NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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July 19, 2013

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-9957-P

Submitted electronically at www.regulations.gov

Re: File CMS-9957-P Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards; 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 June 19, 2013 (the "Proposed Rule")[1].

These comments focus on the Proposed Rule as it relates to self-funded multiemployer plans and the impact that the Proposed Rule will have on the participants and beneficiaries who currently receive their health coverage under such plans. The NCCMP submitted comments on prior proposed rules relating to the reinsurance contribution requirements as applied to self-funded multiemployer plans ("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, building and construction, entertainment, health care, hospitality, longshore, manufacturing, mining, retail food, service and trucking industries.

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[1] 78 Fed Reg 37032 (June 19, 2013).

[2] 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.

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 building and construction, transportation, retail, food, clothing, textiles, service, mining, entertainment, hotel and restaurant, 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 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.

COMMENTS ON THE PROPOSED RULE

1. The statute does not support application of the reinsurance contribution requirement to self-funded, self-administered multiemployer plans. [Prop. reg. sec. 45 CFR 153.20]

Proposed Rule defines a contributing entity for purposes of the contribution requirement as "a health insurance issuer or a self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage). A self-insured group health plan is responsible for the reinsurance contributions, although it may elect to use a third party administrator or administrative services-only contractor for transfer of the reinsurance contributions." As discussed in the Prior Comments, the statute does not support the application of the contribution requirement to self-funded, self-administered multiemployer plans.

ACA section 1341 provides for the establishment of the transitional reinsurance program and provides a funding mechanism for that program through a contribution requirement imposed on "health insurance issuers, and third party administrators" (ACA section 1341(b)(A)). When read together, the relevant sections of section 1341 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 Proposed Rule, like the rule that is being amended, expands the liability for the reinsurance contribution and requires TPAs of all self-insured plans to contribute to the reinsurance program. The Proposed Rule further requires a self-insured, self-administered group health plan without a TPA or administrative-services-only contractor to make its reinsurance contributions directly. We see no basis for requiring self-administered, self-insured plans to pay the reinsurance contribution as contemplated in Proposed Rule. The statute, the scope of the enforcement authority of HHS, and various provisions of the reinsurance contribution rules support the contrary result – that is, that the reinsurance contribution should not be applied with respect to self-administered, self-insured non-profit multiemployer plans.

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 takes a narrower approach. 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:

> (i) the 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. (See Section 1341(b)(3)(B)(i).)

This means that issuers make their contribution based on revenue from their insured products as well as from their administrative-services-only ("ASO") line of business for 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 ASO business 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 specifically to "each issuer's contribution." Further, there does not appear to be a basis in the statute to define a self-administered plan as a TPA for purposes of making payments. The statutory provisions do not, on their face, apply to self-funded, self-administered multiemployer plans where there is no ASO contract with a health insurance issuer. Even if HHS continues to apply the reinsurance contribution generally to self-administered, self-funded multiemployer plans, there is no basis in the statute for imposing the additional $5 billion for general revenues on self-funded plans generally; rather, as noted above, in referring to the additional $5 billion amount, the statute refers specifically to "issuers" not to group health plans.

In contrast to the structure of the reinsurance contribution requirement, the fees financing the Patient Centered Outcomes Research Institute (PCORI) are clearly structured to apply both to fully insured and self-funded plans. In particular, Internal Revenue Code section 4376 provides that the PCORI fee applies with respect to "any applicable self-insured health plan" and is payable by the "plan sponsor". Thus, when Congress intends to impose fees on certain types of plans, it has done so clearly within the ACA.

We also note that the traditional enforcement authority of HHS does not extend to self-funded, self-administered multiemployer plans. Thus, the Public Health Service Act ("PHSA") gives HHS enforcement authority only with respect to self-funded plans that are non-federal governmental plans (PHSA Section 2723(b)). The HHS enforcement authority does not extend generally to multiemployer group health plans.

Further, the regulations relating to the reinsurance contribution program provide numerous additional exceptions to the contribution requirement in the case of fully-insured business. These additional exceptions are provided on the basis that the contribution requirement only applies to "commercial insurance." Excepting self-administered, self-funded multiemployer plans would be consistent with these exceptions. Multiemployer plans 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. 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. 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 fee will equal 28.5% of operating expense. In another situation for a plan covering 5,200 active employees, the expected amount of the fee, disregarding any adjustment for dependent coverage, is approximately 50% of administrative expenses. Just as the health insurance that is not "commercial insurance" is exempted from the contribution requirement, not-for-profit multiemployer plans should be exempted from the contribution requirement.

