NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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August 11, 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-AB41

Dear Ms. Borzi:

The National Coordinating Committee for Multiemployer Plans (the NCCMP) is pleased to provide these comments on the interim final rule implementing Section 2714 of the Patient Protection and Affordable Care Act (the "age-26 mandate") published by the Departments of Labor, Treasury, and Health and Human Services (the "agencies") on May 13, 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 health and welfare 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.

Summary of Recommendations

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

- Adopt a definition of "child" that makes clear that the mandate to provide unconditional eligibility to age 26 does not extend beyond a well-defined core group (*i.e.*, the participant's sons/daughters, adopted children, children placed for adoption, and foster children).
- Make clear that plans are not required to cover all children who fit the definition. In other words, plan sponsors could choose to cover only some of those groups (*e.g.*, sons/daughters, adopted/placed for adoption) and not cover others (*e.g.*, not step or foster children). Only if a plan chose to cover such categories of children would the age-26 mandate attach to those children.

- Confirm that a plan may voluntarily extend coverage to other groups of young people – such as grandchildren and stepchildren – subject to reasonable restrictions on eligibility linked to a participant's expectation of providing (or a legal duty to provide) medical coverage.
- Adopt a uniform national standard for when a child is considered an "adult" and therefore may be excluded, by grandfathered plans, if other employer-funded coverage is available – a critical issue for multiemployer plans that cover people who live and work in different states.

These issues are of critical importance to multiemployer plans for several reasons. These plans typically do not have enrollment periods where participants add specific named dependents to the plan. They rarely require explicit participant contributions for individual or family coverage, not just because they want to be sure that families have coverage, but because the apparatus for assessing and collecting participant contributions would be cumbersome, expensive and not necessarily effective. Without the ability to limit their coverage of people who may be associated with a participant by drawing reasonable and verifiable lines, multiemployer plans are especially vulnerable to fraudulent claims that can be difficult to identify and resist. This could subject them to claims they were not in a position to anticipate when they determined their budget, recommended employer contribution rates to the bargaining parties, and arranged for stop-loss coverage.

Introduction

Since the interim final rule was published, multiemployer plan sponsors seeking to implement the law have raised several questions concerning which children are subject to the law. Some groups of children (*e.g.*, a participant's son or daughter or adopted child) are clearly encompassed by the age-26 mandate. However, it is not clear whether the age-26 mandate applies when plans extend coverage beyond that core group of children to other groups such as grandchildren, stepchildren, or legal guardianship situations. The regulations require continuation of coverage to age 26 with no additional surcharge and no change in benefits. The cost implications of these rules, combined with the prohibition on having eligibility requirements other than "the relationship between the child and the participant" and age (typical requirements include residence with the participant and/or financial dependence), make it essential for plan sponsors to know with certainty to which categories of children the mandate applies.

Accordingly, we urge the agencies to provide a clear definition of the term "child" for purposes of the age-26 mandate so that plan sponsors know which groups of children, if covered by the plan, must be covered to age 26 and without any other eligibility requirements being imposed. We also urge the agencies to allow plan sponsors to maintain flexibility as to which groups of children they choose to cover. Without clear guidance, some plan sponsors would eliminate coverage for certain groups of children altogether in order to assure that the plan is not exposed to costs that cannot be anticipated.

Multiemployer Plans Typically Cover a Range of Individuals Under the General Category of "Dependent Children"

Many multiemployer plans cover various types of "children" who are not the participant's child and who may be "children" only in the sense that they are young people. This group includes

grandchildren, stepchildren, legal guardianships (where the young person might be related to the employee (*e.g.*, niece/nephew) or might not), foster children, and children of domestic partners. Plan documents and summary plan descriptions typically lump these young people together with the participant's children under the general category of "dependent children," and that becomes a general term used throughout the documents to refer to these individuals as a group (*e.g.*, eligibility for continuation coverage under COBRA).

Multiemployer plans also include specific eligibility requirements for these types of dependents , such as a requirement that the person live in the participant's home and/or rely on the participant for more than half of her or his support. These extra eligibility requirements stem in part from the applicable tax requirements (*i.e.*, the complex definitions of "qualifying child" or "qualifying relative" under IRC §152), but also from the understandable desire on the part of plan sponsors to extend coverage only where the functional equivalent of a parent-child relationship exists.

Plans often cover stepchildren, but again typically only in certain situations (*e.g.*, only if the stepchild lives in the participant's home in a parent-child relationship and/or relies on the participant for more than half of his or her support). Many multiemployer plans will also cover grandchildren, but only where the participant is raising the child in a parent-child relationship and providing for their the grandchild's support. In many cases, grandchildren are only covered if a participant has been appointed as a legal guardian.

