



The
ERISA
Industry
Committee

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Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-1850
Attention: OCIIO-9991-IFC

Ladies and Gentlemen:

The ERISA Industry Committee (“ERIC”) is pleased to submit these comments on the 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 (PPACA). The interim final regulations were published in the *Federal Register* on June 17, 2010.

The Fact Sheet accompanying the release of the grandfather regulation provides the rationale for the policy underlying the regulation:

“The rule announced today preserves the ability of the American people to keep their current plan if they like it, while providing new benefits, by minimizing market disruption and putting us on a glide path toward the competitive, patient-centered market of the future. While it requires all health plans to provide important new benefits to consumers, it allows plans that existed on March 23, 2010 to innovate and contain costs by allowing insurers and employers to make routine changes without losing grandfather status. Plans will lose their “grandfather” status if they choose to significantly cut benefits or increase out-of-pocket spending for consumers – and consumers in plans that make such changes will gain new consumer protections.”

ERIC members appreciate the desire of many employees to preserve their existing health coverage in the face of increasing medical costs and the significant changes introduced by PPACA. At the same time, however, and as explained in more detail below, we are very concerned that not only will PPACA’s new rules, as interpreted by the regulation, not result in a competitive market in the future, but they will actually lead in the opposite direction.

In our comments on the regulation, we also express our concern over the unprecedented omission of a delayed effective date for self-insured collectively bargained plans and urge clarification with respect to the exemption from the grandfather rules for certain “retiree only” plans. In addition, we note our concern with respect to the disclosure requirement and with specific provisions of the regulation regarding an elimination of benefits that lead to the loss of grandfathered status. Last, we respond to the Departments’ request for comments on our perspective on the impact on grandfather status wrought by changes to plan structures, provider networks, and prescription drug formularies.

ERIC’s Interest in the Interim Final Regulations

ERIC is a nonprofit association committed to the advancement of the employee retirement, health, incentive, and welfare benefit plans of America’s largest employers. ERIC’s members sponsor some of the largest private group health plans in the country, which provide comprehensive health benefits to tens of millions of workers and their families.

ERIC’s members are committed to, and known for, providing high-quality, affordable health care. Our members expend considerable resources to maintain plans of this caliber. High-quality, affordable health care has become an increasingly difficult standard for many companies, however, as medical costs continue to grow at unsustainable rates. Thus, we are concerned over the impact of the grandfather regulation on our ability to provide this health care in a manner that makes efficient use of our resources while maximizing high-quality health care appropriate to the needs of our unique work forces.

Comments on the Regulation

1. Loss of grandfather status should be limited to significant and fundamental plan changes and should provide more flexibility to plan sponsors to accommodate their need both to control costs and to tailor plan changes to the needs of plan participants.

Maintaining status as a grandfathered plan in the face of regulatory uncertainty

Under PPACA, a group health plan faces a choice between keeping its plan provisions much the same as they were on March 23, 2010, thus maintaining its grandfather status, or to lose this status and operate as a “non-grandfathered” plan for plan years beginning on or after September 23, 2010.

While both grandfathered and non-grandfathered plans must meet certain new PPACA standards (such as a ban on lifetime limits and making coverage available to adult children), non-grandfathered plans must comply with other significant additional rules in a very short period of time. These new rules include a requirement to cover certain preventive services without participant cost-sharing as well as adherence to new claims and external review rules. (Other rules relevant only for non-grandfathered plans become effective in 2014.) Although explanatory regulations have been published for nearly all of the PPACA statutory requirements that are applicable in the near future, many open questions remain, and plans are reluctant to commit themselves to giving up their grandfathered status and following these additional rules before the parameters have been made explicit.

The ability of a plan to remain grandfathered also has been made unusually difficult by regulatory rules that restrict a plan’s efforts to control costs and tailor its provisions to the needs of its participants. Many plans thus face the choice of struggling to maintain grandfather status, often at the expense of changing plan provisions to more closely align with and balance the needs of employers and employees, or forgoing this status, and being forced to immediately comply with ambiguous regulatory mandates that could entail significant cost and administrative challenges.

ERIC recently surveyed its members to ascertain how many were planning, as of that particular point in time, to keep their grandfather status. Slightly more than half were then planning to do so. The key reason cited by almost all of the plans choosing to remain grandfathered was the necessity to buy time to understand how the new rules applicable only to non-grandfathered plans would affect them. For instance, despite the prevailing view that most large plans would meet the new PPACA preventive care standards, most of our plan sponsors expressed reservations that they currently fully adhered to these standards. (This was due primarily to uncertainty over the scope and duration of the preventive care requirements and ambiguity concerning their application. We intend to submit comments separately on those issues.) Similarly, most of our members expressed the view that they would not have

sufficient time to analyze and comply with the new claims and external review regulation. Thus, these plans wanted to remain grandfathered until they could fully understand how the new PPACA rules would affect current practices.

