NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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Submitted via www.Regulations.gov

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

Re: Patient Protection and Affordable Care Act
Establishment of Exchanges and Qualified Health Plans Proposed Rule
File Code CMS-9989-P

Ladies and Gentlemen:

The National Coordinating Committee for Multiemployer Plans (the NCCMP) is pleased to provide these comments regarding the proposed rule that would implement the new Affordable Insurance Exchanges under the Patient Protection and Affordable Care Act. The proposed rule was published by the Department of Health and Human Services (HHS) on July 15, 2011, reference number CMS–9989–P.

The NCCMP is the only national organization devoted exclusively to protecting the interests of the approximately twenty-six million workers, retirees, and their families who rely on multiemployer plans for health and other benefits. The NCCMP's purpose is to assure an environment in which multiemployer plans can continue their vital role in providing benefits to working men and women. The NCCMP is a nonprofit, non-partisan organization, with members, plans, and plan sponsors in every major segment of the multiemployer plan universe, including in the airline, building and construction, entertainment, health care, hospitality, longshore, manufacturing, mining, retail food, service and trucking industries.

Introduction

The Department specifically requested comments on the role of multiemployer plans in the Exchanges:

> *We propose to define ''health plan'' in accordance with section 1301(b)(1) of the Affordable Care Act to encompass health insurance coverage and a group health plan. The Affordable Care Act specifies that, except to the extent specified, the term ''health plan'' shall not include a group health plan or multiple employer welfare arrangement (MEWA) to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of ERISA. However, we recognize that section 514 of ERISA allows State regulations of MEWAs, provided that such regulation does not conflict with standards of ERISA. We request comment on how to reconcile this inconsistency. We have also received questions about whether Taft-Hartley plans and church plans can participate in the Exchange. We request comment on how such plans could potentially provide coverage opportunities through the Exchange.* 76 Fed. Reg. 41869 (July 15, 2011).

In this comment letter, we raise issues concerning the new Exchange system that becomes effective in 2014 that will be important to the participants and beneficiaries currently receiving health benefits from multiemployer plans. Many of the issues important to these plan participants are identified herein. We also direct your attention to letters submitted to Ken Choe, Deputy General Counsel, on August 8, 2011 and August 30, 2011, which provide further detail in some of these areas.

Background on Multiemployer Plans

Due to their unique structure, for over 60 years multiemployer plans have provided affordable, high quality health coverage for American workers who are often left out of typical employer plans, including part-time workers and workers in industries with very fluid employment patterns.

Multiemployer plans are established as a not-for-profit plan under section 501(c)(9) of the Internal Revenue Code (the "Code"). They are maintained through the collective bargaining process in accordance with the provisions of the National Labor Relations Act (the "NLRA,"

also known as the Taft-Hartley Act). Pursuant to section 302(c)(5) of that Act, these plans are sponsored by a joint board of trustees composed of equal numbers of employee and employer representatives. The board of trustees, not the individual employers, makes decisions regarding the coverage provided under the plan. Each employer contributes to the plan in accordance with the terms of the applicable collective bargaining agreement. The boards of trustees of these plans deliver health care exclusively for the benefit of participants and beneficiaries pursuant to the requirements of the NLRA and the Employee Retirement Income Security Act of 1974 (ERISA). Although these plans are often referred to as "Taft-Hartley plans," the term "multiemployer" plans is the preferred terminology, because jointly managed single-employer plans are also subject to the NLRA.

Approximately 26 million Americans including active and retired workers and their families are covered by multiemployer plans today, and it is estimated that approximately 90 percent of contributing employers are small employers with fewer than 50 employees. In some industries, like construction, most contributing employers have 20 or fewer employees.

Multiemployer plans have a unique structure that in some ways reflects typical employer sponsored group health plans and in other ways reflects insured arrangements. For over 60 years, this unique structure has enabled multiemployer plans to provide affordable, high quality health coverage for a broad segment of the American workforce cutting across the economy who are often left out of typical employer plans, including part-time workers and workers in industries with very fluid employment patterns. While most often associated with the building and construction and trucking industries, multiemployer plans are pervasive throughout the economy including the airline; automobile sales, service and distribution; building, office and professional services; chemical, paper and nuclear energy; entertainment; food production, distribution and retail sales; health care; hospitality; longshore; manufacturing; maritime; mining; retail, wholesale and department store; steel; and textile and apparel production; industries. These plans can provide coverage on a local, regional, multi-State, or national basis, and the coverage is designed to address the unique needs of a particular industry.

