

ALSTON&BIRD LLP

TO: Ken Choe
Deputy General Counsel
Office of the General Counsel
United States Department of Health and Human Services

FROM: Alston & Bird LLP

DATE: August 30, 2011

RE: Treatment of Multiemployer Plans Under the Affordable Care Act

This memorandum, provided on behalf of the National Coordinating Committee for Multiemployer Plans (NCCMP), is a follow-up to our earlier memorandum dated August 9, 2011 (the "August 9 memorandum") and our discussions in the August 11, 2011 meeting (the "August 11 meeting") regarding the treatment of multiemployer plans under the Affordable Care Act (ACA). This memorandum responds to the questions and issues you raised in that meeting. NCCMP appreciates the time that you and your colleagues have spent on the issues relating to multiemployer plans, as well as the opportunity to provide this follow-up.

This memorandum reflects the input of UNITE/HERE and their lawyers at Covington and Burling; the United Food and Commercial Workers and their counsel from Slevin and Hart; the International Brotherhood of Teamsters and their consultants at RAK Consulting; and the Segal Company.

EXECUTIVE SUMMARY

Proposed Treatment of Multiemployer Plans

You had some questions regarding the proposed treatment of multiemployer plans as described in the August 9 memorandum, and additional clarifications are addressed in this section.

First, based on the structure of multiemployer plans, clear legislative intent to preserve such plans, and the relevant authorities and provisions of ACA, NCCMP requests that implementing regulations provide that coverage under a multiemployer plan (both self-funded and fully insured) be deemed to be coverage under a qualified health plan (QHP) purchased through an Exchange for which otherwise qualified individuals may receive a premium subsidy. Under these regulations, Exchanges would not be required to offer self-funded multiemployer plan

coverage on the Exchange (and self-funded plans would not be issuers subject to State licensing requirements).¹

In the case of a fully insured multiemployer plan, the licensed insurer would be subject to the requirements that normally apply to such insurer under State law. Thus, the normally applicable ACA rules under State law and ACA would apply to such coverage. These rules are not applicable to self-funded multiemployer plans; thus, the August 9 memorandum as supplemented by this memorandum, includes a discussion of the rules that would apply to self-funded multiemployer plans. In order to maintain the quality and continuity of coverage currently provided to multiemployer plan participants, the ultimate objective of this treatment is that individuals who otherwise meet the income thresholds for the premium tax credit under Code section 36B² would be eligible for the tax credit with respect to coverage under the multiemployer plan. Thus, for purposes of such Code section, the coverage would be treated as individual coverage purchased through an Exchange. We understand that this result also involves questions within the jurisdiction of the Treasury Department; this discussion focuses specifically on treating multiemployer plan coverage as coverage purchased through an Exchange, which is within the jurisdiction of HHS.

Second, NCCMP requests that multiemployer plans be permitted to purchase coverage on the Exchange, acting as a “purchasing aggregator” for plan participants if they desire. This could be done, for example, either by having the multiemployer plan’s joint board of trustees select one of the Exchange options for all participants, or by enabling individual selections (as is done through the Federal Employees Health Benefits Program). The rationale for allowing the multiemployer plans’ trustees to purchase directly through the Exchange on behalf of their participants is tri-fold: (1) trustees and their professional advisors would be better qualified to make informed decisions about coverage—the role they have fulfilled since their inception and recognized as a fiduciary duty under ERISA; (2) by aggregating contributions from all employers for which the employee works, for eligibility purposes, it recognizes that the fund acts on behalf of the participant rather than any one employer; and (3) it allows the fund to maintain the group for purposes of providing benefits beyond those obtainable from the Exchange. This option is not discussed further in this follow-up memorandum, but remains an important option for some multiemployer plans.

Finally, NCCMP requests that implementing regulations ultimately provide as follows (these issues are primarily within the jurisdiction of the Treasury Department, but are provided here for your information regarding the complete proposed treatment of multiemployer plans):

- While most employers contributing to multiemployer plans are small employers that are not subject to the employer responsibility requirements in Code section 4908H, for those that are, employer contributions to a multiemployer plan in accordance with the applicable collective bargaining agreement would satisfy the employer responsibility requirement;

¹ Multiemployer plans are not multiemployer employer welfare arrangements (MEWAs). MEWAs have a different regulatory structure and are not addressed in this memorandum.

² References to the “Code” are to the Internal Revenue Code.

- Coverage under a multiemployer plan would be considered minimum essential coverage for purposes of the individual responsibility provisions of Code section 5000A;
- Otherwise eligible small employers would be eligible to receive the tax credit under Code section 45R with respect to contributions to multiemployer plans, both with respect to coverage purchased through an Exchange and self-funded coverage that is deemed to be purchased through an Exchange. NCCMP will be happy to work with the Treasury Department to develop appropriate rules coordinating the individual credit and the small employer credit.

As discussed in the August 9 memorandum, there are three different ways that coverage under a multiemployer plan could be deemed to be coverage under a QHP purchased through an Exchange. Under each of the three approaches, multiemployer plans would comply with specified requirements applicable to QHPs as well as appropriate requirements consistent with those that apply to issuers who offer coverage in the Exchanges. These are presented as options; due to the different structure of multiemployer plans, some options may work better for some plans than for others. NCCMP believes that the simplest approach is to deem multiemployer plans to be QHPs. The three approaches under which the Federal government could certify or deem a multiemployer plan as being a QHP are as follows:

- (a) In the case of a self-funded plan, the plan satisfies specified requirements relating to the definition of a QHP as defined under ACA section 1301(a), as well as certain requirements applicable to health insurance issuers. As noted above, in the case of a fully insured plan, the licensed insurer would be subject to all the requirements that normally apply to such carrier under ACA and State law.
- (b) The plan is the equivalent of a multi-State plan under section 1334 of ACA.
- (c) The plan is the equivalent of a CO-OP plan under section 1322 of ACA. The CO-OP grant program is designed to foster the adoption of CO-OPs; multiemployer plans are already a CO-OP model, and so would not need development grants if the plan may be deemed to be a CO-OP plan and therefore a QHP.

Under each of these approaches, with respect to self-funded plans, compliance with the standards set forth in the regulations (as discussed here and in the August 9 memorandum) would be deemed to be compliance with any requirements applicable to QHPs.

HHS has the authority, both under the statute and applicable precedent, to develop implementing regulations following the proposed structure.

Failure to Adopt a Regulatory Structure that Effectively Considers Multiemployer Plans Will Cause the Termination of Many Multiemployer Plans, Adversely Affecting Previously Covered Employees and Their Families

For decades, the risk pooling currently provided by multiemployer plans has enabled contributing employers to provide quality, affordable coverage for their employees. Multiemployer plans currently cover 26 million Americans. This coverage has also contributed to the health care system as a whole, by reducing the “churning” that can occur when individuals

have changed circumstances that cause a dramatic change in health care coverage (e.g., a termination of coverage or moving in and out of eligibility for Medicaid). Churning results in repeated and often lengthy coverage gaps. This can cause severe negative consequences for the affected individuals, including failure to obtain coverage for chronic diseases (such as hypertension and diabetes) and needed preventive care, including pediatric preventive care. Affected individuals may also face increased illness and increased debt due to noncovered medical care. Churning also causes increases in overall health care costs, due to such factors as sporadic and delayed care, increased use of emergency room services, and repetition of administrative services. One study has found that the adverse effects of churning occur quickly after loss of coverage.

Multiemployer plans currently reduce churning by providing continuity of coverage. This continuity is provided in a number of ways, including through coverage of part-time workers, coverage based on working in an industry rather than for a single employer, and a variety of other features, including hours banks and similar approaches that allow individuals to continue coverage when they are not working, have become disabled, or have retired. For those employees who are no longer working, this coverage is far more affordable than COBRA coverage.

If subsidies are available only for plans purchased through Exchanges, employers contributing to multiemployer plans will face tremendous economic pressure to stop contributing to multiemployer plans. This pressure will be the greatest in circumstances in low wage industries, where the small employer responsibility penalties do not apply (including employers that are not subject to the penalties because of their size), and in industry sectors that have significant numbers of entry-level (including apprentices) and part-time employees. Economic analysis at the macro level, as well as examples from particular industries and employee groups, demonstrates that the economic effects of the subsidies will be substantial. Many employers will feel the need to drop coverage and access the subsidies to remain competitive.

Loss of multiemployer plan coverage would increase the adverse effects of churning. In addition, for those employees who do purchase coverage through an Exchange following termination of a multiemployer plan, the benefits will be less generous in many cases. This is because the subsidies are set at the silver level benchmark, while most multiemployer plans provide coverage at least at the gold level, in most instances without any additional employee premium. Once lost, the multiemployer plan structure would be difficult to replace.

The goals of ACA to provide access to quality, affordable health coverage should be supported by an appropriate regulatory structure that preserves what already works well for 26 million Americans.

While these Exchange provisions do not go into effect until 2014, issues regarding health care coverage are already surfacing in the bargaining process as bargaining agreements of three- to five-year terms are the norm. Appropriate regulatory guidance is needed in a timely fashion so that it can be considered in bargaining process before 2014.

Issues Addressed in This Document

In accordance with the discussion in the August 11 meeting, the following issues are addressed in this document: agency authority; guaranteed issue requirements; risk adjustment, risk corridors, and reinsurance; multi-State plans; and economic issues relating to subsidies and the effect on coverage if the proposed regulatory structure for multiemployer plans is not adopted.

This document is intended as a supplement to the August 9 memorandum and does not revisit all the issues addressed in that document.

ORGANIZATION OF THE DOCUMENT

The remainder of the document provides detailed discussion of the issues that you identified for further follow-up. The document is organized as follows:

- I. HHS Has the Authority to Implement ACA so as to Preserve Multiemployer Plans as a Viable Coverage Option, Both Explicitly under the Statute and Pursuant to a Valid Exercise of Agency Discretion under Well-Established Legal Precedent
 - A. The Statute Confers Authority on HHS to Develop Regulations Deeming Multiemployer Plans to Be Treated as Exchange Plans
 - B. HHS Has the Authority to Develop Regulations to Preserve Multiemployer Plans under the *Chevron* Doctrine
- II. Multiemployer Plans Are Not Subject to State Licensing Requirements and Should Be Considered Health Plans for Purposes of Exchange Requirements
- III. Discussion of Issues Relating to the Guaranteed Issue Requirement
 - A. Clarification of Issues
 - B. Summary of Requested Approach
 - C. Self-Funded Multiemployer Plans That Are Deemed to Be Exchange Plans Should Be Considered to Satisfy the Guaranteed Issue Requirement If the Plan Provides Coverage to Individuals as Required under the Applicable Trust Agreement and the Plan Does Not Base Eligibility on Medical Underwriting
 - Multiemployer plans are precluded by law from covering all individuals
 - Requiring multiemployer plans to accept all individuals is not necessary to prevent “cherry picking”
 - A “mirror plan” approach would create numerous practical difficulties with respect to self-funded multiemployer plans

- D. In the Case of Multiemployer Coverage That Is Provided on a Fully Insured Basis, the Insurer Would Be Subject to Section 2702 and a “Mirror Plan” Approach May Be a Workable Option to Allow Insurers to Offer Coverage That Is Limited to Certain Eligible Classes as Determined by the Collective Bargaining Process
- IV. Discussion of Issues Relating to Reinsurance, Risk Corridors and Risk Adjustment
- V. The Federal Government May Certify Multiemployer Plans as Multi-State Plans Eligible to Participate on the Exchanges
- VI. Economic Analysis Relating to the Effects of Failure to Adopt the Proposed Regulatory Structure
 - A. “Churning” of Coverage Due to Fluctuations in Employment and Income Can Be Reduced by Multiemployer Plans
 - B. Without an Appropriate Regulatory Structure, the Availability of Subsidies in Exchanges Will Result in Economic Forces that Will Cause the Termination of Many Multiemployer Plans Due To Employer “Dumping” of Coverage, Which Will Adversely Affect Previously Covered Employees and Their Families

I. HHS HAS THE AUTHORITY TO IMPLEMENT ACA SO AS TO PRESERVE MULTIEMPLOYER PLANS AS A VIABLE COVERAGE OPTION, BOTH EXPLICITLY UNDER THE STATUTE AND PURSUANT TO A VALID EXERCISE OF AGENCY DISCRETION UNDER WELL-ESTABLISHED LEGAL PRECEDENT

A. The Statute Confers Authority on HHS to Implement Regulations Deeming Multiemployer Plans to Be Treated as Exchange Plans

Congress has explicitly given the Secretary broad authority in issuing regulations to implement title I of ACA, which HHS has already recognized in rulemaking. In the preamble to the proposed rule that would establish Exchanges and QHPs, HHS states that section 1321(a)(1) of the ACA “provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs, and other components of title I of the Affordable Care Act.”³

³ 76 Fed. Reg. 41866, 41867 (July 15, 2011). *See also id.* at 41868 (“In general, this NPRM is based on the broad rulemaking authority of 1321(a)(1)...”).

