

NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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Submitted via: Notice.Comments@irs.counsel.treas.gov

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Courier's Desk
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

Re: CC:PA:LPD:PR (Notice 2011-36)

To Whom It May Concern:

The National Coordinating Committee for Multiemployer Plans (the NCCMP) is pleased to submit these comments to Notice 2011-36, which address certain issues related to implementation of the Patient Protection and Affordable Care Act (the Affordable Care Act or the Act). The Treasury Department and the Internal Revenue Service (IRS) released Notice 2011-36 on May 3, 2011.

The NCCMP is the only national organization devoted exclusively to protecting the interests of the approximately 26 million workers, retirees, and their families who rely on multiemployer plans for health, retirement 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 airline, building and construction, entertainment, health care, hospitality, longshore, manufacturing, mining, retail food, service and trucking industries.

Overview of Multiemployer Plans

Multiemployer plans are established and maintained pursuant to collective bargaining agreements between one or more unions and at least two employers. Typically structured in accordance with section 302(c)(5) and (c)(6) of the Taft-Hartley Act, the plans are operated through stand-alone trusts managed by a joint labor-management Board of Trustees. They serve participant populations in industries where employment is historically fluid, such as the construction, trade, maritime, entertainment, and the hotel and restaurant industries. Participants often move from one contributing employer to another. Contributing employers may be very small and may not have access to sophisticated payroll technology. Small employers may be unable to obtain affordable health coverage due to their size or the age and mobility of the workers. The multiemployer plan enables small employers to pool their resources, and mobile employees to pool their service with many different employers, to achieve the critical mass to make it cost efficient to provide group health plan coverage.

In multiemployer plans, the individual employer's role is typically limited to contributing the amounts required by the collective bargaining agreement, which are usually pegged to the intensity of work by covered employees (e.g., \$2 for each hour of covered service). The employee and employer representatives, acting together, make all plan design and operational decisions including eligibility, coverage, administration, funding (insured, administrative-services-only (ASO) arrangements, partially insured, or fully self-insured), selection of the plan's benefit delivery systems, and selection of the plan's service providers and advisors. This work is done through a joint Board of Trustees with an equal number of union and employer representatives. Unlike a typical single employer program in which the employer generally has complete, unilateral discretion, this joint labor-management organizational structure gives the employees, through their union, an equal voice in all plan matters. Because there may be many individual employers contributing, they do not have a direct say over plan details; their influence is expressed through the employer trustees, as well as through the contribution agreement negotiated with the union.

Multiemployer Plans are not Addressed in the ACA

The Affordable Care Act only references multiemployer plans in a glancing manner. The Act contains references to multiemployer plans with respect to the excise tax, the Early Retiree Reinsurance Program, and a report regarding health coverage. However, when the core of the new law is examined – i.e., the individual mandate to obtain minimum essential coverage, the employer penalty, and individual subsidies, the role of multiemployer plans in the functioning of the new health insurance delivery structure contemplated in the Act is completely absent from the statute or legislative history.

The purposes of the ACA include increasing the number of insured individuals, bending the curve of spiraling health care costs, and allowing individuals with health coverage to keep the coverage that they have. Multiemployer plans play a key role in providing affordable, comprehensive, and consumer-oriented health coverage to 26 million participants, including retirees, and their families. Consequently, the regulatory agencies have the responsibility to interpret the ACA to effectuate the purposes of the Act and allow multiemployer plans to continue to provide this role. While we recognize and respect the fact that the agencies must dedicate resources to address interpretation of the law for a wide variety of health coverage, the agencies have authority to resolve this technical and complex statute in a manner that reconciles the conflicting provisions of the statute and fashions a reasonable solution that will allow multiemployer plans to continue to provide the superior coverage they currently have.

Executive Summary

These comments address the Act's ban on waiting periods of more than 90 days, as well as the employer responsibility provision (the free-rider penalty) imposed on large employers.

As explained more fully below, we ask the Treasury Department and the IRS to respect the decisions reached by the collective bargaining parties and each plan's Board of Trustees by:

- Starting the waiting period's 90-day clock at the end of the work period during which the participant works sufficient hours (or meets another relevant measure of work in the industry) to become eligible for health coverage through the multiemployer plan.
- Clarify that a three-month period or a calendar quarter will be treated as satisfying the 90-day rule.
- Exempting contributing employers from the free-rider penalty *with respect to collectively bargained employees for whom the employer makes collectively bargained contributions to a multiemployer plan that provides health benefits*. This means that such employees (a) would not be counted in determining whether the employer is large enough to be subject to the free-rider penalty; and (b) would not be taken into account in determining how much is owed, if the penalty applies with respect to the employer's non-bargained employees who may not be covered under a multiemployer plan.

