



August 27, 2010

Submitted Electronically

The Honorable Kathleen Sebelius
Department of Health and Human Services
Hubert H. Humphrey Building,
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: HHS Waiver of Restricted Annual Limits

Dear Secretary Sebelius:

The Department of Health and Human Services ("HHS"), Department of Labor, and Department of Treasury (the "Agencies") issued an interim final regulation implementing the prohibition of lifetime limits on essential health benefits and establishing, until 2014, the restricted annual limits on essential health benefits as required under the Patient Protection and Affordable Care Act ("PPACA"). 75 Fed. Reg. 37188 (June 28, 2010) (the "Rule"). Although the Rule permits restricted annual limits on essential health benefits for plan years beginning before January 1, 2014, the Rule as written would prevent employers from offering most limited benefit plans of the type that are routinely offered to part-time, temporary and seasonal employees. The preamble to the Rule, however, indicates that HHS will establish a program to waive the restricted annual limits requirements under certain circumstances. We wish to comment on the possible waiver program and the guidance HHS expects to issue on the waiver process. 75 Fed. Reg. at 37191.

Wakefern is the largest retailer-owned cooperative in the United States and comprises 48 member companies that own and operate over 220 retail supermarkets under the ShopRite banner. Wakefern and ShopRite (together, the "Wakefern Cooperative") employ more than 50,000 people throughout New Jersey, New York, Connecticut, Pennsylvania, Delaware and Maryland. The Wakefern Cooperative offers medical, dental, eye, pension, education, and legal benefits to their associates. In most cases, these benefits are provided under self-funded, multiemployer plans pursuant to the terms of collective bargaining agreements the Wakefern Cooperative negotiated with their unions. These benefits are typically provided to part-time employees after they undergo a collectively bargained waiting period based on length of service, with benefits becoming increasingly generous as employees achieve tenure.

According to a July 27, 2010, Bureau of Labor Statistics report, only 24 percent of part-time workers are offered access to medical coverage. The Wakefern Cooperative is

proud to be among the few employers that provide -- and pay for -- quality, affordable health benefits for these workers. However, the supermarket industry operates on a 1% profit margin, our benefits generally are self-funded, and our Cooperative operates under previously-negotiated collective bargaining agreements. We simply cannot afford the enormous increase in health benefit costs that complying with the restricted annual limit rule for our part-time employees will impose. Absent relief through the waiver program, we cannot continue to provide and pay for these benefits without significant job losses.

As a key stakeholder affected by PPACA and by the Rule, we welcome the opportunity to work with HHS to develop a waiver process that addresses these concerns.

Issue

For plan years beginning on or after September 23, 2010, PPACA, by amending the Public Health Service Act ("PHSA") § 2711, prohibits group health plans from imposing lifetime or annual limits on the dollar value of essential health benefits, except that it provides that the Secretary of HHS may permit certain "restricted annual limits" for plan years beginning before January 1, 2014. In permitting restricted annual limits on essential health benefits, PPACA directs the Secretary to "ensure that access to needed services is made available with a minimum impact on premiums." *Id.* The restriction on annual limits on essential health benefits applies to both new plans and grandfathered group health plans. *See* PPACA § 1251(a)(4)(B)(i).

The recently issued Rule implements the restriction on annual limits requirement by permitting annual limits on essential health benefits starting at \$750,000 for plan years beginning on or after September 23, 2010 and climbing to \$2 million for plan years beginning on or after September 23, 2012. 45 C.F.R. § 147.126(d). Annual limits are prohibited entirely beginning in 2014.

PPACA's prohibition on lifetime limits eliminates one of the key tools the Wakefern Cooperative, our unions and health benefit plans have used to provide affordable health insurance to our part-time employees. Moreover, the restricted annual limits set forth in the Rule far exceed the typical annual limits established under our health benefit plans for part-time employees.

Because we have a varied workforce, our plans offer varied benefits, including some annual and lifetime limits established for our part-time employee coverage. Wakefern has contracted with consultants to project how much the restricted annual limit requirement would raise the cost of covering its part-time employees. Our consultants project that eliminating a \$10,000 lifetime limit, the lowest limit offered to some of our part-time employees, and replacing it with a \$750,000 annual limit, would increase the cost of providing health benefits to the affected part-time employees by 79%.

Unless HHS establishes a timely waiver process that allows our health benefit plans for part-time employees to establish annual dollar limits that are lower than these restricted annual limits, the Wakefern Cooperative will have no choice but to bargain to cease employer-paid coverage of their over 32,000 part-time workers, or be forced to layoff a

significant amount of associates exacerbating the job losses our country is witnessing. We are convinced that Congress and the Administration did not intend for businesses like the Wakefern Cooperative, who were already doing the right thing by funding health benefits for part-time employees, to be prevented from continuing to do so. But that will be the result if an unrealistic annual limit waiver process is adopted.

Recommended Solution

Wakefern strongly supports the creation of a restricted annual limit waiver program and believes it is essential that it apply to self-funded, multiemployer plans like those to which the Wakefern Cooperative contribute. We believe it is critical that the process for obtaining a waiver be efficient, realistic and allow workers like ours who have limited benefit plans to keep the coverage they have, as promised, at least until 2014.

