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Office of the General Counsel
United States Department of Health and Human Services

FROM: Alston & Bird LLP

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RE: Treatment of Multiemployer Plans Under the Affordable Care Act

On behalf of the National Coordinating Committee for Multiemployer Plans (NCCMP),¹ this memorandum addresses issues relating to the treatment of multiemployer plans under the Affordable Care Act (ACA) as qualified health plans (QHPs). This memorandum follows up on previous discussions regarding multiemployer plan issues and provides legal background supporting the treatment of multiemployer plans under ACA with respect to issues within the jurisdiction of the Department of Health and Human Services (HHS). NCCMP appreciates the opportunity you have provided for discussion of these issues and intends that this memorandum will serve as a framework for more detailed discussions as needed on selected issues.

EXECUTIVE SUMMARY

Need for regulatory guidance

Multiemployer plans provide a unique structure for the delivery of health benefits that has been successful for decades in providing affordable, high quality health coverage for millions of American workers, retirees and families who are often left out of typical employer plans. Examples of those individuals who are often otherwise denied coverage include part-time workers and workers in industries with very fluid employment patterns. Multiemployer plans provide coverage for approximately 26 million Americans today.

ACA evidences Congressional intent that multiemployer plans and the coverage they provide is valuable and should be preserved. However, the statutory provisions do not fully address how ACA applies to multiemployer plans, leaving this to agency regulatory authority to “fill the

¹ NCCMP is a non-profit, non-partisan organization of national, regional, and local multiemployer pension and health and welfare plans, International and Local Unions, national and local employer associations, individual local employers, and multiemployer fund professionals. NCCMP was founded in 1974 in response to the lack of understanding of multiemployer plans demonstrated by lawmakers during the enactment of the Employee Retirement Income Security Act (ERISA). The organization is dedicated exclusively to the advocacy and protection of multiemployer plans and their participants and their families.

gaps” as recognized by the Supreme Court. Further, it is expected that, if the ultimate implementation of ACA results in multiemployer plans being excluded from the favorable tax treatment that Exchange based plans receive, thousands of employers will cease participation in these plans in order to access the tax subsidies. This effect will be particularly strong in industries covering low wage workers, where many multiemployer plans will likely cease to exist.

Multiemployer plans should be treated in the same manner as qualified health plans purchased on Exchanges

Based on the structure of multiemployer plans, clear legislative intent to preserve such plans, and the relevant authorities and provisions of ACA, NCCMP requests that regulations provide that multiemployer plans (including both fully-insured and self-insured plans) are treated in the same manner as qualified health plans (QHPs) purchased through Exchanges.

There are three different ways that this result could be obtained; each of these may provide an independent basis for implementing regulations treating multiemployer plans as QHPs. Further, the similarity between multiemployer plans and the requirements and purposes under all of the three provisions together provide further weight to the position that implementing regulations should consider multiemployer plans as QHPs. Under each of the three approaches, multiemployer plans would comply with specified requirements applicable to QHPs as well as appropriate requirements consistent with those that apply to issuers who offer coverage in the Exchanges.

The three approaches under which the Federal government would certify or deem a multiemployer plan as being a QHP are as follows:

- (a) The 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.
- (b) The plan is the equivalent of a multi-State plan under section 1334 of ACA.
- (c) The plan is the equivalent of a CO-OP plan. The CO-OP grant program is designed to foster the adoption of CO-OPs; multiemployer plans are already a CO-OP model, and so would not need development grants if the plan may be deemed to be a CO-OP and therefore a QHP.

Under each of these approaches, compliance with the standards set forth in the regulations (and discussed in detail below) would be deemed to be in compliance with any requirements applicable to QHPs.

A number of other results should ultimately flow from this treatment – individuals who meet the applicable income requirements will be eligible for the premium assistance tax credit provided with respect to coverage under a multiemployer plan that is a QHP and coverage under such plans should be considered to be minimum essential coverage for purposes of the individual responsibility provisions of ACA. Additionally, while most employers contributing to the multiemployer plans are not subject to the employer responsibility provisions of ACA due to

their size, for those that are, employer contributions to such plans would satisfy the employer responsibility requirement. Many of these related issues are within the jurisdiction of the Treasury Department and will be addressed separately; this memorandum focuses on issues relating to QHP status within the jurisdiction of HHS.

Treatment of multiemployer plans as QHPs is supported by the statute and applicable precedent. Moreover, failure to provide this treatment will ultimately cause many more employers who are currently offering quality, affordable health coverage to shift employees to exchanges and eliminate coverage that has proved successful for decades.

Multiemployer plans should be allowed to purchase coverage through the Exchanges on behalf of contributing employers

Multiemployer plans currently 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 should be enabled to continue to play this role as the exchanges develop. Further, as approximately 90 percent of contributing employers are small employers, multiemployer plans should be allowed to perform this intermediary function even if some percentage of their contributing employers are large employers within the meaning of ACA.

ORGANIZATION OF THE DOCUMENT

The remainder of the document provides detailed discussion of the legal basis for the requested treatment. The document is organized as follows:

- I. Background Relating to Multiemployer Plans
- II. Issues Presented with Respect to Multiemployer Plans and Need for Regulations
- III. Proposed Structure For Multiemployer Plans
- IV. Discussion and Analysis
 - A. Under Existing Precedent HHS has the Regulatory Authority and Responsibility to Implement ACA so as to Preserve Multiemployer Plans as a Viable Coverage Option
 1. The details of how particular provisions of ACA are to apply to multiemployer plans are left open. Under long-standing Supreme Court precedent, the regulatory agencies have the authority to fill the gaps left in the statute by the Congress.
 2. Congressional intent to preserve multiemployer plans as a viable coverage alternative is reflected in the statutory provisions and the purposed underlying ACA. Implementing regulations should reflect this intent.

