

NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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Submitted Electronically via *Regulations .gov*

August 16, 2010

The Honorable Phyllis Borzi
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Room S-2524
Washington, D.C. 20210

Re: RIN 1210-AB42

Dear Ms. Borzi:

The National Coordinating Committee for Multiemployer Plans (the NCCMP) is pleased to provide these comments on the interim final rule implementing the grandfather requirements of the Patient Protection and Affordable Care Act published by the Departments of Labor, Treasury, and Health and Human Services (the “agencies”) on June 17, 2010.

As you know, 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 retirement, 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.

Background

The structure of multiemployer health plans is quite different from that of a single employer plan, resulting in the need to address specific concerns of multiemployer plans separately in the health reform regulations. In a typical single employer plan, the firm’s management determines health benefits and the amount spent on them. This financing model has historically been followed by larger single employer plans, even when the covered employees are represented by a union. Typically, the amount of employer contributions is not specified in the plan or any related documents; however, if there is collective bargaining, the obligation to provide group health plan benefits, and often the amount and nature of the benefits, is codified in the bargaining agreement.

In the multiemployer plan, however, a “wage package” is negotiated in the collective bargaining process, usually for terms of three to five years, consisting of an hourly wage and a fringe benefit component from which an allocation is made to various other fringe benefit programs (typically health, pension, annuity, apprenticeship and perhaps industry development funds) that specifies contribution rates to each. Alternatively, and especially in the construction industry, the allocations may be determined outside the bargaining process by or with input from the union. Typically, such contributions are made to the plan based on a unit of work (usually hours worked, but daily, weekly or monthly contributions or a percentage of compensation are not uncommon in certain industries). These contributions are remitted regularly, usually monthly, to the trust fund. If the contributions are not made, they are vigorously pursued through legal collection efforts that will also usually include recovery of interest and liquidated damages on the unpaid amounts. Funds also typically employ audit programs to provide both a real verification of contribution amounts that are due, and to provide a “sentinel” effect to encourage employers to make their contributions when they become due.

Summary of Recommendations

As discussed more fully below, we ask the agencies to:

- Consider the consequences of depriving collectively bargained, multiemployer plans of the time needed to secure adequate funding to implement the Act.
- Confirm that the addition of new contributing employers to a multiemployer plan would not result in the plan losing grandfathered status.
- Clarify the language of the regulations to avoid any implication that changes in the formulas used to determine what employers contribute to a multiemployer plan would not result in the plan losing grandfathered status.
- Provide that changes in a multiemployer plan’s eligibility rules would not result in loss of grandfathered status.
- Clarify that changing from insured to self-insured, changing networks, or changing formularies would not, by themselves, result in loss of grandfathered status.
- Clarify that when grandfathered status is lost, the effective date is the first day of the first plan year following the event that caused the loss of that status.
- Confirm that changing insurance issuers during the period that an insured collectively bargained plan is grandfathered does not affect the plan’s grandfathered status.
- Clarify that multiemployer plans with self-insured dental or vision benefits may treat these benefits as excepted benefits for purposes of determining whether the Act applies to them.
- Provide further guidance as to what constitutes a “benefit package.”

Delayed Effective Date for Collectively Bargained Plans

The regulations adopt a bright-line test for when collectively bargained plans must implement the Title I requirements (i.e., no delayed effective date) and when and under what circumstances they retain “grandfathered” status. While we understand that the Departments are constrained by the statutory language of the Act, it should be understood that interpreting the laws to provide for *no delayed effective date* for some provisions of the law (e.g., age 26, annual and lifetime limits, etc.) and *no grandfather plan exception* unless the plan is insured, has extensive and devastating

consequences for the participants and beneficiaries who receive coverage under multiemployer plans.

