

**NATIONAL HEALTH CARE SYSTEM REFORM & LABOR-MANAGEMENT,  
MULTIEMPLOYER HEALTH AND WELFARE TRUST FUNDS:  
CONCERNS REGARDING PENDING HEALTH REFORM LEGISLATION  
AND PROPOSALS**

**September 3, 2009**

The multiemployer community has been and continues to remain supportive of the efforts by President Obama and the Congress to reform the national health care system.

However, in developing reform legislation, it is crucial to understand that joint labor-management, multiemployer health and welfare trust funds are simply pools of workers' money held in trust under federal law to provide the workers and their dependents with medical, hospital and other health benefits coverage as well as other vital employee benefits.

These trust funds are funded by collectively bargained "employer" contributions for which covered workers explicitly tradeoff wages, dollar-for-dollar, through the collective bargaining process. The workers pay the full cost of their and their dependents' coverage. All costs—including benefits and administrative expenses—are paid from the pool of workers' money.

If the trust fund's costs increase, despite the trustees' best efforts at cost-containment, the burden falls directly on the workers in the form of lower wages and/or reduced benefits. Increases in the costs of a health and welfare trust fund typically create a need for higher collectively bargained contribution rates, which reduce wage rates or preclude wage rate increases. If contribution rates cannot be increased or increased sufficiently, the board of trustees may have to reduce benefits or tighten eligibility rules.

Our health and welfare trust funds are not insurance companies motivated by profit; to the contrary, the funds are non-profit, tax-exempt trusts. The trust funds are not single employer health plans whose terms and conditions are unilaterally set by company executives and that can draw on the company's treasury whenever they need money. To the contrary, the trust funds are pools of workers' money governed by joint labor-management board of trustees who are legally required to operate the fund for the sole and exclusive benefit of the participants (covered workers) and their beneficiaries (dependents) in accordance with ERISA's strict fiduciary standards.

Faced with persistent, systemic health care cost inflation over the past 20 years, our health and welfare funds have endeavored to develop innovative means for cost containment including preferred provider arrangements, promoting preventive care and wellness, engaging in disease management, and forming group purchasing coalitions to maximize bargaining power. These serious efforts have made a difference. But, they have not been enough to contain costs sufficiently because most of the causes of inflation in health care costs are beyond the funds' control, including: costs attributable to preventable medical errors; unrestrained proliferation of medical technology; the inefficiencies of the fee-for-service system; the failure of the system to adequately coordinate care of individuals with multiple chronic conditions; and unfair cost

shifting by irresponsible employers and by government programs.

It has been our hope that national health care system reform legislation will put in place sensible measures to control the drivers of health care system cost inflation, and that our health and welfare trust funds, and the workers and families they cover, will realize cost savings in the short-run and long-run.

### **1. “Insurers Tax” / “Excess Benefits” Tax**

The “health insurers” tax being considered by the Senate Finance Committee would be, as practical matter, a tax on workers covered by health and welfare trust funds. Health and welfare trust funds that are self-funded (as a great many are) would be directly subjected to the tax. Funds that are insured by health insurance policies would be impacted by the tax too; the insurer would pass-through the tax to the trust fund in the form of higher insurance premiums.

In both cases, the tax burden would be borne by the trust funds’ covered workers in the form of lower wages and/or reduced benefits. The tax or the higher insurance premiums paid by a trust fund would have to be paid from the trust fund’s assets—the pool of workers’ money—like all other administrative expenses. And, as described above, increases in the costs of a health and welfare trust fund typically create a need for higher collectively bargained contribution rates which reduce wage rates or preclude wage increases.

The proposed tax has been referred to by some Senators and media as a tax on insurance companies and employers. But, to the extent that the tax applies to self-funded multiemployer health and welfare funds, it is a tax on the covered workers, not an insurance company, nor an employer. The fund’s assets, the workers’ money, would necessarily be used to pay the tax or higher insurance premiums.

There have been various reports as to the benefits value that will be deemed “excess” and trigger the tax, and whether adjustments will be made to reflect geographical and demographical variations in cost for the same benefits. It is important to realize in setting the tax trigger amount that (a) 2013 benefit costs will certainly be higher than 2009 costs in the normal course of health care cost inflation, and (b) the reform legislation itself will substantially increase the benefit and administrative costs of health plans including health and welfare trust funds.

