

NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

815 16th Street, N.W., Washington, DC 20006 • Phone 202-737-5315 • Fax 202-737-1308



Mark H. Ayers
Chairman

Randy G. DeFrehn
Executive Director
E-Mail: RDEFREHN@NCCMP.ORG

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Submitted electronically at: <http://www.regulations.gov>

David Mlawsky
James Slade
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: Early Retiree Reinsurance Program; File DHHS-9996-IFC

Gentlemen:

These comments are filed by the National Coordinating Committee for Multiemployer Plans (“NCCMP”) in response to the request for public comments on the Interim Final Regulations implementing the Early Retiree Reinsurance Program issued by the Department of Health and Human Services, 45 CFR Part 149, published in the Federal Register on May 5, 2010. The Interim Final Regulations implement section 1102 of the Affordable Care Act.

The NCCMP is the only national organization devoted exclusively to protecting the interests of the approximately ten million workers, retirees, and their families who rely on multiemployer plans for retirement, health and other benefits. Our 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 non-partisan, nonprofit organization, with members, plans, and plan and construction, retail food, trucking and service and entertainment industries.

Overview of Multiemployer Plans. Very briefly, multiemployer plans are benefit plans to which two or more employers contribute pursuant to collective bargaining agreements with the labor unions that represent employees of those employers. Multiemployer plans are governed not only by the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code of 1986, but also by the Taft-Hartley Act. The great majority of multiemployer plans are structured in conformance with section 302(c)(5) of the Taft-Hartley Act (29 USC s. 186(c)(5)), which stipulates that a union can only participate in the management of an employer-funded retirement, health or other benefit plan if, among other things, the assets are held in a trust fund that is managed jointly by employer and union representatives.

While multiemployer plans must, by definition, cover people working for more than one employer, most have considerably more than two. The plans range in size and geographic coverage, from say, a plan covering a single city or county to statewide, regional or even national plans, with anywhere from 100 to 500,000 or more participants, working for, say, from 5 to several thousand employers. They are often self-funded for part or all of their coverages. The employer contributions that fund the plans represent a designated portion of the negotiated compensation package and would otherwise be paid as wages. For that reason, plus the fact that payroll deduction is rarely feasible given the fact that the benefit fund is separate and independent from the employers, multiemployer plans rarely require explicit contributions from the active covered employees for individual or family coverage. By contrast, retiree coverage is often partially or fully contributory, albeit usually with a substantial subsidy from the fund.

Under ERISA, the “plan sponsor” of a multiemployer plan is its joint labor-management board of trustees. The trustees, collectively, are also typically the legally designated “plan administrator”, although they hire professionals to perform the actual administrative functions.

Two features of multiemployer plans distinguish them from other group health plans: 1) they are operated through a stand-alone trust that is independent of, and separate from, any given employer, and 2) they are financed by employer contributions that are fixed in collective bargaining agreements, usually defined as, for example, \$8 per hour for each hour worked in covered service. These contribution rates are not determined separately for each employer based on the cost of covering the participants who work for that employer, but are designed to allocate the expected cost for the group as a whole.

Multiemployer plans were created primarily to enable people whose jobs are mobile and who may work for several employers in the course of the year to qualify for health coverage and other benefits through their service with the industry as a whole, since many of them would not work long enough for any one company to qualify under a traditional corporate model. The contributing employers, too, are usually small businesses that would not be in a position to provide health coverage on their own.

We wish to bring to your attention aspects of the regulation that are of particular concern to multiemployer plans.