Indeed, that subsection provides in relevant part:

(a) Establishment of Standards.—

(1) In general.—The Secretary shall, as soon as practicable after the date of enactment of this Act, issue regulations setting standards for meeting the requirements *under this title and the amendments made by this title*, with respect to—

(A) the establishment and operation of Exchanges (including SHOP Exchanges);

(B) the offering of qualified health plans through such Exchanges;

(C) the establishment of the reinsurance and risk adjustment programs under part V; and

(D) *such other requirements as the Secretary determines appropriate*...⁴

A plain meaning reading of this subsection indicates that the Secretary is directed to issue regulations setting standards for meeting the requirements under title I of the ACA related to Exchanges, QHPs, the reinsurance and risk adjustment programs and “other requirements” determined appropriate by the Secretary. Thus, the language explicitly grants broad authority to HHS to create standards for other requirements the Department deems appropriate. Such requirements could include deeming multiemployer plans to be equivalent to QHPs, multi-State plans or CO-OP plans, all of which are provided for under title I and, therefore, are within the ambit of the Department’s rulemaking authority under this subsection.

We believe this subsection provides sufficient basis for HHS’ authority to deem multiemployer plans equivalent to QHPs, multi-State plans or CO-OP plans. However, the next section provides additional legal authority for our argument in the August 9 memorandum that HHS has discretion under the Chevron cases to interpret ACA so as to preserve multiemployer plans.

B. HHS Has the Authority to Develop Regulations to Preserve Multiemployer Plans under the *Chevron* Doctrine

Longstanding legal precedent supports the exercise of broad Federal agency discretion to fill gaps or silences and resolve ambiguities in Congress’ drafting. The landmark Supreme Court case *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.* originally set forth the now familiar two-step test for when courts are to defer to an agency’s interpretation of a statute:

When a court reviews an agency’s construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines *Congress has not directly addressed the precise question at issue*, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. *Rather, if*

⁴ ACA § 1321(a)(1) (emphasis added).

*the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.*⁵

Thus, in situations where Congress has not spoken directly to a particular issue and has not explicitly directed the responsible agency to fill the gap, the resulting ambiguity constitutes an implicit delegation from Congress to the agency to fill the statutory gaps,⁶ and “a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency so long as it is reasonable.”⁷ “The power of an administrative agency to administer a congressionally created...program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress.”⁸ Furthermore,

In determining whether Congress has specifically addressed the question at issue, a reviewing court should not confine itself to examining a particular statutory provision in isolation. The meaning—or ambiguity—of certain words or phrases may only become evident when placed in context. It is a “fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme.” A court must therefore interpret the statute “as a symmetrical and coherent regulatory scheme” and “fit, if possible, all parts into an harmonious whole.”⁹

Thus, under the precedent set by a long line of Supreme Court cases, Federal agencies are accorded broad discretion in their interpretation of gaps and ambiguities in statutes: under an implicit delegation of authority from Congress, an agency’s interpretation of a gap or ambiguity—which may be identified in light of the “overall statutory scheme”—will not be overturned by a court unless the interpretation fails the “reasonableness” standard.

Applying the *Chevron* test to the issue at hand, we find that both parts of the test are satisfied: (1) Congress did not speak the issue at hand, i.e., the statute is ambiguous as to the place of multiemployer plans in the scheme of private insurance under the ACA, and (2) the regulatory approach we have proposed would be a reasonable interpretation to resolve the ambiguity.

⁵ *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 (1984) (emphasis added).

⁶ “When relevant statutes are silent on the salient question, we assume that Congress has implicitly left a void for an agency to fill... [and] must therefore defer to the agency’s construction of its governing statutes, unless that construction is unreasonable.” *Ass’n of Pub. Agency Customers, Inc. v. Bonneville Power Admin.*, 126 F.3d 1158, 1169 (9th Cir. 1997) (citing *Chevron*, 467 U.S. at 843-44).

⁷ *Chevron*, 467 U.S. at 844.

⁸ *Id.* at 843 (quoting *Morton v. Ruiz*, 415 U.S. 199, 231 (1974)).

⁹ *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 132-33 (2000) (citing *Brown v. Gardner*, 513 U.S. 115, 118 (1994) (“Ambiguity is a creature not of definitional possibilities but of statutory context.”)); *Davis v. Michigan Dept. of Treasury*, 489 U.S. 803, 809 (1989); *Gustafson v. Alloyd Co.*, 513 U.S. 561, 569 (1995); *FTC v. Mandel Brothers, Inc.*, 359 U.S. 385, 389 (1959); *United States v. Estate of Romani*, 523 U.S. 517, 530-31 (1998); *United States v. Fausto*, 484 U.S. 439, 453 (1988)).

The first question under the *Chevron* analysis is whether Congress has spoken directly to the issue at hand. The “issue” presented here involves the place of multiemployer plans within the “overall statutory scheme”¹⁰ and the answer to this first question is clearly “no”. While the “overall statutory scheme” evidences Congress’ intent to preserve multiemployer plans, precisely how to do so in the context of the interrelated provisions relating to QHPs and Exchanges,¹¹ premium tax credits¹² and individual and employer responsibilities¹³ is wholly ambiguous.¹⁴

Specifically, there are ambiguities in numerous sections of ACA that require agency interpretation with respect to the issues at hand. Some of the specific ambiguities were addressed in the August 9 memorandum as well as this memorandum. However, the inquiry does not stop there—in determining whether there is an ambiguity, it is incumbent on the agency to avoid “examining a particular statutory provision in isolation”.¹⁵ Rather, the “words of a statute must be read in their context and with a view to their place in the overall statutory scheme.”¹⁶

When looked at under this standard, it is clear from the statute that Congress expected and intended multiemployer plans to continue to operate as they have from the beginning of health care reforms through the establishment of Exchanges and beyond. Specifically, multiemployer plans are referenced in the following three key provisions:

- The standard for the essential health benefits package (EHBP) is to be based on the typical employer plan, *including multiemployer plans*.¹⁷ The EHBP is at the core of the health care reforms, and the specific reference to multiemployer plans in this context indicates the Congress recognized the significance of these plans and that they serve as a model for coverage.
- Multiemployer plans are specifically mentioned as being eligible to participate in the early retiree reinsurance program, one of the first ACA provisions to become effective.¹⁸
- The high cost plan tax, which is one of the last ACA provisions to become effective in 2018, contains specific rules for multiemployer plans, and treats these plans as similar to insurance coverage for purposes of applying the tax.¹⁹

¹⁰ See *Davis*, *supra* note 9.

¹¹ ACA §§ 1301-1343.

¹² ACA §§ 1401-1416.

¹³ ACA §§ 1501-1502.

¹⁴ Some of these provisions are codified in other laws, including the Internal Revenue Code. All of these provisions are contained in title I of ACA, which includes sections 1001 through 1563 (there is more than one section numbered 1563).

¹⁵ *Brown & Williamson*, *supra* note 9.

¹⁶ *Davis*, *supra* note 9.

¹⁷ See ACA § 1302(b)(2).

¹⁸ See ACA § 1102.

¹⁹ See IRC § 4890I.

These provisions clearly demonstrate Congress' intent to preserve multiemployer plans in the "overall statutory scheme" of private health insurance. Furthermore, there can be little doubt that Congress sought to build on the existing employer-based health care system, as demonstrated in many of the regulations that have already been issued. For example, the Treasury Department has recently formally acknowledged this objective, stating that "the regulations will seek to further the objective of preserving the existing system of employer-sponsored coverage..."²⁰ In addition, Congress' goals of facilitating continuity of coverage, offering consumers a "choice of health plans to fit their needs", and "giv[ing] individuals and small businesses the same purchasing clout as big businesses"²¹ are recognized and emphasized in the proposed Exchange regulations.²² Multiemployer plans, uniquely, already provide these functions for the many businesses that contribute to and individuals who participate in such plans.

Although the intent to preserve multiemployer plans clearly exists in the text of the ACA and has been recognized by the agencies responsible for its implementation, title I of the ACA does not explicitly describe how multiemployer plans are to be treated with respect to the new and revised structures within this scheme—QHPs, Exchanges, premium tax credits and individual and employer responsibilities—leaving an ambiguity for the responsible agencies to resolve in implementation. While each of the statutory provisions, taken individually, may not appear to contain gaps or ambiguities, the entire statute must be considered as a whole, as explained above, leading to the conclusion that substantial ambiguity exists regarding the place of multiemployer plans within the overall scheme of private health insurance under the ACA. Therefore, HHS and the other agencies responsible for administering the ACA have the authority to resolve the ambiguity and "fit...all parts into an harmonious whole."²³

Under step two of the *Chevron* analysis, a court would next determine whether the agency's rule is a "reasonable" interpretation of the statute. In general, agencies have been accorded broad discretion by the judiciary to interpret ambiguities in statutes.²⁴ For an agency interpretation to

²⁰ Preamble to Health Insurance Premium Tax Credit notice of proposed rulemaking. 76 *Fed. Reg.* 50936 (Aug. 17, 2011). The precise wording in the preamble raises another ambiguity that appears in the statute, which references "employer-sponsored coverage." While multiemployer plan coverage is employment-based, the sponsor is not the employer. Rather, under ERISA, the sponsor is the joint board of trustees, not the employer.

²¹ 76 *Fed. Reg.* 41866 (July 15, 2011).

²² For further discussion of this point, see August 9 memorandum at 10-11.

²³ *Mandel Brothers*, *supra* note 9.

²⁴ See, e.g., *Entergy Corp. v. Riverkeeper, Inc.*, 129 S. Ct. 1498 (2009) (finding that the EPA could consider costs in setting standards that "reflect the best technology available for minimizing adverse environmental impact" from power plants' operations although the statute made no mention of costs); *Mayo Foundation for Medical Education and Research v. United States*, No. 09-837, slip op. (U.S. Jan. 11, 2011) (upholding the Treasury Department's interpretation of the Federal Insurance Contributions Act (FICA) to require medical residents to pay FICA taxes although "neither the plain text of the statute nor the District Court's interpretation of the exemption [for students] 'speak[s] with the precision necessary to say definitively whether [the statute] applies to' medical residents") (citing *United States v. Eurodif S.A.*, 555 U.S. ___, __ (2009) (slip op., at 13); *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158 (2007) (finding that "the [Fair Labor Standards Act] explicitly leaves gaps, for example, as to the scope and definition of statutory terms such as 'domestic service employment' and 'companionship services'" and

be considered reasonable, it is not necessary that it be “the only possible interpretation, nor even the interpretation deemed *most* reasonable by the courts”.²⁵

An HHS regulation that interprets the ACA as permitting the deeming of multiemployer plans as “QHPs” in order to be made available through the Exchanges and eligible for the premium tax credit would be determined to be reasonable in view of the context of the entire ACA and Congress’ intent to preserve the employer-based system of health insurance and, therefore, a valid exercise of the Department’s discretion.

First, the proposed structure would facilitate the implementation of Exchanges and foster a smooth transition to a stable Exchange-based system, as contemplated by the Exchange-related provisions in title I of ACA, by reducing the likelihood of increased “churning” of coverage and the potential adverse selection associated with potentially massive numbers of employees with existing coverage from being “dumped” on Exchanges immediately in 2014. The economic background relating to these issues is discussed further in section VI of this memorandum. The proposed structure will also harmonize other interrelated provisions and goals of ACA, including preserving coverage for those that already have and like their coverage and preserving the employer-based health care system.

Further, a clear line can be drawn between self-funded multiemployer plans and self-funded plans generally. There is a clear legal distinction between multiemployer plans and single-employer plans that is specified by statute and that has significance outside of the context of ACA. Further, the key factors that are part of the definition of a multiemployer plan are the features that, in operation, enable multiemployer plans today to serve the functions envisioned for the Exchanges starting in 2014.

The ERISA and the Code contain the same definition of a “multiemployer plan”. Under both these statutes, a multiemployer plan is a plan:

- (i) to which more than one employer is required to contribute,
- (ii) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and
- (iii) which satisfies such other requirements as the Secretary [of Labor] may prescribe by regulation.²⁶

that the statute “provides the Department [of Labor] with the power to fill these gaps through rules and regulations” and that the Department’s interpretation was reasonable). *See also* Robin Kundis Craig, *Administrative Law in the Roberts Court: The First Four Years*, 62 Admin. L. Rev. 69 (2010) (noting at 144 that in comparison to the preceding Rehnquist Court, “[o]ne of the more subtle but important changes in the Roberts Court’s administrative law jurisprudence is an increased willingness to subordinate the Federal courts’ role in statutory interpretation to Federal agencies, particularly when neither constitutional issues nor questions of the agency’s own authority are involved” and at 158 “The Roberts Court is far more likely to defer to agency constructions of statutes outside jurisdictional and federalism contexts”).

