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Via Electronic Mail - E-OHPSCA2715.EBSA@dol.gov
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-AB52

Re: Comments regarding Notice of Proposed Rulemaking for the Summary of Benefits and Coverage and the Uniform Glossary

Dear Sir and/or Madam:

My firm, Reid and Riege, P.C. ("Reid and Riege"), was formed in 1950, and since that time pensions and employee benefits have been a cornerstone of our practice. The firm began working with trustees of Taft-Hartley funds in 1956, and multiemployer fund representation remains an important part of the firm's practice today. Personally, I have been providing legal services to multiemployer retirement and welfare funds and other tax-exempt entities at Reid and Riege for my entire 19-year legal career. Our firm is counsel to over twenty (20) Taft-Hartley funds throughout Connecticut and Massachusetts, including six (6) health funds. In addition, since I began practicing in 1992, our firm has served as counsel to two coalitions of Taft-Hartley health funds.

I have prepared this letter to provide you with my comments to the above-noted regulations. Before I do so in Section II, I want to share some brief background information regarding Taft-Hartley health funds in Section I so that you can understand the basis for these comments.

I. Background Information

In general, Taft-Hartley health funds are tax-exempt, multiemployer health and welfare funds which are governed by various federal laws, including the Internal Revenue Code of 1986 (the "Code"), the Employee Retirement Income Security Act of

1974, as amended ("ERISA") and the Taft-Hartley Act of 1947, as amended ("Taft-Hartley"). Funds generally have an affiliation with a specific labor union, and they are normally tax-exempt under Code §501(c)(9) as a "voluntary employees' beneficiary association."

Further, these 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 by a Board of Trustees, normally consisting of an equal number of employee/union representatives and management representatives. Importantly, these 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. As these funds are primarily governed by federal law, each fund's Board of Trustees sets the type of benefits provided (e.g., medical, dental, vision, prescription drug, disability benefits, etc.) and the level of such benefits. Taft-Hartley health funds are not insurers or insurance companies in the traditional sense, but they do provide critical medical and health coverage, along with other benefits, to hundreds of thousands of union employees and their eligible dependents in Connecticut and surrounding states.

II. Comments

Based on my review of the Notice of Proposed Rulemaking ("NPR") with respect to the Summary of Benefits and Coverage and the Uniform Glossary (which I will refer to as "SBC") issued on Monday, August 22, 2011 in Volume 76 of the Federal Register, commencing on page 52442, I have two basic comments. First, Taft-Hartley health funds should have sufficient flexibility to modify the SBC "Template" (commencing on page 52481 of the NPR) to reflect the fact that they *are not* insurers or insurance companies. Second, I believe that the NPR is too restrictive with respect to benefit *improvements* in 29 Code of Federal Regulations ("CFR") §2590.715-2715(b) of the proposed regulations (which govern any "notice of modifications"). I will discuss each comment in turn below.

A. Flexibility for Taft-Hartley health funds with respect to the SBC Template

As outlined in the NPR, pages 52443-44, the SBC Template was created by the National Association of Insurance Commissioners, along with other stakeholders, to develop its recommendations. While the SBC Template generally does a good job of

consolidating the important benefit and coverage rules of both insurance policies and Taft-Hartley health funds, the SBC Template falls short in a few specific areas as noted below. This is especially concerning, as the general instructions for both Group Health Plan Coverage and Individual Health Insurance note that: "Form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise."

1. Reference to Policy Period

Each page of the SBC Template includes a "Policy Period" in the top right-hand corner. For Taft-Hartley health funds, the term Policy Period does not have any relevance. Specifically, the general rule in most Taft-Hartley health funds is that if an employee covered under a collective bargaining agreement works a specified number of hours in a set period of time, and contributions are received for such hours, then such plan will provide coverage for the employee, and any eligible dependents, for a set time into the future. For example, some Taft-Hartley health funds have monthly (or quarterly) eligibility tests in connection with eligibility for a future month (or quarter). So, for Taft-Hartley health funds, I believe it would be more appropriate for the SBC Template to note that it provides a listing of coverage and benefits during the particular plan's plan year (e.g., "Coverage/Benefits for the 2012 Plan Year").

