EQUITY – LEAGUE

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CC:PA:LPD:PR (Notice 2012-58)
Courier's Desk
Internal Revenue Service
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Re: Comments to Notices 2012-58 and 2012-59

To Whom It May Concern:

The Equity-League Health Fund (the Fund) submits these comments to Notice 2012-58 and Notice 2012-59, which address certain issues related to implementation of the Patient Protection and Affordable Care Act (the Affordable Care Act or the Act). Notices 2012-58 and 2012-59 were jointly released by the Departments of Labor, Health and Human Services (HHS) and the Treasury on August 31, 2012.

The Fund submitted comments in the past jointly with other multiemployer funds in the entertainment industry, including the AFM Local 802 Health and Benefits Fund, the Directors Guild of America-Producer Health Plan, the Equity-League Health Trust Fund, the IATSE Local One Welfare Fund, the IATSE Local 306 Health Fund, the IATSE Local 764 Welfare Fund, the IATSE National Health and Welfare Fund, the League-ATPAM Welfare Fund, the Motion Picture Industry Health Plan, the Screen Actors Guild-Producers Health Plan, the SDC League Health Fund and the USA Local 829 Welfare Fund. On April 9, 2012, the joint group of funds submitted comments to Technical Release 2012-01. A copy of that joint letter is included with this comment letter for background purposes.

At the outset, we would like to state our appreciation for the guidance the Departments recently released in Notices 2012-58, on determining full-time employees for purposes of shared

responsibility for employers regarding health coverage (Section 4980H), and 2012-59, on the 90-day waiting period limitation under public health service act Section 2708. In the Notice 2012-58 guidance, the Departments expanded the safe harbor method to provide the look-back measurement period of up to 12-months to determine whether new variable hour employees or seasonal employees are full-time employees, defined variable hour and seasonal employees, provide an optional administrative period and provided a process for employers to transition new employees to the determination of eligibility method for ongoing employees. In the Notice 2012-59 guidance, the Departments defined the waiting period and set out its application to variable hour employees where a specific number of hours of service per period is a plan eligibility condition. We applaud the Departments for recognizing the fact that many multiemployer health benefit plans have developed eligibility provisions to fit the variable and/or seasonal nature of work in the covered industries, and by their nature cover employees that may not fall under the shared responsibility provisions, because either the work would not be considered full-time or the contributing employers are not applicable large employers. We applaud the Departments for providing guidance that allows the waiting period to begin at the end of the measurement period for variable hour employees.

We are submitting these comments concurrently to Notices 2012-58 and 2012-59, since the 90-day waiting period and employer shared responsibility provisions are interrelated with respect to multiemployer plans.

Overview of Comments

We ask the Departments to respect the decisions reached by the collective bargaining parties and the Fund's Board of Trustees (comprised of an equal number of union and employer representatives) by:

1. Allowing a waiting period of **three calendar months** after the employee is otherwise eligible to enroll under the terms of the plan (the measurement period), ***or***

   Allowing a waiting period under which **coverage becomes effective the first of the calendar month following a period of no longer than 90-days** after the employee otherwise is eligible to enroll under the terms of the plan (the measurement period), ***and***

   Providing guidance so that neither of the above noted waiting periods would be considered designed to avoid compliance with the 90-day waiting period limitation.

2. Applying the 90-day waiting period limitation only to initial eligibility, and not to ongoing eligibility.

3. Eliminating the requirement that coverage be made effective within 13 months (plus the time remaining until the first day of the next calendar month) of an employee's start date for multiemployer plans, ***or***

4. Exempting contributing employers from the shared employer responsibility provisions of Section 4980H of the Internal Revenue Code (Code) ***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.

Rationale for Comments

In Notice 2012-58, although in a different context, the guidance states that new employees who are reasonably expected to work full time will not be subject to the employer responsibility payment under Section 4980 by reason of its failure to offer coverage to the employee for up to the initial three calendar months of employment. We are asking for recognition that any waiting period of three calendar months will satisfy the 90-day waiting period limitation.

In Section III. D. of Notice 2012-58, the safe harbor for variable hour and seasonal new employees allows the combined total of the measurement period and the administrative period not to exceed 13 months, plus a fraction of a month, to account for the fact that the anniversary of an employee's start date may not be at the beginning of a calendar month. We are asking for recognition that coverage provided by the Fund starts at the beginning of a calendar month, so we ask that a waiting period may be allowed if coverage becomes effective the first of the calendar month following a period of no longer than 90-days.

Since many of the Health and Welfare Funds in the entertainment industry collect contributions from tens or hundreds of employers, it takes time to collect those contributions, allocate them properly to participants and generate information to determine eligibility. This aggregation allows the Funds to extend coverage to participants who do not work enough with one employer to achieve eligibility. We believe that this is consistent with the overall goal of the Patient Protection and Affordable Care Act, to provide health care coverage to more individuals throughout the country. This is the rationale behind requesting that the requirement to provide coverage within 13-months of the date of hire be eliminated for multiemployer plans, or at least amended to 15 months to allow additional time for the Funds to process the necessary information.

This Fund, like all funds in the entertainment industry, accepts contributions that are set forth in collective bargaining agreements negotiated by contributing employers and union representatives. Many of those agreements call for contributions to be made to the Funds based on a requirement other than hours, so the Fund and often the contributing employers do not know how many hours a participant works. In our case, contributions are made for each week (or part thereof) worked and contributions for other entertainment industry Funds are often made to the Fund based on days, specific projects or as a percentage of earnings. There is an information gap between the employers that make the contributions and the benefit fund. The employers may make contributions to a large number of multiemployer funds for various types of employees, such as actors, makeup artists, lighting specialists, camera crew, etc., and the employers may have no way to determine whether the employees are eligible for coverage

information gap between the employers that make the contributions and the benefit fund. The employers may make contributions to a large number of multiemployer funds for various types of employees, such as actors, makeup artists, lighting specialists, camera crew, etc., and the employers may have no way to determine whether the employees are eligible for coverage under the various multiemployer plans to which the employer is required to make such contributions. Employers, by contributing to multiemployer funds based on their collective bargaining agreements, are offering their employees the opportunity to enroll in minimum essential coverage. Since employees can work for multiple employers, it is almost impossible for any one employer to determine whether the employees are achieving eligibility and whether the employee's required contribution to the plan does not exceed 9.5% of the employee's household income. The relief to use Form W-2 wages to determine affordability will not help employers with employees who work for multiple employers throughout the year.