Health and welfare trust funds’ benefit costs vary greatly even for the same benefit package. The costs vary according to regional differences in health care costs. They vary according to the health status of the participants and beneficiaries. They vary according to the health risks inherent in the covered work (*e.g.* building and construction vs. office work vs. longshore, etc...). They vary according to the number of retirees who are covered by the trust funds (usually at self-payment rates that are subsidized by the collectively bargained contributions made for active workers). It is simply wrong for economists to theorize that health and welfare trust funds with high costs are excessively “insuring” the workers and families they cover. Construction workers are not going to tradeoff any more take-home pay for health coverage than they need,

regardless of what economists and academicians may theorize. Comparisons to a “Goldman Sachs type” health plan are way off the mark and simply inappropriate.

Workers covered by the health and welfare trust funds will see an “insurers tax” as a tax on them. And, based on the 2008 Presidential election campaign and comments from the White House since then, their expectation is that middle class workers will not be subjected to higher taxes, particularly health care taxes to pay for others’ health plan coverage. The recent comment by President Obama that workers should not be taxed to pay for the health care coverage for others is well-known. The tax would be very upsetting to the workers and the trust funds’ trustees.

## **2. Other Assessments (Taxes) On Health And Welfare Trust Funds**

- (a) The House’s Tri-Committee bill, *America’s Affordable Health Choices Act of 2009* (HR 3200), would amend the Internal Revenue Code to impose on the sponsors of group health plans, including self-funded and insured plans, an annual assessment (tax) to help fund a Health Care Comparative Effectiveness Research Trust Fund starting in 2013. The tax would be a “fair share per capita amount” multiplied by the average number of covered lives under the plan (indexed for medical inflation).

This would be a tax on the workers covered by health and welfare trust funds. Health and welfare trust funds that are self-funded (as a great many are) would be directly subjected to the tax.

As for trust funds that are insured by health insurance policies, it appears that the tax would be imposed on the “plan sponsor” which, in the case of a multiemployer health and welfare trust fund, is the labor-management board of trustees, according to ERISA. That means that the trust fund’s assets—the pool of workers’ money—would have to pay the tax.

And, even if the insurance company that insures the trust fund’s benefits were subjected to the tax, the insurer would pass-through the tax to the trust fund in the form of higher insurance premiums.

As explained under point 1, above, in any event this tax burden would be borne by the trust funds’ covered workers in the form of lower wages and/or reduced benefits. And, this tax too would be very upsetting to the workers and the trust funds’ trustees.

- (b) Some proposals in the House and Senate have included “risk adjustment procedures” under which group health plans (including health and welfare trust funds) outside of a Gateway or Exchange could be assessed by the Gateway or Exchange authority to even out risks among plans inside and outside of the Gateway or Exchange. If a health and welfare fund outside of the Gateway or

Exchange had healthier participants (lower risk, lower cost), the fund could be taxed and the proceeds of the tax used to subsidize higher risk plans in the Gateway or Exchange.

As explained under point 1, above, this tax burden would be borne by the trust funds' covered workers in the form of lower wages and/or reduced benefits, and would be very upsetting to the workers and the trust funds' trustees. Furthermore, such an approach is inappropriate in light of the idiosyncrasies of health plan claims experience. In any given year, a plan may have favorable claims experience, which would allow for the accumulation of reserves to be used in subsequent, less favorable years. By taxing plans based on such favorable experience, plans would be less able to build such claims reserves and therefore, subject to greater cost variability when their experience is less favorable.

### **3. Benefit Mandates Adding To Cost Burdens On Health & Welfare Trust Funds**

- (a) Prohibition on annual and lifetime benefit limits: Self-funded health and welfare trust funds typically include in their health plan rules annual and/or lifetime limits on benefits. The amount of the limits vary from fund-to-fund according to various factors, including the health and welfare fund's financial status and the level of income from collectively bargained contributions. All benefits, as well as administrative expenses, are paid from the trust fund's assets and the fund's assets are limited. Unlike in a corporate plan where the employer can arbitrarily dictate benefit reductions strictly as a cost reduction approach, the statutory construct of boards of trustees of multiemployer plans requires equal representation by employee and employer representatives. So, the fund's board of trustees tries to design the health plan to balance the benefit coverage costs for the participants as a whole with the available funding (collectively bargained contributions). As a practical matter, this requires limitations on the benefits.

