**NCCMP Testimony - May 6, 1999**
**Hearing on Impact of External Review on**
**Health Care Quality**

Mr. Chairman and Members of the Subcommittee:

My name is James S. Ray. On behalf of the National Coordinating Committee for Multiemployer Plans (NCCMP) and its Chairman, Robert A. Georgine, I thank you for this opportunity to participate in the Subcommittee's bipartisan hearings on health care reform issues. We congratulate Chairman Boehner, Ranking Member Andrews, and all Members of the Subcommittee on your efforts to examine these vitally important issues.

Health care policy issues are a major concern of the NCCMP, as reflected in Bob Georgine's service as a member of President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

We are particularly pleased to be invited to describe the essential role in our Nation's health care system played by joint labor-management, multiemployer health and welfare plans, commonly referred to as "Taft-Hartley funds." Tens of millions of American workers, retirees and family members depend on multiemployer health and welfare plans for health care coverage. But for these plans, many, if not most, of these working families would lack health coverage because of the transient employment patterns and small size of employers in covered industries.

Multiemployer health and welfare plans are a success story of the health care system largely because, over several decades, they have been responsive and adaptable -- e.g., to the employment patterns and economics of a particular industry, and to the particular needs and wants of the covered workers. A key to this responsiveness and adaptability is the composition and authority of a plan's joint labor-management board of trustees, including the essential role played by the board in resolving benefit claims disputes. That dispute resolution process is particularly relevant to today's Subcommittee hearing on external review of benefit claims disputes.

## ***THE NCCMP***

The NCCMP is a nonpartisan, national, non-profit organization of multiemployer pension, health and welfare plans and their labor-management sponsors. The NCCMP was established in 1975, shortly after enactment of the Employee Retirement Income Security Act (ERISA), to represent the interests of the multiemployer plan community before Congress, the various Federal agencies that regulate employee benefit plans, and the courts. The organization's primary mission is to educate policymakers about the special nature and needs of multiemployer plans so that employee benefits legislation and regulation can reflect the best interests of the many millions of American workers and dependents who support and benefit from these plans. As declared by Congress, national policy recognizes that the retirement, health and income security of millions of Americans depend on the continued existence and well-being of multiemployer plans and encourages the creation, maintenance, and sound funding of these plans.[1] Care must be taken to protect and nurture multiemployer plans. A well-intentioned legislative or regulatory change that might seem good policy as applied to some portion of the health care system could have devastatingly bad, uninhibited consequences for multiemployer plans and for their participants and beneficiaries.

The NCCMP's membership includes national, regional and local benefit plans covering workers in industries such as building and construction, service, transportation, clothing and

textiles, food and commercial, maritime, and entertainment.

## ***THE SPECIAL NATURE OF MULTIEMPLOYER HEALTH & WELFARE PLANS***

[1] See ***Multiemployer Pension Plan Amendments Act of 1980*** amendments to ERISA, PUBLIC LAW 96-364, Section 3(a). _Multiemployer plan_ is a term of art, defined in federal statutes, as a pension, health or welfare plan (1) to which more than one employer is required to contribute, and (2) which is maintained pursuant to one or more collective bargaining agreements between one or more labor organizations and more than one employer. See, ERISA Section 3(37) ,29 U.S.C. _1002(37); Section 414(f) of the Internal Revenue Code, 26 U.S.C. _414(f).

Among the proudest achievements of collective bargaining is the decades-old, nationwide system of joint labor-management, multiemployer health and welfare plans that provide tens of millions of American workers, retirees, and dependents with medical, hospital, sickness, disability, death and related benefits.

Workers covered by multiemployer plans are employed throughout the Nation in industries as diverse as building and construction, retail, food, clothing and textiles, transportation, mining, services, entertainment, longshoring, maritime, hotel and restaurant, and manufacturing. But for multiemployer plans, many, if not most, of these millions of Americans would lack employment-based health care coverage and would be dependent upon government programs for their medical treatment or face financial ruin in the event of accident or illness in the family. The intermittent and mobile employment patterns of most of these industries would prevent the workers from obtaining health benefit coverage absent a central pooled trust fund through which portable coverage is provided to workers as they move from employer to employer. Moreover, most employers in these industries are small and would not maintain their own employee health plans, particularly for transient workers.

Workers' Trust Fund

The hallmark of a multiemployer plan is the involvement of the worker's representatives in the creation and operation of the plan. The mere fact that multiple employers create or contribute to a single plan does not make the plan a multiemployer plan. For example, a "multiple employer welfare arrangement" or "MEWA" is not a multiemployer plan.[2] The unifying force of a multiemployer plan is the labor union, which sponsors the plan and represents the covered workers.

Because a multiemployer plan is co-sponsored by a labor union, the plan can accept employer contributions only if it complies with the structural requirements of the Labor Management Relations ("Taft-Hartley") Act of 1947[3], a federal statute that pre-dated ERISA by more than 25 years. That is why multiemployer plans are often referred to as "Taft-Hartley plans" or "Taft-Hartley funds."[4]

The Taft-Hartley Act requires that a multiemployer plan:

- be established and maintained in the form of a trust fund, legally distinct from the sponsoring union and the contributing employers, for the sole and exclusive benefit of the covered employees, retirees, and their families;
- provide for equal representation of the covered employees and the contributing employers in the trust fund's administration (i.e., a joint board of labor and management trustees must govern the plan);
- not commingle pension and health plan assets in a single trust;
- be maintained pursuant to a detailed written agreement with the employers specifying the basis for contributions;
- provide only certain types of benefits (which include medical and other health care benefits);

---

[2] See ERISA Section 3(40)(A); 29 U.S.C. "1002(40)(A)(excluding collectively bargained plans from the MEWA definition).

[3] Section 302(c) of the Act (29 U.S.C. '186) prohibits employer payments to unions and to organizations in whose administration union representatives participate, with certain specified exceptions. Among the exceptions are pension and health care plans that meet the structural requirements described herein.

