



*Employee Benefit Management Services, Inc.*

August 13, 2010

U.S. Department of Labor  
Office of Health Plan Standards and Compliance Assistance  
Employee Benefits Security Administration, Room N-5653  
Attn: RIN1210-AB42  
200 Constitution Ave NW  
Washington, DC 20210

Department of Health and Human Services  
Office of Consumer Information and Insurance Oversight  
Attn: OCIO-9991-IFC  
PO Box 8016  
Baltimore, MD 21244-1850

Internal Revenue Service  
Room 5205  
Attn: REG-118412-10  
PO Box 7604  
Ben Franklin Station  
Washington, DC 20004

**RE: Comments on Interim Final Rule and Proposed Rule: Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act.**

To Whom It May Concern:

Employee Benefit Management Services, Inc. (EBMS) is the Third Party Administrator for self-funded employee welfare benefit plans. EBMS appreciates the opportunity to comment on the Interim Final Rule and Proposed Rule jointly issued by the Departments for group health plans relating to their status as a grandfathered health plan under the Patient Protection and Affordable Care Act (“Act”) and submits the following comments on behalf of our employer clients.

**Threshold Issues Of Application To Self-Funded MEWA’s.**

Title 1 of the Act includes Sections 1001 through 1563. Section 1301(b)(1)(A) of the Act defines a “health plan” for the purposes of Title 1 of the Act as health insurance coverage and group health plans. Section 1301(b)(1)(B), however, states that a health plan does not include a group health plan or MEWA to the extent such plans are not subject to State insurance regulation under ERISA § 514. Section 1301(b)(3) defines a “group health plan” by adopting the Public

Health Service Act § 2791(a), which section would include a MEWA within the definition of a “group health plan.” The intent of these provisions is unclear.

- a. What is the distinction between a “group health plan” and a “health plan”? Can a plan be a “group health plan” subject to the Act but not be a “health plan” under the 1301(b) language?
- b. If a plan can be a “group health plan” without being a “health plan” under the ERISA exemption rule, what is the significance of the distinction?
- c. Because a MEWA is subject to regulation by the states to the extent not inconsistent with applicable provisions of ERISA, how does the exclusionary language of 1301(b)(1)(B) apply to a MEWA? Is the exclusionary language intended to remove a self-insured MEWA from consideration as a “qualified health plan”, with the understanding that only a “qualified health plan may be sold on an Exchange?

## Multiple Employer Welfare Associations

First, for the purposes of determining whether a plan is “grandfathered” such that many of the Act’s provisions do not apply, are the rules, as applied to a self-funded multiple employer welfare arrangements (MEWA), determined at the plan level or at the adopting employer level?

Section 1251(a)(1) of the Act states that nothing in the Act requires an individual terminate coverage under an existing plan. Section 1251(a)(2) addresses the issue from the plan’s perspective and states Subtitle A (which includes the lifetime and annual limits and other important provisions) and Subtitle C (which includes the preexisting condition prohibition and other provisions) shall not apply to a plan or coverage offered by a group health plan in which an individual was enrolled as of the effective date of the Act.

This grandfathered status benefit is extended to family members enrolling after the effective date (§1251(b)) and to new employees joining a group health plan after the effective date (§1251(c)).

Section 1251(d) addresses plans maintained under a collective bargaining agreement and extends grandfathered status to any plan certified prior to the effective date until all collective bargaining agreements relating to the plan terminate.

The regulations at 26 CFR §54.9815-1251T(a)(1)(i), 29 CFR §2590.715-1251(a)(1)(i), and 45 CFR §147.140 (a)(1)(i) further clarify that the rules of these sections are to apply separately to each benefit package made available under a group health plan or health insurance coverage. Subsection (a)(1)(ii) specifies that if an employer or employee organization enters into a new policy, certificate, or contract of insurance after March 23, 2010 (because for example, any previous policy, certificate or contract of insurance is not being renewed), then that policy, certificate, or contract of insurance is not a grandfathered plan. The regulations also provide special rules for collectively bargained plans. However, there is no reference in either the statute or the regulations to a multiple employer welfare arrangement or other forms of multiple

employer trusts. By definition in Section 3(40) of ERISA, 29 USC §1002(1), a MEWA is a welfare benefit plan established for the purpose of providing benefits to the employees of two or more employers, or to their beneficiaries which suggests the determination is made at the employer plan level. An employer, as defined in Section 3(5) of ERISA, includes any person acting directly as an employer or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

For purposes of evaluating each benefit package made available under a plan sponsored by a MEWA trust to determine grandfathered plan status, is the “employer” considered to be each participating employer within the MEWA trust, or is the “employer” considered to be the MEWA trust itself?