²⁵ *Entergy Corp.*, 129 S. Ct. at 1505.

²⁶ ERISA § 3(37); Code § 414(f).

Related businesses are treated as a single employer for this purpose.²⁷ Thus, a multiemployer plan must involve employees of unrelated employers. For example, consider a large corporation that has many different subsidiaries and affiliates. A plan covering only employees of the various different subsidiaries and affiliates would be considered a single-employer plan (even if maintained pursuant to a collective bargaining agreement) not a multiemployer plan.

Department of Labor regulations²⁸ provide that a multiemployer plan must be established for a substantial business purpose. The following factors are relevant in determining whether a substantial business purpose exists for the establishment of a plan: the plan covers a substantial portion of a trade, craft or industry in terms of number of employees or employees in a locality or geographic area; the extent to which the plan provides benefits more closely related to years of service within the trade, craft or industry rather than with a particular employer, reflecting the fact that an employee's relationship with an employer maintaining the plan is generally short-term, although service in the trade, craft or industry is long-term; and the extent to which the burden and expense of providing benefits through single employer plans would be greater than through a multiemployer plan.²⁹

These types of factors make multiemployer plans unique in operation. For example, by tying benefits to an industry, multiemployer plans are able to provide better continuity of coverage for workers in industries where work is fluid. Specific examples of ways in which multiemployer plans provide continuity of coverage is are provided in section VI.A of this document. Further, for many small employers, the expense of providing benefits through a single-employer plan would be prohibitive; the risk pooling offered by multiemployer plans allows such coverage to be provided in a cost effective manner.

The requirement that a multiemployer plan be established pursuant to one or more collective bargaining agreements is further supported by Department of Labor regulations that provide standards for when a collective bargaining agreement is considered to be bone fide. Code provisions relating to multiemployer plans also provide similar standards. These rules are discussed in detail in part II.C of this document.

The proposed treatment of multiemployer plans is also not unlike treatment of such plans in other circumstances. For example, this is similar to the approach taken by CMS with respect to employer/union-only group plans under Medicare Parts C and D.

Regulatory agencies have developed administrative guidance in other situations specifically addressing issues with respect to multiemployer plans where there has not been specific direction from Congress. For example, as noted in the August 9 memorandum, the Treasury Department has provided an exception to the new W-2 reporting requirements in the case of multiemployer plan coverage.³⁰ While the rationale for this exception is not stated, the structure of

²⁷ ERISA § 3(37)(C); Code § 414(f)(2).

²⁸ DOL Reg. § 2510.3-37.

²⁹ DOL Reg. § 2510.3-37(c)(1).

³⁰ See IRS Notice 2011-28.

multiemployer plans creates distinct issues under the reporting requirement that do not apply to other types of plans.

As another example, the Department of Treasury regulations regarding the maximum benefit that can be provided under a tax-qualified defined pension plan contain special rules for multiemployer plans. Under Code section 415(b), plans may provide a minimum benefit of \$10,000 if certain requirements are satisfied, including that the participant has not been a participant in another plan of the same employer. The regulations adopt a special rule for multiemployer plans, generally allowing the \$10,000 minimum benefit without regard to whether the participant was in another plan of the employer.³¹

Regulations under the COBRA continuation coverage rules contain special rules for determining whether a qualified event has occurred due to the cessation of contributions by an employer to a multiemployer plan. These rules are needed due to the fact that in a multiemployer plan, the relationship between the employer and the plan is different from that in the case of single-employer plans.³² The preamble to the regulations provides further discussion of how the general COBRA rules interact with the special structure of multiemployer plans. The guidance issued under the COBRA premium credit provided under the American Recovery and Reinvestment Act also contain special rules recognizing the special structure of multiemployer plans, in this case, the continuity of coverage provisions under such plans.³³

Thus, in light of the ambiguity in the ACA as to the issue of multiemployer plans' place within the overall scheme of private health insurance and the requirement that courts defer to agencies' reasonable interpretation of ambiguous statutes, we believe that the regulatory scheme we have proposed is consistent with HHS' interpretive authority as recognized under *Chevron* and the decades of ensuing jurisprudence.

II. MULTIEMPLOYER PLANS ARE NOT SUBJECT TO STATE LICENSING REQUIREMENTS AND SHOULD BE CONSIDERED HEALTH PLANS FOR PURPOSES OF EXCHANGE REQUIREMENTS

You asked for further discussion relating to the State licensing issues addressed in section IV.B.3 of the August 9 memorandum. The discussion below supplements that section.

As discussed in the August 9 memorandum, the exercise of regulatory authority to treat all multiemployer plans, including self-funded plans, as QHPs while maintaining the current Federal preemption is supported by the terms of ACA for several reasons. One of these reasons is the specific wording of section 1301(b)(1)(B) of ACA, which excludes a group health plan "to the extent the plan * * * is not subject to State insurance regulation under section 514 of [ERISA]." Under its plain terms, ACA section 1301(b)(1)(B) does not exclude a plan from the definition of "health plan" simply because the plan is shielded from State law by section 514 of ERISA. It

³¹ Treas. Reg. § 1.415(b)-1(f)(3).

³² See Treas. Reg. § 54.4980B-9 Q&A 9 and 10.

³³ See COBRA Questions and Answers, Administration and Eligibility, AE-32, issued by the Internal Revenue Service. Available at: <http://www.irs.gov/newsroom/article/0,,id=205364,00.html>.

only excludes a plan *to the extent that* the plan is protected from State regulation by section 514.³⁴ Multiemployer plans are also protected from State law under section 301 of the Taft-Hartley Act, which predates ERISA by many years.³⁵ Courts have long held that the Taft-Hartley Act preempts the application of State law to claims requiring the interpretation of the terms of a collective bargaining agreement.³⁶ Accordingly, Taft-Hartley preemption has been, and continues to be, applied to claims under collectively bargained health and welfare plans.³⁷ Thus, under the *Allis-Chalmers* decision and its progeny, claims involving multiemployer welfare plans are preempted under the Taft-Hartley Act, as well as ERISA.³⁸

The language in section 1301(b)(1)(B), when viewed in light of the application of Taft-Hartley Act preemption to claims under multiemployer welfare plans, creates an ambiguity in section 1301(b)(1)(B). The preamble to the proposed Exchange regulations notes that there are inconsistencies with respect to the statutory language that create the need for interpretation.³⁹ This is one such inconsistency. Thus, under the *Chevron* doctrine discussed above, HHS may interpret the statute to treat multiemployer plans, including self-funded plans, as QHPs consistent with the proposed regulatory structure discussed in this memorandum, without subjecting such plans to State law requirements.

III. DISCUSSION OF ISSUES RELATING TO THE GUARANTEED ISSUE REQUIREMENT

A. Clarification of Issues

You asked for further discussion of the application of Section 2702 of the Public Health Service Act (“Section 2702”), subsection (a) of which provides as follows: “Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual

³⁴ In contrast, ACA section 1343 (relating to risk adjustment) excludes from risk adjustment self-insured group health plans “which are subject to the provisions of [ERISA]...”. ACA § 1343(a)(1) and (2).

³⁵ Taft-Hartley Act preemption was firmly established by Justice Frankfurter in 1959. *San Diego Building Trades Council v. Garmon*, 359 U.S. 236 (1959). ERISA was not enacted until 1974 and preemption under section 514 did not become effective until 1975. The legislative history of ERISA instructed courts that actions brought pursuant to ERISA should operate “in similar fashion to those [actions] brought under section 301 of [Taft-Hartley].” H.R. CONF. REP. 93-1280, 93d Cong., 2d Sess., *reprinted in* (1974) U.S.C.C.A.N. 5038, 5107. Taft-Hartley Act preemption has continued to exist since ERISA was enacted.

³⁶ *San Diego Building Trades Council v. Garmon*, *supra*; *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202 (1985).

³⁷ *Allis-Chalmers Corp. v. Lueck*, *supra*; *see, e.g., In re General Motors Corp.*, 3 F.3d 980 (6th Cir. 1993); *Goss v. Firestone Polymers, LLC* 2005 WL 1004717 (E.D. Tex. Apr. 13, 2005); *Baumgardner v. Smurfit-Stone Container Corp.* 347 F. Supp. 2d 927 (D. Or. Dec. 2, 2004); and *Arizona Laborers, Teamsters, and Cement Masons, Local 395 Pension Trust Fund* 661 F. Supp. 365 (D. Ariz. May 19, 1987); *see Anselmo v. W. Paces Hotel Grp., LLC*, No. 9:09-2466-MBS, 2011 WL 1049195, at *15-17 (D.S.C. March 18, 2011) (discussing ERISA and Taft-Hartley, both as viable preemption doctrines that may apply to claims involving collectively bargained health and welfare plans).

³⁸ The preemption analysis is the same whether the claim is brought against a multiemployer plan or a single employer plan subject to the Taft-Hartley Act. *See e.g., Laborers Health & Welfare Trust Fund for N. Cal. v. Kaufman & Broad of N. Cal., Inc.*, 707 F.2d 412 (9th Cir. 1983); *Rosen v. Hotel & Rest. Emps. & Bartenders Union of Phila., Bucks, Montgomery & Del. Cntys., P.A.*, 637 F.2d 592 (3d Cir. 1981); *Cent. States, Se. & Sw. Areas Health and Welfare Fund v. Borden, Inc.*, 736 F. Supp. 788 (N.D. Ill. Jan. 31, 1990).

³⁹ 75 Fed. Reg. at 41869.

or small group market in a State must accept every employer or individual in the State that applies for such coverage.”

In the August 9 memorandum, we indicated that this requirement should be considered satisfied by self-funded multiemployer plans treated as QHPs if the plan provides coverage to individuals as required under the applicable trust agreement and the plan does not base individual eligibility on medical underwriting.⁴⁰ In addition, multiemployer plans do not (and would not) discriminate on the basis of race, color, national origin, disability, age, sex gender identity, or sexual orientation.⁴¹

You indicated that in an earlier meeting another possible approach was discussed—to allow a plan to limit eligibility as provided under a collective bargaining or trust agreement if there is “mirror” plan on the Exchange that would be open to all. None of the participants in our August 11 meeting were present at the earlier meeting; our understanding is that meeting addressed issues with respect to single employer collectively bargained plans, not multiemployer plans. Multiemployer plans have a different structure so that different issues arise. As a threshold matter, there would be significant legal impediments for multiemployer plan to create an affiliated mirror plan open to all individuals and employers in the jurisdiction of the multiemployer plan. Further, different issues arise with respect to self-funded plans than fully insured plans because self-funded plans are not subject to Section 2702. Thus, the issue with respect to self-funded multiemployer plans is whether a “mirror approach” under Section 2702 should be applied to such plans merely because they would be deemed to be QHPs under the requested regulatory structure. Applying Section 2702 to self-funded plans is not necessary to prevent “cherry picking” or to protect the rights of participants or contributing employers. Further, a mirror plan approach is not workable in that context. A mirror plan approach may be more workable in the full insured context. These issues are addressed below.

B. Summary of Requested Approach

With respect to self-funded multiemployer plans, consistent with the overall legal structure (including ERISA and the Labor Management Relations Act (LMRA)) applicable to multiemployer plans, NCCMP requests that implementing regulations provide as follows:

- Self-funded multiemployer plans that are deemed to be Exchange plans should be considered to satisfy the guaranteed issue requirement if the plan provides coverage to individuals as required under the applicable trust agreement and the plan does not base individual eligibility on medical underwriting. This treatment is necessary because:
 - multiemployer plans cannot make benefits available to all individuals or use plan assets to establish a “mirror” plan available to all individuals and employers,
 - multiemployer plans already provide coverage to all eligible individuals without medical underwriting, and, further,

⁴⁰ Multiemployer plans currently do not and would not use underwriting as a basis for individual eligibility.

⁴¹ See Prop. Reg 45 CFR § 156.200(e).

- a “mirror plan” approach would create numerous practical difficulties in the self-funded plan context.

With respect to a multiemployer plan that provides coverage on a fully insured basis, the insurer would be subject to Section 2702. In this context, a “mirror plan” approach may be a workable option to allow insurers to offer coverage that is limited to certain eligible classes as determined by the collective bargaining process.

These issues and the supporting analysis are discussed below.

