NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Attention: CMS-9954-P

Submitted electronically at www.regulations.gov

Re: File CMS-9954-P: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Proposed Rule

Dear Ladies and Gentlemen:

The National Coordinating Committee for Multiemployer Plans (NCCMP) appreciates the opportunity to provide comments on the above-referenced proposed rule as published in the Federal Register on December 2, 2013 (the "Proposed Rule").[1]

These comments focus on the proposed changes to the reinsurance contribution requirements as relevant to self-funded multiemployer plans. The NCCMP has previously submitted comments on this issue in response to prior proposed rules ("Prior Comments").[2]

The NCCMP is the only national organization devoted exclusively to protecting the interests of the over 20 million active and retired American workers 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 contributing employers in every major segment of the multiemployer plan universe, including in the airline, agriculture, building and construction, bakery and

[1] 78 Fed Reg 72322 (Dec. 2, 2013).

[2] Letter from Randy G. DeFrehn, Executive Director, NCCMP, July 19, 2013 (submitted via www.regulations.gov) on File CMS-9957-P Patient Protection and Affordable Care Act, Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards, Proposed Rule; Letter from Randy G. DeFrehn, Executive Director, NCCMP, December 30, 2012 (submitted via www.regulations.gov) on Patient Protection and Affordable Car Act, HHS Notice of Benefit and Payment Parameters for 2014, Proposed Rule, File Code CMS-9964-P; Letter from Randy G. DeFrehn, Executive Director, NCCMP, October 31, 2011 (submitted via www.regulations.gov) on Patient Protection and Affordable Care Act Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, File Code CMS-9975-P.

confectionery, entertainment, health care, hospitality, longshore, manufacturing, mining, retail food, service, steel and trucking industries.

I. SUMMARY OF COMMENTS

Application of the contribution requirement to self-funded, self-administered plans; definition of contributing entity

The focus of the NCCMP's Prior Comments is that the relevant statutory provisions impose the contribution requirement only on health insurance issuers, both with respect to their fully insured major medical plans and with respect to "costs of coverage administered by the issuer as a third party administrator," and do not support the application of the contribution to entities other than health insurance issuers. The NCCMP continues to maintain this position; however, given that the Department continues to maintain that the contribution is directly applicable to certain self-funded plans, these comments address the specifics of the Proposed Rule. *These comments are not intended to indicate a departure from the NCCMP's position that the statute imposes the contribution requirement on health insurance issuers and that self-funded plans should not be directly subject to the contribution.*

The NCCMP appreciates the recognition in the Proposed Rule that the contribution requirement should not apply to self-insured, self-administered plans and the specific request for comments on the definition of such plans. However, as currently proposed, the definition of a "third party administrator" is crafted so that the Proposed Rule will provide relief at best for only a very small number of plans, if any. The NCCMP recommends a number of changes to the Proposed Rule in order to appropriately limit the contribution requirement as provided in the statute and to provide a more workable rule that is consistent with the imposition of a fee on issuers. In particular, the NCCMP recommends that:

- The definition of a third-party administrator (TPA) should be crafted so as to provide a meaningful rule that reflects current market practices. As currently drafted, the Proposed Rule is virtually nominal in effect, and will provide relief for at most a handful of plans, and possibly none.
- In particular, the definition of a third-party administrator (TPA) should be limited to a TPA that is a health insurance issuer (or affiliate) that performs a full complement of administrative functions including determining whether the service is covered under the terms of the plan document, managing utilization of health care services, determining the amount that the plan covers and what the participant owes for the item or service, sending out Explanation of Benefits forms ("EOBs") to participants, paying health care providers for services covered by the plan, handling at least the first levels of appeals, and maintaining books and records on behalf of a multiemployer plan. A service provider should not be considered a TPA for reinsurance purposes for any activities in which it engages on behalf of its client other than major medical services and specifically if the service provider performs some or all of the following functions: development of a network of providers, negotiating discounts with providers, and/or the re-pricing of claims. These are not administrative functions performed by a TPA; rather network development, the negotiation of discounts, and the re-pricing of

claims are separate functions that are under the control of the entity offering the network to the plan and are the subject of a separate contractual arrangement with the plan. Further detail is provided below.