Maintaining status as a grandfathered plan while keeping healthcare affordable

Employers do appreciate the concerns that drove healthcare reform and the desire of proponents to extend coverage and many consumer protections to a wider universe of individuals. Unfortunately, however, these goals are often not easily reconciled with the need to keep healthcare affordable for both employers and employees. For instance, the extension of health coverage to adult children (for which no supplemental premiums may be charged) adds significant new expenses for employers whether or not their plans are grandfathered. The PPACA provision creating the right to external review will impose additional costs on non-grandfathered plans.

Under the grandfather regulation, employers face serious constraints in their ability to rationally allocate costs. As noted above, the regulation's Fact Sheet states that employers will be able to make routine changes without losing their grandfather status and that only significant benefit cutbacks or cost-sharing increases will cause a loss of grandfather status. The regulation itself seems to take a different tack; employers are prevented from making such commonplace changes as adjusting coinsurance levels to reflect new mandates imposed by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") or from increasing copayments by relatively small amounts over a number of years to reflect increasing costs of health care and coverage.

Employers must have sufficient flexibility to reflect increasing medical costs in a manner that is most suitable for their employees and their own ability to continue to maintain their plans. What may be appropriate for the demographics of one plan population could be completely inappropriate for an older, younger, sicker, or healthier plan population. Employers must be able to take these differences into account when designing their plan premiums and cost-sharing structures. Plans that are not able to reflect these differences will not meet the needs of their participants and will not maximize their ability to control expenses. This will often result in unnecessary cost increases for employees as well as employers. The unintended result of imposing an inflexible and unnecessarily narrow interpretation of grandfathering will likely be to generate more plan curtailments and cutbacks and increased costs for participants, all inconsistent with the objectives of PPACA.

Recommendation for a more flexible standard

Rather than relying on a series of rules restricting nearly all changes in benefit structures or contributions in order to maintain grandfather status, we urge that a more general standard be used instead. For instance, plans should be able to maintain their grandfather status if they do not significantly decrease the benefits

provided to the average plan participant from one year to the next based on the expected average out-of-pocket costs for participants. This would allow for a more flexible allocation of costs among all plan participants, as appropriate, while still maintaining the sponsor's overall support of the plan.

Alternatively, the standard could be based on actuarial equivalence; in this case, the plan would be considered to have retained grandfather status if it were still the actuarial equivalent of the plan in existence on March 23, 2010.

Either of these standards would be far superior to the current tests, which do not give adequate scope to the efforts of plan sponsors to restrain costs and maximize benefit efficiency in the manner most suitable for their own unique plan populations.

2. Collectively bargained plans, whether insured or self-funded, should have a delayed effective date that treats the plan's coverage as grandfathered until termination of the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010.

Section 147.140(f) of the regulation applies the grandfathering rules to collectively bargained plans, providing a delayed effective date for insured collectively bargained plans. Unfortunately, no delayed effective date is provided for self-funded collectively bargained plans.

We believe the lack of a delayed effective date for self-funded collectively bargained plans to be extremely rare, if not unprecedented. It does not serve the interests of plan participants, nor does it further any broader health care goals. Instead, it seriously disrupts existing collective bargaining agreements, potentially undermining the negotiating relationships between employers and employees.

We urge that the Departments use the same authority they exercised to essentially exclude retiree-only plans from the coverage mandates of PPACA to apply a delayed effective date to self-insured collectively bargained plans. For instance, the preamble to the grandfather regulation states that “[t]here is no express statement of intent that nonfederal governmental retiree-only plans should be treated differently from private sector plans or that excepted benefits offered by nonfederal governmental plans should be treated differently from excepted benefits offered by private sector plans.” This part of the preamble goes on to provide that treating nonfederal plans differently “would create confusion” and, thus, HHS does not intend to use its resources to enforce the requirements of PPACA to nonfederal government retiree-only plans.

Similarly, IRS Notice 2010-38, which addresses the tax treatment of health care benefits provided with respect to children under age 27, notes that prior to PPACA, the exclusion for employer-provided accident or health plan coverage under §106 of the Internal Revenue Code paralleled the exclusion for reimbursements under §105(b). After PPACA, this was no longer the case. Part III of the Notice states that there “is

no indication that Congress intended to provide a broader exclusion in §105(b) than in §106. Accordingly, IRS and Treasury intend to amend the regulations under §106, retroactively to March 30, 2010, to provide that coverage for an employee's child under age 27 is excluded from gross income.”

