NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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Submitted via e-mail at:
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Internal Revenue Service
1111 Constitution Ave., NW
Washington, DC 20224

Re: Notice 2011-35

To Whom It May Concern:

The National Coordinating Committee for Multiemployer Plans (the NCCMP) is pleased to submit these comments to Notice 2011-35 regarding provisions of the Affordable Care Act that fund comparative effectiveness research on patient-centered outcomes.

The NCCMP is the only national organization devoted exclusively to protecting the interests of the approximately 26 million workers, retirees, and their families who rely on multiemployer plans for health, retirement 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.

Multiemployer plans are established and maintained pursuant to collective bargaining agreements between one or more unions and at least two employers. Typically structured in accordance with section 302(c)(5) and (c)(6) of the Taft-Hartley Act, the plans are operated through stand-alone trusts managed by a joint labor-management Board of Trustees.

Multiemployer plans provide health benefits in various ways. Multiemployer plans are typically self-insured and rely on third party administrators (TPAs) and other outside entities (e.g., pharmacy benefit managers and outside vendors that administer dental or vision benefits) to administer their benefits. Some multiemployer plans administer some or all benefits in-house. In other situations, multiemployer plans provide some benefits through insured arrangements, but continue to provide other benefits on a self-insured basis. In some cases, all health benefits are provided on a fully insured basis but this is not the norm.

Background on Comparative Effectiveness Research Fees & Notice 2011-35

The Affordable Care Act created a new Patient-Centered Outcomes Research Institute (PCORI), a nonprofit organization, to conduct research evaluating and comparing health outcomes and the

clinical effectiveness, risks and benefits of medical treatments. The Patient-Centered Outcomes Research Trust Fund, which will pay for the work of the PCORI, will be funded through the comparative effectiveness research fees and other federal funding sources.

Two new sections in the Internal Revenue Code (IRC) address the comparative effectiveness research fees. One section (section IRC § 4375) applies to health insurance policies, with the fees paid by the issuers of the policies. The other section (section IRC § 4376) applies to self-insured health plans, with the fees paid by the plan sponsor of the plan.

In the first year, the fee will amount to $1 multiplied by the average number of lives covered under the plan (including dependents). In subsequent years, the multiplier is $2 times the average number of covered lives. This dollar amount will be adjusted, starting in 2014 or 2015 (depending on the plan year), by the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Department of Health and Human Services before the beginning of the fiscal year.

Overview of Comments

The NCCMP's primary concern relates to how the IRS will assess the comparative effectiveness research fees in situations where a group health plan provides various types of health benefits, including situations where some benefits are provided on an insured basis and some are provided on a self-insured basis. This raises the prospect of double counting of covered lives, with the result that the fees would be assessed twice on one group of covered lives. For example, unless clear rules address this, both the issuer and the plan could end up paying the fees in connection with the same group of plan participants. The NCCMP offers below a recommended approach to address this issue, as well as the other issues raised by the IRS in Notice 2011-35.

Finally, with respect to clarifying the party responsible for payment of the fees, the NCCMP respectfully requests that the IRS clarifies that the required fees are appropriately to be paid by the trustees from plan assets. Details concerning these concerns are provided below.

IRS Should Impose the Fees Once, With Respect to One Group of Covered Lives, Regardless of the Various Types of Health Benefits Provided

One important issue not addressed in Notice 2011-35 is how the fees will apply when one group health plan provides both self-insured and insured benefits. For example, a plan sponsor might offer insured medical benefits but self-insured prescription drug coverage. It is not clear if the IRS would require both the issuer (with respect to the medical coverage) and the plan sponsor (with respect to the drug coverage) to report and pay the fees with respect to same group of covered lives. Nor is it clear how the IRS would assess the fees if one group health plan offers different benefit packages with some overlapping benefits. Although different benefit packages would likely cover different groups of covered lives, all these individuals could also be enrolled in one benefit common to both (e.g., prescription drug coverage administered by a separate vendor).

The NCCMP recommends that the IRS develop clear rules that will ensure that these fees are not imposed more than once with respect to the same covered lives. Where one plan or package of benefits is provided through insured and self-insured arrangements, we propose that the IRS allocate the fees as follows:

- The issuer pays the comparativeness effectiveness research fees with respect to the covered lives receiving insured benefits (other than insured HIPAA excepted benefits), and

- The plan sponsor of the group health plan only pays the fees if the plan provides self-insured benefits to a different group of covered lives (and then, only with respect to that different group of covered lives).

