposes of PPACA, many plan sponsors will be confronted with having to choose between two very bad options – having to either (i) fully insure their dental and vision coverage at an increased cost to participants, or (ii) charge their employees for coverage that is currently paid for in whole by the sponsor. Regarding the former, little if anything is gained by requiring plan sponsors to fully insure the exact same coverage at an increased cost; this is especially so given that employers and employees alike are already struggling to keep up with ever-increasing health care costs. Moreover, it would be a shame for employers to now have to charge employees for self-insured dental and/or vision coverage that up until now they have fully paid for, merely to ensure that such coverage is not subjected to PPACA provisions, including the insurance reform provisions (such as third-party external review) that were not intended to apply to dental and vision coverage in the first instance. Accordingly, the Council and HR Policy request additional guidance that self-insured dental and vision coverage qualifies as a HIPAA “excepted benefit” for purposes of PPACA, even where such coverage is fully employer-paid and/or the coverage may be provided on a “bundled” basis to employees.

#### **CLARIFICATION NEEDED AROUND ELIMINATION OF CERTAIN PLANS OR BENEFIT PACKAGES**

Under the rule set forth in paragraph (a)(2)(ii) of the Interim Final Rules regarding “change[s] in plan eligibility,” it appears to be the case that a transferee plan that takes in new participants from a terminated plan or “benefit package” loses grandfathered status unless there is a “bona fide employment-based reason” for the transfer of the new participants to the transferee plan. Paragraph (a)(2)(ii)(C) of the Interim Final Rules states only that for this purpose, “changing the terms or cost of coverage is not a bona fide employment-based reason.”

Given the importance of the rule set forth in paragraph (a)(2)(ii) of the Interim Final Rules, the Council and HR Policy request additional guidance clarifying what constitutes a “bona fide employment-based reason” for purposes of paragraph (a)(2)(ii) of the Interim Final Rules. Specifically, we request guidance setting forth those factors that should be considered by an employer when evaluating whether a change in plan eligibility rules is based on a “bona fide employment-based reason.”

In addition to the foregoing, past experience has shown that plan sponsors may be required to terminate certain plans or benefit packages because of circumstances largely outside of their control. For example, plan sponsors sometimes have to eliminate inefficient plan options or have inefficient plan options eliminated when an insurer

drops an employer plan option. A practical example would be a case in which a company offers an HMO, and the participation level in that HMO declines to so few employees that it is not feasible to continue offering the plan. For instance, an employer may have 17,000 employees in a geographic area and only 20 employees elect to participate in a selected HMO. The administrative costs, including set-up, open enrollment, producing plan materials, and vendor management, for so few plan participants would outweigh any benefit of continuing to offer the plan when other options exist. In other cases, an insurer may drop an employer plan, forcing the plan participants to join another plan option offered by the employer.

Notwithstanding the above, under the rule set forth in paragraph (a)(2)(ii) of the Interim Final Rules, it appears to be the case that even where a plan sponsor has little to no choice regarding the elimination of a plan or benefit package, if a transferee plan or benefit package enrolls individuals previously covered under a terminated plan or benefit package, the transferee plan or benefit package itself could be deemed to lose grandfathered status. This would seem to unfairly disadvantage existing plan participants of the transferee plan or benefit package, who might now lose grandfathered status merely because the transferee plan or benefit package enrolls individuals previously covered under the terminated plan or benefit package.

Accordingly, to ensure that plan sponsors have sufficient flexibility to respond to changing participation rates and related issuer behavior, the Council and HR Policy request additional guidance that a “bona fide employment-based reason” includes both (i) changes in eligibility rules, including a plan or benefit package termination, where such change is by reason of events outside of an employer’s control, such as where an issuer declines to provide coverage with respect to the plan or benefit package at issue, and (ii) the termination of a plan or benefit package where participation in such plan or benefit package has decreased by at least 20 percent prior to the date of termination, as measured from the date of PPACA’s enactment, *i.e.*, March 23, 2010. This guidance, if issued, will provide essential protections to participants in existing grandfathered plans, while also ensuring that employers have the ability to transition participants to existing grandfathered plans when economics so dictate.

#### **INTERIM FINAL RULES APPLICABLE TO COVERAGE MAINTAINED PURSUANT TO COLLECTIVE BARGAINING AGREEMENTS NEED CLARIFICATION**

In addition to the foregoing, we are requesting a host of clarifications regarding the provisions contained in the Interim Final Rules applicable to coverage maintained pursuant to a collective bargaining agreement (“CBA”). We address them in sequence below.