While we recognize and applaud the public policy objective of preventing medical bankruptcies, it must be noted that if these limits are barred by the health reform legislation, the health and welfare funds will have to either convert to insured status or purchase "stop-loss" insurance to protect the fund's assets from catastrophic claims. In either case, the premiums for this insurance will substantially increase costs for the health and welfare fund and workers covered by the fund.

To the extent that a health and welfare fund is already insured, the cost of the insurance premiums payable by the fund will increase.

- (b) Limits on annual cost-sharing: The HELP Committee bill (*Affordable Health Choices Act of 2009*) and House's Tri-Committee bill would place federal limits on the cost-sharing requirements that a group health plan, including a health and welfare trust fund, could impose. These limits include a prohibition on cost-sharing for preventive services

and an annual dollar limit on all cost-sharing.

Self-funded health and welfare trust funds typically do not limit cost-sharing (*e.g.* deductibles, co-insurance, co-payments). All benefits, as well as administrative expenses, are paid from the trust fund's assets and the fund's assets are limited. So, the fund's board of trustees tries to design the health plan to balance the benefit coverage costs for the participants as a whole with the available funding (collectively bargained contributions), and this often requires cost-sharing by participants. The extent of the cost-sharing will vary from fund-to-fund depending of each fund's financial circumstances.

- (c) Dependent Coverage Until Age 26: The HELP Committee bill would require group health plans, including health and welfare trust funds, to extend coverage of dependent children until age 26. While some funds do provide for coverage until the attainment of age 25, to the extent that this represents an expansion of eligibility, it also reflects increased costs.
- (c) Essential Benefits Package: H.R. 3200, as reported by the House Committees, lists the types of benefits that every employment-based group health plan would have to eventually provide, and authorizes and directs the Secretary of HHS, upon recommendation of the Health Benefits Advisory Committee, to set the levels at which such benefits must be provided. Similarly, the HELP Committee bill directs and authorizes HHS to develop an essential benefits package as a regulatory matter.

To the extent that health reform legislation (or implementing agency regulation) requires health and welfare funds to provide certain types of benefits at certain levels, a health and welfare fund that does not currently meet those standards would have to provide additional benefits or a higher level of benefits. This would increase the trust fund's costs and limit the flexibility of the fund's board of trustees to balance the benefit coverage costs for the participants as a whole with the available funding (collectively bargained contributions).

- (d) COBRA Extension: HR 3200, as reported by the House Education and Labor Committee, would require group health plans, including self-funded and insured health and welfare trust funds, to allow participants and beneficiaries who have otherwise lost coverage under a trust fund to continue "COBRA" coverage beyond the current 18, 29 and 36-month duration limits. More specifically, individuals would be entitled to continue their COBRA coverage under the trust fund until they obtain other health insurance coverage with a new employer or under a health exchange established under the legislation (effective 2013).

COBRA coverage is expensive for trust funds because, even though the individual is required to self-pay at the "COBRA rate", the time frames that apply during which an individual may elect and pay for such coverage encourages adverse selection by

individuals who know they have claims. Therefore those who elect COBRA coverage are generally more costly to cover than the average participant.

- (e) Restriction On Changes In Retirees' Benefits: HR 3200, as reported by the House Education and Labor Committee, would prohibit a group health plan (including a labor-management multiemployer health and welfare trust fund) from reducing any retiree health benefits offered under the plan unless the same reduction is made in active employees' health benefits. This statutory mandate would override any plan rule authorizing the fund's sponsor (*e.g.* board of trustees) to amend or terminate health benefits after retirement.

The multiemployer community is unalterably opposed to this provision. Many, if not most, labor-management multiemployer health and welfare trust funds provide retiree health benefits, usually on a subsidized self-pay basis. This is especially true for pre-Medicare retirees. There is no legal requirement that the trust funds provide retiree coverage; they do so voluntarily. The retirees often pay less than the actual cost of their coverage to the trust fund, and the difference is, as a practical matter, paid by the active employees whose covered work generates the collectively bargained contribution income. To prudently protect the trust fund's assets against the vagaries of the trust fund's income and unexpected cost burdens, the trustees necessarily reserve the right to amend or terminate retiree coverage at any time.

