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Subject: Draft ERISA Handbook

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We as Consumer Representatives to the NAIC support the proposed redraft of the ERISA handbook. It is important that state regulators understand the scope—and the limits—of federal regulation of health plans under ERISA, as well as the considerable authority that states retain to regulate ERISA plans. It is also vital that state regulators be aware of attempts by health insurers to avoid state regulation or requirements of the Affordable Care Act (ACA) and other consumer protection laws by claiming protection of ERISA, and that regulators oppose these attempts when they are not justified. We offer the following comments on more specific sections of the proposed handbook revisions:

Discretionary Clauses

We support the NAIC Prohibition on the Use of Discretionary Clauses Model Act and oppose attempts by insurers to evade it. We support the draft manual's provisions on this topic.
As we were drafting our comments, we sought assistance on this topic from Michael Quirk, an attorney with Pillsbury and Coleman LLP who specializes in ERISA issues, and he provided us with the following comment:

> The "plan documents" to an ERISA benefit plan are generally not limited to a certificate of coverage or policy. Insurers facing the "clear prohibition" of discretionary clauses have highlighted this fact in attempting to circumvent state discretionary clause bans by arguing that the bans should be limited to the insurance contracts themselves. Nagy v. Grp. Long Term Disability Plan for Employees of Oracle Am., Inc., No. 14-CV-00038-HSG, 2016 WL 1611040, at *10 (N.D. Cal. Apr. 22, 2016). Courts reviewing these arguments have held that the bans survive ERISA preemption—and that the bans will

void discretionary language—even where the discretionary language is located outside the insurance policy (but included elsewhere in another ERISA plan document). Gonda v. The Permanente Med. Grp., Inc., 10 F. Supp. 3d 1091, 1095 (N.D. Cal. 2014) ("state laws regulating discretionary clauses in insurance policies fall under the saving clause . . . . The Court sees no reason why the result should differ when a state law is directed toward a discretionary clause contained in an agreement or another document relating to the administration of an insurance policy.") It is simply "common sense" to not concede a "distinction between" plan documents—otherwise the discretionary bans would be meaningless. Curtis v. Metro. Life Ins. Co., No. 3:15-CV-2328-B, 2016 WL 2346739, at *7 (N.D. Tex. May 4, 2016).

For example, California's discretionary clause ban will apply to discretionary language contained in an "integral part of the ERISA welfare benefit plan's plan document, not part of an insurance policy or certificate." Lin v. Metro. Life Ins. Co., No. C 15-2126 SBA, 2016 WL 4373859, at *5 (N.D. Cal. Aug. 16, 2016). Discretionary language in an Appointment of Claim Fiduciary form also falls within the scope of a ban on discretionary clauses, and thus the ERISA saving clause applies. Gonda, 10 F. Supp. 3d at 1095. ("The ACF merely delegated the discretionary authority that was established by the Policy. Once [the discretionary clause ban] voided the Policy's grant of discretionary authority, it also voided any delegation of that authority made pursuant to the Policy."); see also Ehas v. Life Ins. Co. of N. Am., 2012 WL 5989215, at *7 (N.D. Ill. Nov. 29, 2012) (applying discretionary ban to trust document and summary plan description).

Benefit plan administrators have even argued that discretionary language in a Summary Plan Description ("SPD") should be considered as a source of discretionary authority not affected by the bans, even though an SPD for an ERISA plan is not considered to be part of the written ERISA plan it summarizes. See Skinner v. Northrop Grumman Ret. Plan B, 673 F.3d 1162, 1165 (9th Cir. 2012). Most courts have rejected this argument. Hodjati v. Aetna Life Ins. Co., No. CV 13-05021 SVW, 2014 WL 7466977, at *11 (C.D. Cal. Dec. 29, 2014) ("Because the Summary Plan Description simply summarizes the insurance policy discretionary language, which is void under Section 10110.6, Aetna cannot use the Summary Plan Description to avoid Section 10110.6's mandate."); Murray v. Anderson Bjornstad Kane Jacobs, Inc., No. C10-484 RSL, 2011 WL 617384, at *2 (W.D. Wash. Feb. 10, 2011) (interpreting Washington ban to void discretionary clause in summary plan description; but see Markey-Shanks v. Metro. Life Ins. Co., No. 1:12-CV-342, 2013 WL 3818838, at *6 (W.D. Mich. July 23, 2013) (holding that insurer may avoid the ban by referencing discretionary language in plan SPDs).

Recently, some insurers have argued that an ERISA plan's "Master Wrap Document" should fall outside the confines of state discretionary clause bans. However, it is unclear under what circumstances these wrap documents convey discretionary authority, if at all, and based on recent district court decisions interpreting discretionary clause bans, it is likely these arguments will fail. Nagy, 2016 WL 1611040, at *10. ("whether the plan afforded such discretion . . . any provision to that effect would be void") (emphasis added). Nonetheless, it should be expected that insurers and plan administrators will

> continue to attempt to push discretionary clauses outside the scope of the saving clause, and fight the application of discretionary bans upon ERISA plan documents.