C. Self-Funded Multiemployer Plans That Are Deemed to Be Exchange Plans Should Be Considered Compliant with the Guaranteed Issue Requirement if the Plan Provides Coverage to Individuals as Required under the Applicable Trust Agreement and the Plan Does Not Base Eligibility on Medical Underwriting

Multiemployer plans are precluded by law from covering all individuals

Multiemployer plans are subject to regulation under ERISA, the LMRA, and the Code. Substantial authority under each of these statutes restricts multiemployer plans from making coverage available to all individuals whether directly or under an affiliated plan; rather, eligible individuals must be limited to the employment context and as provided under the trust.⁴²

ERISA requires that “the assets of a plan...shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan.”⁴³ “Participant” is defined by ERISA as “any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.”⁴⁴

ERISA requires a plan fiduciary to discharge his or her duties for the exclusive benefit of the plan’s participants and beneficiaries. Specifically, a fiduciary must discharge his or duties with respect to a plan “solely in the interest of the participants and beneficiaries and (A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan...”⁴⁵

The exclusive benefit rule in ERISA is similar to provisions contained in the LMRA.⁴⁶ Section 302(c)(5) of the LMRA requires that multiemployer trust funds be established for the “sole and

⁴² In the case of a fully insured multiemployer plan, the legal authorities discussed here would similarly preclude the plan itself from covering all individuals, whether on a self-funded or fully insured basis. However, as discussed in the text, the insurer would remain subject to Section 2702.

⁴³ ERISA § 401(c)(1).

⁴⁴ ERISA § 3(37).

⁴⁵ ERISA § 404(a).

⁴⁶ As noted in the August 9 memorandum, the LMRA, in addition to ERISA, preempts certain State laws as applied to multiemployer plans.

exclusive benefit of the employees of such employer” and their beneficiaries. Case law under the LMRA reinforces that multiemployer plan funds cannot be used to provide benefits to individuals other than plan participants.⁴⁷

Department of Labor (DOL) regulations require that a multiemployer plan must be established or maintained under a bona fide collective bargaining agreement. These regulations were established pursuant to a lengthy process. In 1995, the Department of Labor convened a Negotiated Rulemaking Advisory Committee (the “Committee”) to assist DOL in developing a regulation that would protect legitimate collectively bargained plans, but allow States and DOL to take action against fraudulent plans. The Committee was composed of representatives of unions, multiemployer welfare plans, State insurance departments (including Secretary Sebelius, who was then the Kansas Insurance Commissioner) and plan administrators. The Committee made recommendations to the DOL in 2000 and regulations were finalized in 2003. The final regulation requires that in order for a plan to be established or maintained under a bona fide collective bargaining agreement, a number of requirements must be satisfied, including that, in any plan year, at least 85 percent of the participants in the plan must have a nexus to a collective bargaining agreement (e.g., workers, retirees, employees of the plan).⁴⁸

Code provisions also restrict participation in multiemployer plans. Section 419A of the Code contains rules for the funding of collectively bargained health benefit plans. To be considered a collectively bargained plan, in addition to other requirements, the plan must satisfy the DOL regulations discussed above and, in addition, at least 90 percent of the employees eligible to receive benefits under the plan must be subject to the collective bargaining agreement.⁴⁹

Multiemployer plans are generally tax-qualified under Code section 501(c)(9) as voluntary employees’ beneficiary associations (“VEBAs”).⁵⁰ Treasury regulations under this section require that the membership of an organization described in section 501(c)(9) must consist of individuals “whose eligibility for membership is defined by reference to objective standards that constitute an employment-related common bond among such individuals.”⁵¹ The regulations further provide that the “benefits provided by a [VEBA] must be payable to its members, their dependents, or their designated beneficiaries”⁵² and that “no part of the net earnings of a [VEBA]

⁴⁷ See, e.g., *Blassie v. Kroger Co.*, 345 F.2d 58 (8th Cir. Mo. 1965) (a multiemployer health plan could not use trust assets to make discounted drugs available to individuals outside the participant class); *Upholsterers’ International Union v. Leathercraft Furniture Co.*, 82 F. Supp. 570 (D. Pa. 1949) (the fund, which is actually money earned by the employee-members, must be used for their sole and exclusive benefit); *Reiherzer v. Shannon*, 581 F.2d 1266 (7th Cir. Wis. 1978) (multiemployer pension fund cannot pay benefits to self-employed individuals, because such plans must be for the exclusive benefit of employees).

⁴⁸ 29 C.F.R. § 2510.3-40. Failure to satisfy these regulations will result in the plan being treated as a multiple employer welfare benefit arrangement (MEWA) and a different regulatory structure than that applicable to multiemployer plans, including application of State law.

⁴⁹ Treas. Reg. § 1.419A-2T. In the case of a plan in existence on July 1, 1985, the percentage is 50 percent.

⁵⁰ Some multiemployer plans are exempt under section 501(c)(5) of the Code.

⁵¹ Treas. Reg. § 1.501(c)(9)-2(a)(1).

⁵² Treas. Reg. § 1.501(c)(9)-3(a).

may inure to the benefit of any private shareholder or individual other than through the payment of benefits permitted [the regulations].”⁵³

Thus, consistent with these authorities a multiemployer plan itself cannot expand coverage to all individuals and assets of the plans cannot be used to do so.

Requiring multiemployer plans to accept all individuals is not necessary to prevent “cherry picking”

Section 2702 (together with related reforms) is designed primarily to address “cherry picking” practices in the individual market that precluded individuals from obtaining coverage, such as medical underwriting and exclusion of pre-existing conditions.⁵⁴ Multiemployer plans historically have not, and under the proposed regulatory structure could not, engage in such practices with respect to eligible individuals as determined under the trust agreement. Thus, the protections of Section 2702 would apply under the proposed regulatory structure with respect to eligible employees.

Further, the proposed regulatory structure would keep multiemployer plans on an equal footing with other self-funded plans. Self-funded plans generally are not subject to Section 2702. We note also that ACA section 1324, entitled “Level Playing Field”, provides that certain requirements will not apply to coverage offered by licensed health insurance issuers in a State unless the requirement also applies to CO-OP plans and multi-State plans that offer coverage in the State. The guaranteed issue requirement is not among those listed. ACA section 1324 does refer to guaranteed renewal requirements – since HIPAA, multiemployer plans have been subject to guaranteed renewal requirements under both the Code and ERISA.⁵⁵

A “mirror plan” approach would create numerous practical difficulties with respect to self-funded multiemployer plans

As we understand the “mirror plan” concept, a self-funded plan that is deemed to be a QHP under the suggested regulatory structure would be subject to the guaranteed issue requirement of Section 2702. Because eligibility for the multiemployer plan must be limited to those eligible as provided under the applicable trust agreement, Section 2702 would be satisfied if there is a plan offered on the relevant State Exchange that provides comparable or “mirror” coverage that is provided to all on a guaranteed issue basis. (As discussed above, the multiemployer plan itself could not provide the “mirror” coverage.)

The details of determining whether an insured plan “mirrors” a self-funded multiemployer plan are complex. This is because the benefit delivery structure encompasses not only the basics of what benefits are covered and cost sharing requirements, but many other factors. These factors

⁵³ Treas. Reg. § 1.501(c)(9)-4.

⁵⁴ The preamble to the interim final regulations on the “Patient Protections” provisions of ACA notes: “For policy years beginning on or after January 1, 2014, additional protections will apply in the individual market, including guaranteed issue of all products, nondiscrimination based on health status, and no preexisting condition exclusions.” 75 Fed Reg 37188, 37192 (June 28, 2010).

⁵⁵ Code § 9803; ERISA § 703.

may vary from plan to plan, and include such things as prescription drug formularies, provider networks, claims processing, standards for medical necessity, pre-certification procedures, rule and regulations that apply to benefit determinations, and customer service options. Many of these functions may be proprietary to the multiemployer plan, depending on how the plan is structured. Some self-funded multiemployer plans utilize third party administrators that are not insurance companies, some plans self-pay claims, other plans use insurers as third party administrators. In all these situations, the plan design has been determined over time to fit the needs of the particular plan population. The purpose of trying to provide a “mirror” plan in this context is unclear; it is because the plan has determined that the benefits can be provided in a more efficient manner that the joint board of trustees would have decided to structure the plan as self-funded. Further, for those plans that operate on a regional or national basis, it is even less likely that a plan offered on a State by State basis will match the multiemployer plan.

However, should HHS determine that a mirror approach is necessary for a self-funded multiemployer plan to be deemed to be an Exchange plan, then the structure might be workable if appropriate standards for defining the mirror plan are adopted that address the impracticality of providing a detailed mirror plan. Thus, for example, a “mirror” plan in this context could be a plan offered by an issuer in a State where a multiemployer plan is offered that provides benefits with the same or higher actuarial value of a silver or gold plan on the Exchange. The simplest, and preferred approach, which would still be consistent with ACA, would be to not require such a mirror plan.

D. In the Case of Multiemployer Coverage That Is Provided on a Fully Insured Basis, the Insurer Would Be Subject to Section 2702 and a “Mirror Plan” Approach May Be a Workable Option to Allow Insurers to Offer Coverage That Is Limited to Certain Eligible Classes as Determined by the Collective Bargaining Process

As noted above, if the coverage under a multiemployer plan is provided through the purchase of insurance, then the issuer will be subject to the ACA provisions as they apply to issuers. In this context, the issue presented is whether an issuer of insurance may offer coverage to a restricted group if the issuer offers a “mirror” plan that satisfies Section 2702. A “mirror” plan approach is more workable in this context, because the same issuer that provides the coverage to the multiemployer plans could also provide the mirror plan. There still may be some questions as to the appropriate definition of a “mirror plan” that would need to be resolved.

IV. DISCUSSION OF ISSUES RELATING TO REINSURANCE, RISK CORRIDORS AND RISK ADJUSTMENT

You asked for further clarification with respect to how the requirements relating to reinsurance, risk corridors and risk adjustment in ACA sections 1341-1343 would apply under the proposed regulatory structure.

These provisions are designed to reduce uncertainty that might otherwise cause insurers to be cautious about offering plans in the Exchanges. The three provisions together are intended to

“foster a stable marketplace from year one” as the Exchanges become operational.⁵⁶ Each of the proposals has somewhat different parameters: (1) the temporary reinsurance program is designed to reduce the uncertainty of insurance risk in the individual market by making payments for high cost enrollees; (2) the temporary risk corridor program is designed to protect against uncertainty in setting rates in the Exchanges by limiting insurer gains and losses with respect to QHPs offered in the individual and small group markets in the Exchanges; (3) the permanent risk adjustment program is intended to provide adequate payments to insurers so that they will attract high-risk populations with respect to the individual and small group market both inside and outside of Exchanges.

These three programs apply only to licensed insurers. Multiemployer plans are not seeking to enter the Exchange market generally; rather they seek to be able to continue to provide the same coverage that they have been providing to those eligible. They are not a substitute for the Exchanges for all individuals. Thus, multiemployer plans that are deemed to be QHPs under the proposed regulatory structure would be treated in this regard the same as other self-funded plans and would not participate in these programs. By preserving multiemployer plans, the proposed regulatory structure may also serve to reinforce the stability of the Exchanges, particularly in the early years of development, by protecting against churning (as discussed above) and “dumping” of additional groups on the market.

We note that under the temporary reinsurance program, ACA section 1341 authorizes the Secretary to develop a method to impose contribution requirements on health insurance issuers and third party administrators. The method of determining the contribution is to be designed so that “the contribution amount for each issuer proportionately reflects each issuer’s fully insured commercial book of business for all major medical products and the total value of fees charged by the issuer and the costs of coverage administered by the issuer as a third party administrator.”⁵⁷ Under the regulatory structure proposed here, third party administrators of self-funded multiemployer plans would be subject to the contribution requirements to the extent applicable under section 1341. Comments on the contribution requirements applicable to self-funded multiemployer plans will be provided separately in response to the proposed regulations implementing section 1341.

Again, if the multiemployer plan coverage is provided through insurance, the issuer would be subject to the normally applicable provisions under these programs.

V. THE FEDERAL GOVERNMENT MAY CERTIFY MULTIEMPLOYER PLANS AS MULTI-STATE PLANS ELIGIBLE TO PARTICIPATE ON THE EXCHANGES

You asked us to provide further information regarding multi-State plans. The following supersedes the discussion in the August 9 memorandum. This option provides a structure that will be manageable for some but not all multiemployer plans. The structure of some plans is more consistent with the other approaches presented. Thus, implementing regulations should

⁵⁶ 75 *Fed. Reg.* 41930, 41931 (July 15, 2011).

⁵⁷ ACA § 1341(b)(3)(B).

preserve a number of options for multiemployer plans to ensure that all existing plans may continue to serve the 26 million Americans who, in the absence of multiemployer plan coverage, would not today have the access to quality, affordable health care that ACA seeks to provide for others.

