ERIC

The ERISA Industry Committee

December 20, 2013

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9954-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: RIN 0938-AR89 (Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015)

Ladies and Gentlemen:

The ERISA Industry Committee ("ERIC") is pleased to respond to the request of the Department of Health and Human Services ("HHS") for feedback on the proposed HHS Notice of Benefit and Payment Parameters for 2015 (the "proposed regulations").[1]

ERIC'S INTEREST IN ACA REPORTING

ERIC is a nonprofit association committed to the advancement of the employee retirement, health, and other welfare benefits of America's largest employers. ERIC's members sponsor some of the largest private group health plans in the country. ERIC's members are committed to, and known for, providing high-quality, affordable health care. Our members expend considerable resources to maintain plans that cover many disparate populations across a wide range of geographic areas and that operate in all states and territories. These plans provide health care to millions of workers and their families.

SUMMARY

As discussed below, ERIC's recommendations include:

- Any change to HHS's long-standing position on application of the reinsurance fee should apply fairly and impartially to all self-insured group health plans.
- Detailed information about the impact of any re-calculation of the reinsurance fee should be provided to the regulated community.
- Amounts to be collected from plans for the reinsurance fee should be offset by any excess contributions from prior years.

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[1] Dep't of Health and Human Services, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015*, 78 Fed. Reg. 72322 (Dec. 2, 2013).

- The open enrollment period for the Exchanges should begin no later than November 1st in 2014.

OVERVIEW

The transitional reinsurance fee is assessed for three years based on the number of individuals covered under a group health plan or insurance policy. 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 that is paid to the U. S. Treasury (collectively, the "reinsurance fee"). HHS has proposed to calculate the fee as a per capita amount based on the number of covered lives in plans subject to reinsurance contributions.

Although the transitional reinsurance program is temporary, ERIC's members must 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 not only does the method for computing the fee not impose unnecessary administrative burdens or costs on employers, but that it is perceived to be imposed on a fair and impartial basis.

DETAILED COMMENTS

I. Any change to HHS's long-standing position on application of the fee should apply fairly and impartially to all self-insured group health plans.

In numerous publications of proposed and final regulations, HHS has consistently interpreted the Affordable Care Act ("ACA") to provide that the reinsurance fee applies to health insurance issuers and self-insured group health plans.[2] Despite the consistency of its position, HHS now proposes to exempt self-insured, self-administered group health plans from the reinsurance fee.

HHS dramatically changed its interpretation of the ACA, exempting self-insured, self-administered group health plans from the fee for 2015 and 2016 (but not 2014) because they do not involve a "commercial book of business".

By exempting self-insured, self-administered group health plans from this obligation for 2015 and 2016, HHS is, in fact, shifting the fee that would have been paid by self-insured, self-administered group health plans to the other group health plans and health insurance issuers that continue to be burdened by the fee.

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[2] Dep't of Health and Human Services, *Proposed Rule for Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment*, 76 Fed. Reg. 41930 (Jul. 15, 2011); Dep't of Health and Human Services, *Final Rule for Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment*, 77 Fed. Reg. 17220 (Mar. 23, 2012); Dep't of Health and Human Services, *Proposed Rule for Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014*, 77 Fed. Reg. 73118 (Dec. 7, 2012); Dep't of Health and Human Services, *Final Rule for Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014*, 78 Fed. Reg. 15410 (Mar. 11, 2013).

A. HHS's position should be based on risk pooling and risk shifting, instead of the use of a third-party administrator.

Despite its previously consistent position to the contrary, HHS now proposes to change its interpretation of the ACA, an interpretation not compelled by the statute. The ACA states that the reinsurance fee must be paid by health insurance issuers and group health plans described in regulations issued by HHS.[3] The ACA also directs the method of collection of the reinsurance fee by stating that health insurance issuers and TPAs will be responsible for submitting the payments on behalf of group health plans.[4]

HHS asserts that it is changing its interpretation of the statute because there is more than one possible interpretation of the statute. As the agency interpreting the statute, however, HHS must adopt one of the two possible interpretations and apply it consistently. HHS can interpret the statute either way, but the statute cannot reasonably be read to mean one thing in 2014 and something entirely different in 2015 and 2016. Further, the agency acts arbitrarily when it fundamentally changes its interpretation of the statute partway through the reinsurance program. The proposed change is particularly inappropriate as it favors a particular sub-group of plans at the expense of other plans, which now must bear the burden of the reinsurance fee that HHS has shifted to them.