[4] A single employer plan may also be subject to the mandates of the Taft-Hartley Act if a labor union or its representative participates in the plan_s administration. However, single employer Taft-Hartley health plans are rare. An employer may collectively bargain with its employees' union over the content and operation of the company's employee health plan, but rarely does an employer agree to involve the union's representatives in the administration and control of the plan. In contrast, multiemployer plans typically are established at the request of a union.

- provide for arbitration of disputes between labor and management trustees; and

- undergo an annual financial audit and disclose the audit results to interested parties.[5]

These statutory mandates are enforceable under civil and criminal provisions of the Taft-Hartley Act.[6] Contributions to plans that do not comply with these statutory requirements may constitute a federal crime and are enjoinable by the federal district courts.[7]

As a practical matter, a multiemployer health plan is established normally by a labor union and employers of the employees represented by the union agreeing to establish such a plan to provide health benefits to the employees and their families. The union, the employers, and individuals designated as labor and management trustees enter into an "agreement and declaration of trust" or "trust indenture" which creates the trust fund and defines the rights and responsibilities of the trustees with regard to the management of the fund. The union and the employers also enter into one or more collective bargaining agreements obligating the employers to contribute to the plan for all employees in the bargaining unit at certain rates for a set period of time (usually the term of the agreement, which may be one to three years or longer)[8].

Over the years that follow the plan's founding, the union and the original employers periodically renegotiate and enter into new collective bargaining agreements requiring contributions to the plan. Additional employers may be negotiated into the plan under the same or different collective bargaining agreements. A single employer may be obligated to contribute to the plan pursuant to multiple collective bargaining agreements (e.g., separate agreements cover employees at different plants or project sites). An employer may be permitted to obtain coverage under the plan for its non-bargaining unit (i.e., not union-represented) employees as well as its union-represented employees.[9]

Some plans have grown to include hundreds of employers contributing pursuant to hundreds of different collective bargaining agreements on behalf of thousands of workers in multiple States. Some plans are national in coverage. Some cover workers in multiple States in a region. Some are statewide. Some cover the workers of relatively few employers in a local area.

In some cases, more than one union representing workers in the same industry will jointly establish a multiemployer plan with a group of employers (e.g., various building and construction trades unions in an area may form a multi-union, multiemployer plan covering workers represented by all of those unions in the area).

Pooled Fund: Portability & Economies of Scale

All of the collectively bargained employer contributions to the multiemployer health plan are pooled and invested. It is from this pool that all of the plan's expenses of operation are paid. It is also from this pool that benefits are paid to covered workers, retirees and their dependents ("participants" and "beneficiaries," as defined in ERISA[10]) to the extent that the plan is self-funded, and from which premiums are paid to the extent that the plan's benefits are insured through contracts with insurance companies or (in the unusual case) benefits are delivered through managed care organizations.

---

[5] Taft-Hartley Act Section 302(c)(5), 29 U.S.C. _186(c)(5).

[6] Taft-Hartley Act Section 302(d), 29 U.S.C. _186(d).

[7] Id.; Local 144 Nursing Home Pension Fund v. Demisay, 508 U.S. 581 (1993).

[8] Multiemployer plans accept all employees covered by the collective bargaining agreement as they are, subject to uniform eligibility rules. They do not "cherry pick" the good risks in a bargaining unit and exclude the bad risks.

[9] Coverage of non-bargaining unit employees is often in response to an employer_s concerns that cost-effective health plan coverage would not be available for these employees if they are separated from the union-represented group.

[10] ERISA Sections 3(7), (8); 29 U.S.C. __1002(7), (8).

This pooling characteristic of multiemployer plans provides workers with true portability of health coverage. A covered worker who changes jobs from one contributing employer to another maintains seamless coverage under the plan despite frequent changes in employment. The plan continues to receive contributions for the worker, just from a different employer.

This portability is essential for workers in industries characterized by mobile and intermittent patterns of employment, such as building and construction, entertainment, clothing, and longshoring. For example, a building tradesman may be employed by a particular employer for only a day, a week, a month, or a few months to work on a specific project, and then move on to work on another employer's project for a time, and then another, etc. Between jobs, the worker might be off work for a day, a week, a month, or longer, depending on the availability of work. A building tradesman might work for scores of different employers over his working life, with varying periods of unemployment in between. In another industry, a longshoreman may work for several employers in a single day.

Moreover, many multiemployer plan industries are characterized by small employers[11] who would not maintain a separate health plan for their employees, particularly transient workers, because of the costs involved. Participation in a multiemployer health plan enables these employers to provide benefit coverage for their workers by simply making contributions and without the burdens of administering or designing a plan.[12]

For several decades, multiemployer plans have been accommodating these employment patterns by providing a central fund through which portable coverage is provided to workers as they move from one contributing employer to another. In effect, all of the contributing employers' scores, hundreds, or even thousands of employers _ are treated as a single employer for purposes of providing health and welfare benefits coverage to workers and their families.

Beyond this internal plan portability, many multiemployer health plans have reciprocal arrangements with other multiemployer plans sponsored by affiliates of the same union(s). Reciprocal arrangements help workers who take employment outside of the geographic area of one multiemployer plan to maintain health plan coverage if their new jobs are with employers, which contribute to another multiemployer plan covering workers represented by affiliates of the same union(s). So, for example, a laborer who participates in a Laborers Union health fund covering the Northern California-Nevada area may maintain health plan coverage even if he accepts a job in Albany, New York with an employer which contributes to the Laborers' multiemployer plan that covers the Albany area, depending on the terms of the reciprocal arrangement between the plans.

Even in the absence of a formal reciprocal agreement, arrangements are made by many plans to accept contributions on behalf of participants working outside of the plan's jurisdiction. Through these arrangements, "traveling" participants can maintain coverage for themselves and their families under their "home plans."

Multiemployer plans also enjoy economies of scale in administration and enhanced purchasing power with health care providers, insurers and managed care organizations not available to individual employers, particularly small employers. Multiemployer plans are prototype purchasing cooperatives.

