MurphyAnderson
PLLC

Washington
1701 K Street NW, Suite 210
Washington, DC 20006
202.223.2620 Fax 202.223.8651

Boston
111 Devonshire Street, 5th Floor
Boston, MA 02109
617.227.5720 Fax 617.227.5767

Cincinnati
2406 Auburn Avenue
Cincinnati, OH 45219
513.784.1280 Fax 877.748.1449

www.murphypllc.com

Reply to Washington

August 11, 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

Attn: RIN 1210-AB41

Re: Comments on Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act
Issued May 13, 2010, Fed. Reg. Vol. 75, No. 92

To Whom It May Concern:

I represent and work with Taft-Hartley welfare benefit funds that provide welfare benefits to tens of thousands of employees pursuant to collective bargaining agreements in the retail grocery and other industries.

I write to raise some issues in connection with the recently issued regulations enacting Section 2714 of the Public Health Service Act, as added by Section 1001 of the Patient Protection and Affordable Care Act ("the Act") that have been raised as I have worked with my clients to implement and comply with this new law.

1. Clarification is needed as to whether COBRA coverage is included in "eligible employer-sponsored health care," and it should be included in the exclusion.

Under the Act and the interim final regulations, for plan years beginning before January 1, 2014, grandfathered group health care plans may exclude from coverage adult child dependents who are eligible to enroll in employer-sponsored health plans other than a group health plan of a parent. *See* 75 Fed. Reg. No. 92, p. 27124.

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There is confusion among plan administrators as to whether this exclusion applies to adult child dependents who are eligible to obtain COBRA coverage through their own employer-sponsored health plans, or who are on such COBRA coverage at the time Section 2714 becomes effective for the group health plan. Clarification of this point would be much appreciated. More specifically, the regulations should make clear that group health plans may exclude adult child dependents who can access their own employers' health plans through COBRA.

Currently, until 2014, group health plans may exclude adult child dependents who are eligible for their own employer-sponsored health coverage,[1] regardless of whether they actually enroll in such coverage, and regardless of the cost to them of such coverage. This provision appears to have been a vehicle that would allow group health plans to phase in the costs of covering a new group of dependents, and the logic of this provision should be extended to adult child dependents with access to their own employer-sponsored health coverage through COBRA.

This is especially important for Taft-Hartley health funds, which typically have their contribution rates bargained as part of an overall wage package for covered employees and have contribution rates for employees, if any, far below those typically

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[1] It is not entirely clear whether the exclusion also includes adult child dependents who have access to their spouses' employer-based health coverage. Section 1251(a)(4)(ii) of the Act states that group health plans may exclude adult child dependents eligible to enroll in "an eligible employer-sponsored health plan" as defined by Section 5000A(f)(2) of the Code (other than the grandfathered plan in which the parent seeks to enroll the adult child dependent). Section 5000A(f)(2) of the Code defines eligible employer-sponsored plan as follows: "The term 'eligible employer-sponsored plan' means, with respect to any employee, a group health plan or group health insurance coverage offered by an ***employer to the employee*** which is ..." (emphasis added). It would seem that for any particular adult child dependent, only coverage offered to the adult child dependent by his or her employer is "an eligible employer-sponsored health plan." However, the Departments wrote the regulation as follows: " ... may exclude an adult child who has not attained age 26 from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) ***other than a group health plan of a parent***." *See*, e.g., 29 CFR § 2590.715-2714(g). The bolded/italized phrase in the regulations seems unnecessary if Section 5000A(f)(2) means the coverage must be offered by an employer to the adult child dependent to be an eligible employer-sponsored plan for purposes of Section 1251(a)(4)(ii). Is the addition of this phrase an indication that the Departments read Section 5000A(f)(2) more broadly to include, for example, coverage of a person through a parent's or spouse's employer-sponsored health plan? Clarification as to whether Section 1251(a)(4)(ii) includes coverage through a spouse's employer-sponsored health plan would be helpful as well.

paid by non-union employees. These plans will experience a substantial financial cost in covering this new group of dependents that they cannot offset over the life of the existing collective bargaining agreement, which could threaten the overall financial integrity of the fund.

For example, one fund I work with has a collectively-bargained $65.00/month employee contribution rate for family coverage, which represents less than 10% of the combined employer-employee contribution rate. By contrast, the Kaiser Family Foundation estimates the average family coverage premium rates for 2008 to be 28% of the total premium for employer-sponsored health coverage; it is even higher (32-33%) for employees in the states covered by this Taft-Hartley fund. By this fund's estimates, if all eligible adult child dependents that it knows of enroll, the population of the plan will increase by up to 24%. Of course, there could be many other eligible adult child dependents that the fund does not know of because they never sought coverage for a variety of reasons, including that they exceeded the plan's age limits at the time their parent became eligible for family coverage. The increase in covered lives under Section 2714 could be much higher than the fund anticipates.