Joint labor-management, multiemployer health and welfare trust funds are simply pools of workers' money held in trust under federal law to provide the workers and their dependents with medical, hospital and other health benefits coverage as well as other vital employee benefits. These trust funds are funded by collectively bargained "employer" contributions for which covered workers explicitly trade off wages, dollar-for-dollar, through the collective bargaining process. The workers pay the full cost of their and their dependents' coverage. All costs – including benefits and administrative expenses – are paid from the pool of workers' money.

If the trust fund's costs increase, despite the trustees' best efforts at cost-containment, the burden falls directly on the workers in the form of lower wages and/or reduced benefits. Increases in the costs of benefits typically create a need for higher collectively bargained contribution rates, which reduce wage rates or preclude wage rate increases. If contribution rates cannot be increased or increased sufficiently, the board of trustees may have to reduce benefits or tighten eligibility rules.

Faced with persistent, systemic health care cost inflation over the past 20 years, our health and welfare funds have endeavored to develop innovative means for cost containment, including preferred provider arrangements, promoting preventive care and wellness, engaging in disease management, and forming group purchasing coalitions to maximize bargaining power. These serious efforts have made a difference. But, they have not been enough to contain costs sufficiently because most of the causes of inflation in health care costs are beyond the funds' control, including: costs attributable to preventable medical errors; unrestrained proliferation of medical technology; the inefficiencies of the fee-for-service system; the failure of the system to adequately coordinate care of individuals with multiple chronic conditions; and unfair cost shifting by irresponsible employers and by government programs.

Our health and welfare trust funds are not insurance companies motivated by profit; to the contrary, the funds are non-profit, tax-exempt trusts. The trust funds are not single employer health plans whose terms and conditions are unilaterally set by company executives and that can draw on the company's treasury whenever they need money. To the contrary, the trust funds are pools of workers' money governed by joint labor-management board of trustees who are legally required to operate the fund for the sole and exclusive benefit of the participants (covered workers) and their beneficiaries (dependents) in accordance with ERISA's strict fiduciary standards.

By not allowing lead-time to comply with the mandates, and by limiting access to the collectively bargained deferred effective date for compliance to insured plans the Act and perhaps to a lesser extent the proposed regulations, have placed an additional cost burden onto those trusts which provide benefits on a self-insured basis. This will require the trustees to adjust the plan in other ways to accommodate the cost increases required by the Act. For example, plans that need to remove lifetime limits may need to increase deductibles in order to pay for those costs. Plans required to cover dependents up to age 26 may need to tighten other eligibility rules in order to cover those costs. There is no employer to provide money to offset these costs

because the trust is funded through collective bargaining agreements, and there has been insufficient time to renegotiate those agreements to reflect the new costs of administering the plan.

Addition of New Employers to the Multiemployer Plan

Multiemployer plans frequently have dozens or even hundreds of collective bargaining agreements (CBA) at any one time. Each CBA includes a provision requiring contributions into the trust fund by the signatory employer. The duration of each CBA will vary according to the terms and conditions of the contract. Similarly, unions are constantly negotiating with new employers to contribute to their multiemployer plan, typically because it is the most cost-effective way to provide acceptable health coverage for their employees. These employers come into the multiemployer plan at whatever point they agree to do so, which may or may not coincide with the start of a plan year. When a new employer joins a multiemployer plan, there is no impact on the benefits provided to participants and beneficiaries who are already in the plan. The plan simply expands its membership to another group of individuals, for whom contributions will now be made by their employer. Most multiemployer plans have a minimum standards policy, which requires that contributing employers meet a certain contribution level (e.g., \$x per hour), in order for their employees to be eligible for benefits under the plan. Some plans have multiple benefit levels (e.g., \$x purchases plan A; \$y purchases plan B). However, the trustees establish the benefits and the contributing employer is merely acceding to the terms of the trust in order to provide health benefits, through the multiemployer plan, to its covered employees.

