

NATIONAL COORDINATING COMMITTEE FOR MULTIEmployer PLANS

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May 22, 2009

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Greetings:

On behalf of the millions of American workers and families who depend on joint labor-management, multiemployer health and welfare trust funds for their medical and other health benefits, I am pleased to submit these comments on the Finance Committee's health care system reform options papers to supplement the valuable comments being submitted by the AFL-CIO.

Let me first congratulate you for taking on one of the most important challenges confronting our Nation: the need for a national health care system that provides universal access to affordable, quality health care, that responsibly controls costs, and that distributes costs fairly, without unnecessarily disrupting established employment-based health plans that are meeting their participants' needs. National, systemic reform has long been an aspiration. Hopefully it will soon become reality beginning with enactment of comprehensive legislation this year.

However, as explained herein, great care must be taken in crafting legislation to avoid harming Taft-Hartley, multiemployer health and welfare funds which are an essential part of the employment-based system that the Committee is trying to preserve. As you know, even the best intended legislation can have destructive unintended consequences.

The Importance of Labor-Management Health & Welfare Funds

One of the proudest achievements of collective bargaining over the past 50 years is the thousands of labor-management, multiemployer health and welfare trust funds that provide to covered, union-represented workers and their dependents various benefit coverages, including medical, hospitalization, preventive and wellness care, prescription drugs, dental care, and vision care. These trust funds are often referred to as “Taft-Hartley funds” because they are regulated by the Labor Management Relations (“Taft-Hartley”) Act of 1947, as well as by the Employee Retirement Income Security Act (“ERISA”) and the Internal Revenue Code (“Code”).

These health and welfare trust funds cover workers in industries as diverse as building and construction, transportation, retail, food, clothing, textiles, service, mining, entertainment, hotel and restaurant, maritime, longshore, and manufacturing. But for these trust funds, millions more working families would be uninsured and at risk for financial ruin in the event of a serious illness. The transient, project-based, mobile and seasonal employment patterns that characterize many of these industries would prevent workers from obtaining health coverage absent a central, pooled fund through which portable coverage is provided to workers as they move from employer to employer.

Multiemployer funds solve the problem of real portability as workers change jobs; they don’t have to “take their coverage with them” because they remain in the same health and welfare fund as long as they are employed by contributing employers. Further, many funds have reciprocal agreements so that coverage can be continued even for employment with an employer obligated to contribute to another fund. Without the unifying arrangement provided by a Taft-Hartley fund, frequent changes in employment would make coverage by any one employer infeasible, and most are small that employers would not maintain an employee health plan on their own, especially for transient workers.

In assessing the impact of any health reform proposal on Taft-Hartley, multiemployer health and welfare funds and their participants, one must be mindful of the special characteristics of, and challenges faced by, these funds, including the following.

1. A Taft-Hartley, multiemployer health and welfare fund is established and maintained through collective bargaining between one or more labor unions and more than one employer.

As a matter of federal law, fund must be structured as a trust that is a separate legal entity, distinct from its sponsoring union(s) and contributing employers. The fund must be governed by a joint board of trustees on which labor and management are equally represented. Generally, the labor trustees are elected union officials and the management trustees are representatives of contributing employers. But, in performing their fund-related duties, the trustees have a fiduciary responsibility solely to the fund and its participants and beneficiaries, and not to the contributing employers or sponsoring union(s).

Among the board of trustees' responsibilities is structuring the fund, engaging appropriate service providers, and designing the plan of benefits to be provided by the fund to covered workers and dependents ("participants and beneficiaries"). The trustees, of course, rely on professional assistance in performing these duties.

In designing the benefit plan, the trustees take into consideration the fund's available and projected financial resources as well as the needs and wants of the participants and beneficiaries, among other relevant facts and circumstances. This balancing of interests requires a lot of innovation and flexibility to maximize value and adjust to changing circumstances, including the ability to adjust benefits to affordable levels and modify eligibility rules.

