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Submitted electronically via e-mail to Sharon.Arnold1@cms.hhs.gov

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7501 Wisconsin Ave.
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Re: Comments Regarding Implementing Standards Related to the Transitional Reinsurance Program

Dear Ms. Arnold:

We write on behalf of the American Benefits Council ("Council") to provide comment regarding the transitional reinsurance program, as implemented by section 1341 of the Patient Protection and Affordable Care Act, as amended (the "Affordable Care Act"), 77 Fed. Reg. 17,220 (Mar. 23, 2012) (the "Final Regulations"). We request consideration of these comments as you develop the draft HHS Notice of Benefit and Payment Parameters for issuance later this fall.

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans.

Section 1341 of the Affordable Care Act requires the Department of Health and Human Services ("HHS"), in consultation with the National Association of Insurance Commissioners ("NAIC"), to implement standards enabling each state to establish and maintain a transitional reinsurance program. Health insurance issuers and plan administrators (on behalf of self-insured group health plans) will generally be required

to make a contribution ("Fee") to the transitional reinsurance program, calculated based on the total number of individuals covered by a plan with respect to which the contributions must be made, for the three-year period beginning January 1, 2014. These contributions will be used to make reinsurance payments to health insurance issuers that cover high-risk individuals in the individual market (excluding grandfathered health plans) for such three-year period.

The Fee is a priority concern for Council members, given the significant cost of the Fee (preliminary estimates of the Fee are approximately $60 per covered life for 2014) and implementation challenges, as discussed below. While we appreciate the issuance of the Final Regulations, we urge HHS to consider addressing certain open issues with regard to the Fee through additional "Frequently Asked Questions" or other sub-regulatory guidance. Below are issues for your consideration. In several instances, we have included specific recommendations. We further request that any future guidance include an opportunity for stakeholder comment.

FEE LIABILITY

Clarification is needed regarding whether ultimate Fee liability with respect to self-insured plans will lie with the self-insured plan itself or whether a third party administrator (if any) will be liable for the Fee. The statute and the Final Regulations provide that the third party administrator pays the Fee "on behalf of" a group health plan but do not expressly identify the party that is actually liable for the Fee.

ALLOCATING RESPONSIBILITY FOR THE FEE AMONG MORE THAN ONE THIRD PARTY ADMINISTRATOR

Questions have arisen regarding whether more than one third party administrator could be liable for collecting and remitting the Fee where the coverage at issue involves the services of more than one third party administrator (*e.g.*, where one third party administrator provides administrative services regarding major medical benefits and another third party administrator provides administrative services for pharmacy benefits).

Guidance, including guidance as to whether a plan sponsor may contract with its third party administrators to apportion or otherwise delegate liability, would be helpful on this point. We urge HHS to issue guidance confirming that the plan sponsor may designate the administrator(s) that will be responsible for paying the Fee.

LIABILITY FOR FAILURE TO COLLECT AND REMIT FEE

Additional guidance is needed as to whether, with respect to a self-insured plan, a third party administrator and/or the self-insured plan itself can be held liable for the failure by the third party administrator to collect and remit the Fee. If such liability exists, guidance regarding the determination of liability and the penalty would be helpful.

EMPLOYER CERTIFICATION OF GROUP HEALTH PLAN STATUS

Employer business practices vary widely in defining what constitutes a single group health plan for various purposes under federal law. To eliminate any confusion among and between plan sponsors and third party administrators regarding whether a given arrangement constitutes a single group health plan for purposes of the Fee, we urge HHS to issue additional guidance providing that an employer's characterization is controlling with respect to whether a plan is a single group health plan for purposes of the Fee.

ELIMINATING DOUBLE-COUNTING

As noted above, employer practices in defining what constitutes a single group health plan vary widely. As a result, it is often the case that what one employer treats as a single group health plan may be treated as two separate group health plans by a different employer.

For example, one employer might treat major medical coverage and a wellness program as a single group health plan whereas another employer treats an identical arrangement as two separate group health plans.