- Third-party administration should also not be construed to include cost-sharing arrangements between affiliated multiemployer plans.
- The revised definition of contributing entity should apply to all benefit years to which the contribution requirement applies, and should not be limited to 2015 and 2016. Given the recognition that certain plans should not be subject to the contribution, it is inexplicable why the contribution requirement should be applied for any year.
- HHS should reconsider the proposal that all amounts collected and allocable to reinsurance in a benefit year be used in that benefit year. This aspect of the prior rules would have provided some flexibility and possible relief for contributions in subsequent years based on the needs of the reinsurance program in prior years. NCCMP is particularly concerned with this change, given the proposal to allow the exception for self-insured, self-administered plans only for 2015 and 2016. This change is likely to further increase the burden of the contribution requirement on plans that do not benefit from the reinsurance program and should not be subject to the contribution requirement in any event.

Other comments

The NCCMP has additional comments on other aspects of the Proposed Rule, as follows:

- The NCCMP supports the proposed flexibility to allow contributing entities to pay the portion of the contribution attributable to payment to the US Treasury and administrative expenses either with the bulk of the contribution (in January following the benefit year) or separately in the fourth quarter of the year following the benefit year.
- We support the clarifications to help ensure that a contribution is not required with respect to the same life more than once.
- We reiterate the position noted above that any actions regarding the TPA function relating to anything other than major medical should be disregarded and specifically request clarification that certain types of supplemental coverage are not subject to the contribution requirement.

II. BACKGROUND RELATING TO MULTIEMPLOYER PLANS

One of the crowning achievements of collective bargaining over the past 50 years is the creation of thousands of labor-management, multiemployer health and welfare trust funds that provide to covered workers and their dependents various benefit coverages, including medical, hospitalization, preventive and wellness care, prescription drugs, dental care, and vision care. These trust funds are often referred to as "Taft-Hartley funds" because they are regulated by the Labor Management Relations ("Taft-Hartley") Act of 1947, as well as by ERISA and the Code ("Code"). We note, however, that some single-employer plans may operate as joint labor-management funds and therefore believe the more appropriate term is "multiemployer" plans with respect to comments contained herein.

Multiemployer plans provide health and welfare plan coverage to plan participants and their beneficiaries pursuant to the negotiated wages, hours, and other terms and conditions of employment (including requiring contributions to be made to a multiemployer benefit trust) of a collective bargaining agreement between one or more unions and more than one employer. Even for employees who are not union members but whose work is covered as part of a certified bargaining unit, existing labor law provides that discussions of employee benefits are a mandatory subject of bargaining and therefore subject to negotiation with the union under their status as the statutory bargaining agent. The ACA did not repeal the Labor Management Relations Act. Relationships are established between employers and employees under the Taft-Hartley Act, and these relationships should continue to be recognized in regulations implementing the ACA.

Health and welfare trust funds cover workers in industries as diverse as agriculture, aerospace, bakery and confectionery, building and construction, trucking, transportation, retail, food production, distribution and sales, clothing, health care, textiles, service, mining, entertainment, hospitality , maritime, longshore, and manufacturing. But for these trust funds, millions more working families would be uninsured and at risk for financial ruin in the event of a serious illness. Indeed, were it not for these plans, many millions of workers in these funds would not be eligible for coverage even under the enhanced eligibility requirements mandated for employers by ACA. The transient, project-based, mobile and seasonal employment patterns that characterize many of these industries would prevent workers from obtaining health coverage absent a central, pooled fund through which portable coverage is provided to workers as they move from employer to employer.