Because a Taft-Hartley, multiemployer health and welfare fund is a legal entity unto itself, the fund's administration is wholly separate and distinct from any individual employer's operations or human resources functions. For example, a fund has no involvement in a contributing employer's payroll operations including income tax withholding or payroll tax payments.

The cost of fund administration is paid from entirely from the fund's assets by the trustees, not by any contributing employer.

2. A Taft-Hartley, multiemployer health and welfare fund is financed by collectively bargained employer contributions and investment of its pooled reserves. Financing methods can vary from industry to industry according to employment patterns, cash flow, and financial structures in an industry. In many industries, like building and construction, contributions are required at a set rate for each hour worked in employment covered by the collective bargaining agreement and submitted to the fund monthly. While there are industry-based variations—some assess contributions based on days, weeks or shifts worked rather than hours, for example—contributions are almost always based on the activity levels of each employer's covered workforce. The contribution rate is generally set in the collective bargaining agreement for the term of the agreement (sometimes allowing for re-openers in special situations).

Even though contributions are calculated based on each participant's work, the contributions made for any particular participant may bear no correlation whatsoever to the actual cost of that participant's or his family's coverage by the fund. Taft-Hartley funds create multiemployer pools over which costs are spread without a determination as to the cost of each contributing employer's employee group. That aggregate cost—plus the costs of fund administration, reasonable reserves, and coverage for non-working participants—must be covered by total employer contributions based on the participants' covered employment. Typically

no distinction is made between employers based on the differing demographics of their respective workforces.

Typically, in the bargaining process between the union(s) and employers, the health and welfare fund contribution rate is just one of multiple “money issues”. In essence, once a total amount of compensation per hour is negotiated, that sum has to be allocated among wages, health and welfare fund contributions, pension fund contributions, and other employee benefits. The reality, not just economic theory, is that workers trade off wages for health and welfare fund contributions, recognizing that they and their families need the coverage. That is, the workers collectively pay for their own health and welfare coverage, although the law treats the contributions as employer contributions. Very few, if any, workers want to give up take home pay for more health coverage than they need. This process makes workers very sensitive to the cost of their and their families’ health care.

A single Taft-Hartley, multiemployer health and welfare fund may have anywhere from two to thousands of contributing employers. They may all be contributing pursuant to one bargaining agreement or a few agreements, or pursuant to hundreds or thousands of separate agreements with varying expiration dates.

- . Health and welfare funds necessarily have eligibility rules for determining whether a worker and/or dependent is eligible for benefits during any given period of time. Funds have developed various industry-specific systems for maximizing coverage, taking account of the employment patterns of the industry and the funds’ financing needs. Typically, these systems feature eligibility periods during which a worker’s covered employment with any contributing employer builds credit towards eligibility in a future period (e.g. covered employment in the first calendar quarter earns the worker benefit eligibility for claims incurred in the second quarter). Since eligibility is based on the level of covered work in a prior period, sometimes individuals are not actually working in covered employment during their period of coverage. This pattern of establishing eligibility after the necessary contributions are received by the fund is essential to the structure of Taft-Hartley funds.

It is common for covered employment to fluctuate and for workers to have temporary periods of under-employment or unemployment in the normal course of an industry’s employment pattern. When no or insufficient covered employment with a contributing employer is available for a worker, he and his family may lose eligibility under the fund unless the fund provides means for bridging gaps in employment. Many funds, particularly in the building and construction industry, maintain “hours bank” arrangements under which some of a worker’s hours of covered employment are “banked” and used to pay for benefit eligibility during periods of unemployment.

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Some funds allow workers to self-contribute to make-up a shortage in hours of covered employment during an eligibility period. And, of course, the health and welfare funds also offer self-paid COBRA continuation coverage for participants and beneficiaries who lose eligibility.

During times of high unemployment, like now, the funds face a major challenge to maintain unemployed workers' and dependents' eligibility without current employer contributions to finance the coverage. And too often the worker exhausts a fund's system for bridging gaps in employment before finding new covered employment. When that happens, a fund's trustees may try to address the situation by modifying the continuation of coverage rules; but that is only possible if the fund has accumulated and maintained sufficient reserves of assets.