In general

Section 1334 of ACA gives the Federal government the authority to certify multi-State plans as eligible to participate on State Exchanges.⁵⁸

Under ACA, the Director of the Office of Personnel Management (OPM) has the authority to contract with multiemployer plans to offer multi-State qualified health plans.⁵⁹

- Section 1334(a)(1) provides that “[t]he Director of the Office of Personnel Management (referred to in this section as the ‘Director’) shall enter into contracts with health insurance issuers... without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding, to offer at least 2 multi-State qualified health plans through each Exchange in each State.” The statute allows OPM to contract with entities other than health insurance issuers to offer multi-State plans, however.⁶⁰
- ACA gives OPM the authority to enter into contracts with multiemployer plans by incorporating into section 1334 OPM’s process for selecting carriers under chapter 89 of title 5 of the United States Code. Section 1334 requires OPM to administer its selection of entities to sponsor multi-State plans “in a manner similar to the manner” in which it implements its selection of carriers for Federal health plans under chapter 89 of title 5 of

⁵⁸ ACA § 1301(a)(2) (“Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1332, and a multi-State plan under section 1334, unless specifically provided for otherwise.”).

⁵⁹ Section 1334(a)(1) refers to “multi-State qualified health plans.” That term is not defined by ACA.

⁶⁰ If Congress wished to restrict OPM’s ability to contract with other entities, it would have stated that OPM can contract *only* with health insurance issuers to provide a multi-State plan. *See America Online, Inc. v. United States*, 64 Fed. Cl. 571, 759 (Ct. Fed. Cl. 2005) (rejecting an argument based “on the implicit addition of the word ‘only’ to the statute in an attempt to make the statute’s plain meaning seem absurd,” where the text of statute did not require that the factors at issue be the only factors); *see also FDIC v. McSweeney*, 976 F.2d 532 (9th Cir. 1992) (discussing the FDIC’s authority based on the language of a statute, “Had Congress intended this authorizing provision to limit the FDIC to claims alleging gross negligence or greater culpability, it would have inserted the word ‘only’ in the sentence. We may not torture the language chosen by Congress to infer such a meaning.”); *FDIC v. McSweeney*, 772 F.Supp. 1154, 1158 (S.D.Cal.1991) (citing *Rose v. Rose*, 481 U.S. 619, 627-28 (1987) (discussing that where the plain language of a statute does not “indicate exclusivity; this court is prohibited under standard norms of statutory construction from implying such exclusivity when Congress has not done so itself.”); *In re Coltex Loop Central Three Partners, L.P.*, 138 F.3d 39, 43 (2d Cir. 1998) (“If Congress had intended to modify [‘on account of’] with the addition of the words ‘only,’ ‘solely,’ or even ‘primarily,’ it would have done so. For the court to add such modifiers would work a significant and unwarranted change in the meaning and consequence of the statute.”); *In re DBSD North America, Inc.*, 634 F.3d 79, 96 (2d. Cir. 2011) (same).

the United States Code.⁶¹ Under chapter 89 of title 5 of the United States Code, OPM has the authority to enter into contracts with an entity other than a health insurance issuer, including a “voluntary association, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts... including a health benefits plan duly sponsored or underwritten by an employee organization.”⁶² Multiemployer plans are established and maintained as voluntary employees’ beneficiary associations (VEBAs) pursuant to section 501(c)(9) of the Code. Accordingly, if OPM chooses VEBAs, such as multiemployer plans, as sponsors of multi-State plans, it would be adopting a selection process in accordance with section 1334 of ACA that is similar to the one under chapter 89 of title 5 of the United States Code.

In addition, section 1334 requires OPM to contract with non-profit entities as sponsors of multi-State plans, but does not state that the non-profit entities must be health insurance issuers.⁶³ Accordingly, ACA permits OPM to contract with multiemployer plans, which are non-profit entities under section 501(c)(9) of the Code, as multi-State plans.

Multiemployer plans are not subject to the requirements of section 1334(b) which applies only to health insurance issuers who sponsor multi-State plans. Under section 1334(b)(2), health insurance issuers are required to be licensed in each State and to be subject to all requirements of State law in order to sponsor a multi-State plan. As explained above, multiemployer plans are not health insurance issuers; therefore, they are not subject to section 1334(b).

Even if multiemployer plans were subject to the same requirements as health insurance issuers for this purpose, they still could not be subject to State licensing requirements or State insurance laws, for the reasons discussed in section II of this memorandum.

Because multi-State health plans sponsored by multiemployer plans are not subject to section 1334(b), they also are not subject to section 1334(b)(1), which requires health insurance issuers to agree to offer a multi-State plan that meets the requirements of section 1334(c).⁶⁴ The requirements for multi-State qualified health plans are set forth in paragraphs (1), (2), and (5) of subsection (c). Although multiemployer plans would be exempt from these requirements, multiemployer plans would meet the requirements of multi-State qualified health plans set forth in these paragraphs if required by an OPM contract *except* certain requirements that apply to health insurance issuers. The requirements that multiemployer plans would meet if required by an OPM contract and the requirements that multiemployer plans would not meet (and would not be required to meet) are described below.⁶⁵

⁶¹ ACA § 1334(a)(4).

⁶² 5 U.S.C. § 8901(7).

⁶³ See ACA § 1334(a)(3).

⁶⁴ ACA § 1334(b)(1).

⁶⁵ HHS and OPM will need to collaborate to ensure that the process for multiemployer plans to contract with OPM and regulatory guidance regarding multi-State plans will facilitate multiemployer plans’ efforts to meet the applicable requirements of section 1334.

Requirements that OPM could require a multiemployer plan to meet by contract

- (a) As required by section 1334(a)(4), multiemployer plans would negotiate with OPM with respect to a medical loss ratio, a profit margin, the premiums to be charged, and other terms and conditions of coverage as are in the interests of participants in the plan, recognizing that current laws governing multiemployer plans require that multiemployer plans be operated on a not-for-profit basis and that all contributions be used for the sole and exclusive benefit of plan beneficiaries.
- (b) Multiemployer plans would also meet the requirements for a qualified health plan described in section 1301(a)(1) that apply to a health plan. In particular:
 - (i) Multiemployer plans would offer an essential health benefits package described in section 1302 of ACA.⁶⁶ Multiemployer plans would satisfy the requirement under section 1334(c)(1)(A) to offer the essential health benefits package on a uniform basis in each State by offering a package that provides minimum essential health benefits that are at least actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.⁶⁷ For example, plans that exist within different parts of the same State based upon jurisdiction or type of work performed could satisfy the uniformity requirements by providing benefits of the same or greater actuarial value, provided that they offer minimum essential health benefits that are at least actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan. As explained below, regional and local multiemployer plans would be able to satisfy this requirement based on reciprocity agreements with other multiemployer plans or by being aggregated with other members of the multiemployer plan community which provide coverage on a national basis. In addition, we could collaborate with OPM to contract with one organization on behalf of one or more multiemployer plans to satisfy this requirement.
 - (ii) Multiemployer plans would meet the criteria for certification by OPM described in section 1311(c) determined to be applicable to multiemployer plans.⁶⁸ These criteria include meeting marketing requirements; ensuring a sufficient choice of providers; including within plan networks essential community providers (where available) that serve predominately low-income medically-underserved individuals; being accredited with respect to local performance on clinical quality measures; implementing a quality improvement strategy; utilizing a uniform enrollment form and the standard format established for presenting health benefits plan options;

⁶⁶ ACA §§ 1334(c)(1)(A); 1301(a)(1)(B).

⁶⁷ ACA § 1334(c)(1)(A) and (c)(1)(B).

⁶⁸ ACA §§ 1334(c)(1)(B); 1301(a)(1)(A).

providing information to enrollees and prospective enrollees on quality measures (as applicable); and reporting to HHS, at least annually, pediatric quality reporting measures. Further details of how these rules would be applied to multiemployer plans would be determined through the contracting process.

- (c) Multiemployer plans would also comply with the requirements under chapter 89 of title 5, United States Code, which include the requirements for health insurance coverage provided to Federal workers, to the extent that these requirements do not conflict with section 1334 of ACA and apply to group health plans.⁶⁹ Most, if not all, of the requirements for Federal health plans under chapter 89 of title 5 are already addressed in section 1334's requirements for multi-State plans or already apply to group health plans, including multiemployer plans, under Federal law. For example, multiemployer plans offer COBRA continuation coverage and do not (1) exclude individuals from participation based on race, sex, health status, or (2) cancel a participant's coverage for reasons other than fraud or nonpayment.⁷⁰
- (d) Multi-State qualified health plans must be initially offered in multiple States and eventually must be offered in all States.⁷¹ Multiemployer plans are offered at national, regional, and local levels and many multiemployer plans provide coverage across multiple jurisdictions through broad based reciprocity agreements.

National multiemployer plans that are offered to participants who reside in all of the States would satisfy this requirement based on their own participants. Other national multiemployer plans, such as UNITE HERE HEALTH, that do not currently have participants residing in all States, nevertheless provide coverage to participants who reside in all States. Although UNITE HERE HEALTH's network of health providers is generally only available in the States in which its participants work, UNITE HERE HEALTH provides coverage to its participants for services received anywhere in the nation, including from providers who do not participate in UNITE HERE HEALTH's network. Moreover, in certain circumstances, UNITE HERE HEALTH will provide coverage to its participants for services received by an out-of-network provider as if the participant had received the coverage from an in-network provider. Accordingly, coverage is offered to their participants in all States.

Moreover, many regional and local multiemployer plans have reciprocity agreements under which contributions made to a multiemployer plan that serves the area in which the employee works may be transferred to the (home) multiemployer plan in which the covered employee is a participant and from whom the employee receives benefits. These reciprocity agreements provide participants of these plans with access to coverage throughout the nation.

⁶⁹ ACA § 1334(f) (“The requirements under chapter 89 of title 5, United States Code, applicable to health benefits plans under such chapter shall apply to multi-State qualified health plans provided for under this section to the extent that such requirements do not conflict with a provision of this title.”).

⁷⁰ 5 U.S.C. § 8902.

⁷¹ ACA §§ 1334(c)(1)(A) and (D), and 1334(e).

Finally, in certain industries, such as retail food, there is a more decentralized health care delivery system with many multiemployer plans that are offered locally in only one State or region. These plans could satisfy this rule since the multiemployer health plans collectively currently provide coverage to their participants in all States. NCCMP would work with OPM to ensure that multiemployer plans continue to satisfy this rule. In addition, an umbrella organization could contract with OPM on behalf of one or more local multiemployer plans to satisfy this rule, provided that such contracting arrangement is consistent with the contracting organization's and multiemployer plans' tax exempt status.

Requirements that do not apply to multiemployer plans

Because multiemployer plans are not health insurance issuers, they could not be required:

- (a) to offer bronze, silver, gold and catastrophic levels of coverage,⁷²
- (b) to calculate premiums in accordance with the rating requirements of Part A of title XXVII of the Public Health Service Act, including any State age rating requirements that are lower than a 3:1 ratio,⁷³ or
- (c) to provide coverage that is open to every employer and individual in the State that applies for coverage under the plan.⁷⁴ Rather, multiemployer plans would be open to all eligible individuals pursuant to the applicable trust agreement.⁷⁵

Moreover, there is no requirement under ACA that requires multi-State qualified health plans that participate in an Exchange to be included in single risk pool.⁷⁶ In addition, section 1334(g)(2) indicates that multi-State qualified health plans must be treated as separate risk pools.⁷⁷ Accordingly, multiemployer plans could continue to maintain separate risk pools even after they are certified as multi-State plans.

By meeting these requirements, multiemployer plans would satisfy the requirements of a multi-State qualified health plan and, pursuant to section 1334(c)(3), individuals enrolled in these plans

⁷² ACA § 1334(c)(1)(B).

⁷³ ACA § 1334(c)(1)(C) and (c)(5).

⁷⁴ ACA § 1201 (adding § 2702 to Part A of Title XXVII of the Public Health Service Act) provides that “each *health insurance issuer* that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage” (emphasis added).

⁷⁵ In 2011, multiemployer plans covered 26 million individuals despite the absence of any requirement for them to be open to any individual or employer in the State in which they operate.

⁷⁶ ACA § 1312(c) requires only that health insurance issuers consider all enrollees in plans offered by the issuer in the individual market to be members of the same risk pool and enrollees in plans offer by the issuer in the small group market to be members of the same risk pool.

