NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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The Honorable Phyllis Borzi
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Room S-2524
Washington, D.C. 20210

J. Mark Iwry
Senior Adviser to the Secretary and
Deputy Assistant Secretary for
Retirement and Health Policy
U.S. Department of Treasury
Departmental Offices
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Re: Notice 2012-17 *"Frequently Asked Questions from Employers Regarding Automatic Enrollment, Employer Shared Responsibility and Waiting Periods"*

Dear Assistant Secretary Borzi and Deputy Assistant Secretary Iwry:

The National Coordinating Committee for Multiemployer Plans (the NCCMP) is pleased to submit these comments to Notice 2012-17, "Frequently-Asked-Questions from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods," which addresses certain issues related to implementation of the Patient Protection and Affordable Care Act (the ACA or the Act). The Notice is also reproduced as Department of Labor Technical Release 2012-01.

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.

The NCCMP has previously provided comments on a variety of ACA issues. In particular, we provided comments on Notice 2011-36, which raised many of the same questions as the instant Notice. These comments are attached for your reference.

Brief Statement

The NCCMP commends the agencies for the thoughtful approach to review of these issues. We agree that employers should not be required to comply with the Automatic Enrollment provisions of the ACA in 2014, and that it is important to issue guidance on automatic enrollment which takes into account all of the market changes which will be operational in 2014, many of which are not yet well-defined in regulatory guidance. We urge the Department of Labor to consider the structure and administrative realities of multiemployer plans which are distinctly different from a typical single employer structure when the proposed automatic enrollment guidance is announced.

With respect to the employer shared responsibility penalty, the NCCMP continues to believe that contributing employers who make collectively bargained contributions to a multiemployer plan that provides minimum essential health benefits should not be required to pay the employer shared responsibility penalty. We suggest that the process of requiring employers to test employees based on whether they are "full-time employees" does not matter when the employee earns coverage not from the employer but from the multiemployer plan. Consequently, as long as the multiemployer plan to which the employer contributes provides minimum essential health benefits, and is compliant with the 90-day waiting period limit, the employer should not be subject to the shared responsibility penalty.

We agree with the agencies that the 90-day waiting period begins when an employee is otherwise eligible for coverage under the terms of the group health plan. Coverage under a multiemployer plan begins when an individual satisfies a prescribed eligibility criteria, such as a certain number of hours/days worked, or a certain amount of dollars banked. Because they are not criteria that are "based solely on the lapse of a time period," these eligibility rules should survive intact. The waiting period's 90-day clock should begin 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. This comment provides additional details on the 90-day rule.

Finally, we agree with the agencies that a three-month period should be treated the same as a 90-day period for purposes of the statute.

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 and frequently highly mobile, 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 is the functional embodiment of many of the objectives of the ACA as it 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. Moreover, this Board of Trustees has a statutory obligation to administer the trust for the sole and exclusive benefit of the participants. 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.

The Affordable Care Act does not address how employers that contribute to multiemployer plans meet their obligations under the shared responsibility penalty of IRC section 4980H. Many small employers that contribute to multiemployer plans do not have 50 full time employees (or their equivalents). These small employers would therefore not be subject to the 4980H penalty. Even more employers have fewer than 200 employees, and would therefore not be subject to the automatic enrollment rules. Since the ACA requirements are employer-specific tests, these employers would not have to offer coverage to participants whose eligibility is determined based on an aggregation of service with multiple employers.

It is important to note that multiemployer plans expand the reach of the ACA to include many employers and employees (and their families) who would not otherwise benefit from the Act, because the specific employer is not otherwise subject to the employer shared responsibility penalty or the automatic enrollment rule. It is only through the collective bargaining obligation that many of these contributing employers have any obligation to provide health coverage, even after implementation of the ACA. Through a combination of reaching employers who are otherwise not subject to the ACA, and through implementation of a reasonable 90-day waiting period rule, multiemployer plans will expand coverage further than contemplated by the ACA. Consequently, rules should be implemented to assure that multiemployer plans can continue to provide the coverage they currently do to the plan's participants and dependents.

