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August 16, 2010

VIA E-MAIL: *e-ohpsca1251.ebsa@dol.gov*

U.S. Department of Labor
200 Constitution Ave., NW
Washington, DC 20210

Re: RIN 1210-AB42 / grandfathered health plans

Dear Sir or Madam:

We appreciate the opportunity to comment on the proposed regulations relating to the status of a group health plan as a grandfathered health plan under the Patient Protection and Affordable Care Act ("PPACA"). These comments are based on direct communications with employers which sponsor health plans, many of them self-insured, in various industries. Employers are concerned that the proposed regulations add unnecessarily to the costs which they share with their insured employees. They note that each additional dollar that is spent for additional mandates will be diverted from business and household needs.

We request that the final regulations:

1. Adopt a less stringent approach to defining the events which cause a health plan to lose grandfathered status.

2. Make clear that changes which were announced prior to March 23, 2010 and subsequently implemented will not jeopardize grandfathered status, even if not yet contained in a formal plan amendment.

3. Clarify the special transition relief for plans which implemented disqualifying changes during the period from March 23 – June 14, and provide additional relief for changes made in that period.

Our reasons for these requested changes appear below.

1. The final regulations should be less strict in defining events which cause a plan to lose grandfathered status.

The view of regulators seems to be that the incremental cost to provide non-grandfathered benefits is not that much compared with the entire cost of a plan, and is therefore inconsequential. Regulators

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have been candid that they expect most plans to lose grandfathered status within the next few years due to the structure of these proposed regulations. We disagree with this *a la carte* analysis which disregards the totality of plan costs. Adding another 2% or more for additional benefits if a plan is not grandfathered just makes health insurance less affordable.[1] And a regulatory decision to disqualify plans from grandfathering for even modest changes is at odds with the statute and with the public statements which were made during the long campaign prior to its enactment.

Section 1251(a)(2) of PPACA – Preservation of Right to Maintain Existing Coverage – is brief and clear:

> *"CONTINUATION OF COVERAGE. With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment."*

Contrary to the proposed regulations, the statute does not say that amendments or changes to a plan cause it to lose grandfathered coverage. Congress has had plenty of experience in drafting ERISA and Code statutes where amendments to a plan cause it to lose protected status. This statute does not provide that. Instead, it says that a plan which was in existence prior to enactment does not have to be changed, except for changes which apply to all plans regardless of grandfathering.

The proposed regulations do what Congress did not. Even minor changes, such as a change in insurance carrier, modest adjustments to co-pays, a shift in premium sharing of more than 5% since March 23, 2010, and any shift in co-insurance, trigger a full menu of non-grandfathered mandates. We respectfully request that the final regulations get closer to the statute's clear language. Plans which were in existence prior to enactment should be allowed to continue without losing grandfathered status unless there is a major change in covered procedures, or a major shift in cost-sharing. The hair-trigger adjustments in the proposed regulations are not authorized by the statute.

However, if it is deemed appropriate to have some bright line rules, they should not deprive a plan from changing insurers, or from converting to self-insured status, or from raising the cost of co-pays and deductibles beyond the meager allotment in the proposed regulations. Most importantly, plans should be allowed to increase the premium share of employees by more than five (5) percentage points from the level in effect on March 23, 2010. Changes such as these, which have probably occurred many times in a plan's existence, should not deprive a plan of grandfathered status without some suggestion in the statute that this is what Congress intended. The debates preceding enactment, the statute, and its scant legislative history contain no suggestion that minor changes in cost structure would trigger loss of grandfather status.

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[1] Bear in mind the substantial additional costs which all plans – grandfathered or not - must incur under the amended Public Health Services Act ("PHS"), including PHS Act Sections 2708, 2711, 2712, 2714, 2715, 2718.

In addition to the legal argument that these proposed regulations exceeds the authority of the rule-making agencies, there is also the common sense argument that unfunded mandates created by regulatory authorities do not help employers or employees. Increasing an employee's share of costs may actually be the only way for a plan to preserve a benefit package. The alternative, for self-insured employers which need to cope in a bad economy, may be to concede to grandfathering, and then to remove coverage which is not mandated by federal law and which is exempt from state mandates, such as mental health coverage. Do employees win in that scenario? There is no credible evidence that insured employees have been asking for the additional protections of non-grandfathered status, especially if they have to bear some or all of the cost. In sum, the proposed regulations remove the promised right that PPACA would not take away coverage under existing plans.

2. Changes which were announced prior to March 23, 2010 should not jeopardize grandfathered status, provided that plan amendments are executed promptly.

It is not unusual for plan sponsors to announce changes in premium and cost sharing prior to making changes to a plan document.[2] This form of notification is usually by clear written notice, and prior to the actual reduction from employee paychecks (in the case of premium sharing) and prior to the additional billing (in the case of coinsurance, co-pays, and deductibles).

Unfortunately, the proposed regulations require that an amendment to a plan must also have been adopted by March 23, 2010. We suggest an additional paragraph D to that portion of the regulation which deals with determining whether such changes may be considered to be plan provisions as of March 23, 2010. As amended, the provision would read:

> The following changes are considered to be plan provisions as of March 23, 2010:
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> A) Changes effective after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010;
> B) Changes effective after March 23, 2010 pursuant to a filing on or before March 23, 2010 with a State insurance department; or
> C) Changes effective after March 23, 2010 pursuant to written amendments to a plan that were adopted on or before March 23, 2010.
> ***D) Changes communicated in writing to participating employees prior to March 23, 2010, provided that the plan is amended no later than the first day of the plan year commencing on or after September 23, 2010.***

This modification of the proposed regulation would allow all parties to proceed under plan designs that were clearly in effect as of March 23, 2010, but simply not yet reduced to the terms of a plan amendment.

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[2] In fact, there are probably thousands of health plans which do not even have a "plan document," but simply provide benefit booklets, certificates of coverage, and the like.

3. Clarify the transition relief for plans which implemented disqualifying changes during the period from March 23 – June 14, and provide additional relief for changes made in that period.

The transition rule in the proposed regulations is meant to assist plans which implemented disqualifying changes (i.e. changes which would cause a health plan to lose grandfathered status) during the period between enactment and the date the proposed regulations were first available to the public. Depending on how it is interpreted, the transition rule may not give adequate time for some plans to act to preserve grandfathered status.

As indicated earlier in this letter, it would be better if the regulations did not penalize employers at all for relatively minor plan changes after enactment. At a minimum, there should be more protection for employers which implemented changes prior to June 14 unless the changes were so drastic as to be unreasonable. This would eliminate the need for many plans to go through an expensive remedial process of calculating amounts necessary for refund (if a change in co-pay exceeded the limits of the proposed regulations, for example).

Clarification is also needed. What does it mean to revoke or modify a change as of the effective date of the first plan year starting on or after September 23, 2010? Do employee refunds actually have to be processed by that date? Does each affected employee have to be notified of the precise amount of the adjustment? This is a virtually impossible task for those unlucky plans with fiscal years starting in October, November, December, and even January. It would be more reasonable to require: (1) that a blanket notice be issued to all participants no later than December 31, 2010, and (2) that refunds should be processed no later than the end of the first PPACA plan year.

In conclusion, we hope you will consider these comments when you finalize the regulations. We appreciate that you were working under tight deadlines, and we ask that you consider the extraordinary pressure this law places on employers which would like to provide good health insurance but which do not have unlimited resources to do that.

Very truly yours,

George L. Chimento

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Enclosure