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Implications for Multiemployer Welfare Benefit Plans

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As part of our continuing initiative to help clients understand the complexities of the new health care reform changes in the Patient Protection and Affordable Care Act (H.R. 3590) (the Reform Act), as amended by the Health Care & Education Affordability Reconciliation Act of 2010 (H.R. 4872) (the Reconciliation Act), the Proskauer Health Care Reform Task Force has prepared this client alert focusing on the most significant ways in which the new law affects multiemployer welfare benefit plans.

Multiemployer welfare benefit plans will have particular difficulty navigating the new requirements because the text of the Reform Act and the Reconciliation Act affecting many of the key issues (most particularly effective dates and the impact of grandfathering) is very ambiguous, leaving the resolution of those issues open to interpretation. We expect to issue future client alerts on these issues once the ambiguities are clarified through the issuance of regulations and other authoritative guidance.

I. Grandfathered Multiemployer Welfare Benefit Plans

As we have addressed in our prior client alerts titled, Health Care Reform Has Arrived and Health Care Reform Has Arrived: Grandfathered Plans, "grandfathered plans" are eligible for compliance relief from many of the new requirements. Grandfathered plans generally include group health plans in effect on March 23, 2010 (*i.e.*, the date of the Reform Act's enactment). First, grandfathered plans may entirely avoid the application of a number of the new health reform rules. Second, grandfathered plans receive the benefit of delayed effective dates with respect to the implementation of other required changes.

With respect to provisions that do apply to grandfathered plans, non-collectively bargained plans generally must implement these health reform changes[1] by the first plan year that begins on or after September 23, 2010 (General Effective Date). For calendar year plans subject to the General Effective Date, changes will need to be implemented as of January 1, 2011.

Multiemployer welfare benefit plans appear to be able to benefit from two grandfathering rules. The first rule provides a general delayed effective date whereby multiemployer welfare benefit plans do not have to implement any of the health care reform requirements until after the expiration of the last of the collective bargaining agreements (that were ratified before March 23, 2010) relating to the coverage under such plan (the CBA Effective Date).[2] The second rule applies at the time of that CBA Effective Date and appears to then apply the grandfathering rules otherwise applicable to non-bargained plans at that time.

However, at this early stage following the passage of the new law, there remains a great deal of uncertainty about the scope and application of the CBA Effective Date. The following identifies some of those material uncertainties and provides our current views on these issues.

- *Retention Of Grandfathered Status* – There is a fair degree of ambiguity as to whether a multiemployer welfare benefit plan will retain its grandfathered status upon reaching its CBA Effective Date. Some commentators have expressed the view that a multiemployer welfare benefit plan could lose its grandfathered status upon reaching its CBA Effective Date. That would mean that the plan would have to comply with all of the health care reform mandates at that point and lose any ability to be treated as a grandfathered plan. We believe that this interpretation will ultimately be rejected and, instead, that the relevant provisions will be interpreted to mean that grandfathered collectively bargained plans retain that status beyond the CBA Effective Date assuming that they continue to satisfy the requirements for maintaining grandfathered status. Of course, any new plans that are established through collective bargaining would not likely satisfy the grandfathering requirements.
- *Application To Self-Insured Plans* - There is a technical reading of the Reform Act's delayed effective date for collectively bargained plans whereby an argument could be made that it only applies to insured plans and not self-insured plans. Although

this technical point exists the way the statute is drafted, we anticipate that a technical correction or some other type of guidance may be issued to clarify that the delayed effective date for collectively bargained plans applies to self-insured as well as to insured plans.

- *Impact of Covering Employees Not Subject to Collective Bargaining* - Another area of uncertainty relates to what it means to say that the delayed effective date applies to plans "maintained" pursuant to one or more collective bargaining agreements. That is, it is not clear what impact there will be on the delayed effective date if a multiemployer welfare benefit plan covers non-bargained employees as well. In our view, reasonable arguments can be advanced to support the application of the delayed effective date at the plan level regardless of whether the plan covers some participants who were not covered by collective bargaining agreements. The exact limits of this rule are expected to be developed. In other benefits-related legislation, plans have been considered to be collectively bargained if at least 25 percent of the participants in the plan are members of collective bargaining units for which benefit levels under the plan are specified under a collective bargaining agreement.

The foregoing issues are likely to remain open until such time as regulatory guidance is released by government agencies. At this point, the new law does not provide any relief for making "good faith" or "reasonable" efforts to comply with and/or interpret ambiguous issues for which there is no definitive guidance at the time that such decisions are made. Accordingly, it is important that trustees, fiduciaries and plan administrators confer with plan counsel for guidance before making any decisions about compliance issues arising from these ambiguous provisions.

In considering grandfathering and delayed effective date issues, it is worth noting that multiemployer welfare benefit plans will not lose the delayed effective date protection merely because they are amended for only some of the new health care reform rules before they are otherwise required to do so. As noted above, multiemployer welfare benefit plans may wish to do so in any case to avoid the application of certain provisions in the middle of a plan year. In any event, it is important for all multiemployer welfare benefit plans to confirm as soon as practicable when the applicable longest running collective bargaining agreement (ratified before March 23, 2010) will terminate so that the plan can address and plan for the various mandated changes.