III. DETAILED COMMENTS ON THE PROPOSED RULE

A. Application of the Contribution Requirement to Self-Funded, Self-Administered Plans – Definition of Contributing Entity (Prop. Reg. 45 CFR § 153.20)

The NCCMP appreciates the Department's reconsideration of the application of the contribution requirement to self-funded, self-administered plans and supports the concept of excluding such plans from the definition of a contributing entity, provided that the final rule adopts a meaningful definition of what constitutes "the costs of coverage administered by the issuer as a [TPA]". Such definition should also recognize how plans operate and current contracting practices. A TPA for this purpose should include only an issuer that performs a full range of services so as to be truly administering coverage. The contribution should not be triggered merely because a plan outsources certain functions, such as leasing provider networks and leveraging discount arrangements from issuers or other entities. The NCCMP believes certain changes to the Proposed Rule are needed to better conform the rule to the statutory provisions and provide a more workable rule. In particular, the NCCMP continues to believe that the regulation fails to appropriately limit the contribution requirement to health insurance issuers and the cost of coverage administered by the issuer as a TPA.[3] Detailed comments follow.

[3] As noted above, these comments are not intended to imply in any way that the NCCMP agrees with the Department's position that the contribution should be imposed directly on self-funded multiemployer plans. Rather, these comments react to the specifics of the Proposed Rule.

1. The definition of a TPA for purposes of determining when a self-funded plan is a contributing entity should be limited to a TPA that is a health insurance issuer (or affiliate).

The Proposed Rule defines a contributing entity for the 2015 and 2016 benefit years to include only self-insured group health plans that use a TPA in connection with certain services. The preamble to the Proposed Rule indicates that a TPA for this purpose is an entity that is not under common ownership or control with the self-insured group health plan or its sponsor that provides certain services to the plan. (The scope of services that are included in the definition of a TPA is addressed in the following comment.)

As discussed in detail in the Prior Comments,[4] when read as a whole, the relevant sections of section 1341 of the Affordable Care Act (ACA) indicate that the contribution requirement is intended to apply to health insurance issuers both when providing health insurance coverage and when providing services to a self-funded plan as a TPA (ACA section 1341(b)(3)(B)). The statute generally requires HHS to develop standards for programs under which "health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable reinsurance entity." (See Section 1341(b)(1)(A).) Reading this portion of the statute in isolation could lead one to believe that TPAs of all group health plans must contribute. However, when read in its entirety, the statute clearly takes a narrower approach and focuses specifically on ***health insurance issuers***. As HHS has noted in other regulations, health insurance issuer is a defined term that does not include self-funded plans. In particular, the specific details in the statute for how the contributions will be calculated focus on the business of health insurance **issuers**. The statute directs HHS to establish standards so that:

> [T]he contribution amount **for each issuer** proportionally reflects each issuer's fully insured commercial book of business for all major medical products and the total value of all fees charged by the issuer and **the costs of coverage administered by the issuer as a third party administrator**. ACA § 1341(b)(3)(B)(i) (emphasis added)

This means that issuers make their contribution based on revenue from their insured products as well as from those situations in which they act as third-party administrators on behalf of group health plans. There is no mention in 1341(b)(3)(B) of how contributions are to be calculated for group health plans themselves. Section 1341(b)(3)(A) refers to "the total costs of providing benefits to enrollees in self-insured plans" as providing some basis for the group health plan calculation, but that phrase is qualified by the reference to "the percentage of revenue of each issuer" and thus indicates that the contribution is limited to a health insurance issuer's business of third-party administration and does not apply where the TPA is not a health insurance issuer. Further support for limiting the contribution requirement to TPAs that are health insurance issuers is found in section 1341(b)(3)(B)(iv), which includes an additional $5 billion for general revenues, and refers clearly and explicitly only to "each **issuer's** contribution" and makes no mention whatsoever of self-funded plans, clearly indicating the contribution does not apply to self-funded plans.

As a basis for imposing the contribution requirement with respect to self-funded plans that use

[4] Please refer to the Prior Comments for more detailed discussion of this issue.

TPAs, the preamble to the Proposed Rule relies on the reference in ACA section 1341(b)(3)(B) to the "commercial book of business". However, the preamble fails to take into account the entire section, which refers specifically to "each **issuer's** fully insured commercial book of business". (Emphasis added). There is no basis in the statute for extending the requirement beyond issuers.

