

NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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

Re: Patient Protection and Affordable Care Act
HHS Notice of Benefit and Payment Parameters for 2014
Proposed Rule
File Code CMS-9964-P

Dear Ladies and Gentlemen:

The National Coordinating Committee for Multiemployer Plans (the “NCCMP”) is pleased to provide these comments regarding the proposed notice of benefit and payment parameters that would implement the new transitional reinsurance program under section 1341 of the Affordable Care Act (the “ACA”)¹ (the “Proposed Parameters”). A proposed rule on the transitional reinsurance program was published in the Federal Register on July 15, 2011 (76 Fed Reg 41930) (the “Proposed Rule”) and a final rule was published in the Federal Register on March 23, 2012 (77 Fed Reg 17220) (the “Final Rule”). The Final Rule contemplated that further details on the reinsurance program, including details on the calculation of the reinsurance contribution, would be provided in the future. The Proposed Parameters provides this additional detail. The NCCMP provided comments on the Proposed Rule on October 31, 2011.²

This letter focuses on the provisions of the Proposed Parameters relating to the required reinsurance contribution as they would apply to multiemployer plans, which are generally self-funded, self-administered plans.

The NCCMP is the only national organization devoted exclusively to protecting the interests of the approximately 26 million American workers, retirees, and their families who rely on multiemployer plans for health and other benefits. The NCCMP’s purpose is to assure an environment in which multiemployer plans can continue their vital role in providing benefits to working men and women. The NCCMP is a nonprofit, non-partisan organization, with members,

¹ The Affordable Care Act refers collectively to the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152).

² See letter from Randy DeFrehn dated October 31, 2011, submitted via www.regulations.gov.

plans, and plan sponsors in every major segment of the multiemployer plan universe, including in the agricultural, airline, building and construction, entertainment, health care, hospitality, longshore, manufacturing, mining, retail food, service and trucking industries.

Introduction

In this comment letter, we address issues concerning the application of the new reinsurance contribution requirement that are of importance to the participants and beneficiaries currently receiving health benefits from multiemployer plans, including the following:

- The statute does not support application of the contribution requirement to self-funded, self-administered multiemployer plans.
- The NCCMP agrees with the comments in the preamble regarding the lack of authority of States to impose additional contribution requirements on self-funded multiemployer plans and requests that HHS clarify that States may not impose such additional requirements.
- The NCCMP supports the provisions in the Proposed Parameters that exempt coverage that is not major medical coverage, including the provisions relating to situations in which the group health plan is secondary to Medicare coverage. NCCMP requests two clarifications: (a) clarification that all dental and vision plans, regardless of whether they qualify as an “excepted benefit,” are exempt from the contribution requirement and (b) clarification that prescription drug coverage is not major medical coverage when offered by itself or offered separately from major medical coverage..
- The NCCMP supports the provision in the Proposed Parameters that exempts integrated health reimbursement arrangements (HRAs) from the fee, and requests that the exemption be expanded to all HRAs.

Background on Multiemployer Plans

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

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

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

Multiemployer plans have a unique structure that in some ways reflects typical employer sponsored group health plans and in other ways reflects insured arrangements. For over 60 years, this unique structure has enabled multiemployer plans to provide affordable, high quality health coverage for a broad segment of the American workforce cutting across the economy who are often left out of typical employer plans, including part-time workers and workers in industries with very fluid employment patterns. While most often associated with the building and construction and trucking industries, multiemployer plans are pervasive throughout the economy including the agricultural; airline; automobile sales, service and distribution; building, office and professional services; chemical, paper and nuclear energy; entertainment; food production, distribution and retail sales; health care; hospitality; longshore; manufacturing; maritime; mining; retail, wholesale and department store; steel; and textile and apparel production industries.

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

In other ways, however, multiemployer plans clearly function more as insurers, performing the functions usually associated with an insurance company. Multiemployer plans provide coverage for all employees of contributing employers – essentially creating a community-rated risk pool consisting of ALL covered employees of contributing employers. Unlike individual market insurers, they do not use medical underwriting criteria to exclude participants or to charge some participants higher rates, nor do they exclude any pre-existing conditions (two of the main practices that the ACA bans in the individual market beginning in 2014). Multiemployer plans receive contributions from which benefit payments are made, make eligibility determinations, and set benefit levels. Plan trustees determine whether, and to what extent, benefits should be paid – either directly (self-insured) or on a fully insured basis, or some combination of insured and self-insured coverage. They also determine the administrative structure – whether fully self-

administered, through a third party administrator, through an administrative services only (“ASO”) agreement with an insurer, or some combination of the above.

The Proposed Parameters

The Final Rule provides that the reinsurance contribution is payable by a “contributing entity” meaning “a health insurance issuer or a third party administrator on behalf [of] a self-insured group health plan.” [sic] 45 CFR 153.20. The Final Rule does not contain a definition of a “third party administrator” nor does it specify details as to ultimate liability for the contribution in the case of a self-funded plan. The Proposed Parameters does not modify the definition of a contributing entity or include a definition of a third party administrator (“TPA”); however, the preamble states that “with respect to self-insured group health plans, the plan is liable, although a third-party administrator or administrative-services-only contractor may be utilized to transfer reinsurance contributions on behalf of a self-insured group health plan, at that plan’s discretion. A self-insured, self-administered group health plan without a third-party administrator or administrative-services-only contractor would make its reinsurance contributions directly.”