1. Process Consistency with the Retiree Drug Subsidy Program (RDS): We applaud the efforts by HHS to make the new Early Retiree Reinsurance program similar to the RDS program. Many multiemployer plans have received payments from the RDS program, which have assisted the plans to maintain the level of retiree health benefits for their Medicare-eligible retirees and their spouses. By simplifying the terms and using similar definitions for the two programs, the administrative process will be familiar for those plan sponsors that currently receive the RDS. However, we do have concerns about the application process.

a. First-come, First-processed Application Process: We are concerned that the Department’s adoption of a first-come, first-processed application process will create a situation in which plans that have superior technological and administrative support will have an advantage in the application process to those plans that do not. We suggest that the Department establish an application period (e.g., one month) during which plan sponsors could submit applications for the reinsurance program. This would accomplish the goal of learning about the volume of requests for the funds, but would not result in a rush to

complete the applications that will drain resources of both the Department and the plans. Claims reimbursement could still occur on a first-come, first-processed basis, within a more workable and equitable framework.

More specifically, we encourage the Department to put in place a claims submission and reimbursement process that would not heavily advantage the more technologically advanced and largest submitters. For example, the Department could process all of the claims submitted during a specified 6-month period and reimburse them on a pro rata basis if the funds are not enough to cover them in full. In addition, it would allow plans additional time to consolidate claims for a single individual and perfect those claims submissions. Plan sponsors would prefer some delay in receiving the reimbursement to the challenge of figuring out how to be among the first inside the door for a winner-take-all prize, and the recriminations that would follow for falling short.

b. Transition Time for Application Process: In addition to rationalizing the application and claim-submission processes, we encourage the Department to provide a training program for the Reinsurance application process that gives all interested plan sponsors the opportunity to learn how to handle it. That way, larger plans with more sophisticated systems capabilities, or those that currently receive the RDS, will not have an undue advantage, and the program will provoke fewer complaints and less confusion from the public. Specifically, we suggest the following:

- The Department should publish the final online application format and content in advance, and make sample completed application pages available online. The Department should also consider providing online training on the application, including one or more live webinars. These steps should be taken *prior* to the application's "going live" online. This will allow all plan sponsors to examine the application and prepare to complete it when it is "live." The Department should publicize the availability of these training resources. We are concerned that without an available training and education opportunity, all plan sponsors will rush to file their applications as soon as the gates open. This creates resource strains for plan sponsors, service providers and the Department. It is likely without advance training plan sponsors will have significant numbers of errors in the application, resulting in delayed or denied applications.
- If the Department uses the RDS system for the Reinsurance application process, the Department should give plan sponsors that do *not* currently receive RDS an opportunity to open an online application and verify the Account Manager and Authorized Representative before the application is opened. In our experience, when a plan sponsor begins an RDS application, there is often a delay due to the need to verify the identity of the plan's Account Manager and/or Authorized Representative. In some cases, we are aware of situations where the RDS application has been delayed because the application could not be completed until the verification process was completed for a new Authorized Representative. Many multiemployer plans provide retiree coverage only for those who are not yet eligible for Medicare. These plans should have the same opportunity to complete the application as those plans that are already in the RDS program.

2. Use of Program Funds: Plan sponsors that receive the reinsurance proceeds must use them to (1) reduce the plan sponsor's health benefit premiums or health benefit costs, (2) reduce plan participant health benefit premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs, or any combination of these costs, or (3) reduce any combination of the above.¹ In addition, the Preamble to the regulation states that because the statute requires the proceeds not be used as general revenue, HHS is requiring plan sponsors to maintain their current level of effort in contributing to support their applicable plan.

This has raised several questions for multiemployer plans. As noted, they are trust funds established under the Taft-Hartley Act and recognized as tax exempt voluntary employees' beneficiary associations under IRC Section 501(c)(9). Because they are independent of the sponsoring employers and unions, all of the funds used to operate and pay benefits under a multiemployer plan come from the plan assets – the fund contributions and earnings on any reserves. Unlike most single employer plans, where payments are made from company assets as they are needed, multiemployer plans are formally funded, financed by contractually defined employer contributions (and sometimes retiree contributions) payable at fixed rates at specified intervals. All of the plan assets are dedicated to providing health and welfare coverage for the plan's participants and beneficiaries. Since the plans are subject to ERISA, none of the assets can be used for any purpose other than paying benefits and meeting the plan's reasonable and necessary operating expenses. Consequently, the prohibition against a plan sponsor's using reimbursements under the program as "general revenue" is not relevant to multiemployer plans. By definition, all of the revenues of a multiemployer plan are used for purposes that fit the terms of the Reimbursement program.

