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| **From:** | Robin van Vliet |
| **To:** | E-OHPSCA1251.EBSA |
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| **Subject:** | OCIIO-9991-IFC - Comment on Interim Final Rules for Group Health Plans relating to Status as a Grandfathered Health Plan under PPACA |
| **Date:** | Wednesday, June 16, 2010 12:30:24 PM |

OCIIO-9991-IFC
Dept of Treasury: RIN 1545-BJ51
Dept of Labor: RIN 1210-AB42
Dept of HHS: RIN 0991-AB68
http://www.federalregister.gov/OFRUpload/OFRData/2010-14488_PI.pdf

I am an employee benefits broker and am trying to understand how to apply these regulations. I (and many of my colleagues in the industry) need further clarification. Hopefully these answers can be provided in the next round of guidance.

1. Please define "benefits package". It seems to mean any component coverage under an employer's entire Health & Welfare Plan that may be wrapped together under a single plan document but is not defined anywhere.
2. A "group health plan" (as defined by part 7 of ERISA) includes not only Medical Insurance/HMO plans, but also dental, vision, EAP, FSAs and HRAs. How is an employer or insurance company supposed to apply all of the PPACA provisions to these "benefit packages". It creates a tremendous reporting, testing and financial burden, and does nothing to address the core issue that PPACA was designed to address, which was access and affordability of medical and prescription drug insurance. In order to reduce the burden on employers and simplify the implementation of PPACA, I would suggest narrowing the scope of PPACA to medical and prescription drug plans, and excluding dental, vision, FSA and EAP plans, regardless of whether they are a component of the medical plan or can be elected by the employee standalone from their medical coverage.

3. I have the following examples and would like to know if the change would impact grandfathered status:

a) Changes to Plan components (5500): An employer has several divisions and offers various benefit packages based on which division the employee is employed in. They are currently all wrapped together and reported under their "501" plan for ERISA purposes. Scenario 1: The employer wants to separate the divisions into entirely distinct plan documents, thus creating a 501, 502 and 503 plan. The benefits packages otherwise remain the same and employees remain consistently enrolled. Have they lost their grandfathered status? Scenario 2: They acquired another company and want to include their current benefit package under their main plan (501). They will not be changing their medical and dental benefits package, but newly acquired employees will be going on the same Vision, Life and Disability benefits as the parent company. Have they lost grandfathered status?

b) Changes to contributions: An employer currently provides medical benefits with a 10% employee contribution. For 2012 plan year, they have informed employees that they can keep this 10% contribution if they participate in the voluntary wellness program*. If they do not participate, their contributions will increase 30% to 40% of premium. Have they lost grandfathered status?
*(*Note: Assuming that this scenario would be acceptable, we may need guidance from the CDC and ADA/EEOC regarding what an acceptable wellness program would be in this scenario so that it is not overly burdensome, e.g. participation only is required not achievement of any health standard.)*

c) Changes to deductible: An employer currently has a $500 deductible in network, with a $2,500 out of pocket maximum (total out of pocket risk: $3,000). For 2011 they want to implement a

HDHP with a $1,500 deductible for employee only with a $4,000 out of pocket maximum (total out of pocket risk $4,000). The employer will contribute $600 to the employee's H.S.A. automatically, and will contribute another $400 if they complete a Health Risk Appraisal and Biometric Screening, thus reducing out of pocket exposure to $3,000 plus now employees can carryover any unspent funds. Have they lost grandfathered status?

d) Changes in contributions: In 2010, Employer H provides a 'cafeteria' style benefits contribution of $10,000 per year towards benefits. An employee can elect to purchase any tier of benefits they choose, but any amount above $10,000 per year is taken pre-tax from their paycheck. In 2010 most employees are covered as "Employee Only" and this $10,000 is covering nearly 100% of all of their benefits elections for medical, dental, and vision. In 2011, a large nearby employer shuts down its factory and the families of employees from Employer H are now added to Employer H's plan, nearly doubling the total premiums for the current year. Employer H's renewal is 20%, so for 2011 the total annual premiums are 150% of what they were in January 2010. How does Employer H calculate it's contribution for 2011?

I appreciate your consideration of these comments and questions.
Sincerely
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