It should be noted that a discretionary clause placed in an administrative agreement outside of the policy is in reality an amendment to the policy, and therefore is required to be filed as a policy form amendment. Failure to do so should support enforcement action and market conduct examination findings for violating form filing requirements.

Revisions on Professional Employer Organizations (PEOs)

We support the proposed revisions concerning PEOs. It should be noted that whether a PEO is an employer for purposes of the employer shared responsibility requirement of the Affordable Care Act is also a question of federal law.

Revisions to Case Law

We considered many of the objections raised by AHIP in their comments on the case law revisions to be petulant and tendentious, but do not object to the revisions as revised.

New Section on Association Coverage

We support the new section on association coverage. We are grateful for the assistance of Fred Nepple, who contributed to our comments.

We ask that you delete the term "onerous" that modifies ACA requirements in the second paragraph. We believe that the ACA's requirements are beneficial to consumers and do not result in an "onerous" outcome.

The critical point of this text relates to the discussion of "large group" status fictitiously established through aggregating employees of employers joining an "association" to avoid ACA small employer requirements, particularly the discussion of the "rare" circumstances where the association is actually the plan sponsor

Footnote 8 references the DOL opinions on this topic. The text would be clearer on the specifics of how "rare" this situation will be (i.e., in effect an exemption from small employer ACA restrictions) if the key text from the opinions were actually quoted in the text. For example, Advisory Opinion 2001-04A (www.dol.gov/ebsa/regs/aos/ao2001-04a.html) states that a multiple employer plan may exist:

> . . . where a cognizable, bona fide group or association of employers establishes a benefit program for the employees of member employers and exercises control of the amendment process, plan termination, and other similar functions on behalf of these members with respect to a trust established under the program. On the other hand, where several unrelated employers merely execute participation agreements or similar documents as a means to fund benefits, in the absence of any genuine organizational relationship between the employers, no employer association can be recognized.

> A determination of whether a group or association of employers is a bona fide employer group or association must be made on the basis of all the facts and circumstances involved. Among the factors considered are the following: how members are solicited; who is entitled to participate and who actually participates in the association; the process by which the association was formed, the purposes for which it was formed, and what, if any, were the preexisting relationships of its members; the powers, rights, and privileges of employer members that exist by reason of their status as employers, and who actually controls and directs the activities and operations of the benefit program. In addition, the employers that participate in a benefit program must, either directly or indirectly, exercise control over the program, both in form and in substance, in order to act as a bona fide employer group or association with respect to the program.

ACA Changes Incorporated into ERISA:

The proposed changes to the ERISA handbook incorporating the ACA are generally accurate and we support them. We offer, however, a few comments:

First page, Note 2, or text accompanying note 2 and section on grandfathered plans under "significant reforms":

It should be noted that the grandfather clause only limits the application of federal law to grandfathered plans. States are free to adopt any state regulatory requirements, including requirements that apply to grandfathered plans. 42 U.S.C. § 1321(d). The only limit to this is that states may not require grandfathered plans to participate in the single risk pool. 42 U.S.C. § 1312(c)(4).

Second Page, paragraph preceding note 3:

> The HHS, USDOL and the Treasury (the "Departments") issued a series of regulations in phases implementing PHS Act sections 2701 through 2719A, some of which became effective on September 23, 2010, six months after the effective date of the ACA. Those regulations contained what is referred to as the "immediate market reforms," which are discussed in more detail below. The immediate market reforms include: coverage for adult children up to age 26 (PHS 2714), $0 preventive care (PHS 2713), no lifetime limits, phased in elimination of the "no annual limit" requirement (PHS 2711), no pre-existing condition exclusions for children under the age of 19 (PHS 2704), and limits on rescissions of coverage (PHS 2712). Some of these reforms applied only to non-grandfathered health plans. Other reforms apply to both grandfathered and non-grandfathered. Therefore, it was also necessary for the "immediate reform" regulations to include regulations defining the types of changes to an insurance policy or self-insured plan that would trigger the loss of grandfathered status. ~~Many more regulations have been issued since that time.~~ Beginning ~~For instance,~~ in 2014, the immediate reforms were extended by eliminating pre-existing condition exclusions for all enrollees, regardless of their age, and annual dollar limits were eliminated entirely for all healthcare services that are considered "essential health benefits." In addition, a broader set of reforms took

effect in the individual and small group markets, including rating rules, the provision of Essential Health Benefits, and tiers of coverage based on actuarial value.