If the “employer” is the participating employer and not the MEWA trust, and the MEWA trust covers employers 1 through 100 as of March 23, 2010, but after March 23, 2010, new employer 101 adopts the plan. Is the MEWA grandfathered as to:

- a. employers (and employees/families) 1 through 100, but not 101;
- b. employers (and employees/families) 1 through 101; or
- c. none of the employers?

In the alternative, if the “employer” is the MEWA trust itself, is each benefit option offered by the MEWA trust for participating employers to be separately evaluated and a determination made as to the grandfathered status of each benefit option? For example, if the MEWA covers 100 employers and one existing employer makes a change in the benefit structure greater than allowed by the grandfather rules does:

- a. the group health plan adopted by employer 1 lose its grandfathered status, but the plans of employers 2 through 100 retain grandfather status;
- b. do all employers 1 through 100 lose the grandfathered status; or
- c. do all employers maintain their grandfathered status?

### Comments on Plan Changes Causing a Cessation of Grandfathered Status

The Departments invited comments on other changes that may cause cessation of a group health plan’s grandfathered status. We submit the following suggestions for changes that group health plans should be permitted to make without a cessation of grandfathered status.

a. Administrative Vendors

Group health plans commonly make changes to their administrative vendors, including but not limited to preferred provider networks or claims negotiation services, reinsurance carriers, pharmacy benefit managers, claims administrators, disease management vendors, utilization review vendors, accounting and legal consultants, and brokers, in order to control costs and better manage utilization of the benefit dollars. As long as the change of any one or more administrative vendors does not result in one or more of the changes listed under in subsection (g)(1) that would cause a cessation of grandfathered status, a group health plan should be permitted to make changes to its administrative vendors as needed without a resulting loss of grandfathered status.

b. Changes in Prescription Drug Programs

In addition to changing pharmacy benefit managers, group health plans will commonly change the pharmacy benefits to allow for a mail-order option where the plan may not have previously offered this option, or convert a tiered co-payment structure for brand name, generic, and certain specialty drugs to a deductible and coinsurance structure, or implement a drug formulary with a new co-payment structure. Group health plans implement these changes to increase access to more affordable drugs for their plan members, particularly those plan members with chronic conditions requiring long term maintenance medications, such as diabetes, high cholesterol, or cardiovascular disease. For example, converting a tiered co-payment structure to deductible and coinsurance or implementing a mail order option with a different copayment structure can actually decrease the costs for those plan members on high cost long term maintenance medications. As long as the plan administrator makes a reasonable determination of actuarial equivalency between the prescription drug benefits before and after the change and the plan does not eliminate all or substantially all benefits to treat a certain condition pursuant to Subsection (g)(1)(i), the plan should be permitted to change the terms of its pharmacy benefits as described in this paragraph without a cessation of grandfathered status due to any of the events described in Subsection (g)(1)(ii)-(iv).

c. Converting from an Insured Product to a Self-Insured Product

Group health plans will also commonly change plan structure to increase benefits for plan members. For example, an employer may convert its employer-sponsored plan from an insured product to a self-insured product, to gain the flexibility to offer benefits designed to meet the particular needs of its own employees. As long as the change in plan structure does not significantly change the benefits to a level that would cause a cessation of grandfathered status as defined under Subsection (g)(1), this change in plan structure should not cause a cessation of grandfathered status of the employer-sponsored plan and the now self-insured plan of the employer should have grandfathered status.

#### d. Change in Plan Structure

Employers will change the structure of their group health plan, such as adding a health reimbursement arrangement option to provide additional benefits and incentivize employees to participate in wellness activities. If for example, an employee participates in the employer-sponsored wellness program, the employee receives employer contributions to the health reimbursement arrangement. Those contributions can be used to reduce the deductible, or pay coinsurance or copayment amounts. We suggest that as long as the combined effect of the new health reimbursement arrangement option and any increases in deductible or copayments do not exceed the “safe harbor” under Subsection (g)(1) for permitted changes, this change in plan structure should not cause a cessation of grandfathered status as to the group health plan nor should the health reimbursement arrangement be considered as anything other than a benefit enhancement to the group health plan.