- B. ACA supports Treatment of Multiemployer Plans as Qualified Health Plans
 - 1. In General: ACA provides three mechanisms to treat multiemployer plans as QHPs.
 - 2. Multiemployer plans satisfy the QHP requirements under all three approaches and multiemployer plans should be deemed to be QHPs.
 - 3. Multiemployer plans are not subject to State licensing requirements and should be considered health plans for purposes of exchange requirements.
 - 4. OPM should deem multiemployer plans to be multi-State plans.
 - 5. HHS should deem multiemployer plans to be CO-OP plans.
- C. Multiemployer Plans Should be Allowed to Purchase Insurance on Exchanges on Behalf of Contributing Employers

I. BACKGROUND RELATING TO 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 Taft-Hartley provisions of the National Labor Relations Act (the “NLRA”). Pursuant to section 302(c)(5) of the Taft-Hartley 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. These plans can provide coverage on a multi-State, regional, or national basis, and the coverage is designed to address the unique needs of the particular industry. The board 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). While these plans are often referred to as “Taft-Hartley plans,” the term “multiemployer” plans is the preferred terminology. 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, including the airline; automobile sales, service and distribution; building and construction; 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; textile and apparel production; and trucking industries. These plans can provide coverage on a multi-State, regional, 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 pool 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).

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. Similarly, multiemployer plans are attractive to employees because they provide, among other things, consumer-oriented plan design and administration, portability, stability and flexibility.

II. ISSUES PRESENTED WITH RESPECT TO MULTEIMPLOYER PLANS UNDER ACA AND NEED FOR REGULATIONS

The statutory provisions are not sufficient to provide guidance with respect to how the myriad provisions of ACA apply to multiemployer plans or to provide a complete framework for how such plans will fit in as the Exchanges and related provisions come into effect in 2014. Thus, regulatory guidance is necessary to fulfill Congressional intent to preserve multiemployer plans. Failure to provide appropriate guidance will significantly impact this highly successful model that currently provides not-for-profit health care to a population often otherwise left without coverage.

Before the enactment of ACA, the success of multiemployer plans meant that they garnered little attention from either the Congress or the regulators.² 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. They 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. The “sponsor” of the plan is not each employer, but the joint board of trustees.³

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.⁴ As another example, the Medicare secondary payor rules look through the multiemployer plan at the size of each contributing employer to determine what rules apply.⁵

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

² There are some statutory and regulatory provisions that are designed specifically for multiemployer plans, many of which are the result of comments from multiemployer groups and their advisors. These provide some guidance as to an appropriate structure for such plans, and are discussed further below.

³ See, e.g., ERISA § 3(16)(B)(iii).

⁴ IRS Notice 2010-82.

⁵ 42 USC § 1395y(b)(A)(iii).

(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 participants⁶ and in fact are precluded from considering the interests of contributing employers in making decisions regarding the operations of the trust.⁷

III. PROPOSED STRUCTURE FOR MULTIEMPLOYER PLANS

Based on the structure of multiemployer plans and the relevant provisions of ACA, NCCMP proposes the following:

If certain requirements are satisfied, coverage under multiemployer plans (including both fully-insured and self-insured plans) should be treated in the same manner as QHPs purchased through Exchanges, with the results that individuals who meet the applicable income requirements will be eligible for the premium assistance tax credit provided with respect to coverage under a QHP and coverage under such plans will be considered to be minimum essential coverage for purposes of the individual responsibility provisions of ACA.⁸ While most employers contributing to multiemployer plans are not subject to the employer responsibility provisions of ACA due to their size, for those that are, contributions to such plans should satisfy the employer responsibility requirement. This structure would preserve ERISA preemption for multiemployer plans.

There are three mechanisms through which multiemployer plans may be deemed or recognized as being a QHP, as follows:

⁶ The Labor Management Relations Act (LMRA) §302(a)(5) (29 USC § 186(c)(5)).

⁷ *NLRB v. AMAX Coal Co.*, 453 U.S. 322 (1981).

⁸ Multiemployer plan QHP coverage would be considered the type of minimum essential that would qualify individuals for the premium tax credit under Code section 36B.

- (a) The 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.
- (b) The plan is deemed to be a multi-State plan under section 1334 of ACA.
- (c) The plan is deemed to be a CO-OP plan. The CO-OP grant program is designed to foster the adoption of CO-OPs; multiemployer plans are already a CO-OP model, and so would not need development grants if the plan may be deemed to be a CO-OP and therefore a QHP.

NCCMP also requests that multiemployer plans be allowed to purchase coverage through the Exchanges for contributing employers.

The legal basis for this position is discussed in the following sections of this memorandum.

IV. DISCUSSION AND ANALYSIS

A. Under Existing Precedent, HHS Has the Regulatory Authority to Implement ACA so as to Preserve Multiemployer Plans as a Viable Coverage Option.

1. The Details of How Particular Provisions of ACA Are to Apply to Multiemployer Plans Are Left Open. Under Long-Standing Supreme Court Precedent, the Regulatory Agencies Have the Authority to Fill the Gaps Left in the Statute By The Congress. The Agencies Have Already Exercised This Authority under ACA.

There are few specific references to multiemployer plans in ACA.⁹ While these references are helpful in some respects, they are not sufficient to provide guidance with respect to how the myriad provisions of ACA will apply to multiemployer plans. Among the many issues left open by the statute are how multiemployer plans will fit in and interact with the Exchanges as they come into effect in 2014. It is precisely this situation where the Supreme Court has recognized agency authority to fill the gaps left by the Congress.

Courts are generally deferential to an agency's interpretation of a statute and give broad discretion to agencies to interpret statutes unless the Congress has spoken directly to the precise question at issue.¹⁰ The Supreme Court has set forth the standards to be used in reviewing agency interpretations. If the Congress has not spoken directly to the issue at hand, then the Court will not substitute its judgment for that of the agency, but rather will analyze "whether the agency's answer is based on a permissible construction of the statute."¹¹ The Supreme Court has recognized that "[t]he power of an administrative agency to administer a congressionally created

⁹ These references are discussed further below.

¹⁰ See, e.g. *Christensen v. Harris County*, 529 U.S. 576 (2000); *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837, 842 (1984); *United States v. Mead Corp.*, 533 U.S. 218 (2001). This is particularly the case where the interpretation involves notice and comment rulemaking.

¹¹ *Chevron*, 467 U.S. at 843.

... program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress.”¹² Where the Congress expressly delegates authority to an agency to fill a gap left in the statute, regulations promulgated to fill that gap “are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute.”¹³ Even where the delegation to the agency is implicit, “a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency.”¹⁴

Because the statute does not address issues specific to multiemployer plans, it is incumbent upon the regulatory agencies to exercise their authority to do so. While the structure of multiemployer plans necessitates the need for unique rules to address such plans, the need for regulatory guidance to fill the gaps is not unique to multiemployer plans. There are many health benefit structures and issues that are not addressed in the statute but that need to be addressed in regulations.