This type of default allocation will ensure that the fees are paid only once and will simplify the administrative burden on plan sponsors. Only the plan sponsor will be aware of the different types of benefits offered through the plan to various groups of participants. Having no default rule would either lead to double payment or require that the plan sponsor contact the issuer(s) to determine which entity would report and pay the fees.

Similarly, where the benefits are all provided on a self-insured basis, but through different administrators, the plan sponsor (or a designated TPA) would pay the fees once with respect to the plan's covered lives. In essence, the number of covered lives determines the fees, not the different types of benefits offered by the plan to that group of participants.

As noted above, the NCCMP recommends that the IRS develop clear rules that will ensure that fees are not imposed more than once with respect to the same covered lives. In many cases, workers are covered under two group health plans, because a husband and wife are both working and both eligible for coverage under their respective benefit plans. The spouses may enroll as employees in their plan and as dependent spouses in their spouses plan. They may enroll children in one or more of the parents' plans. This type of coverage duplication is more common in multiemployer plans because they generally do not charge employee contributions for active coverage.

Many plan administrators have detailed tracking of employee, spouse, and dependent eligibility in order to administer coordination of benefits rules. These plans would easily be able to determine whether a particular spouse or child has other health coverage that is primary to the coverage under the multiemployer fund. In cases where plan sponsors can identify that they provide secondary coverage, and a spouse or child has other primary coverage, plan sponsors should not have to pay the fee for those individuals.

IRS Should Adopt a Safe Harbor for Counting of Covered Lives

Notice 2011-35 asks for comments on reasonable methods to calculate the number of covered lives that would reduce the administrative burden. The notice suggests a safe harbor that would permit plan sponsors to compute covered lives using a formula based on the number of participants and one or more additional factors that account for the number of dependents.

This type of safe harbor approach is especially important for multiemployer plans, because many do not have an enrollment process where participants affirmatively enroll their dependents. Nor

do they conduct annual open enrollment. Coverage takes effect for the participant and for any eligible dependents when the plan receives sufficient contributions from contributing employers n accordance with the plan's particular eligibility rules. In many cases, the plan will not know that eligible dependents exist until the plan receives a claim form for medical care provided to that dependent. This is especially problematic in industries in which there is a high degree of mobility, both in employment and residence and lower than average levels of literacy (in any language), where written communications are not the norm.

Multiemployer plans should have the option of actually counting covered lives (looking backwards at the actual average number of covered lives, rather than projecting forward) or using any reasonable method that the plan uses or could use to count covered lives for accounting valuation, pricing of benefits or other plan design purposes. For example, the plan could multiply the number of participants by a reasonable dependency factor, which would likely vary based on active/retiree status, general age of participants, geography, etc.

IRS Should Clarify Types of Coverage Subject to and Exempt from the Fees

HIPAA Excepted Benefits: Under the Act, the fees will not be assessed in connection with benefits that are "excepted benefits" under the Health Insurance Portability and Accountability Act (HIPAA). For example, dental and vision benefits that are separately insured would clearly not be subject to the fee. It appears that *self-insured* dental and vision benefits would also be exempt if participants elect this coverage separately from the medical benefit and pay an additional premium if they elect the coverage. This is called a "limited-scope" dental/vision benefit under HIPAA's definition of excepted benefits. However, given the statute's linkage of the term "health insurance policy" to the exception for HIPAA excepted benefits, it would be helpful for the IRS to clarify that all HIPAA excepted benefits, including those that are self-insured, are exempt from the fees.

Many multiemployer plans provide self-insured dental or vision coverage that does not meet HIPAA's definition of excepted benefits. That is because the coverage is bundled with medical coverage and is not elected separately. Or, if elected separately, there is no premium charged for the dental/vision coverage. Under the approach that we recommend above to ensure that the fees are imposed only once per group of covered lives, the plan sponsor would pay the fees once for this group of covered lives, not twice (i.e., not once for the medical coverage and then again in connection with the dental or vision coverage).

