December 31, 2012

Submitted electronically via http://www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9964-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Proposed Rule Regarding HHS Notice of Benefit and Payment Parameters for 2014

Dear Sir/Madam:

We write on behalf of the American Benefits Council ("Council") to provide comment regarding the proposed rule entitled "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014," 77 Fed. Reg. 73,118 (Dec. 7, 2012). Specifically, our comments relate to the portion of the proposed rule that addresses the provisions and parameters for the transitional reinsurance program as implemented by section 1341 of the Patient Protection and Affordable Care Act, as amended (the "Affordable Care Act").

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

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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.

As noted in prior Council comments regarding the transitional reinsurance program, the Fee is a priority concern for Council members, given its significant cost (which is proposed to be $63 per covered life for 2014) and implementation challenges. The requirements of the transitional reinsurance program will substantially impact employer-sponsored group health plans (whether insured or self-funded). This is because the Fee will be imposed directly on self-funded employer-sponsored group health plans, and will be indirectly imposed on insured employer-sponsored group health plans as a result of insurers passing their Fee costs through to the plans they insure. As a result, employers are concerned about whether they will be able to afford to continue to provide affordable health care coverage to employees and retirees.

We appreciate the guidance HHS and other agencies have provided to date, especially with respect to the following items set forth in the recently proposed rule, among other things:

- the provision for an annual collection of the Fee late in the year, as opposed to a quarterly collection;
- the clarification that the Fee only applies to major medical coverage, for which we believe there is strong statutory support;
- the development of counting rules, including confirmation that a plan may use data from the preceding year's Form 5500 in order to determine the number of covered enrollees for the current year;
- the imposition of a single national rate across the country, as opposed to state-by-state rates;
- the decision to have all Fee amounts collected by the HHS Secretary, as opposed to individual states having the option to collect Fee amounts, and the subsequent elimination of state-by-state reporting requirements;
- clarification that nothing in the Fee guidance necessarily allows states to collect additional contributions in addition to those collected by the HHS Secretary;
- the development of plan aggregation rules;
- the clarification that self-funded group health plans may remit the Fee directly to

HHS or may utilize a third party administrator to do so on its behalf;

- the Internal Revenue Service's acknowledgment of the deductibility of the Fee by health insurance issuers as an ordinary and necessary business expense; and

- the Department of Labor's acknowledgment that the Fee would constitute a permissible plan expense for purposes of Title I of the Employee Retirement Income Security Act ("ERISA").

Despite this helpful guidance, we urge HHS to continue to consider addressing certain open issues regarding the Fee in final regulations relating to the HHS Notice of Benefit and Payment Parameters for 2014 and/or sub-regulatory guidance, as appropriate, as discussed below.

Future Modification of Collections: We recognize that the statute directs the HHS Secretary to collect specific total Fee amounts from contributing entities (i.e., $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016). We further recognize that the proposed rule has identified attachment points based on amounts estimated to achieve that purpose. However, in the event that the amount disbursed through the transitional reinsurance program is less than the collected amount, we urge HHS to consider whether amounts less than those specified in the statute should be collected in 2015 and 2016 to reflect the lower amount of claims expenditures while still achieving the program's goal of helping to stabilize premiums in the individual insurance market place.

Possibility of Delaying Collection of Additional Amounts: The recently proposed rule specifically requests comments regarding whether HHS has the authority to delay collection of the 2014 installment of the additional payments to the US Treasury until 2016 ("Additional Amounts"). We interpret the statute to permit such a delay in collection, given that the statute only provides that the amounts be contributed for 2014, 2015 and 2016, rather than in 2014, 2015, and 2016. This is in contrast to the statutory language regarding the Fee collections, which indicate the Fee Collections must be calculated in 2014, 2015 and 2016, respectively. We also note that as a practical matter, these Additional Amounts may be distinguished from the Fee collections. Whereas the Fee collections must be made in the specified years, because they are being disbursed through the transitional reinsurance program for eligible claims incurred in those years, the Additional Amounts are by statute not to be used for the transitional reinsurance program, but rather contributed to the U.S. Treasury, and, thus, do not correspond with disbursements in specified years.

