

NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS



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October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

Re: Patient Protection and Affordable Care Act
Standards Related to Reinsurance, Risk Corridors and Risk Adjustment
File Code CMS-9975-P

Ladies and Gentlemen:

The National Coordinating Committee for Multiemployer Plans (the NCCMP) is pleased to provide these comments regarding the proposed rule that would implement the new reinsurance rules under the Patient Protection and Affordable Care Act. The proposed rule was published by the Department of Health and Human Services (HHS) on July 15, 2011 reference number CMS-9975-P.

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 other benefits. The NCCMP's purpose is to assure an environment in which multiemployer plans can continue their vital role in providing benefits to working men and women. The NCCMP is a nonprofit, non-partisan organization, with members, plans, and plan sponsors in every major segment of the multiemployer plan universe, including in the agricultural, airline, building and construction, entertainment, health care, hospitality, longshore, manufacturing, mining, retail food, service and trucking industries.

Introduction

In this comment letter, we raise issues concerning the new temporary reinsurance program that will be important to the participants and beneficiaries currently receiving health benefits from multiemployer plans.

Background on Multiemployer Plans

Due to their unique structure, for over 60 years multiemployer plans have provided affordable, high quality health coverage for American workers who are often left out of typical employer plans, including part-time workers and workers in industries with very fluid employment patterns.

Multiemployer plans are established as a not-for-profit plan under section 501(c)(9) of the Internal Revenue Code (the “Code”). They are maintained through the collective bargaining process in accordance with the provisions of the National Labor Relations Act (the “NLRA,” also known as the Taft-Hartley Act). Pursuant to section 302(c)(5) of that Act, these plans are sponsored by a joint board of trustees composed of equal numbers of employee and employer representatives. The board of trustees, not the individual employers, makes decisions regarding the coverage provided under the plan. Each employer contributes to the plan in accordance with the terms of the applicable collective bargaining agreement. The boards of trustees of these plans deliver health care exclusively for the benefit of participants and beneficiaries pursuant to the requirements of the NLRA and the Employee Retirement Income Security Act of 1974 (ERISA). Although these plans are often referred to as “Taft-Hartley plans,” the term “multiemployer” plans is the preferred terminology, because jointly managed single-employer plans are also subject to the NLRA.

Approximately 26 million Americans including active and retired workers and their families are covered by multiemployer plans today, and it is estimated that approximately 90 percent of contributing employers are small employers with fewer than 50 employees. In some industries, like construction, most contributing employers have 20 or fewer employees.

Multiemployer plans have a unique structure that in some ways reflects typical employer sponsored group health plans and in other ways reflects insured arrangements. For over 60 years, this unique structure has enabled multiemployer plans to provide affordable, high quality health

coverage for a broad segment of the American workforce cutting across the economy who are often left out of typical employer plans, including part-time workers and workers in industries with very fluid employment patterns. While most often associated with the building and construction and trucking industries, multiemployer plans are pervasive throughout the economy including the agricultural; airline; automobile sales, service and distribution; building, office and professional services; chemical, paper and nuclear energy; entertainment; food production, distribution and retail sales; health care; hospitality; longshore; manufacturing; maritime; mining; retail, wholesale and department store; steel; and textile and apparel production industries. These plans can provide coverage on a local, regional, multi-State, or national basis, and the coverage is designed to address the unique needs of a particular industry.

Multiemployer plans are attractive to employers because they provide consistent long-term health coverage for workers with predictability and cost-effectiveness for employers encouraging retention and ensuring the availability of a ready pool of highly trained, qualified workers. Unlike the majority of insured small employers whose premium rates are entirely determined by the insurance carrier, contribution rates are negotiated by the employers (often through employer associations) and the unions and are known and predictable for the term of the bargaining agreement. In years in which costs rise unexpectedly, benefits may be adjusted or the contribution rate increased, yet because such contributions are a part of the total compensation package, it is likely that some or all of the increased costs are borne by the employee through a reallocation of the contributions within that package. The integral nature of the plans to the bargaining relationship, along with the statutorily mandated requirement that boards of trustees operate the plans for the sole and exclusive benefit of participants, have resulted in consumer oriented, cost-conscious, design and management of plans. Similarly, multiemployer plans are attractive to employees because they provide, among other things, consumer-oriented plan design and administration, portability, stability and flexibility.

In other ways, however, multiemployer plans clearly function more as insurers, performing the functions usually associated with an insurance company. Multiemployer plans provide coverage for all employees of contributing employers – essentially creating a community-rated risk pool consisting of ALL covered employees of contributing employers. They do not use medical underwriting criteria to exclude participants, nor do they exclude any pre-existing conditions

(two of the main practices that ACA has codified into law). They receive contributions from which benefit payments are made, make eligibility determinations, and set benefit levels.