2. Additional Comments

As discussed above, NCCMP continues to believe that self-funded, self-administered non-profit multiemployer plans should not be subject to the reinsurance contribution. In the event that HHS continues to impose the requirement on such plans, NCCMP has the following specific comments on the Proposed Rule.

(a) Treatment of Partially Self-Funded and Partially Insured Group Health Plans [Prop. reg. sec. 45 CFR 153.20]

The Proposed Rule provides that the term "contributing entity" includes a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage. As described in the preamble, this means that the term "contributing entity" includes "a self-insured group health plan that is partially self-insured and partially insured, ***but only*** where the insured coverage does not constitute major medical coverage (whether or not the self-insured coverage is major medical coverage)."[3] Consequently, if the insured portion constitutes major medical coverage, the issuer (and not the plan) would pay the fees.

NCCMP supports this provision in the Proposed Rule to the extent that it imposes the contribution requirement on the insurer in the event that major medical coverage is provided through health insurance. However, the NCCMP suggests that the rule be clarified to provide that the contribution requirement also does not apply to a self-funded plan in the event that health insurance coverage offered under the plan, when combined, constitutes major medical coverage. For example, suppose one insurance policy covers prescription drug benefits and another provides other benefits that are not major medical benefits, but that the two policies combined provide major medical benefits. In addition to this coverage, a multiemployer plan provides additional prescription drug coverage on a self-funded basis. In this circumstance, the plan should not be liable for the fee; rather it should be imposed on the insurer (as determined under the rule discussed below).

[3] 78 Fed Reg 37037 (June 19, 2013). (emphasis added)

(b) Treatment of Fully-Insured Plans Where Major Medical Coverage is Offered Through A Combination of Policies [Prop. reg. sec. 45 CFR 153.400(a)(3)]

The proposed rule also provides that a health insurer must make reinsurance contributions with respect to coverage provided under a group health plan even if the coverage is not major medical coverage if (1) the plan provides health insurance for covered lives through more than one policy that in combination constitute major medical coverage but individually do not; (2) the lives are not covered by self-insured coverage (except for self-insured excepted benefits); and (3) the average premium per covered life is greater than the average premium per covered life under other health insurance coverage provided under the group health plan. For example, if a group health plan provides benefits under two different policies that together constitute major medical coverage and the average premium under one is $200 per covered life and the average premium under the other is $250 per covered life, then the insurer under the latter policy would be required to pay the contribution requirement.

The preamble to the Proposed Rule specifically asks for comments on how to administer such a rule and whether and in what circumstances an issuer should be entitled to rely on representations from the plan or the employer sponsoring the plan.

NCCMP supports the application of the reinsurance contribution requirement to health insurers in this situation. NCCMP also recommends that a simplified method of applying the rule should be determined. In the case of a multiemployer plan, the plan sponsor as defined under ERISA is the joint board of trustees that administers the plan. Neither the plan, nor the plan sponsor may readily have the information contemplated by the proposed rule. Plans (or plan sponsors) should not be required to provide any information to insurers (nor is it clear that HHS has the authority to impose such a requirement in this case). A rule that looks to the type of coverage provided, as suggested in the Proposed Rule, may be easier to administer

(c) Contribution Requirement Where Some Benefit Options are Insured and Some are Self-Funded

The preamble seeks comments on a proposed approach that would apply where some options offered under a plan are self-funded and some are insured. Under the proposal, in this situation, HHS would impose the contribution requirement on the insurer for the insured option and the group health plan would be responsible for the contribution for the self-funded option. If such a rule is adopted, then we request that HHS clarify that the contribution will not be imposed twice, i.e., on the same covered life more than once. In particular, the rules regarding application of the fee in the case of integrated HRAs should be retained.

(d) Prior Comments

NCCMP requests that HHS consider the following additional issues previously raised (and that are full addressed in the Prior Comments:

- All HRAs should be exempt from the reinsurance contribution.

- Retiree-only plans that are exempt from the ACA reforms should not be subject to the reinsurance requirement.

Conclusion

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,

Randy G. DeFrehn
Executive Director