*The CBA safe harbor rule should apply to self-insured as well as fully insured plans.* Currently under the Interim Final Rules, health insurance coverage maintained pursuant to one or more CBAs ratified before March 23, 2010, qualifies as a

grandfathered health plan until the CBA terminates. However, this safe harbor only applies to fully insured, as opposed to self-insured, plans.

As noted in the Council's letter dated June 3, 2010, we urge the Agencies to apply the same safe harbor applicable to fully insured coverage pursuant to a CBA to self-insured coverage maintained pursuant to a CBA. The reasoning behind the current distinction is discussed in the preamble to the Interim Final Rules, and the Agencies indicate that it is based on the fact that the statutory provision providing for the rules applicable to collectively bargained plans refers solely to "health insurance coverage," but not "group health plans," therefore indicating that the rules applicable to collectively bargained plans should only apply to fully insured plans, and not self-insured, plans.

We believe there is little policy justification for distinguishing between fully insured and self-insured plans in this context. It is our understanding that the reference to "health insurance coverage" in PPACA section 1251(d) is not based on any specific intention by legislative counsel or Congress as a whole, to limit the provision to fully insured plans. In fact, it is our understanding that all parties involved intended for the provisions to apply equally to fully insured and self-insured plans. Based on the foregoing, it seems clear to us that the absence of a reference to "group health plans" was merely a drafting oversight in what was a very large and complex piece of legislation. Furthermore, a review of existing federal legislation indicates that, in legislating with respect to coverage maintained pursuant to a CBA, Congress has apparently never before made a distinction between fully and self-insured plans. This lends great weight to the notion that the exclusion of self-insured plans from the statutory language was based more on oversight than intention.

*Clarification is needed regarding how the CBA safe harbor rule applies in instances where the underlying CBA is extended versus terminated.* As noted above, under the Interim Final Rules, health insurance coverage maintained pursuant to one or more CBAs ratified before March 23, 2010, qualifies as a grandfathered health plan until the CBA terminates. Specifically, PPACA section 1251(d) provides:

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* (emphasis added).

Clarification is needed regarding how this rule applies where the CBA does not terminate but is extended either (i) by mutual assent of the parties, or (ii) by operation of federal law. The Council and HR Policy urge the Agencies to clarify that an extension either by mutual assent of the parties or by reason of federal law operates to

delay the termination date for purposes of PPACA section 1251(d) unless and until the CBA actually terminates. Such a rule is necessary given that one or both parties to the CBA, by reason of the extension, may lack the authority to change the terms of the group coverage to which the CBA relates unless and until the CBA actually terminates. A contrary rule would seem to penalize the parties to the CBA, along with the employees and their families who rely on the underlying group coverage.

*Clarification is needed that the CBA safe harbor remains in effect following the termination of the CBA unless and until a prohibited change is undertaken with respect to a plan.* Based on the preamble to the Interim Final Rules, it appears to us that plans do not lose grandfathered status the moment the corresponding CBA terminates, and that the plan retains grandfathered status unless and until the plan is subsequently modified in such a manner as to invoke paragraph (g)(1) of the Interim Final Rules. Given the importance of grandfathered plan status to many of our members, we request written confirmation of this reading of the Interim Final Rules.

*Additional guidance is requested that the CBA safe harbor remains in effect for the full plan year in which the corresponding CBA terminates.* Another concern that is being raised by our members is the fact that, in many instances, a CBA may terminate in the middle of a plan year. When this happens, the parties to the CBA may have little to no ability to modify the terms of the plan as in effect for the remainder of that plan year. Accordingly, we request additional guidance which extends the CBA safe harbor until the end of the plan year “[a]fter the date on which the last of the collective bargaining agreements . . . terminates.” Such a rule will help ensure that the CBA safe harbor is available on an equitable basis to all interested parties.

## CONCLUSION

Thank you for giving us the opportunity to comment on the Interim Final Rules and to highlight questions and issues from our employer members as they work toward compliance. We look forward to further clarification.

If we can be of further assistance, please contact Kathryn Wilber at 202-289-6700 or [kwilber@abcstaff.org](mailto:kwilber@abcstaff.org), or Marisa Milton at 202-789-8671 or [mmilton@hrpolicy.org](mailto:mmilton@hrpolicy.org).

Sincerely,



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