The ERISA Industry Committee

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Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Attention: File Code CMS−9964−P

Ladies and Gentlemen:

Section 1341 of the Patient Protection and Affordable Care Act ("ACA") imposes fees on issuers of health insurance policies and on self-insured group health plans to fund a transitional reinsurance program. The Department of Health and Human Services published a proposed rule[1] on December 7 that amends a previous regulation implementing the transitional reinsurance fee program.[2] The ERISA Industry Committee ("ERIC") is pleased to respond to HHS's request for comments regarding the proposed amendments to the transitional reinsurance fee regulation.

ERIC's Interest in the Transitional Reinsurance Fee

ERIC is a nonprofit association committed to the advancement of the employee retirement, health, incentive, and welfare benefit plans of America's largest employers. ERIC's members sponsor some of the largest private group health plans in the country. These plans provide high-quality, affordable health care to tens of millions of workers and their families.

ERIC's members are committed to, and known for, providing high quality, affordable health care. Employers do not have unlimited resources to spend on health care, however. ACA has imposed a number of expensive new benefit mandates, fees, taxes, and administrative requirements on employer health plans that were already struggling to cope with ever-increasing medical costs. Many of ERIC's members are approaching, and many have already reached, the tipping point: they cannot spend more money on health care. As a result, every additional dollar that they must spend to satisfy a new administrative requirement or pay a new fee or excise tax is a dollar that they must recover by reducing employees' health benefits.

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[1] 45 C.F.R. part 153 (proposed), 77 *Fed. Reg.* 73,118–218 (Dec. 7, 2012).

[2] HHS published the previous transitional reinsurance fee regulation as a final rule on March 23, 2012, at 77 *Fed. Reg.* 17,220–52.

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The transitional reinsurance fee is assessed for three years based on the number of individuals covered under a group health plan or insurance policy. In addition to paying the fee, ERIC's members will have to develop administrative systems that will enable them to determine the number of covered lives for a variety of group health plans covering a large and dynamic work force, including the lives of dependents, whom they do not count for purposes other than to comply with ACA's transitional fees and taxes.

Although the transitional reinsurance program is temporary, ERIC's members will have to make a significant investment at the outset to understand and comply with the new administrative requirements associated with the fee. The transitional reinsurance fee and the associated administrative costs apply at a time when ERIC's members are struggling to cope with a mounting roster of expensive health mandates. ERIC's members have a vital interest in ensuring that the method for computing the fee does not impose unnecessary administrative burdens or costs on employers.

Comments Regarding the Transitional Reinsurance Fee

The transitional reinsurance fee is designed to collect $10 billion for 2014, $6 billion for 2015, and $4 billion for 2016 (plus additional amounts for administrative expenses) to fund the transitional reinsurance program, and another $2 billion for 2014, $2 billion for 2015, and $1 billion for 2016 to reimburse the U. S. Treasury for the cost of the early retiree reinsurance program. HHS has proposed to calculate the fee as a per capita amount based on the number of enrollees in plans that must make reinsurance contributions.

The total number of reinsurance contribution enrollees will not be known until November 15, 2014, when insurance issuers and plan administrators must report this information to HHS for their covered policies and plans. HHS proposes to divide the $12.02 billion that it intends to collect for 2014 by the total reported number of reinsurance contribution enrollees in order to determine the fee that insurance issuers and self-insured group health plans must pay for each enrollee. HHS will notify the contributing entity of its reinsurance contribution amount by December 15, and the contributing entity will have 30 days after the notification to pay the transitional reinsurance fee to HHS. HHS currently estimates that the fee for 2014 might be $63 per enrollee;[3] but the fee for each enrollee could be significantly greater if the number of reinsurance contribution enrollees reported in November 2014 is less than HHS estimates.

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[3] *See* preamble, 77 *Fed. Reg.* at 73,154–55, estimating a 2014 fee of $5.25 per month for each reinsurance contribution enrollee.

1. HHS should defer collection of the $5 billion U. S. Treasury contribution beyond 2016.

HHS has requested comments on the question whether the collection of the $2 billion payable to the U. S. Treasury for 2014 should be deferred until 2016.[4] If HHS implements this proposal, the per capita fee due in (or immediately following) 2014 will be reduced by nearly 17 percent. ERIC strongly supports the proposal to defer collection of the U. S. Treasury contribution and believes that the proposal is consistent with section 1341 of ACA. ERIC urges HHS to go even further, however, and defer collection of the entire $5 billion Treasury contribution beyond 2016, in order to reduce the financial burden in the initial years of the transitional reinsurance program and to give employers and employees time to budget for a portion of the increased cost.