The Department of the Treasury ("Treasury") acknowledged this reality in its guidance relating to the Patient-Centered Outcomes Research Institute fee ("PCORI Fee") and has set forth proposed rules that would eliminate the possibility of double-counting with respect to the PCORI Fee. Guidance is needed clarifying that a covered life is to be counted only once for purposes of assessing the Fee.

EAPS, WELLNESS PROGRAMS, DISEASE MANAGEMENT PROGRAMS

We request clarification that the Fee does not apply to employee assistance plans ("EAPs"), wellness programs, disease management programs and other types of coverage that include limited amounts of medical care benefits within the meaning of section 213 of the Internal Revenue Code of 1986, as amended.

RETIREE-ONLY COVERAGE

Guidance is needed regarding whether retiree-only plans and other plans for former employees are excepted from the Fee. We urge HHS to except retiree-only coverage from the Fee in light of the strong public policy reasons for encouraging employers to sponsor retiree-only plans and other plans for former employees.

COBRA CONTINUATION COVERAGE

Additional guidance would be helpful to clarify whether the Fee is intended to be assessed based on persons receiving coverage as a result of COBRA.

COLLECTION OF FEES FROM SELF-INSURED PLANS

We strongly support the change made in the Final Regulations that provides that Fees from self-insured plans will be collected by the Secretary, not by the States or by entities on their behalf. As affirmed in the Final Regulations, this approach should be used "whether or not a state elects to establish a reinsurance program." This is very important to the sponsors and administrators of these plans in order to reduce administrative burdens. Similarly, we note that section 1341(b)(3)(B) of the Affordable Care Act states that, "[n]othing in this subparagraph shall be construed to preclude a State from collecting additional amounts from issuers on a voluntary basis." We believe that this provision indicates quite clearly that Congress recognized that, while states might seek to collect additional amounts, any additional amounts collected as part of the transitional reinsurance program can only be collected from issuers and not self-funded plans.

DETERMINING THE PER CAPITA FEE AMOUNT

In order to determine the per capita Fee amount, HHS will need to make certain determinations, including (i) what types of coverage are subject to the Fee, and (ii) how to count reinsurance contribution enrollees. In addition, we believe that the calculation of the per capita Fee amount for the purpose of determining the national rate should be based on data for the relevant population of covered lives from contributing entities in 2014. We further request that information regarding these determinations be made available for public comment when the Notice of Benefit and Payment Parameters is issued this fall.

It is our understanding that many reinsurance programs determine assessment amounts at year end so that the prior year's claims experience can be accurately determined. We believe that such an approach should be considered for the transitional reinsurance program so that insurers and third party administrators on behalf of self-insured plans are not over-assessed for payment amounts. This approach would not preclude periodic advance reinsurance payments in 2014 being made by the Secretary for eligible reinsurance expenses and would assure that funds collected from contributing entities match the actual expenses of the program.

POTENTIAL ADJUSTMENT OF CONTRIBUTION AMOUNTS

It seems possible, if not likely, that, notwithstanding the best efforts of HHS, the aggregate Fee amount collected for a given year may be greater or less than the aggregate amount mandated by statute. Guidance is needed regarding whether HHS intends to alter contribution amounts mid-year or in the next year to correct for an over- or under-collection, given the statutory mandate to collect a specified aggregate amount each year.

COUNTING OF REINSURANCE CONTRIBUTION ENROLLEES

Although the determination of the number of reinsurance contribution enrollees may appear straightforward at first glance, in reality, it is quite difficult, especially

considering that enrollees may move in and out of coverage during a given calendar year. Similar to the guidance provided by Treasury with regard to the PCORI Fee, guidance is needed regarding how plan sponsors and third party administrators will calculate the number of reinsurance contribution enrollees under a plan.

DEDUCTIBILITY OF FEE

We note that there is no provision in the statute limiting the deductibility of the Fee assessed under section 1341 of the Affordable Care Act. We recommend that HHS work with Treasury and the Internal Revenue Service to issue guidance affirming that the Fee is deductible in order to eliminate any uncertainty on this matter.

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Thank you for considering these comments related to the transitional reinsurance program. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,

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