CENTRAL STATES
SOUTHEAST AND
SOUTHWEST AREAS
HEALTH AND WELFARE FUND

2013 - SPECIAL BULLETIN 2013-1

DATE: APRIL 2013

TO: ALL LOCAL UNIONS AND EMPLOYERS WITH PARTICIPANTS IN THE CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND

RE: FREQUENTLY ASKED QUESTIONS ABOUT THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Recently there have been a number of questions raised by employers about the impact of, and their compliance with, the Patient Protection and Affordable Care Act ("ACA"), regarding participation in the Central States, Southeast and Southwest Areas Health and Welfare Fund ("Central States"). The ACA and its regulations created a complex set of rules that both employers and group health plans such as Central States must follow. In order to address these most frequently asked questions, the Central States' Board of Trustees is issuing this Special Bulletin.

Question 1:
What *waiting periods* are allowed under the ACA?

Answer: Beginning in 2014, the ACA requires that a plan not impose a waiting period of more than 90 days for an eligible employee. This rule applies to all plans regardless if the coverage is provided to the employees by a large or small employer. Eligibility conditions based solely on the lapse of time cannot exceed 90 days. The obligation to provide coverage to an otherwise eligible employee within 90 days is imposed on the plan, not the employer. For a detailed discussion of the waiting period rules, visit the following webpage: http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=26730.

Under the Central States' Plan, there is an "establishing period" consisting of 8 weeks of consecutive contributions before coverage is provided to the employee. Therefore, to comply with the requirement that the waiting period be no more than 90 days, Central States will no longer accept a collective bargaining agreement which was ratified on or after July 1, 2013, unless the waiting period under the terms of the collective bargaining agreement is **no more than 30 calendar days** unless the Board of Trustees explicitly consents in writing to a longer period. For collective bargaining agreements that have already been accepted by Central States (as well as collective bargaining agreements accepted in the future), Central States will require a participating employer to make contributions on any person for any time period for which Central States is required to provide health coverage notwithstanding any provision to the contrary in the collective bargaining agreement. The Central States' Trust Agreement has been amended to include this requirement.

Question 2:
What happens under the ACA if a *large employer* does not provide its *full-time employees* with *minimum essential coverage* under an *eligible employer-sponsored plan*, that coverage does not provide *minimum value*, or that coverage is not *affordable* (these italicized *terms* are explained later in this Bulletin)?

Answer: It depends on whether an employer is considered a "large employer" under the ACA. **If the employer is not a large employer, the ACA does not require that the employer provide its full-time employees minimum essential coverage under an eligible employer-sponsored plan (or that the coverage provide minimum value or be affordable).** A large employer is defined as an employer with at least 50 full-time equivalents ("FTEs"). Note that this figure is based upon all of the employer's employees, not just those employees that are members of a bargaining unit (or who participate in a multiemployer plan). Further, in counting the number of FTEs, the employer's entire controlled group is considered. FTEs include both full-time employees as well as other employees (whose hours are aggregated). The number of full-time equivalents (FTEs) in the prior year is used to determine whether an employer is a large employer for purposes of the ACA. Each full-time employee (see answer to Question 3 for a discussion of the definition of the term "full-time employee") is counted as one FTE, and the aggregate number of hours of service per month for all other employees (not exceeding 120 hours for any one employee) is divided by 120, and that amount is added to the number of FTEs. For a detailed discussion of how to determine whether an employer is considered a large employer under the ACA, visit the following webpage: http://www.gpo.gov/fdsys/pkg/FR-2013-01-02/pdf/2012-31269.pdf. Additional guidance is available at the following webpage: http://www.gpo.gov/fdsys/pkg/FR-2013-03-15/pdf/2013-05954.pdf.

There is a special transition rule for large employers that contribute to a multiemployer plan that at present only covers 2014. This rule applies to a large employer that is required by a collective bargaining agreement to make contributions, with respect to some or all of its employees, to a multiemployer plan that offers, to individuals who satisfy the plan's eligibility conditions, coverage that is affordable and provides minimum value, and that offers coverage to those individuals' dependents. Under the rule, the large employer will not be treated, with respect to employees for whom the employer is required by the collective bargaining agreement to make contributions to the multiemployer plan, as failing to offer the opportunity to enroll in minimum essential coverage to full-time employees (and their dependents). However, any waiting period for coverage under the plan must separately comply with the waiting period rules. Further, employers entering into (or already subject to) a collective bargaining agreement that extends beyond 2014 should use caution in relying upon the transition rule as there is no guarantee that its provisions will extend beyond 2014.

Beginning in 2014, if the employer is a large employer, and the large employer fails to provide minimum essential coverage under an eligible employer-sponsored plan, the large employer must make an assessable payment to the federal government of $2,000 per full-time employee minus 30 full-time employees regardless of whether the employees seek coverage on the Exchanges. Also, if the coverage provided by the large employer does not provide minimum value or is not affordable, the large employer must pay an assessable payment to the federal government of $3,000 for each full-time employee that obtains coverage on the Exchange.

It is important to note (see answers to Questions 4, 5, and 6) that employers in Central States meet the requirement of providing essential coverage that provides more than the required minimum value under an eligible employer-sponsored plan for employees for whom the

employer is obligated to contribute. However, Central States cannot make the determination that this coverage is affordable under the ACA (see answer to Question 7).

Question 3:
Who is defined as a *full-time employee* under the ACA (pertinent to *large employers* as defined by the ACA)?

