

# NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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The Honorable Charles B. Rangel  
Chairman  
Committee on Ways and Means  
U.S. House of Representatives  
1102 Longworth House Office Building  
Washington, D.C. 20515

Greetings:

On behalf of the approximately 26 million 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 recent House Tri-Committee Health Reform Discussion Draft to supplement the record of your Committee's June 24, 2009 hearing.

Let me first congratulate you and the Ways and Means Committee as a whole, along with Chairman George Miller's Education and Labor Committee and Chairman Waxman's Energy and Commerce Committee, 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 in this Congress.

However, great care must be taken in crafting legislation to avoid harming our members' "Taft-Hartley" multiemployer health and welfare funds. These long-established collectively bargained funds are a large and essential part of the employment-based health plan system that national health reform is trying to preserve. As you know, even the best intended and carefully considered legislation can have unintended, counter-productive consequences.

We have been heartened by President Obama's recent public statements that health reform should ensure that workers "who already have health care aren't suddenly seeing their costs go up to pay for other peoples' costs going down" and that reform should be designed so that "everyone's costs can go down effectively." The President has often said that health reform should only fix what is broken in the health care system, not create solutions looking for a problem or that cause more problems than they fix.

Nevertheless, we have grave concerns that provisions of the Discussion Draft, if enacted into law without changes, would have the opposite effect for our health and welfare funds and the millions of working families who depend on them. It appears that the Discussion Draft may result in substantially higher costs for our health and welfare funds and the covered workers; yet the “small employers” who compete against the responsible employers participating in our funds (over 90% of whom employ fewer than 20 workers and more than half who employ fewer than 10) would continue to escape any responsibility and continue to shift the costs of their employees’ health care to our funds and workers. The effect of the Discussion Draft would be to discourage participation in our health and welfare funds by employers and individuals to the serious detriment of the covered workers and their families.

### **The Importance & Special Nature of Multiemployer 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 airlines, 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.

**Collectively-Bargained Trust Funds:** A Taft-Hartley, multiemployer health and welfare fund is established and maintained through collective bargaining between one or more labor unions

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and more than one employer. As a matter of federal law, a 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).

**Plan Design:** 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 entirely from the fund's assets by the trustees, not by any contributing employer.

**Funding:** 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

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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.

**Eligibility Rules:** 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.

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.

**ERISA Preemption:** 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.

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.

**Administration:** Some 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. But, many 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.

**Retirees:** 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 eligibles. 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.

**Unfair Competition & Cost-Shifting:** Taft-Hartley, multiemployer health and welfare funds are especially harmed by unfair 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.

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, true universal health insurance coverage is an essential element of that reform.

### **Discussion Draft and Multiemployer Health & Welfare Funds**

**Costly New Mandates and Restrictions:** Application of the benefit and regulatory mandates of Title I to a multiemployer health and welfare fund (a group health plan that is a multiemployer plan under section 3(37) of ERISA), especially to a self-funded health and welfare fund, would substantially increase the costs of the fund's benefits and administration. Higher costs to the funds for benefits, administration, and legal compliance necessarily translate into a greater portion of the workers' pay package being dedicated to health and welfare fund contributions and less in cash wages. There is no other source of revenue to offset higher health plan costs than the workers' pay, as explained above.

The health and welfare funds are not insurance companies motivated by profit; to the contrary, the funds are non-profit, tax-exempt trusts. The 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, our health and welfare 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 and beneficiaries.

Participation by an employer in a health and welfare fund, and its compliance with its collectively bargained contribution obligations to the fund, must be deemed to satisfy any employer responsibility ("play or pay") requirement. And, coverage by a health and welfare fund by a participant or beneficiary must be deemed to satisfy any individual responsibility mandate.

Some multiemployer health and welfare funds might eventually wish to purchase coverage for their participants and beneficiaries through the Health Exchange. They should be permitted to do so, once the Exchange is opened to large employers. And, if any fund does so, it will thereby choose to assume the costs, mandates and responsibilities associated with Exchange participation.

**Health Choices Commissioner:** The Discussion Draft would create an expansive new regulatory regime and federal agencies (*e.g.* Health Choices Commissioner) on top of the existing, complex regulatory regime of ERISA, multiplying the regulatory and administrative costs that a health and welfare fund's participants and beneficiaries would have to bear. The Commissioner, in particular, would be granted very broad, discretionary to regulate the benefit programs and operations of the funds, and impose unlimited additional obligations and costs.