2. Question "What is the premium?"; Section entitled "Your Rights to Continue Coverage"; and Section entitled "Questions and answers about Coverage Examples:"

The concept of a "premium" is contained throughout the SBC Template. As a starting point, the NPR acknowledges on pages 52446-47 that the "premium" for a self-insured plan should reflect the cost of coverage. The NPR also notes that, "[t]his raises issues regarding the ability to compare premium or cost information between coverage options." These issues are especially acute in Taft-Hartley health funds, as it is common for an employer's hourly contribution to such a fund for each hour of work performed by a covered employee *to provide funding for all of the benefits provided under the fund's plan of benefits*. As a result, references to a premium in the SBC Template are, at best, confusing, and may actually cause an individual covered by a Taft-Hartley health fund to erroneously believe that their coverage is provided through an insurer or insurance company.

With respect to the Question "What is the premium?" on page 1 of the SBC Template, certain modifications should be allowed. As a simple example, a collective bargaining agreement may call for an employer to make a contribution of $8.75 to the Taft-Hartley health fund for each hour worked by a covered employee. That hourly contribution of $8.75, in turn, provides a funding source for coverage of: (a) the actual employee, assuming he or she is eligible, (b) the employee's eligible dependent(s), if any, and (c) any retirees covered by the plan. In short, while it would be relatively simple for a Taft-Hartley health fund to list its applicable hourly contribution rate, that rate can have a number of component parts. To provide flexibility to Taft-Hartley health funds, I believe this question of the SBC Template should provide flexibility for such plans to enter their applicable contribution rate, along with an estimated breakdown of the hourly contribution rate to provide coverage for a covered employee, along with any dependents (e.g., those who are "active"), and those who are retired (e.g., "retirees"). Moreover, Taft-Hartley health funds should be able to modify the question itself to read: "What is the cost of coverage?", as this more accurately reflects their funding.

A related comment applies to the section entitled "Your Rights to Continue Coverage" on page 4 of the SBC Template. That section begins, "You can keep this insurance as long as you pay the premium...." As described in more detail above, a premium is not truly a relevant term in a Taft-Hartley health fund, and it does not reflect how coverage is maintained. A more accurate answer would be, "You, along with any eligible dependent(s), will maintain coverage under the plan as long as you (and they) meet the eligibility requirements...." Also, in the same section, I believe a more accurate listing of the bullets for a Taft-Hartley health fund would be:

"▪ you commit fraud
▪ the plan is terminated, or
▪ certain other events occur as provided in the plan (e.g., your child attains age 26)"

A third issue with respect to premiums is the section entitled "Questions and answers about Coverage Examples:" on page 6 of the SBC Template. As premiums are not relevant in Taft-Hartley health funds, the first bullet on the left-hand side should simply be modified to read: "Examples assume you are covered under the plan." In the last question on this same page ("Are there other costs I should consider when comparing plans?"), there is another reference to premium in connection with analyzing

overall costs. For Taft-Hartley health funds, the answer to this question should be permitted to be modified, and an example would be as follows:

> "**Yes.** Under your plan, your coverage is basically provided through employer contributions to the plan as negotiated under applicable collective bargaining agreement(s) governing the work of active employees. As a result, the plan does not charge a premium as an insurance company would. The plan's Board of Trustees set the coverage, and the out-of-pocket costs, such as co-payments, deductibles, and co-insurance, based on the plan's overall financial health. To the extent your plan offers ways to pay out-of-pocket expenses, for example, through health savings accounts (HSAs), you should consider those sources."

3. Section "Your Grievance and Appeals Rights"

This section of the SBC Template, on page 4, does not accurately reflect the fact that Taft-Hartley health funds which have maintained their grandfathered status under the Patient Protection and Affordable Care Act ("PPACA") need not comply with the new external review processes for group health plans.[1] Accordingly, for grandfathered Taft-Hartley health funds, I believe the second bullet in this section should be altered so that references to the state office of health insurance customer assistance and/or any governmental website are deleted and replaced with the appropriate plan contacts with respect to appeals.

B. PPACA §2715(d)(4) - Notice of Modifications

The above-noted section of the PPACA contains specific rules in the event a group health plan, which would include a Taft-Hartley health fund's plan of benefits or "plan," made a material modification to the plan's coverage. It provides, in relevant part, as follows:

> [i]f a group health plan ... makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section

[1] *See e.g.*, United States Department of Labor Technical Release 2011-02, issued June 22, 2011, which states in the background section: "Section 2719 of the PHS [Public Health Service] Act applies to group health plans and health insurance issuers in the individual and group health insurance markets *that are not grandfathered plans* within the meaning of section 1251 of the Affordable Care Act" (emphasis added).

