

NATIONAL COORDINATING COMMITTEE FOR MULTIEmployer PLANS



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October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

Re: Patient Protection and Affordable Care Act
Health Insurance Premium Assistance Tax Credit
File Code IRS REG-131491-10

Ladies and Gentlemen:

The National Coordinating Committee for Multiemployer Plans (the NCCMP) appreciates the opportunity to provide comments regarding the proposed rule that would implement the new Health Insurance Premium Assistance Tax Credit under the Patient Protection and Affordable Care Act. The proposed rule was published by the Internal Revenue Service (IRS) on August 17, 2011, reference number IRS REG-131491-10.

The NCCMP is the only national organization devoted exclusively to protecting the interests of the approximately twenty-six million workers, retirees, and their families who rely on multiemployer plans for health and other 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 multiemployer plan universe, including in the agricultural, airline, building and construction, entertainment, health care, hospitality, longshore, manufacturing, mining, retail food, service and trucking industries.

The NCCMP has prepared comments with respect to the Health Insurance Exchanges, which have been provided to HHS separately and are attached hereto. We respectfully submit the following synopsis of these broader remarks and request the opportunity to provide additional comments regarding these issues as they develop.

The National Coordinating Committee on Multiemployer Plans (NCCMP) has developed a comprehensive proposal relating to the treatment of multiemployer plans under the Affordable Care Act (ACA). Under this proposal, through the exercise of regulatory authority by the Department of Health and Human Services (HHS), if certain requirements are satisfied, multiemployer plans (fully-insured and self-insured) would be deemed to be qualified health plans (QHPs) purchased in the individual market through Exchanges. As a result of this treatment, multiemployer plans would be able to access the premium tax credit on an advance basis in a manner similar to how the credit would be paid to insurance companies under section 1412 of ACA. In addition, certain tax consequences would apply with respect to multiemployer plans as follows:

1. Qualified individuals (based on income) would be eligible for premium tax credits for coverage under a multiemployer plan.
2. Multiemployer plan coverage would be minimum essential coverage.
3. Multiemployer plan coverage would satisfy the individual responsibility requirements.
4. Employer contributions to multiemployer plans in accordance with the applicable collective bargaining agreement would satisfy the employer responsibility requirements.
5. Employer contributions to a multiemployer plan would remain excludable for income and payroll tax purposes, even if the contributions are used to pay for premiums for coverage for which a premium tax credit is available.
6. Otherwise eligible small employers would be eligible to receive the small employer tax credit for contributions to a multiemployer plan (both fully insured and self-insured).

The legal basis supporting treatment of multiemployer plans as QHPs, as well as the requirements that would apply to multiemployer plans in order to be treated as QHPs was addressed in detail in two memoranda provided to Ken Choe, Deputy General Counsel, Office of the General Counsel, United States Department of Health and Human Services, dated August 9, 2011 and August 30, 2011. These memoranda also include responses to specific questions raised by the staff of HHS, including an analysis of the likely negative effects on continued employer contributions to multiemployer plans if premium subsidies cannot be accessed by multiemployer plans, as well as further background information on multiemployer plans. We understand that these memoranda have also been provided to staff of the Departments of Labor and Treasury, as well as the Office of Personnel Management (OPM).

This memorandum addresses the legal support for the requested tax treatment relating to multiemployer plans, assuming that such plans are deemed through the regulatory process to be QHPs offered in the individual market in Exchanges. As discussed in further detail below, the statutory provisions support the exercise of regulatory authority to achieve the requested approach.¹

1. Eligibility for Premium Tax Credit Under Code Section 36B

In order for the premium tax credit to be available, there are three relevant requirements that must be satisfied: (1) an applicable taxpayer² (or his or her spouse or dependents) must be enrolled in a QHP purchased in the individual market on an Exchange; (2) the taxpayer cannot be eligible for certain other types of coverage; and (3) the premium for the QHP must have been paid by the taxpayer (or through advance payment under section 1412 of ACA). Each of these requirements should be satisfied here.

