The New Normal for Multi-Employer Plans:
Health Care Reform

By Cindy Lapoff, Esq.

In the ongoing hubbub regarding the Affordable Care Act (ACA), it can be difficult to decipher the rights and obligations of the employers who contribute to collectively bargained multi-employer plans. Individual participants are also struggling to understand how the ACA may affect them.

As part of this discussion, it is crucial to remember that health insurance is a commodity that can affect an individual's economic security at every phase of life. Contrast the apprentice member who is not yet eligible to participate in the union health plan with the retiree member who is not yet 65 and therefore not eligible for Medicare. One is likely younger, less concerned about health issues, less likely to have dependents, and reluctant to spend scarce resources on insurance they believe they don't need. The other may have one or more health conditions and dependents to support. They have different needs and objectives, but both seek affordable health insurance options that meet their needs at their particular life stages. Under health care reform law, new options should be explored to ensure that members at all career stages have affordable options. Concerns about the ongoing viability of Social Security and Medicare make it more likely that members retiring in the future will have more responsibility for their own medical costs. Fund trustees are concerned about providing meaningful retiree coverage in the face of an uncertain health care future.

Multi-Employer "Exemption" To Shared Responsibility Penalties Extended Until Further Notice

We have been waiting since early 2013 to learn whether the multi-employer "exemption" to the ACA's "pay or play" regulation would be extended past 2014. This exemption, written into the preamble of the proposed regulation, simplified compliance for contributing employers, with the employer-shared responsibility provisions, or the "pay or play" mandate. Under the mandate, employers with 50 or more employees who fail to offer adequate and affordable coverage to their full-time employees will owe a tax penalty. The provision does not comfortably apply to the multi-employer context, where employees may work for a number of employers throughout the year and be covered through the multi-employer plan instead of through a single employer. Signatory employers remit contributions to the plan at the rate provided in the governing collective bargaining agreement. Plan administration is carried out by the plan office, not by any one employer.

In proposed regulations issued in January 2013, the agencies provided an exemption from the mandate for employers who contribute to multi-employer plans. The exemption only covered 2014, and we have been waiting to learn what will happen next. On February 10, 2014, the IRS released final regulations on the employer mandate, which extends the exemption until further notice.

The exemption works like this: Employers who are required by a collective bargaining agreement (CBA) or a participation agreement to contribute to a multiemployer health and welfare plan that offers coverage to individuals who satisfy the plan's eligibility conditions, will be exempt from the "pay-or-play" mandate as long as:

- The multi-employer plan offers dependent coverage
- The multi-employer plan provides minimum value
- The coverage provided is affordable as defined in the ACA regulations

Signatory employers therefore have an extended "pass" on the employer mandate regarding employees covered under the CBA or any participation agreements.

Individuals Must Have Insurance or They Will Owe a Penalty

Generally, in construction industry health and welfare plans, members have to complete a certain number of hours or accrue a minimum balance in their fund account before they are eligible to participate in a health plan. For the period of time when the member is ineligible to participate in the union plan, they are now legally required to have health insurance (with some exceptions). Aside from legal obligations, they may need insurance because of existing health conditions or anticipated

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medical events (such as having a child or hip surgery). As of 2014, the public marketplaces implemented by the ACA may be the only source of affordable individual policies for these individuals.

On the other end of the spectrum, many members retire due to physical disabilities before they are eligible for either Social Security or Medicare. More than ever, they will need access to affordable health care. Some plans will not be able to offer comprehensive retiree health coverage, leaving members responsible for covering more of the cost.

In the past, members who were ineligible to participate in the multi-employer plan have typically had three options:

1) self-paying their premiums, if the plan allowed it;
2) COBRA continuation coverage, if they qualified; or
3) "going without."

Starting January 1, 2014, "going without" may no longer be a viable option, since almost everyone (with a growing number of exemptions) is required to have health insurance or will owe a penalty to the federal government. Some members will undoubtedly choose to go without, at least initially, when the penalty is relatively modest. Others will recognize that they need health insurance coverage and will need to understand their options. The individual penalty increases over time and therefore will eventually become a factor in the decision.

Allowing the self-paying of premiums is a common feature of multi-employer plans, apart from COBRA requirements. Some members, however, because of personal financial circumstances, or because of untimely contributions from employers, are unable to afford the premiums.

For both of these populations, depending on the situation in your state and other factors, subsidized coverage on the public health insurance exchange may be a viable option for members until they achieve eligibility under the plan or are eligible for Medicare. Online resources can help estimate the premium tax credit (subsidy) based on household income and family size. The plan's health broker or consultant should be able to help locate the best resources in your local area.

Where Can I Get More Information?

Even if covered under an existing plan, members need actionable information about how to use health care cost-effectively, at every stage of life. The reality is simple: someone will have to pay rising health costs, and it will likely be either the individual or the fund. Informed members can be an asset to a fund that is working to reduce costs for all participants. The plan's carrier, broker or health consultant should be able to direct the fund trustees to available resources to engage members in their health decisions. Investment advisors and consultants can provide guidance on plan designs that maximize members' opportunities to prepare to be responsible for more of their own health costs.

For more information about health care impacts on multi-employer plans and how Manning & Napier can assist plan trustees, contact: info@manning-napier.com.

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