Waiting Periods

1. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) introduced the concept of a waiting period for group health coverage. Existing HIPAA regulations provide that a waiting period is the period that must pass before coverage can become effective with respect to an employee or dependent otherwise eligible to enroll. Under HIPAA, time spent in a waiting period does not count as a break in coverage for purposes of HIPAA portability. This is important because individuals who have a break in coverage of 63 days or longer do not get credit for their prior coverage and can face a pre-existing condition exclusion.

HIPAA defined a waiting period but did not put a finite amount of time on any such waiting period. Under the Affordable Care Act, effective with plan years beginning on or after January 1, 2014, group health plans such as multiemployer plans (whether grandfathered or not) may not impose a waiting period of more than 90 days.

2. Eligibility Rules for Multiemployer Health Plans in General

Notice 2011-36 specifically asks for comments on how the waiting period should be applied when employees become eligible for coverage under a multiemployer plan after working a specific number of hours during an earlier period (such as the previous calendar quarter or the calendar quarter that began six months before the coverage quarter).

Eligibility rules for multiemployer health plans are established by a plan's joint Board of Trustees (comprised of an equal number of union and employer representatives) and are designed to reflect the unique working conditions of the particular industry. Usually, these conditions reflect a recognition of work patterns in which employees may be expected to suffer periods of temporary unemployment (such as in the construction industry where weather related slow periods in northern areas are expected and planned for) in which case the plan's longer eligibility "tail" will provide uninterrupted coverage spanning such periods. Typically, contributing employers pay an amount to a multiemployer plan that is set forth in a collective bargaining agreement. The amount is based on the number of hours, days, or weeks of covered

work performed by a covered employee (or another relevant measure of work in the industry, such as earnings in much of the entertainment industry).

The Trustees typically establish a **work period**, with work during that period leading to a later **coverage period**. Many plans have a lag period between the end of the work period and the effective date of coverage (i.e., the start of the coverage period), to allow reports from the contributing employers to be prepared and sent to the plan and to allow the plan to determine eligibility. Once hours have been counted and eligibility determined, coverage typically takes effect at the start of the coverage period, on the first day of a month, without the participant needing to enroll or take affirmative action.¹ Coverage is provided during the full period for which the person is eligible, even if he or she is no longer working in the industry by the time the coverage period begins.

The plans are familiar with how to determine eligibility for benefits based on the specific unit of service (hours (or other units of time), or earnings) as reported by contributing employers. Plans have established employer reporting, collection, and billing and reconciliation systems to assure that benefit eligibility is maintained for the full period for which the employee is entitled, taking into account all of the covered employers for which he or she works.

Many multiemployer plans use a single calendar quarter as the work period, but a fair number have longer work periods. Employees who do not accumulate sufficient hours or earnings in their first work period may not qualify for coverage until the end of the second work period or possibly later. Employees who regularly work in the industry in the region (or even across the country where reciprocity agreements are involved) maintain continuous coverage, even if they frequently change covered jobs.

As an example, a multiemployer plan may require that a participant work 300 hours in a 3-month work period to gain eligibility in a subsequent coverage period. Typically, work performed in a calendar month is reported by the contributing employers by a specific date (e.g., the 20th day) in the subsequent month. Therefore, if an employee completes the necessary hours to meet this standard based on hours worked in January through March, the plan would receive documentation by April 20, and the employee would be eligible for the May-July coverage period. The established periods reflect the ebb and flow of work availability in the particular industry.

We anticipate that the Treasury Department and Internal Revenue Service will receive a number of comment letters from multiemployer plans which will illustrate the variation in eligibility rules which are established in particular industries. We urge the Department and IRS to consider these unique eligibility rules as you prepare regulations on the waiting period requirements.

¹ Although Notice 2011-36 does not seek comments on the Affordable Care Act's automatic enrollment provisions (added by § 1511), Notice 2011-36 (see especially footnote 1) states that Treasury/IRS and the Department of Labor are coordinating the development of their respective guidance on the definition of full-time employee for purposes of the automatic enrollment provision (DOL) and the free-rider penalty (Treasury/IRS). As multiemployer plans automatically enroll participants as soon as they are eligible under the plan's particular eligibility rules, we urge the agencies to exempt contributing employers from the auto enrollment requirement (where otherwise applicable) with respect to employees for whom they make collectively bargained contributions to a multiemployer plan that provides health benefits.