Further, self-funded multiemployer plans, whether or not they contract out some administrative functions rather than having them performed by permanent staff, are not commercial in nature; rather, they are by law not-for-profit. Multiemployer plans are funded by contributions made by employers pursuant to collective bargaining agreements and have no other source of funds from which to pay the reinsurance contribution. The plans are not available to the general public, but rather participation is limited pursuant to the bargaining process. Just as the health insurance that is not "commercial insurance" is exempted from the contribution requirement under regulations, not-for-profit multiemployer plans should be exempted from the contribution requirement.

By distinguishing between those plans that maintain their own fund office and those plans that have decided to retain an independent service provider unrelated to an insurer, HHS has created an artificial distinction not intended under Section 1341 of ACA that unfairly penalizes self-insured plans which may not have any alternative but to retain outside service providers. Self-funded multiemployer plans, particularly plans that are smaller in size, may not have the resources to maintain a separate fund office that involves hiring staff, including directors, claim processors, accountants/bookkeepers, and IT personnel. Additionally, providing up-to-date technology to allow for quick processing of claims and maintaining privacy of health records can be costly. In many instances, a more efficient alternative is to retain a service provider that can provide better trained staff at lower costs. Further, such entities are able to offer state of the art technology that would otherwise not be available to multiemployer plans because of size. In effect, the Proposed Rule unfairly punishes a Board of Trustees that in the proper exercise of its fiduciary responsibilities determines that the use of a third-party, independent service provider is a more cost-effective way to administer the delivery of health benefits to participants and beneficiaries. This is a particularly inequitable result given the statute's express reference only to an "issuer as a third-party administrator" as opposed to all instances of third-party administration.

2. The definition of a third-party administrator (TPA) should be crafted so as to provide a meaningful rule that reflects current market practices. As currently drafted, the Proposed Rule is virtually nominal in effect, and will provide relief for at most a handful of plans, and possibly none. In particular, the definition of a TPA should be limited to a TPA that is a health insurance issuer (or affiliate) that performs a full complement of administrative functions, as described below.

The Proposed Rule would treat as self-administered (and thus exempt from the reinsurance contribution) only those self-insured plans that do not use a TPA in connection with claims processing or adjudication (including the management of appeals) or plan enrollment. If more than "ancillary administrative support" (undefined in the Proposed Rule) is provided by an outside entity, the plan would not be treated as self-administered. This narrow definition of self-administration could effectively require that a plan sponsor handle all plan functions in-house.

This approach does not reflect how self-insured plans typically operate, is not consistent with the statute, and, unless clarified, would likely require virtually all self-insured multiemployer plans to pay the reinsurance contribution.

Trustees of multiemployer plans today use a wide variety of arrangements to administer their plans. In our view, the only type of administrative arrangement that the statute allows to be subject to the reinsurance contribution is the well-defined situation where a self-insured plan contracts with an insurance carrier as a third-party administrator for full administrative services (sometimes referred to as an administrative services only contract). In that arrangement, insurance carriers perform a full complement of administrative functions including determining whether the item or service is covered under the terms of the plan document, managing utilization of health care services, determining the amount that the plan covers and what the participant owes for the item or service, sending out Explanation of Benefits forms ("EOBs") to participants, paying health care providers for services covered by the plan, handling at least the first levels of appeals, and maintaining books and records on behalf of the multiemployer plan. The Fund Office itself handles other administrative functions such as: employer contribution accounting, eligibility tracking and determinations, vendor contracting, and member services primarily as they relate to eligibility. The Fund Office provides the carrier with eligibility files on a periodic basis, and the carrier uses that eligibility list in administering the entire claims process.[5]