Participants often move from one contributing employer to another. The problems associated with such mobility under a typical single-employer model cannot be overstated. Employees who

change employers regularly (in the entertainment industry, for example, artists moving from venue to venue may change employers every few days or weeks) would rarely, if ever, establish eligibility for health benefits under the traditional "first of the month following the completion of thirty days of employment" rule. By allowing employees to aggregate service, pooling contributions and hours from all contributing employers, they not only establish eligibility, but typically accrue sufficient service to enable them to bridge predictable periods of unemployment, such as are typical in the construction industry.

Typically, the contributing employers are too small to maintain benefit departments and may not have access to sophisticated payroll technology. Additionally, a significant number of employers may be unable to obtain affordable health coverage due to their size or the age and mobility of the workers. The multiemployer plan enables small and medium size employers to pool resources with other employers, and mobile employees to pool their service with many different employers, to achieve the critical mass to make it cost efficient to provide group health plan coverage.

In multiemployer plans, the individual employer's role is typically limited to contributing the amounts required by the collective bargaining agreement, which are usually pegged to the intensity of work by covered employees (e.g., $2 for each hour of covered service). Employers file a regularly-scheduled contribution report with the plan (most often monthly). The contribution report will contain certain standard information, including: a list of names, social security numbers, and one or more units of work or contribution amounts for each employee, and one or more rates at the bottom. The total number of units might be hours, days, or weeks, depending on the terms of the collective bargaining agreement. Many reports are customized, but the data being requested is the same. Large employers may send a spreadsheet that was downloaded from their system(s) and the receiving plan will program its systems to be able to accept the report and load the data to their contributions system. More sophisticated plans may permit employers to send files electronically. Some employers complete forms via the Internet that are loaded directly into the plan's system. Payments can also be made electronically. But for many small employers, paper reports completed at the job site and submitted to the fund office is still the norm.

Multiemployer plans are attractive to employers because they provide consistent long-term health coverage for workers with predictability and cost-effectiveness for employers encouraging retention and ensuring the availability of a ready pool of highly trained, qualified workers. Unlike the majority of insured small employers whose premium rates are entirely determined by the insurance carrier, contribution rates are negotiated by the employers (often through employer associations) and the unions and are known and predictable for the term of the bargaining agreement. In years in which costs rise unexpectedly, benefits may be adjusted or the contribution rate increased, yet because such contributions are a part of the total compensation package, it is likely that some or all of the increased costs are borne by the employee through a reallocation of the contributions within that package. The integral nature of the plans to the bargaining relationship, along with the statutorily mandated requirement that boards of trustees operate the plans for the sole and exclusive benefit of participants, have resulted in consumer oriented, cost conscious management of plans. Similarly, multiemployer plans are attractive to employees because they provide, among other things, consumer-oriented plan design and administration, portability, stability and flexibility.

Failure to Adopt a Regulatory Structure that Effectively Considers Multiemployer Plans Will Cause the Termination of Many Multiemployer Plans, Adversely Affecting Previously Covered Employees and Their Families

For decades, the risk pooling currently provided by multiemployer plans has enabled contributing employers to provide quality, affordable coverage for their employees. Multiemployer plans currently cover 26 million Americans. These plans have evolved to respond to the unique needs of each industry to ensure continued eligibility throughout predictable periods of unemployment to enable participants to maintain coverage and beyond through often heavily subsidized self-payment provisions that apply before and in addition to COBRA continuation requirements. This coverage has also contributed to the health care system as a whole, by reducing the "churning" that can occur when individuals have changed circumstances that cause a dramatic change in health care coverage (e.g., a termination of coverage or moving in and out of eligibility for Medicaid). Churning results in repeated and often lengthy coverage gaps. This can cause severe negative consequences for the affected individuals, including failure

to obtain coverage for chronic diseases (such as hypertension and diabetes) and needed preventive care, including pediatric preventive care.

Affected individuals may also face increased illness and increased debt due to noncovered medical care. Churning also causes increases in overall health care costs, due to such factors as sporadic and delayed care, increased use of emergency room services, and repetition of administrative services. One study has found that the adverse effects of churning occur quickly after loss of coverage.

Multiemployer plans currently reduce churning by providing continuity of coverage. This continuity is provided in a number of ways, including through coverage of part-time workers, coverage based on working in an industry rather than for a single employer, and a variety of other features, including hours banks and similar approaches that allow individuals to continue coverage when they are not working, have become disabled, or have retired. For those employees who are no longer working, this coverage is far more affordable than COBRA coverage.