While plans that provide dependent coverage are also legally required to cover children who are adopted or placed for adoption, plans are not required to extend coverage to additional categories of children. These voluntary extensions of coverage are made to enable participants who function as the children's parents to cover them under their health plan, but the extensions of coverage come with a condition that there must be some evidence proof of that parent-child relationship. Absent the ability to place restrictions upon the coverage provided to these categories of children (e.g., stepchildren, legal guardianships, grandchildren), the plan could face unforeseen costs by being required to cover children who are not living with the participant and not dependent upon the participant for their support.

Many multiemployer plans do not have an open enrollment period during which a participant enrolls dependents, including dependent children. Typically a multiemployer plan provides eligibility to the participant when they satisfy the plan's eligibility criteria. Generally, in a multiemployer health plan, eligibility continues as long as the participant continues to work sufficient hours during an eligibility period to earn coverage during a coverage period. Dependents of the participant are not necessarily enrolled during the coverage periods – instead, the plan will accept claims from dependents and verify eligibility prior to paying the claim.

Consequently, unlike plans that may have an open enrollment period where dependents are identified, multiemployer plans do not generally identify and verify dependent status at the beginning of a plan year. The plan could face claims from individuals claiming dependent status and be unable to determine whether a parent-child relationship actually exists with the participant. Being able to maintain plan language requiring that verification is critically important to assuring that only dependents with a parent-child relationship to the

participant are covered. This reduces the opportunity to manipulate by people whom the plan (and maybe even the participant) may not have known about until they were on the brink of incurring catastrophic medical expenses. A prime example would be stepchildren for which the participant's spouse does not have custody or legal responsibility to provide medical coverage.

A Broad Definition of "Child" Would Impose Additional Costs and Hardships and Could Have Unintended Consequences

If a multiemployer plan sponsor extends coverage beyond a well-defined narrow group consisting of the participant's children, the plan sponsor should be allowed to include additional eligibility requirements other than "the relationship between the child and the participant" and age and to terminate coverage prior to age 26. In other words, the age-26 mandate should not apply to this larger set of individuals.

For example, if a plan sponsor voluntarily covers grandchildren, the plan sponsor should be allowed to continue to apply typical eligibility requirements (*e.g.*, that the grandchild live in the employee's home). If the age-26 mandate applies to this group, with the result that the plan must cover all grandchildren up to age 26 without any other eligibility requirements, this would represent a significant expansion of coverage, resulting in additional costs to the plan – an odd result considering the statute's (and the interim final rule's) express language that the age-26 mandate does not require that grandchildren be covered.

Extending the age-26 mandate to grandchildren would also result in the need to impute income to participants in some situations because grandchildren do not fit within the new simplified tax rule (which applies only to a child defined in IRC §152(f)). The inability to include the applicable tax requirements as eligibility requirements, coupled with the need to determine which specific grandchildren may receive health coverage on a tax-free basis, would create administrative hardships for plan sponsors. Rather than attempting to address those hardships, many plan sponsors would choose instead to eliminate coverage for grandchildren (or other groups) altogether.

The same issues apply to other groups – such as legal guardianship situations and children of domestic partners. If the age-26 mandate applies to these groups, it would represent a significant expansion of coverage, compounded by the additional tax burdens.[1]

Even though stepchildren get the benefit of the new simplified tax rule, we urge the agencies to state that stepchildren are not encompassed by the age-26 mandate. This would permit plan sponsors to terminate coverage prior to age 26 and to continue to apply typical eligibility requirements to stepchildren, so that plan sponsors have the ability to extend coverage only where a true parent-child relationship exists between the participant and the stepchild.

Recommendation

[1] We recognize that children of domestic partners rarely qualify for tax-free health coverage because they are typically the "qualifying child" of the domestic partner and thus cannot be the "qualifying relative" of the employee. That said, it is still important to know whether plans may impose additional eligibility requirements on the domestic partner's children and/or terminate coverage at some age younger than 26.

It is our view that the universe of children to whom the mandate should apply should be defined by reference to the Internal Revenue Code's definition of "child" found in IRC §152(f) – in other words, that group of children who benefit from the new simplified tax rule included in the Health Care and Education Reconciliation Act (Section 1004(d)). This group consists of the following:

- sons/daughters,
- stepchildren,
- adopted children (including those placed for adoption), and
- eligible foster children.

However, the agencies should define the term "child" for purposes of the age-26 mandate to apply only to some of the children encompassed by IRC §152(f) – specifically, the participant's sons/daughters, adopted children (including those placed for adoption), and eligible foster children – but not include stepchildren. Children, adopted children, and foster children are all either required to be covered under current law or under a legal requirement, such as a placement by a child protection agency. Our reasoning for excluding stepchildren is set out above – principally that the plan needs to be able to verify that the stepchildren are living in a parent-child relationship with the participant.

In addition, the agencies should make it clear that plans are not required to cover all children who fit the definition. In other words, plan sponsors could choose to cover only some of those groups (*e.g.*, sons/daughters, adopted/placed for adoption) and not cover others (*e.g.*, not stepchildren). Only if a plan sponsor chose to extend coverage to a certain category of children (encompassed by both §152(f) and the age-26 mandate) would the mandate to cover them to age 26 (and without other eligibility requirements) apply.