⁷⁷ Section 1334(g)(1) provides that “[e]nrollees in multi-State qualified health plans under this section shall be treated as a separate risk pool apart from enrollees in the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.”

would be eligible for premium tax credits under section 36B of the Code and eligible for cost-sharing assistance under ACA section 1402.⁷⁸

VI. ECONOMIC ANALYSIS RELATING TO THE EFFECTS OF FAILING TO IMPLEMENT THE PROPOSED REGULATORY STRUCTURE

A. “Churning” of Coverage Due to Fluctuations in Employment and Income Can Be Reduced by Multiemployer Plans

Increased ‘churning’ is a risk embedded in the Exchanges

One of the concerns identified by health policy experts with respect to the American health coverage system, which will be exacerbated under the Exchanges, is “the likelihood of abrupt changes in coverage or financial responsibility when individual circumstances change.”⁷⁹ This phenomenon, known as “churning,” occurs when individuals cycle on and off public and private insurance. For example, changes in employment and income may affect an individual’s eligibility for employer plan coverage or coverage limited to lower-income individuals, such as State low-income coverage, CHIP, and Medicaid. While key provisions of ACA were designed to increase access to health coverage (including for lower-income individuals), churning is likely to occur. This is partly because of the complexity of new plan selection and enrollment under an exchange system. However, churning will be further exacerbated because of shifting eligibility for premium subsidies, changes in exchange choices, the cost of exchange coverage, the impact of changing providers and -income fluctuation and reporting delays.

Churning is the result of coverage gaps that persist or repeat over time, as access to health care is disrupted due to a variety of factors. Coverage gaps lead to corresponding gaps in treatment. Chronic conditions go untreated (such as hypertension and diabetes). Preventive care services are not obtained, such as pediatric checkups, immunizations, and dental screenings. Churning increases morbidity and medical debt for affected families. It also drives up costs in the health care system through delayed and disjointed care (including greater use of emergency care), further fragmentation of the system and repetition of administrative processes.

The effects of churning take hold rapidly. One study that examined the adverse effects of gaps in coverage described above found that these effects may occur within 10 months of coverage changes.⁸⁰ Continuity of coverage reduces these effects. Some of the groups most at risk for the fragmentation caused by churning are those covered by multiemployer plans: low-income individuals and families, minorities, young adults age 19-24, those in unstable or part-time employment, and those working for small employers.

⁷⁸ See ACA § 1334(c)(3).

⁷⁹ Short, Swartz, Uberoi, and Graefe, “Realizing Health reform’s Potential: Maintaining Coverage, Affordability, and Shared Responsibility When Income and Employment Change,” The Commonwealth Fund, May 2011.

⁸⁰ Carlson, DeVoe, and Wright “Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results From a Prospective Cohort Study of the Oregon Health Plan”, *Annals of Family Medicine*, Vol 4, no. 5 (Sept.-Oct 2006).

Multiemployer plans currently mask the churning that will otherwise result on the Exchanges

Because of the mobile nature of employment which characterizes employees in industries that utilize multiemployer plans, many individuals currently covered through multiemployer plans would be at significant risk of losing coverage for either short or long periods of time if the regulatory structure does not preserve multiemployer plans as a coverage option as the Exchanges become effective in 2014. This is because multiemployer plans cover individuals who work for small employers, perform sporadic or seasonal work, have multiple employers or work part-time. In some cases multiemployer plans are the predominant vehicle through which workers in lower income occupations receive their health coverage. In the absence of the coverage provided under multiemployer plans, such individuals may “churn” through the system, failing to enroll in the Exchanges at all, and switching between eligibility for subsidies and State-based programs for low income individuals.

The current existence of multiemployer plans provides, above all, substantial continuity in coverage that masks the scale of the problem that will result if this private sector safety net is not available when the Exchanges become operational. These plans provide significant relief for the problems that face lower income families in accessing affordable health care.

While Federal COBRA permits individuals to maintain coverage, most individuals do not take advantage of this benefit because of the high cost of COBRA continuation coverage.⁸¹ Multiemployer plans have adopted substantial continuation of coverage mechanisms that keep members covered at costs that are lower than the cost of COBRA coverage before COBRA is required. The methods used by multiemployer plans to provide continuity of coverage are described below.

Multiemployer plans minimize churning by providing continuity of coverage in the event of changes in employment and income

Multiemployer plans have minimized the problem of churning because they have evolved over decades to fit the special circumstances of the people and industries that they serve. Regulatory agencies have recognized this and have adopted rules that are designed to avoid interrupting the benefit continuity under multiemployer plans. A general summary of typical multiemployer plan eligibility rules with some specific examples follows. Further, in every industry there are dozens of additional examples not addressed here that demonstrate how multiemployer plans continue health coverage for employees and their dependents in ways completely unavailable in the commercial insurance market that will dominate the Exchanges. One of the key factors that enables multiemployer plans to provide this continuity is the risk-pooling that the plans offer.

Automatic enrollment: Multiemployer plans typically cover an employee and family members automatically, in many instances without employee contributions for coverage. Coverage is typically automatic when the employee satisfies the eligibility rules of the plan.

⁸¹ Schwartz and Streeter, “Health Coverage for the Unemployed,” Kaiser Commission on Medicaid and the Uninsured, publication #8201 (June 2011).

Continuity through portability for an industry rather than one employer: A participant in a multiemployer plan can move from job to job among the employers that contribute to the plan without losing the benefit of eligibility credits that have built up during their employment. For example, a painter or electrical worker may work for five or six different building contractors in the course of a year, without interrupting his or her family's health coverage.

Continuity through credit for all covered work: Employees establish eligibility for health coverage by working during a fixed "work" period at least a minimum number of hours for which employer contributions are made. It does not matter how many employers contribute during the "work" period. For example, a plan may require 300 hours of covered service during a calendar quarter to qualify for coverage starting on the first day of the next calendar quarter. An employee working for covered employers has the full three-month period in which to accumulate the necessary 300 hours, from one-day assignments to one-month projects, to year-long engagements. Health plan coverage would start in the quarter after the 300-hour requirement is met and would continue throughout that quarter.

Continuity during periods of part-time employment: Multiemployer plans have provided high quality minimum essential benefits to part-time employees, particularly in lower wage sectors of the economy. Many employees working in the retail, hospitality, and service industries without this coverage would be otherwise eligible to receive coverage through public sources, such as CHIP and Medicaid. Instead, these employees receive uninterrupted coverage from multiemployer plans even if because of scheduling or reduced available work they move from full-time to part-time status. Thus, multiemployer plans provide an important backstop against the higher levels of churning that will invariably take place during periods of economic downturn when increased numbers of individuals can find only part-time employment. The problem of churning becomes even more acute in industries where flexible work schedules result in frequent income movements above and below 133% of the Federal poverty line which is the benchmark utilized for determining eligibility for Medicaid under the ACA.

Continuity through providing coverage during periods when the employee is not currently working, including during disability and early retirement: Unlike single-employer plans, multiemployer plans provide for continuation of coverage *without current service*. Multiemployer plans address the "churning" inherent in a system where an individual works for many different employers, or in an industry with cyclic "peak" and "light" work periods such as seasonal work. The particular plan provisions may vary by the plan or industry, and include reciprocity agreements, "hour banks," short-term coverage extensions, disability coverage extensions, and self-pay options. Generally, all of these plan provisions provide significant continuity protection *before* an individual moves to COBRA coverage, thus extending coverage beyond the COBRA period. The various types of typical continuity provisions used by multiemployer plans are summarized below:

- **Reciprocity agreements:** Reciprocity agreements are agreements signed by both a "home" and "away" plan that allow a worker to maintain health coverage under his or her "home" plan while working elsewhere in the country under a different bargaining agreement.

- **“Hour Banks” or “Dollar Banks”:** Hour banks allow individuals who work substantially more than the amount needed for eligibility in a “work” period to bank the extra hours or dollars, and then draw on them when work drops off. For example, a plan may require 300 hours of service in a “work” period to earn eligibility in a “benefits” period. If the plan uses an hour bank, and a participant worked 450 hours in a “work” period, 300 hours would be used to “buy” coverage and the remaining 150 would be banked to use in coverage in future periods when work hours did not meet the requirements. Detailed examples of how hour banks work in two different multiemployer funds are provided in Appendix A.
- **Short-term coverage extensions:** Many multiemployer plans have a variety of special provisions aimed at maintaining uninterrupted health coverage for people who remain available for work in the industry, but are between covered jobs. For example, a plan may use a concept similar to a break in service, which allows an employee who has met the minimum eligibility test and been covered for a certain number of years to remain covered until his or her service drops below a level that is much lower than what was needed for initial eligibility.
- **Disability coverage extensions:** Some multiemployer plans provide for extended coverage through periods of disability. This may be done in a variety of different ways. For example, a fund may credit the employee’s “hour bank” with 30 hours per week for the period during which the employee is receiving weekly disability income benefits from the fund’s disability benefit, up to a maximum of 26 weeks. After disability income benefits are exhausted the fund would allow the employee to exhaust the hours in his or her hour bank to maintain coverage. In a second example, a fund could have a disability program under which an individual who is totally disabled (pursuant to SSDI standards) due to either a work or non-work related injury earns 120 disability credits per month for a maximum of 24 months. The disability credits are sufficient to allow the individual to maintain coverage under the fund, and the 24-month period allows the coverage to continue until the individual is eligible for Medicare based on their disability.
- **Self-Pay:** A common mechanism used by multiemployer plans to continue health coverage is the opportunity to “self-pay” for coverage to make up for shortfalls in employer contributions. The cost of coverage on a self-pay basis is generally considerably less than COBRA continuation coverage because the self-pay rate is generally derived from the employer contribution rates, whereas COBRA premiums are more of a true premium-equivalent. In addition, self-pay is often used as a gap filler by those who are not working enough hours when no hours bank is available—an employee can pay the hourly rate just for the hours they are short rather than losing eligibility entirely and starting over. For example, if an employee needs 250 work hours to remain eligible, but only 230 were worked, the employee can pay for the 20 remaining hours in order to ensure continued eligibility. Self-pay coverage is sometimes time limited (e.g., 3-6 months) after which period the individual would be eligible for true COBRA. However, some funds allow self-pay coverage on an unlimited basis.
- **Early retirement coverage extensions:** Many multiemployer plans allow members who retire prior to Medicare eligibility to continue coverage at little or no cost. Surviving

spouses and dependents of a Medicare eligible retiree also are frequently eligible for little or no cost coverage.

Regulatory guidance has reinforced the ability of multiemployer plans to reduce churning by providing continuity of coverage

Federal regulations implementing health care laws have recognized the role of multiemployer plans in providing continuity of coverage. For example, Treasury regulations implementing COBRA requirements permit multiemployer plans to offer COBRA at the end of an extension of coverage under the plan, rather than at the time of the qualifying event.⁸²

In addition, guidance under the COBRA premium subsidy that was enacted as part of the American Recovery and Reinvestment Act provides special rules for multiemployer plans coverage. In the experience of most multiemployer plan trustees, participants in multiemployer plans utilized the COBRA subsidy significantly later than participants in single-employer plans, because of the long run-out period in multiemployer plan eligibility rules. Guidance concerning the COBRA subsidy recognized the special rules used by multiemployer plans and permitted employees to receive the premium assistance subsidy if the involuntary termination occurred during the premium assistance period (through May 31, 2010), even if COBRA coverage began after that date. Moreover, guidance recognized that the loss of coverage and eligibility for COBRA do not have to occur immediately after the involuntary termination, for example, because the employee has “banked” hours at the time of the involuntary termination.⁸³

Failure to preserve the multiemployer plan structure will result in increased churning

If implementing regulations do not preserve multiemployer plans as a coverage options, then individuals who currently covered under multiemployer plans risk losing health care coverage. While individuals that had been previously covered under a multiemployer plan would be eligible to purchase coverage on an Exchange, the process of transferring from familiar coverage to coverage on an Exchange would not be seamless, and would likely be particularly difficult in the beginning years of the Exchange. For example, the enrollment process for employees covered under a multiemployer plan is very different than the enrollment process for individual coverage through the Exchange. As described above, in many cases there is streamlined automatic enrollment, with little or no employee contributions. Enrollment through an Exchange would be more difficult and could deter some individuals from seeking coverage, even if subsidies were available. For many individuals, the possibility of potential penalties that might be imposed under ACA for failure to obtain coverage would not be sufficient to overcome the obstacles needed to prevent coverage gaps.

⁸² Treas. Reg. § 54.4980B-4, A-1(c). While this rule is not limited to multiemployer plans, the ability of multiemployer plans to use this rule was specifically discussed in the preamble to the regulations. See Treasury Decision 8928.

⁸³ See COBRA Questions and Answers, Administration and Eligibility, AE-32, issued by the Internal Revenue Service. The Questions and Answers may be found at <http://www.irs.gov/newsroom/article/0,,id=205364,00.html>

Lower-income populations currently served by multiemployer plans are likely to see a great deal of churning between Medicaid and the insurance exchanges, with more than 35 percent of adults below 200 percent of the poverty level crossing the Medicaid eligibility threshold in at least one month out of six.⁸⁴ Churning will also impact those who are looking for more affordable care. Churning is likely to be most severe in the case of individuals who work either for small firms, or work part-time schedules of under 30 hours per week, as the employer responsibility penalties do not apply and thus are not a factor in determining whether to continue to contribute to a multiemployer plan. Some increased shifting to part-time work (i.e., less than 30 hours per week) may result as employers who have control over scheduling respond to employer responsibility provisions, thus potentially adding to those that may experience churning.