If subsidies are available only for plans purchased through Exchanges, employers contributing to multiemployer plans will face tremendous economic pressure to stop contributing to multiemployer plans. This pressure will be the greatest in circumstances in low wage industries, where the small employer responsibility penalties do not apply (including employers that are not subject to the penalties because of their size), and in industry sectors that have significant numbers of entry-level (including apprentices) and part-time employees. Economic analysis at the macro level, as well as examples from particular industries and employee groups, demonstrates that the economic effects of the subsidies will be substantial. Many employers will feel the need to drop coverage and access the subsidies to remain competitive. Moreover, due to the prolonged underperformance of the economy, especially in, but not exclusive to the construction industry, even groups normally considered to be among the better compensated middle class occupations are expected to be adversely impacted due to the lack of employment opportunities which has resulted in substantially lower household income and, therefore, a much higher incidence of subsidy eligibility.

Loss of multiemployer plan coverage would increase the adverse effects of churning. In addition, for those employees who do purchase coverage through an Exchange following termination of a multiemployer plan, the benefits will almost always be less generous than currently provided by multiemployer plans. This is because the subsidies are set at the silver level benchmark, while most multiemployer plans provide coverage at least at the gold level, in most instances without any additional employee premium. Once lost, the multiemployer plan structure would be difficult to replace.

The goals of ACA to provide access to quality, affordable health coverage should be supported by an appropriate regulatory structure that preserves what already works well for 26 million Americans.

While these Exchange provisions do not go into effect until 2014, issues regarding health care coverage are already surfacing in the bargaining process as bargaining agreements of three- to five-year terms are the norm. Appropriate regulatory guidance is needed in a timely fashion so that it can be considered in bargaining process before 2014.

Multiemployer Plans Operate as Exchanges for their Contributing Employers and Participants

Before the enactment of ACA, the success of multiemployer plans meant that they garnered little attention from either the Congress or the federal agencies. Because of this, multiemployer plans were not the focus of attention in the deliberations of ACA, and the specifics relating to such plans were not adequately addressed in the statutory drafting process.

Multiemployer plans are "group health plans" as defined under ERISA and the Code and thus, must comply with the basic health care reforms that were added by ACA to the Public Health Service Act (PHS Act) and incorporated by reference into the Code and ERISA. Multiemployer plans are employer-based because they arise out of the employment context through the bargaining process under existing labor law, including the National Labor Relations Act and the

Taft-Hartley Act, and employers contribute to such plans on behalf of their employees in accordance with the applicable collective bargaining agreement. However, the plans are not sponsored by an employer; rather, the "sponsor" of a multiemployer plan is not each contributing employer, but the joint board of trustees.

ACA focuses primarily on two different mechanisms for delivering health care (whether in the group or individual context), through insurance provided by health insurance issuers licensed under State law and through self-funded plans offered by employers. Multiemployer plans present a hybrid approach, in some ways reflecting the employer and in other ways acting more as an insurer. It is this hybrid structure that is not fully addressed in the statutory provisions.

It is estimated that approximately 90 percent of the employers who contribute to multiemployer plans are small employers within the meaning of ACA, and most have 20 or fewer employees. For such employers, the multiemployer plan fulfills the benefits department function otherwise only available to much larger individual employers (including such functions as determining eligibility, enrollment, regulatory compliance) thereby enabling the small employers to provide benefits that are on par with their much larger corporate competitors. This is especially important because of the mobile work patterns of their employees.

Other provisions of the law recognize this aspect of multiemployer plans. Thus, for example, the Internal Revenue Service (the "IRS") has provided that qualifying small employers may receive the small employer tax credit added by ACA for their contributions to a multiemployer plan, in essence, looking through the plan to the individual qualifying employers. As another example, the Medicare Secondary Payer rules look through the multiemployer plan at the size of each contributing employer to determine what rules apply.

In other ways, however, multiemployer plans clearly function more as insurers, performing the functions usually associated with an insurance company. Multiemployer plans provide coverage for all employees of contributing employers – essentially creating a community-rated risk pool consisting of ALL covered employees of contributing employers. They do not use medical

underwriting criteria to exclude participants, nor do they exclude any pre-existing conditions (two of the main practices that ACA has codified into law). They receive contributions from which benefit payments are made, make eligibility determinations and set benefit levels.