In sharp contrast to the insurer-provided administrative contract described above, the more common arrangement in many parts of the country is one in which the multiemployer plan performs the core administrative functions, but contracts with an insurance company to in effect "rent" the insurance company's network of hospitals, physicians, and other providers. This model has grown in popularity because it is an excellent way for the Trustees of multiemployer plans to leverage the provider discounts that large national carriers have negotiated with their health care providers and thus lower the plan's total costs. In fact, for most plans, this is the only practical way to access a comprehensive network of providers offering significant discounts for services. Most important, under this contractual arrangement, the Trustees retain control over the administration of the adjudication of claims, including control over the plan design and the way claims are paid. In essence, the Trustees are only purchasing a discount arrangement through an insurance carrier. The process works as follows:

- Health care providers submit major medical claims to the carrier, and the carrier re-prices the claims. Re-pricing means that the carrier applies the discounts that the carrier has negotiated with the providers. Almost all insurance carriers insist on retaining control over re-pricing since the discount arrangements with the underlying hospitals and physicians is considered proprietary by the carrier.

[5] There is another very important difference between the ASO and shared administration arrangements. Under an ASO contract the carrier establishes a working rate, comparable to a premium, wherein the carrier projects the expected costs to the plan. The plan pays a monthly premium of the working rate to the carrier. The carrier holds the assets and a reserve on behalf of the plan sponsor. Ultimately the risk is born by the plan sponsor, not the carrier. However, in a shared administration arrangement, multiemployer plans do not pay premiums or working rates. They pay a relatively small monthly administrative fee. In some cases, the carrier takes a monthly draw off the multiemployer plan's accounts, but the carrier does not hold the plan's assets in any kind of carrier controlled reserve.

- Once the discount is applied, the Fund Office or independent third-party administrator adjudicates the claim by determining whether the participant or family member is eligible for coverage, whether the service is covered under the plan, whether any applicable deductible has been met, how much of the discounted amount the plan will pay, and how much the participant owes for the care.
- The Fund Offices provides EOBs to the participant.
- The Fund Office handles any appeals because it is responsible for claims adjudication.
- For claims from in-network providers, the Fund Office may also send the adjudicated claim back to the carrier so that the carrier can send the payment to the health care provider. Carriers tend to insist that the carrier be the entity that pays the in-network providers, but the carrier does so only after the plan actually adjudicates the claim. The reason many insurance carriers insist on performing this functions is simple: the underlying contracts between the carrier and the providers typically require prompt payment usually within 30 days or less of the submission of claims and the payment by the carrier ensures that its contractual commitment is satisfied. The Fund Office, however, typically pays out-of-network providers directly because these providers are not under contract with the carrier, and, in some cases, the carrier may permit the Fund Office to pay in-network providers as well if it has assurance that payment can be made in a manner that satisfies its commitments to providers. In our view, the carrier-driven determination over which entity pays the in-network providers at the end of this process is a ministerial function that is part of the contract to gain access to the network; it is not third-party administration. Therefore, the payment of the claim by the insurance company should not affect whether the plan is subject to the reinsurance contribution. Regardless of which entity transmits the payment to the health care providers, the retention by the plan of the claims adjudication function should be sufficient to deem the plan self-administered for purposes of the reinsurance contribution.

Another administration model selected by some Trustees involves the leasing of a provider network, usually from an entity other than an insurer. The popularity of this type of arrangement varies considerably depending on the region of the country and the market dynamics. The network provider's role is typically limited to the re-pricing of claims (i.e., the application of the negotiated discounts to the health care provider's bill). The Fund Office performs all other functions, including receiving claims from health care providers, claims adjudication, sending EOBs, handling appeals, and paying health care providers. In some arrangements, the network provider may receive the claims from the providers and forward them to the Fund Office, but the claims adjudication and payment functions are still handled by the Fund Office.

