American Federation of Labor and Congress of Industrial Organizations

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Submitted via email to: E-OHPSCA1251.EBSA@dol.gov

August 16, 2010

Office of Health Plan Standards
and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Attention: RIN 1210-AB42

Re: Interim Final Rule on Status as a Grandfathered Health Plan
Docket ID EBSA-2010-0014-0001
RIN 1210-AB42

Ladies and Gentlemen:

These comments are submitted on behalf of the AFL-CIO and its 57 affiliated unions in response to the Interim Final Rule on Status as a Grandfathered Health Plan ("Rule") issued jointly by the Department of the Labor, Department of Treasury, and Department of Health and Human Services (the "Departments") on June 17, 2010.[1] Together with its community affiliate, Working America, the AFL-CIO represents more than 11 million workers. Collectively, our unions negotiate health benefits for almost 40 million workers, retirees and their family members.

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1 The Interim Final Rule is at 75 Fed. Reg. 34538 (June 17, 2010).

The AFL-CIO, its affiliates, allied organizations and members have worked for decades to reform our health care system. We were pleased to help gain passage of the Patient Protection and Affordable Care Act and the Health Care and Education and Reconciliation Act of 2010 (together, the "Affordable Care Act" or "Act"), legislation that makes progress toward quality, affordable health care for all.

The Rule provides much-needed guidance to unions, employers and plan sponsors on the scope of changes that may be made to existing plans before their status as grandfathered plans ends. We applaud the Departments' speedy release of the Rule, as well as the other interim final rules on the reforms that become effective with the first plan year beginning on and after September 23, 2010.

As we discuss below, there are a number of areas where additional guidance or clarification from the Departments would be helpful to unions and plans as statutory reforms are implemented and modifications are made to existing benefit programs. In addition, our comments respond to the Departments' solicitation in the preamble on whether other plan changes should result in the cessation of grandfathered status. *See* 75 Fed. Reg. at 34544.

Definition of Benefit Package (29 CFR §2590.715-1251(a))

Under the Rule, each "benefit package" under a plan is considered separately in determining its status as grandfathered health plan coverage. 29 CFR §2590.715-1251(a)(1)(i). However, there is no definition of "benefit package," and we urge the Departments to provide one. It would be particularly helpful to specify what differences among coverage option features lead to the establishment of separate "benefit packages."

While the examples included in the Rule provide some illustrations of the term, they do not address all the possible variations in features that may distinguish one option available under a plan from another. The examples indicate that how an option is funded matters.[2] Although it is not clear, it may be that options covering different participant groups are also separate benefit packages.[3] However, none of the examples tell us whether benefit and cost-sharing differences among options result in different benefit packages.

Other regulations issued under Part 7 of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA) also use the term benefit package (or benefit package option), but like the Rule, they too provide only illustrations without ever defining the term. In the special enrollment regulations, a plan with an HMO option and an indemnity option is considered to have two benefit packages. 29 CFR §2590.701-6(a)(2)(iii), Example 4. These regulations also note that, for special enrollment purposes, differences in benefits or cost-sharing requirements are considered different benefit packages. 29 CFR §2590.701-6(d).

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[2] Example 2 in 29 CFR §2590.715-1251(a)(5) addresses a change in issuer for one of two insured options under a plan. The change causes that insured option to cease being grandfathered health plan coverage, the status of the remaining options, one insured and one self-insured would be separately determined based on any changes made to those benefit packages.

[3] The plan in Example 3 in 29 CFR §2590.715-1251(b)(3) includes two options, one of which covers only a single plant. No other distinguishing features between the two options are noted, such as their funding, which suggests eligibility rules may be a factor in determining whether there is more than one benefit package.

The recently issued interim final rules on covering children to age 26 and annual and lifetime limits each provide special enrollment opportunities using language similar to the original special enrollment regulations. Under each of these rules,[4] the individual treated as a special enrollee

> ... must be offered all the benefit packages available to similarly situated individuals who did not lose coverage .... For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package.

29 CFR §2590.715-2714(f)(4) and 29 CFR §2590.715-2711(e)(4).

The examples provided in the Rule and other regulations are useful but provide only incomplete guidance. It is important to know what constitutes a benefit package under a plan since grandfathered status determinations are made on a benefit package basis and the scope of the benefits that must be provided to participants under the Act depend on grandfathered status.

Participation of New Employers in Multiemployer Plans (29 CFR §2590.715-1251(b))

Section 1251 of the Act and the Rule clearly permit grandfathered group health plan to cover new employees without affecting its grandfathered status. We believe this provision clearly permits an existing multiemployer plan to cover the employees of an employer who first agrees to make contributions to the plan after March 23, 2010. But, to avoid any issue, we recommend that the Departments clarify the Rule to explicitly provide that the addition, after March 23, 2010, of new contributing employers or new groups of employees of an employer who was already contributing does not affect a multiemployer plan's status as a grandfathered health plan.