If active employee-participants in a health and welfare trust fund were subjected to the risk of their benefits being reduced because retiree benefits had to be reduced, support for subsidized retiree coverage would evaporate and such coverage would be terminated. The effect of the HR 3200 provision would be to legally require active employees to continue subsidizing retiree coverage in order to maintain their own benefits, and they would not tolerate this mandate.

- (f) Medical Loss Ratio: It has been unclear whether the "medical loss ratio" provisions of some bills were intended to apply to health and welfare trust funds or only to insurance companies. The idea of these proposals is to require plan sponsors to pay rebates to participants if the medical loss ratio was less than 85%.

Such an attempt to regulate the non-benefit and benefit costs of a health and welfare fund would be totally inappropriate. A health and welfare trust fund is not a for-profit business. It is a pool of workers' money managed by a labor-management board of trustees who are fiduciaries under ERISA's regulatory scheme. As explained under item 2(b), (above), such a year to year variation in claims experience may be simply coincidental and requiring the payment of such rebates rather than permitting plans to add to their reserves is both bad policy and an unnecessary administrative burden.

- (g) "Grandfathering" / Deferrals: Perhaps recognizing that the legislation's benefit mandates will impose higher costs on employment-based health plans (including health and welfare

trust funds), the HELP bill includes a “grandfathering” provision. However, that provision provides illusory relief inasmuch as a trust fund would have to apply the new mandates to new participants. Maintaining a two-tier benefit program (pre-2013 and post-2013) is impractical for most trust funds and is inconsistent with their overall objective of sharing risks equitably among all participants. The House bill provides a five-year grace period for all employment-based plans to comply. Under either bill health and welfare trust funds would be compelled to comply with the mandates eventually.

- (h) In addition to the aforementioned items for which we have provided detailed comments, without going into greater detail, the following items also present anticipated additional cost burdens to our plans:
  - (i) Change in Reimbursement Practices: The HELP Committee bill would require group health plans, including health and welfare funds, to develop and implement provider payment policies that incentivize providers to provide quality care, and including measures such as case and chronic disease management.
  - (ii) Network Adequacy: The House bill would require group health plans, including health and welfare funds, using provider networks to meet network adequacy standards.
  - (iii) Claims Payment Standards: The House bill would require group health plans, including health and welfare funds, to comply with federal claims payment standards.

**4. Regulatory Changes Adding To Cost Burdens Or Unworkable Restrictions On Health & Welfare Trust Funds**

- (a) ERISA Preemption Exemptions:
  - (1) HR 3200, as reported by the House Education and Labor Committee, would allow any State to enact a single-payor health plan law and thereby put health and welfare trust funds in that State out of “business”.

The labor-management multiemployer health and welfare trust fund community is unalterably opposed to this and any other breach of the uniform federal regulatory scheme established by ERISA 35 years ago. ERISA’s preemption provisions currently protect health and welfare funds from the costs and whims of 50 varying sets of State laws, and make it possible for employment-based group health plans to operate in multiple States. Many multiemployer health and welfare trust funds cover workers and dependents in multiple States; indeed, some trust funds are national in scope. ERISA’s uniform federal regulatory scheme is the legal foundation for the voluntary employment-based health plan system that currently covers more than 150 million workers and dependents. The granting of

exceptions would undermine this foundation. Allowing one or more States to impose a single payor system would further fragment the health care system at a time when the Nation needs a national approach to contain costs, improve quality and assure universal coverage.

- (2) Beyond HR 3200's single payor provision, we are concerned about any proposal that would enable States to regulate, tax or otherwise impose obligations on health and welfare trust funds. Inasmuch as ERISA preemption does not apply to other federal laws, health reform legislation could, inadvertently or intentionally, grant a State authority that ERISA would otherwise preempt, and cause serious damage to health and welfare trust funds and their participants and beneficiaries.
- (3) HR 3200's provisions concerning the new Health Insurance Commissioner's authority over claims and appeals may be construed as authorizing State law review and remedies for denial of benefit claims. This would be a dramatic, unacceptable breach of ERISA preemption and subject health and welfare trust funds to State law regulation and open plans to potentially costly new additional litigation costs which will reduce the assets of the trust available to provide benefits to all participants and their dependents.
- (4) Particular care must be taken with regard to State-based "Gateways" or "Health Insurance Exchanges" to ensure that they are not given any authority over employment-based plans (including health and welfare trust funds) outside of the Gateway or Exchange, including any authority to regulate, tax or assess in any way.