Third page, middle paragraph:

By contrast, the ACA applies relatively extensive requirements to employer health plans.~~is largely mandatory in nature.~~ Because substantial parts of the ACA have been incorporated into ERISA, the nature of ERISA has been changed. In addition, even though the ACA preserves the employer's right to decide whether to offer a health plan at all, the ACA includes an employer "shared responsibility" provision, sometimes called "play or pay," [Office1]that gives large employers (50 or more fulltime or fulltime equivalent employees) a strong[Office2] incentive to provide "affordable" health plans to employees and their child dependents. Although this law is sometimes referred to as the large employer "mandate," it does not literally mandate that employers offer such plans. However, even though employers that choose not to do so are not deemed to be in violation of any ACA requirement, they may be subject to substantial[Office3] financial penalties under the ACA's employer "shared responsibility" provisions. Small employers, under 50, are not subject to the penalties associated with shared responsibility

Third page, final paragraph, text accompanying notes 9 and 10:

Under revised regulations, "minimum value" employer plans must also cover substantial inpatient hospital services and physician services.

Fourth page:

This limits the impact of a major distinction between the ACA's requirements for individual and small group insurance and the ACA's requirements for large group insurance and self-funded benefit plans. Individual and small group insurance policies must include all essential health benefits and (with the exception of the catastrophic individual plan) must provide at least a "bronze" level of coverage (60% actuarial value), but large employers (and self-funded small employers) are not subject to those requirements. However, even though large employer health plans do not have to include all 10 categories of "essential benefits," the "minimum value" calculation is based on[SL4] ~~or used by the Treasury to calculate the value of a group health plan does factor in~~ the extent to which certain EHB categories are covered. If major categories, such as prescription drugs, maternity, habilitation or rehabilitation services or devices, or mental health, are left out of the plan, the plan may not meet the minimum actuarial value of 60% and therefore could subject the employer to "shared responsibility" penalties. Minimum value plans must also cover substantial inpatient hospital and physician services. In addition, all health plans, including self-funded ERISA plans, are subject to a maximum "in-network" out-of-pocket limit on services that are considered EHB that is adjusted annually for inflation by CMS (in 2016 set at $6850 individual/$13,700 family).

~~The large employer "shared responsibility" provisions of the ACA can have significant financial impacts on large employers that previously did not offer coverage to all of their employees who work at least 30 hours a week, or that offered coverage that did not meet MEC, affordability or minimum value requirements. There is speculation that the ACA will have even broader impacts.~~

~~For instance, the "play or pay" employer mandate only requires health plan coverage for employees who work 30 hours or more a week. This creates incentives for employers to limit or reduce hours for their employees. Some ERISA experts argue that if employers use that strategy to limit their costs, they may be exposing themselves to an action under ERISA Section 510, which makes it unlawful for a person to interfere with the attainment of any right a participant may become entitled to under a plan. Another strategy to avoid the penalty and/or the cost of offering "real" coverage is to offer minimal coverage that still meets MEC, such as coverage consisting of outpatient preventive services only, and then "gamble" on the proposition that few employees will actually sign up for individual coverage with a tax credit. Additionally, an employee who enrolls in Medicaid, rather than in subsidized insurance through the Exchange, does not trigger the penalty for failing to offer MEC and is not counted in calculating the penalty for failing to offer affordable coverage with minimum value. This discussion is beyond the scope of this handbook, but it is interesting to note here.~~ ~~[CS]~~

Fifth page:

2. Wellness Program Provisions – (29 CFR 2590.702 and 29 CFR 2590.715 – 2705) Wellness programs are programs of health promotion or disease prevention operated in conjunction with an employer health plan, and they must comply with the final wellness program regulations, which use joint authority under HIPAA and the ACA. A wide range of wellness programs are permitted, but the regulations generally prohibit discrimination based on health factors, with exceptions for benign discrimination (e.g., making benefits specifically available to persons with designated health conditions) and participation incentives (provided that outcome-based incentives must make reasonable alternatives available if necessary for all participants to have a reasonable opportunity to earn the incentive).

It should be noted that wellness programs are also regulated by the EEOC under the Americans with Disabilities Act and Genetic Information Nondiscrimination Act. See http://healthaffairs.org/blog/2016/05/17/eeoc-rules-allow-significant-rewards-penalties-in-connection-with-wellness-program-participation/.

Seventh page:

9. Summary of benefits and coverage
Mention that a new 2017 summary of benefits and coverage form is being phased in.

Eighth page:

10.b. Coverage of emergency services.
It should be noted that the emergency services regulation requires health plans to pay out-of-network emergency care providers the greater of: 1) its in-network rate, 2) its out-of-network rate, or 3) the Medicare rate.

Preventive Services

11. Preventive Services – (29 CFR 2590.715-2713(a)(1)) Group health plans must provide coverage for certain recommended preventive services, without imposing any cost sharing requirements. A complete list of recommendations and guidelines that include services that are required to be covered can be found at www.healthcare.gov/center/regulations/prevention.html. Any changes to or new recommendations and guidelines must be covered with the plan year that begins on or after the date that is ~~within~~ one year after the date the recommendation or guidance is issued. Plans that utilize networks are not required to provide coverage for preventive service delivered by out-of-network providers and may impose cost-sharing for out-of-network preventive services. Plans may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for the recommended preventive service to the extent not specified in the recommendation or guidelines.

Ninth page

Delete Prohibition on Waiting Periods. This duplicates discussion on p. 7.