Due to the nature of the collective bargaining agreements, the Fund rarely knows the number of hours that a participant works, as contributions are made based on earnings, days or weeks of work or on a project basis. The structure of the payments to the Fund makes it difficult or impossible for the employers to know what amount the employees pay for coverage, if any, and the Fund generally does not know the number of hours that an employee works for an employer. This is the reason we are asking for the contributing employers to be exempt from the shared employer responsibility provisions of Section 4980H of the Internal Revenue Code (Code) with respect to collectively bargained employees for whom the employer makes collectively bargained contributions to a multiemployer plan that provides health benefits.

We appreciate the opportunity to submit comments on these important issues. Please do not hesitate to contact Arthur Drechsler, Executive Director of the Fund, at 212.293.4430 (phone number) if you have any questions about our comments or need additional information.

Respectfully submitted,

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Executive Director

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Re: Comments on Technical Release 2012-01

To Whom It May Concern:

These comments with regard to Technical Release 2012-01 (the "Technical Release" or "Release") are presented on behalf of multiemployer health plans in the entertainment industry[1] (collectively, the "Plans"). These Plans are multiemployer plans established by collective bargaining agreements pursuant to Section 302(c)(5) of the Labor Management Relations Act and together provide health benefits to over 250,000 participants and dependents.

Certain of these Plans previously submitted comments on June 17, 2011, in response to Notice 2011-36. There, we noted the importance of utilizing a measurement period/stability period safe harbor as a method to determine whether an employee should be considered "full-time" under §4980H and we explained in those comments why such an approach is necessary for these Plans. For your convenience, we have attached the June 17th Comments, along with the

[1] The Plans submitting these comments are the AFM Local 802 Health and Benefits Fund, Directors Guild of America-Producer Health Plan, Equity-League Health Trust Fund, IATSE Local One Welfare Fund, IATSE Local 306 Health Fund, IATSE Local 764 Welfare Fund, IATSE National Health & Welfare Fund, League-ATPAM Welfare Fund, Motion Picture Industry Health Plan, Screen Actors Guild – Producers Health Plan, SDC-League Health Fund, USA Local 829 Welfare Fund.

related comment letter of September 17, 2010.[2] We continue to support the approach outlined in the June 17th Comments, and encourage the regulatory agencies to formalize this approach in the proposed regulations, as was suggested in the Technical Release.

These comments address some additional suggestions regarding the coordination of the employer shared responsibility provisions under Code section 4980H and the 90-day waiting period limitation under PHS Act section 2708. These suggestions are necessary in order to clarify operation of the new rules and to permit successful implementation in the unique context of the entertainment industry. Specifically, for the reasons explained below, we urge that future guidance provide:

- That the Code Section 4980H penalty not apply either (a) to any employer contributing to a plan as long as the plan to which that employer contributes provides coverage in a time and manner consistent with the 90-day waiting period limit or (b) to any employee for the first six months of hire, regardless of circumstances at the time of hire or hours worked for the first six months

- In determining whether an eligibility condition based on a specified cumulative number of hours of service will not be treated as being designed to avoid compliance with the 90-day waiting period limitation, guidance should provide that it will be appropriate to take into account the length of time that benefits will be provided after the employee become eligible.

- In determining whether an eligibility condition based on earnings or contributions requirements are designed to avoid compliance with the 90-day waiting period, guidance should provide that it will be appropriate to take into account the length of eligibility that is earned and also the amount that employees earn under the applicable collective bargaining agreement and the contribution rates to the plans.

- Guidance should clarify that 90 calendar days is equivalent to three calendar months.

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[2] Those June 17 Comments also referred to, and relied upon, correspondence dated September 17, 2010 correspondence which was submitted on behalf of six of these Plans. As both the June 17 Comments and the September 17 correspondence will reflect, all of these Plans share common eligibility structures that are discussed in these Comments. Together the June 17 Comments and the September 17 correspondence are referred to in these comments as the "June 17 Comments."

Background - Nature of the Entertainment Industry and Structure of the Plans

As we explained in our June 17th Comments, these Plans have developed eligibility and benefit provisions that permit them to provide comprehensive and affordable benefits to employees in an industry with the following unique characteristics:

- Participants in these plans are primarily employed on a freelance basis.
- Participants commonly work for many different employers for short periods of time.
- It is not unusual for a participant in the Plans to be unemployed for long periods of time and, when they are employed, it is common for them to be employed on less than a full-time basis.

Although all of the Plans have distinguishing characteristics, they generally share key features that will be uniquely impacted by the issues discussed in the Technical Release.[3] These include:

- Full-time employees[4] establish eligibility for health coverage in most cases over a period of three to six months based on hours worked, employer contributions, or earnings on which contributions are based (depending on the Plan).
- Once an employee satisfies the hours or earnings requirement, the participant is eligible for continuous health benefits beginning one calendar quarter after the end of the quarterly period during which the participant established eligibility for benefits.
- A participant will then continue to receive benefits for up to one year (depending on the Plan) – regardless of whether the participant is employed at all by employers contributing to the plan during that extended period of time.

Thus, employees will establish eligibility to commence benefits in the calendar quarter after the end of the quarterly period during which the participant first established eligibility for

[3] The Plans' benefits and eligibility structures are described in detail in our previous correspondence and Comments.

[4] These comments do not address the still unanswered question of how to measure full-time employment, an issue that is often difficult to apply in this industry where employees hours of work are often not tracked by employers and where employees are commonly paid on a project basis, rather than based on the time spent to complete the project.

benefits. Once benefits commence, employees will continue receiving them for a very generous period of time even if they stop working (again, in recognition of the project-oriented and freelance nature of the industry).

