The Connecticut Coalition of Taft-Hartley Health Funds, Inc.

Making Quality Health Care Affordable

Member Health Funds

Bricklayers Local 1 CT

Connecticut Carpenters

Connecticut Pipe Trades

Electrical Workers Local 35

Electrical Workers Local 90

Heat & Frost Insulators & Asbestos Workers Local 33 CT

Iron Workers Local 15 & 424

NE Health Care Employees District 1199, SEIU

Operating Engineers Local 478

Painters & Allied Trades District Council 11

Plumbers & Steamfitters Local 131

Rooters Local 9

Roofers Local 12

Sheet Metal Workers Local 40

Southern CT IBEW

August 6, 2010

Via United States Mail
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

ATTN: RIN 1210-AB42
RIN 1210-AB43

Re: Comments regarding Interim Final Rules for: (1) Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; and (2) Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers … Relating to … Lifetime and Annual Limits ….

Dear Sir and/or Madam:

I am the Executive Director of The Connecticut Coalition of Taft-Hartley Health Funds, Inc. ("Coalition"), and with assistance from the Coalition's legal counsel, I have prepared this letter to provide you with the Coalition's comments to the above-noted regulations. Before I do so in Section II, I want to briefly share some background information regarding the Coalition, its members, and myself in Section I so that you can understand the basis for these comments.

I. Background Information

The Coalition is a non-stock membership corporation under Connecticut law, and it is operated on a "not-for-profit" basis. The Coalition was incorporated in 1992, and the Internal Revenue Service has confirmed that the Coalition is a tax-exempt organization under Section 501(c)(6) of the Internal Revenue Code of 1986 (the "Code"). In general, the Coalition's members are tax-exempt, multiemployer health and welfare funds which are governed by various federal laws, including the Code, the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and the Taft-Hartley Act of 1947, as amended (Taft-Hartley"). Each of these Coalition member funds has an affiliation with a

Robert F. Tessier, Executive Director
(860) 249-6100 • (fax) 249-6500
www.ctcoalition.org
[illegible]alition.org

Mailing Address
P.O. Box 231443 • Hartford, CT 06123

Street Address
942 Main Street • Hartford, CT 06103

specific labor union, and each is normally tax-exempt under Code §501(c)(9) as a "voluntary employees' beneficiary association" or VEBA.

The Coalition currently has fifteen member health funds covering Connecticut residents. I would estimate that the Coalition member funds, and other similar funds in Connecticut, provide health benefit coverage to approximately 200,000 total covered lives in the state, consisting of eligible active employees, retired individuals and their eligible dependents (hereinafter "covered individuals"). Coalition member funds provide comprehensive health and welfare benefits (e.g., life insurance, weekly disability and scholarship benefits) to their covered individuals, and they spend nearly $200 million annually on medical, prescription drug, and other benefit payments.

Coalition member funds are established, maintained and funded pursuant to the terms of collective bargaining agreements ("CBAs") negotiated by the sponsoring unions and respective employers and/or employer groups. The individual health funds are independently managed and the plan of benefits for each fund is established by a Board of Trustees. Currently, all Coalition member funds provide benefits on a "self-insured" basis (i.e., directly from trust fund assets), although some member funds do maintain stop-loss insurance policies and/or may provide a life-insurance benefit funded via an insurance policy. These not-for-profit health funds are unique in the health care marketplace in that they are both payor and consumer. Also, as these funds are governed by ERISA, they exist for the 'sole and exclusive benefit" of the covered individuals, and my experience is that when the funds are able to achieve savings, those savings are returned to the covered individuals in the form of increased or improved benefits.

On a personal level, I have extensive experience with labor unions and their associated employee benefits plans. Prior to becoming the Coalition's Executive Director in January of 2008, I was the plan administrator of two distinct Connecticut-based multiemployer pension and welfare benefit funds for a total of thirteen years. I was also the Coalition's President from 2000 through 2007.