In some cases, the Trustees staff the Fund Office functions by hiring an independent administrator to handle some or all of the duties that would otherwise be handled by employees of the Fund Office, however, we believe that questioning the Trustees' decision to retain the services of a non-issuer provider of staff services rather than directly employing fund staff is more a distraction than a relevant distinction in determining the applicability of this fee to such groups. These independent administrators are not associated with an insurance carrier and they

are not in the business of insurance. In our view, as explained above, the Trustees' decision to staff some or all of these functions by hiring an entity that is not an insurance carrier should have no bearing on whether the reinsurance contribution should be paid. If this staffing arrangement by itself caused the plan to be treated as not self-administered, it would penalize small to medium sized plans that have found it more cost effective to outsource certain functions instead of hiring their own employees. As noted above, these are the very plans that will be most burdened by paying the reinsurance contribution.

Very few multiemployer plans perform all functions in-house as that would require the plan to create its own provider network by entering into direct negotiations and contracts with health care providers. Generally, it is more cost effective for the plan and its participants if the plan leases existing networks or purchases discount arrangements such as those described above. In those arrangements, there will have to be at least one outside entity that performs some administrative function: the re-pricing of the claims. Even when the Fund Office administers the major medical benefit completely in-house, there will likely be a pharmacy benefit manager handling prescription drug claims or a separate dental network provider. However, the existence of a separate administrator for benefits that by themselves are not major medical coverage should not affect whether reinsurance contributions applicable to major medical coverage should be paid.

Administrative arrangements other than the insurer-provided administrative contract described above should not trigger the reinsurance contribution. The preamble refers to the "core administrative processing functions" as "adjudicating, adjusting, and settling claims (including the management of appeals), and processing and communicating enrollment information to plan participants and beneficiaries."[6] Yet, the proposed regulatory text would subject to the contribution a self-insured plan that uses a third-party administrator for any one of those functions. The proposed regulatory text could even be interpreted to mean that merely having the required contracts with Independent Review Organizations for the purpose of handling ACA-required external appeals would subject a non-grandfathered self-insured plan to the reinsurance contribution.

In our view, the definition of a third-party administrator (TPA) should be limited to a TPA that is a health insurance issuer (or affiliate) that performs a full complement of administrative functions including determining whether the service is covered under the terms of the plan document, managing utilization of health care services, determining the amount that the plan covers and what the participant owes for the item or service, sending out Explanation of Benefits forms ("EOBs") to participants, paying health care providers for services covered by the plan, handling at least the first levels of appeals, and maintaining books and records on behalf of a multiemployer plan.

All of the other models described above, which involve the leasing of networks and the leveraging of provider discounts, as well as slight variants of those models, should be treated as self-administered for purposes of the reinsurance contribution. The development of a network of providers, negotiating discounts with providers, and the re-pricing of claims are not administrative functions performed by a third-party administrator; rather network development,

[6] 78 Fed. Reg. at 72340 (Dec. 2, 2013)

the negotiation of discounts, and the re-pricing of claims are separate functions that are under the control of the entity offering the network to the plan and are the subject of a separate contractual arrangement with the plan.

3. **Third-Party Administration Should Not Include Cost-Sharing Arrangements Between Affiliated Multiemployer Plans.**

The Proposed Rule provides that "HHS will consider a third-party administrator to be, with respect to a self-insured group health plan, an entity that is not under common ownership or control with the self-insured group health plan or its sponsor". However, in many instances, a Fund Office will be under control of one multiemployer plan but provide services to a number of other affiliated multiemployer plans through cost-sharing arrangements. These cost-sharing arrangements have long been recognized as a permissible and effective way for multiple affiliated multiemployer plans to save expenses and leverage greater numbers of covered lives into more sophisticated high quality administration. These cost-sharing arrangements comply with all the requirements of ERISA and are sanctioned by the Department of Labor under Prohibited Transaction Class Exemption 77-10. Although the multiemployer plan that is the employer of the Fund Office is technically not under common control with the other affiliated multiemployer plans for which the Fund Office is providing services, none of the affiliated multiemployer plans that are part of a cost-sharing arrangement should be considered "contributing entities" under the Proposed Rule.

4. The new definition of contributing entity as it applies to self-funded, self-administered plans should apply for 2014 as well as 2015 and 2016.