With respect to the first requirement, the premium tax credit is available to an applicable taxpayer for each “coverage month”. Code § 36B(b)(1). A coverage month is defined as any month if, as of the first day of the month, the taxpayer, the taxpayer’s spouse or a dependent of the taxpayer “is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act.” Code § 36B(c)(2)(A)(i). Subsection (b)(2)(A) mirrors the language quoted above and refers to premiums for “1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer’s spouse, or any dependent (as defined in section 152) and which were enrolled in through an Exchange established by the State under [section] 1311 of the Patient Protection and Affordable Care Act...”.

As noted above, this discussion is premised on the assumption that the HHS has exercised its regulatory authority to deem multiemployer plans to be a QHP purchased in the individual market through an Exchange. As a result, this threshold requirement for eligibility for the credit would be satisfied.

Under Code section 36B, even if this threshold requirement is satisfied, the individual may be disqualified for the credit if the individual is eligible for certain other types of coverage. In particular, the credit is not available for any month “if for such month the individual is eligible for minimum essential coverage *other than* eligibility for coverage

¹ The memoranda provided to Ken Choe discuss in detail the extent of agency authority as recognized under case law; this discussion is not repeated here.

² The term “applicable taxpayer” is defined by reference to household income (Code § 36B(c)(1)) and is not at issue here.

described in section 5000A(f)(1)(C) (relating to coverage in the individual market). Code § 36B(c)(2)(B). (emphasis added). The highlighted language indicates that coverage that disqualifies an individual for the premium credit must be minimum essential coverage (MEC) *other than* the coverage that qualifies an individual for the credit.³ In this case, there would not be MEC “other than” the credit-eligible coverage. Rather, because the multiemployer plan coverage would be considered to be credit-eligible coverage (pursuant to HHS regulatory authority), the only coverage is the multiemployer plan coverage. It would be nonsensical to have a rule that provides that the same coverage that qualifies an individual for the credit also disqualifies the person from the credit. Thus, multiemployer plan coverage that constitutes MEC should not disqualify the individual for the credit.⁴ Note also that the fact that the multiemployer plan coverage is deemed to be Exchange coverage in the individual market distinguishes such coverage from other employer-based coverage that is minimum essential coverage. The August 9 and August 30 memoranda provide detailed discussion of the legal basis for distinguishing multiemployer plan coverage from other types of coverage. (Further discussion of the definition of MEC is below

Finally, in order for the credit to be available, the premium must be paid for the coverage month “by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).” Code § 36B(c)(2)(A)(ii). The proposed regulations under the premium tax credit provide that “[p]remiums another person pays for coverage of the taxpayer, taxpayer’s spouse, or dependent are treated as paid by the taxpayer.” Prop. Reg. § 1.36B-3(c)(2).

This requirement would also be met. It is anticipated that in many cases the premium would be paid on an advance basis to the multiemployer plan, similar to the way advance payments would be made to insurers offering QHPs in Exchanges. The multiemployer plan might also pay for a portion of the premium using the contributions paid to the plan by employers. Under the proposed regulations, such payments would satisfy the requirements for credit eligibility. (Discussion of the tax treatment of the employer contributions is in 5, below.)

³ Eligibility for employer-sponsored MEC does not disqualify an individual for the credit if the MEC is unaffordable or does not provide minimum value, unless the individual actually enrolls in the coverage. Code § 36B(c)(2)(B). This rule is not an issue here.

⁴ Vision, dental or other supplemental coverage that is not MEC should not disqualify an individual from being eligible for the premium credit.

2. Minimum Essential Coverage (Code § 5000A(f))

The definition of “minimum essential coverage” is relevant for purposes of both the individual responsibility provisions and the employer responsibility provisions. An individual who does not have “minimum essential coverage” is subject to a penalty under Code section 5000A. Large employers who do not offer full-time employees “minimum essential coverage under an eligible-employer sponsored plan” are subject to penalties under Code section 4980H. For both these purposes, the relevant terms are defined in Code section 5000A(f). As discussed more fully below, the statute supports treating multiemployer plans as minimum essential coverage for both these requirements. As discussed in 1, above, this treatment would not disqualify otherwise eligible individuals from receiving the premium credit.