Plan trustees determine whether, and to what extent, benefits should be paid – either directly (self-insured) or on a fully insured basis, or some combination of insured and self-insured coverage. They also determine the administrative structure – whether fully self-administered, through a third party administrator, through an administrative services only (ASO) agreement with an insurer, or some combination of the above.

Depending on the degree to which such coverage is self-insured, the trustees must determine how eligibility will be established and documented, benefit payment levels (often negotiating directly with providers), make payment decisions, make payments, keep and report payment records for tax purposes and to prevent fraud and abuse, and ultimately determine the merits of appeals to adverse payment determinations. All of these functions replicate those of an insurance carrier.

Compared to typical insurance carriers, however, multiemployer plans are more efficient and patient oriented – they operate on a not-for-profit basis, meaning that more dollars are used directly for payment of benefits. Perhaps more importantly, the board of trustees is required by law to administer the plans for the sole and exclusive benefit of plan participants and in fact are precluded from considering the interests of contributing employers in making decisions regarding the operations of the trust.

Multiemployer Plans Should Be Able To Choose To Purchase Exchange Coverage Through A SHOP Exchange on Behalf of Contributing Employers.

Multiemployer plans often act as a purchaser of health insurance coverage that combines the purchasing power of many employers to leverage cost-efficient, consumer-oriented coverage for employees. Multiemployer plans that so choose should be enabled to continue to play this role as the exchanges develop, by being permitted to purchase coverage on a State Exchange on behalf

of contributing small employers who would otherwise be eligible to purchase from such Exchange. Further, because approximately 90 percent of contributing employers are small employers, before Exchanges are open to employers of all sizes (scheduled to begin in 2017), multiemployer plans should be allowed to perform this intermediary function for any of their contributing employers.

Multiemployer plans that purchase coverage on an Exchange would act as a "purchasing aggregator" for plan participants if they desire. This could be done, for example, either by having the multiemployer plan's joint board of trustees select one of the Exchange options for all participants, or by enabling individual selections (as is done through the Federal Employees Health Benefits Program). The rationale for allowing the multiemployer plans' trustees to purchase directly through the Exchange on behalf of their participants is threefold:

- trustees and their professional advisors are better qualified to make informed decisions about coverage—the role they have fulfilled since their inception and recognized as a fiduciary duty under ERISA;
- by aggregating contributions from all employers for which the employee works, for eligibility purposes, it recognizes that the fund acts on behalf of the participant rather than any one employer; and
- the plan is able to maintain the group for purposes of providing benefits beyond those obtainable from the Exchange (e.g., dental, vision, accident, etc.).

In § 155.710, CCIIO proposes that the SHOP ensure that an entity is a small employer. Specifically, the employer must employ no more than 100 employees, with the exception that a State may elect to limit enrollment in the small group market to employers with no more than 50 employees until January 1, 2016.

Trustees of multiemployer plans should be able to choose to purchase coverage in the SHOP Exchange on behalf of plan participants and beneficiaries, particularly if the terms of the SHOP coverage are more favorable than options of purchasing insurance outside of the Exchange market. Consequently, regulations should provide that for purposes of considering whether an entity is a qualified employer, the State Exchange must permit multiemployer plans to meet the definition of qualified employer.

Since the employers who participate in multiemployer plans are overwhelmingly small employers, we suggest that HHS permit any multiemployer plan to purchase coverage in an SHOP Exchange, beginning in 2014. In the construction industry in particular, even when employers are at full capacity they are likely to have fewer than 50 employees and when they are between major projects, the workforce is likely to dwindle to a skeleton level (fewer than 10).

Additionally, the employees for whom the plan would be purchasing coverage are the ones permitted by the terms of the trust agreement and may be limited with respect to non-bargaining participants due to other laws and regulations beyond the scope of the ACA.

Additional regulatory guidance may be needed to permit multiemployer plans to purchase coverage in a SHOP Exchange. For example, references to an employer's "worksite" are not relevant to a multiemployer plan, because individuals work at multiple worksites – some individuals may work at several different worksites for different contributing employers. In addition, multiemployer plans should be able to purchase coverage through the Exchange for any of the collectively bargained employees and their dependents in the plan – regardless of whether an employer obtains coverage elsewhere for other employees – e.g., purchases coverage on the individual Exchange for the owners of the business. Plan participants should be permitted to be enrolled based on the plan's eligibility and enrollment procedures. As suggested in the proposed regulation, self-reporting by the plan should be considered sufficient to verify that the plan meets applicable requirements.