Workers' Money

Multiemployer plans are financed by the covered workers through their labor; that is, through collectively-bargained contributions. While the law considers these to be "employer contributions," the workplace reality is that these collectively bargained contributions are substitute wages for labor received. Instead of putting this money into the workers' paychecks, the employer agrees to pay it into the multiemployer health plan to finance coverage for the workers and their families.

The basis for the collectively bargained contributions varies by industry according to the nature of employment patterns, cash flow, and financial structures of the industry. In many

---

[11] For example, in the construction industry, 82% of contractors have fewer than ten employees. ***The Construction Chart Book: The U.S. Construction Industry & Its Workers,*** Center to Protect Workers' Rights, February 1997.

[12] In the construction industry, virtually all union-represented workers have health coverage through multiemployer plans. In contrast, few non-union workers receive health care coverage through their employment.

industries, like building and construction, the contribution is dollars-and-cents per hour of work or pay. In other industries, the contribution is based on units of production, weeks of covered work, or earnings. Who is responsible for making these contributions (i.e., who is the "employer") is the subject of special industry rules designed to maximize the collection of contributions. For example, in building and construction, a general contractor is often responsible for guaranteeing payment of plan contributions owed by subcontractors. In the garment industry, manufacturers or jobbers, who have greater financial stability, typically are required to make the contributions even though separate firms (contractors) are the covered workers' direct employers.

In a single employer plan setting, it is common to distinguish between the employer's share and the employee's share of the health insurance or plan premium. Cost-sharing and cost-shifting from employers to their employees are matters of concern. In contrast, multiemployer plans normally do not think in terms of employer's share versus employee's share. All of the contributions are workers' money. Employers do not pay anymore than they would otherwise pay in wages.

Because they pay the full cost, the workers are well aware of the cost of health care coverage. The nature of collective bargaining in most multiemployer plan industries is that the union and the employers negotiate total compensation package cost; a total per hour labor cost. The workers, through their union, decide how to allocate the total monetary rate among cash wages, pensions, health and welfare, apprenticeship and training, and other benefits programs. There is an express tradeoff between cash and benefits. Given the fixed compensation pie, an increase in the contribution rate needed to finance the health plan means lower cash wages, or a reduction in the pension plan contribution rate or in some other benefit.

During the mid-1980s to early 1990s, many workers did not receive increases in their cash wages because health care cost inflation had driven health plans to demand higher contribution rates to maintain benefits.

From the plan's perspective, collectively bargained contributions are the life-blood; plans cannot pay benefits unless they receive contributions to finance the coverage.[13] Financing depends primarily on two factors: the amount of covered work that generates the contributions and the contribution rate. A plan generally receives contributions only for work that is covered by a collective bargaining agreement requiring contributions to the plan. If the level of covered work declines, plan income declines. So, for example, if union construction work in the area of a carpenters health plan is slower than expected, the plan will receive less in contributions because the covered carpenters will not be working as many hours in covered employment.

On the expense side of a plan's budget are benefit payments (e.g., hospital and doctor bills) for participants and beneficiaries, or premium payments, and costs of administering the plan. These expenses are affected by a variety of factors including health care costs, utilization of plan benefits and regulatory costs.

Over the years, the labor-management boards of trustees[14], with professional assistance,[15] have designed health and welfare programs that balance the benefit needs and wants of the covered workers with the financing that can be provided by the collectively bargained contributions. In so balancing the income and expense sides of the budget, trustees have developed various eligibility rules, benefit packages, and operational practices for the particular circumstances of the plan, its participants, and the industry.

For example, plans have developed various systems for benefit eligibility that are designed to maximize coverage given the employment patterns in the industry and the financing needs of the plan. Some systems require a worker to work a minimum number of hours in a period (e.g., month or quarter) to earn eligibility for the following period (e.g., the next month or quarter). Some systems

---

[13] This essential link between multiemployer health plan coverage and receipt of contributions has been recognized by Congress in formulating legislation affecting plans. See, e.g., ***Report on the Family and Medical Leave Act of 1993***, Committee on Labor and Human Resources, U.S. Senate, S. Rep. No. 103-3, 103d Cong., 1st Sess. 32-34 (1993).

[14] In a few situations, like the mining industry, the bargaining parties, rather than the trustees, design the plan.

[15] Boards of trustees typically hire actuaries and consultants, attorneys, auditors, and investment advisors among other professionals.

include "hours banks" arrangements under which a worker's covered work hours in excess of a set level are "banked" and used to obtain benefit eligibility during future periods of unemployment or underemployment.

So, too, do the benefit packages vary from plan-to-plan according to circumstances. Given that the plan is financed by the workers and that one-half of the plan's board of trustees are labor representatives (usually elected union officers), the tendency is for a board to adopt the most generous benefit package that the plan can reasonably afford. The trustees are accountable to the covered workers.

A number of plans offer multiple levels of benefit packages at different contribution rates. These plans enable the bargaining parties to select a specific benefit package at a cost that fits their financial circumstances, and to obtain better benefits over time as they are able to negotiate increases in contribution rates.

The trustees' budget balancing may be upset by unexpected declines in contribution income or increases in cost. At times, a plan may experience both; for example, an economic recession in the industry may cause a reduction in covered work and, therefore, contribution income, and may also cause an increase in benefits utilization by the idled workers. Plans normally take steps to protect against economic adversity, such as maintaining reserves, obtaining stop-loss insurance, or insuring some or all of the plan's benefits.

However, these protective devices may not be appropriate or sufficient in some circumstances such as hyper-inflation of health care costs or prolonged economic recession. Trustees have traditionally relied upon other tools to maintain the plan's viability in times of economic adversity. These tools include adjusting eligibility rules (e.g., requiring more covered employment for benefit eligibility), reducing benefit levels, increasing out-of-pocket charges, and eliminating types of benefits.