(b) Additional Regulatory Agencies And Rules / "Consumer Protections":

- (1) HR 3200, for example, would create an expansive new regulatory regime and federal agencies (e.g. Health Choices Commissioner) on top of the existing, complex regulatory regime of existing labor law (e.g. the Labor Management Relations Act of 1947 (aka the "Taft-Hartley Act"); and ERISA for employment-based group health plans like health and welfare trust funds. This creates a real potential for conflict, confusion and years of litigation as regulators and the regulated try to figure out how the two regulatory regimes relate. In any event, it means a lot more cost for regulatory compliance and litigation.

The Commissioner, in particular, would be granted very broad, discretionary authority to regulate the benefit programs and operations of ERISA-covered group health plans, like the trust funds, and impose unlimited additional obligations and costs.

- (2) Among the Commissioner's missions is to develop and impose a claims and appeals procedure even though ERISA and Labor Department regulations already



impose clear and unambiguous requirements on ERISA-covered health plans with regard to claims and appeals procedures. ERISA Section 503 requires that any participant or dependent whose claim has been denied must receive written notice explaining the specific reason for such denial, written in a manner calculated to be understood by the participant. It also requires plans to afford participants whose claims have been denied the opportunity for a “full and fair review” by the appropriate named fiduciary of the decision to deny the claim. In the thirty-five year years since the passage of ERISA, plans have developed quite comprehensive procedures recognized by the courts to comply with these legal obligations.

The Energy and Commerce Committee’s version of HR 3200 goes far beyond ERISA’s claims and appeals requirements to impose by statute, through the Commissioner, a reticulated claims review mandate that includes an unnecessary and expensive external review procedure.

- (3) We are concerned that this regulatory expansion will increase the legal compliance costs of trust funds and restrict the flexibility needed by the funds’ boards of trustees to balance administrative and benefit costs with available collectively-bargained financial resources. New “consumer protections” may be appropriate for insurance companies that put profits before people. But, health and welfare funds are not for-profit insurance companies. They are pools of workers’ money managed jointly by a board of trustees consisting equally of worker representatives and employer representatives. Regulatory costs are all paid from the trust fund’s assets—the pool of workers’ money—not by an insurer or employer and directly reduce the funds available for the payment of covered benefits.
- (4) In addition to imposing new costs, there are bill provisions that would invalidate appropriate cost controls that health and welfare trust funds have lawfully developed over the years. For example, HR 3200 would authorize the Commissioner to establish standards for subrogation of benefits. This provision creates a serious potential for conflict with subrogation rights that health and welfare funds have long had under ERISA.

ERISA permits a health and welfare trust fund to include in its plan rules so-called subrogation provisions. Subrogation serves two important functions:

- (i) When a participant is injured in an accident or otherwise hurt by a third party and requires medical services, the subrogation provisions of the plan and trust permits health and welfare trust fund to pay for these services and enables the participant to obtain treatment while payment responsibility for the incident is sorted-out. This saves the participant from having to pay out of pocket, borrow money, or deal with bill collectors in the meantime.

The trust fund, under the plan rules, is subrogated to the participant's rights of recovery, if any, against the injuring party to the extent that the fund pays medical costs that are ultimately determined be the responsibility of the injuring party (or his / her insurer). This right of reimbursement financially enables the trust fund, the pool of workers' money, to provide coverage under such circumstances. Absent the ability to recover assets that are not otherwise payable from the trust, funds will simply be unable to continue to provide this service to plan participants, making them vulnerable to having to contend with the these additional cost concerns and to the vagaries of third party liability actions while responsibility is ultimately sorted out.

