

# NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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Submitted Electronically via *Regulations .gov*

August 27, 2010

The Honorable Phyllis Borzi  
Assistant Secretary  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue, NW  
Room S-2524  
Washington, D.C. 20210

Re: RIN 1210–AB43

Dear Ms. Borzi:

The National Coordinating Committee for Multiemployer Plans (the NCCMP) is pleased to provide these comments on the Interim Final Rule implementing the patient protection requirements of the Patient Protection and Affordable Care Act published by the Departments of Labor, Treasury, and Health and Human Services (the “Departments” or the “agencies”) on June 28, 2010.

As you know, the NCCMP is the only national organization devoted exclusively to protecting the interests of the approximately twenty-six million workers, retirees, and their families who rely on multiemployer plans for retirement, health and other benefits. The NCCMP’s purpose is to assure an environment in which multiemployer plans can continue their vital role in providing benefits to working men and women. The NCCMP is a nonprofit, non-partisan organization, with members, plans, and plan sponsors in every major segment of the multiemployer plan universe, including in the airline, building and construction, entertainment, health care, hospitality, longshore, manufacturing, mining, retail food, service and trucking industries.

## **Background**

The structure of multiemployer health plans is quite different from that of a single employer plan, resulting in the need to address specific concerns of multiemployer plans separately in the health reform regulations. In a typical single employer plan, the firm’s management determines health benefits and the amount spent on them. This financing model has historically been followed by larger single employer plans, even when the covered employees are represented by a union. Typically, the amount of employer contributions is not specified in the plan or any related

documents; however, if there is collective bargaining, the obligation to provide group health plan benefits, and often the amount and nature of the benefits, is codified in the bargaining agreement.

In a multiemployer plan, however, contributions are made to a separate, trust fund which is independent of either the employers or unions, but which is jointly managed. The rate(s) of contribution are negotiated in the collective bargaining process, usually for terms of three to five years. Typically, contributions are made to the plan based on a unit of work (usually hours worked, but daily, weekly or monthly contributions or a percentage of compensation are not uncommon in certain industries). These contributions are remitted regularly, usually monthly, to the trust fund. If the contributions are not made, fund trustees, as fiduciaries, pursue vigorous legal collection efforts that will also usually include claims for interest and liquidated damages on the unpaid amounts. Funds also typically employ audit programs to provide both a real verification of contribution amounts that are due, and to provide a “sentinel” effect to encourage employers to make their contributions when they become due.

### **Summary of Recommendations**

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

- Clarify the application of the annual and lifetime limit rules to multiemployer plans, including health reimbursement arrangements offered by multiemployer plans;
- Modify the anti-rescission rule to reflect the obligations of trustees of multiemployer plans under the Taft-Hartley Act; and
- Eliminate the requirement that plans reimburse out-of-network hospital emergency rooms according to a formula based largely on Medicare payment standards.

### **Annual and Lifetime Limits**

The Rule prohibits lifetime limits on the dollar amount of essential health benefits, and sets the level of restricted annual dollar limits permissible between now and 2014. We applaud the level of detail provided in some parts of the Rule. For example, the Rule calls for a special enrollment process for individuals who remain eligible but had previously exhausted their lifetime benefits. Whether individuals who exhausted lifetime maximums had a right to reenroll in the plan was a critical question, and the Departments provided clear and direct guidance on that issue.

We also appreciate the provision in the Rule that permits plan sponsors to make good faith efforts to comply with a reasonable interpretation of the term “essential health benefits,” pending further guidance from the Departments. While a definition of “essential health benefits” will be helpful when it is developed by the Departments, it was important to provide plan sponsors with assurance that, in the meantime, the Departments will not hold them accountable if they adopt a reasonable definition that ultimately turns out not to coincide precisely with that formal guidance. These comments are concerned with several issues that were either not clearly addressed in the Rule or on which the Departments requested comments.