Code section 5000A(f) provides as follows:

“(f) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—

“(1) IN GENERAL.—The term ‘minimum essential coverage’ means any of the following:

“(A) GOVERNMENT SPONSORED PROGRAMS.— Coverage under—

“(i) the Medicare program under part A of title XVIII of the Social Security Act,

“(ii) the Medicaid program under title XIX of the Social Security Act,

“(iii) the CHIP program under title XXI of the Social Security Act,

“(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

“(v) a health care program under chapter 17 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

“(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

“(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103–337; 10 U.S.C. 1587 note).

“(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

“(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.

“(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.

“(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

“(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term ‘eligible employer-sponsored plan’ means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

“(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

“(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

“(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term ‘minimum essential coverage’ shall not include health insurance coverage which consists of coverage of excepted benefits—

“(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

“(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.”

Under the NCCMP proposal, multiemployer plans would be deemed to be individual coverage purchased through an Exchange. Thus, such coverage would constitute minimum essential coverage as described in Section 5000A(f)(1)(C) (relating to plans in the individual market). While this result should follow directly from the exercise of HHS regulatory authority, we also note that Code section 5000A(f)(5) provides that any term used in the section which is also used in title 1 of ACA shall have the same meaning as when used in that title. The provisions of ACA relating to the exchanges, qualified health plans, and premium tax credits were all contained in or added by title 1 of ACA, and the regulatory authority of HHS would relate to title 1 of ACA.

In addition, multiemployer plan coverage should also qualify as an “eligible employer-sponsored plan” for purposes of this provision. There are two questions raised with respect to this treatment: First, does coverage under a multiemployer plan meet the definition of “eligible employer-sponsored plan” and second, can the same coverage be considered more than one type of minimum essential coverage.

The statutory definition of “eligible employer-sponsored plan” is confusing and creates a number of ambiguities that will need to be resolved through the regulatory process. For example, one possible reading of the statute is that only fully insured group health plans of private employers are considered eligible employer-sponsored plans. The Treasury Department has noted this ambiguity and indicated in the proposed regulations relating to the premium tax credit are that regulations are expected to provide that self-funded group health plans may qualify as eligible employer-sponsored plans. Thus, the Treasury will need to exercise its regulatory authority to clarify the meaning of MEC in a number of situations.

Multiemployer plans should meet the definition of an eligible employer-sponsored plan. While the sponsor of a multiemployer plan is not the employer,⁵ multiemployer plans are group health plans within the meaning of the Code and they are employment based. Therefore, they should be considered “group health plan coverage offered by an employer to the employee”. Some multiemployer plans may be grandfathered plans, and thus would also constitute an eligible employer-sponsored plan by reason of the last sentence of Section 5000A(f)(2), quoted above.

As to the second issue, the statute on its face appears to allow a plan to fall within more than one category of minimum essential coverage. The list of plans is not mutually exclusive. Thus, for example, a grandfathered plan in the individual market could be minimum essential coverage under both categories (C) and (D) of section 5000A(f)(1). Similarly, an eligible employer-sponsored plan could fall within categories (B) and (D). Thus, the statute does not prohibit multiemployer plans from being treated as more than one type of minimum essential coverage and the Treasury Department could exercise its regulatory authority to provide that multiemployer plans that are deemed to be QHPs fall into more than one category of minimum essential coverage.

3. Individual Responsibility Requirements (Code §5000A).

Code section 5000A imposes penalties on individuals if the individual (and dependents of the individual) is not covered by minimum essential coverage for a month. Because, as

⁵ Under section 3(16) of ERISA, the sponsor of a multiemployer plan is the joint board of trustees.

described above, multiemployer plan coverage would constitute minimum essential coverage, individuals with such coverage would satisfy the individual responsibility requirements.

4. Employer Responsibility Requirements (Code § 4980H)

Section 4908H subjects “applicable large employers” to penalties if at least one full-time employee of the employer receives a premium tax credit or cost-sharing reduction (as provided in ACA § 1402) and the employer either (a) fails to offer minimum essential coverage under an “eligible employer-sponsored plan” to full-time employees (and their dependents) or (b) offers minimum essential coverage under an “eligible employer-sponsored plan” to full-time employees (and their dependents) and that coverage is not affordable or does not provide minimum value. The amount of the penalty varies based on whether (a) or (b) applies. The penalty under (a) is calculated based on the number of full-time employees, whereas the penalty in (b) is based on the number of full-time employees who receive a premium credit or a cost-sharing reduction.