In 2014, it is also likely that measurement of eligibility for Federal subsidies to purchase coverage in the Exchange will be problematic, because income will be measured based on prior tax returns instead of current income. Using income tax returns from 2012 to measure 2014 subsidy eligibility could result in some adults falling into higher income categories that receive more limited assistance than they would be in based on current income.⁸⁵ One study estimates that 28% of adults with income between 139% and 400% of the FPL based on current income would fall into a higher or lower income category based on prior tax income.⁸⁶ The impact of this on these individuals would be significant: many would have difficulty paying for coverage and cost sharing and would not be able to continue needed care. In addition, some individuals could receive premium credits for which they are ineligible, requiring them to repay them at the end of the year.

Preserving the availability of multiemployer plans as the Exchanges become operational will avoid these results and enable a population that already enjoys quality, affordable, continuous coverage to be able to continue to do so. It would be incongruous at best to interpret ACA to allow the dismantling of a health coverage system that works in favor of a system that is likely to lead to disruption of health care delivery.

B. Without an Appropriate Regulatory Structure, the Availability of Subsidies in Exchanges Will Result in Economic Forces That Will Cause the Termination of Many Multiemployer Plans Due to Employer “Dumping” of Coverage, Which Will Adversely Affect Previously Covered Employees and Their Families

Overview

You asked us to provide further information regarding the effects on multiemployer plan coverage in the event the proposed regulatory structure is not adopted. ACA changes significantly the factors that an employer must consider in deciding whether to provide or continue to provide coverage, including the availability of subsidies, whether employer

⁸⁴ See Sommers and Rosenbaum, “Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges,” *Health Affairs*, February 2011.

⁸⁵ Kaiser Family Foundation, “Determining Income for Adults Applying for Medicaid and Exchange Coverage Subsidies: How Income Measured with a Prior Tax Return Compares to Current Income at Enrollment,” *Focus on Health Reform*, March 2011.

⁸⁶ *Id.*

responsibility provisions apply, and the effects of the health insurance reforms on coverage options, such as the elimination of restrictions on pre-existing conditions. Until the ACA, employers could only provide coverage to its entire employee population and their dependents through a plan that did not have pre-existing conditions. Generally, large employers and multi-employer plans are the only plans with large enough risk pools to offer coverage without pre-existing condition limitations.

If the Exchanges and subsidies work as intended, Exchanges will provide coverage options and financial assistance that were previously unavailable. Thus, ACA creates a new decision-making environment for contributing employers. While there may be reasons other than financial ones for providing coverage, employers will now evaluate whether they are better off economically providing health coverage through a multiemployer plan or ceasing to provide such coverage, knowing that coverage and subsidies are available through Exchanges. It is important to note that benefit plans have already undergone significant declines over the last 30 years. This is shown by the vast majority of employers that have ceased offering retiree health benefits as well as the dramatic decrease in the number of employers that offer defined benefit retirement programs to current and future employees.

While these provisions do not go into effect until 2014, issues regarding health care coverage are already surfacing in the bargaining process. Appropriate regulatory guidance is needed in a timely fashion so that it can be considered in bargaining process before 2014.

The following discussion provides an overview of the economic factors relating to employer decisions regarding whether to continue to contribute to multiemployer plans under ACA. As this discussion demonstrates, the availability of subsidies in the Exchanges creates tremendous economic pressure for contributing employers to drop multiemployer plan coverage as soon as Exchanges are effective. While all employers may ultimately face similar decisions, the effects of the Exchanges on multiemployer plans will be adverse and unique.

A significant portion of the total population currently served by multiemployer plans are individuals and employers that will be most affected by the premium subsidies

Multiemployer plans provide coverage to participants in a wide variety of industries across the economy. Plans range in size from small local plans covering a few hundred participants in a relatively small geographic area to large national plans that cover several hundred thousand participants in every State in the nation. Most fall somewhere in between—regional plans covering several thousand participants in geographic areas that span two or more States, but with retirees spread across a much wider geographic area.

Plan participants are equally diverse, working in jobs that mirror the wide array of workers' skill and income levels ranging from entry level, part-time or low wage/low skill jobs (such as are commonly found in the hospitality, building services, health care and retail food industries), to those in more highly skilled and more highly compensated industries in some construction trades, entertainment and long-haul trucking.

In evaluating the impact of premium tax subsidies on the continuation of multiemployer plans it is apparent that plans which serve low-wage industries, or those which have as a significant

component of the workforce engaged in entry level (including apprentices) or part-time employment will face greater challenges than those in higher wage industries. While it is clear that not all plans or the populations they serve are the same, plans serving the “at risk” industries represent a significant portion of the total population served by multiemployer plans and the ramifications for those plans cannot be overstated.

The economic realities of the premium subsidies and the employer penalties will place tremendous pressure on contributing employers to drop multiemployer coverage

For both employers and employees, the subsidies represent a new potential source of revenue that impacts decision making

By definition, the ACA was crafted to provide “affordable” care with recognition that what is affordable will be determined by household income. For those at lower income levels, ACA anticipates that even basic coverage may be unaffordable for many and provides a premium assistance tax subsidy for those households based on a sliding scale that ends at amounts above 400% of the Federal Poverty Level (FPL). How the concept of “affordability” will ultimately be defined (whether as a percent of annual income or whether it is applicable to single coverage or family coverage) is still in the regulatory process and how employers and employees may agree to a restructuring of the compensation package to take advantage of available subsidies is a matter of ongoing debate.⁸⁷ Nevertheless, for potentially eligible individuals and their employers, the outcome will have a direct effect on the future structure of negotiated compensation packages and ultimately on the very continuation of the multiemployer plans that are dependent upon employer contributions determined pursuant to such negotiations.

For employees whose taxable income is less than 400 percent of the FPL, especially those making less than 200 percent of FPL, the tax exclusion for employment based health coverage is less relevant than the subsidy, as their effective tax rate is minimal. Under the current rules, whether the amount employees contribute towards their health benefits coverage is paid directly into a health plan which is not subject to payroll taxes, or in the form of direct wage compensation, is also not particularly relevant for the employer. This is because the simple substitution of taxable income is merely a matter of reallocation of compensation dollars to account for such taxes, all of which would also be deductible to the employer and would not necessarily result in a change in total compensation. Therefore, one might conclude that the responsible employer that has traditionally provided coverage through multiemployer plans would have no particular interest in changing the current arrangements. At least the current arrangement ensures that employees (setting aside the question of dependents, for the moment) have coverage, thereby protecting the employee from the financial risk of illness. In fact, the continuation of health coverage has the ancillary benefit of increasing the probability that the employees would avail themselves of health care services that would lessen the employer’s costs related to lost time due to illness and reduced turnover, all of which involves additional costs in terms of recruitment and training of new employees. In many industries, this has been the rationale for retaining the current system of providing coverage through employment.

⁸⁷ See Richard Burkhauser et al., *The Importance of the Meaning and Measurement of “Affordable” in the Affordable Care Act*, National Bureau of Economic Research (August 2011).

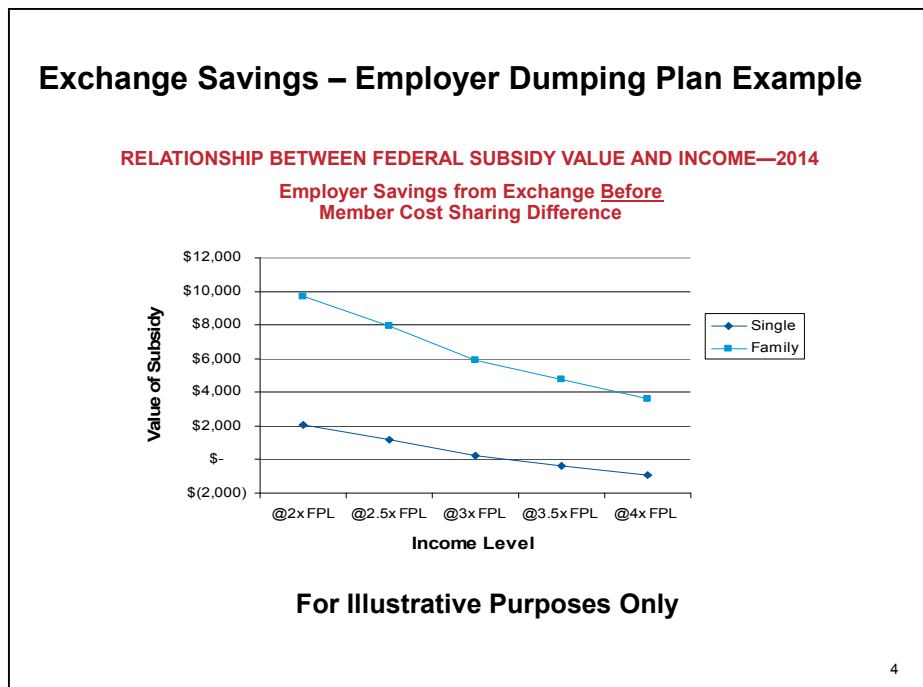
While economists may say that this will continue to be the case, this conclusion ignores the presence of the premium assistance tax subsidies. For both the employer and the employee, these subsidies are viewed as a potential source of revenue that could offset a portion of the employers' compensation costs, providing net new income to the employee while offsetting the competitive disadvantage to the employer.

The extent to which this is true can be seen by examining how the subsidies work with respect to a macro assessment of the relationship between the value of the Federal premium subsidies and income as an inducement to employer “dumping” coverage and in viewing more specific examples as they apply in two typically low-wage industries and with respect to the Teamsters (see below).

A macro assessment of the subsidies indicates that they have a significant impact on employer costs at all subsidy-eligible income levels

The following two tables below demonstrate the impact of the subsidies at a macro level. The first table (Table 1) shows the impact without regard to any possible increase in out of pocket expenses that employees may incur as a result in a change of coverage under an Exchange. However, a termination of most multiemployer plans would be likely to increase out of pocket expenses, because Exchange plans at the silver benchmark level have a lower actuarial value than the terminating multiemployer plans, which typically would exceed the gold level. The second table (Table 2) takes into account these out of pocket expenses.

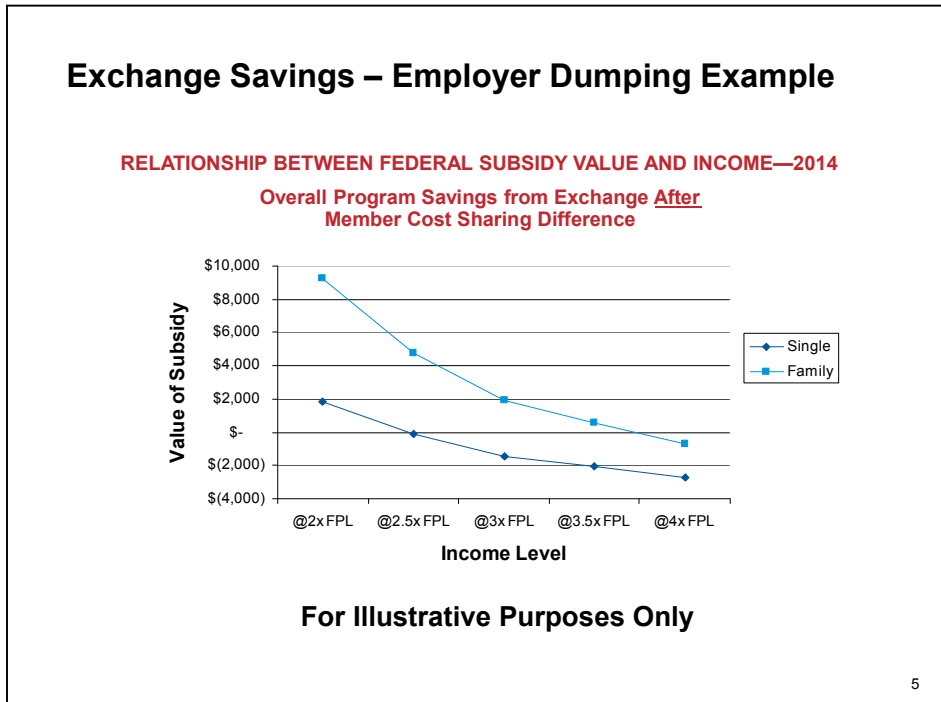
Table 1



The tables demonstrate the greatest savings to an employer that drops coverage for family coverage up to 350 percent of FPL even after factoring in the increased member cost sharing, but remain positive for single coverage to 250 percent of FPL. These examples assume that the

employer is subject to the “free rider” employer responsibility penalty.⁸⁸ Approximately 90 percent of employers contributing to multiemployer plans are small employers that would not be subject to this penalty. In those cases, the value of the subsidy is greater than for larger employers because the value of the employees receiving the premium assistance tax credit subsidy does not have to be offset against the cost of the employer penalty. The same would be true with respect to large employers with significant part-time employees.