The Final Rule provides that the contribution imposed on behalf of self-funded plans is payable to the Department of Health and Human Services (“HHS”), whereas the contribution with respect to fully-insured plans may be payable in some cases to a State.³ The Proposed Parameters provide that, in all cases, the Federal contribution requirement is payable to HHS.

The Proposed Parameters provide that if a State establishes a reinsurance program, the State may collect more than the amounts collected by HHS to provide for administrative expenses or additional funds for reinsurance payments. The preamble, however, notes that “nothing in section 1341 of the Affordable Care Act or this proposed rule gives a State the authority to collect from self-insured group health plans covered by ERISA, and that Federal law generally preempts State law that relates to an ERISA-covered plan.”

The Final Rule provides that the reinsurance contribution requirement does not apply to plans that only provide excepted benefits as defined under HIPAA. The Proposed Parameters provide additional exceptions to the contribution requirement, providing that it does not apply to “major medical coverage” (e.g., health flexible spending arrangements are not subject to the contribution requirement) or to certain types of insurance coverage that are deemed not to be “commercial insurance” as defined under the Proposed Parameters.

The Proposed Parameters set the national contribution rate for the reinsurance contribution at \$5.25 per month per covered life, and contain rules for determining how this contribution is to be determined.

Detailed Comments

1. The statute does not support application of the reinsurance contribution requirement to self-funded, self-administered multiemployer plans.

³ Under the Final Rule, whether insurers were required to pay the required contribution to HHS or to the State depended on whether the State or HHS would be administering the reinsurance program within the State. The Proposed Parameters would provide that all contributions are payable to HHS.

ACA section 1341 provides for the establishment of the transitional reinsurance program and provides a funding mechanism for that program through a contribution requirement imposed on “health insurance issuers, and third party administrators”. ACA section 1341(b)(A). When read together, the relevant sections of section 1341 indicate that the contribution requirement is intended to apply to health insurance issuers both when providing health insurance coverage and when providing services to a self-funded plan as a TPA. ACA section 1341(b)(3)(B). The Final Rule expands the liability for the reinsurance contribution and requires TPAs of all self-insured plans to contribute to the reinsurance program. The preamble to the Proposed Parameters would go even further and require a self-insured, self-administered group health plan without a TPA or administrative-services-only contractor to make its reinsurance contributions directly. We see no basis, and there is no discussion in the preamble of the Proposed or Final Rule or the Proposed Parameters, as to why self-administered, self-insured plans should be required to pay the reinsurance contribution as contemplated in the preamble to the Proposed Parameters. The statute, the scope of the enforcement authority of HHS, and various provisions of the Proposed Parameters support the contrary result – that is, that the reinsurance contribution should not be applied with respect to self-administered, self-insured non-profit multiemployer plans.

The statute generally requires HHS to develop standards for programs under which “health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable reinsurance entity.” (See Section 1341(b)(1)(A).) Reading this portion of the statute in isolation could lead one to believe that TPAs of all group health plans must contribute. However, when read in its entirety, the statute takes a narrower approach. In particular, the specific details in the statute for how the contributions will be calculated focus on the business of health insurance issuers. The statute directs HHS to establish standards so that:

- (i) the contribution amount for each issuer proportionally reflects each issuer’s fully insured commercial book of business for all major medical products and the total value of all fees charged by the issuer and the costs of coverage administered by the issuer as a third party administrator. (See Section 1341(b)(3)(B)(i).)

This means that issuers make their contribution based on revenue from their insured products as well as from their administrative-services-only (“ASO”) line of business for group health plans. There is no mention in 1341(b)(3)(B) of how contributions are to be calculated for group health plans themselves. Section 1341(b)(3)(A) refers to “the total costs of providing benefits to enrollees in self-insured plans” as providing some basis for the group health plan calculation, but that phrase is qualified by the reference to “the percentage of revenue of each issuer” and thus indicates that the contribution is limited to a health insurance issuer’s ASO business and does not apply where the TPA is not a health insurance issuer. Further support for limiting the contribution requirement to TPAs that are health insurance issuers is found in section 1341(b)(3)(B)(iv), which includes an additional \$5 billion for general revenues, and refers specifically to “each issuer’s contribution.” Further, there does not appear to be a basis in the statute to define a self-administered plan as a TPA for purposes of making payments. The preamble to the Proposed Parameters asserts that a self-administered, self-funded plan is subject to the contribution requirement, but does not explain the statutory basis for this requirement. The statutory provisions do not, on their face, apply to self-funded, self-administered multiemployer plans where there is no ASO contract with a health insurance issuer.

