

NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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Internal Revenue Service
CC:PA:LPD:PR (Notice 2012-32)
Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Comments regarding IRS Notices 2012-31,32 and 33

Dear Friends:

Comments Regarding Notices 2012-31, 2012-32 and 2012-33

The Treasury Department and the Internal Revenue Service have requested comments concerning the Affordable Care Act reporting requirements added through a new Section 6055 of the Internal Revenue Code (IRC) for persons that provide minimum essential coverage to an individual. Notice 2012-32 notes that these persons would include health insurance issuers, government agencies, and employers that sponsor self-insured plans. Notice 2012-32 specifically requests comments regarding whether special rules should apply when minimum essential coverage is provided through a voluntary employees' beneficiary association (VEBA) or other type of welfare benefit fund, which is required to report under § 6055. The Notice also requests comments as to whether any specific concerns should be taken into account when minimum essential coverage is provided under a multiemployer plan.

Additionally, the Department has published Notice 2012-33, which requests comments on reporting under IRC Section 6056 by large employers subject to the employer shared responsibility penalty (IRC Section 4980H). This provision of the ACA requires reporting of certain information on employer-provided health care coverage provided on or after January 1, 2014, and the furnishing of related statements to employees, beginning in 2015.

Finally, the Department published Notice 2012-31, which requests comments on several possible approaches to determine whether health coverage under an eligible employer-sponsored plan provides minimum value within the meaning of IRC Section 36B.

These comments are submitted on behalf of the National Coordinating Committee for Multiemployer Plans.

Background

The National Coordinating Committee for Multiemployer Plans (the NCCMP) is the only national organization devoted exclusively to protecting the interests of the more than 20 million workers, retirees, and their families who rely on multiemployer plans for health and other welfare benefits. The NCCMP's purpose is to assure an environment in which multiemployer plans can continue their vital role in providing benefits to working men and women. The NCCMP is a nonprofit, non-partisan organization, with members, plans, and plan sponsors in every major segment of the economy, including in the airline, building and construction, entertainment, health care, hospitality, longshore, manufacturing, mining, retail food, service and trucking industries.

When employees receive coverage through a multiemployer plan, the plan pools contributions from all employers and pools the employees' service with all of the employers for eligibility purposes, so that the "industry" rather than the specific employer, which provides the coverage to people who have the requisite degree of service in the industry. When coverage is provided under a multiemployer plan, the individual employer does not know whether an employee actually achieved eligibility under the health plan; the period of coverage for which such coverage was in force; whether the individual has single or family coverage; what benefit option the employee has selected; or the value of the health care coverage. In addition, it is complicated for individual employers to determine what share of the employee's coverage during the year was attributable to which employer and what the level of each employee's coverage was.

To further develop these concerns, there is no way for an individual employer to know whether its union-represented employees in a multiemployer plan actually achieved eligibility under the health plan or what the value of the coverage was. This problem is particularly acute in mobile industries like construction, longshore, or building maintenance and entertainment, where it is clear that no one employer is responsible for the coverage that many of the people who work for them receive.

The issue is further complicated by the fact that an employer contributes at the same rate for everyone in the bargaining unit, or everyone in the same job classification. There is no differential in the contributions between people with individual coverage and those with family coverage (and in almost all cases, no explicit employee contribution). From the employee's perspective, the contributions to the health and welfare fund are a matter of allocating a portion of the bargained wage package, in which case, the employee contributes the entire amount. An employer would not know whether an employee is receiving coverage as a single person, single + one, or family. All an employer knows is how much it contributed with regard to each person covered by an agreement that requires contributions to the fund for each hour worked (or a variation on that model).

Employer contributions are made to multiemployer plans based on the collective bargaining agreement. The contributions are generally remitted to the plan on "remittance forms" which list the employee, the hours worked (or applicable standard for contributions to be made), and the contribution amount required under the relevant collectively bargained agreement. Once the contributions are remitted to the plan, the contributing employer has fulfilled its obligation under the agreement and is "out of the business" of providing benefits. In fact, the economies of scale

and simplified administration of the multiemployer plans are primary considerations by many employers in agreeing to participate in such plans.

Finally, most of the plans are on a calendar year basis, but a significant portion are not. This will obviously complicate the process of alignment with the calendar-year schedule for reporting purposes.