If the agencies decline to define "child" for purposes of the age-26 mandate, we ask the agencies to indicate whether plan sponsors have the flexibility to create new categories of non-adult beneficiaries outside the general category of "dependent children" – categories to which the age-26 mandate would not apply. Such a category could be labeled "Covered Individuals" and could include at a minimum grandchildren, legal guardianships, and children of domestic partners. This approach, while potentially useful as an approach to the age-26 mandate, would raise questions about how other requirements (*e.g.*, COBRA) would apply to these individuals.

Plan Sponsors Need Flexibility and Certainty

We understand that in declining initially to define the term "child," the agencies wanted to preserve the flexibility that plan sponsors currently have in deciding which groups of "children" to cover. Our suggestions preserve that flexibility while providing plan sponsors with certainty about what rules apply if they choose voluntarily to cover certain groups.

The agencies could provide clear guidance while preserving plan sponsor flexibility by defining the universe of children to which the age-26 mandate applies by reference to §152(f) – but

preferably minus stepchildren.[2] Plan sponsors could then decide which of those §152(f) children the plan would cover (*e.g.*, sons/daughters and adopted/placed for adoption, but not foster children). Any other groups of young people (*e.g.*, grandchildren) would fall outside the scope of the age-26 mandate, thus allowing plan sponsors to tailor the plan's eligibility requirements to the applicable tax requirements or as the plan sponsor otherwise deems appropriate.

Without clear rules to guide them, plan sponsors facing escalating costs while trying to comply with the age-26 mandate face a difficult choice: treat all young people the same (cover to age 26 and eliminate eligibility requirements other than the relationship between the child and the participant" and age) or eliminate coverage for certain groups entirely.

Adult Children with other Employment-Based Coverage

Another issue we request the agencies to address is the definition of "adult" child. Section 1251(a)(4)(B)(ii) of the Affordable Care Act temporarily permits grandfathered group health plans to refuse to extend coverage to an "adult" child if the child has other employer-sponsored coverage (other than a group health plan of a parent). The interim final rule does not explain what "adult" means in this context, so it is not clear at which age plans may deny coverage to "adult" children with other coverage. We encourage the agencies to draw a clear line, such as age 18, so that plan sponsors taking advantage of this option (until January 1, 2014) can develop eligibility requirements and devise administrative processes that comply with the law.

A search for the legal definition of "adult" revealed that an individual becomes an "adult" at different ages for different purposes. Does this refer to the age at which a child may contract, or marry or vote or legally drink alcohol? Is adulthood the same as the "age of majority"? In the United States the "age of majority" is 18 in all jurisdictions except for Alabama and Nebraska (age 19); Mississippi and Puerto Rico (age 21). Pennsylvania defines an "adult" as one who is age 18 or older but the "age of majority in Pennsylvania is 21. *See* http://minors.uslegal.com/age-of-majority/california-age-of-majority-law/

We also encourage that the agencies reconsider applying this provision only to grandfathered group health plans. There is no consistent statutory rationale for eliminating the ability of a non-grandfathered plan to limit coverage only to those children who do not have a right to their own employer-sponsored coverage. The ability to screen out children who already have access to coverage can result in substantial cost savings to a multiemployer plan, with little or no effect on the children themselves. Consequently, the ability to exclude these children should not be limited only to grandfathered health plans.

Treatment of Retiree-Only Benefit Options and Benefit Schedules

As you know, multiemployer group health plans often have multiple benefit schedules within a single plan. For example, a plan may offer multiple benefit schedules with each schedule

[2] Plan sponsors could still choose to cover stepchildren on the same terms as a participant's own children, but they should not be required to do so.

covering a particular category of participant – e.g. active employees and retirees, which are further classified as early retirees and Medicare eligible retirees. Often, retiree schedules of benefits may offer less generous benefits than those offered under the active employees' schedules, but they often do so at very competitive and sometimes highly subsidized premiums.

The preamble to the interim final rules pertaining to grandfathered-status group health plans indicates that certain provisions of the Affordable Care Act, including adult child coverage, do not apply to retiree-only health plans.

As group health plans with multiple benefit schedules begin implementing the adult child rules, they experience difficulties in reconciling the many requirements of Title I of the Affordable Care Act (including adult child coverage) with the sometimes limited-coverage benefits provided through retiree-only benefit schedules. In effect, mandatory compliance with the Title I would prohibitively increase the cost-sharing and premium requirements for retiree-only benefit schedules to the point where plans will have to increase premiums to levels that many retirees would not be able to afford coverage or would eliminate retiree coverage altogether. A better option for these plans and the retirees they cover is to exclude retiree participants from the mandates of Title I.

Accordingly, we request clarification with respect to whether plans that have established separate active and retiree-only schedule of benefits under one plan could exclude retirees from the mandates of Title I of the Affordable Care Act, including adult child coverage requirements.

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