The agencies have already exercised their regulatory authority to fill the gaps in the many pieces of regulatory and subregulatory guidance issued so far under ACA (with or without an explicit grant of regulatory authority). With respect to multiemployer plans specifically, the IRS has exercised its regulatory authority with respect to specific multiemployer plan issues that have arisen to date under ACA. ACA requires employers to report the cost of applicable employer-sponsored coverage on employees’ Forms W-2.¹⁵ The IRS has delayed the application of this requirement with respect to benefits under multiemployer plans, reflecting the fact that an appropriate structure must be created if the requirement is to apply to multiemployer plan coverage.¹⁶ The Treasury also developed special rules accommodating multiemployer plans under the small employer credit, at least through 2014. Further guidance is needed with respect to 2014 and later years.¹⁷

Other areas in which the agencies have used general regulatory authority to implement the law in a manner the agencies determined to be consistent with underlying purposes of ACA include the Rules for grandfathered plans, allowing cost sharing with respect to preventive health services, providing certain exceptions to the annual and lifetime limits, and providing delays for certain provisions.¹⁸

These are but a few examples where ACA has left gaps that have been filled by the regulatory agencies. Similarly, ACA leaves many gaps with respect to the treatment of multiemployer

¹² *Chevron*, 467 U.S. at 843 (quoting *Morton v. Ruiz*, 415 U.S. 199, 231 (1974)).

¹³ *Chevron*, 467 U.S. at 843-44.

¹⁴ *Id.* at 844; see also *Mead*, 533 U.S. at 229.

¹⁵ Code § 6051(a)(14) as amended by ACA.

¹⁶ IRS Notice 2011-28. NCCMP has separately submitted comments on Notice 2011-28.

¹⁷ The initial guidance on the credit did not address multiemployer plans at all; follow up guidance issued in Notice 2010-82, addressed multiemployer plans.

¹⁸ Examples of delays include the grace period for certain claims and appeals requirements, the implementation of the State Recovery Audit Contractor Program, and the nondiscrimination rules for self-funded plans.

plans, and these gaps must be filled by the agencies in a manner consistent with Congressional intent to preserve such plans.

2. Congressional Intent to Preserve Multiemployer Plans as a Viable Coverage Alternative is Reflected in the Statutory Provisions and the Purposes Underlying ACA. Implementing Regulations Should Reflect This Intent.

Although the few specific references to multiemployer plans are not adequate to address all issues with respect to how ACA should apply to such plans, they serve as evidence of overall Congressional intent.

Multiemployer plans are mentioned expressly in the ACA only three times, but these three mentions indicate that the Congress expected and intended multiemployer plans to continue to operate as they have from the beginning of health care reforms through the establishment of Exchanges and beyond. The three provisions are:

- The standard for the essential health benefits package (EHBP) is to be based on the typical employer plan, *including multiemployer plans*. ACA § 1302(b)(2). The EHBP is at the core of the health care reforms, and the specific reference to multiemployer plans in this context indicates the Congress recognized the significance of these plans and that they serve as a model for coverage.
- Multiemployer plans are specifically mentioned as being eligible to participate in the early retiree reinsurance program, one of the first ACA provisions to become effective. ACA § 1002.
- The high cost plan tax, which is one of the last ACA provisions to become effective in 2018, contains specific rules for multiemployer plans, and treats these plans as similar to insurance coverage for purposes of applying the tax. IRC § 4890I.

Thus, ACA on its face demonstrates that the Congress expected and intended that multiemployer plans would continue to be part of our health care delivery system throughout the entire span of health care reform.

The underlying purposes of health care reform also support the preservation of multiemployer plans. There is little doubt as to the overall goals of health care reform – to ensure access to quality, affordable health coverage for all Americans. In order to fulfill this promise, ACA core reforms focus on fostering competition in the health care marketplace. The Exchanges are a prime example of this goal,¹⁹ and the recently issued proposed regulations on the Exchanges

¹⁹ The importance of competition is also reflected throughout various parts of ACA, both in the private insurance market and government programs. For example, the medical loss ratio provisions added to section 2718 of the PHS Act allow States to lower the otherwise required medical loss ratio if needed to preserve competition; ACA section 1332 requires the General Accountability Office to periodically study and report to the Congress on the effects of health care reform on competition and market concentration in the health care industry, including recommendations to increase competition; and a number of Medicare-related provisions are directed at increasing competition.

reinforce the importance of competition beginning with the very first paragraph of the preamble: “[T]he Exchanges, which will become operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing clout as large businesses.”²⁰ As another example, the preamble states further: “Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs. And Exchanges will give individuals and small businesses the same purchasing clout as big businesses.”²¹ A similar statement appears again in addressing the need for regulations.²² The theme repeats through the proposed Exchange regulations.²³

The relevance of competition in the context of multiemployer plans is straightforward – these plans serve today to fulfill the goals of the Exchanges. For over 26 million Americans – active and retired workers, their dependents and survivors – workers who are employed by the 60,000 or more small businesses who contribute to the plans – multiemployer plans “help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing clout as large businesses.”²⁴ Through appropriate regulatory guidance, multiemployer plans can continue to act as a type of Exchange in the post health care reform market.

President Obama’s pledge to Americans who already have health insurance coverage is also relevant. This was more than just rhetoric – rather, it was an important factor in the enactment of health care reform, and served to assure the millions of Americans who already have health insurance that they would not have to change their coverage merely for the sake of change.

This pledge is reflected throughout the statutory provisions as well. Thus, the health care reforms seek to build on, rather than replace, the current employer-based health care system.

The agencies should implement the gaps left by ACA in a manner consistent with Congressional intent to preserve what currently works in the system. For decades, multiemployer plans have been filling coverage needs for millions of Americans. Without regulatory guidance that preserves that role with respect to Exchanges, the result may be a quick end to such plans. Particularly given that most contributing employers are not subject to ACA’s employer responsibility provisions, if purchasing coverage on the Exchanges is the only viable option to obtain subsidies, many small employers will negotiate to end their contributions, shifting the entire burden of coverage to Exchanges.

²⁰ 76 Fed. Reg. 41866 (July 15, 2011).