It would be useful for the Department to issue guidance to confirm that, and reconfirming that multiemployer plans can use the proceeds to pay all benefits authorized by the plan, including the plan's operating expenses, reducing any costs for participant costs, offsetting the increases in health care costs that plans face each year, or meeting reducing other current costs of plans, even if early retirees are not the direct beneficiaries of those expenditures. Also, multiemployer plans typically try to maintain reserves to assure that they will have sufficient cash to pay benefits as claims come in, even in times like the present when dwindling covered employment means employer contributions are likely to drop off. Whether the plan adds its receipts from the Reimbursement program to its reserves or applies those funds to current expenses while crediting other amounts to the reserves should be immaterial. The existence of a reserve is prudent plan management that protects the participants' interests, and should not impair the multiemployer plan's flexibility as to the use of the proceeds.

3. Chronic care programs: To be eligible for reimbursement under the program, a plan sponsor must have in place programs and procedures that have generated or have the potential to generate cost savings for plan participants with chronic and high-cost conditions. The regulations define a chronic and high-cost condition as a condition for which \$15,000 or more in health benefit claims are likely to be incurred during a plan year by one participant. The preamble includes two examples of such programs: a diabetes management program that includes aggressive monitoring and behavioral counseling to prevent complications and unnecessary hospitalizations, and a program that covers all or a large portion of a cancer patient's coinsurance or copayments or reduces the plan deductible for cancer treatments.

¹ 45 CFR § 149.200.

We support the goal of assuring that plans that take advantage of the Reimbursement program are taking the initiative to provide participants with help in the management of chronic conditions. We encourage the Department to continue to be flexible in its consideration of what constitutes a qualifying program. For example, we assume that these programs do not have to target a particular condition, or but that on the other hand they can be targeted to select, rather than all, chronic conditions. Multiemployer plans use a variety of programs to manage chronic diseases, including case management, disease management, specialty pharmacy programs, center-of-excellence programs, transplant management benefits and other programs that are designed to lower the cost of treatment for chronic and high cost conditions for the plan and the participant, and to provide higher-quality care. The programs may be designed by a self-insured multiemployer plan to be specific to its membership, or they may be programs offered by administrators, insurers, plan coalitions or community organizations as a turn-key approach for plans that purchase or otherwise qualify to use their services.

In some cases, self-insured multiemployer plans have designed programs that use data mining to identify conditions that are prevalent in their covered population, and then design programs to address these conditions. Many plans have diabetes management programs that operate in this manner.

However, as the Department has noted, there is no one-size fits all condition management program. Consequently, the standards should be flexible for these programs. We believe it is reasonable to ask plan sponsors to maintain documentation of projected cost savings likely to be produced by the programs. Generally, plans and their service providers prepare reports documenting the program, but the actual cost savings are difficult to determine. Also, innovation comes with its own uncertainties: a plan may implement a creative, culturally sensitive program to direct participants with specific health problems to the type of care that is considered best for them, and it may turn out, after the fact, not to have saved money for the plan, or to save money only over the longer term.

We urge the Department to confirm that a plan using experimental or pilot programs like these will be eligible for the reimbursement program.

Thank you for your consideration. The NCCMP looks forward to working with the Department in the implementation of the Affordable Care Act to help it achieve our common goal of making sure America's workers have access to affordable, universal and high-quality health care. If you have any questions or would like further information about the items discussed here or about multiemployer plans in general, please feel free to call or write me, at rdefrehn@nccmp.org, (202) 756-4644,

Sincerely,



Randy G. DeFrehn
Executive Director