With respect to premium payment, multiemployer plans would continue to collect contribution and eligibility information from contributing employers and would make payments to the Exchange on behalf of eligible employees. This will allow individuals to obtain sufficient work credits to obtain coverage, as under the current system. As suggested by the proposed regulation, we believe that a lag period between work and eligibility is important to maintain, because this reflects the current system by which contributing employers report work to the plans and make contributions, and allow the plan time to determine eligibility and make the appropriate payments to the Exchange.

Existing multiemployer plans provide administrative services, including determining eligibility, collecting and enforcing employers' contribution obligations, administering COBRA, and extended coverage under the FMLA. These functions should be able to be continued by the plan when plan participants are enrolled in an Exchange.

The multiemployer plan should also have the option of providing one application to one or more state Exchanges for all the contributing employers to participate. The contribution level and benchmark plan would be decided by the Board of Trustees. The multiemployer plans would continue to administer the collection of the contribution amount and track eligibility under existing eligibility rules.

Related to this issue, employers who participate in exchanges through a multiemployer plan should not lose tax credits or other subsidies for which they would otherwise be eligible. Currently, pursuant to IRS Notice 2010-82, otherwise eligible employers who pay for premiums by making contributions to a multiemployer plan which purchases insurance can qualify for small business tax credits under Code section 45R. However, this relief expires in 2014 when the exchanges become operational. To ensure that the implementation of exchanges does not incentivize employers to leave multiemployer plans in order to obtain the tax credits, further relief will be needed in this area. It will also be important for multiemployer plans to be able to participate in exchanges with minimal disruption to their existing design and structure. To this end, multiemployer plans should be permitted to provide benefits that supplement the benefits available through the exchanges, without adverse consequences under the Exchange rules.

Definitions

The definition section in the regulation contains no definition of multiemployer plan. A "multiemployer plan" is a plan:

(1) to which more than one employer is required to contribute;

(2) is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer; and

(3) which satisfies other requirements that Department of Labor (DOL) may prescribe by regulation.

ERISA § 37(A)(i)

We suggest that a definition of multiemployer plan be included in the proposed regulations in section 155.20.

In addition, the proposed regulation contains a definition of "Qualified Employer" as follows:

> *Qualified employer means a small employer that elects to make, at a minimum, all full-time employees of such employer eligible for one or more QHPs in the small group market offered through a SHOP. Beginning in 2017, if a State allows large employers to purchase coverage through the SHOP, the term ''qualified employer'' shall include a large employer that elects to make all full-time employees of such employer eligible for one or more QHPs in the large group market offered through the SHOP.* 76 Fed. Reg. 41913.

We request that the definition of "Qualified Employer" include a multiemployer plan as defined in ERISA Section 3(37) that provides health benefits. Additionally, the definition of "Qualified Employee" should include individuals who are *participants* in a multiemployer plan, not just individuals who are employed by a qualified employer.

Exchange Boards

The proposed regulation invites comments on the types of representatives that should be on Exchange governing boards to ensure that consumer interests are well-represented and that the Exchange board as a whole has the necessary technical expertise to ensure successful operations. The regulation also proposes that an Exchange consult on an ongoing basis with key stakeholders.

Like the Massachusetts Connector, we propose that the regulation encourage states to appoint representatives of multiemployer plans to the state Exchange governing board, and to require that representatives of multiemployer plans be considered key stakeholders and consulted with respect to implementation of the Exchange in the state. The Massachusetts Commonwealth Health Insurance Connector Authority Board has one representative sitting on the Board who is

the Executive Director of the Massachusetts Coalition of Taft-Hartley Funds. We suggest that this model be followed for all states.

Navigators

The proposed regulation seeks comment as to whether at least one of the two types of entities serving as Navigators include a community and consumer-focused non-profit organization or whether HHS should require that Navigator grantees reflect a cross section of stakeholders. The proposal also seeks input on the timeframe for grants.

As the Department develops rules on the Navigator program, we encourage you to provide flexibility in regulations that would permit multiemployer health and welfare plans to become Navigators to the extent that it would facilitate providing information about the Exchanges to both participants and contributing employers. Multiemployer plans have a long history of providing a bridge between employers, unions, plan administrators, insurers, and participants and their families.

Although the landscape for 2014 and beyond is still unclear, we believe that this flexibility should be included in the regulations so that if being a Navigator is an appropriate role for a multiemployer plan, it is available. Some multiemployer plans may be able to communicate with the Exchanges to help track participants who enroll in Exchanges and assist contributing employers in their obligations to comply with the employer mandate/free rider penalty (e.g. makes sure coverage meets any minimum standards). This function should be voluntary, as each plan's trustees will need to determine whether the plan is able to provide these services.