- (ii) Subrogation rules also prevent double payment of the same medical expenses incurred by a participant, an important cost control measure. The U.S. Supreme Court ruled years ago that ERISA protects the subrogation rights of self-funded health and welfare trust funds against State anti-subrogation laws, reflecting the importance of this cost-savings measure to the funds.
- (c) Individual Opt-Out Rights: The labor-management multiemployer health and welfare trust fund community is strongly opposed to any proposal that would entitle a worker to opt-out of a health and welfare trust fund and require his employer to make payments to a "Gateway" or "Health Insurance Exchange" because of this individual election. HR 3200, for example, may be interpreted as granting such an individual right.

Such a right to opt-out would:

- (1) Undermine the financial soundness and viability of the trust fund by diverting income from the fund to the Gateway or Exchange to the extent that the legislation could be read as superceding the employer's collective bargaining agreement obligation to contribute to the trust fund for the employee's hours worked.
- (2) Undermine the financial soundness and viability of the trust fund by allowing younger, healthier employees (who, in harsh economic times may opt-out to take advantage of subsidies for lower income participants) and leave behind in the trust fund older, less healthy employees whose higher health costs would be spread over a smaller pool.
- (3) Undermine the financial soundness and viability of the trust fund by pressuring employers to bargain out of the trust funds to the extent that they are compelled to pay twice for the same employee: compelled by their collective bargaining agreement to contribute to the health and welfare trust fund for the employee's hours, and compelled by the law to pay an assessment to the Exchange / Gateway

because the employee elected to opt-out of the fund.

- (4) Be inconsistent with the exclusive bargaining representative status of the labor union that is party to the collective bargaining agreement requiring contributions to the health and welfare trust fund. Under the National Labor Relations Act, employers are prohibited from bargaining individually with workers who are represented by a labor union and covered by a collective bargaining agreement. Health reform legislation must not supercede collective bargaining rights and duties under federal labor-management relations laws.

**5. All Employers Should Have Responsibility To “Play-or-Pay” To Stop Unfair Cost-Shifting & Unjust Business Competition Among “Small Employers”.**

- (a) Every employer, including “small business” employers, should bear some significant responsibility for the health care coverage of their employees and their employees’ dependents, either by maintaining a meaningful employee health plan or paying a meaningful amount towards coverage under another health plan. A serious “play or pay” requirement is necessary to contain costs, minimize unfair cost-sharing, and end unfair competition by irresponsible employers who refuse to provide employee health insurance. And, “small business” is a major cause and beneficiary of the unfair cost-shifting and unjust competition.
- (b) A particularly egregious cost-shifting problem afflicts health and welfare funds in the building and construction industry. Comprehensive health and welfare coverage for the employee and his/her family is nearly universal in the unionized part of the industry, but is rare in the non-union part. The uninsured employees (and their dependents) of non-union contractors receive uncompensated care at hospital emergency rooms and from other providers who shift the costs to other payers including the union workers’ health and welfare trust funds. As a result of this cost-shifting, the irresponsible non-union contractors gain two unfair competitive advantages: (1) they avoid the cost of providing health insurance for their employees, and (2) they impose higher costs on their union competition. This unfair competition means a loss of union jobs which means less income to the health and welfare funds which depend on the collectively bargained contributions that are only generated by union jobs.
- (c) This destructive unfair competition can only be ended by enactment of a robust employer “play or pay” mandate that is applicable to all employers and that includes meaningful “play” and “pay” requirements. The exemptions for “small business” in various bills are well-intended, but they are based on a false premise that providing or paying for employee health insurance is unduly burdensome. In fact, tens of thousands of small businesses contribute to labor-management health and welfare trust funds for their employees and dependents under collective bargaining agreements around the Nation. These responsible union “small business” employers have to compete against non-union “small businesses” employers for the same work.

The building and construction industry, among others in the multiemployer community, consists overwhelmingly of small businesses. Over 50% of construction companies employ 10 or fewer employees; 90% employ fewer than 20 employees. The average payroll is less than \$500,000. Beyond the unionized sector of the industry, comprehensive health insurance coverage for workers and their families is virtually non-existent.