There is also no indication that Congress intended to treat self-funded collectively bargained plans differently from insured plans. The regulation focuses on an overly restrictive interpretation of PPACA §1251(d) in limiting the intended delayed effective date to insured plans only, a result that is inconsistent with a long history of allowing collectively bargained plans to retain bargained-for provisions until the applicable union agreements expire.

Moreover, this disparate treatment would create “confusion” among participants in these plans as well as their unions and employers. Thus, we recommend that the Departments exercise their regulatory discretion, as they have done in the two examples cited, to provide a delayed effective date for self-funded collectively bargained plans with respect to the grandfather regulation.

3. The exemption for retiree-only plans should be clarified to include plans covering rehired retirees, individuals on long-term disability, and certain individuals with end stage renal disease.

The preamble to the grandfather regulation clarifies that retiree-only plans are exempt from coverage mandates added by PPACA to Part 7 of Title I of ERISA and Chapter 100 of the Code and will remain exempt from mandates that existed under these sections before PPACA. More specifically, the provisions under ERISA and the Code exempting retiree-only plans from these mandates state that the mandates do not apply to plans that cover fewer than two current or active employees.¹

Many plans provide retiree medical coverage to individuals who, for reasons unrelated to the coverage, are also employees of the employer providing the coverage. For example, retiree plans may cover retirees who have been rehired by the employer after retiree medical coverage began and spouses and dependents of retirees who may themselves be employees of the employer. In addition, retiree medical plans may provide benefits to individuals receiving long-term disability benefits from the employer and to certain individuals who have been diagnosed with End Stage Renal Disease (ESRD).

Because employers face penalties of up to \$100 per day per covered individual if they fail to comply with these mandates, it is important for employers to have clear standards to apply in determining whether their retiree plans are exempt from the mandates. Accordingly, we request further clarification, as set forth below, for determining whether a retiree plan covers fewer than two current or active employees.

¹ Code § 9831(a) and ERISA § 732(a).

Rehired Retirees

Former employees (including their spouses and dependents) usually become eligible to participate in an employer's retiree health plan if they have completed significant years of service and reached a specified age at termination of employment. It is not unusual for an employer to allow retired employees who become re-employed to remain eligible to participate in the employer's retiree health plan after they return to work. Retirees have already served a full career with an employer, which serves as the basis for their retiree health coverage, and retirees may be re-employed for a specific project, on a temporary basis, or for a limited period of time. In addition, retiree health plans often cover spouses and dependents of retirees, including surviving spouses and dependents, even if the spouse or dependent is currently working for the employer. During periods of employment, retirees (and their spouses and dependents) continue to participate in the retiree health plan based upon their retiree status (or their status as spouses or dependents of deceased retirees) and not because of any services performed during the current period of employment.

There are several reasons for sponsors to allow re-employed retirees (or their employed spouses and dependents) to continue to participate in a retiree health plan. Sponsors often make changes to retiree health plans that apply only to retirees who become eligible to, or begin to, participate in the plan after a prospective date. Accordingly, to avoid penalizing retirees for returning to work, sponsors allow retirees to remain in the retiree plan after returning to work so that they can continue to maintain the level of coverage to which they were entitled when they initially retired. Retiree plans that cover spouses and dependents do not typically exclude spouses and dependents who happen to be employed by the sponsor or force the retiree and family members into separate plans. Excluding individuals from coverage during periods of employment with the sponsor could be disruptive; permitting continued retiree medical coverage provides continued access to the same network of providers and preserves an individual's satisfaction of deductible and out-of-pocket limits.

The Departments should clarify that a plan does not fail to be a retiree-only plan merely because the plan provides coverage to current employees if such coverage is provided for a reason other than, and is not a condition of, current employment. For example, a retiree medical plan that provided coverage to employees who terminated employment after completing 10 years of service and reaching the age of 55 would not fail to be a retiree-only plan merely because, after retiring and beginning to receive coverage, more than two retirees were rehired and continued to be covered by the plan. Similarly, the plan would not fail to be a retiree-only plan merely because the plan covered more than two surviving spouses who, at the time their retiree spouses died, were employed by the employer. In each case, coverage would be provided based on the retiree's retirement from the employer and would not be a condition of any current employment.