II. Comments

One of the Coalition's primary tax-exempt purposes is: "[t]o promote the financially sound continued long term survival of Taft-Hartley health funds.[1] Based on our review of the Interim Final Regulations ("IFRs") with respect to status as a grandfathered health plan issued on June 17, 2010, the Coalition believes that the rules contained in the IFRs could possibly lead to the termination, or significant restructuring, of one or more Coalition member funds. The primary issues, dealing with the rules governing "grandfathered health plans," are described below in subsections B, 1 and B, 2, after a brief outline of the relevant statutory rules in subsection A. The Coalition also comments on the recently issued IFRs (issued on June 28, 2010) regarding lifetime and annual limits in subsection B, 3, below.

A. Discussion of statutory rules

A critical point in the health care debate was President Obama's promise that people who liked their current health care coverage would be permitted to keep it. Indeed, the White

House's web site stated: "If You Like the Insurance You Have, Keep It: Nothing in the proposal forces anyone to change the insurance they have. Period."[1]

This broad principle was reflected in Section 1251(a) (entitled "preservation of right to maintain existing coverage") of the Patient Protection and Affordable Care Act ("PPACA"). In general, group health plans, including those maintained pursuant to CBAs, which were in effect on the date of PPACA's enactment (March 23, 2010) are exempt from some, but not all of the health care reforms under PPACA.[2] Such plans are known as "grandfathered health plans" under PPACA §1251(e).

With respect to the effect of the above rules on grandfathered health plans which involve collective bargaining agreements, section 1251(d) of PPACA provides:

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1 The specific web address is: http://www.whitehouse.gov/health-care-meeting/proposal/titlei/keepit.

2 PPACA §1251(a), as amended by the Health Care and Education Reconciliation Act of 2010, provides:

'(1) IN GENERAL. Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.

(2) CONTINUATION OF COVERAGE. Except as provided in paragraph (3), 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.

(3) APPLICATION OF CERTAIN PROVISIONS. The provisions of sections 2715 and 2718 of the Public Health Services Act (as added by subtitle A) shall apply to grandfathered health plans for plan years beginning on or after the date of enactment of this Act.

(4) APPLICATION OF CERTAIN PROVISIONS.

(A) IN GENERAL. The following provisions of the Public Health Services Act (as added by this title) shall apply to grandfathered health plans for plan years beginning with the first plan year to which such provisions would otherwise apply:

(i) Section 2708 (those relating to excessive waiting periods).

(ii) Those provisions of 2711 relating to lifetime limits.

(iii) Section 2712 (relating to rescissions).

(iv) Section 2714 (relating to extension of dependent coverage).

(B) PROVISIONS APPLICABLE ONLY TO GROUP HEALTH PLANS.

(i) PROVISIONS DESCRIBED. Those provisions of section 2711 relating to annual limits and the provisions of section 2704 (relating to pre-existing condition exclusions) of the Public Health Services Act (as added by this subtitle) shall apply to grandfathered health plans that are group health plans for plan years beginning with the first plan year to which such provisions otherwise apply.

(ii) ADULT CHILD COVERAGE. For plan years beginning before January 1, 2014, the provisions of section 2714 of the Public Health Services Act (as added by this subtitle) shall apply in the case of an adult child with respect to a grandfathered health plan that is a group health plan only if such adult child is eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2) of the Internal Revenue Code of 1986) other than such grandfathered health plan."

[i]n the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements ... that was ratified before the date of enactment of this Act [March 23, 2010], the provisions of this subtitle [subtitle C] and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates....

B. Interpretations in the IFRs; Analysis

1. *Use of term "health insurance coverage" versus "group health plan."*

Section II, E of the IFRs relating to status as a grandfathered health plan seizes a particular passage of the statutory language noted directly above, specifically the term "health insurance coverage," to conclude that because the statutory language fails to refer to a "group health plan," the exception in PPACA §1251(d) applies: "... only to insured plans maintained pursuant to a collective bargaining agreement and not to self-insured plans." This same analysis is reflected in the Department of Labor's proposed regulation, specifically, 29 C.F.R. §2590.715-1251(f)(1).

