



AMERICAN BENEFITS COUNCIL

May 13, 2011

The Honorable Kathleen Sebelius
U.S. Department of Health and Human Services
Attention: CMS-9987-P
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Office of Benefits Tax Counsel
Attention: Waivers for State Innovation
Room 3050
Department of Treasury
1500 Pennsylvania Avenue, NW
Washington, DC, 20220

Submitted via the Federal Regulations Web Portal, <http://www.regulations.gov>

Re: Comments on State Waiver Proposed Regulation

The American Benefits Council (the "Council") appreciates the opportunity to provide comments to the Departments of Health and Human Services and Treasury (the "Departments") on the Proposed Rule (the "Proposed Regulation") regarding the Application, Review, and Reporting Process for Waivers for State Innovation under section 1332 of the Patient Protection and Affordable Care Act ("ACA"). 76 Fed. Reg. 13553 (March 14, 2011). The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly, or provide services to, retirement and health plans that cover more than 100 million Americans.

Our members sponsor and administer health plans that cover employees and retirees in many states, most of which are self-insured and subject to a uniform scheme of federal regulation under the Employee Retirement Income Security Act of 1974

("ERISA"). For the past year, our members have focused significant resources in complying with the myriad of rules under the ACA that apply to group health plans. On behalf of our members, the Council has worked closely with the Departments in developing reasonable and administrable guidance under the ACA for group health plans.

The Council has unique concerns with respect to the state waivers authorized under section 1332 of the ACA. We are concerned that, unless properly and carefully administered, state waivers could undermine the uniform design and administration of employer plans that deliver health benefits to over 150 million Americans and could impose excessive costs on employers, particularly in those states where waivers are granted. Such a result would conflict with goals of the Administration and the ACA of expanding health care coverage and making it more affordable to consumers. Our concerns with the state waiver law are set forth below and are accompanied by our recommendations to address these concerns as you develop final rules to implement section 1332 of the ACA.

1. State Waivers Under the ACA are Intentionally Narrow and Were Not Intended to Permit Regulation of Self-Insured Employer Plans

In adopting section 1332, Congress intentionally established a high bar for state waivers subject to HHS and Treasury review and approval. Specifically, before a waiver can be granted, a state must have actually enacted a law, and that law must provide coverage that is as comprehensive as the federal essential health benefits package, has limits on cost-sharing and out-of-pocket spending, will cover a comparable number of residents as would have been covered under the ACA, and will not increase the federal deficit. ACA § 1332(b). In addition, waivers are not available until 2017, which means that a state must first comply with all of the ACA's 2014 rules (insurance reforms, exchanges), before it can apply for a waiver for a state law that would establish an alternative mechanism. This structure clearly indicates that Congress intended that waivers under section 1332 may only be granted where a state can first demonstrate that it meets each of these significant conditions.

The narrow scope of the waiver program is further illuminated with a careful parsing of the statutory text delimiting the scope of permitted waivers. The statute specifically provides that "with respect to health insurance coverage" within the state, a state may apply for a waiver of any or all of the following rules: (1) qualified health plan standards, (2) exchange rules, (3) individual premiums subsidies and small employer tax credits, and (4) employer and individual responsibility standards. ACA § 1332(a)(2).

In adopting this narrow framework, it is clear that the ACA does not provide for state waivers of all of the ACA's requirements, which would have permitted greater

state flexibility as to implementing health care reform. For example, none of the key insurance market reforms are within the scope of the waiver authority of the Departments. As a result, states cannot be granted a waiver to substitute their own less stringent regulatory schemes for insurance market reforms included in the ACA.

Perhaps most importantly, by its terms section 1332 only authorizes waivers for "health insurance coverage" offered within a state. ACA § 1332(a)(1), (2). The term "health insurance coverage" is defined under section 1301(b)(2) of the ACA as having the meaning given such term by section 2791(b) of the Public Health Service Act ("PHSA"). "Health insurance coverage" is defined under section 2791(b)(1) of the PHSA as insured coverage offered by a health insurer licensed in a state. And the Administration has interpreted the term in the same manner for provisions that are found in the ACA.¹ As a result, the Council believes that limiting waivers to state laws that regulate insured coverage is required under the statute and the Departments should recognize that only state laws relating to such coverage are within the realm of a state waiver.² Such an interpretation will preserve the traditional role that states have had in regulating the business of health insurance, while at the same time respecting the traditional role that ERISA has played in allowing employers to adopt uniform design and administration practices for their health plans.

In addition, the text of the statute makes clear that the waiver authority accorded to HHS and Treasury does not extend to any federal law or requirement that is not within the authority of the Departments. ACA § 1332(c)(1), (2). Importantly, Congress could have extended waiver authority to the Department of Labor to waive the requirements of ERISA but did not do so. This clearly indicates that Congress did not intend to alter the applicability of ERISA to employer-provided health plans, nor did Congress intend to subject self-funded plans to varying state laws pursuant to a section 1332 waiver. As such, it is beyond the authority of HHS and Treasury to waive the application of ERISA to employer plans or alter the continued application of ERISA preemption to state laws that regulate employer plans either explicitly or via implication.

¹ Specifically, the Administration interpreted the grandfathered health plan rule that relates to health insurance coverage offered under a collectively bargained plan as limited to fully insured collectively bargained plans and not applying to self-funded collectively bargained plans. See Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan, 75 Fed. Reg. 34538, 34542 (June 17, 2010) (Preamble).

² See generally *Dept. of Revenue of Oregon v. ACF Industries, Inc.*, 510 U.S. 332 (1994); see also *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 230 (1993); *Atlantic Cleaners & Dyers, Inc. v. United States*, 286 U.S. 427, 433(1932) ("identical words used in different parts of the same act are intended to have the same meaning").