Reporting Obligations under the Affordable Care Act

Section 6055 requires persons that provide minimum essential coverage to file annual returns that report:

- (1) the name, address, and taxpayer identification number of the primary insured and each other individual covered under the policy or plan,
- (2) the dates each individual was covered under minimum essential coverage during the calendar year,
- (3) in the case of health insurance coverage, whether the coverage is a qualified health plan offered through an Exchange,
- (4) if the coverage is a qualified health plan offered through an Exchange, the amount (if any) of any advance payment of the premium tax credit under § 1412 of the Affordable Care Act, or of any cost-sharing reduction under § 1402 of the Affordable Care Act for each covered individual, and
- (5) other information that the Secretary requires.

For minimum essential coverage provided by a health insurance issuer through an employer's group health plan the reports must also include:

- (6) name, address, and Employer Identification Number (EIN) of the employer maintaining the plan,
- (7) the portion of the premium to be paid by the employer, and
- (8) any other information that the Secretary may require for administering the tax credit under § 45R (credit for employee health insurance expenses of small employers).

Section 6056(b) requires the following information to be reported to the IRS by large employers

- (1) Name and Employer Identification Number (EIN) of the applicable large employer;
- (2) Certify whether the applicable large employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in § 5000A(f)(2)) and, if so, certify

- a. The duration of any waiting period (as defined in § 6056(b)(2)(C)) with respect to such coverage;
 - b. The months during the calendar year when coverage under the plan was available;
 - c. The monthly premium for the lowest cost option in each enrollment category under the plan; and
 - d. The employer's share of the total allowed costs of benefits provided under the plan.
- (3) The number of full-time employees for each month of the calendar year;
- a. For each full-time employee, the name, address, and taxpayer identification number (TIN) of the employee and the months (if any) during which the full-time employee (or any dependents) were covered under the eligible employer-sponsored plan; and
- (4) Include such other information as may be required by the Secretary of the Treasury.

Discussion

I. Simplify and reconcile the reporting obligations between Sections 6055 and 6056

As is evident by the repetition in the lists of required reporting under these IRC Sections, the reporting obligations as set forth in the statute are at the same time both repetitive and confusing. We suggest that the reporting obligations should be consolidated and simplified to provide clear and easy-to-follow directions for the reporting entity. The lists of required data elements should be well defined and clear, so that administrators and plan sponsors can easily identify the required elements.

The list of elements should be clarified for the common office person; a summary with bullets for information to report and/or a checklist would be helpful. Plan sponsors will need to determine whether their systems can pull the required information out, or if special programs will be required (e.g., do they currently store the required information). The bullets and/or checklists would help identify what plan sponsors currently capture and what needs to be reported. If programming is needed, significant lead-time should be given in the regulations to allow plan sponsors to assure that systems are in place that can collect the required data.

For example, the list of data elements in Notices 2012-32 and 2012-33 are similar but not exact. One Notice refers to dates each individual was covered under minimum essential coverage during the calendar year. However, the second refers to "months" of coverage. One methodology for reporting length of time of coverage should be settled upon so that plan sponsors do not need to report different but similar information.

Similarly, plan sponsors that provide group health plan coverage should not be required to report on information that they do not know or control. Specifically, it is important to clarify that only insurers need to report on coverage related to plans under a Health

Insurance Exchange. Plan sponsors that do not provide coverage through an Exchange should not be required to report on any issues related to coverage under an Exchange. For example, if an employee or dependent opts-out of a health plan and decides to obtain coverage under an Exchange, the plan sponsor would have no way of knowing about this, and should have no reporting obligations for that coverage.

- II. Simplify the reporting obligations with respect to collection of information on dependents. Many multiemployer group health plans do not collect social security numbers for dependents, particularly children. While certain Medicare reporting laws, e.g., Section 111, require that social security numbers be reported for dependents over the age of 45, there are no requirements that dependent SSNs be collected for other purposes. Moreover, the reporting of dependent SSNs is not necessary for purposes of administering the Affordable Care Act.

We suggest that the Treasury Department and Internal Revenue Service make data reporting obligations consistent with those that already exist. Specifically, this would mean that the name, address and SSN for individuals other than the participant would not be required unless they are required under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173).¹ Under the Section 111 rules, reporting of SSN or HICN information is only required for individuals covered in a GHP age 45 through 64 who have coverage based on their own or a family member's current employment status. We suggest that the reporting and procedures under Section 111 should significantly inform the Treasury Department's implementation of the ACA reporting requirements so that the government can achieve efficiencies of scale and not significantly burden plan sponsors.

Moreover, we suggest that the manner in which the Section 111 requirements have been phased in should be reviewed. The Centers for Medicare & Medicaid Services understood that plan sponsors did not generally collect SSNs on dependents, and assured that the requirements were implemented in a phased-in manner, to allow collection procedures to be implemented. However, since the Section 6055 and 6056 rules appear to require a more broad collection scope, additional time should be allowed for the requirements to be implemented.