Answer: Generally, under the ACA a full-time employee is an employee that works 30 or more hours per week on average (130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week, provided the employer applies this equivalency rule on a reasonable and consistent basis). There are complex rules to determine whether an employee is a full-time employee. For a detailed discussion of how to determine whether an employer is considered a large employer under the ACA, visit the following webpage: http://www.gpo.gov/fdsys/pkg/FR-2013-01-02/pdf/2012-31269.pdf. Additional guidance is available at the following webpage: http://www.gpo.gov/fdsys/pkg/FR-2013-03-15/pdf/2013-05954.pdf.

However, it is important to note that for purposes of the ACA and providing minimum essential coverage under an eligible employer-sponsored plan (including the minimum value and affordability requirements), **a full-time employee is determined by using the ACA definition, not the definition that may be set forth in the collective bargaining agreement**.

Question 4:
Is Central States an *eligible employer-sponsored plan* under the ACA?

Answer: **Yes.** A group health plan (including grandfathered plans) like Central States is an eligible employer-sponsored plan under the ACA.

Question 5:
Does Central States provide *minimum essential coverage* under the ACA?

Answer: **Yes.** Coverage under an eligible employer-sponsored plan constitutes minimum essential coverage under the ACA if coverage is offered to the employee and the employee's dependents (defined as children under age 26). Central States is an eligible employer-sponsored plan (see answer to Question 4).

Question 6:
Does Central States provide *minimum value* under the ACA?

Answer: **Yes.** Under the ACA, a plan fails to provide minimum value if the plan's share of the total allowed cost of benefits provided under the plan is less than 60 percent of those costs. At present, all of Central States' plans (benefit packages) exceed that minimum and the plans that cover the vast majority of participants have benefits that exceed 80 percent of the costs.

Question 7:
Is the coverage provided by Central States *affordable* under the ACA?

Answer: Although this is one of the most frequently asked questions to the Fund, neither Central States nor any other health plan for that matter can make this determination since neither Central States nor other health plans have the information necessary to make this determination.

Under the ACA, coverage is deemed "affordable" if the employee's required contribution for member-only coverage is no more than 9.5% of the employee's household taxable income for the taxable year. Household income is defined under the ACA as the modified adjusted gross income of the employee and any members of the employee's family (including a spouse and dependents) who are required to file an income tax return.

There are several safe harbor methods of determining whether coverage is affordable: (1) the Form W-2 method; (2) the Rate of Pay method; and (3) the federal poverty line method. These methods are described in detail at: http://www.gpo.gov/fdsys/pkg/FR-2013-01-02/pdf/2012-31269.pdf.

Further, coverage under a multiemployer plan will be considered affordable with respect to a full-time employee if the employee's required contribution (payroll deduction), if any, toward member-only health coverage under the plan does not exceed 9.5 percent of the employee's wages reported to the qualified multiemployer plan, which may be determined based on actual wages or an hourly wage rate under the applicable collective bargaining agreement.

It is important to note that if the employer pays the entire required contribution to Central States without requiring an employee to pay any portion of the member-only coverage, then the coverage is deemed affordable since the employee's required contribution would be zero. However, Central States does not control how much an employee is required to contribute for coverage as that amount is determined in collective bargaining between the employer and the local union.

Question 8:
Is a participating employer obligated to pay the Patient-Centered Outcomes Research Institute ("PCORI") fee?

Answer: **No**. The ACA established the PCORI to compile and provide comparative clinical effectiveness research findings. In order to fund the PCORI, health plans (regardless of whether insured or self-insured, and regardless of whether a single employer plan or a multiemployer plan), must pay a per capita fee. This fee is imposed for plan years ending on and after October 1, 2012, and before October 1, 2019. Under the ACA, it is the plan sponsor (the Board of Trustees in the case of a multiemployer plan), not the contributing employers, that is responsible for paying the PCORI fee.

Question 9:
Is a participating employer obligated to pay the Transitional Reinsurance Program fee?

Answer: **No.** The ACA established the Transitional Reinsurance Program to help stabilize premiums for coverage in the individual market from 2014 through 2016. In order to fund the program, plan sponsors of both insured and self-insured plans must pay a fee for each covered life. Under the ACA, it is the plan sponsor (the Board of Trustees in the case of a multiemployer plan), not the contributing employers, that is responsible for paying the fee.

Question 10:
Is a participating employer obligated to pay an excise tax on high cost health plans ("Cadillac Tax")?

Answer: **No.** Under the ACA, an excise tax is imposed on the value of health coverage that exceeds a certain threshold. This tax does not take effect until 2018. The threshold for the tax is $27,500 in 2018 for family coverage. A multiemployer plan's coverage is treated as family coverage even if the coverage is member-only or composite coverage. This excise tax, which is imposed on the plan (not the employer), is equal to 40 percent of the amount the cost of the coverage exceeds the threshold. The cost includes the total contributions paid by the employer and the contributions paid by the employee, if any. The threshold is indexed to the CPI-U.

For local unions with questions regarding this Special Bulletin, please contact your Field Service Representative at 1-800-323-2152, extension 3080. For employers with questions regarding this Special Bulletin, please contact Pete Priede, Director of Employer Services, at 1-800-323-2152, extension 3053.

Sincerely,

BOARD OF TRUSTEES, CENTRAL STATES SOUTHEAST AND
SOUTHWEST AREAS HEALTH AND WELFARE FUND, BY:

THOMAS C. NYHAN
EXECUTIVE DIRECTOR