Many of ERIC's members sponsor self-insured group health plans that cover more than 100,000 lives. If HHS's estimate of the 2014 fee is accurate, a self-insured plan covering 100,000 lives will owe a transitional reinsurance fee of $6.3 million. Accordingly, ERIC's members face an unknown liability for 2014 that is likely to amount to many millions of dollars. They will not learn the actual amount they owe until mid-December 2014, when HHS will determine the national contribution rate and notify employers and insurance issuers of their transitional reinsurance fee. The contributing entities must pay this fee within 30 days after HHS notifies them of the amount they owe.

ERIC's members are deeply concerned at the potential magnitude of the transitional reinsurance fee, particularly when it is combined with the other fees, taxes, assessments, benefit mandates, and administrative expenses imposed by ACA. Any cost savings that employer group health plans receive from health reform will be realized years in the future, if the savings materialize at all. In contrast, the burdens and costs of compliance with ACA are real and immediate, and they fall heavily on employers in the near term.

The transitional reinsurance fee for 2014 is a particular concern. Because neither HHS nor plan sponsors will have any prior experience with the program, the national contribution rate for 2014 cannot be predicted with confidence. As a result, it will be very difficult for employers to budget for the fees that they will owe with respect to their self-insured group health plans, or for the premium increases that their health insurance issuers will impose in order to recoup the insurance-based fees. Employers must cope at the same time with the many burdens, costs, and uncertainties associated with the other significant health reform provisions that become effective in 2014, such as the shared responsibility assessments and the need to coordinate with health insurance exchanges.

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[4] *See* preamble, 77 *Fed. Reg.* at 73,154.

The concerns associated with the transitional reinsurance fee are magnified by the fact that the fee for the first year of the program is expected to be so much larger than the fee for the two following years of the program. As the total targeted collections decline from $12.02 billion for 2014 to approximately $5 billion for 2016, there will be a corresponding reduction in the transitional reinsurance fee assessed for each enrollee. HHS can provide important relief to employers and insurance issuers, without jeopardizing the purpose or operation of the transitional reinsurance program, by deferring collection of the initial $2 billion contribution to the U. S. Treasury from 2014 to a later year. Deferring the $2 billion contribution will reduce the size of the fee that is due in the initial year of the program and will diminish the impact of the uncertainty that contributing entities will face when they attempt to predict or budget for the initial fee.

Section 1341 of ACA provides that the transitional reinsurance program must collect an additional $2 billion *for* 2014, but the statute does not specify that the program must collect this amount *in* 2014.[5] HHS will comply with the statute if it computes an additional transitional reinsurance fee based on the number of reinsurance contribution enrollees reported for 2014 but does not collect the additional $2 billion fee until a later year. Accordingly, ERIC urges HHS to defer collection of the $2 billion U. S. Treasury contribution for 2014 in order to reduce the substantial burden on contributing entities in the initial year of the program.

ERIC believes, however, that HHS should not limit the deferral of the U. S. Treasury contribution to $2 billion, but should instead defer collection of the entire $5 billion. Many of ERIC's members will not be able to absorb all of the additional costs imposed by ACA, and will be forced to pass along some of these costs to their covered employees in the form of increased contributions. The front-loaded structure of the transitional reinsurance fees is especially difficult for both employers and employees to accommodate, since the fees will impose a sharp (and unpredictable) increase in costs for three years followed by an abrupt termination of the added cost.

For the employees who will bear part of this cost, as for their employers, the transitional reinsurance fee comes at the worst possible time: in the years when they are struggling to understand and adjust to the market reforms implemented as part of ACA, before they have begun to realize any cost savings that might result from those reforms. It will be ironic (and counter-productive) if a program designed to stabilize premiums in the individual market has the effect of destabilizing employee contributions under self-insured group health plans. By deferring collection of the entire $5 billion U. S. Treasury

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[5] HHS's proposed regulation already recognizes that ACA does not require the program to collect the transitional reinsurance fee *in* the calendar year for which it is computed, since the regulation permits a contributing entity to pay the transitional reinsurance fee for a given year in January of the following year (30 days after the December 15 notice date).

contribution, HHS can reduce the impact of the transitional reinsurance program on both employers and employees who are struggling to absorb the effect of market reforms.

ERIC does not believe that it is necessary for HHS to collect the deferred Treasury contribution in 2016. ERIC recognizes that the amounts earmarked to stabilize insurance premiums in the individual market ($10 billion for 2014, $6 billion for 2015, and $4 billion for 2016, plus administrative expenses) must be collected and distributed to offset excess claims in the initial years of the program if these amounts are to serve their intended purpose. In contrast, however, the additional $5 billion Treasury contribution does not play a role in stabilizing the insurance market in 2014 through 2016: instead, this contribution offsets the cost to the U. S. Treasury of early retiree reinsurance payments that have already been made.[6]

Accordingly, no reinsurance need will go unmet if the collection of this amount is delayed beyond 2016. Because the additional $5 billion is paid directly to the U. S. Treasury when it is collected, rather than paid to health insurance issuers that incur excess claims for high-risk enrollees, it is not necessary for HHS to collect the $5 billion while the system for computing reinsurance payments and distributing them to issuers is still in place.