4. There are thousands of Taft-Hartley, multiemployer health and welfare funds in the United States. Many of them are multi-state in coverage; that is, they cover workers employed in two or more States. This is largely attributable to mobile work patterns, expanding union geographical jurisdictions, and changes in collective bargaining structures. Some funds provide regional coverage, others provide national coverage. The geographical scope of health and welfare funds is expected to increase over time as funds merge to increase their purchasing power and contain costs.

Multi-state coverage by health and welfare funds would not be feasible without the uniform, federal regulatory scheme provided by ERISA and related laws and, in particular, the protection provided by ERISA preemption against multiple, conflicting and costly State laws. As Congress wisely determined in enacting ERISA, dual Federal and State regulation of even intra-state funds would be counter-productive.

5. Most Taft-Hartley health and welfare funds are fully or partially self-funded. That is, benefits are paid by the fund from its pooled assets, rather than by an insurance company. Many of these funds carry "stop loss" insurance to spread the risk of catastrophic claims.

On the other hand, some funds still purchase insurance policies for all or some of the benefits. The fund negotiates and pays the group premiums to the insurance company for the eligible participants and beneficiaries, and the benefits are paid from the insurance company's assets.

The proliferation of burdensome State mandated benefit laws, as well as insurers' need for profit and other insurance related costs, drove many funds from the group insurance market and into self-funding. State laws became a problem for insured funds once the U.S. Supreme Court misinterpreted ERISA's preemption

provisions as allowing States to regulate the content of insurance contracts including contracts with ERISA-regulated health plans.

6. Many Taft-Hartley, multiemployer health and welfare funds, particularly larger funds, are self-administered; that is, they employ an in-house staff to perform all of the administrative functions such as collecting contributions, determining eligibility, processing and paying benefit claims, handling appeals, record-keeping, and reporting and disclosure. Others contract with third-party administration companies, or have “administrative services only” contracts with insurance companies, for all or some of the fund’s administrative functions. Many also contract with insurers or other organizations that maintain provider networks or group purchasing arrangements.

Importantly, all of a health and welfare fund’s administrative costs are paid from the fund’s pool of assets; the same pool from which benefits are paid. In other words, a dollar paid in administrative costs (including regulatory compliance) is one less dollar available for paying benefits.

7. Taft-Hartley, multiemployer health and welfare funds commonly provide coverage to retirees, particularly for pre-Medicare retirees, although many also provide supplemental coverage for Medicare eligible retirees. Retirees self-contribute to the funds for a portion of this coverage normally, but their cost is often subsidized by the contributions made for active workers; that is, the retirees contribute less than the actual cost of their coverage.

Retiree coverage is becoming rare in non-unionized private sector employment, and many workers are compelled to remain actively employed just for health insurance coverage. However, many Taft-Hartley health and welfare funds cover workers in industries, like building and construction, who engage in physically demanding labor and become unable to continue working in covered employment before the age of Medicare eligibility. Pre-Medicare retiree health coverage is very important to these workers, but subsidized retiree coverage is also expensive for the funds and active workers; a higher collectively bargained contribution rate for active workers’ covered employment is needed to support the retiree coverage.

8. Unfair cost-shifting in the health care system is a problem for all employment-based health plans. Taft-Hartley, multiemployer health and welfare funds are especially harmed by this cost-shifting. First, the funds are charged higher prices by providers or otherwise forced to subsidize the uncompensated medical care provided to uninsured workers and their dependents by hospitals and other providers. Second, a fund’s contributing employers are commonly competing against non-union employers that do not maintain employee health plans and whose employees are uninsured. These irresponsible, non-union employers have

an unfair cost advantage over union employers that contribute for their employees to the health and welfare funds. This unfair competition by non-union employers results in a loss of the covered, union employment that generates contribution income for the health and welfare funds and benefit eligibility for the workers and their families. This unfairness is exacerbated by the fact that the uninsured, non-union workers and dependents receive uncompensated medical care, the cost of which is shifted to employee health plans including health and welfare funds.