**Opting-Out of Funds:** Multiemployer health and welfare funds are very concerned about any legislation that would entitle individual participants to opt-out of fund coverage so they can buy coverage through a health Exchange. We are absolutely opposed to such an opt-out if the

participant's exercise of such a right could be construed under the law as relieving an employer of its collectively bargained obligation to contribute to the health and welfare fund or as requiring the employer to make a payment to the Health Exchange or government agency in addition to paying contributions to the health and welfare fund.

Such leakage would undermine the financial foundation of health and welfare funds, and the fundamental labor law concepts of exclusive bargaining representation and mandatory subjects of bargaining. Younger, healthier, unmarried workers would be incentivized by the legislation to opt-out of their health and welfare funds and buy cheaper coverage through the Health Exchange. The pool of higher risk covered lives left in the funds would be costlier to cover, of course.

This draining effect would be exacerbated if individual workers would receive government subsidies to buy coverage through the Health Exchange.

As noted above, multiemployer health and welfare funds are creatures of collective bargaining. The workers as a group, through their union as the exclusive bargaining representative, negotiate a collective bargaining agreement that requires the employer(s) to contribute to the health and welfare fund for the work performed by all employees covered by the agreement. An individual employee is not permitted to exempt himself from the collective agreement, cut his own deal with the employer, and relieve the employer of its obligation to contribute to the fund for the work performed by the employee.

Moreover, any requirement that the opt-out individual's employer pay an assessment to the Health Exchange or other entity, in addition to complying with the employer's obligation to contribute to the health and welfare fund would incentivize employers to bargain out of the fund.

**Employer Responsibility-“Small Employer” Exemption:** We strongly support enactment of federal legislation that would require all employers to contribute significantly to the cost of providing health care coverage for their workers and the workers' families. As noted above, the cost of health care for the workers of irresponsible employers and their dependents is being shifted to health and welfare funds and their participants and, through them to the small employers who must compete with those firms. Moreover, these free-riding employers enjoy a big, unfair competitive advantage over responsible employers that contribute to our health and welfare funds. In other words, the workers covered by our funds are being required to pay the health care costs of their non-union competitors by the current system.

We are pleased to see that the Discussion Draft would require employers to “play or pay”. However, we are alarmed to hear that the Committee intends to exempt “small employers” and extend the exemption to employers who have less than 25 employees. Such an exemption would allow, indeed encourage, the unfair competition and cost-shifting that led us to support national health care reform.

As noted above, many, if not most, employers participating in multiemployer health and welfare

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funds are small employers; often with fewer than 10 employees. To exempt the business competitors of our employers from any responsibility for their employees' health coverage would be to grant irresponsible employers a great competitive advantage over responsible small employers. This would discourage employers from remaining in or joining our health and welfare funds.

In addition, a "small employer" exemption would provide even more financial incentives for employers to misclassify workers as "independent contractors" and avoid any "play or pay" responsibility.

**Government Subsidies:** The individual and employer subsidy programs that would be created by the legislation should be designed to (a) enable workers and dependents (participants and beneficiaries) to keep their health and welfare fund coverage and (b) encourage employers to continue participating in and contributing to the funds.

We read the Discussion Draft as providing for subsidies for employers who obtain health plan coverage for their employees outside of the Health Exchange, including employers that contribute to multiemployer health and welfare funds. If this is, in fact, the drafters' intent, we applaud it, but ask for an opportunity for input on how to make the subsidy program effective in a multiemployer fund context.

With regard to individual subsidies, we read the Discussion Draft as providing such subsidies only for individuals who buy health plan coverage through the Health Exchange. We urge that any individual subsidy be extended to participants and beneficiaries in multiemployer health and welfare funds that would otherwise qualify by virtue of their income level.

We applaud the Discussion Draft's commitment to provide for a subsidy program for pre-Medicare retirees. A great many of the workers covered by our health and welfare funds, particularly in the building and construction industry, are physically unable to continue working at their trades until Medicare eligibility age.

The individual "COBRA" subsidy program under the American Recovery and Reinvestment Act of 2009 is helping to maintain health and welfare fund coverage for unemployed workers, and the Medicare Part D subsidy program is helping retirees to maintain their prescription drug coverage under our funds. Both of these programs were designed to be workable for our funds and participants. Similar, widely available subsidy programs for active workers and pre-Medicare retirees should be included in health reform legislation. We would be pleased to discuss with the Committee's staff how such programs can be designed to be workable in the multiemployer fund context.

There are other aspects of the Discussion Draft on which we have comments and concerns. But, in view of the Committee's strict guideline for submissions, let me conclude by again congratulating you for taking on the daunting task of crafting national, systemic health care

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reform legislation. We look forward to the Committees, the House, and eventually the Congress passing reform legislation that helps multiemployer health and welfare funds and their millions of participants and beneficiaries. 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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