According to NCCMP information, most contributing employers to multiemployer plans will face no or little penalty because they are small employers or have a workforce with substantial part-time employees. However, there are applicable large employers who currently have a large number of employees who participate in multiemployer plans and thus may be subject to the employer responsibility penalty.

The NCCMP proposal is that the employer responsibility requirements should be considered satisfied if the employer makes contributions to a multiemployer plan in accordance with the applicable collective bargaining agreement. A primary basis offered for this approach is administrative – that is, unlike single employer plans, the involvement of each employer is typically limited to making contributions, the employer is not responsible for setting plan benefits or administering the plan. Contributing employers do not know or have control over when an individual is covered under the plan. Rather, eligibility is typically based on work that is performed within an industry, not just a particular employer. Contributing employers do not have control over plan design issues, such as whether a plan would be considered to be “affordable” or to provide minimum value.

The employer does know, however, the contributions that the employer is required to make to the multiemployer plan. Thus, an easily administrable approach is to provide that the employer responsibility provisions are met if the employer makes required contributions as provided in the applicable collective bargaining agreement.

The Treasury Department has already recognized that appropriate rules may be dictated by administrative realities in a variety of contexts, including guidance issued to date under ACA. For example, the Treasury Department has indicated that they are considering an employer safe harbor under section 4980H whereby the employer's responsibility would be satisfied if the offered plan is affordable based on W-2 income rather than household income. IRS Notice 2011-73. This is based upon the administrative reality that employers do not have information regarding household income. As another example, the Treasury Department has provided an exception to the new W-2 reporting requirements for multiemployer plans, reflecting that employers do not know the value of the coverage provided. The guidance with respect to the small employer tax credit under section 45R also recognizes this approach by providing that the credit is available to a qualifying employer with respect to contributions made to a multiemployer plan. IRS Notice 2010-82.

Consistent with the rule that a penalty may be imposed if a plan does not provide minimum value, NCCMP has indicated that the proposed rule could be limited to situations in which the plan provides coverage at least at the bronze level (i.e., 60% level) as provided under Code section 36B(c)(2)(C). (Note that as part of the proposal that multiemployer plans be deemed to be QHPs, the plans would have to meet certain requirements, including a requirement that the plan provides coverage at least at the silver level. See the August 9 and August 30 memoranda.)

5. Exclusion for Employer Contributions to a Multiemployer Plan

Code section 106(a) provides that “employer provided” coverage under an accident or health plan is excludable from the gross income of employees. Regulations define the breadth of this exclusion as follows: “The gross income of an employee does not include contributions which his employer makes to an accident or health plan (through insurance or otherwise) to the employee for personal injuries or sickness incurred by him, his spouse, or his dependents....” Treas. Reg. § 1.106-1. Similar exclusions are provided for payroll tax purposes.⁶

This exclusion has existed in the law for decades, and the application of the exclusion to contributions made by an employer to a multiemployer plan is not in doubt. Thus, the question is whether the exclusion was modified by the Affordable Care Act. The answer to this question also is not in doubt – the exclusion was not amended by the Affordable Care Act.

⁶ See Code §§ 3121(a)(2)(FICA taxes); 3306(b)(2)(FUTA). (For convenience, this document refers simply to “the exclusion” or “this exclusion” to mean the exclusion from income and payroll taxes.)

Similarly, the ACA does not contain a rule that expressly prohibits the application of the exclusion to employer contributions that are used to purchase credit-eligible insurance. The only rule that relates to the interaction of the exclusion and the purchase of QHPs is the rule in new Code section 125(f)(3), which generally provides that contributions made through a cafeteria plan cannot be used to purchase a QHP offered on an Exchange (with an exception for exchange-eligible employers). This rule does not apply to the exclusion generally and thus, on its face, does not prohibit the continued application of the exclusion to contributions to a multiemployer plan for subsidy eligible individuals who participate in the plan.

The high cost plan tax (effective starting in 2018) similarly does not affect the exclusion. It was specifically structured so that, even if the tax applies, the benefits remain excludable from gross income and wages for payroll tax purposes. If the tax is triggered, it is payable by the “coverage provider”. It is not imposed on the employee. Code § 4980I.