Waiting Period

Notice 2012-17 states that guidance will address employees or classes of employees who are eligible for coverage once they complete a specified cumulative numbers of hours of service within a specified period (such as 12 months). The Notice states that eligibility conditions will not be treated as designed to avoid compliance with the 90-day limit, so long as the required cumulative hours of service do not exceed a number of hours to be specified in future guidance.

It is troubling to attempt to place a maximum number of hours of service on the criteria for cumulative numbers of hours of service, particularly since eligibility conditions not based on lapse of a time period are permissible, e.g., full-time status, bona fide job category, or receipt of a license. Industries which require completion of standards during a work period, which result in eligibility during a coverage period, tend to do so because of the exigencies of the workplace.

For example, in the construction industry, eligibility periods are typically based on monthly or quarterly reporting. The eligibility standards for the number of hours that must be worked in order to achieve eligibility are set by the trustees of the multiemployer plan, not by the employer, and could be adjusted based on plan costs and to provide for extended eligibility for participants during predictable periods of unemployment (such as are typically encountered in the construction industry in northern climates during winter). For example, a worker may need to work 200 hours/month to obtain coverage under a comprehensive plan that provides 90% coverage. However, the worker might need to only work 150 hours/month to obtain coverage under a less comprehensive plan – for example an 80% plan. Trustees should have the flexibility to set the hours requirements to be able to provide cost-effective coverage for plan participants.

In addition, a maximum number of hours standard would not work in other industries, such as entertainment, where eligibility may be determined based on earnings. Similarly in seasonal industries, such as resort workers, a worker may work during a "season" to earn eligibility for the next calendar year. For example, earning 1000 hours during a summer season would provide eligibility for the entire next calendar year.

We believe that the statute merely provides that a 90 day period starts when an individual is otherwise eligible for benefits under the plan. Setting a maximum number of hours standard for industries is counterproductive and not consistent with the plain language of the law.

An example may help illustrate how a typical multiemployer plan with staggered eligibility periods would be treated under the 90-day rule.

> **Proposed Regulation Implementing PHSA 2708**
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> Example 1 (i) Facts. To be eligible for coverage under a multiemployer group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the quarter previous to the most-recent quarter. For example, to obtain coverage in July-August-September, an individual must have worked 250 hours in covered employment during January-February-March. If the hours requirement is satisfied, coverage becomes effective on the first day of the current calendar quarter. The intervening calendar quarter is a "lag" period during which contributing employers report hours and make contributions to the plan. Employee A begins work on January 28 and works 250 hours in covered employment during the first quarter (ending March 31). A is enrolled in the plan with coverage effective July 1 (the first day of the third quarter).
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> (ii) Conclusion. Waiting period means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. In this Example, A's enrollment date is the first day of the first quarter during which A is otherwise eligible to enroll, which is July 1. The period from April 1 through June 30 is a waiting period.
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> Example 2 (i) Same plan terms as Example 1. Employee A begins work on January 28 and works 150 hours in covered employment during the first quarter (ending March 31). A works 250 hours in covered employment during the second quarter (ending June 30). A works 250 hours in covered employment during the third quarter (ending September 30). A is enrolled in the plan with coverage effective October 1 (the first day of the fourth quarter).
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> (ii) Conclusion. In this Example 2, A's enrollment date is the first day of the first quarter during which A is otherwise eligible to enroll, which is October 1. A was not eligible to enroll until the fourth quarter, because he did not earn enough hours of work until the end of the second quarter. The period from July 1 through September 30 is a waiting period.

As illustrated by the examples, the plan's trustees establish the eligibility periods necessary to earn coverage in a coverage period. As hours are reported to the plan, it would not matter how many employers A worked for during the eligibility period, as long as hours were earned to satisfy the plan's eligibility rules. The plan would satisfy the requirements of PHSA 2708 because its waiting period, or "lag time" is less than 90 days.