Trustees may also request the bargaining parties to negotiate an increase in the collectively bargained contribution rate. It may take months or even years to effectuate such an increase, particularly where the contribution rate is fixed for the term of the collective bargaining agreement and where the plan receives contributions pursuant to many collective bargaining agreements with differing expiration dates and terms. Some bargaining agreements provide for mid-term adjustments in the allocation of the compensation package so that the union and employer(s) may agree to reallocate a portion of the wage rate to increase the rate of contribution to the health plan. Or, they may agree to reduce the rate of contributions to the pension plan and redirect the amount of the reduction to the health plan. Or, they may agree that a scheduled wage increase will be foregone in favor of an increase in the health plan contribution rate.

In short, unlike a single employer corporate-type plan, a multiemployer plan cannot simply dip into the corporate treasury when funding falls short of, or expenses exceed, expectations. The trustees need flexibility to use a combination of tools to innovatively adapt to changing circumstances and maintain the plan's financial soundness. Multiemployer plans have been successfully doing so for decades.

Delivery of Benefits

A plan's board of trustees, typically, is authorized by the plan's trust agreement to decide all questions regarding the types and levels of benefits that the plan will provide, how the plan will provide the benefits, and the eligibility requirements for benefits. And, as noted, these decisions are based on the balance between available funding and the needs and wants of the covered workers and their families.

Among these decisions is whether the plan will "self-fund" some or all of the benefits, will insure all or some of the benefits, or will contract with a managed care organization (e.g., health maintenance organization) to provide all or some of the benefits.

Most multiemployer plans, and virtually all large plans, are "self-funded" in whole or in part. That is, the benefits (e.g., payment of hospital and doctor bills) are paid directly from the plan's assets in the trust fund, whether paid to the provider or reimbursed to the participant or beneficiary. Some plans are fully insured; that is, the trustees purchase policies of insurance from insurers which pay the benefits due under the policies to or for the plan's participants and beneficiaries. The cost of the insurance policies (the premium) is paid by the plan from its trust fund. Some plans self-fund part of their benefits and contract with insurers to provide other benefits (particularly "welfare" benefits like life and disability insurance. And, some plans may contract with managed care organizations to

provide some or all of their health benefits.

Whatever the arrangement for providing the benefits, the plan is the trust fund entity governed by the board of trustees. An insurer or managed care organization with which the plan contracts are merely means by which the plan delivers its benefits to participants and beneficiaries.

The benefits provided by a plan are set forth in plan documents adopted by the board of trustees and distributed to participants. To the extent that a plan insures benefits, the contract or policy issued to the plan by the insurer will reflect the terms of the plan documents and may be incorporated into those documents. To the extent that a plan contracts with a managed care organization, the contract will reflect the terms of the plan. The terms of these contracts and policies with insurers and managed care organizations are subject to renegotiation by the board of trustees. For example, if the board wishes to make improvements in the insured benefits, it so advises the insurer and negotiates with the insurer over the amount, if any, that the improvement will increase the plan's premium cost. For the insurer's part, it may negotiate with the board to increase premiums for the current benefit levels if the claims payment experience has been worse than anticipated.

Self-funded plans often control the risk of unexpected benefit claims experience by purchasing "stop-loss" insurance for the plan. Such coverage typically requires the insurer to compensate the plan if the benefit claims submitted to the plan in a particular period of time exceed a certain amount, or if a particular claim exceeds a certain amount. The stop-loss carrier has no obligation to pay benefits to participants and beneficiaries; rather, its obligation is to reimburse the plan upon certain events. Accordingly, it is not considered "health insurance." The cost of this stop-loss coverage is paid by the plan.

Administration

As noted above, all multiemployer plans are governed by labor-management boards of trustees.[16] The individuals who serve as labor trustees and management trustees on these boards are typically unpaid volunteers.[17] Yet, the performance of their plan-related duties is subject to the standards of fiduciary conduct set by ERISA, which are among the highest standards known to the law. Violations of these standards may subject the offending trustees to personal liability for any losses to the plan, as well as to the removal from his plan position, among other penalties. Indeed, a plan trustee can be held personally liable for plan losses caused by another trustee or plan fiduciary under certain circumstances (e.g., failure to take reasonable steps to correct a breach of fiduciary duty by another trustee).[18]

ERISA prohibits plans from indemnifying trustees against personal liability for breaches of fiduciary duty.[19] Plans are permitted to purchase errors and omissions liability insurance for the trustees, provided that the insurer has recourse against any trustee for whom it pays a claim.[20] However, insurance policies available on the market provide limited coverage in terms of their liability limits and their exclusions of certain types of liability.

Attracting and retaining responsible, competent individuals to serve as trustees, particularly employer representatives, has become more difficult in the fact of increased regulatory burdens and legal responsibility. Many are concerned about good faith judgments resulting in personal liability based on retrospective application of vague legal standards. Yet, multiemployer plans cannot legally exist without management as well as labor trustees. If responsible employer representatives are no longer willing to volunteer was plan trustees, the plans will die.

---

[16] Under ERISA, the board of trustees of a multiemployer plan is typically the "named fiduciary," "plan administrator," and "plan sponsor." See, ERISA Sections 3(16)(A), (B), 402(a)(2); 29 U.S.C. __1002(16)(A), (B), 1102(a)(2).

[17] ERISA prohibits use of plan assets to compensate trustees who are full-time employees of the sponsoring union or contributing employers. See ERISA Sections 406(a) and 408(c)(2); 29 U.S.C. __1106(a), 1108(c)(2).

[18] ERISA _405; 29 U.S.C. _1105 (co-fiduciary liability).

[19] ERISA Section 410, 29 U.S.C. _1110.

[20] Id.

While the board of trustees is ultimately responsibility for the plan's management, the plans hire administrators to conduct the plan's day-to-day operations. Some plans, particularly large plans, establish their own administrative offices and hire a staff (which arrangement is referred to as in-house administration or self-administration). Other plans contract with administrative services companies, which perform the plan's day-to-day administrative functions through the company's (or insurer's) offices (which arrangements are referred to as third-party administration). And, there are variations and combinations of these two general types of administrative arrangements.