Participants Receiving Long-Term Disability Benefits

Many employers provide health benefits to individuals who are receiving employer-provided long-term disability benefits under the employer's retiree health plan. Because employers often treat individuals on long-term disability as current employees for some purposes but not others, we recommend that the Departments provide employers with a bright-line test for determining whether an individual who is receiving disability benefits is no longer considered to have current employment status for purposes of the retiree-only exemption.

Employers have been given clear rules for determining the employment status of individuals on long-term disability for other purposes. For example, HHS issued rules providing that, for purposes of determining whether Medicare is the secondary payer, an individual receiving disability benefits from an employer is considered currently employed only for the first six months that he or she receives disability benefits.² In addition, under the Code, disability benefits are generally subject to FICA and FUTA taxes until the expiration of six calendar months following the last calendar month in which the recipient worked for the employer.³

Accordingly, the Departments should clarify that an individual who is receiving disability benefits will not be considered a current or active employee for purposes of the exemption if the individual has not been in active, current employment with the employer for more than six months. The Departments could apply either the Medicare standard -- i.e., a disabled individual ceases to be employee after receiving benefits for six months -- or the FICA and FUTA standard -- i.e., a disabled individual ceases to be an employee six months after ceasing to work for the employer. Most importantly, there should be a clear standard to apply. Pursuant to this clarification, a retiree health plan will qualify for the retiree-only exemption even if the plan covers individuals who are receiving disability benefits, provided that these individuals have not been actively at work for the employer for more than six months since becoming disabled.

Participants with ESRD

Many employers provide health benefits under their retiree group health plans to active employees (and their spouses and dependents) who have been diagnosed with ESRD and for whom Medicare is the primary payer of benefits. These employers allow active employees (and their spouses and dependents) with ESRD to enroll in the retiree plan after Medicare becomes the primary payer to the employer's group health plan for active employees. Under rules issued by HHS, Medicare becomes primary payer generally 30 months after the earlier of the date that the individual first becomes entitled to Medicare part A on the basis of ESRD or the first month in which

² 42 C.F.R. § 411.104(a)(2).

³ Code §§ 3121(a)(4) and 3306(b)(4).

the individual would have become entitled to Medicare part A on the basis of ESRD if he or she had filed an application for Medicare part A benefits.⁴ Medicare becomes primary payer on the basis of ESRD regardless of whether the individual or other family member has current employment status.⁵

Employers allow employees (and their spouses and dependents) who have been diagnosed with ESRD to participate in their retiree health plans after Medicare becomes primary payer because these plans generally provide coverage in coordination with Medicare that is at least as generous as, and no more expensive than, the coverage available under the plan for active employees. In addition, the retiree health plans are generally more adept at coordinating benefits with Medicare than the group health plan for active employees.

Therefore, the Departments should clarify that the employment status of participants (and their spouses and dependents) with ESRD will be disregarded for purposes of the retiree-only exemption in the same way that it is disregarded for purposes of the Medicare secondary payer rules. Accordingly, a retiree health plan will qualify for the exemption even if it covers active employees (and their spouses and dependents) who have been diagnosed with ESRD and for whom Medicare has become the primary payer to the employer group health plan.

4. The disclosure requirement with respect to grandfathered plans should be modified to limit the frequency with which the new grandfather statements must be distributed as well as to delete any requirement that contact information for a plan administrator be included.

Section 147.140(a)(2) of the grandfather regulation provides that in order to maintain its status as a grandfathered plan, the plan must include a statement describing the benefits provided under the plan, that the plan believes it is a grandfathered plan, and contact information for questions and complaints. The regulation's model language for the disclosure requirement provides that "Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at..." This information must be provided in any materials provided to a participant or beneficiary describing plan benefits.

With respect to this disclosure requirement, we first recommend that it not be interpreted to mandate the provision of this grandfather information every time a plan sends out benefit information to any participant or beneficiary. Many plans send out brief participant communications that highlight particular features of the plan, which can be as short as a postcard. This lengthy disclosure language could take up a significant portion of the communication piece. Thus, we recommend that this

⁴ 42 C.F.R. § 411.162.

⁵ 42 C.F.R. § 411.162(a)(2).

information be included only in significant disclosure documents sent by plans to all participants, such as the Summary Plan Document (SPD) and the Summary of Material Modifications, as well as material provided in conjunction with a health plan's annual open enrollment.