²¹ *Id.*

²² *Id.*, at 41908.

²³ All told, there are ten specific references in the preamble to the proposed Exchange regulations that discuss the benefits of increased competition by using the word “competition.” This count does not take into account the details of the implementing regulations and the various ways in which they strive to increase competition.

²⁴ *Id.* at 41866.

If the premium assistance tax credit is not made available to multiemployer health plans, in effect, the Federal government will be providing a tax subsidy only to those employers that have chosen not to provide health insurance coverage at all to their employees. Ironically, it is precisely those employers – those that did not provide coverage to their employees – that were largely responsible for the creation of the health care crisis that led to the passage of the ACA.

Further, if the tax credits are not made available for the premiums required to be paid by individuals covered under multiemployer plans, there is a significant possibility that employees will no longer receive health coverage through their employment and will instead be shifted to obtain coverage on the Exchanges. And there also is a significant possibility that lower wage employees, particularly in the part-time sector, will simply choose to not purchase insurance and will instead voluntarily become subject to the individual penalties, if applicable, under the ACA. Clearly, the ACA should not be interpreted in a way that results in Americans currently receiving health coverage losing that coverage.

Thus, it is fully consistent with ACA to maintain as much as possible coverage from employment-based plans such as multiemployer plans.

B. ACA Supports Treatment of Multiemployer Plans As Qualified Health Plans Through the Exercise of Regulatory Authority.

1. In General: ACA provides three mechanisms to treat multiemployer plans as QHPs.

There are several different mechanisms under ACA through which a health plan may be treated as a QHP. Multiemployer plans already comply with many of the requirements applicable to each of these provisions, and each of these may provide an independent basis for implementing regulations treating multiemployer plans as QHPs. Further, the similarity between multiemployer plans and the requirements and purposes under all of the three programs together provide further weight to the position that implementing regulations should consider multiemployer plans as QHPs.

Under all of these approaches, multiemployer plans would comply with specified requirements applicable to QHPs (e.g., requirement to provide minimum essential coverage) as well as appropriate requirements consistent with those that apply to issuers who offer coverage in the Exchanges. Plans that satisfy the applicable requirements under each approach would be deemed or recognized as QHPs, and exempt from the State certification process, similar to the exemption currently provided in section 155.1000(b) of the proposed Exchange regulations.²⁵ Compliance with the Federal requirements would be deemed to satisfy State rules applicable to Exchanges.

²⁵ If considered necessary in order to ensure that multiemployer plans satisfy applicable requirements, a federal process could be adopted for this purpose. We note that CMS has a process already in place with respect to employer/union-only group waiver plans (“EGWPs”) under Medicare Parts C and D (Medicare Advantage and the prescription drug program, respectively). A similar process could be adopted here.

The three approaches are as follows:

- (a) The 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. The requirements applicable to QHPs and issuers offering QHPs in Exchanges are addressed in the proposed regulations relating to Exchanges.²⁶ How these requirements would apply to multiemployer plans is discussed below.
- (b) The plan is deemed to be a multi-State plan under section 1334 of ACA.²⁷ Regulations relating to multi-State plans have not yet been issued.²⁸ ACA contemplates that the Director of the Office of Personnel Management (OPM) is to enter into contracts to provide for multi-State plans.
- (c) The plan is deemed to be a QHP offered under a CO-OP established under section 1322 of ACA.²⁹ The proposed CO-OP regulations provide a process whereby the Centers for Medicare & Medicaid Services (CMS) or an entity designated by CMS certifies that the plan meets the applicable standards so as to be treated as a QHP.³⁰ The CO-OP program is set up under ACA as a grant program; however, multiemployer plans would not be seeking Federal grants. The grant program is designed to foster the adoption of CO-OPs; multiemployer plans are already a CO-OP model, and so would not need development grants if the plan may be deemed to be a CO-OP and therefore a QHP.

Certain issues are common to each of these approaches, and there are also issues that are unique to a particular approach.

2. Multiemployer Plans Satisfy Requirements for QHPs Under All Three Approaches and Should Be Deemed to Be QHPs.

ACA imposes various requirements on QHPs as well as issuers that are authorized to offer coverage through the Exchanges. Multiemployer plans already satisfy many of these requirements, or would make adjustments to do so. Under all the approaches, multiemployer plans would comply with these requirements. Under the first approach described above, if these requirements are satisfied, then the multiemployer plan would be treated as a QHP purchased on an Exchange and would be deemed to satisfy Exchange requirements.

Following is a listing of key requirements applicable to QHPs under the statute and proposed Exchange regulations that could be applicable to multiemployer plans as a condition of being

²⁶ 76 Fed Reg 41866 (July 15, 2011) (the “proposed Exchange regulations”).

²⁷ ACA §§ 1301(a)(2).

²⁸ OMB issued a request for information relating to multi-State programs on June 16, 2011.

²⁹ ACA § 1301(a)(2). Proposed regulations relating to the CO-OP program were published in 76 Fed Reg 43237 (July 20, 2011)(the “proposed CO-OP regulations”).

³⁰ Prop. Reg. 45 CFR § 156.520(e).

treated as a QHP. NCCMP would be happy to discuss these in further detail to determine the exact details of particular requirements.

1. Offer Essential Health Benefits. Multiemployer plans will offer the essential health benefits package described in section 1302(a)(1) of ACA.
2. Out-of-pocket maximums. Multiemployer plans will comply with out-of-pocket maximum requirements. All QHPs must have out-of-pocket maximums that do not exceed the standards that apply to Health Savings Accounts (HSAs) under Code section 223(c)(2)(A)(ii). In 2011, those limits are set at \$5,950 for self-only coverage and \$11,900 for coverage other than self-only coverage. These numbers will be indexed beginning in 2015.³¹
3. Maximum deductibles. QHPs offered in the small group market cannot have deductibles that exceed \$2,000 for single individuals and \$4,000 for any other levels of coverage.³² Multiemployer plans do not now and would not have deductibles that exceed these amounts and would satisfy this requirement.
4. Benefit level. ACA describes four different levels of benefit coverage that may be provided under a QHP (ranging from lowest to highest), bronze (60%), silver (70%), gold (80%), and platinum (90%).³³ Multiemployer plans typically provide coverage that would exceed the gold level, and sometimes exceed the platinum level. As a QHP, multiemployer plans would offer coverage that at a minimum meets the silver (70%) level.
5. Medical Loss Ratio (MLR). The medical loss provisions imposed on health insurance companies are intended to “help ensure policyholders receive value for their premium dollars.”³⁴ Most multiemployer plans have a medical loss ratio that exceeds the new Federal standards for commercial insurance, i.e., an 85% MLR. However, imposing minimum loss ratios for self-funded multiemployer plans is unnecessary because the assets of such plans may only be used to pay benefits and reasonable cost of administration of the plan. By law, the board of trustees is required to administer multiemployer plans for the sole and exclusive benefit of the plan participants.³⁵ In addition, multiemployer plans generally are funded through tax-exempt trusts known as

³¹ ACA § 1302(a)(2) and (c)(1).