#### **1. Waiver of Restricted Annual Dollar Limits**

The restricted annual dollar limits in the Rule begin at \$750,000 in 2011 and rise to \$2 million in 2013, and are phased out altogether in 2014. It is likely that these limits would present a cost hardship to many multiemployer plans. Section 2711 of the Public Health Service Act requires the Secretary (of Health and Human Services) to ensure that access to needed services is made available with a minimal impact on premiums. Consequently, we believe that the right to obtain a waiver of the requirements relating to restricted annual limits is a critically important aspect of health reform. We believe that the Secretary should take into account the unique circumstances of multiemployer plans with respect to the annual limit waiver program.

Multiemployer plans have a long history of providing health benefits to workers in industries where corporate employers may have been unwilling or unable to insure them. In particular, multiemployer plans have endeavored to make benefits available to a workforce that would otherwise not have been able to receive the coverage. For example, multiemployer plans extend coverage to workers in small businesses<sup>1</sup> many of which are in low-wage industries or industries where there is a large part-time or mobile workforce.

The benefits provided by multiemployer plans tend to be the maximum amount that can be supported by the collective bargaining contributions negotiated by the bargaining parties. A typical limited benefit plan would cover preventive services, health care provider visits, hospitalization, and other comprehensive health services. Benefits often are made available with very modest copayments, deductibles, and coinsurance, because these workers do not have sufficient disposable income to cover these out-of-pocket charges. However, to offset the extensive coverage for prevention and other cost-effective services, the plans have rather low annual and lifetime maximum benefits. If the multiemployer plan must increase annual dollar limits to the restricted amounts in the Rule, the plan would have to increase copayments, coinsurance, and deductibles to a point that these benefit plans may not be affordable to this workforce, or require an increase in contributions made by employers beyond the levels at which the employers can remain competitive with employers who choose not to provide coverage of any kind.

Many multiemployer plans will simply not be able to afford the enriched benefit plans generally mandated by the Act. Bargaining pressures, the fact that participants typically do not contribute to multiemployer plan coverage, typically generous eligibility standards, the directly competing demands on collective bargaining parties to fund retirement plans, and the lack of other coverage available to these participants and their families are special circumstances that should justify allowing these plans to continue providing somewhat limited benefits for the next few years.

We urge the Department to consider the impact of requiring compliance with the annual limit requirements in industries where, either because of the salary or part-time nature of the workforce, or because of the impact of the recession on the economy, funds are not sufficient to provide a more generous benefits package, and the effect of compliance would be to eliminate coverage or even loss of employment. If coverage is eliminated for these plan participants and their families, there may be no alternative coverage available, at least until the health insurance

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<sup>1</sup> Over 90% of all employers who contribute to multiemployer plans employ fewer than 20 employees.

Exchanges are available. Consequently, requiring compliance could result in these individuals being uninsured until the Exchanges are effective. Therefore, adopting flexible waiver standards that allow plans to continue to provide some level of coverage for the three years leading up to 2014 is critical to ensure that this workforce remains covered.

As the Department considers the standards for the waiver, we encourage development of alternatives for qualifying for a waiver. For example, if a numerical standard is developed (e.g., if the current cost of the plan was above the average national cost (or some other metric) so that if the richness of the current plan would be taken into consideration, or if plan costs rise 10% or more due to compliance with the annual limits, the plan could receive a waiver), then a plan that cannot meet that financial standard should also be able to obtain a waiver by showing that it cannot continue to provide coverage to its plan participants and beneficiaries.

## 2. Health Reimbursement Arrangements

Second, the Departments note that when health reimbursement arrangements (HRAs) are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements of the Act, the fact that benefits under the HRA by itself are limited does not violate the Act because the combined benefit satisfies the requirements. We agree with this conclusion, and with the statement that a retiree-only HRA would not be subject to the Act. We request that the Departments clarify that when an HRA is used by a multiemployer plan as an account in which to record contributions made on behalf of an employee, and money is taken from that account to provide a comprehensive health plan, that arrangement is considered an integrated HRA and as long as the comprehensive health plan is compliant with the Act, the HRA is not subject to the annual or lifetime dollar limit restrictions.