HHS indicates that it believes that a self-insured plan with a third-party administrator ("TPA") more closely resembles an insured plan.[5] HHS states in the preamble to the proposed regulations that it is basing its decision on ACA § 1341(b)(3)(B) and that "reinsurance contribution amounts are to reflect a 'commercial book of business'." HHS's reliance on ACA §1341(b)(3)(B) is misplaced. That section of the ACA references a "commercial book of business" only in the context of fully insured health plans. It states "The method under this paragraph shall be designed so that—(1) 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." (Emphasis added.) Thus, it is clear that self-funded plans, whether or not they use a TPA, cannot be considered part of a commercial book of business.

There is no indication that Congress intended to exempt self-insured, self-administered plans from the category of plans subject to the fee, nor is there any other obvious reason why this particular subset of self-insured plans is more worthy of an exemption from the fee than any other group of self-insured plans. The language in ACA §1341(b)(3)(B) is simply not relevant to the interpretation of whether self-insured group health plans are subject to the reinsurance fee.

Whether a plan resembles an insured plan should be based on the defining characteristics of insured plans. As many cases have held, the key "insurance" functions are risk pooling and risk

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[3] ACA § 1341(b)(3) (stating "The Secretary shall include in the provisions under paragraph (1) the method for determining the amount each health insurance issuer and group health plan described in paragraph (1)(A) contributing to the reinsurance program under this section is required to contribute…").
[4] ACA § 1341(b)(1)(A) (stating "the Secretary…shall include provisions that enable States to establish and maintain a program under which—(A) health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments…").
[5] 78 Fed. Reg. at 72340.

distribution.[6] Self-insured plans are fundamentally different from insured plans with respect to their key characteristics – risk pooling and risk distribution. In self-insured plans, employers are financially responsible for the risks related to providing coverage. For fully-insured plans, the insurer – not the employer – bears these risks. The use of a TPA does not affect these fundamental elements of health plans.

Thus, the statute in no way compels HHS to exempt only self-insured, self-administered plans from the obligation to pay reinsurance contributions. Furthermore, if HHS were to feel obligated to distinguish between fully-insured and self-insured plans, then the defining line must be drawn between these two groups as a whole, given the fundamental difference between the two with respect to the key characteristics of risk pooling and risk distribution.

Further, HHS's re-interpretation of the governing ACA statutory provision leads to the proposed imposition of a reinsurance fee on self-insured, self-administered group health plans for 2014, but not 2015 and 2016, a distinction clearly not raised in the language of the statute itself. It is difficult to reconcile the statutory foundation for the imposition of the reinsurance fee in 2014 with its convenient disregard the following two years.

B. HHS's new position creates an uneven playing field.

Additionally, the position in the proposed regulations suggesting an exemption from the reinsurance fee for self-funded plans that are self-administered is patently unfair to companies with plans that are self-funded but not self-administered. While we recognize that groups of plans with certain defining characteristics tend to be self-administered, the vast majority of large self-insured group health plans use a TPA.

Large companies provide health benefits to their employees for a variety of reasons; one reason is that they need to provide health benefits to remain competitive in recruiting and retaining employees. Under the proposed regulations, some companies would bear the expense of the reinsurance fee in 2015 and 2016, while others - those that participate in a self-insured, self-administered plan - would not. In some industries, this distinction would be particularly pronounced. As a result of the position taken by HHS in the proposed regulations, companies using a TPA to administer their self-insured group health plans would be placed at a competitive disadvantage where there is no compelling policy reason to do so.

ERIC strongly urges HHS to exempt all self-insured group health plans from payment of the reinsurance fees. In the event that HHS is unwilling to do so, ERIC strongly encourages HHS to revoke its proposed exemption of self-insured, self-administered group health plans given that its "new" interpretation : (1) is not compelled by the statute; (2) directly conflicts with final regulations that were issued pursuant to the Administrative Procedure Act only a few months ago;[7] (3) results in

[6] *See, Helvering v. LeGierse*, 312 U.S. 531 (1941). ERISA preemption cases also focus on risk pooling and distribution when determining whether a statute "regulates insurance" for purposes of ERISA. For example, the Supreme Court has established that a state law must substantially affect the risk pooling arrangement between the insurer and the insured to avoid ERISA preemption. *Kentucky Association of Health Plans v. Miller*, 538 U.S. 329, 341-42 (2003).