Table 2:



Note that the examples assume that when multiemployer plan coverage is terminated, wages will increase by the amount of maximum individual premium required after all Federal subsidies are applied. However, such an adjustment is not required by law, and the extent of any wage adjustment will be determined through the collective bargaining process. Experience indicates that a dollar-for-dollar increase in wages is not likely, with the result that previously covered employees will be left with increased health costs, without a fully offsetting increase in wages.

⁸⁸ Examples assume that the employer terminates their existing multiemployer plan and increases the employees’ wages to purchase coverage on State exchanges. The extent to which wages will in fact be adjusted will be determined through the bargaining process and may not be a dollar-for-dollar adjustment. They further assume: the employer pays the maximum premium to the employee in wages; and the employer pays the “free-rider” penalty. The value is greater for employers for which the penalties are not applicable due to the employers’ size. Additionally, the model includes the impact of additional taxes to both the employer and employee. The savings are compared to 2014 group health plan costs (claims plus administrative expenses of current medical and prescription drug coverage). *Source: The Segal Co.*

Examples from the retail sales and grocery industries support a similar result

Looking specifically at the retail sales and grocery industries, many individuals working in these sectors of the economy receive health care coverage from multiemployer plans. If these individuals cease to receive benefits from existing multiemployer plans, they will instead be eligible for substantial subsidies in the form of premium assistance tax credits on the Exchanges. For example, the Bureau of Labor Statistics shows that in 2010, the average weekly earnings for production and non-supervisory employees in the retail trade industry was \$399.74. The average weekly earnings for production and non-supervisory employees in 2010 in the grocery store industry was \$351.03. Thus, two wage earners with the same income in those industries would have household income of between approximately \$36,500 and \$41,600 per year. For a family of four, this is less than 200 percent of the FPL.

The magnitude of the tax subsidies can be shown in the following example. Assume the second lowest cost silver plan on the Exchange is \$10,000 per year for family coverage, and a two-wage earner family of four in the retail food industry makes \$44,100 a year, which is 200 percent of the FPL. Under the premium tax credit provisions, the maximum individual premium for Exchange coverage would be \$2,778 (6.3 percent x \$44,100) and the amount of the premium assistance tax credit would be \$7,222. Even with the imposition of the employer responsibility payment of \$2,000, the amount of the tax subsidies would dwarf the costs associated with maintaining existing coverage. Moreover, in the retail industry hundreds of thousands of workers are part-time employees who currently are eligible for health care coverage under multiemployer plans. Because the employer responsibility payments would not apply with respect to part-time employees, there would be an even greater incentive for employers to cease providing coverage for those employees under the present multiemployer system.

Data from the Teamsters shows significant cost savings to employers from dropping multiemployer plan coverage

The International Brotherhood of Teamsters has analyzed the effects of the availability of subsidies through Exchanges on members in Teamster multiemployer plans. This analysis shows that 81 percent of Teamsters have family income of 400 percent of FPL or less, thus qualifying for subsidies through Exchanges. Ten percent of Teamsters will be eligible for Medicaid under ACA. Over the last decade, Teamster Locals have typically given up wage increases in order to maintain their benefits in terms of coverage levels and cost. However, the value of the subsidies creates an incentive for employers to drop coverage. The average savings per employer if employers no longer offer coverage through the Teamster plans is shown below.

	If Employer Pays Employee Share of Exchange Costs	If Employer Does Not Pay Employee Share of Exchange Costs
Health care cost per teamster Member (using CBO estimate of exchange cost)	\$11,667	\$11,667
Member cost in the exchange	\$4,860.91	0
Additional SS taxes	\$371.86	0
Loss of tax deduction	\$1,351.24	\$2,450.12
Penalty for not providing coverage	\$2,000.00	\$2,000.00
Net savings	\$3,083.23	\$7,217.11
Average savings for the median size employer (8 employees)	\$24,666	\$57,737
Average savings per employer (average number of Teamsters per employer is 59)	\$181,910	\$425,810

These estimates assume the \$2,000 employer penalty applies; however not all Teamster employers are subject to these penalties.

One additional consideration to those noted above involves the added exposure to the Federal and State budgets for individuals at the lowest end of the income scale- those below 200 percent of FPL. In the hospitality industry, housekeepers represent the largest employment category covered by multiemployer plans. These workers make less than 200 percent of FPL. If they lose access to their current coverage and obtain coverage through Exchanges it will add State and Federal costs to both Medicaid (for those less than 133 percent of FPL) and the Basic Health Plans in those States where the Basic Health Plans are offered (for those between 133 percent and 200 percent of FPL).

When viewed in the broader context of the collective bargaining parties' responsibilities under existing labor law, especially in many low-wage industries where profit margins tend to be razor thin, avoiding the costs of providing health coverage may be sufficient to enable increasing numbers of contributing employers to remain in business; thereby providing a more fundamental objective of jobs to their employees—the unions' members—on which fringe benefits are based.

In anticipating this consideration, Congress imposed certain disincentives to the employer to simply abandoning its health benefits plan. These disincentives take the form of penalties that apply to certain employers that fail to provide coverage that meets minimum essential coverage and affordability requirements and, through the ACA's individual mandate, to individuals who fail to avail themselves of the new source of coverage made possible through the State Exchanges.

Allowing access to subsidies through multiemployer plans will level the playing field by enabling employers to continue to provide coverage through multiemployer plans

In determining the amount of the disincentive and the groups to which they would apply, Congress chose to exclude employers of fewer than 50 employees from the penalty provisions

and, for those employers that are subject to the penalties, set the penalties at levels that are considerably less expensive than the cost employers would incur by choosing to provide benefits coverage. The exclusion of part-time employees from the employer penalty provisions creates incentives for employers otherwise subject to the penalty to reduce work schedules to levels where the penalties will not apply at all. Additionally, the individual penalties that apply for violating the individual mandate are priced too low to be an effective disincentive to large numbers of young and healthy individuals who are likely to make the economic decision to forego coverage, since they assume that the likelihood of encountering a serious illness is minimal. Therefore, rather than choosing to participate by paying monthly premiums into the exchange many will “take their chances” and pay the nominal penalty. This may have a detrimental effect on the risk pool of the Exchanges, causing health care inflation to be greater than anticipated.

For the large numbers of multiemployer contributing employers that employ fewer than 50 employees,⁸⁹ the new structure compounds and only exacerbates a problem that has plagued them for decades. Those employers have long recognized that the cost of uncompensated care, such as that which the medical community has provided to their competitors’ employees (largely through the more expensive service options, including deferring care until the severity of the illness increases along with the costs, and seeking care in more costly settings such as emergency rooms) has been passed along informally to them in the form of higher costs. In recent years this cost shift has been estimated at as much as 30 percent of a plan’s total costs. This is one of the more critical, but often overlooked, reasons that many employers initially welcomed and supported health care reform. For them, the promise of health reform meant that at last they would get some relief by having all employers be required to be responsible for the cost of their own employees. Unfortunately, the structure of the ACA, including the premium tax subsidies and the limited application of penalties, has done nothing to level the playing field for those employers. In fact, the structure as enacted provides a great incentive to drop coverage, if only employees of employers that do not provide coverage are eligible for the premium assistance tax subsidies—in essence, rewarding the employers who do not offer coverage by providing them with a competitive edge. Given these effects, if appropriate regulatory guidance is not provided with respect to multiemployer plans, current contributing employers may have little choice from an economic perspective but to cease contributing to multiemployer plans..

NCCMP appreciates the opportunity to provide additional comments on this important issue and looks forward to discussing these issues further.

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⁸⁹ In certain industries, such as construction, this restriction exempts virtually the entire industry.

APPENDIX A: HOURS BANK EXAMPLES

Example 1

Employee works as a plumber and contributions are made on his behalf to a multiemployer plan pursuant to a collective bargaining agreement. Employee is initially eligible for benefits on the first day of the Benefit Quarter next following the date on which he has been employed by one or more contributing employers for a period of one Work Quarter or two consecutive Work Quarters, provided he has worked at least 350 hours for one or more contributing employers during the period.

Work Quarters and Benefit Quarters are outlined below:

Work Quarters	Benefit Quarters
January 1 – March 31	June 1 – August 31
April 1 – June 30	September 1 – November 30
July 1 – September 30	December 1 – February 28
October 1 – December 31	March 1 – May 31

Once the Employee becomes eligible, he will continue to be eligible for succeeding Benefit Quarters provided he works at least 350 hours for one or more contributing Employers in the previous Work Quarter. If during any Work Quarter, the Employee fails to work the required 350 hours, the necessary number of hours, if available in the Hour Bank account, will be automatically withdrawn to continue eligibility in the next Benefit Quarter.

After the Employee becomes eligible, hours worked in excess of 350 during a Work Quarter will be credited to the Employee’s Hour Bank account. The maximum number of hours that may accumulate at any one time is 700. Hours in an individual Hour Bank account may be used to continue eligibility for benefits during a period where the Employee did not work sufficient hours for an Employer to maintain eligibility. In addition, if the Employee dies, the Dependents may use up remaining hours in the Hour Bank prior to being required to pay for COBRA coverage.

Example 2

Employee works in the pipe trades and contributions are made on his behalf to a multiemployer plan pursuant to a collective bargaining agreement.

Initial Eligibility: Employee and his dependents will become eligible for coverage on the first day of the second calendar month following the month in which the Employee has at least 390 hours worked credit based on contributions received by the plan in the preceding 12 months.

Hours Bank: Each hour an Employee works in Covered Employment for which the plan receives contributions from a participating Employer on the Employee's behalf will be credited to the Employee's bank of hours. The maximum number of hours that may be accumulated in the bank of hours is 780 hours (or six months of coverage). Hours reported by participating Employers for which contributions have been received by the plan will be credited to the Employee's bank of hours. One hundred and thirty (130) hours will be deducted from the hour bank for each month of coverage.

Whenever an Employee is credited with more than 130 hours during a month, either through work in Covered Employment or reciprocal transfer of contributions, the excess hours will be added to the bank of hours accumulation. The Employee will be allowed to accumulate excess hours in the "hour bank" up to a maximum of six months of coverage (780 hours) after deduction for the current month's coverage.

Skip Month: Eligibility will be continued during the first calendar month in which the Employee fails to maintain 130 hours in the bank. The Employee is entitled to one skip month every 12 months.

A detailed example of how this Hours Bank operates is provided on the following page.

Example of Hours Bank:

1st of Month	Bank of Hours	Monthly Deduction For Benefits	Contributions Received for Hours Worked	Bank of Hours – End of Month Total	Eligible For Benefits?
July				390	Yes
August	390	– 130 = 260	+ 200	= 460	Yes
September	460	– 130 = 330	+ 0	= 330	Yes
October	330	– 130 = 200	+ 0	= 200	Yes
November	200	– 130 = 70	+ 0	= 70	Yes
December	70	– 130 = 0	+ 0	= 0	Yes (skip month)
January	0	– 130 = 0	+ 135	= 135	No
February	135	– 130 = 5	+ 0	= 5	Yes (reinstated)
March	5	– 130 = 5	+ 200	= 205	No
April	205	– 130 = 75	+ 200	= 275	Yes (reinstated)
May	275	– 130 = 145	+ 200	= 345	Yes
June	345	– 130 = 215	+ 200	= 415	Yes
July	415	– 130 = 285	+ 200	= 485	Yes
August	485	– 130 = 355	+ 200	= 555	Yes
September	555	– 130 = 425	+ 200	= 625	Yes
October	625	– 130 = 495	+ 200	= 695	Yes
November	695	– 130 = 565	+ 200	= 765	Yes
December	765	– 130 = 635	+ 200	= 780	Yes (maximum bank)
January	780	– 130 = 650	+ 0	= 650	Yes
February	650	– 130 = 520	+ 0	= 520	Yes
March	520	– 130 = 390	+ 0	= 390	Yes
April	390	– 130 = 260	+ 0	= 260	Yes
May	260	– 130 = 130	+ 0	= 130	Yes
June	130	– 130 = 0	+ 0	= 0	Yes
July	0	– 130 = 0	+ 0	= 0	Yes (skip month)
August	0	– 130 = 0	+ 0	= 0	No
September	0	– 130 = 0	+ 200	= 200	No
October	200	– 130 = 70	+ 200	= 270	Yes (reinstated)
November	270	– 130 = 140	+ 200	= 340	Yes