In order to spread out the financial burden associated with the transitional reinsurance fees, and to give contributing entities more time to budget for the fees, ERIC recommends that HHS collect the $5 billion Treasury contribution over a three-year period that follows, rather than coincides with, the period in which HHS collects fees to stabilize insurance premiums in the individual market. As noted above, the statute requires HHS to collect the Treasury contribution at a rate of $2 billion *for* 2014, $2 billion *for* 2015, and $1 billion *for* 2016, but the statute does not require HHS to collect these amounts *in* the years specified, or by any particular deadline.

In order to comply with the statute, HHS should calculate the additional transitional reinsurance fee for each year based on the number of reinsurance contribution enrollees reported for that year, and should notify the contributing entity of the additional amount when HHS notifies the contributing entity of the basic reinsurance fee. The due date for the additional fee, however, would fall three years after the due date for the basic fee. Thus, for example, a contributing entity's share of the $10 billion basic fee for 2014 would be due in mid-January 2015 (30 days after the mid-December notice date), but the contributing entity's share of the $2 billion additional fee for 2014 would not be due until mid-January 2018.

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[6] *See* preamble, 77 *Fed. Reg.* at 73,154 (noting that the amount of the additional Treasury contribution matches the amount appropriated for the early retiree reinsurance program under section 1102 of ACA). HHS announced in February 2012 that it had received requests for reimbursement under the early retiree reinsurance program that exceeded the $5 billion appropriated, and it had actually distributed $4.73 billion of the appropriated funds. *See* HHS Report, *Early Retiree Reinsurance Program Status Update* (February 2012); HHS Announcement, *Update on ERRP Payment Processing* (February 17, 2012).

Under ERIC's proposed schedule, the total targeted collections under the transitional reinsurance program would be spread out over six years, with $10 billion (before collections for administrative expenses) due in January 2015, $6 billion due in January 2016, $4 billion due in January 2017, $2 billion (for 2014) due in January 2018, $2 billion (for 2015) due in January 2019, and $1 billion (for 2016) due in January 2020.

Because the $5 billion Treasury contribution would be based on reinsurance contribution enrollee counts for 2014, 2015, and 2016, ERIC's proposal would not require contributing entities to perform additional enrollee counts, nor would it require HHS to calculate additional contribution rates or provide additional notices. The amount collected for each year would conform to the requirements of the statute; only the collection date (which is not specified in the statute) would change.

2. ERIC supports the proposed amendments designed to reduce the administrative burdens on large employers.

The transitional reinsurance program lasts only three years, from 2014 through 2016. Especially in light of the short-term nature of the program, ease of administration is a vital consideration. Employers should not have to spend more of their scarce health-care resources than absolutely necessary in order to develop systems and train staff to calculate and pay the temporary reinsurance fee.

ERIC appreciates and strongly supports the steps HHS has taken to reduce the administrative burdens that the transitional reinsurance fee program imposes on sponsors of self-insured plans. The following rules are particularly important to large employers, and ERIC urges HHS to retain these rules in the final regulation:

- The rule providing for centralized collection of the fee by HHS in all States, including States that operate their own reinsurance program.

- The rule requiring collection of the fee annually rather than quarterly (or more frequently).

- The rule clarifying that the fee applies only to enrollees who receive major medical coverage under a group health plan or insurance policy.

- The decision to use a national per capita uniform contribution rate to calculate the fee, rather than a fee based on the cost of coverage.

- The decision to permit many of the same participant-counting techniques that are used to determine the Patient-Centered Outcomes Research Trust Fund ("PCORTF") fee.

3. The regulation should make clear that States may not collect additional fees from self-insured plans.

The proposed regulation at § 153.220(d) permits States to collect additional reinsurance contributions to provide funds for reinsurance payments or administrative expenses under the State's reinsurance program. The preamble of the proposed regulation explains, however, 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 . . . Federal law generally preempts State law that relates to an ERISA-covered plan."[7]

ERIC strongly agrees with this interpretation of ACA. ERIC believes that it is important to make this point clear in the regulation, where it will have the force of an authoritative pronouncement by the agency,[8] and not merely in the preamble. The States are inconsistent in their interpretation and application of ERISA's preemption provision, and ERIC's members do not wish to litigate this issue in order to establish that their self-funded group health plans are exempt from any additional State collections. Accordingly, ERIC urges HHS to amend the proposed regulation at § 153.220(d)(1) (in the portion of the regulation that precedes clause (i)) to read as follows:

> "(d) Additional State collections. If a State establishes a reinsurance program:
> (1) The State may elect to collect <u>from a health insurance issuer (but not from a self-insured group health plan), with respect to reinsurance contribution enrollees who reside in the State,</u> more than the amounts that would be collected based on the national contribution rate set forth in the annual HHS notice of benefit and payment parameters for the applicable benefit year to provide: [etc.]"