We urge the Departments to clarify that when multiemployer plans add a new contributing employer to the plan, and provide benefits to these participants and beneficiaries, the plan does not lose its status as a grandfathered plan. This is no more than a feature of the statutory and regulatory provisions that permit plans to retain their grandfather status when new employees enter the plan. The way new groups of employees enter a multiemployer plan is for their employer to agree to contribute for them. It should not matter whether their employer had previously agreed to contribute for a different group of employees, perhaps at another facility or working for a related corporation, or is new to the plan itself.

Employer Contribution Changes

Subsection (g) of the regulations lays out the principle that a reduction in the share of the premium or cost of coverage that is paid by the employer is a change that triggers a loss of the grandfather protection. Paragraph (3)(iii)(B) of that subsection states:

The term *contribution rate based on a formula* means, for plans that, on March 23, 2010, made contributions based on a formula (such as hours worked or tons of coal mined), the formula.

This statement is mystifying and, as it stands, is causing confusion and could cause problems for multiemployer plans. What is important in connection with this general point, based on the policy of the grandfather regulations, is whether the plan is still one that participants would want

to keep, given that they now have to pay a greater share of the cost of their coverage. It should not matter how the employer contribution obligation to the fund is determined, or whether the employers are still required to contribute the same amount, if the participants' rights are not affected.

Some unions and employers negotiating over multiemployer-plan contributions might change the basis on which contributions are determined to meet immediate funding needs, shore-up the plan's reserves, or they may determine that their reserves are adequate and divert some of the money previously earmarked for the health fund to the pension plan, often to meet obligations under the Pension Fund's Funding Improvement or Rehabilitation Plan. Indeed, as noted above, many bargaining agreements, particularly in the construction and trucking industries, reserve a portion of the negotiated economic package that the union is authorized to direct, from year to year, to whichever form of compensation is appropriate in that year – wages, health contributions, pensions, etc. If that unallocated money went 50-50 to the health and the retirement plans in year 1, and then goes 100% to the retirement plan in year 2, would that be a cutback that could cause the health plan to lose its grandfather status?

Even if there is a direct cutback in the formula for employer contributions to the welfare fund, we do not see why that would be relevant as long as the employees' share of the coverage costs does not go up. What if it does not result in any changes to benefits under the health plan, or if the changes are minimal and within the margins authorized by the regulation? What if the reduction in employer contributions only results in cutbacks to other welfare benefits, such as life insurance or hour-bank credits, but not health benefits? Indeed, what if it results from achieving the Act's primary goal, which is the reduction in overall health care costs? One could spin out a long list of variables that should be harmless from the perspective of the grandfather rule.

The confusion here is, we submit, due to the unfortunate choice of examples to illustrate the point the regulation is trying to make. The important distinction is between a formula used **under the plan** to allocate the cost of plan coverage between the employers and the participants, and a formula used **in a collective bargaining agreement** to assess employer contribution rates. Although the language from the regulation that is quoted above does refer to "plans that ... made contributions based on a formula", that is the kind of language that is often inaccurately used to refer to multiemployer plans, e.g., "the plan increases contributions ...". Since the regulations illustrate the point with language commonly used to describe multiemployer-plan employer-contribution formulas, practitioners have read this and wondered whether – or concluded – that a plan's grandfathered status would be affected by a change in employer contribution rates.

We do not know what the regulation drafters had in mind when they included a change in the formula under which a plan contributes to the cost of employees' health insurance that is not already covered by its prior language. If the reference to "hours worked" as a determinant of

employees' contribution obligations is intended to refer to distinctions between part-time and full-time employees, the rule would be easier to understand if the regulation stated that.

Parenthetically, if the formula for determining the plan's share of the cost of health coverage is relevant to a plan's grandfather status, the rule stated in the regulations appears to be overbroad. The current language appears to trigger a loss of grandfathered status even if the formula were altered to *reduce* the employees' share of the cost. Perhaps the more appropriate rule would be to refer back to the rules describing various types of benefit reductions that would cause a loss of grandfathered status. The rule could be that grandfathered status is lost by adoption of a change in a formula that results in an increase in employees' costs for coverage under the plan as described in those subsections of the regulation.