Finally, we suggest that the Navigator grant program be established in a timely manner – preferably in 2012, so that it can be ready to assist individuals as soon as the required employer notices begin to be published in March of 2013.

Multiemployer Plans should be Deemed to meet Qualified Health Plan (QHP) Standards

As discussed in detail in the two letters submitted to Ken Choe on August 8 and August 30, which are available at www. nccmp.org, multiemployer plans should be treated in the same manner as Qualified Health Plans purchased on Exchanges for purposes of permitting individuals to receive the federal premium assistance tax credit and to permit small employers to receive the small business tax credit.

If a multiemployer plan satisfies specified requirements relating to the definition of a QHP as defined under ACA Section 1301(a), as well as certain requirements applicable to health insurance issuers, it should be deemed to be in compliance with QHP regulations. As a result individuals who meet the income requirements will be eligible for premium assistance tax credit; coverage under the plan would be minimum essential coverage for purposes of the individual

responsibility provisions of the ACA, and employer contributions to such plans would satisfy the employer responsibility requirement.

In response to the specific question on establishing Exchange certification of QHPs, we recommend that rather than providing each Exchange the discretion to determine certification standards, that QHP certification standards for multiemployer plans be uniform across Exchanges. With respect to the requirement in section 1301(a)(1)(C)(i) that a QHP issuer be licensed and in good standing to offer health insurance coverage in each State in which such issuers offers health insurance coverage, we recommend that for multiemployer plans, the licensure requirements can be met through other methods.

Specifically, we suggest that the procedures established for employer/union direct contract Prescription Drug Plans (PDP) under the Medicare Part D program provide an example of another method through which multiemployer plans could meet state financial integrity standards without being state licensed. The Part D program permits employers and multiemployer plans to contract directly with the Centers for Medicare & Medicaid Services

(CMS) to offer Medicare Part D plans to their participants and beneficiaries.[1] Sections 20.16.2 and 20.16.3 set forth the guidelines for an alternative to these direct contract plans meeting state licensure requirements:

20.16.2 In general, a Part D sponsor must be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers coverage (42 CFR 423.401(a)(1) and 42 CFR 423.504 (b)(2)). However, an employer/union Direct Contract EGWP [Employer Group Waiver Plan] applying to become a PDP solely for purposes of providing prescription drug coverage to its retirees will not have to meet the state licensing requirements set forth in 42 CFR 423.401(a)(1) and 42 CFR 423.504(b)(2) as a condition of being a Medicare prescription drug plan sponsor. CMS waived the licensure requirement for employer/union Direct Contract EGWPs that provide coverage to their own retirees. However, as a condition of this waiver, CMS requires that these entities meet certain financial solvency standards (see section 20.16.3).

20.16.3 The financial solvency requirements for employer/union Direct Contract EGWPs are set forth in Appendix I of the 2009 Solicitation for Applications for New Employer/Union Direct Contract Prescription Drug Plans (PDP) Sponsors, dated January 24, 2008. CMS requires that the entity demonstrate that its fiscal soundness is commensurate with its financial risk and that through other means, the entity can assure that claims for benefits paid for by CMS and beneficiaries will be covered. In all cases, CMS will require that the employer/union sponsor's contracts and sub-contracts contain beneficiary hold harmless provisions as described in Appendix I and in other CMS guidance. The employer/union may request waivers/modifications of the requirements in Appendix I by completing Appendix III ("HPMS Technical Plan Bidding Instructions for Organizations Offering Part D Employer/Union-Only Group Waiver Plans in Contract Year 2009). CMS may, at its discretion, approve requests for such waivers/modifications on a case-by-case basis.

In our experience, the financial reporting standards of the CMS program would represent an effective proxy for state licensure.

[1] http://www.cms.gov/PrescriptionDrugCovContra/Downloads/R6PDB.PDF Pub. 100-18 Medicare Prescription Drug Benefit Manual Centers for Medicare & Medicaid Services (CMS), Chapter 12-Employer/Union Sponsored Group Health Plans, Sections 20.16.2 and 20.16.3.

Conclusion

We greatly appreciate the opportunity to comment on these rules as they apply to multiemployer plans and are more than happy to discuss any questions you may have regarding these comments.

Respectfully submitted

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