In view of this long-established eligibility structure, we have two basic concerns regarding the Technical Release. First, Code Section 4980H, as proposed, could potentially subject a number of employers to penalties, despite the fact that the coverage provided under the Plans is far more generous than the rules would require. Specifically, we request that the Code Section 4980H penalty not apply to any employee for at least the first six months of hire, regardless of circumstances at the time of hire or hours worked for the first six months. Second, while the Technical Release proposes some flexibility under PHS Section 2708, there are some clarifications needed to make sure that it operates in the intended fashion.

Employer Shared Responsibility for Employees Other than New Hires Under Code Section 4980H

With regard to most freelance employees, the Technical Release outlines an approach that would appear to permit these Plans to continue to provide benefits in accordance with their current eligibility structure. Specifically, Q&A 4 indicates that employers may use a "look-back/stability period safe harbor" to determine full-time status for employees other than new-hires. Thus, the employer would have up to a twelve-month period to determine whether that employee is actually working full-time. Based on the eligibility and benefit structure of these Plans, most if not all freelance employees who would be considered "full-time" utilizing a six month safe harbor method will qualify for benefits from these Plans and an employer would therefore not be subject to section 4980H penalties.

The Plans will also be able to continue to provide benefits utilizing their current eligibility and earnings structure with regard to newly-hired employees who are not expected to work "full-time" and who do not do so. With regard to newly-hired employees, Q&A 5 states that an employer will not be subject to section 4980H penalties for the first three months following date of hire if the employee is both not expected to work "full-time" during the first three months of employment and does not do so. With regard to a freelance employees or any other employee who is not "reasonably expected" to work full-time for the first three months of employment, and who does not do so, an employer would therefore not be subject to the section 4980H penalties.

Employer Shared Responsibility for New Hires Under Code Section 4980H

Q&A 5 indicates that employers will be required to provide coverage for new hires within three or six months, depending on (1) the facts and circumstances at the time of hire and (2) hours worked during the first three (or six) month period. This approach would be detrimental to participants and would impose a costly administrative burden on the Plans and on contributing employers. In addition, it would result in the kind of disruption that the "look

back/stability period safe harbor" is intended to avoid. Finally, we note that the distinction between "new hires" and "other than new hires" is a concept that is largely inapplicable to the Plans given the nature of the industry, and application of the concept here is illogical.

To begin with, as noted above and in our June 17th Comments, a "full-time" employee in the Plans who begins receiving benefits within six months after initial employment will continue to receive benefits for many months after that employee is employed on a full-time basis by that employer. Indeed, for many employees who qualify for benefits, their coverage will extend for more than a year after any employment for any employer making contributions to these Plans. In other words, while the beginning of coverage may be delayed on the front end, it is extended for much more time on the back end. As a further beneficial result, individuals who are faced with intermittent and unpredictable employment with many different employers know that they will receive benefits for an extended period of time and will have advance knowledge of when they might lose that coverage so that they can obtain other coverage.

While the current system therefore does not disadvantage any newly-hired employee, the proposed new-hire full-time status measurement process could disadvantage employees in the entertainment industry. This is because if plans revise their eligibility structure to provide benefits more quickly to permit contributing employers to avoid section 4980H penalties, those plans simply could not afford to provide such benefits on the back end. As a result the plans might cease providing those benefits to these "full-time" employees once they lose "full-time" status. This would lead to the incongruous result of longer periods of coverage for employees who are *not* full-time and shorter periods for employees who the statute is presumably intended to benefit – employees who *are* working full time.

While the Plans could attempt to shift the eligibility period forward and provide benefits to "full-time" employees within three months of their date of hire and extend that coverage for six or twelve months, such an approach is not economically or practically feasible. Since three months of employment does not lead to eligibility under most of these Plans, the Plans would have to reconstruct their entire eligibility system to accommodate the accelerated eligibility and the possibility that the Plan would never receive contributions sufficient to cover the cost of extended coverage for the relevant eligibility period.

In addition, the requirement to provide benefits more quickly to certain newly hired employees would also lead to an enormous administrative burden on these Plans and the employers that contribute to these Plans. Employers themselves have limited or no involvement in the day-to-day operation of the Plans. The Plans are Taft-Hartley funds, sponsored by a joint board of trustees made up of both employer and union representatives. There is no system in place for contributing employers to gauge and provide information to the Plans regarding whether they "think" a newly hired employee will be working full-time. While this sort of facts-and-circumstances analysis might work for most traditional employers in a single employer setting, it presents nearly impossible compliance hurdles in the multiemployer context in the entertainment industry (as discussed in greater detail below). Add to this the disconnect between

the employer and the Plans, and the problems are not only disruptive of longstanding eligibility rules, but become simply insurmountable.

Finally, in an industry characterized by frequent short stints of employment with numerous employers by employees who are frequently not working on any kind of hourly basis, it becomes impossible to apply the two concepts that are central to the approach suggested by the Technical Release: the concept of a "newly hired" employee and the concept of "full-time" employee.

"Newly hired" employees

It would be very difficult to determine on any kind of consistent and predictable basis who should be considered a "newly-hired" employee in this industry. In this regard, the Technical Release creates more questions than it answers, including:

- How can an entertainment industry employer gauge whether an employee is expected to be full-time at the time of hire, considering the project-oriented nature of the industry?
- Is an employee who worked for that same employer as a freelance employee in the past considered "newly-hired" employee when hired on a "full-time" basis?
- What if that freelance employment was within weeks, or even days, of the day that that employee is hired as a "full-time" employee?
- What if an employee worked "full-time" for the employer on one motion picture, and then begins working for that employer on a "full-time" basis on another motion picture several years later?

Thus, requiring employers to make a distinction based on which employees are "newly hired" will lead to unnecessary confusion and complication for all involved. Furthermore, if the term is not specifically defined by regulatory guidance, thousands of individual employers will be defining the term for themselves and for the several different multiemployer plans that they might be making contributions to on behalf of employees covered by different collective bargaining agreements. Given the impact that this determination might have on eligibility, this uncertainty would be extremely problematic for the Plans, the employers and plan participants.