9. Faced with persistent, systemic health care cost inflation over the past 20 years, Taft-Hartley, multiemployer 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, like unfair cost shifting by irresponsible employers and by government programs. As a result, health and welfare funds have been compelled to press the collective bargaining parties—actually, the active workers—to shift more wages into health and welfare contributions.

The fact is that national, systemic reform legislation is needed to deal with unsustainable health care cost inflation. And, universal health insurance coverage is an essential element of that reform.

Committee's Options Papers

With the foregoing background, we offer the following comments on the Committee's options papers concerning Expanding Health Care Coverage and Financing Comprehensive Health Care Reform from the perspective of the Taft-Hartley health and welfare fund community.

1. Personal Responsibility Coverage Requirement

We are supportive of a federal requirement that all individuals have health plan coverage that meets certain minimum standards, as part of comprehensive health care system reform. However, any legislation containing an individual mandate needs to clearly provide that coverage under a Taft-Hartley health and welfare fund satisfies the mandate, and provide workable means for continuing compliance with the mandate during periods of temporary unemployment or under-employment, such as payment of subsidies to a health and welfare fund for COBRA continuation coverage (like the COBRA subsidies provided under the American Recovery and Reinvestment Act of 2009.).

Further, the legislation must not enable or encourage individual opt-outs from health and welfare fund coverage. Allowing individuals to voluntarily exit health and welfare fund coverage to obtain coverage through a Health Exchange or otherwise would encourage adverse selection and destabilize the fund's financing. More than that, it would undercut the fundamental purpose and function of the collective bargaining process and the union's role as the exclusive bargaining representative for the whole employee unit, contrary to federal labor law and policy.

Any minimum standards for the mandated health plan coverage must take into consideration the need of Taft-Hartley, multiemployer health and welfare funds for plan design flexibility as well as the public interest in universal coverage for basic benefits.

To the extent that government subsidies are provided to individuals for the purchase of health plan coverage, the subsidies should be available to workers who otherwise qualify (based on income or other criteria) and obtain coverage under a Taft-Hartley health and welfare fund. As Congress has recognized in other laws, like the Medicare Part D prescription drug program and the COBRA subsidy provisions of the American Recovery and Reinvestment Act of 2009, the most effective means for subsidizing the coverage of individuals under a Taft-Hartley health and welfare fund is direct cash payments to the funds. We would be pleased to participate in working out the important details of such a government subsidy program as it relates to our funds.

2. Employer Shared Responsibility

We strongly support an employer mandate on the "play or pay" model. As noted above, irresponsible employers that do not provide health plan coverage for their employees have had an unfair competitive advantage over responsible employers contributing to Taft-Hartley health and welfare funds, and this unfair competition has adversely affected health and welfare funds through loss of contribution income and cost-shifting. However, it is important that the "play or pay" mandate be carefully designed to prevent evasion, end unfair competition among employers, and be supportive of employer sponsored plans including Taft-Hartley, multiemployer health and welfare funds.

First, "small employers", however defined in legislation, should not be exempted from the mandate. The vast majority of employers that contribute to health and welfare funds pursuant to collective bargaining agreements are small employers in terms of numbers of employees and payroll, particularly in industries like building and construction. And, the employers against whom our contributing employers compete are often small employers.

Second, the financial consequences to an employer of not providing at least the minimum employee health plan coverage must be sufficiently high to encourage employers to sponsor employee health plans and to discourage employers from dropping their existing employee health plans. In particular, the tax or assessment should be sufficient in amount to pay the full cost of the employees' and their dependents' coverage through the Health Exchange.

Third, the legislation must close the “independent contractor loophole” through which non-union employers evade various legal obligations for their employees including income tax withholding and payroll taxes. This is a major problem in the building and construction industry; a loophole that is being flagrantly and widely abused by non-union contractors and that is costing the U.S. Treasury a huge amount of revenue. A “play or pay” health care mandate will undoubtedly result in more misclassification of employees as independent contractors unless the legislation closes the loophole. Misclassification would enable an employer to evade both the “play” and the “pay” requirements, and shift full responsibility for health insurance coverage to the individual. Worse, the misclassified employee may qualify for a government subsidy for individual health insurance coverage through the Health Exchange. In other words, by misclassifying an employee, the non-union employer could shed all responsibility, shift costs to the government, and gain a competitive advantage over responsible employers.