3. Recommendation

It is our view that eligibility rules should continue to be set by each plan's Board of Trustees. To implement the Act's ban on waiting periods of more than 90 days, we recommend that the Treasury Department and the IRS start the 90-day clock at the **end** of the work period during which the participant works sufficient hours (or meets another relevant measure of work in the industry) to become eligible for plan coverage. This would mean that a plan's lag period – if it had one – could not be longer than 90 days.

We also recommend that three (3) consecutive months (and, similarly, a calendar quarter) be treated as the equivalent of 90 days so that enrollment can take effect at the start of a month, as is typically the case today. These reflect the accumulated experience of decades of bargaining over these benefit plans and honing the administrative practices to take into consideration the needs of those industries and is clearly consistent with the intent of the PPACA with respect to these issues.

An example in the existing HIPAA regulations² takes a slightly different approach by stating that a waiting period starts at the **beginning** of the work period during which the participant meets the hours requirement. This approach makes sense for HIPAA portability because it protects individuals from experiencing a break in coverage. In that context, the entire waiting period (no matter how long) should not count as a break in coverage. However, this approach should not be carried over and applied to the 90-day limit. For purposes of the 90-day limit, the lag period (if any) should be treated as the waiting period because prior to the end of the work period (i.e., the start of the lag period) the participant is not otherwise eligible for coverage under the plan.

The Free-Rider Penalty

1. Background

The Affordable Care Act requires large employers (those with 50 or more full-time employees) to pay a penalty if one of their full-time employees obtains subsidized coverage through a state health insurance exchange beginning in 2014. The amount of the penalty will vary depending on whether or not the employer offers health coverage to its employees.

Employers that do **not** offer coverage would pay an annual penalty of \$2,000 multiplied by the total number of full-time employees minus the first 30 employees (determined on a monthly basis). Employers that do offer coverage would pay a penalty of \$3,000 per year, but only for each full-time employee who obtains subsidized coverage in the exchange. An employee is eligible for subsidized coverage in the exchange if the employer's plan is unaffordable (i.e., the cost of self-only coverage is more than 9.5% of household income) or does not provide minimum value (i.e., provides coverage worth less than 60% of plan costs).

To determine whether the employer is a large employer, hours worked by part-time employees and some seasonal employees will also be counted. However, if the employer meets the 50-full-time-employee threshold and becomes subject to the penalty, the penalty will only be assessed

² 26 C.F.R. § 54.9801-3(a)(3)(iv)(example 5).

with respect to employees who work full time during the month at issue. The Act treats a person as a full-time employee if he or she works on average at least 30 hours per week.

As stated in Notice 2011-36, the definition of “full-time employee” is critical to the operation of the Act’s free-rider penalty. Notice 2011-36 contemplates using 130 hours per month as the monthly equivalent of 30 hours per week ($30 \times 52 = 1560/12 = 130$). It also suggests various ways of counting hours of service, depending on whether employees are paid hourly or are non-hourly employees. The notice also suggests ways of dealing with the requirement to count full-time employees on a monthly basis, including using a “look-back measurement period” that would determine which employees would be treated as full-time employees in a subsequent “stability period.”

2. Workers Covered by Multiemployer Health Plans

As discussed above, multiemployer plans cover participants in industries where employment is historically fluid, with participants moving from one employer to another. Indeed, the essential purposes of the multiemployer plan are to allow its contributing employers (which often are small employers) to pool their resources to provide benefits, and to allow the plan’s participants to pool their service with multiple employers in order to obtain health coverage and other benefits. Hours can fluctuate daily, weekly or monthly, and work can be erratic and episodic. But for the multiemployer plan, these workers would not have access to affordable, comprehensive health coverage for themselves and their families. Furthermore, especially in construction, longshore and entertainment, many employees would rarely, if ever, be considered “full-time” and achieve eligibility for benefits if the traditional corporate model were employed due to the frequency with which they change employers. Nevertheless, such employees will typically receive and maintain health and pension benefits coverage for their entire career and into retirement because of the aggregation and reciprocity arrangements within and among plans in that industry. For example, while many construction employees work for the same employer for prolonged periods; many others do not, changing employers with the completion of each new assignment. Some may last for several months or even a year or more, but the predominant employee pattern in that industry would be to move several times throughout the years; wherever his particular set of skills is required.

Several entertainment industry trust funds are submitting detailed comments on the specifics of their employment and eligibility patterns to which we would refer you. Although it would be redundant to reiterate those arguments in detail here, we would only note that the mobility in the entertainment industry can be even more frequent than that in the construction industry.

This is also the pattern in the longshore industry, where employees are assigned to unload the freight from vessels as they dock and employment in those instances is through the owners of each vessel, making traditional corporate notions of full time employment and establishing benefits eligibility virtually impossible. In these situations, the multiemployer model is the only practical alternative.