Whatever the administrative arrangements, the administrator is required to perform its functions in accordance with the plan's governing documents and with the rules and policies set by the board of trustees. The administrator is responsible to and overseen by the board. Typically, the board meets periodically to receive and review reports from the administrator (and the plan's other professional service providers) concerning the plan's operations. The reports include matters such as contributions received, delinquent contributions, reserves, investments, benefit payments, benefit denials, and appeals from benefit denials.

In the case of a plan whose health benefits are insured, a representative of the insurer will report to the board of trustees on the benefit claims received, paid, and denied by the insurer. So, too, where the plan contracts with a managed care organization to provide some or all of the health benefits, a representative of that organization will report to the plan's board of trustees on care provided and care denied, among other matters regarding implementation of their contract with the plan.

Benefit claims are submitted to the plan's administrative office, as are eligibility questions. To the extent that the plan is self-funded and self-administered, claims and questions are handled in the first instance (and, often, for reconsideration) by the administrative staff. Appeals from the administrative staff's decisions are taken to the board of trustees in accordance with procedures set forth in the plan documents. The board may, as appropriate, use medical advisors when considering appeals based on medical issues rather than issues of plan interpretation or application.

To the extent that a plan is insured, it may rely on the insurer to make the initial decision on benefit claims and eligibility, or the plan's administrative staff and the insurer may jointly make the initial determinations. So, too, the managed care organization with which the plan has contracted may make the initial determination on a questions of eligibility or a benefit claim, or may make the determination jointly with the plan's administrative staff. But, generally, appeals from these determinations are made to the labor-management board of trustees. Even where a managed care organization may have an internal appeals or grievance procedure, the multiemployer plan's board of trustees retains authority to review the organization's conduct.

These "internal" claims and appeals procedures are described in more detail below.

Retiree Coverage

Many multiemployer plans provide health benefits coverage for workers and retire from covered employment, particularly if the retiree is receiving retirement benefits from a multiemployer pension plan sponsored by the same union and group of employers. This retiree coverage reflects a philosophy on the part of plan trustees and the bargaining parties that the workers have earned a secure retirement without fear of financial ruin if they become sick or injured without health benefits coverage.

Retiree coverage is particularly important for workers who retire before the Medicare eligibility age of 65 years. In several multiemployer plan industries, pre-Medicare eligibility age retirements are the norm. Many covered workers are engaged in heavy physical labor that wears down their bodies and drives them from the workforce earlier than the average worker. But for their multiemployer plan coverage, these workers would be without health care coverage for 5, 10, or even more years before becoming eligible for Medicare.

Most plans require the retirees to pay for plan coverage, but the charge is typically less than the plan's true cost of providing the coverage. In other words, the plans subsidize the retirees' coverage from the contribution income generated by the labor of the active workers covered by the plan.

Accordingly, a plan's ability to provide affordable retiree coverage is affected by fluctuations in the covered work that generates the collectively bargained contributions. Retiree coverage is also dependent upon the continued willingness of the active workers to allow a portion of the

contributions they generate to be used to subsidize the retirees.

Health care for retirees is generally more costly. The cost pressures on the plan are increased by various factors including earlier retirements, longer life expectancy, and cost-shifting by the Medicare program to private sector plans.

## ***CONCERNS OF THE MULTIEMPLOYER HEALTH PLAN COMMUNITY***

Multiemployer health and welfare plans are models of collective self-determination by workers who responsibly choose to provide for their families' health care needs. Multiemployer plan participants and beneficiaries like their plans, which are custom-designed for the particular circumstances of the covered group and responsive to their concerns.

The multiemployer plan community's core concerns about the current health care system and any proposals for change in the regulatory scheme are three-fold: first, the cost of health care and plan administration; second, maintaining trustee flexibility with regard to plan design and operations to address changes in circumstances; and third, attracting and retaining responsible, qualified labor and management representatives to serve as plan trustees.

Policymakers must be mindful that the Nation's employment-based health plans are a voluntary system. Employers are not required by law to establish or maintain employee health plans. In the multiemployer plan universe, plans depend for their existence on collective bargaining, which is also a voluntary system. At some point, costs, including regulatory costs, discourage the creation and maintenance of plans. As recalled by the Supreme Court on several occasions, ERISA reflects a policy balance struck by Congress between protecting the rights of plan participants and beneficiaries on the one hand, and encouraging the voluntary creation and maintenance of plans on the other. As observed by the Court:

Thus, unless an employer contractually cedes its freedom, it is "generally free under ERISA, for any reason at any time, to adopt, modify, or terminate [its] welfare plan." The flexibility an employer enjoys to amend or eliminate its welfare plan is not an accident; Congress recognized that "requiring the vesting of these ancillary benefits would seriously complicate the administration and increase the cost of plans." Giving employers this flexibility also encourages them to offer more generous benefits at the outset, since they are free to reduce benefits should economic conditions sour. If employers were locked into the plans they initially offered, "they would err initially on the side of omission."[21]

### Importance of an Exclusive, Uniform Federal Regulatory Scheme

The multiemployer plan community strongly supports the uniform, federal regulatory scheme for all employee benefit plans that Congress intended in enacting ERISA in 1974. The regulation of multiemployer plans must be the exclusive province of federal law. State regulation of multiemployer plans would impose unbearable costs and unworkable administrative burdens on plans that have been successfully providing health care coverage to millions of Americans for decades. Moreover, adding State regulation to the already extensive federal regulatory scheme would crush multiemployer plans.

Many multiemployer plans cover workers, retirees and dependents in multiple States; some on a regional basis, some on a national basis. And, the workers covered by multiemployer plans tend to be highly mobile, crossing State borders to follow the covered employment opportunities. Even plans that primarily cover local areas have participants and beneficiaries who work and/or live in other States (e.g., workers who live across the border from a State where the plan is administered, college students who go to school in another State, retirees who move to Florida). As recently observed by U.S. Senator Bob Bennett in explaining his new health records privacy proposal, Federal regulation of employee health plans is a must because 50% of Americans live on or near State lines and States have varying, often conflicting law.[22]

---

[21] Inter-Modal Rail Employees Assn. v. Atchison, Topeka & Santa Fe Railway Co., 520 U.S. 510, 515 (1997), citations omitted.