The Proposed Rule would apply the new definition of contributing entity only for the 2015 and 2016 benefit years, and not for 2014. The preamble states that this limitation was based on "public policy" concerns that a change for 2014 would disrupt settled estimates with respect to reinsurance payments that were used to establish the premiums, rather than legal concerns. Given the conclusion that certain plans should be excluded from the contribution requirement, there is no clear basis for not applying that rule to all years.

Further the analysis of the public policy issues fails to adequately take into account the effect on self-funded, self-administered plans that are not contributing entities under the Proposed Rule. The 2014 benefit year involves the largest aggregate contribution level for the 3-year period.

The impact of the contribution requirement may be substantial. For example, in the case of one moderately sized multiemployer plan, the contribution requirement would mean an additional expense of approximately $971,000 per year (6424 active employee plan participants x 2.4 (dependents) x 5.25 x 12). Total annual operating expenses of self-administering the program are approximately $3.4 million, meaning that the contribution will equal 28.5% of operating expenses. In another situation for a plan covering 5,200 active employees, the expected amount of the contribution, disregarding any adjustment for dependent coverage, is approximately 50% of administrative expenses. In the extreme instances, several very large funds anticipate costs related to this fee in excess of $30 million in 2014 – dollars that directly reduce funds available for claims payment.

Multiemployer plans are funded by contributions made by employers pursuant to collective bargaining agreements and have no other source of funds from which to pay the reinsurance contribution. Because the plans are not-for-profit, unless or until contributions can be adjusted through the bargaining process, funds for paying the reinsurance contribution may come at the cost of reduced benefits.

There are many other instances in which HHS has changed its position on ACA implementation, which would have varying effects on affected parties. As recently as last month, HHS announced that insurance carriers would not have to cancel individual policies in 2014 that were not ACA-compliant even though the obvious result is that those policyholders would not obtain ACA-compliant coverage on the Health Insurance Marketplaces, which in turn would adversely impact premiums. The impact of allowing hundreds of thousands of non-ACA compliant policies to continue in 2014 on premium rates had to have been considered by HHS. Plans should not have to bear the burden of that decision. Further, here, any small negative impact on rate setting by insurance carriers is far outweighed by the significant negative impact on participants in self-funded multiemployer plans required to pay the reinsurance fee which may include offsetting reductions in benefits.

The NCCMP recommends that the new definition of contributing entity should be applied for the 2014 benefit year. Because the contribution requirement for 2014 is not payable until 2015, there is time to make an adjustment.

B. Allocation Of Contributions Not Needed For Reinsurance Payments (Prop. Reg. 45 CFR § 153.20(d))

Current HHS rules provide that any excess contribution amounts collected are to be used in future years for reinsurance payments. The Proposed Rule provides, instead, that excess amounts are to be used to increase the amount of reinsurance payments in the benefit year to which the contribution relates.

The current rule potentially provided some flexibility with respect to the contribution requirement, as excess amounts could potentially reduce the amount needed to fund the reinsurance payments in future years. Under this rule, that flexibility will not be present, thus potentially increasing the burden on plans that do not share in the reinsurance payments, including self-funded, self-administered plans that will be exempt under the Proposed Rule.

C. Additional Comments

NCCMP has the following additional comments on the Proposed Rule.

1. Clarify that certain types of coverage, even when provided in combination, are not subject to the contribution and create clearer rules for when "supplemental" or "secondary" coverage is not subject to the contribution.

The previously issued final regulations explicitly exempt self-insured plans that consist "solely" of excepted benefits under section 2791(c) of the Public Health Service Act.[7] It is unclear whether this language exempts dental or vision coverage when that coverage does not qualify as an excepted benefit, even though such coverage is clearly not major medical coverage as that term is now defined in the Proposed Rule. The final rule also exempts coverage that consists "solely" of benefits for prescription drugs.[8]

Some multiemployer plans provide coverage that is supplemental to coverage provided through other plans (such as supplementing major medical coverage provided directly by the participant's employer). The multiemployer plan might provide coverage consisting of dental and/or vision benefits, which would not qualify as excepted benefits where the plan provides the coverage automatically without requiring any type of affirmative election by the participants. This dental and/or vision coverage might also be combined with other coverage such as prescription drug coverage or a hearing aid benefit. In this type of situation, the plan's coverage would not consist "solely" of prescription drug coverage, yet none of the coverage that the plan provides, even in combination, would constitute major medical coverage.