3. Multiemployer Plans and the Free-Rider Penalty in General

Many contributing employers to multiemployer plans will not be subject to the penalty due to their small size. Many other contributing employers will not actually have to pay the penalty because the health coverage provided to their employees through the multiemployer plan will meet the 60% minimum value test and the coverage will be affordable. Health coverage provided through multiemployer plans is typically comprehensive, with cost-sharing requirements that would easily meet the 60% test. The coverage will typically meet the affordability test because it is rare for participants to contribute for self-only coverage (indeed, it is also rare for multiemployer plan participants to be required to contribute for family coverage). As a result, it may not make sense to try to design creative and workable ways to count the hours worked by different types of workers, for multiple employers, for the purpose of assessing a financial penalty that will rarely apply. Indeed, in certain industries (such as the entertainment industry), due to the nature of the employment relationship, it may be next to impossible to count hours (or use time-based equivalencies).

4. Recommendation

We recommend that the Treasury Department and the IRS exempt contributing employers from the free-rider penalty *with respect to collectively bargained employees for whom the employer makes, or is required by a collective bargaining agreement to make, contributions to a multiemployer plan that provides health benefits* (whether those health benefits are self-insured, insured, or some combination). This means that such employees (a) would not be counted in determining whether the employer is large enough to be subject to the free-rider penalty; and (b) would not be taken into account in determining how much is owed, if the penalty applies with respect to the employer's non-bargained employees who may not be covered under a multiemployer plan.

Recently, in Notice 2011-28 (regarding informational reporting on the cost of health coverage on employees' W-2 forms), the Treasury Department and the IRS exempted contributing employers from the need to include the cost of coverage on these employees' W-2 forms, until further guidance is issued.³ We understand that this conclusion was based on an understanding of the disconnect between individual contributing employers and workers' coverage under multiemployer plans, which is the principle to which we are referring here.⁴

Most of the complexity in implementing the free-rider penalty where employers provide health benefits through a multiemployer plan stems from the difficulty in applying the concept of full-time employee to many of the workers typically covered by multiemployer health plans. Part of the complexity stems from the contributing employers' lack of critical information relevant to the operation of the free-rider penalty, plus their lack of control over the plan design decisions. With eligibility rules, benefit levels, and participant contribution requirements (if any) set by the plan's Board of Trustees, contributing employers generally will not know (a) whether a

³ We appreciate this recognition of the difficulty that contributing employers would face in complying with this requirement and hope the transition relief provided in that notice will be extended permanently.

⁴ There is precedent for disregarding certain collectively bargained employees when determining certain employer obligations under the Internal Revenue Code. Notably, IRC §§ 105(h) (self-insured health plans) and 401(a)(4) and 410(b)(3) (retirement plans) allow employers to disregard collectively bargained employees for purposes of nondiscrimination testing if there is evidence that health or retirement benefits, respectively, were the subject of good faith bargaining.

particular individual has accrued enough hours or earnings to be eligible for plan coverage; (b) the effective date(s) of that coverage and coverage period(s); (c) whether the plan meets the 60% minimum value test; or (d) whether participant contributions are required and, if so, the amount of those contributions.

Finally, we would like to emphasize that exempting contributing employers from the free-rider penalty with respect to the collectively bargained employees for whom the employer is making contributions to a multiemployer plan that provides health benefits reflects the interplay between the ACA and the National Labor Relations Act's recognition that this is a mandatory subject of bargaining⁵. The existence of the employer's contractual obligation to contribute to these plans should be sufficient to meet the ACA's requirement. The ACA has not repealed any aspect of labor law; therefore, the existing obligations of employers under labor law must be respected

Conclusion

We appreciate the efforts of the Treasury Department and Internal Revenue Service as you work to implement the Affordable Care Act. We appreciate the opportunity to submit comments on these important issues and would welcome the opportunity to clarify any point which appears unclear. Please do not hesitate to contact me if you have any questions about our comments or need additional information.

Respectfully submitted,

Randy G. DeFrehn
Executive Director

⁵ In 2006, Massachusetts passed a similar employer responsibility requirement in its health reform law. Although the obligations are not identical to the ACA, the Massachusetts law contains a "Free Rider Surcharge." The Free Rider Surcharge is assessed on employers with 11 or more full-time employees that do not offer a cafeteria plan, and whose employees obtain \$50,000 or more in state-funded "free care" during a year. The Free Rider Surcharge does not apply with respect to employees covered under a collective bargaining agreement. (114.5 CMR 17.00 et seq.).