In addition, many multiemployer plans are funded entirely with employer contributions. In such a case a reduction in the amount of employer contributions would not increase the portion of the cost of the benefit contributed by employees – the employer would still contribute 100% of the cost of coverage. In such a case, the reduction in the amount or rate of employer contribution should not affect grandfathered status.

In any event, the NCCMP urges that the regulation be revised to make clear that changes in the formula for or the amount of employer contribution rates to a multiemployer health and welfare plan are *not*, by themselves, relevant to the plan's grandfathered status. ***Stated simply, if the participant is not exposed to additional out of pocket costs (beyond those minimal changes authorized by the regulation, we believe it is irrelevant whether the "formula" under which the employer contribution is made (i.e. the portion of compensation allocated to the multiemployer health fund) changes in either direction.***

Change in Eligibility Rules

We note that the list of items that would result in loss of grandfathered status does not include events that are eligibility changes. We encourage the Departments to clarify that a change in eligibility rules does not result in a loss of grandfathered status. This is consistent with the rationale for the grandfather rule, which is that participants should be able to retain the coverage that they currently have. However, the rule does not affect how an individual attains eligibility for coverage.

Specifically, plans have been concerned that a change in a multiemployer plan's eligibility rules could result in loss of grandfathered status. For example, a multiemployer plan may require that a covered employee work 100 hours in one month to attain eligibility for coverage in the next coverage period. In light of the current economic pressures and lack of work, some plans are increasing eligibility requirements. For example, in the situation above, the plan could change the eligibility requirement from 100 hours/month to 120 hours/ month. The change should not result in a loss of grandfathered status.

Similarly, some multiemployer plans have found it necessary to revise eligibility rules for retiree coverage due to the lack of income because of the lack of work. Other plans may determine that it is necessary to terminate retiree eligibility altogether, or to spin retirees off into a separate plan. These eligibility rule changes regarding retirees should also not result in loss of grandfathered status by the plan.

Finally, changes to the definition of eligible dependents should not result in a loss of grandfather status. Due to the Age-26 coverage rule, many plans are evaluating eligibility rules and coverage policies for dependent children. A plan should not lose grandfathered status due to a modification of its dependent eligibility rules.

Response to Specific Questions Raised in the Regulations

The Departments asked whether several changes should result in cessation of grandfathered status. These include changes in plan structure (e.g., switching from a health reimbursement arrangement to major medical coverage or from an insured product to a self-insured product); changes in a network plan's provider network; or changes to a prescription drug formulary. We do not believe that any of these changes should result in a loss of grandfathered status.

Multiemployer plans are often self-insured (at least in part), and often offer a health reimbursement arrangement together with medical coverage. The plan will sometimes implement a health reimbursement arrangement or change a benefit delivery system from an insured one to a self-insured one. In many cases, the plan will go to great lengths to assure that the benefits in the two plans remain the same. This benefit equalization can be done when moving delivery systems, although it does require substantial effort by the plan. Generally, however, plan sponsors are willing to make this effort to assure that the delivery mechanism chosen by the plan sponsor does not affect the benefits available to the individuals in the plan.

Consequently, we recommend that mere changes in delivery systems, such as implementing an HRA, moving from insured to self-insured, changing third party administrators or pharmacy benefit managers, etc. should not, by themselves, result in a loss of grandfathered status. If the change results in a benefit modification, then the modification can be tested under existing grandfathered rule requirements, but the benefit delivery system should not result in a *per se* change.

While comments were not specifically requested on this issue, we also challenge the regulation's position that simply changing insurance companies (in the regulation, this is referred to as "entering into a new policy, certificate, or contract of insurance") causes a loss of grandfathered status. In that regard, this has the unfortunate side effect of insulating the incumbent insurer from healthy competition, if it knows it will be extremely costly to the plan to change to a different carrier. In addition, a carrier change can be made with little or no change in benefits – the only difference would be the name on the individual's insurance card. We agree with the comments in the preamble that simply renewing an insurance contract would not result in a loss of grandfathered status.