Notice 2012-17 also requests comments on how the maximum cumulative hours approach would apply to plans that credit hours of service from multiple different employers and plans that use hours banks. The comments we have provided generally relate to plans that credit hours of service from multiple different employers.

Plans that use hour banks are popular in some industries. In one common model, an individual who earns hours in excess of those required to achieve initial eligibility for coverage based on hours standards established by the multiemployer plan may "bank" such excess hours which can be applied to satisfy shortfalls in hours of contributions in subsequent periods when work is slow and insufficient hours were accumulated. Many plans have also taken a "dollar bank" approach. This allows individuals to gain eligibility based on credit for the amount worked by having dollar equivalents reported to the fund, and the fund using the dollars to provide coverage at current contribution rates. Again, unused bank dollars would be used for coverage when insufficient hours are earned in the work period.

Plans that use an hours bank would be treated no differently from other plans, because eligibility is earned in the same manner. The only difference with an hours bank is that the hours can accumulate to support eligibility in future coverage periods. This is illustrated in the following example. Dollars banks would be treated in the same manner.

> Example 3 (i) Same plan terms as Example 1, except that any excess hours earned by an employee that are not used during a coverage period are allowed to carry forward.
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> Employee A begins work on January 28 and works 150 hours in covered employment during the first quarter (ending March 31). A works 350 hours in covered employment during the second quarter (ending June 30). A works 250 hours in covered employment during the third quarter (ending September 30). A is enrolled in the plan with coverage effective October 1 (the first day of the fourth quarter)[1].
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> (ii) Conclusion. In this Example 3, A's enrollment date is the first day of the first quarter during which A is otherwise eligible to enroll, which is October 1. A was not eligible to enroll until the fourth quarter, because he did not earn enough hours of work until the end of the second quarter. The period from July 1 through September 30 is a waiting period. A has achieved eligibility for three quarters, because the hours carry forward.

Conclusion

We appreciate the opportunity to comment on these items and to reiterate some of the points we had made in conjunction with earlier requests regarding Notice 2011-36. As noted above, we are encouraged that the Notice positively responds to several of the practical considerations of

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[1] Alternative models exist which credit all hours worked. For example, in the third illustration, if the employee had earned 200 hours rather than 350, the result would be the same; that is, the employee would be able to apply the 150 hours earned during the first quarter to the 200 earned hours, thereby meeting the 250 hour requirement in the second quarter and initiating coverage in the fourth quarter following the required waiting period.

administering plans that are dependent on decentralized eligibility determinations and lag time associated with the filing of reports and submission of hours-based contributions.

We are hopeful that the final rules also acknowledge the value of and recognize that the objectives of the ACA will be advanced beyond the threshold population envisioned in the Act through continuation of the multiemployer system. This happens when employers that, because of their size, are otherwise exempt from the employer shared responsibility and automatic enrollment requirements, nevertheless, chose to provide coverage to their employees by fulfilling their collective bargaining obligations to make timely payments to plans that are already inherently more stable than are single employer plans because they are comprised of include both large (i.e. "covered") and small ("exempt") employers. However, by definition, the economies of scale that have proven so successful in providing comprehensive, cost-effective health care coverage for the employees of such employers are accomplished only by removing direct control over many such administrative functions from the contributing employer.

Recognizing that the existing collection policies and procedures required of such plans under ERISA already provide significantly greater incentives to employers to make timely payments on behalf of covered employees than are provided under the Act, it would appear both counterintuitive and counterproductive to this effort to undermine their continued participation by also exposing such employers to these new penalties.

We are available to expand upon and clarify any of the points described above at your convenience by phone or e-mail at the addresses captioned in our letterhead.

Respectfully submitted,

Randy G. DeFrehn
Executive Director