³² ACA § 1302(a)(2) and (c)(2).

³³ ACA § 1301(d).

³⁴ Preamble to the interim final regulations on the MLR provisions under PHS Act § 2718, 75 Fed Reg 74864, 74865 (Dec. 1, 2010).

³⁵ The Labor Management Relations Act (LMRA) §302(a)(5) (29 USC § 186(c)(5). (payments may be made from “a trust fund established...for the sole and exclusive benefit of the employees of [the] employer, and their families and dependents (or of such employees, families, and dependents jointly with the employees of other employers ..., and their families and dependents). *NLRB v. AMAX COAL CO.*, 453 U.S. 322 (1981) (“The language and legislative history of [the LMRA] ERISA therefore demonstrate that an employee benefit fund trustee is a fiduciary whose duty to the trust beneficiaries must overcome any loyalty to the interest of the party that appointed him.”).

voluntary employees' beneficiary associations (VEBAs). The Federal tax laws also impose restrictions of the use of funds held in the trust.³⁶ These requirements ensure that multiemployer plans maintain a high medical loss ratio.

6. Guaranteed issue/medical underwriting. Multiemployer plans do not use medical underwriting to determine eligibility. Coverage is available to all eligible individuals through the collective bargaining process and there are no pre-existing condition exclusions.
7. Quality. Multiemployer plans would implement and report to the Federal government on a quality improvement strategy consistent with the standards of ACA section 1311(g).³⁷
8. Nondiscrimination. Multiemployer plans will not discriminate on the basis of race, color, national origin, disability, age, sex gender identity, or sexual orientation. See Prop. Reg 45 CFR § 156.200(e).
9. QHP rate and benefit information. Multiemployer plan sponsors would provide benefit information, including participant contributions (if any), covered benefits and cost-sharing requirements, similar to requirements under proposed Exchange regulation sections 156.201 and 155.1040. This type of information is already provided through information available to the Department of Labor (see next item number) and the requirements should be consistent with existing rules. Rate increase information and justification would not be required due to the legal requirements that plans be operated for the benefit of participants. In any case, most multiemployer plans do not require participant contributions. As discussed above under medical loss ratio requirements, the plan trustees are required to act in the best interests of participants.
10. Transparency in coverage. Section 156.220 requires the provision of information regarding coverage, including periodic financial disclosures, data on enrollment, information on cost-sharing and information on participant rights. Multiemployer plans already are subject to substantial reporting requirements under ERISA. For example, multiemployer plans are required to file annual Forms 5500 – Annual Return/Report of Employee Benefit Plan with the Department of Labor. The precise information required depends on the type and size of plan, but in general Form 5500 includes information relating to enrollment (i.e., numbers of participants) as well as detailed financial information. As another example, multiemployer plans must provide plan participants with a Summary Plan Description explaining their benefits in easy to understand language, as well as a Summary Annual Report (SAR) including financial information. The Summary Plan Description as well as any other plan documents must be provided to the Department of Labor upon request. Existing filing requirements should include sufficient information to satisfy transparency requirements.

³⁶ Code § 501(c)(9); Treas. Reg. § 1.501(c)(9)-1 *et seq.* (For example, the organization must “provide for the payment of life, sick, accident, or other benefits to its members or their dependents or designated beneficiaries, and substantially all of its operations [must be] in furthers of providing such benefits....”)

³⁷ See Prop. Reg. 156.200(b)(5).

11. Network adequacy. Multiemployer plans would certify that they meet network adequacy standards pursuant to an appropriate measurement criterion, e.g., the CMS geoaccess standards. 45 CFR § 156.230.
12. Risk adjustment, reinsurance and risk corridors. These rules would not apply to multiemployer plans because multiemployer plans accept all eligible participants and dependents regardless of the health of the group and premiums are stable across all risk categories.
13. Enrollment. Multiemployer plans would enroll and disenroll individuals in accordance with the applicable eligibility rules for the plan. If an individual premium is required or a subsidy is being received, similar requirements to those in section 156.270 of the proposed Exchange regulations, would be observed.
14. Compliance with all applicable laws. Multiemployer plans are already required to comply with all group health plan standards such as HIPAA, Mental Health Parity and Addiction Equity Act, Part VII of ERISA, etc., and these would continue to apply.

These standards will satisfy statutory requirements as well as fulfill the objective of ACA to ensure that quality, affordable coverage options are available.

3. Multiemployer Plans Are Not Subject To State Licensing Requirements And Should Be Considered Health Plans For Purposes of Exchange Requirement.

The statutory provisions relating to each of the three approaches use the terms “health plan” and/or “health insurance issuer”.³⁸ The term “health insurance issuer” is defined as an insurance company or organization which is licensed under State law to engage in the business of insurance.³⁹ ACA section 1301(a) refers to a QHP as a “health plan” that meets certain requirements. The term “health plan” is defined in ACA section 1301(b)(A) as health insurance coverage and a group health plan. Section 1301(b)(B) excludes a group health plan “to the extent the plan ... is not subject to State insurance regulation under section 514 of [ERISA].” While some multiemployer plans provide coverage on a fully insured basis, making them compliant through the selected licensed carrier, many are self-funded group health plans to which section 514 of ERISA applies.

The ability to operate on a multi-state basis is one of the key features of multiemployer plans that benefits both employers and employees, by providing seamless portable consistent coverage. The high quality multi-State coverage that multiemployer plans now provide is fostered by the uniform, Federal regulatory scheme currently applicable to such plans. Exercise of regulatory

³⁸ ACA section 1301(a) defines a QHP (in relevant part) as a “health plan” offered by a “health insurance issuer”. Among the requirements applicable under the Co-Op provisions, ACA section 1322(c)(1) refers to a “qualified nonprofit health insurance issuer” as a “health insurance issuer” that meets certain requirements. Under the multi-State program, ACA section 1334(a)(1) directs the Director of OPM to enter into contracts with “health insurance issuers”.