While we agree that the definition of health insurance coverage (through PPACA §1301(b)(2) and section 2791(b) of the Public Health Service Act, 42 U.S.C. §300gg-91(b)), governs coverage offered by a health insurance issuer (which is generally an insurance company and not a group health plan), the Department of Labor's interpretation of PPACA §1251(d) essentially ignores the concepts in PPACA §1251(a)(1) and (2), which permit individuals in group health plans and covered by health insurance coverage to maintain the coverage they have. As noted earlier, all of the Coalition's member funds, which are governed by CBAs, provide health benefits on a self-insured, and probably more prudent, basis. We also believe that the vast majority of Taft-Hartley plans throughout the United States which are governed by CBAs provide health benefits on a self-insured basis. As a result of the interpretation above:

a. those few Boards of Trustees of Taft-Hartley plans which chose to provide health benefits prior to March 23, 2010 solely through a "health insurance issuer" (i.e., an insurance company) are rewarded with grandfathered health plan status guaranteed through the end of their current CBA term, and

b. the remaining majority of Boards of Trustees of Taft-Hartley plans which chose to provide health benefits prior to March 23, 2010 on a self-funded basis initially have grandfathered status, but are subject to all of the other rules of the IFRs, which could cause such a plan to lose grandfathered status in the event a specific event occurs (e.g., those events noted in 29 C.F.R. §2590.715-1251(g)).

Such disparate treatment, based solely on whether health benefits are provided directly through an insurance company or via self-insurance, simply defies logic and common sense. Moreover, such an interpretation, while admittedly viable, essentially means that the entire statutory

exception in PPACA §1251(d) will apply to a small handful of fully-insured collectively bargained plans.

Another extremely serious issue is that the Department of Labor's interpretation runs counter to all previous federal legislation with respect to plans governed by CBAs. As we are sure you know, federal legislation which has imposed new benefit requirements on collectively bargained retirement plans and/or collectively bargained group health plans has always included a delayed effective date (e.g., ERISA, HIPAA, the Mental Health Parity and Addiction Equity Act, etc.). Congress has consistently respected the fact that finalized CBAs address a multitude of topics, including wages and benefits, at a set point in time, and that when new legislation imposes additional mandates the collective bargaining parties need time to analyze the changes and then negotiate with respect to those mandates. It is unrealistic and extremely burdensome to change the rules which apply to collectively bargained group health plans without giving them sufficient time to consider: (i) how, and whether it is even possible, to comply with the additional mandates <u>based on current employment, wage and benefit levels</u>, and (ii) other ways to pay for the additional mandates. We sincerely and strongly doubt that Congress would have intended the exception in PPACA §1251(d) to be so limited without extended debate and discussion on that point.

Moreover, ignoring this "black letter" rule means that self-insured group health plans maintained under CBAs are left to scramble to comply with the provisions of the PPACA with little or no time to spare (as some of the PPACA's provisions apply to grandfathered health plans beginning with plan years commencing on and after September 23, 2010). For such a group health plan that is maintained under a single collective bargaining agreement, it <u>may</u> be possible for the bargaining parties to negotiate over the costs and requirements of the PPACA, but for those group health plans which have multiple bargaining agreements (some into the hundreds!) each agreement would have to be bargained and coordinated separately. As an example, the Coalition is aware of a particular Connecticut union which completed its collective bargaining agreement negotiations with its largest contributing employer in early March of 2010, prior to the adoption of the PPACA. Under that collective bargaining agreement, a group health plan is maintained which provides health benefits on a self-insured basis. While this group health plan provides coverage for full-time employees, it also provides coverage for eligible part-time employees, subject to specific annual limits. With the passage of the PPACA and the impact of these IFRs, the collective bargaining parties are forced to either renegotiate an agreement which they just completed five months ago, or significantly cut back or eliminate the coverage for part-time employees so as to comply with other interim final rules which apply to grandfathered health plans with respect to lifetime and annual limits. In short, such a plan is essentially left in a no-win situation, and the entire legal structure of the plan of benefits is now in jeopardy. The Coalition will comment further on this plan in paragraph 3, below.