Plan trustees determine whether, and to what extent, benefits should be paid – either directly (self-insured) or on a fully insured basis, or some combination of insured and self-insured coverage. They also determine the administrative structure – whether fully self-administered, through a third party administrator, through an administrative services only (ASO) agreement with an insurer, or some combination of the above.

The Proposed Rule

Under the proposed rule, each state that operates an Exchange would be required to establish a reinsurance program. Each state would enter into a contract with at least one existing not-for-profit reinsurance entity or establish a new entity. If a state used more than one reinsurance entity, each one would have to operate in a distinct geographic region. Multiple states could also contract with a single reinsurance entity. The federal government will administer a reinsurance program for any state that does not operate an Exchange and also chooses not to administer a reinsurance program.

Each reinsurance entity would then collect the necessary funds (from contributing entities) and make reinsurance payments to issuers in the individual market that cover high-cost individuals. The goal is to collect, on a national basis, the following amounts for purposes of making reinsurance payments: \$10 billion in 2014, \$6 billion in 2015 and \$4 billion in 2016. Reinsurance entities would also need to collect funds for deposit into the general fund of the U.S. Treasury (\$2 billion in 2014 and in 2015, \$1 billion in 2016); these funds would not be available for reinsurance payments to issuers.

Under the proposed rule, a contributing entity is any health insurance issuer and, in the case of a self-insured group health plan, the TPA of the group health plan. The proposed rule defines a TPA as the claims processing entity for a self-insured group health plan. According to the rule's preamble, a self-insured plan that processes its own claims will be treated as a TPA and thus be required to contribute. The frequency and manner of making these contributions will be determined by the state or by HHS.

Under the proposed rule, a contribution rate would be used to determine the dollar amount that each issuer and TPA must contribute to the reinsurance entity. It would be based on a “percent of premium,” which means the percent of total revenue, based on earned premiums, in a fully insured market, or the percent of total medical expenses in a self-insured market. Contributing entities would be required to submit data to substantiate the amount of their contributions. Issuers would have to submit enrollment and premium data. TPAs would have to submit data on covered lives and total expenses. HHS considered but declined to adopt a contribution rate based on a per capita amount applied to all covered enrollees of contributing entities. Under the proposed rule, states would be allowed to collect additional funds from contributing entities if needed to cover the reinsurance payments that the state will pay out.

Although the proposed rule adopts a percent-of-premium approach for collecting contributions from issuers and TPAs, it does not set the percentage. HHS will establish the percentage (along with other critical values such as the attachment point discussed below) through a forthcoming annual notice of benefit and payment parameters, based on HHS’ estimate of total premiums in the fully insured market and medical expenses in the self-insured market.

Under the proposed rule, the issuer of any health plan offered in the individual market with the exception of grandfathered plans would be eligible to receive reinsurance payments. An individual market plan becomes eligible for payments when the plan pays more than a set amount (called the attachment point) for essential health benefits for an enrollee in the plan. HHS will set the attachment point in the annual notice described above, but states will be able to increase or decrease it. Self-insured plans would not be eligible to receive any reinsurance payments.

Impact on Self-Insured Multiemployer Plans

The proposed rule requires TPAs of all self-insured plans to contribute to the reinsurance programs. While it is not entirely clear whether this interpretation is required by the statute itself, we see no basis, and there is no discussion in the preamble, as to why a self-administered, self-insured plans would also be required to pay the reinsurance fee.

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 would lead one to believe that TPAs of all group health plans must contribute.

However, when the statute provides specific details for how the contributions will be calculated, it appears to take a narrower approach. That part of 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. Although one could interpret part of 1341(b)(3)(A) (“the total costs of providing benefits to enrollees in self-insured plans”) as providing some basis for the group health plan calculation, that phrase is connected by “and” to “the percentage of revenue of each issuer” and thus could be interpreted as also relating to an issuer’s ASO business.

Even if there is a statutory basis for requiring TPAs of group health plans to make a contribution to the temporary reinsurance program, 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 Joint Committee on Taxation Technical Explanation of the PPACA (March 21, 2010), states the following description of the program: “In general, issuers of health benefit plans that are offered in the individual market would be required to contribute to a temporary reinsurance program for individual policies that is administered by a nonprofit reinsurance entity.”

Conclusion

We submit that the statute does not require self-insured, self-administered group health plans to contribute to the temporary reinsurance program, which funds certain individual insurance companies, but which offers no comparable protections for the self-insured, self-administered plans. We greatly appreciate the opportunity to comment on these rules as they apply to multiemployer plans and are more than happy to discuss any questions you may have regarding these comments.

Respectfully submitted

A handwritten signature in black ink, appearing to read "Randy G. DeFrehn". The signature is written in a cursive style with a large initial "R".

Randy G. DeFrehn
Executive Director