By way of background, many of the multiemployer health plans that have an HRA fund their HRA with employer contributions at an hourly rate determined through collective bargaining. On the other hand, some plans give their boards of trustees the authority to determine how to fund the HRA. In many cases, the HRA is used to collect contributions on behalf of a participant, and then the cost of coverage for each month is subtracted from the account. If a participant has not worked during a particular month or other time period, he or she may draw down the HRA account to pay for coverage during that time.

An example of this type of arrangement could occur where contributions are made by employers pursuant to collective bargaining agreements into individual accounts, and then participants are allowed to elect coverage into one of three plan options. Rates for the plan options are established by the plan's board of trustees annually based on projected plan costs. The accounts are treated as an HRA but the three plan coverage options would all be compliant with the Affordable Care Act.

HRA accounts are generally not funded, and are usually self-administered as "notional" accounts by the multiemployer plan. In addition to paying for the plan's "premium" or if self-insured, the "premium equivalent," the HRA may also reimburse the participant and their family for out-of-pocket medical costs. Many multiemployer HRAs limit reimbursement to only those deductible and copayment/coinsurance costs which are payable by the major medical plan (e.g., the HRA

would not reimburse for over-the-counter medications because they are not payable by the major medical plan).

The HRA account would never be funded at a specific dollar amount that would approach the restricted annual dollar limit amounts (e.g., \$750,000). However, the HRA would generally be offered in conjunction with a major medical plan that is sponsored by the board of trustees, and thus should be considered integrated for purposes of the Rule.

Finally, we encourage the Departments to not eliminate the opportunity for stand-alone HRAs to exist independent of a major medical plan, without the HRA having to meet the lifetime and annual limits rules. Multiemployer plan trustees need to have a vehicle to provide health care coverage in situations where the major medical plan may be eliminated because it is unaffordable. In that situation, it would be helpful to be able to provide an account-based plan to workers whose major medical benefits have been eliminated, so that they have some source of reimbursement for their medical costs. For example, in some cases, the costs of health care reform, including observing the annual and lifetime dollar limits may make it impossible for the plan to continue to provide meaningful health coverage. In that circumstance, it may be appropriate for the trustees to convert the contributions into an individual account that the individual can use to either purchase coverage on his or her own, purchase coverage from a spouse's plan, or obtain reimbursement for his or her qualified medical expenses. This flexibility is particularly important during the transition period to the Exchange providing coverage.

### 3. Annual or Lifetime Dollar Limits on Specific Items and Services

As multiemployer plan sponsors have begun implementing the Affordable Care Act, one of the most common questions that has arisen is whether the Act bars dollar limits on specific items and services covered under the plan. The NCCMP believes that the Act was intended to bar only the overall aggregate limits that essentially bar a person from obtaining or using his or her health care coverage, not specific limits on benefits. We request clarification from the Departments about this issue.

Setting aside the question of whether a benefit is an essential benefit, plans typically have a range of coverage rules that place dollar limits on specific items or services. This might include a \$300 annual limit on chiropractic care, a \$9,000 annual limit on physical therapy, or a \$15,000 annual limit on prescription drugs. The Rule appears to permit these limits, as it generally refers to the annual and lifetime dollar limits as relating to the overall or aggregate limits on benefits under the plan. This reading of the Act is consistent with its purpose – to assure that individuals have access to care without having it limited by way of overall dollar amounts. To reach into the plan and address specific limits on payment for specific items and services would require extensive redesign of plan benefits and could affect the plan's cost-control measures.

Consequently, we request that the Departments confirm that annual or lifetime dollar or treatment limits (such as limits on the number of office visits, number of times a particular procedure will be covered, etc.), on specific items or services payable under the plan are still permissible, provided they are not being used as a subterfuge to evade the ban on overall dollar limits. that the Departments confirm that a plan may still have.

## **Anti-Rescission**

The regulations provide that a rescission may not take place "unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage." We are pleased to see a broad general prohibition of rescissions within the Interim Final Rule, with only limited exceptions allowed. We applaud the goals of the Rule, to provide "new rights to individuals" and avoid consequences which were "overly broad and unfair" for unintentional misstatements of fact on coverage enrollment questionnaires in the past. 75 Fed. Reg. 37188, 37193. However, we are concerned that the broad language stating that a rescission is "a cancellation or discontinuance of coverage that has retroactive effect" could have unintended effects for multiemployer plans, and we wish to highlight some of these concerns below.