II. Excise ("Cadillac") Tax on High-Cost Health Plans

Effective January 1, 2018, a non-deductible 40 percent excise tax will be imposed on multi-employer welfare benefit plans that offer heath coverage (single, single plus, or family) valued at more than $27,500. This dollar threshold will be indexed to inflation and may be increased if healthcare costs escalate prior to 2018. For plans that do not impose premiums for participant coverage, pending the issuance of technical guidance, our sense is that a plan's COBRA premium rates (minus 2 percent) can be used as a reasonable barometer for determining this threshold.

For insured plans, the insurer is responsible for payment of the excise tax. As such, it is important for a multiemployer welfare benefit plan to coordinate with the plan's insurer to confirm that the insurer will be responsible for the payment of any excise tax. With respect to certain arrangements, such as minimum premium arrangements, plans will need to await regulatory guidance as to whether such programs are deemed by the statute to be insured or self-insured. However, if a self-insured plan provides benefits in excess of this threshold, it will be directly responsible for the payment of the excise tax. In either case, insured and self-insured plans are responsible for calculating the amount of the excess benefit subject to the excise tax imposed for each applicable period. Even though the threshold is relatively high, consideration should be given to the impact of this excise tax when structuring and/or modifying plan benefits – particularly for plan years leading up to and commencing in 2018 and beyond.

III. Employer Mandates

The new law also imposes specific obligations and penalties for non-compliance on certain employers as a way to ensure that their full-time employees are offered and have access to affordable health coverage. Although employers remain solely responsible for these mandates, trustees, fiduciaries and plan administrators should be mindful of these requirements and the likelihood that contributing employers may request or demand plan information and/or changes to the plan of benefits to ensure compliance with such mandates. As contributing employers may look to bargain out of multiemployer welfare benefit plans that do not institute measures to avoid the imposition of these penalties, multiemployer welfare benefit plans may want to review the costs of achieving compliance with employer mandates (as of no later than the applicable effective dates). Two examples of employer mandates are:

Automatic Enrollment – Employers with more than 200 employees will be required to automatically enroll new full-time employees into employer-sponsored health plans. Employers must provide adequate notice to employees and the opportunity to opt out of coverage. For this purpose, a full-time employee is any employee who works on average at least 30 hours per week. The Secretary of the Department of Labor (Secretary) is expected to issue guidance explaining the hours requirement. The statute does not contain an exemption from this requirement for employer sponsored coverage provided through multiemployer welfare benefit plans. In addition, at this time, there is no specific effective date for complying with this requirement and, presumably, this requirement will not be effective until the Secretary issues regulations.

Employer Mandated Coverage - As a way to establish a market for the purchase of affordable health insurance, each state is required to establish and operate a regulated Insurance Exchange as of January 1, 2014. At that time, certain employers will be assessed penalties for failing either to offer or provide affordable health coverage to their full-time employees. For example, employers with more than 50 full-time employees that do not offer "minimal essential" health coverage and that have at least one full-time employee who receives a premium tax credit, will be assessed a penalty of 1/12th of $2,000 per month for each full-time employee in its workforce, excluding the employer's first 30 employees from the assessment. To the extent that an employer offers "minimal essential" health coverage, but has at least one full-time employee receiving a premium tax credit through an exchange, the employer will be assessed a penalty equal to the lesser of: 1/12th of $3,000 per month for each employee receiving a premium credit, or 1/12th of $2,000 for each full-time employee. These mandates apparently are imposed directly upon employers, and not upon plans (including multiemployer welfare benefit plans). At this time, the law does not impose any obligations upon multiemployer welfare benefit plans to collect, remit or pay the penalties otherwise owed by a contributing employer for violations of the mandates.

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The provisions and issues discussed above are certain of the key issues embedded in the Reform Act and the Reconciliation Act that will affect multiemployer welfare benefit plans. However, this is not intended as an exhaustive discussion of the panoply of potential issues. There are many issues relevant to multiemployer welfare benefit plans emanating from the statute that will need to be addressed through regulatory and other authoritative guidance. Plan trustees, fiduciaries, and administrators of multiemployer welfare benefit plans will need to remain informed with respect to developments as they unfold. Consideration will need to be given to each of the changes to be implemented, including the effect that certain provisions of the new law will have on contributing employers and the manner in which these provisions may have a material impact on the collective bargaining process.

We will provide more in-depth analysis of these issues in future client alerts and will continue to update our clients on new developments in this rapidly changing area of the law. In the meantime, please feel free to contact your Proskauer attorney or any member of our Health Care Reform Task Force should you have questions regarding health care reform. To ensure compliance with requirements imposed by U.S. Treasury Regulations, Proskauer Rose LLP informs you that any U.S. tax advice contained in this communication (including any attachments) was not intended or written to be used, and cannot be used, for the purpose of (i) avoiding penalties under the Internal Revenue Code or (ii) promoting, marketing or recommending to another party any transaction or matter addressed herein.

[1] As explained in our earlier client alerts, these mandates include prohibitions on: (1) lifetime dollar limits, (2) rescissions, and (3) pre-existing conditions for children under the age of 19; and requires coverage for non-dependent adult children up to the age of 26 regardless of marital status unless they are eligible to enroll in coverage under another employer’s plan.

[2] It is noteworthy that the CBA Effective Date is the date of termination of the last collective bargaining agreement and not the beginning of the following plan year. Thus, a plan that foregoes implementation of the new health care requirements until required by law may have to implement changes in the middle of a plan year.

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