With respect to changes in a provider network or a prescription drug formulary, we suggest that it would be impossible to require that the plan lose grandfathered status when these changes occur because (1) the changes are happening continuously during the plan year, and (2) the plan sponsor often has no control over the changes. Most multiemployer plans that are self-insured retain a provider network and a pharmacy benefit manager to provide benefit administration services. The plan may contract for a general scope of services that outlines a specific kind of network or a certain level of formulary (e.g., expansive v. narrow) but the plan generally does not have any method by which to monitor changes in the networks or formularies. Consequently, the plan would not be able to control, or even know, when it would or would not retain grandfathered status. We also urge the Departments to conclude that a plan's deliberate decision to switch from one preferred provider organization to another (with resulting change in some aspects of the provider network) or from one pharmacy benefit manager to another would not cause a loss of grandfathered status.

We also note that the Departments have encouraged the use of value-based plan designs in the regulations concerning preventive care. Many multiemployer plans monitor network size as a way in which to control the quality and cost of health benefits. A network may expand or contract as a method by which the plan sponsors attempt to control the quality of health care provided to participants and beneficiaries; however, the nature of the services available to the participants and beneficiaries does not change. They are still eligible for the same care. Similarly, plans may change incentives to utilize providers based on the need to provide a more narrow or expansive network in order to deliver services more effectively. These changes in participant incentives to utilize network providers should also not result in a loss of grandfathered status.

Timing of Loss of Grandfathered Status

The regulations provide for a delay in the loss of grandfathered status for insured collectively bargained plans until the expiration of the last collective bargaining agreement ratified prior to March 23, 2010. The regulations do not state when grandfathered status is lost. We encourage the Departments to provide guidance that if a group health plan loses its grandfathered status when the collective bargaining agreement expires, the plan must comply with the new requirements applicable to non-grandfathered plans at the beginning of the next plan year.

The best way to illustrate this concern is by example. Suppose a collectively bargained plan has collective bargaining agreements (ratified prior to March 23, 2010), the last of which terminates on September 30, 2011. The plan is tested to determine whether it retains its grandfathered status when the agreement terminates, on September 30, 2011. If the plan fails the test (for example, there has been an increase in coinsurance in the interim) on September 30, 2011, it will not be able to immediately implement the new rules applicable to non-grandfathered plans. The new requirements are extensive and cannot be implemented overnight. The only reasonable manner in which to allow the plan to implement the new requirements is to provide that the plan becomes a non-grandfathered plan on the first day of the first plan year beginning on or after the loss of grandfathered status.

Changing Issuers Before Termination of Last Collective Bargaining Agreement

Under the regulations, insured collectively bargained plans will not lose their grandfathered status until at least the termination of the last collective bargaining agreement ratified before March 23, 2010. The preamble to the regulations states that, for insured collectively bargained plans, a change in issuers during the period of the agreement, by itself, would not cause a plan to lose its grandfathered status at the termination of the agreement. However, a change in issuers after the termination of that agreement terminates would trigger loss of grandfathered status. (75 Fed. Reg. at 34542)

A close reading of the interplay between subsection (f) (and its Examples 1 and 2) and subsection (a)(1)(ii) supports the preamble's statement, but it would be helpful if the Departments stated this more explicitly in the regulations themselves. As many collective bargaining agreements last three to five years, it is important to know if a plan's trustees are locked into staying with a particular issuer for the duration of the last agreement or may change issuers without losing grandfathered status when that last CBA terminates. While we recognize that the regulations provide that grandfathered status would be lost if the change in issuers resulted in benefit changes of the types listed in subsection (g), the change in issuers in and of itself should not carry that result. It would also be helpful if the Departments clarified whether the same rule applies when the trustees add a new insured benefit option under the plan during the period of the agreement (e.g., adding a new PPO plan to the mix of coverage options available under the plan).