[22] ***How Can Congress Protect The Privacy of Personal Medical Information***, Health Care Policy Briefing, ROLL CALL, April 12, 1999.

How could these plans comply with the varying, conflicting laws, regulations, and regulatory agency demands of multiple States? And, what would be the cost of trying to comply? Beyond the additional administrative and professional costs, plans would be required to conform to State mandates regarding the benefit packages and other features of plans. Such State mandates burden plans with unwanted, additional benefit costs. They also deprive plan trustees of flexibility to meet the benefit needs of the participants and beneficiaries and the financial needs of the plan. State regulation substitutes the whim of State legislators and provider group lobbyists for the needs and wants of plan participants and beneficiaries.

And, then there is the added cost of State taxation of plans, directly or indirectly. States tax insurers, and they want to tax multiemployer health plans, too.

The added, unnecessary cost of State regulation is the main reason why multiemployer plans, like many single employer plans, have dropped their insurance and become self-funded over the past 10-15 years.[23] In 1985, the Supreme Court opened a loophole in the federal regulatory scheme by interpreting ERISA's State law preemption provisions as allowing States to control the content of insurance policies sold to ERISA-covered health plans.[24] As a consequence, plans that purchase policies are burdened by a wide range of benefits and other content mandated by the States,[25] as well as by the premium taxes and other charges imposed by States on insurance products. Only by self-funding can plans avoid these State-imposed costs because self-funded employee health plans remain protected by ERISA's preemption provisions.

Unfortunately, the Supreme Court has opened another loophole in ERISA's scheme that enables States to, in effect, tax even self-funded multiemployer health plans by taxing the health care provided to plan participants and beneficiaries by hospitals and other providers; costs that get added to the bills paid by plans.[26]

Such State taxes inflate the cost of creating and operating a multiemployer health plan. And, in so doing, discourage health plan coverage. Taxing those, and only those, who have health plan coverage is counterproductive if our Nation's goal is universal health plan coverage.

The 1974 Congress that designed ERISA's federal regulatory scheme for employee benefit plans was quite conscious of and concerned about the counterproductive burden of State regulation and taxation. As observed by the Supreme Court about Congress' intent:

> "[The basic thrust of [ERISA] preemption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.
>
> [Congress intended] to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government to prevent the potential for conflict in substantive law requiring the tailoring of plans and employee conduct to the peculiarities of the law of each jurisdiction...."[27]

---

[23] See generally ***Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA,*** General Accounting Office Testimony, July 25, 1995 (GAO/T-HEHS-95-223); ***Self-Insurance Is Working,*** 142 Cong. Rec. E237 (daily ed., February 28, 1996).

[24] Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985).

[25] Reportedly, there are more than 1,000 State mandated benefit laws applicable to health insurance policies.

[26] New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) (ERISA not preempt State law requiring hospitals to collect surcharges from patients covered by commercial insurers and ERISA-covered plans); DeBuono v. NYSA-ILA Medical & Clinical Services Fund, 117 S.Ct. 1747 (1997) (State tax on gross receipts for patient services at hospitals and other health care facilities not preempted by ERISA as applied to medical centers operated by self-funded multiemployer health plans).

[27] Travelers, supra, 514 U.S. at 650.

> To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, providing inefficiencies that employers might offset with decreased benefits.[28]

> Statements by ERISA's sponsors in the House and Senate clearly disclose the problem that the pre-emption provision was intended to address. In the House, Representative Dent stated that "with the preemption of the field [of employee benefit plans], we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." Similarly, Senator Williams declared: "It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulations of employee benefit plans."
>
> These statements reflect recognition of the administrative realities of employee benefit plans. An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others.[29]

Plainly, the product of the 1974 Congress contained more detailed regulations of the content of pension plans than it did for health and welfare plans. For example, ERISA's participation, vesting, benefit accrual, and funding standards apply only to pension plans.[30] However, many other, important protections in ERISA were made applicable to health and welfare, as well as pension, plans, including the reporting and disclosure, fiduciary standards, prohibited transactions provisions, bonding requirements, and enforcement provisions. And, in ERISA, Congress created a federal statutory vehicle through which additional regulation of all employee health plans (whether insured or self-funded [31]) could be imposed if and when Congress deemed necessary or appropriate, as the health legislation passed by Congress since ERISA's enactment, including the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA, PUBLIC LAW NO. 99-272), the ***Health Insurance Portability and Accountability Act of 1996*** (HIPPA, PUBLIC LAW NO. 104-191), the ***Mental Health Parity Act of 1996*** (PUBLIC LAW NO. 104-204), and the ***Newborns' and Mothers' Health Protection Act of 1996*** (PUBLIC LAW NO. 104-204). Critics who discount ERISA's substantive regulation of employee health plans do not understand the statute.

If additional regulation of employee health plans is necessary or appropriate, ERISA, and not State law, is the proper vehicle. It ensures application to all employee health plans on a nationally uniform basis.

Cost Shifting Concerns

Multiemployer plans are concerned about cost because, it is the covered workers who pay these costs and it can be very difficult for plans to increase their incomes, particularly on short notice.

---

[28] FMC Corp. v. Holliday, 498 U.S. 52, 60 (1990).

[29] Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9 (1987) (citations to ***Congressional Record*** omitted).

[30] ERISA Sections 201 and 301; 29 U.S.C. __1021, 1031.

[31] ERISA generally covers all employee welfare benefit plans without regard to whether they are insured or self-funded. See ERISA Sections 3(1), 4; 29 U.S.C. __1002(1), 1003.

Boards of trustees have been compelled by cost pressures to cutback benefits, tighten eligibility rules, and introduce or increase out-of-pocket payments by participants, among other actions.