[7] HHS issued final regulations on March 11, 2013 that defined "contributing entity" to include self-insured, self-administered group health plans. 45 C.F.R. § 153.20. Additionally, the preamble to the final regulations stated that "A self-insured, self-administered group health plan without a TPA or ASO contractor would make its reinsurance

a competitive advantage for companies that participate in plans that are self-administered; and (4) creates an undue burden on the other plans that are subject to the reinsurance fee.

II. Detailed information about the impact of any re-calculation of the reinsurance fee should be provided to the regulated community.

The President has acknowledged the importance of minimizing the regulatory burden on American businesses and has encouraged HHS and other departments and agencies to provide open and transparent information to the public.[8] Although the preamble to the proposed regulations provides some information regarding the calculation of the reinsurance fee, it is significantly limited and does not directly address the implications of excluding self-administered, self-insured plans from payment of the fee.

ERIC requests that HHS provide the regulated community with more detailed information regarding the impact of any re-calculation of the reinsurance fee. In particular, ERIC urges HHS to disclose the types of plans on which they expect to impose the reinsurance fee (e.g., fully-insured, self-insured, self-administered, single-employer, etc.), the number of participants expected for each of those plans (and for those plans that were excluded), and the per participant charge.

III. Amounts to be collected from plans for the reinsurance fee should be offset by any excess contributions from prior years.

The ACA provides for the collection of $10 billion for 2014, $6 billion for 2015, and $4 billion for 2016 (plus additional amounts for administrative expenses) from issuers and self-funded plans to offset a portion of the costs of issuers in the individual market attributable to very large claims. HHS has established a formula for determining the amount of reinsurance payments to be paid to issuers, which they expect will result in an appropriate allocation of the funds collected.[9]

In the final regulations issued for the 2014 reinsurance fee, HHS indicated that excess contributions collected in one year would be used to augment reinsurance payments in subsequent years.[10] HHS is now proposing to modify that rule, such that if the reinsurance fees collected for a particular year do not equal the requested payments, then the corresponding reinsurance payments would be adjusted up or down to reflect the amounts collected.[11] Thus, for instance, if $10 billion of reinsurance fees were collected in 2014 but issuers requested only $9 billion under the prescribed formulas, then under this proposal, the $1 billion in "excess contributions" would be allocated to insurers in 2014 according to the prescribed formulas.

We believe that this re-allocation of "excess" reinsurance contributions is inappropriate. Given the substantial burden placed by the reinsurance fee on large employers – equaling millions of dollars in some cases – excess contributions should not simply be doled out to issuers that have already received the amounts to which they are entitled under the formula. This is especially true given that HHS also proposes to lower the attachment point (from $60,000 to $45,000) used to define

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contributions directly". Dep't of Health and Human Services, *Final Rule for Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014*, 78 Fed. Reg. 15410, 15455 (Mar. 11, 2013).

[8] *Improving Regulation and Regulatory Review*, Executive Order 13563 (Jan. 18, 2011).

[9] 78 Fed. Reg. at 72344.

[10] 78 Fed. Reg. at 15470.

[11] 78 Fed. Reg. at 72343.

those claims that are subject to reimbursement for 2014, which in and of itself will result in larger reinsurance payments to issuers.

If plans have paid reinsurance fees for 2014 or 2015 in excess of the amount requested by issuers in accordance with the prescribed formula, ERIC urges HHS to provide that the amount to be collected from plans in 2015 or 2016, respectively, be correspondingly reduced to reflect any excess contributions from the prior year. Thus, in the example above, $1 billion in "excess contributions" would not be re-allocated to issuers but, rather, would be rolled over from 2014 to 2015. As a result, plans would be charged only $5 billion ($6 billion contribution minus $1 billion rollover) in total reinsurance contributions for 2015 because of the rollover.

IV. The open enrollment period for the Exchanges should begin no later than November 1st.

For the 2015 benefit year, HHS proposes that the open enrollment period for the Exchanges run from November 15, 2014, through January 15, 2015.