4. The regulation should define "major medical coverage."

The proposed regulation at § 153.400(a)(1)(i) makes clear that a plan is required to pay the transitional reinsurance fee only to the extent that the plan provides "major medical coverage." The term "major medical coverage" is discussed in the preamble to the proposed regulation, but is not defined in the regulation itself.

ERIC believes that the provision limiting the transitional reinsurance fee to major medical coverage correctly exempts from the fee a number of programs that provide

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[7] 77 *Fed. Reg.* at 73,151.

[8] Courts generally defer to an agency's implementing regulation unless the position adopted in the regulation is unreasonable. *See, e.g., Chevron U.S.A., Inc. v. Natural Resources Defense Council Inc.,* 467 U.S. 837 (1984). An agency's statement in the preamble of a regulation does not receive the same degree of deference. *See, e.g., Hecker v. Deere & Co.,* 569 F.3d 708 (7th Cir. 2009).

important benefits to employees and their families. For example, the proposed regulation excludes most wellness programs, disease management programs, employee assistance programs, and Medicare supplemental coverage from the transitional reinsurance fee, since these programs do not provide major medical coverage. These broad exclusions are important: employers might have to reduce the benefits they provide under these programs if the programs were subject to the transitional reinsurance fee or were forced to fit within a narrower exemption.

Because of the importance of this exclusion, ERIC believes that the regulation should define the term "major medical coverage." ERIC urges HHS to add the following definition to the proposed regulation at § 153.20:

> *"Major medical coverage* means health coverage, which may be subject to reasonable enrollee cost sharing, for a broad range of services and treatments (including diagnostic and preventive services as well as medical and surgical conditions) provided in various settings, including inpatient, outpatient, and emergency room settings. Coverage that is limited in scope (for example, dread disease coverage, hospital indemnity coverage, stand-alone vision coverage, or stand-alone dental coverage) or limited in extent (for example, coverage that is not subject to Public Health Service Act section 2711 and its implementing regulations, or coverage that is secondary to Medicare coverage) would not be major medical coverage."

5. HHS should clarify that the enrollee counting methods exclude plan participants who do not have major medical coverage.

The proposed regulation at § 153.405 provides a number of methods for counting covered lives of "reinsurance contribution enrollees." As explained in the preceding comment, the proposed regulation at § 153.400(a)(1)(i) makes clear that a plan is required to pay the transitional reinsurance fee only *to the extent* that the plan provides "major medical coverage." Accordingly, ERIC believes that the intent of the counting rules is (and should be) to count only those enrollees who receive major medical coverage under the plan on the date when the count is made.

For example, an employer's self-insured group health plan might provide major medical coverage to active employees and retirees who are not yet eligible for Medicare, and the same plan might also provide coverage secondary to Medicare to Medicare-eligible retirees or disabled individuals. Because the supplemental coverage provided to individuals who receive primary coverage from Medicare is not "major medical coverage," the employer would not include these individuals in any count of covered lives for purposes of reporting the number of reinsurance contribution enrollees in the plan. If the employer in this example wished to use the Form 5500 method to count reinsurance contribution enrollees, the employer would count the total number of participants reported on the plan's Form 5500 at the beginning and end of the year, and would

subtract from those totals the number of reported participants who received primary coverage from Medicare on the applicable date.

In order to clarify the counting rules, ERIC requests that HHS make two changes in the proposed regulation:

- Revise the definition of "reinsurance contribution enrollee" in § 153.20 to read as follows: "Reinsurance contribution enrollee means an individual who has major medical coverage under a plan for which reinsurance contributions must be made pursuant to § 153.400."

- Add a sentence at the end of proposed § 153.405(b) to read as follows: "For purposes of any of the counting methods in paragraphs (d) or (e), "covered lives," "lives covered," "participants covered," or similar terms refer only to lives or participants who are reinsurance contribution enrollees on the date as of which the count is made."

6. The regulation should provide a "single life" rule for covered HRAs.

The proposed regulation at § 153.400(a)(2)(v) appropriately provides that a health reimbursement arrangement ("HRA") will not be treated as a covered plan for purposes of the transitional reinsurance fee if the HRA is integrated with an insured or self-insured group health plan. The proposed regulation apparently contemplates, however, that at least some stand-alone HRAs will be subject to the transitional reinsurance fee if the HRAs provide major medical coverage.