- (d) To the extent that reform legislation exempts “small businesses” from “play or pay” mandates, it will perpetuate the unfair competitive advantage of irresponsible non-union employers. They will escape any financial responsibility for the health care of their employees and drain much needed resources from the system. In contrast, the labor-management, multiemployer health and welfare trust fund community, including their participating “small business” employers, will incur higher costs as a result of the legislation. This anti-competitive situation will put pressure on union “small business” employers to withdraw from health and welfare trust funds; a result that would be counter-productive for a fundamental purpose of reform legislation: the preservation and strengthening of employment-based health plans.

The HELP Committee bill would exempt “small business” employers with less than 26 employees from any responsibility for their employees’ health care, perpetuating their unjust competitive advantage over responsible employers of the same size workforces and perpetuating the unfair cost-shifting of the costs of their employees’ health care to other payors. HR 3200, as reported by the House Education and Labor Committee, took a more reasoned approach by basing its “small business” exemption from “play or pay” on a reasonable payroll amount. But, the Energy and Commerce Committee, raised the exemption’s payroll trigger amount to an unreasonable level so as to allow more than 80% of all “small businesses” to escape responsibility and gain an unjust competitive edge. This version has rendered the bill’s “play or pay” provisions virtually meaningless.

- (e) Similarly, the \$750 per employee per year “pay” aspect of the HELP Committee’s “play or pay” mandate is *de minimis* and cannot be reasonably expected to incent employers to maintain employee health plans or to significantly contribute to the cost of health care for employees and their dependents. The cost of maintaining a meaningful employee health plan is far greater than \$750.

Moreover, the bill gives an employer an exemption for the first 25 employees. As a result, if an employer employs 30 employees but refuses to sponsor a health plan for them, the employer is required to pay the \$750 assessment only for 5 employees, not 30 employees. This exemption makes the “pay” choice even more attractive. The employer can pay a minimal amount and shift the bulk of its employees’ health care costs to other payors.

The HR 3200 version of “play or pay” would require a “paying” employer to pay a fairer,

but still inadequate, amount: 8% of average wages paid by the employer.

- (f) The HELP Committee's "small business" exemption is also concerning in that it expands the exemption to seasonal businesses (not merely small family farms). This seasonal exemption could be construed, or further expanded in the legislative process, to include building and construction.
- (g) An employer "play or pay" mandate will provide additional financial incentives for employers to misclassify employees as "independent contractors" to escape both "play" and "pay" and shift the cost of his workers' and dependents' health care to other payors. A serious "play or pay" mandate must address the "independent contractor loophole" through which employers currently evade various legal obligations for their employees, including income tax withholding and payroll taxes, costing the U.S. Treasury a huge amount of revenue, and worker compensation laws. This is a particular problem in the building and construction industry. The "independent contractor" loophole is being flagrantly and widely abused by non-union contractors.

The adverse impact on the U.S. Treasury would be multiplied if, under health reform legislation, the uninsured misclassified "independent contractor" qualifies for a government subsidy for individual health insurance coverage through a Gateway or Exchange. By misclassifying an employee, the non-union employer could shed all responsibility for his workers' health care, shift costs to the government or to other payors, and gain a competitive advantage over responsible employers.

- (h) The Senate Finance Committee's proposal, according to reports, will not include a "play or pay" provision but rather will include a so-called "free rider" rule. Under that rule, an employer with 50 or more employees that does not provide health insurance coverage for its employees would be required to reimburse the government to some extent if any of the employees receives government subsidies for individual health insurance obtained through a Health Insurance Exchange or Gateway.

This would be a poor substitute for an adequate "play or pay" mandate. The 50-employee threshold would exempt virtually all non-union employers in the building and construction, entertainment and other industries from any responsibility, thereby codifying their unfair competitive advantage and unjust cost-shifting to other health care payors.

## **6. All "Small Business" Employers Should Be Eligible For Subsidies**

- (a) It is essential that any Government subsidies for "small business" be extended to the responsible small business employers that participate in labor-management multiemployer health and welfare trust funds, and not merely to employers that participate in a Gateway or Exchange.

Otherwise, if only employers participating in a Gateway or Exchange qualify for health plan subsidies, employers will be discouraged from participating in health and welfare trust funds and will be incited to withdraw from the trust funds and join the Gateway or Exchange. This will drive the trust funds out of existence eventually and drive up the Federal Government's subsidy costs.