Fourth, the “play” aspects of the legislation must set minimum standards for coverage that are meaningful and require employers to contribute a substantial share of the cost of coverage for their employees and their employees’ dependents. We are concerned that the 50% employer contribution mentioned in the Committee’s options paper is insufficient, and that an 80% share would be more appropriate and more in-line with the national average employer share of employer health plan premiums.

Any minimum standards for the mandated health plan coverage must take into consideration the need of Taft-Hartley health and welfare funds for plan design flexibility as well as the public interest in universal coverage by basic benefits.

Fifth, an employer that contributes to a Taft-Hartley, multiemployer health and welfare fund meeting the minimum standards must be deemed to satisfy any employer mandate, even if not all of the employees for whom the employer contributes satisfy the fund’s benefit eligibility rules at any given time.

Sixth, the legislation must not enable or encourage individual opt-outs from health and welfare fund coverage. Allowing individuals to voluntarily exit health and welfare fund coverage to obtain coverage through a Health Exchange or otherwise would undermine the fund.

Seventh, to the extent that government subsidies are provided to employers to encourage new or continuing sponsorship of employee health plans, the subsidies must be made available on a workable basis to Taft-Hartley health and welfare funds for the contributing employers and covered workers. As Congress has recognized in other laws, like the Medicare Part D prescription drug program and the COBRA subsidy provisions of the American Recovery and Reinvestment Act of 2009, special care is required in designing government subsidies that are workable for our health and welfare funds and their contributing employers. For example, subsidies in the form of payroll tax reductions for contributing employers or a health plan do not work for our health and welfare funds; rather, direct cash payments to the funds is the only

effective means for subsidizing sponsorship of and coverage under a health and welfare fund. We would be pleased to participate in working out these important details.

This point about employer subsidies also applies to any proposed tax incentives for wellness and preventive care programs. Since it is the health and welfare fund (and not the contributing employers) that adopts and administers these programs, like all of the other benefits provided by the fund, any legislation must provide means for making such incentives available to Taft-Hartley, multiemployer health and welfare funds which include the target programs to the same extent as they would be available to employer-sponsors of health plans. In other words, participants in a multiemployer health and welfare fund should be eligible for federal financial support for their health benefits to the same extent as employees covered by single employer plans.

3. Insurance Reforms & Health Exchange

We understand that the Committee does not intend the insurance reforms to apply to self-funded employee health plans and large group insured plans. However, we recognize that at least some of those reforms will affect Taft-Hartley health and welfare funds, whether self-funded or insured, to the extent of the minimum coverage requirements of any individual mandate or employer “play or pay” mandate. As mentioned above, any minimum standards for the mandated health plan coverage must take into consideration the need of Taft-Hartley health and welfare funds for plan design flexibility as well as the public interest in universal coverage by basic benefits.

Further, no legislation should require any health and welfare fund to allow a covered worker to voluntarily opt-out of fund coverage to obtain alternative coverage through the Health Exchange or otherwise.

Moreover, the Taft-Hartley fund community would strongly object to any legislative proposal that would ease ERISA preemption of State laws relating to the funds. This includes any proposal to empower State authorities to enforce federal standards or to adopt State laws to supplement federal standards. The preservation of a nationally uniform, federal regulatory scheme for employment-based health plans, including Taft-Hartley health and welfare funds, is essential for the reasons described above.

4. Pre-Medicare Retirees

As noted above, Taft-Hartley health and welfare funds commonly provide subsidized coverage for pre-Medicare age retirees under various terms and conditions. This coverage is very important to our retirees, but it can also be a significant burden on the active workers who, in effect, subsidize the retirees’ coverage.