Limited-Scope Dental and Vision Plans

The grandfather regulations provide that the exceptions of ERISA section 732 and Code section 9831 for very small plans (including certain retiree-only health plans), and for excepted benefits, remain in effect. Thus, ERISA section 715 and Code section 9815, as added by the Affordable Care Act, do not apply to such plans or excepted benefits. We urge the Departments to provide guidance clarifying that multiemployer plans with self-insured dental or vision benefits may treat these benefits as excepted benefits.

Multiemployer plans generally provide extensive dental and vision benefits to participants and beneficiaries. Often, these benefits are self-insured and self-administered. The benefits are often paid based on a schedule of benefits, which is listed in the plan's document and Summary Plan Description. In some cases, the plan is administered by a dental or vision service provider on an administrative services only (ASO) basis, but plan benefits are still designed by the board of trustees.

In most cases, multiemployer plan participants do not contribute toward the cost of dental or vision coverage, and therefore do not make separate elections regarding that coverage, as employees in single-employer plans tend to do. The benefits provided by a multiemployer plan are generally determined by the plan's Board of Trustees, not by a contributing employer. The employers' responsibility is to provide contributions to the plan in accordance with the applicable collective bargaining agreement. The employers do not determine benefits or hold open enrollment periods during which participants choose from an array of benefit options.

Multiemployer plans have typically considered dental and vision benefits as separate benefit programs, even if they are administered by the plan. The rules for such benefits are substantially different from the medical benefit rules, and often include limitations, exclusions or annual/lifetime limitations. The HIPAA statute (ERISA section 732 and Code section 9831) provides that dental and vision benefits are excepted benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan. The HIPAA regulations interpret the phrase “not an integral part of the plan” to require that a self-insured dental or vision plan be separately elected and paid for in order to qualify for the exclusion from the group health plan mandates.¹

Multiemployer plans that offer a self-insured dental or vision benefit will almost never qualify for the limited-scope exception under the Affordable Care Act if the dental or vision plan must be separately elected and paid for. Consequently, a self-insured benefit offered by a single-employer plan could be considered an excepted benefit if it is separately elected and paid for by an employee, while the same self-insured benefit offered by a multiemployer plan could not be considered an excepted benefit, solely because the employees do not have to pay out of pocket for that coverage under multiemployer plans. The regulations’ narrow definition of a limited-scope benefit has produced extensive confusion, making it difficult to determine whether a particular dental or vision benefit qualifies. In addition, dental and vision service providers have been reluctant to interpret the rule for an ASO arrangement differently from their insured products. For example, some multiemployer plans have been told that their dental service provider considers all dental plans to be excepted benefits and will not implement separate rules for a self-insured dental plan as opposed to an insured one.

Benefit Package Definition

Subsection (a)(1)(i) of the grandfather regulations states that “[t]he rules of this section apply separately to each benefit package made available under a group health plan.” While the regulations contain several examples of plans with multiple benefit packages, the regulations do not define or describe what a benefit package actually is. Multiemployer plans typically offer many types of benefits that are insured or administered by different entities or administered by the fund itself. Some may offer different benefit plans based on the negotiated contribution rates. If participants are offered medical coverage through one carrier, hospital coverage through a separate carrier, and prescription drug coverage administered by a pharmacy benefit manager, is that one benefit package consisting of medical, hospital and prescription drug benefits, or is that three benefit options because each is administered or insured by a different entity? This is particularly important, as trustees may need to adjust copayments for only one type of benefit – e.g., the prescription drug benefit – but need to know if changing only that benefit could result in a loss of grandfathered status for the medical coverage as well as the hospital coverage.

¹ See 29 CFR § 2590.732(c)(3).

Conclusion

Thank you for the opportunity to provide comments on this important issue. We will be pleased to provide any additional information that you might find useful.

Sincerely,

Randy G. DeFrehn
Executive Director

DRAFT