The Proposed Rule appears to acknowledge this type of supplemental arrangement through a new provision that exempts coverage that is "supplemental or secondary to group health coverage for which reinsurance contributions must be made for the same covered lives." We appreciate this new provision. However, we ask for several clarifications:

- The final rule should expressly state that all dental and vision coverage is exempt from the contribution because it is not major medical coverage.
- The final rule should state that excepted benefits, prescription drug coverage, and other ancillary benefits such as hearing aid coverage may be offered by the same plan without that combination of coverage becoming subject to the contribution. This would be the case because the coverage is not major medical coverage. In essence, any actions regarding the TPA function that relates to anything other than major medical should be disregarded. The plan would not have to rely on the new provision exempting supplemental or secondary coverage.
- With respect to supplemental or secondary coverage, the final rule should clarify that any time a participant's spouse is covered *as an employee* by another group health plan (thus making the spouse's own employment-based coverage primary under standard coordination of benefit rules), the participant's plan may exclude that spouse from the count of covered lives. In this type of situation, the plan sponsor should not be required to obtain any written representations from the other plan sponsor that the other coverage has primary liability for the claims for particular covered lives. In other words, the plan sponsor could assume that the entity that covers the spouse as an employee would be responsible for paying the contribution without further verification.

[7] Section 153.400(a)(2)(i).

[8] Section 153.400(a)(2)(xiii).

Conclusion

As noted above, we appreciate the Department's recognition that the transitional reinsurance contribution should not be applied as broadly as originally contemplated and continue to believe the statutory language of section 1341 clearly limits application of the contribution only to issuers, including the cost of coverage administered by the issuer as a third party administrator. The statute unambiguously and repeatedly refers to the requirements imposed on issuers in describing how the contribution is to be determined. Thus, the statute states that the "contribution amount for **each issuer** [must] proportionally reflect **each issuer's** fully **insured** commercial book of business for all major medical products and the total value of all fees charged **by the issuer** and the costs of coverage administered **by the issuer** as a third party administrator," ACA § 1341(b)(3)(B)(i), and further that "**each issuer's** contribution" must reflect the additional amount to be paid to the general Treasury, with no mention of the application to self-funded plans. (ACA § 1341(b)(3)(B)(iv)).

The notion of whether certain provisions of the ACA could be extended to multiemployer plans has been the subject of intense scrutiny over the past three years. The decision of the relevant regulatory agencies has been that provisions that apply to "issuers" (e.g., the ability to access premium tax credits) do not apply to self-funded multiemployer plans, which are not health insurance issuers.

In considering this round of comments, we would urge that the same "strict constructionist" view of the literal language of the law which led to the earlier conclusion be employed in this context. While the parsing of certain isolated administrative functions may lead the conversation away from this fundamental premise and be used to provide apparent justification for a determination that this is a matter which involves the application of administrative interpretation based on "public policy concerns," to do so would result in a profound inconsistency: that the vast majority of self-funded, self-administered plans as they are considered in the marketplace are de facto "issuers" (but only in this context) and, therefore, subject to the temporary reinsurance contribution. As a result, the participants of multiemployer and other self-funded, self-administered plans that have been denied access to the beneficial provisions of the ACA will be penalized even further by requiring them to pay into a fund to reduce the risk to commercial insurance companies ("issuers") against adverse claims experience, while barring their plans from realizing any benefit of risk pooling were their plans to suffer similar adverse claims experience. For funds that have a been held to a statutory requirement for the last 65 years to be administered for the sole and exclusive benefit of plan participants, such a conclusion that requires plan assets to be diverted in this manner is not only unfair, it is unconscionable.

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

Respectfully submitted,

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