We request that the Departments clarify that a rescission may occur based on the conduct of the employer in addition to the individual. Although the language "or a person seeking coverage on behalf of the individual" might be read to include an individual who is an agent of the employer, such language might be read to only apply to, for example, a participant seeking coverage on behalf of a dependent, or a service provider seeking coverage on behalf of a participant or dependent.

Furthermore, as noted below in the section entitled "*Effect of Rescissions Regulation on Revocations of Coverage for Taft Hartley Act Violations*", employers may report individuals as covered although such individuals are not, in fact, entitled to coverage. Multiemployer plans rely on the employer to report the work history of participants, and coverage is granted based upon that reporting. Multiemployer plans should be allowed to rescind coverage regardless of whether the fraud or intentional misrepresentation is by the individual or the employer.

### *1. Effect of Rescissions Regulation on Notices and Revocations of COBRA Election Rights*

The broad definition of a rescission under the Interim Final Rule could apply to the termination of coverage following a COBRA Qualifying Event (QE) if the employer or Qualified Beneficiary (QB) either fails to provide timely notice of the Qualifying Event or the Qualified Beneficiary fails to timely elect COBRA coverage. The Interim Final Rule does not address the effect of the Patient Protection and Affordable Care Act (PPACA) on the COBRA rules. We request that the Final Rules or the Preamble clarify the impact, if any, of the rescission rules on the COBRA rules.

After a COBRA Qualifying Event, the payment of a COBRA premium is required to continue coverage. Therefore, retroactive termination of coverage because of the failure of an employer or Qualified Beneficiary to provide timely notice of a Qualifying Event or the failure of a Qualified

Beneficiary to timely elect COBRA coverage is not a rescission because it is a termination of coverage because of a failure to timely pay required premiums.

2. *Effect of Rescissions Regulation on Revocations of Coverage for Taft-Hartley Act Violations*

The prohibition of rescissions creates a unique problem for plans subject to the Taft-Hartley Act if such plans are required to refund employer contributions made in violation of the Taft-Hartley Act [the Labor-Management Relations Act (LMRA), 29 U.S.C. § 141 et seq.] and terminate coverage of employees based on those contributions. If such a termination required to comply with the Taft-Hartley Act is retroactive, the termination could violate the PPACA's prohibition of rescissions.

Section 302 of the LMRA strictly delineates how Taft-Hartley Plans may be structured and operated, and who may and who may not receive benefits under such a plan. LMRA § 302(c) (5) [29 U.S.C. 186 (c) (5)]. The LMRA's restrictions on Taft-Hartley plans require that benefits from such plans must be provided only to "employees" of participating employers and payments to the funds must be made pursuant to a "written agreement" with the employer. LMRA § 302(c) (5) (A), (B).

Multiemployer plans will occasionally discover by means of payroll audits or other administrative procedures that contributions have been made and credited and coverage provided in violation of the Taft-Hartley Act. Although fraud or intentional misrepresentation may be involved, often the situation involves simple error or lack of understanding by the contributing employer. An employer may contribute on non-collectively bargained employees not covered by the employer's participation agreement with the multiemployer plan in the mistaken belief that the employee is covered because he/she is a union member.

The employer in such situations may have made an unintentional misrepresentation or no representation at all, on behalf of the employee regarding the status of the employee and therefore there would be no basis to rescind coverage under the Interim Final Rule. To rescind coverage may therefore violate the Public Health Service Act (PHS), as modified by the PPACA and its interpreting regulations.