We strongly support including in reform legislation a government subsidy program for

retiree coverage, similar to the Medicare Part D subsidy program, or making alternative coverage available on appropriate terms through the Medicare program or the Health Exchange if a health and welfare fund ceases to provide retiree coverage. The Committee's options papers describe a Medicare Buy-In proposal, but it is apparent that the proposal would be far from adequate or even helpful, as discussed in the comments submitted to the Committee by the AFL-CIO.

5. Tax Treatment of Health & Welfare Fund Coverage

We cannot overstate our firm opposition to any proposal that would subject workers to income or payroll tax on their Taft-Hartley health and welfare fund coverage or on their employers' contributions to the funds. Such taxation would counter-productively discourage maintenance of the funds, and punish workers for taking responsibility for their health coverage through the funds.

We reject the economic theorists' arguments that the current tax exclusion encourages workers to choose overgenerous, so-called "Cadillac" health plan coverage over taxable wages or that the exclusion keeps workers ignorant of the true cost of their health benefits. Our reality, as described above, is that workers are well aware of the true cost of their health and welfare fund coverage; they, through the collective bargaining process, pay the full cost; they make an explicit choice as to how much of their compensation package will be allocated to health and welfare contributions versus cash wages. And, it is ludicrous to suggest that these workers choose excessive health and welfare coverage at the expense of their take-home pay. Wealthy individuals may have the luxury of manipulating their health plan coverage to maximize their tax advantage, but that is not the world of the workers covered by our health and welfare funds.

Moreover, it would be patently unfair to deem a health and welfare fund's benefits as excessive based on its costs. As the Committee must be aware, funds with identical benefit packages can have widely varying costs depending on various factors such as the fund's geographic location (high cost of living areas versus low cost areas), the ages and health status of the fund's participants and beneficiaries, whether the fund provides retiree coverage, and whether the fund has incurred catastrophic claims.

Also, there would be serious practical problems and unfairness involved in determining how to tax participants in a health and welfare fund. For example:

- If a worker were subject to taxation on collectively bargained employer contributions to a fund based on his covered employment, would the tax still apply if he failed to obtain or maintain benefits eligibility?
- Would a worker be taxed on all contributions made by his employer based on his covered employment even though, as explained above, that amount of contributions bears no correlation whatsoever to the actual cost of that worker's or his family's coverage by the fund because of the fund's pooling mechanisms?

- Given that the same rate of contributions is made for workers without and with dependents, would a worker with dependent coverage be assessed a higher tax than the single worker?
- Conversely, would a single worker, or one whose spouse has health coverage through her own employer, be taxed on the total contributed with respect to him, even though some part of the contributions is going to finance the coverage for other workers' families?
- What of the active workers who participate in a health and welfare fund that provides subsidized retiree coverage; would they be taxed on that portion of the contributions used to pay for the retirees' care?
- What about a worker for whom more contributions are made during an eligibility period than necessary to maintain eligibility; would he be taxed more than a worker for whom the minimum required contributions were paid, even though they both receive the same benefit eligibility?

The Taft-Hartley fund community has been supportive of national health care reform largely because our workers have been paying their own way and carrying an unfair share of the responsibility for others. We have looked forward to keeping what we have, as promised, and unburdening our funds and their participants of unfair costs. The inclusion of a tax on employer contributions or health and welfare fund coverage in any legislation would immediately destroy support for health care reform in our community; indeed, it would arouse active opposition. The proof of this point lies in our experience during the 2008 Presidential Campaign. Senator McCain's "health care reform" plan, including its repeal of the tax exclusion and substitution of a tax credit, was soundly rejected by workers and caused many more workers to vote for President Obama.

In conclusion, we again applaud you for taking on this important task of crafting national, systemic health care reform legislation. We ask that you take care first to do no harm to the Taft-Hartley, multiemployer health and welfare fund community, but also to foster the continued growth and soundness of the funds for the benefit of the many millions of workers and families who depend on them. We would be pleased to assist you in working out any details of legislation as relates to our health and welfare funds.

If you have any questions concerning this matter, please feel free to contact NCCMP Executive Director Randy DeFrehn at (202) 756-4644.

Respectfully,

Mark H. Ayers

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Chairman