"Full time" employees

It is also very difficult to determine who is "full-time" in an industry where many employees work under contracts and where hours worked are not tracked by the employers or reported to the Plans and where employees are commonly paid on a project basis rather than the time it takes to complete the project. Although future guidance may provide some assistance in determining when a salaried employee should be considered "full-time," the unique nature of employment in this industry will inevitably lead to many areas of ambiguity. It is impracticable

to require many thousands of different employers to interpret that guidance to the unique employment situations in this industry, and it is placing the Plans in the untenable position of relying on those individual employer interpretations in determining eligibility for benefits.

Proposed approach to application of Code Section 4980H

The solution to all of these problems is suggested in the Technical Release itself. The Technical Release indicates that "in certain circumstances" employers will have six months to determine whether a newly-hired employee is a full-time employee for purpose of section 4980H. *We strongly urge that the regulations find such circumstances exist where employers contribute to a multiemployer Plan that is providing benefits to participants in a freelance industry such as the entertainment industry. Further, we urge that, due to the volatile nature of employment in the entertainment industry, employers have at least six months to determine whether a newly-hired employee is a full-time employee for purpose of section 4980H, regardless of the circumstances at the time of hire.*

Such an approach will result in the continuation of a system that provides extended benefits to *all* employees who, based on a six-month period, are considered "full-time" employees. It is completely consistent with the "look-back/stability period safe harbor;" it is an approach that is most consistent with the stated goal of avoiding uncertainty and unnecessary administrative challenges for the State Exchanges; and, it would result in absolutely no detriment to "full-time" employees – and to many more employees who are not "full-time" – who would continue to receive valuable extended benefits through a system that has successfully addressed the unique characteristics of the entertainment industry.

In the alternative, we recommend the regulations more closely align the 90-day waiting period with the employer shared responsibility rules. Under the currently proposed regulatory structure, certain circumstances could arise when a plan satisfies the 90-day waiting period limit, but the employer is still subject to a penalty under the employer shared responsibility requirement. The Technical Release proposed that the 90-day waiting period would only commence following satisfaction of otherwise applicable eligibility criteria. However, in many instances, employers will be required to provide coverage within three months of hire. For instance, assume a plan imposes an earnings requirement that employees must satisfy prior to becoming eligible for coverage under the plan. An employee works full-time for the first three months of employment and satisfies the earnings requirement during those three months. At that point, the 90-day waiting period starts, meaning the employee will be eligible for coverage no later than six months following his date of hire. Nonetheless, the employer could be subject to the employer shared responsibility penalties for months four through six, because the employee worked full-time for the first three months of employment.

To avoid this result, the regulations should provide that an employer is never subject to the shared responsibility penalty as long as the plan to which that employer contributes provides coverage in a time and manner consistent with the 90-day waiting period limit.[5]

Either of these approaches would be workable because they absolve employers from any requirement to assess circumstances at the time of hire, track hours, and provide such information to the Plans, and permit these Plans to continue to provide extended benefits to both "full time" and other employees in this industry.

Finally, we note that Notice 2011-36 stated that "[i]t is contemplated that the proposed regulations would make it clear that an employer offering coverage to all, or substantially all, of its full-time employees would not be subject to the §4980H(a) assessable payment provisions." (Notice, page 18.) As discussed above, these Plans have established eligibility structures that will ordinarily result in all "full-time" employees qualifying for benefits – so long as the contributing employers have at least six months to make the determination of "full-time" status. The regulations should provide that employers that contribute to multiemployer plans will be deemed to have met the employer shared responsibility and should not be required to provide accelerated benefits to a small group of Plan participants, when under the Plans' eligibility systems, substantially all participants will receive benefits that far exceed statutory minimums.

90-Day Waiting Period Under PHS Act Section 2708

Q&A 7 indicates the 90-day waiting period may begin after an employee satisfies conditions for eligibility under the terms of a plan "unless the condition is designed to avoid compliance with the 90-day waiting period limitation." It further provides that an eligibility condition based on a specified cumulative number of hours of service will not be treated as being designed to avoid compliance with the 90-day waiting period limitation "so long as the required cumulative hours of service do not exceed a number of hours to be specified in [the regulations]."

In determining the permitted hours threshold, we ask that the regulatory agencies take into account the length of time that benefits will be provided after the employee become eligible. In other words, the Plans' should be afforded a longer initial eligibility hours threshold to account for the fact that they provide extended benefits periods beyond the time when the Plans would otherwise be required to provide coverage.

In addition, the guidance should take into account the fact that some of these Plans do not use hours of service as a condition for eligibility, but instead may use other measurements such

[5] This would be subject to the rule, discussed in connection with Section 2708, that any condition for eligibility is not designed to avoid compliance with the 90-day waiting period limitation.

as contributions to the Plans, weeks worked or earnings on which contributions are based. In determining whether such earnings or contributions requirements are designed to avoid compliance with the 90-day waiting period, the guidance should take into account not only the length of eligibility that is earned, but also the amount that employees earn under the applicable collective bargaining agreement and the contribution rates to the plans.

Finally, we ask that the Regulations clarify that 90 calendar days is equivalent to three calendar months. This is necessary because a plan that provides benefits "90 days" after an employee becomes eligible for coverage actually will normally begin coverage at the beginning of a calendar quarter. Since there are often a few more than 90 days in a calendar quarter, a plan could be required to begin coverage before the beginning of a month. Since the Plans' administrative process, including computer software systems, are already set up on a quarterly basis, it would be extremely difficult and costly to implement a system that tracks the 90 days exactly, would be confusing for participants, and would provide no material benefits to participants.

We appreciate the opportunity to submit comments on these important issues. Please do not hesitate to contact me if you have any questions about our comments or need additional information.

Respectfully submitted,

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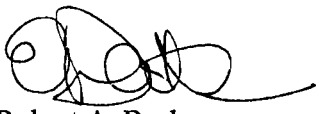

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JUNE 17TH COMMENTS

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CC:PA:LPD:PR (Notice 2011-36)
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Re: Notice 2011-36

To Whom It May Concern:

These comments with regard to Notice 2011-36 are presented on behalf of three of the largest multiemployer health plans in the entertainment industry: the Directors Guild of America – Producer Health Plan ("DGA – Producer Health Plan"), the Motion Picture Industry Health Plans and the Screen Actors Guild – Producers Health Plan ("SAG – Producers Health Plan") (collectively, the "Plans"). Together, these Plans provide health benefits to approximately 200,000 participants and dependents.