> 102 of the Employee Retirement Income Security Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan ... shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

This statutory provision is reflected in new proposed regulation 29 CFR §2590.715-2715(b). In explaining the proposed regulation, the NPR provides as follows on page 52450:

> ... The proposed regulations interpret the statutory reference to the SBC to mean that only a material modification that would affect the content of the SBC would require plans ... to provide this notice. In these circumstances, the notice must be provided to enrollees ... no later than 60 days prior to the date on which the change will become effective.... A material modification could be an enhancement of covered benefits or services or other more generous plan ... terms. It includes, for example, coverage of previously excluded benefits or reduced cost-sharing ....

While I acknowledge the statutory language of the PPACA, and certainly understand the requirements of an agency to follow statutory language, this proposal could actually serve to *delay* the implementation of benefit or coverage improvements to individuals in group health plans, including Taft-Hartley health funds. Specifically, if the Board of Trustees of a Taft-Hartley health fund voted to improve the plan of benefits such that the improvement impacted the SBC, *this proposal would require such fund to delay implementation of the improvement until at least 60 days after an appropriate SBC notice can be drafted.* Such an incongruous result runs counter to the flexibility of such plans to improve benefits on a retroactive basis, would hamstring the ability of Boards of Trustees to respond to appeals, and runs counter to the goal of providing better health care to all Americans.

While ERISA does set limitations on material *reductions* in covered services or benefits provided under a group health plan,[2] in my experience there is no similar restriction on benefit *improvements*, as long as such improvements are prudent and can be absorbed from a cost perspective.

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[2] ERISA §104(b)(1) (in the event of such a material reduction, then a summary description of such modification or change is to be provided to participants and beneficiaries within 60 days after the adoption of the modification or change).

Such a restriction will also impose, in my view, unnecessary restrictions on Boards of Trustees in deciding appeals and/or benefit improvements. As a simple example, assume that the current rule in the NPR is finalized and a Taft-Hartley health fund receives an appeal involving denied medical expenses for maternity expenses incurred by a covered child. Further assume the fund currently provides for coverage of maternity expenses for the female spouse of a covered employee only, and not for similar expenses incurred by a covered female child. As "If you become pregnant" is a common medical event on the SBC, any change to that specific SBC provision could only be effective on a prospective basis (as notice must be provided 60 days prior to the date on which the change will become effective). Thus, assuming the proposed regulation was adopted in its current form, this would effectively mean that the Board of Trustees would be required to deny the appeal request, because any change regarding the plan's maternity coverage can only be made prospectively so as to comply with such regulation. If the Board of Trustees voted to approve the appeal, I note it would then be subject to an argument that the appropriate notice under the proposed regulation was not provided on a timely basis. Those penalties, as contained in 29 CFR §2590.715-2715(e) (which is $1,000 for each failure, *and* a failure with respect to each participant and beneficiary constitutes a separate offense!), could be very significant and costly.

Finally, one of the overall goals of the PPACA is to expand health coverage for all Americans. Examples of such changes are clear through the addition of preventive services (as to non-grandfathered health plans), the general elimination of pre-existing condition rules, and the expanded coverage of children. While I can understand such a restriction with respect to significant *reduction* in coverage under a group health plan, I do not believe the intention of the PPACA was to delay the implementation of any *improvements* to a group health plan. As written, I believe the proposed regulation would do exactly that.

Based on the above, I would strongly suggest that the applicable agency or agencies implement an administrative exception to 29 CFR §2590.715-2715(b) which permits benefit and/or coverage improvements to a group health plan or an insurance policy to be adopted on a prospective or retroactive basis, with appropriate changes to the SBC made as soon as administratively possible, but no later than 60 days after the formal vote or decision to implement such improvement (whether by an employer, Board of Trustees, insurer, etc.).

III. Conclusion

Based on my comments in Section II above, I would respectfully request that the applicable agency or agencies modify the NPR so that: (i) Taft-Hartley health funds have sufficient flexibility to modify the SBC Template to reflect their structure and operation, and (ii) an administrative exception is added to 29 CFR §2590.715-2715(b) which permits benefit and/or coverage improvements to a group health plan or an insurance policy to be adopted on a prospective or retroactive basis, with appropriate changes to the SBC made as soon as administratively possible, but no later than 60 days after the formal vote or decision to implement such improvement.

If you have any questions with respect to this letter, do not hesitate to contact me by utilizing my contact information noted on page 1.

Very truly yours,

REID and RIEGE, P.C.

Douglas K. Knight

DKK/vmm