Changes Causing Cessation of Grandfathered Status (29 CFR §2590.715-1251(g)(1))

Paragraph (g)(1) details what changes to a plan (or benefit package) will end its status as a grandfathered health plan. The Rule, in our view, appropriately focuses on the impact that any change has on plan participants and the standards provide clear, generally objective measurements. However, we do have some concerns about several aspects of the Rule and some suggested changes as discussed below.

Dental and Vision Benefits

In the preamble to the Rule, the Departments make clear the new benefit reforms under ERISA Section 715 do not apply to plans and benefits that are exempt under ERISA Section 732. 75 Fed. Reg. at 34539-34540. This clarification of the Act provides helpful guidance, but it also

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[4] Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 27122 (May 13, 2010) and Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37166 (June 28, 2010).

leads to an inequitable result with respect to changes affecting the maintenance of grandfathered plan status.

For the most part, any self-insured dental and vision benefits included in health care coverage negotiated by our affiliates or provided under multiemployer plans are not structured to satisfy the excepted benefits standards in the existing regulations. Participants do not make separate elections, make additional contributions or pay an additional premium for dental or vision coverage. As a result, changes in cost-sharing or co-payments for dental and vision coverage that exceed the permissible ranges under paragraph (g)(1) of the Rule could end the grandfathered status of the plan even if no changes (or only permitted changes) are made to core medical benefits.

Because dental and vision benefits that are excepted benefits are exempt, changes may be made to them without affecting the grandfathered status of the plan providing core health care benefits even though the impact on participants is identical—they will incur increased costs.

In order to assure that decisions previously made about how to structure dental and vision benefits do not control the maintenance of grandfathered status, the Departments should consider excluding changes to dental and vision benefits in determining the grandfathered status of a plan.

Decrease in Contribution Rate Based on a Formula

The Rule currently provides that a decrease of more than 5 percentage points in the employer's contribution rate towards the cost of any tier of coverage will result in the cessation of grandfathered status for the affected plan. In its definition of contribution rate, the Rule recognizes two methods, one based on the cost of coverage and the other based on a formula, such as hours worked.

The definition of "contribution rate based on a formula" reflects the classic funding mechanism for a multiemployer plan. Contributions to these plans are most typically made on the basis of hours worked by, or paid to, participants. But, changes in the contribution rate do not necessarily result in any benefit changes or increased contributions by participants to the cost of health care coverage. In these circumstances, it would not be appropriate for a decrease in the contribution rate to affect the grandfathered status of the plan.

To address this concern, we suggest that the Departments modify the language in the Rule to make clear that changes in the formula for, or the amount of, the employer contribution to a multiemployer plan do not, by themselves, affect the grandfathered status of the plan. Of course, should these changes result in benefit modifications or cost-sharing increases, then the grandfathered status of the plan would be determined under the other rules in paragraph (g)(1).

Other Changes

In the preamble to the Rule, the Departments invited comments on whether certain other changes should result in cessation of grandfathered health plan status and our responses to two of those questions is below.

- *Changes to Plan Structure*

  Changes in plan structure that restrict participants' access to care by limiting available facilities and providers should end grandfathered health plan status. One example of this type of benefit delivery change is moving from an indemnity arrangement to a PPO network or an HMO. However, changing from an insured to a self-insured arrangement should not, by itself, result in the cessation of grandfathered plan status. If the change reduces the benefits covered or increases participants' financial responsibility, then grandfathered status should end.

- *Changes to a Network Plan's Provider Network*

  Changes in the provider network should affect grandfathered plan status only if there is a substantial decrease in the providers available.

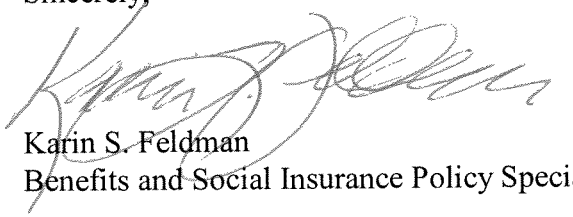
Transitional Rules 29 CFR §2590.715-1251(g)(2)

The transitional rules provided in paragraph (g)(2) of the Rule provide helpful guidance, particularly with respect to changes made before enactment of the Affordable Care Act but become effective thereafter. In many instances, collective bargaining agreements include modifications to health benefits coverage that become effective in the future and the negotiators of these agreements could not have anticipated the impact of benefit design decisions made before March 23, 2010.

It would be helpful, however, if the Departments clarified how the changes considered to be part of a plan under paragraph (g)(2)(i)[5] are treated in determining whether subsequent changes made to the grandfathered health plan exceed the standards under paragraph (g)(1). The Rule clearly states that these changes themselves do not affect grandfathered status. We suggest that it would be appropriate for the terms of the plan, as modified by these changes, to be treated as the baseline for determining whether other changes made after March 23, 2010 cause the cessation of grandfathered status.

We appreciate the opportunity to comment on the Rule, and we urge the Departments to incorporate the modifications suggested here in the final rule or other guidance that is issued.

Sincerely,



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[5] These changes include those pursuant to a legally binding contract entered into before March 23, 2010 or written plan amendments adopted before March 23, 2010. 29 CFR §2590.715-1251(g)(2)(i)(A) and (C).