However, to provide coverage or to pay for coverage mistakenly granted in such a situation would violate the LMRA and its restrictions on Taft-Hartley plans that require payments be made per a written agreement and on behalf of "employees". LMRA § 302 (c)(5)(B). See *Reiherzer v. Shannon*, 581 F.2d 1266, 1267 (7th Cir. 1978) (citing the LMRA § 302 and observing that "employer funding of union pension funds is legal only if eligibility provisions are set forth 'in a Written agreement with the employer.'") The fact that the employer or a plan may or may not have made representations to the employee would not estoppel the plan from withdrawing coverage under the LMRA. See *Black v. TIC Investment Corp.*, 900 F.2d 112, 115 (7th Cir. 1990) (noting a split regarding estoppel for ERISA cases in the circuits involving single-employer plans, but noting estoppel is generally disallowed in the multiemployer context because "the plan has multiple fiduciaries with control over a common fund.") Indeed, a plan would be required to revoke coverage in such a situation.

Similar revocations of coverage could arise in a situation where an employer mistakenly (but unintentionally) misclassifies an individual as an employee covered under a plan, but the plan later discovers that individual does not fit the definition of “employee” under the LMRA. LMRA § 302(c)(5)(A). Under the LMRA, payments from Taft-Hartley plans may only be made “for the benefit of employees, their families and dependants...” Id. The LMRA provides that the definition of “employee” shall have the same definition as in the NLRA, and the NLRA excludes from that definition anyone who is an independent contractor. LMRA § 501(3) [29 U.S.C. 142(3)]; NLRA § 2 (3) [29 U.S.C. 152(3)].

Unintentional misclassification of individuals as “employees” occurs more frequently in the multiemployer context, where persons can be moving from job-site to job-site, and assuming different roles in different locations. If such individuals, who cannot legally be “employees” under the LMRA, are excluded from a plan and their coverage revoked, as required by the LMRA, this could, nevertheless, be a prohibited rescission under the Interim Final Rule.

The NCCMP proposes that the Departments consider one of two possible solutions. First, the Departments could issue guidance that clarifies that the retroactive revocation of coverage by a Taft-Hartley plan to comply with the LMRA is not a rescission under the Interim Final Rule. This would be our preferred solution, and would comport with the interests of the Departments Multiemployer plans rely on the employer to report the work history of participants, and coverage is granted based upon that reporting. Multiemployer plans should be allowed to rescind coverage regardless of whether the fraud or intentional misrepresentation is by the individual or the employer.

This would be our preferred solution, and would comport with the interests of the Departments and the plans in protecting plan assets, enforcing the law, and reconciling the provisions of the PPACA and the LMRA. While the Departments could issue guidance mandating that plans must cover such individuals and continue coverage, even if such coverage would violate the terms the LMRA we would strenuously recommend against such a finding. It is true that this would have the benefit of giving the plans clear guidance prohibiting rescissions in such situations, but it would lead to situations where coverage was mandated under the PPACA but technically barred under the LMRA leaving plan trustees with a “*Hobson’s Choice*” which, by definition, provides plan fiduciaries with an apparently free choice that offers no real alternative. While well meaning, this conclusion would lead only to protracted disputes in which there can be no winner and will only further deplete limited available of both plans, regulatory agencies and ultimately, the courts.

In other more limited situations, plans may be faced with implementing decisions that are made pursuant to circumstances beyond the plan’s control. For example, if the plan document says that the plan does not cover ex-spouses, it would appear that the termination of an ex-spouse’s status as a covered person precipitated by a divorce is a decision by the court, not the plan, regardless of when the plan administrator learns of, or can implement the result of that decision. Would that action constitute a “rescission” under the PPACA?



Based on the foregoing, the NCCMP supports the efforts of the Departments to provide clear guidance to employers and plan administrators in determining when a rescission has occurred under these regulations and when and under what circumstances a Notice of Rescission must be given, and requests further guidance on the specific issues raised above. Clearly defining what is and what is not a rescission under these regulations in the context of COBRA notices and rights, and when violations of federal laws prohibit coverage, will permit the Departments to provide certainty to the multiemployer plan community while protecting the participants and beneficiaries of those plans.

### **Payment for Care in a Hospital Emergency Room**

The Rule requires non-grandfathered health plans that provide any benefits with respect to services in an emergency department of a hospital to comply with specific requirements. For example, plans must provide hospital emergency room services without preauthorization and must not charge higher cost sharing when participants obtain those services from a non-network provider. These requirements appear fairly straightforward and easy to implement. However, we would urge the Departments to avoid imposing requirements that would dramatically increase administrative costs whenever possible and note that the formula described in the regulation for determining the payment for emergency room services would be needlessly expensive to administer and would potentially delay payment (as described below).