2. Waivers Should Only Be Granted If They Would Not Undermine the Legal Framework Established By ERISA

Section 1332 of the ACA permits Treasury to approve a waiver of the ACA's employer mandate. Any waivers granted under section 1332 should not undermine the existing legal framework that has worked so well for employer-provided plans for nearly 40 years. Under ERISA, employers that self-fund their benefit plans can offer and administer coverage across the 50 states that is uniform and tailored to the specific needs of their workforce. This is because ERISA preempts state laws that directly regulate benefit plans (though it preserves the ability of states to regulate insurers and the insured products they offer). Uniformity of regulation for such self-funded employer plans should be continued under any waiver program. It would impose needless costs on employers with employees in more than one state to comply with a patchwork of state regulation. This would conflict with the ACA's goals of improving coverage and its affordability.

The Council is concerned that this authority could be misconstrued such that a waiver might be granted where a state would impose requirements on self-funded employer-sponsored health plans governed by ERISA, particularly if a state has adopted its own employer mandate. The Council requests that the Departments make clear in final regulations that any waivers will not permit states to directly or indirectly regulate the design and administration of self-funded ERISA plans and that waivers will not be granted where the underlying state law involves an employer mandate.

This policy is supported by two clear provisions of the statute. First, as noted above, section 1332 only authorizes waivers for "health insurance coverage" offered within a state. ACA § 1332(a)(1), (2). Thus, by its terms, a state law subject to a waiver cannot extend to self-funded ERISA plans. Second, section 1332 specifically prohibits the Departments from waiving any laws not within their jurisdiction. ACA § 1332(c)(2). To the extent that a waiver was granted that allowed states to regulate self-insured plans, then the Departments would effectively be waiving ERISA preemption, which, as noted above, is not within their purview, nor does the ACA grant such authority to the Department of Labor.

Finally, it is important to note that many employers sponsor both insured and self-funded plans. Requiring an employer to comply with a state employer mandate with respect to participants in insured plans within a state and the ACA employer responsibility provisions with respect to participants in its self-funded plan in that state would be impossible to administer from a practical perspective and would unduly increase the burden of compliance on employers.

3. Waivers Should Not be Granted Where a State Has Adopted a Minimum Essential Coverage Requirement that is More Burdensome than the ACA

As a general matter, the Council recognizes that any waiver of the federal individual mandate should be coupled with some form of underlying individual responsibility provisions in the waiver state, although states may well be able to demonstrate that alternative financial incentives than those in the ACA may still achieve broad coverage. Without some form of such incentives, the key insurance reforms will not work. Specifically, it is important to note that the federal guaranteed issue requirement that applies in 2014 cannot be waived under section 1332, and these provisions are very closely linked to the establishment of adequate incentives for individuals to obtain coverage. If healthy individuals can stay out of the insurance markets in 2014, then the pricing of insurance in the individual market will likely spiral out of control. Moreover, as a practical matter, the requirement that the state law cover the same number of individuals as the ACA also could not be met.

That said, it is critical that waivers of the federal ACA individual mandate not impose administrative burdens on employer plans by allowing states to impose burdensome standards for what constitutes “minimum essential coverage”. Specifically, the ACA generally recognizes that any employer coverage will satisfy an individual's requirement under the individual mandate. And, the employer responsibility provisions of the Act can generally be met by offering coverage that has a 60% actuarial value. If states were to impose a “minimum essential coverage” standard that requires individuals to obtain even more comprehensive coverage, then individuals may not be able to meet the individual mandate by enrolling in their employer's plan. This will create a pressure for employers to offer coverage tailored to meet the individual mandate in every state, effectively creating a “back door” employer mandate, thereby undermining the very uniformity that ERISA preemption is designed to ensure. This burden could compel many employers to reluctantly exit the employer-sponsored system and pay a penalty. Such a waiver, therefore, would undermine, rather than build-upon, the employer-sponsored system which is the source of health coverage for most Americans.

4. Waivers Should Be Granted Only After Meeting the High Bar Established by Congress

As discussed above, the standards for a waiver to be granted were intentionally set very high by Congress. First, the state must have actually enacted a law. In addition, that law must provide coverage that is as comprehensive as the federal essential health benefits package, has limits on cost-sharing and out-of-pocket spending, and cover a comparable number of residents as would have been covered under the ACA. ACA § 1332(b). This indicates that Congress did not intend for waivers to be granted liberally because waivers could undermine the protections Congress set in the ACA. As

such, a judicious application of the waiver process is true to Congressional intent and it will serve to limit unnecessary costs and burdens by allowing state-by-state variations. Consistent with this approach, the Council believes that states should be required to have implemented the ACA provisions effective in 2014 (*e.g.*, establish an exchange) before they can get a waiver in 2017. Otherwise, a state may opt to avoid ACA compliance and let HHS enforce ACA provisions, including maintaining an exchange within the state, in that state for the three year period of 2014 to 2017. This would reward states who have avoided compliance with the law.

5. Employers Will Need Adequate Notice Regarding State Waivers

In states that are granted waivers, the employer community will need adequate time in order to be able to amend their plans, review insurance policies, and communicate those plans to employees. To meet this need, waiver applications should be required to be submitted 24 months in advance of the proposed effective date of the waiver, providing 180 days for the Secretaries to make a decision and an additional 18 months for implementation.

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The Council is pleased to have the opportunity to provide comments regarding the state waiver regulation. Thank you for considering our comments. Should you have any questions, please feel free to contact me.

Sincerely,

A handwritten signature in black ink that reads "Paul W. Dennett". The signature is written in a cursive style with a large initial "P" and a stylized "D".

Paul W. Dennett
Senior Vice President, Health Care Reform