An HRA generally provides a fixed annual credit that an employee may use to reimburse medical expenses for the employee, his spouse, or his dependents. An employer generally has no way to determine how many "covered lives" may receive reimbursement from the HRA. In recognition of this fact, the final regulation implementing the PCORTF fee provides a special counting rule for HRAs, which allows the employer to treat any stand-alone HRA as covering only one life.[9] ERIC urges HHS to adopt the same counting convention for purposes of the transitional reinsurance fee.

7. The regulation should identify a group health plan by reference to the COBRA rules.

The enrollee counting rules require an employer to use only one counting method to determine the number of reinsurance contribution enrollees in a single group health plan, but the rules allow the employer to apply different counting methods to different plans. The proposed regulation at § 153.405(g) also specifies that an employer must

[9] Treas. Reg. § 46.4376-1(c)(2)(vi).

aggregate separate group health plans in certain circumstances. In order to apply the enrollee counting rules accurately, an employer must be able to determine in what circumstances different health coverage options offered to its employees constitute a single group health plan. At present, the proposed regulation does not indicate which arrangements HHS will treat as a single group health plan for purposes of the enrollee counting rules.[10]

To illustrate this problem, ERIC notes that many large employers maintain umbrella welfare plans encompassing a number of different benefit arrangements. The umbrella plan structure allows the employer to consolidate plan documents, participant communications, and administrative functions, so that it can operate the plan more efficiently. An umbrella welfare plan might include both self-insured health coverage options and fully-insured health coverage options covering different groups of employees, as well as benefits unrelated to health care (such as disability insurance, life insurance, or severance pay). Although employers file a single Form 5500 for their umbrella welfare plans, they separately track enrollment in the component plans that make up the umbrella program, and they generally apply the health care continuation coverage ("COBRA") rules separately to different group health coverage options offered under the program.

In other contexts, HHS has used the COBRA rules to determine whether an employer's group health coverage constitutes separate plans or a single plan.[11] Under the COBRA rules, group health arrangements maintained by the same employer generally are treated as a single group health plan unless the instruments governing the arrangements designate them as separate plans and the employer operates them as separate plans. When HHS, the Department of Labor, and the Treasury Department issued proposed regulations in 2004 interpreting the pre-ACA health plan mandates, the agencies used the COBRA rules as the basis for identifying separate group health plans.[12] ERIC urges HHS to apply the same principle in order to determine whether self-

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[10] The final regulation published in March 2012 includes a definition of "group health plan" in § 153.20, but that regulation is not helpful is resolving the question whether multiple benefit arrangements will be treated as a single plan. The final regulation refers to the definition of "group health plan" in 45 C.F.R. § 144.103, which in turn refers to the definition of "group health plan" in 45 C.F.R. § 146.145(a); the latter definition includes a placeholder for a rule determining the number of plans, but states that this rule is "reserved." ERIC is concerned that the transitional reinsurance program will be over before the necessary guidance is issued under this definition (although, as we explain below in note 12 and the accompanying text, HHS has issued a proposed rule under this section that would adopt the definition ERIC advocates).

[11] *See, e.g.,* 45 C.F.R. § 149.2 (defining "group health plan" for purposes of the early retiree reinsurance program); 42 C.F.R. § 423.882 (defining "group health plan" for purposes of the Medicare Part D retiree drug subsidy).

[12] *See, e.g.,* 26 C.F.R. § 54.9831-1(a)(2) (proposed); 29 C.F.R. § 2590.732(a)(2) (proposed); 45 C.F.R. § 146.145(a)(2) (proposed). The proposed regulation at § 146.145(a)(2) would supply the missing rule for determining the number of plans, which is "reserved" under the regulation incorporated in the transitional reinsurance program definitions. See note 10, above. Because this regulation is only proposed (and is unlikely to be finalized before the transitional reinsurance program becomes effective), however, we urge
(continued…)

insured and insured arrangements constitute a single plan that is subject to the restrictive counting rule in § 153.405(f).

8. The regulation should permit employers to disaggregate plans that offer both self-insured and insured coverage options to different groups.

If a single group health plan offers both a self-insured coverage option and an insured coverage option for a benefit year, the proposed regulation at § 153.405(f) provides that the plan administrator must use one of two methods applicable to insured plans to count the plan's reinsurance contribution enrollees. The plan administrator apparently must use the same method to count enrollees in the insured option as well as in the self-insured option. In addition, if the plan offers more than one insured option (for example, insured HMOs or insurance policies covering employees in widely separate geographic regions), the plan administrator apparently must apply the same counting method to all insured options, even if each health insurance issuer has chosen to use a different method to count enrollees under similar policies that the issuer offers on a stand-alone basis.