³⁹ The definition of “health insurance issuer” under section 2791 of the PHS Act applies pursuant to section 1551 of ACA.

authority to treat all multiemployer plans, including self-funded plans, as QHPs while maintaining the current Federal preemption is supported by the terms of ACA for several reasons.

First, as discussed further in section IV.B.2., above, the references to multiemployer plans in the statute itself evidence Congressional intent that multiemployer plans be preserved as the Exchanges and related reforms go into effect. “[T]he best evidence of [Congress’s] purpose is the statutory text adopted by both Houses of Congress and submitted to the President.”⁴⁰

Further, the specific requirements and purposes of each of the three options presented here, as evidenced by the statute as well as proposed regulations, provide further support for maintaining the current status of multiemployer plans while being treated as QHPs. Multiemployer plans currently fulfill the goals of each of these provisions and comply (or will comply) with the core requirements for QHPs as discussed in the preceding section. For example, as discussed above in section IV.B.2, the proposed Exchange regulations emphasize that the purpose of the Exchanges is to foster competition in the health coverage market and to enhance the purchasing power of small businesses and individuals. The fact that approximately 90 percent of contributing employers are small employers underscores that this is just what multiemployer plans do today.

The multi-State program envisioned by section 1334 of ACA is similar to the coverage already provided by multiemployer plans through a combination of local, regional, and national plans. In addition, section 1334 specifically provides that non-profit entities are to be participants in the program.⁴¹ The ways in which multiemployer plans are similar to plans to be offered under the multi-State program and related issues are discussed further in part 4 of this section, below.

Similarly, the CO-OP provisions are designed to foster the creation of non-profit, member run health insurers, with a focus on integrated care and plan accountability.⁴² This is consistent with current operations of multiemployer plans – they are non-profit, consumer oriented, and run by a board that includes equal representation by employee members and that are required by law to act solely in the interests of plan participants, thus ensuring accountability. Further discussion of multiemployer plans and CO-OPs is in part 5 of this section, below.

Support may also be found in the specific wording of section 1301(b)(1)(B) of ACA. Under its plain terms, ACA section 1301(b)(1)(B) does not exclude a plan from the definition of “health plan” simply because the plan is subject to section 514 of ERISA. It only excludes a plan *to the extent that* the plan is protected from state regulation by section 514 of ERISA. Multiemployer plans are also protected from certain State laws through the preemption doctrine of the National Labor Relations Act (NLRA). The NLRA predates ERISA by many years. Similar to holdings

⁴⁰ *West Virginia Univ. Hosps. v. Casey*, 499 U.S. 83, 98 (1991) (*superseded by statute on other grounds*, Civil Rights Act of 1991, Pub.L. No. 102-166, 105 Stat. 1071 (1991)); *see also Sierra Club v. EPA*, 294 F.3d 155, 161 (D.C. Cir. 2002) (“The most reliable guide to congressional intent is the legislation the Congress enacted”).

⁴¹ ACA § 1334(a)(3).

⁴² *See* proposed Co-Op regulations, 76 Fed Reg at 43237; S. Rpt. No 111-89, America’s Healthy Future Act of 2009, at 5.

under ERISA, courts have held that the NLRA preempts the application of State law to claims made under the terms of a collective bargaining agreement.⁴³ The NLRA preemption doctrine applies equally to claims involving health and other welfare benefits under a multiemployer plan.⁴⁴ Thus, under the *Allis-Chalmers* decision and numerous other court decisions following *Allis-Chalmers*, claims under multiemployer welfare plans are preempted under the NLRA, as well as ERISA.⁴⁵

The application of preemption under the NLRA laws creates an issue as to how the statute should be applied. The preamble to the proposed Exchange regulations notes that there are inconsistencies with respect to the statutory language that create the need for interpretation.⁴⁶ The application of the NLRA creates an issue here. Thus, under the *Chevron* doctrine discussed above, HHS may interpret the statute to treat multiemployer plans, including self-funded plans, as QHPs. The statute supports this treatment specifically for multiemployer plans as defined and regulated under Federal law.

Additional support may be found in the apparent purpose of the provision. That is, because Exchanges are run by State law, it helps to protect State interests by requiring that those participating on the Exchanges are licensed entities. However, if States are not required to allow self-funded multiemployer plans to offer coverage on Exchanges, this State interest is not present. Thus, one approach is to allow coverage under self-funded multiemployer plans that meet Federal requirements to be treated as QHP coverage purchased on the Exchanges, but States would not be required to offer such plans through the Exchanges. This would serve the statutory purposes, as well as permit a role for multiemployer plans consistent with their current Exchange-like functions. (See discussion in section IV.A.2, above regarding this issue.)

4. OPM Should Deem Multiemployer Plans to be Multi-State Plans.

Under ACA, the Director of the Office of Personnel Management (“OPM”) has the authority to certify multiemployer plans as multi-State qualified health plans:⁴⁷

- Section 1334(a)(1) provides that “[t]he Director of the Office of Personnel Management (referred to in this section as the ‘Director’) shall enter into contracts with health insurance issuers . . . without regard to section 5 of title 41, United States Code, or other

⁴³ *San Diego Building Trades Council v. Garmon*, 359 U.S. 236 (1959); *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202 (1985).

⁴⁴ *Allis-Chalmers Corp. v. Lueck*, *supra*.

⁴⁵ See, e.g., *In re General Motors Corp.*, 3 F.3d 980 (6th Cir. 1993); *Cent. States, Se. and Sw. Areas Health and Welfare Fund v. Borden, Inc.*, 736 F. Supp. 788 (N.D. Ill. Jan. 31, 1990); *Goss v. Firestone Polymers, LLC* 2005 WL 1004717 (E.D. Tex. Apr. 13, 2005); *Baumgardner v. Smurfit-Stone Container Corp.* 347 F. Supp. 2d 927 (D. Or. Dec. 2, 2004); and *Arizona Laborers, Teamsters, and Cement Masons, Local 395 Pension Trust Fund* 661 F. Supp. 365 (D. Ariz. May 19, 1987) .