These Plans are multiemployer plans established by collective bargaining agreements pursuant to Section 302(c)(5) of the Labor Management Relations Act (the "LMRA"). As required by the LMRA, each of these Plans is governed by a Board of Trustees composed of equal numbers of union-appointed, and employer-appointed trustees. Those trustees establish eligibility criteria and the level of benefits provided to participants in accordance with the mandate of both the LMRA and ERISA §404(a) in that they act strictly for the sole and exclusive benefit of the plan's participants and beneficiaries.

Contributions to the Plans are made by employers who are signatories to collective bargaining agreements on behalf of employees working under those agreements. Currently those collective bargaining agreements require employers to pay to these Plans approximately 7% to 10% of the compensation paid to employees covered by the applicable collective bargaining agreement. Those employers include all of this country's major motion picture and television producers, as well as thousands of other producers of entertainment programs, commercials, and those who provide related services to the entertainment industry. The Plans in turn provide comprehensive health care benefits to the employees of these companies.

The Plans have been providing comprehensive and affordable health care to entertainment industry employees for over five decades. As we expressed previously in a letter to Assistant Labor Secretary Phyllis Borzi,[1] we believe it is essential that the provisions of the Patient Protection and Affordable Care Act (the "ACA") be implemented in a manner that will permit these Plans to continue to do so. Specifically, we are requesting that the relevant regulations (the "Regulations") be designed to preserve the generous eligibility provisions and excellent benefits already provided by the Plans – benefits and eligibility provisions which have been carefully honed by the bargaining parties and the trustees over many years to accommodate the many unique features of the workforce in the entertainment industry.

We believe a key element in accomplishing this objective will be to implement the ACA in a manner that assures that employers who fulfill their collectively bargained obligation to make contributions to the Plans will be deemed to have satisfied their statutory obligations with respect to providing coverage to their employees, and will not be subject to statutory penalties.

While we believe that the ACA is clearly consistent with this goal, we believe it is important that the Regulations clarify key terms and provisions. As we will discuss below, Notice 2011-36 suggests an approach that we believe is both consistent with the statute and that will permit these Plans to continue to provide high quality health care to both "full-time" employees and many others who work in this industry.

In particular, we strongly support the key concept of providing to employers the option of utilizing a measurement period/stability period safe harbor as a method to determine whether an employee should be considered a "full-time" employee under Section 4980H[2] of the Internal Revenue Code. We agree that, as stated in the Notice, "if employer-sponsored coverage were limited to employees who satisfied the definition of full-time employee during a month, employees might move in and out of employer coverage as frequently as monthly, which would be undesirable from both the employee's and employer's perspective, and could also create administrative challenges for the State Exchanges." (Notice, page 14.)[3]

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[1] For your convenience a copy of that letter is attached to these Comments as Appendix A.

[2] All references to Section 4980H throughout this letter refer to 26 U.S.C. §4980H.

[3] Indeed, that problem was central to the concerns expressed in our September 17, 2010 letter to Assistant Secretary Borzi.

Summary of Comments

In order to preserve the comprehensive and affordable coverage provided to entertainment industry employees, we ask the Treasury Department and the IRS to provide Regulatory guidance as follows:

- As noted above, these Plans strongly support the concept of a safe harbor measurement/stability period to determine whether an employee is "full-time" under the ACA.

- The Regulations should clarify that an employer that contributes to a multiemployer health plan, in accordance with the requirements of a collective bargaining agreement, meets its statutory obligation under §4980H with respect to employees for whom the employer makes those collectively bargained contributions. This is particularly true where it can be shown that substantially all of the employer's "full-time" employees would ordinarily become eligible for coverage.

- A measurement period of at least six months should be permitted for new employees.

- With regard to the employer obligation under §4980H, the Regulations should clarify when an employer will be deemed to have offered enrollment to "substantially all" of its full-time employees, particularly where that plan does provide benefits to many employees who are working an average of 130 hours a month, but not for a single employer.

- The 90-day waiting period should be construed as the time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible for benefits under the terms of a group health plan. For example, a plan should be allowed to require that, in order to become eligible for benefits, a participant must have certain minimum earnings or hours worked during a specified measurement period, and that the 90-day waiting period does not commence until the end of the specified measurement period. A three calendar month waiting period should be considered to be in compliance with this obligation, even if the three-month period is a few days longer than 90 calendar days.

Employment in the Entertainment Industry and the Eligibility and Benefit Structure of the Plans

Fundamental to our industry is the reality that the workers in it – the participants of these Plans – are primarily employed on a freelance basis in all aspects of the live entertainment and motion picture industry, including their work on television shows, theatrical motion pictures, commercials, live theatrical events, exhibition and trade shows, and in the recording industry. This reality has several consequences that are relevant to the application of the ACA.

First, individuals commonly work for many different employers for short periods of time. Even during a single month, a participant might work for more than one employer. Thus, an individual might work "full-time" in the industry, but might not work "full-time" for any particular employer. Taking these realities into account for these Plans, determining eligibility for benefits is not based on whether an individual happens to be working "full-time" for any single employer during a particular period of time. Instead, eligibility is based on overall employment for all signatory employers.

Second, it is not unusual for an individual to be unemployed for long periods of time and, when they are employed, it is common for them to be employed on less than a "full-time" basis. Despite the sporadic nature of the employment, and the fact that these individuals are not employed on a "full-time" basis by a single employer or any group of employers, these employees make their living by working under these collective bargaining agreements. The eligibility structures of each of these Plans are fundamentally based on these realities of employment in the industry. Someone who is substantially employed in the industry will be entitled to benefits even though that individual never works "full-time" for any single employer. Once eligible for benefits, that individual will continue to receive benefits even if not employed in the future by that employer, or by any employer making contributions to the Plan.