- (b) Our understanding is that the HELP Committee bill and HR 3200 provide for "small employer" subsidies outside of the Gateway or Exchange. However, the HELP Committee bill's provision contains language suggesting that a "small employer" would be eligible for the subsidy only if it bought employee health insurance from in a State's small group insurance market. This language may be construed as excluding employers that participate in labor-management multiemployer health and welfare trust funds from eligibility for a subsidy, even though they would otherwise qualify. That would be unjust and give business competitors of employers participating in the health and welfare trust funds an unfair competitive advantage and unfairly discriminate against workers covered by the trust funds, which, because of their non-profit structures are inherently more cost effective.
- (c) Special care must be taken to ensure that any subsidies for employers participating in health and welfare funds are designed in a way that accommodates the special characteristics of the trust funds and the collective bargaining systems by which employer contributions are determined. This is particularly important for employers and trust funds in industries, like building and construction, entertainment, trucking, and port workers in which employment patterns are transitory.

## 7. **Pre-Medicare Retiree Health Coverage Program**

- (a) We applaud the inclusion in the HELP bill and the House bill of provisions for a temporary subsidy program for pre-Medicare retirees. A great many of the workers covered by our health and welfare trust funds, particularly in the more physically demanding building and construction, trucking and port industries, are unable to continue working at their trades until Medicare eligibility age. It is important that the final legislation include such a program.
- (b) It is also important that the final bill's language clearly accommodates retirees who participate in multiemployer health and welfare trust funds (group health plans that are multiemployer plans as defined in ERISA Section 3(37)) on a self-pay basis. Accommodations to the special characteristics of health and welfare funds were included in earlier federal subsidy programs including the *American Recovery and Reinvestment Act of 2009* COBRA subsidy program and the Medicare Part D program legislation.
- (c) However, we are concerned that the retiree health program will be under-funded by the appropriations envisioned by the legislation. It is important to note the

likelihood that there will be more pre-Medicare retirees than the legislation anticipates. Understanding that one of the principle deterrents to early retirement is the high cost of retiree health coverage, the existence of a supplement is likely to encourage more individuals to take advantage of this program.

**8. Multiemployer Health And Welfare Participation In Gateway / Health Exchange**

A labor-management multiemployer health and welfare trust fund should be permitted to join a Gateway or Exchange if its board of trustees chooses to do so, just as an employer will be permitted to join a Gateway or Exchange to provide a health plan for its employees. Most health and welfare funds are characterized by participating employers that are small businesses by any definition.

Health and welfare trust funds provide a range of valuable employee benefits beyond health benefits, such as disability and life insurance. It is vital for the income security of millions of workers and families that these trust funds be maintained and not destabilized by employers withdrawing to obtain health insurance through the Gateway or Exchange or by employers releasing their employees onto the Gateway or Exchange to obtain individual coverage. To the extent that participation in a Gateway or Exchange has advantages, the board of trustees of a health and welfare trust fund should be allowed to obtain health plan coverage for the trust fund's group through the Gateway or Exchange and continue to maintain the trust fund.

**9. Technical Miscues Can Make A Big Difference Over Time**

Labor-management multimeployer health and welfare trust funds have special characteristics that are often overlooked in developing legislation based on a single employer model. It is crucial that the health and welfare trust fund community have a real opportunity to conduct a non-policy, technical review of legislation before it is enacted to minimize unintended consequences for the trust funds and the millions of workers and dependents they cover.

The single employer model that policymakers commonly have in mind is as follows: employer purchases health insurance plan for employees; employer unilaterally determines the plan's rules, benefits and limitations; employer pays portion of the monthly premiums; employer requires employees to pay the part of the premium that employer does not pay. That model is the opposite of the multiemployer health and welfare trust fund's world. A trust fund is established and maintained through collective bargaining. The labor-management board of trustees determines the fund's rules, benefits and limitations by balancing the available income (collectively bargained contributions) with the trust fund's costs. The full amount of the trust fund's costs, including benefits and administrative costs, are borne by the trust fund's assets; that is, by the pool of workers' money raised through collectively bargaining contributions for which the workers traded-off wages.

ERISA and various other federal laws have long recognized the particular nature of the health and welfare trust funds and included special provisions to accommodate them, often describing them as “group health plans that are multiemployer plans as defined in section 3(37) of the Employee Retirement Income Security Act.”