⁴⁶ 75 Fed Reg at 41869.

⁴⁷ Section 1334(a)(1) refers to “multi-State qualified health plans.” That term is not defined by ACA. Even assuming it is intended to refer to “qualified health plans” as defined in section 1301(a)(1), as we explain in part 2 and 3 above, multiemployer plans should be treated as qualified health plans within the meaning of section 1301(a)(1) for several reasons, discussed above.

statutes requiring competitive bidding, to offer at least 2 multi-State qualified health plans through each Exchange in each State.” The statute does not prohibit OPM from contracting with entities other than health insurance issuers to offer multi-State plans, however.⁴⁸

- ACA gives OPM the authority to make this certification by incorporating into section 1334 OPM’s process for selecting carriers under chapter 89 of title 5 of the United States Code. Section 1334 requires OPM to administer its selection of entities to sponsor multi-State plans “in a manner similar to the manner” in which it implements its selection of carriers for Federal health plans under chapter 89 of title 5 of the United States Code.⁴⁹ Under chapter 89 of title 5 of the United States Code, OPM has the authority to select an entity other than a health insurance issuer, including a “voluntary association, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, . . . including a health benefits plan duly sponsored or underwritten by an employee organization.”⁵⁰ Multiemployer plans are established and maintained as voluntary employees’ beneficiary associations pursuant to section 501(c)(9) of the Code. Accordingly, if OPM certifies multiemployer plans as sponsors of multi-State plans it would be adopting a selection process in accordance with section 1334 of ACA that is similar to the one under chapter 89 of title 5 of the United States Code under which OPM is permitted to select voluntary associations as sponsors of Federal health plans.

In addition, section 1334 requires OPM to select non-profit entities as sponsors of multi-State plans, but does not state that the non-profit entities must be health insurance issuers.⁵¹ Accordingly, ACA permits OPM to certify multiemployer plans, which are non-profit entities under section 501(c)(9) of the Code, as multi-State plans.

⁴⁸ If the Congress wished to restrict OPM’s ability to contract with other entities, it would have stated that OPM can contract *only* with health insurance issuers to provide a multi-State plan. *See America Online, Inc. v. United States*, 64 Fed.Cl. 571,759 (Ct. Fed. Cl. 2005) (rejecting an argument based “on the implicit addition of the word ‘only’ to the statute in an attempt to make the statute’s plain meaning seem absurd,” where the text of statute did not require that the factors at issue be the only factors); *see also FDIC v. McSweeney*, 976 F.2d 532 (9th Cir. 1992) (discussing the FDIC’s authority based on the language of a statute, “Had Congress intended this authorizing provision to limit the FDIC to claims alleging gross negligence or greater culpability, it would have inserted the word ‘only’ in the sentence. We may not torture the language chosen by Congress to infer such a meaning.”); *FDIC v. McSweeney*, 772 F.Supp. 1154, 1158 (S.D.Cal.1991) (citing *Rose v. Rose*, 481 U.S. 619, 627-28 (1987) (discussing that where the plain language of a statute does not “indicate exclusivity; this court is prohibited under standard norms of statutory construction from implying such exclusivity when the Congress has not done so itself.”); *In re Coltex Loop Central Three Partners, L.P.*, 138 F.3d 39, 43 (2d Cir. 1998) (“If Congress had intended to modify [‘on account of’] with the addition of the words ‘only,’ ‘solely,’ or even ‘primarily,’ it would have done so. For the court to add such modifiers would work a significant and unwarranted change in the meaning and consequence of the statute.”); *In re DBSD North America, Inc.*, 634 F.3d 79, 96 (2d. Cir. 2011) (same).

⁴⁹ ACA § 1334(a)(4).

⁵⁰ 5 U.S.C. § 8901(7).

⁵¹ ACA § 1334(a)(3).

Multi-State plans must meet several requirements under section 1334 of ACA. As explained below, multiemployer plans meet all of these requirements under the terms of our proposal.

1. Through the certification process described above, multiemployer plans would meet the Federal requirements described above in part 2 of this section as applicable to QHPs and issuers.⁵²
2. Multiemployer plans will also provide essential health benefits described in section 1332 of ACA and benefit options as described above in part 2.⁵³
3. Multi-State plans are also required to comply with the requirements under chapter 89 of title 5, United States Code, which include the requirements for health insurance coverage provided to Federal workers, to the extent that these requirements do not conflict with section 1334 of ACA.⁵⁴ Most, if not all, of the requirements for Federal health plans under chapter 89 of title 5 are already addressed in section 1334's requirements for multi-State plans or statutory provisions applicable to group health plans or would be addressed in the process described in part 2 for certifying that multi-State plans are qualified health plans.
4. Multi-State plans must be initially offered in multiple States and eventually must be offered in all States.⁵⁵ Some multiemployer plans are offered to members who reside in all of the States and at least one plan provides coverage in all States on account of its nationwide membership. Accordingly, even multiemployer plans that are offered locally in only one State or region could satisfy this rule since multiemployer health plans collectively currently provide coverage to their members in all States regardless of their State of residence. This requirement can be deemed satisfied by multiemployer plans.

Multiemployer plans are not health insurance issuers; therefore, they are not subject to the requirements of section 1334(b) which requires health insurance issuers who sponsor multi-State plans to be licensed in each State and to be subject to all requirements of State law. Moreover, even if multiemployer plans were subject to the same requirements as health insurance issuers for this purpose, they still could not be subject to State licensing requirements or all State insurance laws for the reasons described in part 3, above.

5. HHS Should Deem Multiemployer Plans to be CO-OPs under ACA.

The ACA requires HHS to establish a CO-OP program to foster the creation of qualified nonprofit health insurance issuers (herein referred to as "CO-OP issuers") to offer qualified health plans in the individual and small group markets and to operate with a strong consumer

⁵² ACA § 1334(a)(4) and (c)(1)(C). Certain of the requirements relating to medical loss ratio, premiums and profit margin would not be applicable to multiemployer plans, for the reasons described above in part 2, relating to medical loss ratios.

⁵³ ACA § 1334(c)(1)(A) and (c)(1)(C).

⁵⁴ ACA § 1334(f).