We note that there are some pre-existing revenue rulings that address certain situations in which the section 106 exclusion was held not to apply to certain so-called “double dipping” situations where a tax exclusion was sought for reimbursements for health insurance coverage already paid for on a pre-tax basis. Rev. Ruls. 2002-3 and 2002-80. The rulings involved three different situations in which health coverage was paid for on a pre-tax basis through salary reduction and the employer then made “reimbursement” payments to the employee in amounts to cause the employee’s after-tax pay to be what it would have been if there had been no salary reduction to pay for the coverage. In Revenue Ruling 2002-3, the taxpayer argued that the reimbursement payments were themselves excludable under section 106 as payments for health coverage. In Revenue Ruling 2002-80, one situations involved a purported “loan” to the employee and the other involved a purported arrangement to reimburse the employee for medical expenses not covered by insurance. The IRS ruled that in each case the “reimbursements” were taxable income.

All of these situations are distinguishable from the current situation. One of the rationales cited by the IRS is that the employee was entitled to the payment even if no medical expenses were incurred. That is not the case here – employer contributions to multiemployer plans must be held in trust and used to provide medical benefits. In the first ruling, the employer in effect paid twice for the same coverage, that also is not the case here, there is no “doubling” of employer contributions or payments. Further, the rulings involved application of the same tax provision (section 106) to the same coverage. In this situation, two different Code sections are involved, the section 106 exclusion and

the section 36B credit, each of which have different requirements. As described further above, the conditions for each of these exclusions is satisfied. Thus, these rulings should not prevent application of the exclusion.

In summary, the Code section 106 exclusion remains in effect after ACA. Neither ACA, nor the Code as amended by ACA, contains an explicit rule that prohibits the exclusion from applying with respect to contributions to multiemployer plans, even if such contributions are used to pay for a portion of the premium for coverage for which a plan participant receives the premium tax credit. Further, pre-existing rulings do not preclude the application of the exclusion. Thus, the exercise of regulatory authority to allow the exclusion for multiemployer plan contributions to continue to apply would be within the agency discretion noted by the Supreme Court under the *Chevron* case.⁷ The August 9 and August 30, 2011 memoranda contain detailed discussion supporting the requested treatment of multiemployer plans, including a discussion of how such plans fulfill the goals of ACA and are similar to exchange plans based upon the provisions in the statute and proposed regulations. Also as discussed in the prior memoranda, multiemployer plans are clearly defined under the law as a distinct type of plan with distinct features, providing a basis for a rule that distinguishes such plans from health plans generally.

6. Small Employer Tax Credit (Code § 45 R)

Section 45R provides a tax credit for certain small employers for a portion of the cost of coverage paid for by the employer. With respect to years before 2014, the credit is available with respect to contributions toward “health insurance coverage within the meaning of section 9832(b)(1). The Treasury Department has issued guidance with respect to the credit for years before 2014, providing that the credit is available with respect to contributions to fully insured multiemployer plans.

For 2014 and later years, the credit is available with respect to qualified health plans offered by the employer on an Exchange. If multiemployer plans are deemed to be QHPs offered on an Exchange, then they should also be treated as such for purposes of the small employer credit. Thus, to the extent the small employer otherwise qualifies for the credit, it should be available with respect to contributions to a multiemployer plan whether the plan is fully insured or self-insured. NCCMP has indicated that it will work with the Treasury Department to develop appropriate rules coordinating the individual premium tax credit with the small employer tax credit.

⁷ See the further discussion in the earlier memoranda.

Conclusion

As noted above, the NCCMP appreciates the opportunity to provide this important perspective on this vitally important issue; one which cannot be overstated that the outcome of which literally will have ramifications for the existence of a significant number of multiemployer plans and which will certainly affect the long-term success of those which remain.

Finally, the NCCMP requests the opportunity to present testimony at the hearing scheduled for November 17, 2011, and will be providing an outline of issues as required by November 10, 2011.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Randy G. DeFrehn". The signature is written in a cursive style with a large initial "R".

Randy G. DeFrehn
Executive Director