If the consolidated counting rule in § 153.405(f) applies, the plan administrator is not permitted to use the "Snapshot Factor Method" or the "Form 5500 Method" for the self-insured coverage option, even though these two counting methods (which allow the employer to estimate the number of covered dependents) are likely to be significantly more workable for most self-insured plans. In addition, although the insurance issuer apparently remains responsible for paying the transitional reinsurance fee with respect to participants who are covered by the insured coverage option, the plan administrator is not permitted to use the "Member Months Method" or the "State Form Method" to count reinsurance contribution enrollees in the insured portion of the plan, even though the health insurance issuer might have chosen to use one of these methods for the rest of its book of business.

In practice, a plan administrator will look to the health insurance issuer to provide a count of reinsurance contribution enrollees for each insured option offered under a group health plan. The proposed regulation at § 153.405(f) would require the plan administrator to coordinate with each unrelated health insurance issuer and to mediate an agreement as to which single method the different issuers will use to count enrollees in, for example, an HMO in California, a minimum premium arrangement in Illinois, and a Blue Cross plan in Florida. Each of the unrelated health insurance issuers that offers these arrangements might have chosen to use a different permissible counting method for that issuer's major medical policies, for business reasons applicable to that issuer. It is unlikely that the issuers will be willing to administer different counting methods for discrete groups under employer group health plans; it is even more unlikely that the plan

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HHS to use the COBRA definition directly in the regulation interpreting the transitional reinsurance program.

administrator will be able to arrive at an accurate enrollee count without the issuers' assistance. Accordingly, the consolidated counting rule is unworkable as applied to group health plans with multiple insured options.

The consolidated counting rule in the proposed regulation at § 153.405(f) imposes a significant and unwarranted constraint on the group health plans maintained by large employers. A large employer often maintains a single group health plan that is predominantly self-insured, but the employer might offer a few fully-insured HMO options or other insured options to employees working in locations where an insurance issuer has a robust provider network or is attractive to employees for other reasons. There is typically no overlap between the employees covered by the plan's self-insured options and the employees covered by the insured options. The health insurance issuer necessarily maintains a separate count of the lives covered by the plan's insured options, since the issuer needs this information in order to calculate premiums for the insured options.

We recognize that HHS generally wishes to require each group health plan to select a single counting method, but the proposed regulation does not explain why it is either necessary or desirable to impose this rule on a group health plan that includes both self-insured and insured coverage options for different groups of enrollees. An employer should not be forced to use the "Actual Count Method" or the "Snapshot Count Method" for self-insured options covering hundreds of thousands of lives merely because a few hundred participants in the same plan have elected to participate in an insured HMO. Similarly, the issuer or issuers responsible for the insured coverage options in the plan should not be precluded from using the "Member Months Method" or the "State Form Method" merely because the insured options are included in a group health plan that also offers self-insured coverage options, and different issuers should not be forced to adopt the same counting method merely because they insure different groups under the same plan.

We recognize that an employer could restructure its group health plan so that the insured coverage options and the self-insured coverage options were offered under separate plans. This step, however, would force the employer to abandon the administrative efficiencies that originally induced the employer to combine the offerings in a single plan. HHS should not force employers to adopt an inefficient structure for their group health plans in order to accommodate the transitional reinsurance fee, especially when one considers that the fee will be in effect for only three years.

If HHS adopts a definition of "group health plan" that incorporates the COBRA rules for identifying separate plans, as ERIC has recommended, this step will do much to address the problem of insured and self-insured health coverage options. In many cases, employers will treat insured and self-insured health coverage options covering different employee groups as separate plans for COBRA purposes, with the result that these options will not be treated as components of a single plan under the transitional reinsurance program's consolidated counting rule.

Even if insured and self-insured health coverage options are part of a single group health plan, however, ERIC believes that the plan administrator and health insurance issuers should not be required to consolidate these options and use a single enrollee counting method under the transitional reinsurance program. The requirement that enrollees with self-insured coverage and enrollees with insured coverage be counted together would be contrary to the rules that apply in determining the PCORTF fees, which permit the sponsor of a self-insured plan to ignore the enrollees with insured coverage when the sponsor counts the enrollees in the plan.[13]

ERIC urges HHS to revise the proposed regulation at § 153.405(f) to allow an employer to disaggregate self-insured coverage options and insured coverage options offered under a single group health plan, and to treat these options as if they were separate group health plans for purposes of the counting rules. Similarly, ERIC urges HHS to make clear that insurance issuers may treat insured coverage options offered by different issuers under a single group health plan as if they were separate group health plans for purposes of the counting rules, so that each issuer may choose which counting rule to apply to its own offering. These permissive disaggregation rules will provide accurate enrollee counts to HHS without imposing unnecessary restrictions on employers or health insurance issuers.