Regulatory costs are particularly controversial because every dollar spent on compliance and administration is a dollar not available to pay benefits to participants and beneficiaries.

Importantly, increases in plan costs also exacerbate a vicious cycle of unfair competition against union employers and workers who support the plans. In most multiemployer plan industries, the competition among employers is tight. Non-union employers whose not maintain employee health plans gain a significant labor cost advantage over employers which the collective bargaining agreements require contributions to multiemployer health plans.

This unfair competitive advantage is multiplied by the shifting to multiemployer plans of the uncompensated cost of health care provided to uninsured workers and their families. This cost-shifting is accomplished through higher hospital and doctor bills for multiemployer plan participants, as well as through State uncompensated care taxes and assessments. In effect, multiemployer plan participants are compelled by the system to pay twice for health care: once for themselves and their families, and a second time for the uninsured non-union workers who compete for their jobs.

Imposing additional costs on multiemployer plans worsens the competitive situation of those workers and employers who are responsible enough to maintain multiemployer health plans. And, this causes the loss of covered jobs, which causes a reduction in the collectively bargained contributions that are the life-blood of multiemployer plans. This can cause a downward spiral of health plan coverage.

The Federal Government, too, plays a major role in health care cost-shifting, particularly through the Medicare and Medicaid programs. Congress has a record of achieving cost savings in these public programs by shifting a portion of their costs to employment-based health plans. Reductions in payment rates for Medicare and Medicaid providers tend to be recouped by the providers from their privately "insured" patients. The Medicare Secondary Payor program shifts costs by requiring employment-based health plans, including multiemployer plans, to provide primary coverage for Medicare eligible workers.

Government cost-shifting, like unnecessary plan regulation, taxes only those who have health plan coverage and drives more people into the ranks of the uninsured whose health care costs are shifted to the shrinking pool of those with health plan coverage. Given that our Nation's system of employment-based health care plans is voluntary, a balance needs to be struck between protections and cost.

Managed Care Reforms

All legislative proposals relating to health plans trigger the concerns of the multiemployer plan community. Would the proposal, if enacted into law, increase the benefit or administrative cost of plans? Would it restrict trustee flexibility that is essential to adapt a plan to changing economic circumstances? Would it discourage responsible, competent labor and management representatives from serving as plan trustees? Would it interfere with the uniform federal regulatory scheme for multiemployer plans?

Proposals to expand the regulation of managed care raise these same critical issues.

The threshold point, that is essential to understanding multiemployer plan concerns regarding managed care reform proposals, is the difference between a multiemployer health plan and a managed care organization. The terminology is critical, but is often confused by policy-makers.

HMOs and other managed care organizations are commonly referred to as "health plans." Whatever the appropriateness of this characterization in other contexts, it causes confusion in the multiemployer plan context. As described above, a multiemployer plan is distinct from a managed care organization. The plan is the trust fund governed by the board of trustees which decides what benefit programs will be provided and how.[32]

---

[32] This distinction is similar to the distinction between employee benefit plans and insurers made in ERISA as originally enacted [see, ERISA Section 514(b)(2), 29 U.S.C. _1144(b)(2)] and in the 1996 HIPPA amendments to ERISA [see, ERISA Sections 701(a), 731; 29 U.S.C. __1181(a), 1191, distinguishing "group health plan" from "health insurance issuer"].

Traditional fee-for-service, indemnity plans and discounted fee preferred provider networks still predominate in the multiemployer plan community. It is unusual to see HMOs as the sole or primary coverage format for a multiemployer plan. However, a plan's trustees may decide to provide benefits to its participants and beneficiaries through an HMO, a PPO, or some other managed care organization. To do so, the trustees would normally follow a prudent decision-making process involving the development of specifications, the solicitation of candidates, and the selection of the most appropriate organization. The plan negotiates and enters into a contract with the selected organization to provide care to the plan's participants and beneficiaries in accordance with the benefit design and other terms of the plan set by the trustees.

In short, the multiemployer plan is a purchaser of the managed care organization's services.

As a purchaser, a plan's board of trustees is concerned about the cost of the managed care organization's services to the plan and to its participants and beneficiaries. It is also concerned about a variety of other issues, such as ability to service the plan's participants and beneficiaries (e.g., number and location of providers, including specialists); access to care (e.g., gatekeeper functions); reporting and communications capabilities; and financial responsibility (e.g., stability of the organization and arrangements with providers).

If the participants and beneficiaries of a multiemployer plan are unhappy with the care, other services, or operations of a managed care organization selected by the plan's trustees, the trustees will be well aware of this dissatisfaction _ particularly the labor trustees who may be held responsible at the ballot box for union officer elections.

From this purchaser's perspective, regulation of managed care organizations to correct abuses or to make those organizations more responsible and responsive to their customers (multiemployer plans and their participants and beneficiaries) can be appropriate and helpful. This is why the NCCMP has expressed support for the ***Patients' Bill of Rights*** as recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The rights described therein are rights that multiemployer plan trustees want, and already voluntarily provide in large measure, for the participants and beneficiaries of their plans.

But, policymakers should not confuse multiemployer plans with HMOs and other managed care organizations.

## ***DISPUTE RESOLUTION***

The horror stories of mistreatment that have driven the campaign for patients' rights legislation do not involve multiemployer health and welfare plans. The workers, retirees and family members covered by multiemployer plans are generally very satisfied with their coverage. Multiemployer plans experience very few benefit disputes, and most of the disputes that do arise relate to a claimant's eligibility for coverage by the plan and not to medical issues.

The plans are responsive and accountable to their participants and beneficiaries for the structural reasons described above. This responsiveness and accountability is reflected in the procedures used by the plans to handle benefit claims and resolve disputes.