More specifically, the essential elements of these Plans' eligibility structure are:

- Eligibility for Benefits. Eligibility for coverage by the DGA – Producer Health Plan and the SAG – Producers Health Plan is established by the amount of earnings and/or residuals[4] upon which contributions are paid to the Plan during a

[4] Most of the collective bargaining agreements requiring contributions to these Plans provide for additional compensation – commonly referred to as "residuals" – to be paid to employees covered by those agreements based on the re-use of the motion picture, television show, commercial or recording on which they worked. Thus, for example, an actor will receive compensation for his or her performance on a theatrical motion picture, and also additional compensation when (and if) that motion picture is shown on television. Consequently, an individual may continue to be eligible for benefits based in whole or in part on compensation (footnote continued)

six or 12-month earnings period. Eligibility under the Motion Picture Industry Health Plans is established if the employee performs a required minimum number of hours of covered services during a six-month period.

- Initial Receipt of Benefits. For the DGA – Producer Health Plan and the SAG Producers Health Plan, once eligibility is established,[5] the participant is eligible for continuous health benefits beginning one calendar quarter after the end of the quarterly period during which the participant established eligibility for benefits. Thus, if a participant has satisfied the eligibility requirements by the end of the calendar quarter ending in March, the participant would be eligible for benefits beginning in July. For the Motion Picture Industry Health Plans, eligibility begins two calendar months after the end of the month during which the participant established eligibility for benefits. In the above example, a participant who established eligibility at the end of March would receive benefits beginning in June.

- Length of Benefits Period. A participant will continue to receive benefits for six months to one year (depending on the Plan) without regard to the amount of any further employment generating contributions to the Plan. Thus, a participant who begins receiving benefits in July will continue to receive benefits through December or June of the following year (depending on the Plan) even if that individual does not work for any employer during that period of time. At the end of that benefit period, the participant will enjoy continuing benefits if the earnings or hours in the previous appropriate six or 12-month earnings period are sufficient.

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paid to that individual for the re-use of that particular show or commercial long after his work has been completed.

[5] Although the earnings requirement must be met within twelve months (or six months, depending on the plan), the participant does not have to wait that full twelve month or six month period in order to qualify for benefits if the participant meets the earnings requirement more quickly. Instead, as soon as contributions are made that satisfy the minimum requirement, the participant is eligible for benefits beginning with the Plan's next benefit period. Thus, for example, if compensation of $29,250 is paid to an individual covered by a Screen Actors Guild contract in January and February, that individual will have satisfied the earnings requirement for the January - March quarter and will become eligible *for a full year of coverage* beginning on July 1.

Based on the current eligibility criteria adopted by the DGA – Producer Health Plan and the SAG – Producers Health Plan, all employees who work at least 130 hours in a month for at least three months will become eligible for benefits.[6] Based on eligibility criteria currently adopted by the Motion Picture Industry Health Plans, employees who have not received benefits from that plan in the previous 2-½ years will become eligible for benefits if those employees work at least 130 hours in a month for at least five months; if the employee has received benefits within 2-½ years, the employee would become eligible for benefits if the employee works at least four months. As a result, if a measurement period of at least five months is adopted, all "full-time" employees participating in these Plans will, virtually without exception, receive coverage. While this result flows automatically from the eligibility provisions of the Plans, it would be extremely difficult in practice for contributing employers, or for the Plans, to timely and realistically track employees on an individual basis to demonstrate that this obligation has, in fact, been satisfied.[7]

Full-Time Employment Under §4980H and the Employer Obligation to Offer Enrollment in Minimum Essential Coverage

The Regulations should clarify that an employer contributing to a multiemployer health plan in accordance with the requirements of a collective bargaining agreement meets its statutory obligation under §4980H with respect to employees for whom the employer makes those collectively bargained contributions.

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[6] As noted above, eligibility for benefits is established for the DGA – Producer Plan and the SAG – Producers Plan based on the amount of *compensation* that is paid to the employee, not on the number of *hours worked.* The determination that a participant would qualify for benefits if he or she works at least 130 hours in a month is based on minimum wages that must be paid to those employees under the applicable collective bargaining agreement. Based on those minimum wages, it is clear that an employee who works at least 130 hours in a month for three months will qualify for benefits.

[7] Eligibility for benefits is determined by the Plan based on contributions reported for an individual participant from all contributing employers. For the DGA – Producer Health Plan and the SAG – Producers Health Plan, those contributions are not even due to the Plan until the end of the month after the month in which the work has been performed. The Plan will not be able to make those determinations until a month after the last month in each calendar quarter. That calendar quarter might not at all correspond to the work period of the employee, and so a Plan's determination of eligibility might not be until several months after the employer's contributions have been received.

Section 5000A(f) of the Internal Revenue Code defines "minimum essential coverage" to include coverage in a group health plan offered by the employer. Multiemployer plans are maintained by each employer that contributes to them and therefore should be considered employer plans that are offered to those full-time employees on whose behalf the employer contributes.

Notice 2011-36 states that "[i]t is contemplated that the proposed regulations would make it clear that an employer offering coverage to all, or substantially all, of its full-time employees would not be subject to the §4980H(a) assessable payment provisions." (Notice, page 18.) As noted above, these plans have established eligibility structures that will result in all employees who work "full-time" for a contributing employer for five or more months qualifying for benefits that will be provided to that employee for at least six months, whether or not that employee works full-time or at all for any employer during the period when that employee receives benefits.[8]

A multiemployer plan that provides coverage to "substantially all" of the "full-time" employees of all contributing employers might not happen to provide coverage to "substantially all" of the "full-time" employees of a particular employer in a particular year. However, where a plan provides benefits to "substantially all" of the "full-time" employees of all reporting employers as a group, the Regulations should clarify that contributing employers would not be required to track hours of individual employees and each of the contributing employers should be considered to be exempt from §4980H penalties with respect to those employees. Accordingly, there is no reason for individual employers to track the hours of individual employees.

The regulatory burden of tracking employee hours in the freelance entertainment industry is not only unnecessary but could, in and of itself, drive employers out of these plans. This is undoubtedly true if the obligation to track employee hours were tied to the possibility that employers that are making contributions to Plans may also be subject to penalties under §4980H(a). If there is no basis to assess those penalties, there is no reason to require employers to track these hours.

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[8] We are assuming for purposes of this discussion that "full-time" means an employee has worked an average of 130 hours in a month. We support this proposed interpretation. As noted above, many employees *who do not work full-time* for any single contributing employer, but who work for a number of contributing employers during the measurement period on less than a full-time basis, will also become eligible for benefits of at least six months.