2. *Effect of "grandfathered health plan" status under PPACA §1251(d).*

Without providing much substantive analysis, Section II, E of the IFRs relating to status as a grandfathered health plan also concludes that, "... collectively bargained plans (both insured and self-insured) that are grandfathered plans are subject to the same requirements as other grandfathered health plans, and are not provided with a delayed effective date for PHS Act provisions with which other grandfathered health plans must comply." The Department

reaches this conclusion despite the language of PPACA §1251(d) which provides, "... the provisions of this subtitle [subtitle C] and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements relating to coverage terminates..." (emphasis added).

While this is a very complicated issue, we believe the Department of Labor has concluded that the exception in PPACA §1251(d) is very limited, in that it only provides an insured collectively bargained plan with "grandfathered health plan" status through the end of its CBA. Such a rule is reflected in the proposed regulation, 29 C.F.R. §2590.715-1251(f)(1). However, the specific language of PPACA §1251(d) appears to provide insured plans which are maintained pursuant to collective bargaining agreements with a complete exemption from the rules of PPACA subtitles C and A until the date the applicable CBA expires. The Department should clarify how it reached this conclusion in light of the PPACA's express statutory language.

In connection with our comments in paragraphs 1 and this paragraph 2, the Coalition respectfully requests that the Department modify the IFRs in light of the issues discussed to provide a complete exemption from the rules of PPACA subtitles C and A for all collectively bargained group health plans (both insured and self-insured) until the date on which the last of the CBAs relating to coverage under the applicable group health plan terminates. Such a result would be fair and equitable, and would be in line with the long-established policy to provide collectively bargained plans with a delayed effective date.

3. *Interaction between the IFRs governing grandfathered status and those governing annual and lifetime limits.*

The Coalition also wishes to comment on the IFRs which were issued on June 28, 2010, particularly those provisions governing lifetime and annual limits. These IFRs generally prohibit group health plans from imposing lifetime or annual limits on the dollar value of certain "essential health benefits." Essential health benefits are defined in PPACA §1302(b), and they include emergency services, hospitalization and prescription drugs, to name just a few. These rules restricting lifetime and annual limits apply to group health plans (whether or not such plan qualifies as a grandfathered health plan) for plan years beginning on or after September 23, 2010, although we do acknowledge that the proposed regulation, 29 C.F.R. §2590.715-2711, has a "transition period" for annual limits in plan years prior to January 1, 2014. Here is a simple chart which contains permitted annual limit "floors" during the transition period:

Applicable Plan Year	Permitted annual limit "floor" on essential health benefits
Plan Year beginning on or after September 23, 2010, but before September 23, 2011	$750,000
Plan Year beginning on or after September 23, 2011, but before September 23, 2012	$1,250,000

Plan Year beginning on or after September 23, 2012, but before January 1, 2014	$2,000,000

Specifically, the Coalition believes that the operation of the IFRs governing grandfathered health plans and those governing lifetime and annual limits, when taken together, will operate to cripple self-insured group health plans maintained pursuant to CBAs which: (i) provide different tiers of coverage to part-time employees and full-time employees, and/or (ii) cover employees in low-wage industries. We note that these IFRs are silent on the issue of coverage for part-time employees, and while the transition period for annual limits is certainly helpful, the IFRs do not seriously consider the impact these new rules will have on group health plans maintained pursuant to CBAs. Even though most employers do not provide health coverage to part-time or low-wage employees, a significant number of self-insured group health plans maintained pursuant to CBAs do. As you would expect, the level of benefits provided under such group health plans to eligible part-time or low-wage employees is commensurate with the contribution level required under the relevant CBA, and are often subject to reduced annual and lifetime limits.

While the Coalition absolutely agrees with the goal of providing quality and affordable health care for all Americans, the Department must acknowledge that it is unrealistic and highly impractical for self-insured group health plans maintained pursuant to CBAs which provide coverage to part-time and/or low-wage employees to put in place a minimum floor of $750,000 for essential health benefits for the plan year commencing on or after September 23, 2010 (or for subsequent plan years as well). The Coalition sincerely doubts that any current level of contributions under a CBA for a part-time or low-wage employee could support a minimum floor of $750,000 for essential health benefits or the rising floors in later years.