Second, we recommend that the requirement for the notice to include contact information for a plan administrator (as illustrated in the regulation's model language) be deleted for the reason that most plan administrators will not be able to answer questions regarding which PPACA provisions do and do not apply to grandfathered plans. Plan administrators are well-versed in the particulars of their own plans but not necessarily in the intricacies of PPACA. Moreover, most plans already provide general reference in the SPD and other relevant communications materials regarding contacting appropriate plan officials. Thus, the reference to plan administrators should be deleted, and readers should be directed solely to the governmental sources listed in the regulation's model language.

5. Elimination of a non-essential health benefit should not result in the loss of a plan's grandfather status. Further, loss of grandfather status should not be linked to the elimination of a "necessary element" to diagnose or treat a condition.

Section 147.140(g) of the regulation describes the changes that would cause a plan to lose grandfather status. One of these is the elimination of all or substantially all benefits to diagnose or treat a particular condition. The regulation goes on to specify that the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition.

We have two concerns with this requirement. First, it goes well beyond the basic thrust of PPACA, which, when fully implemented, will not require any health plans to provide benefits that are not "essential" health benefits. (Group health plans provided outside of the exchanges will not be required to provide any specified health benefits, essential or not. A regulatory definition of essential health benefits has not yet been provided.) Under the Departments' interim and final regulation addressing the PPACA provisions regarding preexisting condition exclusions, lifetime and annual dollar limits on benefits, rescissions, and patient protections, a group health plan is permitted to impose annual or lifetime limits on specific covered benefits that are not "essential" health benefits.

Under this grandfather regulation, however, a plan could lose its grandfather status because it ceased to provide coverage for a health condition that would not be considered to be an essential health benefit and that could be subject to annual and/or lifetime limits. This is an untenable requirement, one that could eventually force plans to curtail key health coverage in order to pay for benefits that are of much less significance to an individual's health and wellness. We recommend instead that,

similar to the treatment under the regulation governing permissible annual and lifetime limits, grandfather status be tied only to the elimination of an essential health benefit.

Second, we strongly urge that the portion of the regulation tying the elimination of a “necessary element” to diagnose or treat a condition to a loss of grandfather status be removed. There simply is no uniformly accepted method or procedure available for plans to use to determine what constitutes a “necessary element” to diagnose or treat a condition.⁶

6. Responses to the Departments’ request for comments on other changes that could lead to the loss of a plan’s grandfather status

Changes to plan structure such as switching from a health reimbursement account to major medical coverage or from an insured to a self-insured product

As we have stated above, we believe that plan sponsors should have maximum flexibility to design their benefits in the way that is most compatible with efficient and effective health coverage for both employees and their employers. If a plan sponsor were to shift from an insured product to a self-funded plan while making no plan changes that would otherwise cause it to lose grandfather status, we see no reason why a change in funding mechanism alone should result in a loss of grandfather status.

Changes to a plan’s provider network

Changes to a provider network outside of the plan sponsor’s control should not result in the loss of grandfather status. These would include providers leaving a network voluntarily due to illness, death, or retirement, as well as vendors eliminating providers from their networks. Changing a plan’s Third Party Administrator, which in and of itself does not cause a loss of grandfather status, generally entails some changes in a plan’s provider network; as these changes follow from the change in TPA, these network changes also should not invoke a loss of grandfather status.

Loss of status should not be geared to the “magnitude” of these network changes as this is primarily a relative concept; the loss of a major provider in a small town, for instance, while significant for participants in that town, would be of minimal importance to a plan covering thousands of employees on a nationwide basis.

⁶ A similar challenge is presented by the Departments’ regulation on preventive services, which requires non-grandfathered plans to provide certain evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. Even this seemingly simple requirement, based on an existing list, has led to innumerable difficult and as yet unanswered questions regarding the scope and duration of the services that must be provided.

Changes to a plan's prescription drug formulary

No changes to a plan's prescription drug formulary should result in a loss of grandfather status. Drug formularies are updated continually in an effort to provide plan participants with the best drugs, reflecting advances in medical research and updated safety concerns. Formulary management is a key component of a plan's ability to control cost and quality.

Other substantial change to overall benefit design

Again, we stress that plan sponsors should have maximum flexibility to design their benefits in the way that is most compatible with efficient and effective health coverage for both employees and their employers. If plan sponsors lose their ability to innovate and seek value in their benefit design, it is ultimately the employees who will suffer from higher costs and less appropriate benefits. Accordingly, we believe that grandfathered plans should be able to retain that status while making reasonable and appropriate changes that are responsive to the needs of participants and plan sponsors.

ERIC appreciates the opportunity to provide comments on the interim final regulation. If you have any questions concerning our comments, or if we can be of further assistance, please let us know.

Sincerely,

Gretchen K. Young
Senior Vice President, Health Policy