9. The plan aggregation rules should be permissive rather than mandatory, and should apply only to overlapping coverage.

Although the rules for counting enrollees generally apply on a plan-by-plan basis, the proposed regulation at § 153.405(g) provides a mandatory aggregation rule for situations in which two or more plans maintained by the same plan sponsor collectively cover one or more of the same employees. These multiple-plan rules presumably are intended to prevent double-counting of employees who are covered simultaneously under two (or more) group health arrangements maintained by the same plan sponsor.

ERIC agrees that the transitional reinsurance program should not require double-counting of enrollees in any circumstance. In their current form, however, the multiple-plan rules present significant disadvantages. For example, they require the employer to use the same enrollee counting method for all of the aggregated plans, as if they were a single plan. If a fully-insured plan is included in the aggregated group, the employer must use either the "Actual Count Method" or the "Snapshot Count Method" for the entire aggregated plan, even if the plan is predominantly self-insured.

In addition, if an aggregated plan includes one or more fully-insured coverage options, the plan (rather than the health insurance issuer) is required to pay the transitional reinsurance fee for the insured options as well as for the self-insured options. As a practical matter, ERIC believes that health insurance issuers will include the

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[13] Treas. Reg. § 46.4376-1(c)(2)(vii).

transitional reinsurance fee in their premiums for an entire line of business, without regard to whether the issuer is excused from paying the premium for certain employee groups under the multiple-plan rule. Accordingly, ERIC believes that the aggregation requirement will in effect force the plan to pay the transitional reinsurance fee twice: once to HHS under the multiple-plan rule in § 153.405(g), and again to the issuer as part of the health insurance premium charged by the issuer.

The PCORTF regulation permits, but does not require, a plan sponsor to aggregate multiple self-insured plans for purposes of performing enrollee counts. If the plan includes fully-insured coverage options, however, the enrollees in those options must be counted separately.[14] In contrast, the proposed multiple-plan rule in the transition reinsurance fee regulation requires the plan administrator to aggregate all coverage options under multiple plans and to count all enrollees using the same method, regardless of whether the coverage is fully-insured or self-insured. Accordingly, the multiple-plan rule in § 153.405(g) is inconsistent with HHS's objective to reduce the administrative burden associated with the transitional reinsurance fee by allowing contributing entities to use the same counting methods that they use for purposes of the PCORTF fee.

In order to address these problems, ERIC proposes several modifications to the multiple-plan aggregation rules.

a. The aggregation rules should be permissive rather than mandatory.

In many cases, only a few employees will receive coverage simultaneously under more than one group health plan. For example, a single plan sponsor might maintain separate group health plans for employees in two different job classifications. Most employees will work only in one job classification or the other, and thus will be covered by only one of the two group health plans, but a few employees might spend part of their time working in more than one job classification, and thus might be covered under more than one group health plan.

Because of the disadvantages associated with the plan aggregation rule (some of which we have described above), a plan sponsor might prefer to double-count the few employees who have overlapping coverage rather than to aggregate the plans in order to count each covered employee only once. The plan sponsor should be permitted to decide whether or not to apply the plan aggregation rules in any situation in which two or more plans provide overlapping coverage.[15] If the plan sponsor elects not to aggregate the

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[14] Treas. Reg. § 46.4376-1(b)(1)(iii).

[15] ERIC notes that the aggregation rules are, in effect, already permissive in some circumstances. If several related employers (for example, a parent company and its wholly-owned subsidiaries) participate in one or more group health plans, the employers can choose to designate a single plan sponsor (in which case the plans will be aggregated under § 153.405(g)(2)(vii)) or can elect not to designate a single plan sponsor (in which case the plans will be disaggregated under § 153.405(g)(2)(viii)).

plans, the result will be that HHS will receive extra transitional reinsurance fees with respect to the enrollees who are double-counted. This result will promote the overall purpose of the program, which is to make funds available to stabilize premiums.

b. Employers should never be required to aggregate insured and self-insured coverage.

Even if HHS does not make the plan aggregation rules permissive in all circumstances, as ERIC has recommended, HHS should always permit a plan sponsor to disaggregate the self-insured coverage and the insured coverage under group health plans that otherwise would be aggregated. As ERIC explained above, it is neither necessary nor reasonable to aggregate self-insured coverage with insured coverage in most cases. Many of the disadvantages of the proposed plan aggregation rules (such as the restrictions on permissible counting methods and the shifting of fees from health insurance issuer to plan) apply principally when self-insured coverage and insured coverage are aggregated.

c. The aggregation rules should apply only to overlapping coverage.