The preamble to the Rule explains that the waiver process is being created "so that individuals with certain coverage, including coverage under a limited benefit plan or so-called 'mini-med' plans, would not be denied access to needed services or experience more than a minimal impact on premiums . . ." 75 Fed. Reg. at 37191. The restricted annual limits may be waived "if compliance with these interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums." *Id.*

We suggest the following with respect to the scope and process for the waiver program:

Self-Funded Plans Should Be Eligible For Waivers

In the discussion of the waiver program in the Preamble, the Agencies appear to focus on insured limited benefit plans (for example, so called "mini-med" plans). That said, the employers that contribute to self-funded group health plans are faced with the same, if not more challenging, decisions. Our businesses are family owned, with a workforce that is 83% unionized. The Wakefern Cooperative are signatories to 45 contracts with 15 unions. The numerous collective bargaining agreements ("CBAs") that relate to the health benefits we offer are continuously being renegotiated as agreements expire in 2010, 2011, and thereafter. A typical plan provides multiple options and most are self-funded.

These self-funded arrangements are equivalent to insured, limited benefit arrangements, and therefore should be eligible for a waiver.

Waivers Should Permit Self-Funded Multiemployer Plans to Operate at Current Limits

Representatives of the Wakefern Cooperative and our unions typically negotiate a "wage package" in the collective bargaining process that, among other things, consists of hourly wage, health and welfare, and pension components. The contribution rates to self-funded, multiemployer group health plans specified in the wage package and the benefit levels those contribution rates fund, are the product of intense negotiations between the

bargaining parties and effectively establish the maximum benefit levels that the parties believe are affordable given the wage, pension and other obligations that must be covered by the wage package.

Applying the coverage mandates to the coverage that we provide to our part-time workers under our collective bargaining agreements will dramatically increase our health care costs to an unaffordable level and strain labor-management relations. The waiver program should respect the expertise of the bargaining parties as to the benefit levels that are affordable under the wage package -- as well as the fact that the immediate effective date of the new restrictions does not give the parties adequate time to make any adjustments to the wage package allocations -- by permitting all self-funded multiemployer plans to impose an *annual* benefit limit for plan years prior to 2014 that is not less than the plan's pre-PPACA *annual* benefit limit (or what previously was the plan's *lifetime* benefit limit).

Alternatively, Self-Funded Plans Should Receive a Waiver if the Costs of Coverage Rise Significantly or the Plan Must Drop Coverage Due to Costs

The Agencies have stated that a waiver should be granted if compliance with the rule would result in (1) a significant decrease in access to benefits or (2) a significant increase in premiums. If HHS chooses not to grant the generic relief requested in the previous section, then an employer that contributes to a self-funded multiemployer plan, or the plan itself, should be permitted to demonstrate that limited benefit arrangements under the plan satisfy this two-part test. "Premiums" for these purposes should be based on the total cost of coverage, including all employee and employer contributions to pay for that coverage.

It is important to include both the employer and employee contributions in this analysis because the two together are the economic equivalent of "premium" in a fully-insured plan. Moreover, if only employee contributions were counted, employers would have an additional incentive to shift the costs of coverage to employees simply to qualify for a waiver.

Accordingly, a self-funded plan should be able to obtain a waiver if it demonstrates that the cost of providing coverage that complies with the restricted annual limits will increase significantly or that the contributing employers to the plan will be forced to substantially diminish the coverage, cease offering it entirely, or have a significant reduction of the workforce. Once a self-funded plan makes such a showing, the plan should be permitted to impose an *annual* benefit limit for plan years prior to 2014 that is not less than the plan's pre-PPACA *annual* benefit limit (or what previously was the plan's *lifetime* benefit limit).

Contributing Employers and Trustees Should Be Permitted to Apply for a Waiver

Employers contributing to a self-funded plan should be permitted to apply for a waiver. In the case of a self-funded, multiemployer plan, the plan trustees also should be permitted to make a waiver application.

The Effective Date Should Be Delayed While a Waiver Application is Pending

The filing of a timely application should delay the effective date (i.e., first plan year beginning on or after September 23, 2010) of the annual limit restrictions so that a plan is not deemed out of compliance with PPACA in the event that HHS does not act on the waiver application in sufficient time for the plan to comply if the waiver application is denied.

Waivers Should Be Valid Until 2014

If an employer or plan obtains a waiver, that waiver should be effective until at least the last date of the plan year beginning before January 1, 2014. Employers and plans should not be required to apply for waivers on an annual basis.

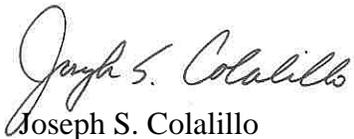
New Employees and Dependents Should Be Permitted to Enroll in Waiver Plans

If an employer or plan obtains a waiver, new employees and dependents should be permitted to enroll in that coverage.

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We thank you in advance for considering our concerns. We believe that our recommendations will result in a successful waiver program that will allow employers such as the Wakefern Cooperative to continue to provide their part-time employees coverage. We look forward to hearing from you and would be pleased to respond to any questions you may have.

Sincerely,



Joseph S. Colalillo
Chairman of the Board & CEO
Wakefern Food Corp.