ERIC members are concerned that the timing of the beginning of the Exchanges' open enrollment period will disadvantage workers, retirees, and their families. Many employers end their plans' open enrollment periods by the beginning of November, if not before. Employers with many thousands of employees, retirees, spouses, and dependents to enroll and many different plan and payroll systems to coordinate must allow sufficient time between the end of the open enrollment period and the beginning of the new plan year to make sure enrollment information is entered correctly in all relevant systems, and to contact enrollees as necessary clear up any discrepancies. In addition, employers that offer prescription drug coverage to Medicare-eligible individuals often wish to begin their open enrollment period in October (or earlier) so that it will overlap with the Medicare Part D open enrollment period commencing on October 15.

Workers and retirees who are eligible for coverage under employer health plans with earlier open enrollment periods will need to make health care choices for themselves and their families well before November 15. If open enrollment for the Exchanges does not commence until November 15, these workers and retirees will not have sufficient time to compare the options available in their employers' plans with those available to them on the Exchanges. In order to give eligible individuals sufficient time to evaluate their options, ERIC recommends that the open enrollment period for the Exchanges begin no later than November 1st.

V. HHS should adopt the definition in the proposed regulations of "major medical coverage".

The proposed regulations provide that reinsurance contributions are required to be made for persons with major medical coverage.[12] HHS proposes to define "major medical coverage" as "health coverage for a broad range of services and treatments provided in various settings that provides minimum value…"[13] As a result, limited-scope and excepted plans are not subject to the fee.

ERIC supports this approach taken by HHS and urges HHS to include this language in the final regulations.

[12] Prop. Reg. § 153.400(a)(1).
[13] Prop. Reg. § 153.20.

VI. The payment of the reinsurance fee should not be required more than once for the same covered life.

HHS indicates in the proposed regulations that the payment of the reinsurance fee is not required more than once for the same covered life.[14] ERIC appreciates the efforts of HHS to reduce the burdens on companies that offer a number of valuable benefits to their workers.

ERIC applauds HHS's position that the payment of reinsurance fee is not required more than once for the same covered life and urges HHS to maintain this position in the final regulations.

VII. Plans should have the option to pay the reinsurance fee in one or two payments for each year.

In the proposed regulation, HHS proposes that a portion of the reinsurance fee will be collected at the end of the calendar year rather than at the beginning. For 2014, the $63 per covered life reinsurance fee will be subdivided into two parts: $52.50 payable in January of 2015 and $10.50 payable in the fourth quarter of 2015.

ERIC members appreciate the approach proposed by HHS. Some of our members note, however, that they will need to accrue for the liability in any event and would prefer to make one payment to avoid the potential for errors.

As a result, ERIC encourages HHS to maintain its current approach of allowing the payment of the reinsurance fee to be split into two payments, while allowing contributing entities the option to elect to consolidate the payments.

VIII. HHS audits of contributing entities should be delayed for the first year.

HHS indicates in the preamble to the proposed regulations that it may audit contributing entities to assess their compliance with these contribution rules.

Large employers are working diligently to comply with all of the new requirements under the ACA. Given the amount of time and effort that must be spent on compliance, ERIC members are concerned that their resources could be diverted from compliance issues in order to handle any audits. As a result, ERIC encourages HHS to delay any audits for at least for the first year to enable plans to focus on compliance. Furthermore, ERIC urges HHS to be cognizant of the fact that new systems can often result in unexpected difficulties through which ERIC members will need to work.

IX. HHS should consider options relating to the transitional policy that would not impose additional burdens on large employers and their plans.

The Administration has indicated that insurers (if permitted by the states) may de-cancel the policies of individuals who wish to keep their non-ACA compliant health coverage. The preamble to the proposed regulations indicates that HHS seeks comments on alternate ways of helping to compensate insurers for any unexpected losses that might be incurred as a result of this transitional policy.

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[14] Prop. Reg. § 153.400.

While ERIC recognizes the challenges posed by this situation, our members are already struggling with the burdens placed on them by the ACA. As a result, ERIC urges HHS to consider alternatives that would not impose additional burdens on large employers and their plans.

ERIC appreciates the opportunity to provide comments on the proposed regulations. If HHS has any questions concerning our comments, or if we can be of further assistance, please contact us at (202) 789-1400.

Sincerely,

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