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

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

Further, the Proposed Parameters provide numerous additional exceptions to the contribution requirement in the case of fully-insured business. These additional exceptions are provided on the basis that the contribution requirement only applies to “commercial insurance.” Excepting self-administered, self-funded multiemployer plans would be consistent with these exceptions. Multiemployer plans are not commercial in nature rather they are by law not-for-profit. Multiemployer plans are funded by contributions made by employers pursuant to collective bargaining agreements and have no other source of funds from which to pay the reinsurance contribution. Because the plans are not-for-profit, unless or until contributions can be adjusted through the bargaining process, funds for paying the reinsurance contribution may come at the cost of reduced benefits. The impact of the contribution requirement may be substantial. For example, in the case of one multiemployer plan, the contribution requirement would mean an additional expense of approximately \$971,000 per year (6424 active employee plan participants x 2.4 x 5.25 x 12). Total annual operating expenses of self-administering the program are approximately \$3.4 million, meaning that the fee will equal 28.5% of operating expense. In another situation for a plan covering 5,200 active employees, the expected amount of the fee, disregarding any adjustment for dependent coverage, is approximately 50% of administrative expenses. Just as the Proposed Parameters exempts from the contribution health insurance that is not “commercial insurance,” not-for-profit multiemployer plans should be exempted from the contribution requirement.

2. The final regulations should clarify that States do not have the authority to impose contribution requirements on self-funded multiemployer plans.

The NCCMP agrees with the statement in the preamble to the Proposed Parameters questioning the authority of the States to impose contribution requirements on self-funded multiemployer plans. As noted in the preamble, ERISA generally preempts State laws that “relate to” group health plans. ERISA section 514. ERISA does not preempt State laws regulating insurance, but also prevents States from treating group health plans as insurance. The NCCMP requests that the final regulations clarify that States may not impose an additional contribution requirement with respect to self-funded multiemployer plans.

3. The NCCMP generally supports the provisions in the Proposed Parameters that exempts coverage from the contribution requirement coverage that is not major medical coverage, and requests a clarification that all dental and vision plans,

regardless of whether they qualify as an “excepted benefit,” are exempt from the contribution requirement.

The Proposed Parameters provide that no reinsurance contribution requirement is imposed with respect to a plan or coverage that is not “major medical coverage.” In addition, the Proposed Parameters specifically exempt certain types of plans (on the basis that they are not major medical coverage), including the following: coverage of excepted benefits as defined under section 2791 of the PHS Act; health flexible spending arrangements; employee assistance plans, disease management programs and wellness programs that do not provide major medical coverage; and stop-loss and indemnity reinsurance. The Proposed Parameters would also apply the Medicare secondary payer rules so that if coverage under a group health plan is secondary to Medicare, then the contribution requirement does not apply to such coverage. The NCCMP supports these provisions and requests that they be included in the final regulations.

In addition, the NCCMP requests a minor clarification with respect to the exemption of dental and vision plans. The Proposed Parameters would specifically exempt plans that do not provide major medical coverage and plans that provide excepted benefits from the contribution requirement. The preamble refers to “stand-alone” vision and dental coverage as being limited coverage that is not major medical coverage. In the case of a self-funded plan, vision or dental coverage qualifies as an excepted benefit if it is not integrated with a major medical plan, meaning that there is a separate election and separate premium for such coverage (which may be nominal). 45 CFR section 145.146. Many self-funded multiemployer plans provide dental and vision benefits through plans that do not qualify as an “excepted benefit” because they are provided automatically to a participant in a major medical plan without any premium. NCCMP understands that, because such a dental or vision plan does not provide “major medical coverage” it would be exempt from the contribution requirement, even though the coverage is not an excepted benefit because it is provided without a separate premium. While NCCMP believes this result is correct under the Proposed Parameters, clarification on this point would be helpful because it is a common situation.

Finally, the only mention of prescription drug coverage in the regulatory text is in the context of a discussion of the counting rules applicable to “multiple group health plans.” The NCCMP believes that coverage that only provides benefits related to prescription drugs (for example, coverage provided through a separate arrangement with a pharmacy benefit manager) is not major medical coverage, and should be added to the list of types of coverage that do not constitute major medical coverage.

4. The NCCMP supports the provision in the Proposed Parameters that exempts integrated health reimbursement arrangements (HRAs) from the fee, and requests that the exemption be expanded to all HRAs.

The Proposed Parameters provide that HRAs that are integrated with a major medical plan are exempt from the contribution requirement. NCCMP supports this provision. However, the NCCMP also requests that this exclusion should be extended to all HRAs. HRAs, whether “integrated” with a major medical plan or provided on a stand-alone basis, do not provide coverage for a specific set of services in particular settings. Rather, both types of HRAs provide for reimbursement for medical expenses that are not covered by insurance. (HRAs may also

provide for payment of insurance premiums, in which case the coverage would be subject to the reinsurance contribution.) Thus, it is appropriate to exempt all HRAs from the contribution requirement.

Conclusion

We greatly appreciate the opportunity to comment on the proposed rules as they may apply to multiemployer plans and are more than happy to discuss any questions you may have regarding these comments.

Respectfully submitted,

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Executive Director

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