As a concrete example, consider the same plan as mentioned in subsection B, 1, above (which is a self-insured group health plan maintained pursuant to CBAs which provides different tiers of coverage for full-time employees and part-time employees). It is our understanding that the plan of benefits provided to the part-time employees has an annual limit on "essential health benefits" which will not comply with the $750,000 floor for the plan year commencing on or after September 23, 2010, but before September 23, 2011. Accordingly, the plan is immediately faced with a choice of either violating PPACA §2711, and through it, ERISA (by leaving the plan as it is and not providing the minimum annual limit of $750,000) <u>or</u> taking action so as to lose its status as a grandfathered health plan (i.e., as to part-time employees, by eliminating coverage or specific benefits to mitigate costs).[3] For a Coalition member fund such as this which has a calendar year plan year, such decisions need to be made no later than January 1, 2011, <u>irrespective of the terms of that plan's CBAs</u>. With little or no time to bargain over the plan of benefits offered to the part-time employees, and the clear cost of eliminating any annual limit on part-time employees prohibitive, the Coalition expects the ultimate result will be this plan eliminating coverage for part-time employees. Such a result will also significantly undermine the plan's ability to provide quality health care benefits to its full-time

[3] Since this plan is self-insured and does not utilize "health insurance coverage" (i.e., the Department of Labor has concluded that PPACA §1251(d) would not apply) it can only maintain its grandfathered health plan status if it complies with the general grandfathering rules of 29 C.F.R. §2590.715-1251(g).

members. The Coalition does acknowledge here that there is "waiver" authority with respect to these annual limits for plan years beginning before January 1, 2014 under 29 C.F.R. §2590.715-2711(d)(3), but regulations implementing this waiver process have not been issued and time is running dangerously short.

Another important point to mention is that the state "exchanges" required by the PPACA will not be coming on-line until 2014 (per PPACA §1321(b)). Therefore, the Coalition expects these and other similar part-time and low-wage employees to lose the health coverage they have, and such employees will have no other health coverage options. Faced with the option of such employees having some level of health coverage, as opposed to no health coverage, the Department should respect the previous decisions of such group health plans, their Boards of Trustees, and their professionals, and permit them to retain any annual and/or lifetime limits they had in effect as of the date of issuance of this IFR (June 28, 2010) through the date the state exchanges are up and running in 2014. Such a decision will, at the very least, allow such part-time and low-wage employees to maintain some health care coverage until they have other PPACA-mandated health coverage choices available to them. It will also be keeping with President Obama's promise to let employees keep the coverage they have.

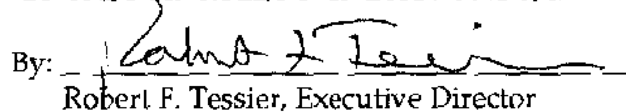
Finally, the Coalition respectfully requests that the Department modify these IFRs for self-insured group health plans maintained pursuant to collective bargaining agreements which: (i) provide different tiers of coverage to part-time employees and full-time employees, and/or (ii) cover employees in low-wage industries, and permit such plans to retain any annual and/or lifetime limits they had in effect as of June 28, 2010 through the date the state exchanges mandated by the PPACA are up and running in 2014.[4]

III. Conclusion

We hope these comments and the above example provide some insight to the issues and difficulties faced by Coalition member funds (and other self-insured group health plans which are maintained pursuant to CBAs) in connection with the IFRs governing grandfathered health plans, as well as those governing lifetime and annual limits. If you have any questions, you may contact me at 860-249-6100.

Sincerely yours,

THE CONNECTICUT COALITION
OF TAFT-HARTLEY HEALTH FUNDS, INC.

By: 
Robert F. Tessier, Executive Director

cc: Coalition Legal Counsel

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4 While the Department could certainly utilize its discretion to grant expedited and liberal waivers to such self-insured group health plans under 29 C.F.R. §2590.715-2711(d)(3), the Coalition believes an express modification to the IFRs will be more efficient.