In the case of the typical self-funded multiemployer health and welfare plan, claims for benefits are received from participants or their health care providers by the plan's administrator. The administrator may be a staff employee of the plan or a third-party administrator (TPA) under contract to the plan. The benefit claim is examined to determine under the terms of the plan's benefit program whether the patient is eligible for coverage, whether the service or treatment received by the patient is covered by the plan, and how much is payable to the participant or provider. The administer may consult with a medical consultant retained by the plan or, in the case of third-party administration, the TPA may consult with its medical consultant, as appropriate for the particular claim. Payments determined to be due are made. If the claim is denied in whole or in part, a notice of benefit denial (complying with ERISA's claims procedure requirements) is sent to the participant.

The participant is entitled to appeal a benefit denial by submitting a request to the administrator. If the administrator finds that the denial was erroneous under established rules and guidelines, the correction is made and the appropriate payment is issued without further review. Otherwise, the administrator prepares the claim for review by the plan's board of trustees. The claim review file will include all documentation received from the patient and care provider, an explanation of the denial, and all documents on which the administrator relied in denying the claim.

The board of trustees, as a whole or through a committee of trustees, reviews the appeal de novo. The trustees have the authority to reverse or affirm the benefit denial by the administrator, in whole or in part. In reaching that decision, there are various actions that trustees can and do take, including the following:

- request further information from the administrator;
- request further information from the patient or provider;
- request a qualified medical professional to review medical issues involved in a claim and provide advice to the trustees;
- reverse the administrator's interpretation of the plan's rules or guidelines; and
- amend the plan's rules or guidelines.

At least two aspects of this procedure are unique to multiemployer plans. First, one-half of the decision-makers -- the trustees -- are patient advocates. The labor trustees are typically elected union representatives whose interest lies in making the plan as responsive to the needs and wants of his constituent members as possible consistent with maintaining the plan's financial soundness.

Second, the board of trustees has the authority to interpret and amend the plan's rules and guidelines. Where a claims appeal brings to light a flaw, inadequacy, or inequity in the plan's coverage, design or operations, the board of trustees can make an immediate correction that will benefit the claimant as well as all other similarly situated participants.

In situations where a plan's board of trustees has contracted with an insurance company to insure some or all of the benefits provided under the plan, the board may rely on the insurer to alone, or jointly with the plan's staff, make an initial determination on claims for insured benefits and to perform the reconsideration function. Similarly, in situations where a board of trustees contracts with a utilization review firm, a PPO, or an HMO, those organizations may alone, or jointly with the Plan's staff, conduct the initial claims determination and the reconsideration function. But, generally, but the plan's board of trustees remains the body to which claimants can appeal for review of the insurer's managed care organizations' decisions. The trustees, in addition to their above-described authority, may reserve by contract the right to modify the contract or guidelines under which the insurer or managed care organization is performing its function. And, of course, the board of trustees can terminate the contract with the insurer or managed care organization in accordance with its terms.

In short, the board of trustees or a multiemployer plan plays an essential, positive role in minimizing and resolving disputes and in promoting participant satisfaction. Legislation that impedes this well-functioning role of boards of trustees would be counterproductive for patients' rights.

## ***EXTERNAL APPEALS***

Prompt, fair benefit claims decisions should be the objective of any patients' rights legislation. The timely reversal of an incorrect benefit claims decision that enables a patient to obtain or pay for treatment is a better policy result than time-consuming, costly litigation that may produce a result long after the need for treatment has passed.

In concept, "external review" of final plan decisions by independent, qualified medical professionals would benefit both the patient and the plan, at least where the decision is based on medical considerations. The patient would obtain timely review by an independent, qualified professional. The plan could avoid unnecessary, expensive litigation.

The multiemployer plan community has substantial experience with alternative means of dispute resolution. For example, the Taft-Hartley Act provides for the resolution of disputes among labor and management trustees through binding arbitration.[33] ERISA, as amended in 1980, provides for the arbitration of disputes between multiemployer pension plans and employers over withdrawal liability.[34] And, the collective bargaining agreements, pursuant to which multiemployer plans are

---

[33] 29 U.S.C. _186(c)(5).

[34] ERISA Section 4221; 29 U.S.C. _1401.

established and maintained, commonly provide for the arbitration of various types of grievances and other contractual disputes as an alternative to strikes and litigation.

However, as often is the case with good ideas, the devil is in the details of "external review." Many issues have to be addressed, including:

- Would plans (as well as insurers and managed care organizations) be required to maintain external review procedures?
- Would claimants be required to exhaust their external review rights as a precondition to litigation?
- What types of plan decisions would be appealable to external review? (Medical as well as non-medical, eligibility decisions?)
- Would a claimant be required to first exhaust the plan's internal review process before appealing to external review?
- How many reviewers would be needed for any particular case?
- Who would select the external reviewer?
- Who would pay the fees of the external reviewer and the other costs of the process?
- Who would determine whether the external reviewer is independent and qualified, and under what standards?
- What standard of review would the external reviewer exercise over plan decisions (including whether the reviewer could interpret or change plan rules)?
- What decision-making procedures would the external reviewer use? (What procedural rights would the claimant and plan have?)
- What time limits would apply to the external reviewer? (Would they be different for retrospective versus prospective or concurrent payment decisions?)
- Would the decision by an external reviewer be binding? If so, would it bind both the claimant and the plan?
- Would the decision by an external reviewer be subject to judicial review? If so, would the review be limited and differential to the external reviewer (e.g., like court review of arbitration decisions) or would the court review the claim de novo?
- What relief could the external reviewer grant if he finds the plan's decision wrong?
- Would the decisions by an external reviewer be precedential (binding as to future similar claims)?
- Would the external reviewer be subject to personal liability as a plan fiduciary under ERISA?

The NCCMP would be pleased to work with your Subcommittee to develop an effective and efficient external review procedure that addresses all of these and other issues. However, I must stress that any external review requirement must be Federal, not State. ERISA Section 503[35], which already regulates internal appeals procedures, would be the appropriate situs for any external review requirement.

External review we can live with. We cannot live with monetary damages awards that may benefit an individual or his heirs, but bankrupt a multiemployer plan and wipe out the health care coverage of the thousands of workers, retirees and family members who depend on, and finance, the plan.

---

[35] 29 U.S.C. _1133.

Thank you.

******