A Measurement Period of at Least Six Months Should be Permitted for New Employees

The Notice states with regard to new employees or employees who move into full-time status during the year, "it is currently anticipated that this safe harbor may apply only in limited form." (Notice, page 16.) Assuming that the safe-harbor would apply, in fact, to freelance employees[9] who are either new or become full-time during a year, it is essential that an employer opting to utilize this safe harbor be able to utilize a measurement period of at least six months.

As described above, these Plans are able to provide excellent health coverage not only to employees who happen to work "full-time" for a single employer but also to employees who work equivalent hours but for more than one employer. Whether an employee happens to work "full-time" for a single employer, rather than multiple employers, should not be a factor in determining whether these Plans provide benefits to employees. Indeed, one of the primary benefits of multiemployer plans in general, and for such plans in a freelance industry such as the entertainment industry, is the ability to provide health benefits to employees who are regularly employed in the industry, even though they are working for many different employers (and who may not work enough for any one employer to earn eligibility under the relevant plan).

Unless a reasonable and adequate measurement period is permitted, the predictable consequence will be that thousands of employees and their dependents who currently receive benefits may be deprived of benefits simply because their "full-time" employment is for more than one employer rather than for a single employer. Such an interpretation would force contributing employers to abandon the multiemployer plan structure in favor of a more traditional benefits structure, or force the Plans to adopt an eligibility structure that favors employees who happen to work for a single employer. The resulting offerings would technically satisfy the employer shared responsibility requirements, but it would result in far fewer employees receiving coverage (even though these employees are working more than 130 hours per month, but for a number of different employers). This approach is inconsistent with the ACA's general goal of expanding health coverage and certainly is not required by the statute. These irrational consequences can be avoided by permitting plan sponsors to utilize a measurement period of at least six months.[10]

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[9] The Regulations should clarify whether freelance employees - who may have worked for a particular employer in the past - would be considered to be "new" employees.

[10] The Regulations should clarify what is meant by "substantially all" in the event that a multiemployer plan does not provide benefits to all "full-time" employees of each employer in each year, particularly where that plan does provide benefits to many employees who are working an average of 130 hours a month, but not for a single employer.

The 90-Day Waiting Period and the Relationship Between the 90-Day Waiting Period and the Suggested "Administrative Interval"

We support the suggested interpretation of the 90-day waiting period as the time that must pass before coverage for an employee or dependent who is otherwise eligible for benefits under the terms of a group health plan becomes effective. Having the waiting period begin after the individual is otherwise eligible for benefits is consistent with the statutory language and with the contemplated safe harbor measurement period under §4980H. It would be confusing and meaningless to impose a waiting period that begins when contributions are first made to the plan for employees who might never become "full time."

In addition, we would like to emphasize the following points:

1. Please clarify that the waiting period under §2708 is the 90 day period before the individual is "covered" – not "enrolled" – by the plan. With regard to the reference in Notice 2011-36 to the prior HIPAA regulations pertaining to "waiting period," we suggest that the term "enroll" used in those prior regulations would be misleading if used in this context since the term "enroll" is used in a completely different sense in ACA to describe the obligation of an employer under §4780H to offer "enrollment" in minimum coverage.

Thus, in the context of multiemployer plans, the Regulations should clarify that the 90-day period begins when the employee is eligible for coverage by the plan, not when contributions are first made to the plan by any particular employer.

2. The Regulations should clarify that 90 calendar days is equivalent to three calendar months. This is necessary because a plan that provides benefits "90-days" after an employee becomes eligible for coverage actually will normally begin coverage at the beginning of a calendar quarter. Since there are often a few more than 90 days in a calendar quarter, a plan could be required to begin coverage before the beginning of a month. This would be extremely difficult and costly to implement, would be confusing for participants, and would provide no material benefits to participants.

With regard to the latter point, we note that the Notice contemplates the possibility of a 30-day administrative interval for employers. Were that interval to be added to a plan's independent 90-day waiting period, the plans could easily span the calendar quarter needed to reasonably and rationally provide benefits to qualifying employees.

* * *

We appreciate the opportunity to submit comments on these important issues. Please do not hesitate to contact me if you have any questions about our comments or need additional information.

Respectfully submitted,

Bush Gottlieb Singer López
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Robert A. Bush
Counsel for Directors Guild of America – Producer Health Plan,
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APPENDIX A

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Phyllis Borzi
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Re: Entertainment Industry Health Plans and the Affordable Care Act

Dear Assistant Secretary of Labor Borzi:

This letter is written on behalf of six of the largest multi-employer health plans in the entertainment industry, providing benefits annually to approximately 250,000 participants and their dependents.[1] These Plans, maintained pursuant to Section 302(c)(5) of the Labor Management Relations Act, have provided a model of comprehensive and affordable health care for entertainment industry employees for over five decades. We want to share with you our very serious concerns that the vitality and viability of these Plans are at risk – an outcome that we know neither the Obama Administration nor the United States Congress would have sought. This vulnerability stems from potential ambiguities in several provisions of the Patient Protection and Affordable Care Act (ACA) which could, if not clarified appropriately, have a materially negative impact on these Plans.

We recognize and applaud the goals of the ACA to extend coverage to many uninsured Americans. Although our Plans will share many of the challenges that other Plans face in meeting the requirements of the ACA, we believe the unique working conditions of the entertainment industry and the necessary differences in how our Plans fund, operate and provide benefits create some special differences that have given rise to our particular concerns.

We therefore welcome this as our opportunity to provide you with information about the entertainment industry health plans, with the sincere hope that we will be able to work with you

[1] The Plans are the AFTRA Health Fund, the Directors Guild of America – Producers Health Plan, the Motion Picture Industry Health Plan, the Screen Actors Guild – Producers Health Plan, the Equity-League Health Trust Fund and the IATSE National Benefit Funds.

to develop regulatory solutions that will permit these Plans to continue to provide quality health benefits to thousands of employees and their dependents - the very kind of health care that was the subject of the health care debate and is a fundamental underpinning of the goals of the ACA.