#### Comments on Specific Standards for Benefits, Cost-Sharing, and Employer Contributions

The Departments also invited comments on the specific standards for benefits, cost sharing, and employer contributions. We submit the following. From the discussion in the preamble, it appears that the Departments determined the best approach to be a one-time increase of 15% added to the cost of medical inflation as calculated from March 23<sup>rd</sup>, 2010. As stated in the preamble, the rationale was that this method best reflected the employers’ need to make adjustments in the near term for market reform as they would apply to grandfathered plans, and only small incremental changes over the next few years would be necessary for the later reforms. While our employer clients appreciate the Departments’ understanding that there will be additional costs, we believe that the costs and burdens of the new benefit mandates and reporting requirements to these employers will significantly exceed the Departments’ estimates of time and cost of implementation. For group health plans with a plan year of September 1<sup>st</sup>, those plans will be subject to the earlier market reforms with the plan year beginning September 1, 2011. These employers will make adjustments to their benefit structure for the earlier reform measures on September 1<sup>st</sup>, 2011 and will continue for the later measures of market reform up through the plan year beginning September 1<sup>st</sup>, 2014. Regulations are still anticipated on several major initiatives of market reform, including the external review requirements for Section 2719. Already published interim final regulations have yet to be implemented, leaving employers with significant uncertainty as to the full cost and effect of these regulations, particularly with the unexpectedly onerous regulations on internal and external claims review procedures, the additional reporting requirements, and the annual fee of \$1 per plan participant. For an approximate six year period, a one-time adjustment of 15% plus the medical inflation as calculated from March 23<sup>rd</sup>, 2010 on copayments and deductibles and a one-time 5% adjustment to the contribution rate of the employer is the only “tool” that employers have to manage their costs and evaluate whether to retain or relinquish the grandfathered status of their plans. This is inadequate, given the magnitude of the market reforms, the length of time necessary for the Departments to publish guidance, and the fact that the Act did not contain equivalent reforms on the actual costs of care billed by the provider community.

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EBMS suggests a more effective tool for employers to manage their costs while the industry implements the market reforms is an annual allowance for cost-sharing increases to copayments, deductibles, and the coinsurance levels indexed to medical inflation over the course of the entire transition period from the effective date of the Act through at least, the plan renewal occurring on or after January 1, 2014. The annual allowance would be a percentage adjustment plus medical inflation as of the 12 month period immediately preceding the adjustments.

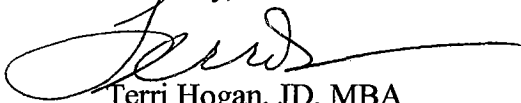
In order to restrict annual increases in the deductible to a reasonable level, we suggest limiting increases in the deductible to the lesser of the percentage adjustment plus medical inflation or the limits of Section 1302(c)(2). For example, if an employer has a deductible for self-only coverage of \$1,500, the employer can make annual adjustments of the percentage adjustment plus medical inflation until the Section 1302(c)(2) limit of \$2,000 for self-only coverage has been reached.

Employers should be permitted to make minimal annual increases to coinsurance levels, if they are permitted to decrease their contribution rate. To limit the financial impact to the employees, permitted adjustments could be limited to a 5% annual adjustment to the coinsurance levels and/or the employer's contribution rates. Minimal increases in coinsurance levels can more effectively manage costs and utilization of medical services, and can be partially offset through wellness activities/incentives provided employees meet certain goals.

The definition of "medical inflation" under 1251(g)(3) is unnecessarily complicated. We'd suggest that definition be simplified to the unadjusted percent change to the month that is the most recently published month from the same month one year earlier. For example, the unadjusted percent change to June 2010 from June 2009 for medical care is 3.5%. So in this instance, the permitted adjustment can simply be the sum of 3.5% plus 15%, or 18.5%. Most employers will evaluate adjustments to benefits, cost-sharing, and premiums on the previous year's claims experience, so the more analogous index would be a percentage that represents the change for the 12 month period immediately prior to the date the employer makes a determination on necessary adjustments to benefit structure, premiums, and the like.

On behalf of its employer clients, EBMS appreciates the opportunity to submit comments to the Departments.

Sincerely,



Terri Hogan, JD, MBA

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