Another fund I work with has no employee contribution at all for family coverage, and there are approximately 1,200 eligible adult child dependents it knows of; if they all enroll, the fund's population will increase by 10%.

Given the comparatively low cost (if any) for employees to have all eligible dependents covered by these funds, my clients fully expect large influxes of adult child dependents when Section 2714 takes effect.[2] Yet the funds cannot access other sources of funding to offset the costs for providing health coverage to this potentially large group of new dependents because the contribution rates for both employers and employees are set by collective bargaining agreements that do not expire until long after the fund is required to cover adult child dependents.

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[2] The estimates given in the interim final regulations of affected individuals likely to seek coverage under their parents' employer-sponsored care do not project to 2014, when the exclusion for employer-sponsored coverage expires. Any estimates for 2014 and beyond must account for the cost differential between the affected individual's own employer-sponsored health coverage and that of his/her parents, as well as recognize that until the Act, these individuals simply could not be covered by their parents' employer-sponsored plans, and so it is difficult to predict behavior patterns in this new environment. Estimates that fail to account for these factors will be speculative at best.

The funds' ability to exclude, until 2014, adult child dependents who have other employer-sponsored coverage available will help them absorb the costs of complying with Section 2714, and give the sponsoring unions and employers time to renegotiate, where possible, both employer and employee contribution rates before all adult child dependents must be offered coverage, regardless of the availability of other employer-sponsored heath coverage. It would help even more by clarifying that group health funds may also exclude adult child dependents who can access their own employer-sponsored health coverage through COBRA.

2. Acceptable methods of providing the notice should include all methods listed in 29 CFR §2520.104b-1(b)(1).

29 CFR § 2590.715-2714(f) provides a transitional rule for adult child dependents whose coverage ended, who were denied coverage, and who were not eligible for coverage because they had "aged out" of the plan before Section 2714 takes effect for the plan. Pursuant to Section 2590.715-2714(f)(2), the plan must provide written notice to all such persons of their right to enroll in the plan.

There is no guidance in the regulations as to how this written notice must be provided, other than that the notice may be included with other enrollment materials that a plan distributes to employees, provided the notice is prominent. *See* Section 2590.715-2714(f)(2)(ii). However, many plans, especially Taft-Hartley health plans, do not have open enrollment periods, and thus they do not have open-enrollment materials. While certainly the written notice can be provided with materials given to new participants upon initial enrollment in the plan, doing so will not meet the requirement to provide such notice to potentially eligible adult child dependents of *existing* participants under the transitional rule.

The class of persons to whom such notice must be provided likely includes many people who are unknown to plan administrators. While plans should have information for former child dependents who "aged out," as well child dependents for whom coverage was denied, they may have no way to know how many, and which, adult child dependents never sought to enroll because, for example, they were not eligible under the prior plan rules. The only way to make sure that notice is provided to all such persons is to notify every participant enrolled in the plan as of the date the Act takes effect of the new opportunity to enroll eligible adult child dependents.

For some plans, the expense of a mailing to all active participants is substantial. I work with plans that have more than 20,000 active participants. The cost of a first-class mailing exceeds $20,000, once the postage, printing, materials and labor costs are calculated.

Group health plans therefore should be given the opportunity to furnish the notice under all methods authorized in 29 CFR 2520.104b-1(b)(1), including most specifically publication in union newspapers or company publications. This latter method of publication is effective and generally inexpensive, and is already in use for several other notices that group health plans and pension plans governed by ERISA are required to give annually, such as the notice required by the Women's Health and Cancer Rights Act, and the notice of availability of pension benefit statements required by Section 105(a) of ERISA. In my clients' experience, people actually read the union newspaper, but they often throw away without reading notices they receive in the mail. [3]

The final regulations should make clear that where a plan is required to provide the notice, it may do so by using any method that conforms to 29 CFR 2520.104b-1(b)(1).

I appreciate your consideration of these issues. Thank you.

Very truly yours,

Joni S. Jacobs

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[3] One of my clients once sent a legally-required notice to retirees in the same envelope in which they received their monthly pension checks. Approximately half of the retirees not only threw away the notice, but the entire envelope, including the pension check, and the client had to reissue the pension checks.