⁵⁵ ACA §§ 1334(b)(3), 1334(c)(1)(D), and 1334(e).

focus.⁵⁶ HHS should deem multiemployer plans to be CO-OP issuers under ACA because (1) multiemployer plans would satisfy the requirements imposed on CO-OP issuers under the program that are not otherwise preempted by Federal collective bargaining laws; (2) although they are not health insurance issuers, multiemployer plans perform many of the same functions as health insurance issuers and are treated like issuers under ACA, and (3) multiemployer plans already exist today, and therefore, will not need start-up loans or other grant monies in order to provide health benefits that CO-OP issuers are intended to provide.

HHS should deem multiemployer plans to be CO-OP issuers because multiemployer plans are able to satisfy all of the requirements of section 1332 that can apply to multiemployer plans under Federal law:

1. Governance By Members. The ACA requires a CO-OP issuer to be organized as a nonprofit, member corporation, the governance of which is subject to a majority vote of its members.⁵⁷ Multiemployer plans are operated through stand-alone, non-profit trusts managed by a joint labor-management board of trustees.⁵⁸ These trustees are comprised of an equal number of employers and union representatives. Any decisions regarding the plans must be approved by a majority of the union representatives and a majority of the employer representatives. Trustees have a fiduciary responsibility to the plan participants.
2. Profits Must Benefit Members. The ACA requires any profits made by a CO-OP issuer to be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members.⁵⁹ A multiemployer plan must use all resources to benefit their members; therefore, any plan savings remain in the plan's trust and are used to offset plan costs, improve benefits or improve the quality of health care delivered to members of the plan.⁶⁰
3. Strong Consumer Focus. The ACA requires a CO-OP issuer to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.⁶¹ Multiemployer plans are designed to be member-directed and oriented. Many multiemployer plans maintain local customer assistance offices where members can discuss questions with a representative in person. In addition, multiemployer plans actively and frequently communicate directly with their members, and invest in health care literacy materials to ensure members understand their benefits. As a testament to multiemployer plans' consumer-oriented focus, members of multiemployer plans generally remain in the plans for long periods of time. For example, members of Unite HERE Health remain in the plan, on average, for 10.5 years and, in the construction industry, members commonly begin coverage as an apprentice and remain continuously covered through retirement.

⁵⁶ ACA § 1322(a).

⁵⁷ ACA § 1322(c)(3)(A).

⁵⁸ 29 U.S.C. § 186(c); IRC § 501(c)(9).

⁵⁹ ACA § 1322(c)(4).

⁶⁰ 29 U.S.C. § 186(c), IRC §501(c)(9).

⁶¹ ACA § 1322(c)(3)(C).

4. Must Offer Qualified Health Plans. The ACA requires CO-OP issuers to issue qualified health plans.⁶² As explained in part 2 above, multiemployer plans already offer comprehensive health coverage that is, or can be adjusted, to meet the most significant requirements of qualified health plans.
5. Must Provide Coverage in the Individual and Small Group Markets. The ACA requires substantially all of a CO-OP issuer's policies to be issued in the individual and small group markets.⁶³ Although many multiemployer plans are self-insured, the majority of their members would otherwise be required to obtain coverage in the individual or small group markets. Moreover, multiemployer plans provide coverage to many part-time workers whom small and large employers have no incentive to cover through the Exchange or otherwise under ACA. In particular, multiemployer plans have unique structures to ensure that part-time workers remain covered under the plans – the plans will often combine the hours of service that a part-time worker performs for several employers to determine whether the worker meets eligibility thresholds and will allow part-time workers to “buy” hours of service in order to remain eligible to participate in the plan. It is estimated that approximately 90 percent of contributing employers are small employers within the meaning of ACA.
6. Must Maintain Reserves. The ACA requires CO-OP issuer to maintain reserves.⁶⁴ Multiemployer plans already maintain reserves.⁶⁵

The only requirements of CO-OP issuers that multiemployer plans cannot satisfy are the requirements for CO-OP issuers to be licensed by a State and organized as a nonprofit member corporation under State law.⁶⁶ However, as explained above in part 2, multiemployer plans are exempt from these requirements under Federal law.

In addition, HHS should deem multiemployer plans to be CO-OP issuers because they perform many of the same functions as health insurance issuers and are treated like health insurance issuers for some purposes under ACA. As explained in section II, multiemployer plans function like insurers by essentially creating a community-rated risk pool consisting of all covered employees of contributing employers. Also like insurers, the trustees of multiemployer plans decide 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 decide appeals of adverse payment determinations.

Finally, HHS should deem multiemployer plans to be CO-OP issuers because they do not need loans or grants from the Federal government to achieve the goals of the CO-OP program. The ACA allows HHS to provide start-up loans to entities that seek to become CO-OP issuers and grants to provide assistance to these entities in meeting State solvency requirements.⁶⁷ However,

⁶² ACA § 1322(c)(1)(B).

⁶³ ACA § 1322(c)(1)(B).

⁶⁴ ACA § 1322(h).

⁶⁵ Code §§ 501(c)(9) and 419A(f)(5).

⁶⁶ ACA § 1322(c)(1).

⁶⁷ ACA § 1322(b).

the statute does not require a CO-OP issuer to receive a loan or a grant in order to be eligible for the premium tax subsidies or cost-sharing assistance. Multiemployer plans do not need start-up loans since they have long been established and they also do not require grants to satisfy State solvency requirements since they are not subject to State insurance laws. Moreover, multiemployer plans have been operating very effectively for decades to achieve the very goals that the CO-OP program is intended to encourage: the provision of comprehensive health care benefits with a consumer focus. The fact that multiemployer plans do not require loan or grant assistance does not preclude them from being considered CO-OP issuers who are entitled to premium tax subsidies and cost-sharing assistance when, as explained above, they otherwise satisfy the goals of the CO-OP program and meet the requirements for being a CO-OP issuer.

C. Multiemployer Plans Should be Allowed to Purchase Insurance on Exchanges on Behalf of Contributing Employers.

Multiemployer plans currently act in some cases 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 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 even if some percentage of their contributing employers are large employers within the meaning of ACA.

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 can qualify for premium 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.

CONCLUSION

NCCMP appreciates the opportunity to provide comments on this important issue, and looks forward to discussing these issues further.

If you have any questions, please contact Earl Pomeroy at 202-239-3835 or Carolyn Smith at 202-239-3566.