Applicability of the Additional Amounts to Self-Funded Plans: In connection with the above issue, we note that Affordable Care Act section 1341(b)(3)(B)(iv) states that

the Additional Amounts must be contributed by "issuers." Group health plans are referenced in Affordable Care Act section 1341(b)(3)(A), and thus seem to be contributing entities for purposes of the Fee; however, any reference to group health plans has been omitted in describing liability for the Additional Amount. Specifically, section 1341(b)(3)(B)(iv) states:

> (iv) in addition to the aggregate contribution amounts under clause (iii), each **issuer's** contribution amount for any calendar year under clause (iii) reflects its proportionate share of an additional $2,000,000 for 2014, an additional $2,000,000 for 2015, and an additional $1,000,000 for 2016. (Emphasis added.)

Given the express reference to "issuers," and the absence of any similar reference to "group health plans," a plain reading of the statute suggests that only issuers – and not group health plans – should be responsible for paying Additional Amounts. To the extent that HHS agrees with this plain language reading of the statutory language, then the per capita national contribution rate should be re-calculated to take into account that only issuers are responsible for paying the Additional Amounts (presumably resulting in two separate per capita national contribution rates – one rate for issuers and another for self-funded plans).

Retiree Coverage: We appreciate the guidance in the recently proposed rule, which provides that coverage for retirees and other former employees is only subject to the Fee to the extent such coverage is primary to Medicare based on the application of Medicare Secondary Payer ("MSP") rules. Given the complexity of the application of the MSP rules, we encourage HHS to consider issuing sub-regulatory guidance in the form of questions-and-answers that could provide specific examples of the application of the Medicare Secondary Payer rules to retiree coverage and other plans for former employees (for example, regarding pre-age 65 retiree coverage where the individual is covered by employer-sponsored coverage but may also be covered by Medicare by reason of End Stage Renal Disease "ESRD") or because of disability).

In addition, we request confirmation that retiree pharmaceutical benefit plans (including employer group waiver plans ("EGWPs") and other employer-sponsored Medicare Part D plans) are not subject to the Fee. Under the proposed regulations, the general requirement is that contributing entities must make reinsurance fees annually, except to the extent that such a plan "is not major medical coverage." Further, the plan aggregation rules provide that coverage that consists solely of prescription drug coverage is not major medical coverage. Accordingly, we believe retiree pharmaceutical benefit plans should be excepted, as they do not provide major medical coverage. However, confirmation in this regard would be appreciated.

Continuation Coverage: We note that the recently proposed rule does not address whether the Fee applies to continuation coverage, including coverage per the

Consolidated Omnibus Budget Reconciliation Act ("COBRA"), state-mandated continuation coverage, and/or voluntary continuation coverage. Clarification as to whether the Fee applies to continuation coverage is needed.

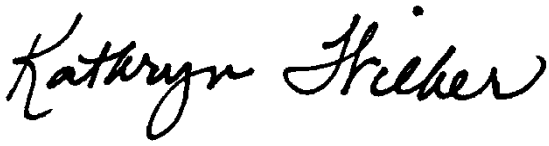
Prescription Drug Coverage: The preamble to the recently proposed rule makes clear, indirectly, that prescription drug coverage is not subject to the Fee, as it does not constitute major medical coverage. However, this conclusion is reached only through a careful read of the preamble, and we urge HHS to provide additional confirmation that prescription drug coverage does not constitute major medical coverage and is not subject to the Fee.

Deductibility of Fee and Treatment as ERISA Plan Expense: Guidance issued by the IRS concurrently with the recently proposed rule provides that health insurance issuers will be able to treat payment of the transitional reinsurance contributions as tax-deductible as an ordinary and necessary business expense. Additionally, the preamble to the proposed rule states that the Department of Labor has determined that the Fee may be charged back to an ERISA plan as a reasonable plan expense. These clarifications are appreciated and will also help to reduce the overall cost to employers and plans.

* * *

Thank you for considering these comments related to the proposed rule entitled "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014." 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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