- III. Permit insurers to satisfy the requirements for all plan sponsors with insured benefit options

Notice 2012-32 states, "If health insurance coverage is provided by a health insurance issuer and consists of coverage provided through a group health plan of an employer, it is anticipated that the regulations would make the health insurance issuer responsible for the reporting." The NCCMP supports the position that health insurance issuers that provide insured coverage to participants in an employer-sponsored plan should be responsible for fulfilling the reporting obligations under IRC Section 6055. However, we believe that the regulations should also require health insurance issuers that provide insured coverage to participants in a multiemployer plan should also be required to fulfill the reporting

¹ <http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/index.html?redirect=/MandatoryInsRep/>

obligations on behalf of the plan's board of trustees. This would require the regulation to specifically refer to the plan sponsor of the group health plan, not simply to the "employer."

Guidance will also be necessary as to how reporting should be provided for plans that insure only a portion of the coverage, e.g., a self-insured plan that contracts with an insurer for insured medical coverage only.

- IV. The regulations should provide the flexibility for multiemployer plan administrators to step into the shoes of contributing employers to allow them to meet their reporting obligations

Multiemployer plans are not expressly mentioned in either IRC Section 6055 or 6056. However, the regulations should provide flexibility for multiemployer plans to step into the shoes of contributing employers to permit them to satisfy their reporting obligations. As noted previously, contributing employers are responsible for remitting contributions to the multiemployer fund based on the hours worked by the individual worker. They are not, however, responsible for determining whether the individual has health coverage, or for what period of time.

In addition, the terms of plan coverage are set by the multiemployer fund's Board of Trustees, not by the contributing employer. Consequently, issues relating to plan terms, such as the waiting period, would not be reported or controlled by the contributing employer.

- V. The regulations should provide the flexibility to adjust reporting requirements to accurately reflect the terms of coverage under a multiemployer plan

The regulations should provide flexibility for multiemployer plans with respect to several of the data elements in the statute, as these elements relate only to coverage under a single employer plan and are not relevant to a multiemployer plan.

First, multiemployer plans should not be required to distinguish and report whether a participant is a full-time employee. Most multiemployer plans do not provide benefits based on full-time or part-time employment. Rather, it provides coverage based on the number of hours worked in the industry. To the extent that reporting is provided by a multiemployer plan, the plan should be able to report on all covered employees and not have to distinguish which are full-time employees.

Second, the multiemployer plan should not be required to report monthly premium for the lowest cost option in each enrollment category under the plan and the employer's share of the total allowed costs of benefits provided under the plan. Multiemployer plans do not charge monthly premiums for coverage. Instead, they collect contributions from employers and provide coverage based on hours worked by the employee. Monthly "premiums" are not even used with respect to self-insured multiemployer plans. Similarly, multiemployer plans do not compile information regarding the "employer's share" of the allowed costs of benefits provided under the plan. Many multiemployer plans provide coverage with

no employee premium, but with employee cost sharing. The plan could report the actuarial value of the plan based on guidance to be provided on setting “minimum value” for employer plans, but it could not provide information on an “employer share” of coverage. Consequently, these two elements should not be required for multiemployer plans that report under Section 6056 on behalf of contributing employers.

The multiemployer plan and its administrator will not automatically know which employers are applicable large employers and therefore subject to the reporting requirements of Section 6056, as contributions are generally required only for that portion of an employer’s workforce within the bargaining unit subject to the contributions. Multiemployer plans will need to collect information from contributing employers certifying whether they are an applicable large employer – this could include requiring contributing employers to provide information with each remittance form stating whether they are an applicable large employer for the time period for which the remittance report is submitted. Multiemployer plans should be entitled to rely on the determination and/or certification of a contributing employer as to whether the employer is an applicable large employer for reporting purposes.

- VI. The Treasury Department and IRS should issue regulations providing that multiemployer plans may use one of several alternative approaches to ascertain that the plan provides minimum value.

Notice 2012-31 proposes three approaches to determining minimum value: using an actuarial value or minimum value calculator to be made available from the Department of Health and Human Services, an array of design-based safe harbors, and for plans with nonstandard features that preclude use of the calculators, an appropriate certification by a certified actuary. We support the flexibility of this approach, which appears to allow plan sponsors to easily determine minimum value in most cases, but allows flexibility to obtain actuarial certification when plans have nonstandard features. Regulations should provide that multiemployer plans may use these approaches as well.

Conclusion

Thank you for the opportunity to provide comments on this important issue. We will be pleased to provide any additional information that you might find useful.

Respectfully submitted,



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