One aspect of the Rule will present particularly serious administrative challenges for many multiemployer plans: the complex payment formula for plan reimbursements to non-network providers. The Departments expressed concern about the potential for plan participants and beneficiaries to be “balance-billed” if the non-participating hospital refuses to accept the plan’s payment as payment in full. To alleviate the possibility of plan participants and beneficiaries having a large out-of-pocket payment to the non-participating hospital, the Departments set forth a complex payment formula for paying out-of-network hospital emergency room charges.

Under the Rule, the plan must pay *the greater of*:

1. The negotiated amount paid to in-network providers for that emergency service (the median amount if there is more than one amount paid to in-network providers),
2. 100 percent of the plan’s usual payment formula for out-of-network services (such as the usual, customary and reasonable amount) reduced by in-network cost sharing, or
3. The amount that Medicare (Part A or Part B) would pay reduced by in-network cost sharing.

While we appreciate the goal of reducing the potential burden of balance billing on plan participants, the payment formula is impractical, and it effectively strips plan sponsors of the ability to control the plan’s costs for emergency care through the common practice of negotiating payment rates with participating providers. The first part of the formula will require calculations that plans do not perform now, and we are concerned that the requirement to determine the median amount paid to all of the plan’s participating providers will prove burdensome. More

burdensome, however, is the requirement to determine what Medicare would pay for the particular service provided.

Many plans will have a difficult if not impossible time determining the Medicare Part A and B payments amounts. The link provided in the Rule does not contain any payment rate details.<sup>2</sup> It is a general outline of the payment rules that apply when Medicare Advantage (MA) plans pay non-contracted providers. According to the document (page 21), MA plans are required to pay non-contracted providers “in combined plan payment and member cost sharing at least the amount the provider would have received in combined Original Medicare payment, beneficiary cost sharing and permitted balance billing.” Rules are different for MA Private Fee-for-Service (PFFS) and non-PFFS plans, and are different depending on the type of hospital. There are links to a variety of rates in the document, but no clear link to the appropriate Medicare payment rates for specific emergency services.

Many multiemployer plans are self-administered and do not routinely pay benefits using Medicare payment rates, or they utilize third party administrators that may not be familiar with such rates. This may be particularly true if the plan does not provide retiree benefits. Determining the appropriate Medicare payment rate in situations where the plan is self-administered or does not utilize the services of a third party administrator who is actually paying Medicare benefits (e.g., a Medicare intermediary such as an insurance company) would present administrative issues which are outside the plan’s expertise and could require the plan to retain outside billing experts to determine the appropriate payment amounts. Indeed, many plans have no way of knowing what the one amount or median amount of what is paid in network is, because networks are often “rented” or managed by third parties (and even they may not have a good handle on what their median reimbursement for a particular procedure is because they have so many varied contracts). Finally, the UCR will almost always be higher than the in-network or Medicare reimbursement, so nothing would be lost by leaving it at the UCR level.

In addition, requiring this type of payment calculation would not necessarily be in a participant’s best interest. It would delay payment while rates are calculated based on schedules not normally utilized by the plan. More importantly, there is still no reason to expect that the participant will not be balance billed by the provider, since the Medicare balance-billing rules applicable to Medicare beneficiaries would not apply.

Accordingly we request that the Departments eliminate these new payment rules for out-of-network hospital emergency room services.

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<sup>2</sup> The Rule provides this link: <http://www.cms.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf>

## **Conclusion**

Once again, we congratulate the Departments on the quality of the product your joint efforts in this massive undertaking have produced, under such necessary, but unfortunately difficult time constraints and thank you on behalf of the multiemployer community for the opportunity to provide comments on these important issues. We will be pleased to provide any additional information that you might find useful.

Respectfully submitted,

A handwritten signature in black ink, reading "Randy G. DeFrehn". The signature is written in a cursive style with a large initial 'R' and a long, sweeping underline.

Randy G. DeFrehn  
Executive Director