NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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April 9, 2012

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

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).

(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.

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).

(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.
>
> 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].
>
> (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

[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,

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Executive Director

NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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Submitted via: Notice.Comments@irscounsel.treas.gov

June 17, 2011

Courier's Desk
Internal Revenue Service
1111 Constitution Avenue, NW
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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 regulations[2] 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 x 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 bargaining[5]. 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.).