ERIC urges HHS to make clear that the mandatory aggregation rule applies only if the separate plans *simultaneously* cover the same employees. A large employer might maintain a number of group health plans for different businesses or different geographic locations. An employee transferred between businesses or locations might receive coverage sequentially from more than one group health plan during the year, but the employee would not receive coverage from more than one group health plan on any given date during the year. Similarly, if the employer maintains separate group health plans for active employees and retired employees, an employee who retires during the year will be covered under the active plan in the first part of the year and under the retiree plan during the second part of the year, but will not be covered simultaneously under both plans.

The counting and averaging rules will automatically avoid double-counting employees in most of these situations, since an employee will be counted in one plan or the other (but not both) on any given counting date. Accordingly, the proposed regulation should make clear that the rules for multiple plans do not apply to this situation.

d. The aggregation rules should not apply to excluded plans or coverage.

The proposed regulation at § 153.405(g)(3) states that a plan sponsor is not required to include in an aggregated group of plans any plan that provides only excepted benefits or prescription drug benefits. ERIC believes that this provision is both unnecessary and misleading.

The provision is unnecessary because the aggregation rule by its terms applies only to plans "that collectively provide *major medical coverage* to the same covered lives," and neither excepted benefits nor prescription drug benefits constitute major medical coverage. The provision is misleading because, by specifically excluding only these two

types of plans, it implies that other types of plans (such as HSAs, wellness programs, and the like) that also are exempt from the transitional reinsurance fee might nevertheless be subject to aggregation. ERIC requests that HHS revise this proposed regulation to state clearly that no plan is required to be aggregated except to the extent that the plan is otherwise subject to the transitional reinsurance fee pursuant to § 153.400(a)(1).

10. HHS should, in the future, comply with the Administrative Procedure Act by allowing a meaningful comment period.

When an agency promulgates legislative rules, or rules pursuant to authority delegated by Congress, the Administrative Procedure Act requires the agency to provide the public with adequate notice of the proposed rule and a meaningful opportunity to comment on the rule.[16] Executive Order 12866, which provides for review of agency rulemaking by the Office of Management and Budget, states that a proposed rule "in most cases should include a comment period of not less than 60 days."[17]

HHS published its proposed Notice of Benefit and Payment Procedures for 2014, including the proposed amendments to the transitional reinsurance fee program, in the *Federal Register* on December 7. The notice of proposed rulemaking establishes a deadline of December 31 for comments. The proposed rule is 100 pages long in the *Federal Register* (383 pages in typescript), and it includes a number of complex and detailed requirements that materially affect a wide variety of participants in the health insurance markets. The rules implementing the transitional reinsurance fee are intended to coordinate with the final regulation implementing the PCORTF fee, which appeared in the *Federal Register* on December 6. Accordingly, the proposed amendment to the transitional reinsurance fee regulation must be considered in conjunction with the final PCORTF regulation.

Although ERIC recognizes that HHS is under great pressure to issue rules implementing ACA in a very short time, ERIC believes that a comment period lasting only 15 business days is not sufficient to give the public a meaningful opportunity to comment. This is especially true when the comment period falls in December, since many individuals and businesses face the added pressures of the holiday season and the end of the calendar year. Although ERIC has done its best to provide thoughtful comments that will help HHS shape the final rule, the short comment period has prevented ERIC from consulting its members and exploring issues and alternatives to the extent that it would have wished.

HHS has generally responded in a constructive way to public comments, particularly comments that explain how the rules can be improved to avoid imposing unnecessary administrative burdens or costs on affected parties. We think that the final

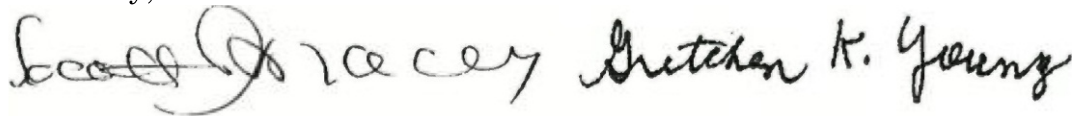
[16] 5 U.S.C. § 553.

[17] Exec. Order No. 12866, § 6(a), 58 *Fed. Reg.* 51,735 (Oct. 4, 1993).

rules implementing ACA would benefit further from carefully-considered comments developed after an appropriate opportunity to review HHS's proposals and understand how they will affect the complex benefit programs maintained by large employers. Thus, we reserve the right to submit supplemental comments on the proposed transitional reinsurance fee regulation after December 31 if ERIC's members bring additional issues to our attention, and we trust that HHS will consider supplemental comments that are submitted within 60 days after the publication date of the proposed regulation. In addition, we respectfully request that HHS provide a more reasonable comment period in future rulemaking, in order to give affected parties a meaningful opportunity to comment.

ERIC appreciates the opportunity to provide comments on the proposed regulation implementing the transitional reinsurance fee program. If HHS has any questions concerning our comments, or if we can be of further assistance, please let us know.

Sincerely,



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