Health Reimbursement Arrangements: Notice 2011-35 asks for comments on whether Health Reimbursement Arrangements (HRAs) or types of HRAs should be subject to or exempt from the fees. We recommend that the IRS not subject any type of HRA to these fees. Subjecting HRAs to these fees would result in double counting of participants (and thus assessing the fees twice on the same covered lives) in nearly all cases because these participants will have other coverage, whether that other coverage is provided through the same multiemployer plan or through another plan of benefits (such as another multiemployer plan or a single-employer plan).

Retiree Benefits: Multiemployer funds that provide benefits to retirees often do so through the group health plan that also covers active participants. In other words, these benefits often do not qualify as retiree-only benefits that are exempt from many of the provisions in the Affordable Care Act. In some cases, however, participants with retiree coverage may receive somewhat

different benefits. For example, they may not receive dental or vision benefits, or they may have to contribute to their coverage while actives do not. This is especially true if the plan covers Medicare-eligible retirees by providing some type of Medicare supplemental coverage that pays secondary to Medicare. While insured Medicare supplemental policies would qualify as HIPAA excepted benefits, and thus not be subject to the fees, Medicare supplemental benefits that are provided on a self-insured basis are not excepted benefits under HIPAA.

While the statute's definition of "applicable self-insured health plan" refers to a plan maintained for the benefit of employees or former employees, we recommend that the IRS not make retiree coverage even more expensive by adding these fees to the cost of that coverage. This exemption should apply to early retirees and Medicare-eligible retirees. This exemption should also apply when benefits are provided as part of a retiree-only plan or as part of the active plan.

IRS Should Set Flexible Rules for Filing Reports and Making Payments

Notice 2011-35 invites comments on whether the fees should be reported and paid annually or quarterly and whether they should be due on a fixed date regardless of the plan year. We recommend that fees be reported and paid not more frequently than annually, well after the close of the plan year to which they relate (not on one fixed date), and that forms and processes be developed so that third party administrators (TPAs) or administrative services providers would be able to submit this information on behalf of a multiemployer plan.

Requirement for Payment of Fee by Sponsor is Unworkable for Multiemployer Plans

As discussed above, Notice 2011-35 provides that the fee is to be paid by the plan sponsor for a self-insured fund. For a single employer plan, this is the employer. For a plan established by a labor organization, this is the labor organization. This makes sense, as these single entities are responsible for the funding of their plans and associated costs.

For a multiemployer plan the plan sponsor is the Committee or joint board of trustees. Unlike the employer sponsoring a single-employer plan or the labor organization sponsoring its plan, the committee or board of trustees of a multiemployer plan is not responsible for funding the plan. In fact the participating unions and employers who are represented by the union and employer trustees respectively are responsible for funding the multiemployer plan through collective bargaining or other written agreements that require contributions to the trust. The sponsor—the board of trustees—have no source of assets with which to pay the fee.

The DOL recognized this problem and provided a partial solution in Field Assistance Bulletin (FAB) 2002-2. While recognizing that the trustees of a multiemployer plan may perform both settlor (sponsor) and fiduciary functions, the FAB provides a means by which all functions performed by the trustees may be considered fiduciary functions to be paid for from plan assets if plan documents so provide.

The 2007 DOL ERISA Advisory Council studied the issue of payment for the fiduciary and settlor functions of trustees of multiemployer plans. The immediate concern of the Working Group was whether expenses for trustee functions to comply with the Pension Protection Act (PPA) would be considered fiduciary or settlor expenses and whether such expenses could be

paid from plans assets. In its conclusion, the Working Group "…welcomed the Department's general proposition that payment for any activity required by the statute would be an appropriate plan expense."

Therefore, NCCMP requests that in accordance with the view of the Department of Labor that expenses required to comply with a statutory requirement are appropriately paid from plan assets, that the IRS similarly clarify that the fees required to fund comparative effectiveness research are appropriately paid by the trustees from plan assets. The board of trustees of a multiemployer plan is only a conduit for payment of the fees, as it is a conduit for payment of all plan costs, and that the joint board may pay the fees out of the contributions received from the various contributing employers. In other words, the trustees are not personally responsible for payment of the fees.

Conclusion

We appreciate the opportunity to submit comments on Notice 2011-35. Please do not hesitate to contact me if you have any questions about our comments or need additional information.

Respectfully submitted,

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