We appreciate that the agencies drafting these regulations face the daunting task of addressing many different situations that exist with health plans throughout the country and while undoubtedly conversant with the statute itself, the agencies cannot be familiar with the different practical problems faced by plans in every sector of the economy. For that reason, this letter focuses primarily on describing the circumstances that we face in this unique and important[2] sector of the economy to illustrate the problems that can be caused if the realities of this industry and these Plans are not adequately taken into account.

As will be described in detail below, these Plans have developed structures that have successfully provided health benefits to millions of participants and their dependents for over 50 years. We are particularly concerned that the regulations implementing the Act make it possible for the Plans to continue to do so. In that regard, our concerns focus on the Act's provisions regarding the employer shared responsibility, the waiting period, and the individual responsibility.

We are, of course, willing to respond to any questions you might have regarding any of these issues and would welcome the opportunity to meet with the appropriate representatives of any of the agencies to discuss these matters further.

The nature of employment in the entertainment industry

Fundamental to our industry is the reality that the workers in it—the participants of these Plans—are primarily employed on a freelance basis for their work in all aspects of the live entertainment and motion picture industry, including their work on television shows, theatrical motion pictures, commercials, live theatrical events, exhibition and trade shows, and in the recording industry. This means that, typically, participants work for many different employers for short periods of time. In other words, they do not work at the same place or for set hours over many years as is common in other industries. Instead, employment in the entertainment industry is typically competitive and sporadic. It is not unusual for participants to be unemployed for long periods of time and, when they are employed, it is common for them to be

[2] In 2008, the motion picture and television industry directly and indirectly generated more than 2.4 million jobs and over $140 billion in wages. Moreover, this industry is one of the few that consistently generates a positive balance of trade. In 2008, that surplus was $11.7 billion, or seven percent of the total U.S. private-sector trade surplus in services. The motion picture and television surplus was larger than surpluses of the telecommunications, management and consulting, legal, medical, computer and insurance services sectors. (U.S. Department of Commerce, Bureau of Economic Analysis, Survey of Current Business, October 2009.)

employed on less than a full-time basis. Thus, an actor might be employed to perform as a guest star on an episodic television show for a week,[3] and then not be employed again by any employer in the industry for several months.

It is common for a single individual to be performing services for more than one employer during the same month. For example, an assistant camera operator might work for several different employers during a single month under International Alliance of Theatrical Stage Employees' collective bargaining agreements. Further, it is also not uncommon for individuals to be employed by a single employer in different capacities, some of which are covered by one or more collective bargaining agreements, and some of which are not covered by any collective bargaining agreement.

Finally, most of the collective bargaining agreements requiring contributions to these Plans provide for additional compensation – commonly referred to as "residuals" – to be paid to employees covered by those agreements based on the re-use of the motion picture, television show, commercial or recording on which they worked. Thus, for example, an actor will receive compensation for his or her performance on a theatrical motion picture, and also additional compensation when (and if) that motion picture is shown on television. The industry collective bargaining agreements generally require contributions to be paid to the Plans based on certain residuals payments. Consequently, an individual may continue to be eligible for benefits based in whole or in part on compensation paid to that individual for the reuse of that particular show or commercial long after his work has been completed.

The eligibility and benefit structure of the Plans[4]

Most of the collective bargaining agreements requiring contributions to these Plans mandate employer contributions to the Plans based on a percentage of *compensation paid* for services performed, or *residuals paid*, under that particular collective bargaining agreement. The collective bargaining agreements requiring contributions to the Motion Picture Industry Health Plan establish an hourly rate of contributions and base the contribution requirement on the number of *hours worked* by (or guaranteed) the participant.

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[3] Many individuals working in the entertainment industry are commonly paid a guaranteed salary for the work performed. We are aware that the statute requires regulations to be drafted to address the issue of how to determine whether a salaried employee is "full-time" and therefore will not address here how an employer in this industry should determine whether an employee not paid on an hourly basis is "full time" within the meaning of the statute.

[4] The eligibility designs of the Equity-League Health Trust Fund and the IATSE National Benefit Funds differ in many ways from the eligibility designs of the other plans that are described here. These two funds support the regulatory clarifications requested in this letter because they share many of these same concerns, but they will forward supplemental letters to address issues particular to these two funds.

While the collective bargaining agreements describe the contribution obligations of the signatory employers, those agreements do not describe the benefits that the Plans will provide to the participants, nor the eligibility criteria for those benefits. Those determinations are made by the trustees of each of the Plans. Thus, employers have no role in determining whether an individual employee will be eligible for benefits. Furthermore, employers do not even know whether any individual ever becomes eligible for benefits from any particular Plan and, if so, when or for what period of time.

While it clearly would be impossible for the Plans to provide benefits to everyone for whom any contributions are made to the Plans, the trustees of these Plans have adopted rules regarding eligibility and benefits that reflect the collective best judgment of the management-appointed and union-appointed trustees regarding the best way to deliver the highest level of benefits to the greatest number of participants and their eligible dependents given the realities of the employment patterns in this industry described above. Fundamental to that eligibility criteria established by each of the Plans is that they *take into account the short duration of much of the employment in the industry to enable participants who do not work "full-time" for any particular employer to be eligible for benefits.* As a result, it is common for employees who work for only a short period of time for any particular employer to become eligible for benefits. Thus, an individual might work one day for five or six different employers during an eligibility period and become eligible for benefits for a full year even though that individual never worked "full-time" for any of those employers.

In this way, many employees who do not work "full-time" for any particular employer nonetheless are eligible for health benefits for extended periods of six months to 12 months, depending on the Plan. On the other hand, it is possible that an employee who has worked an average of 30 hours a week in a calendar month for a single employer, but for only a short period of time, will not be eligible for benefits.

No doubt reflecting a common understanding of the complexities of providing benefits in this industry, the trustees of the Plans have, over the 50 years of these Plans' existence, developed very similar standards for determining eligibility. The essential elements of this eligibility structure are:

- Eligibility for benefits in most of the Plans is established primarily by the amount of earnings and/or residuals[5] upon which contributions are paid to the Plan during a six or 12 month earnings period. These earnings periods are based on all covered earnings for a 12 month period, such as January through December, or April through the following

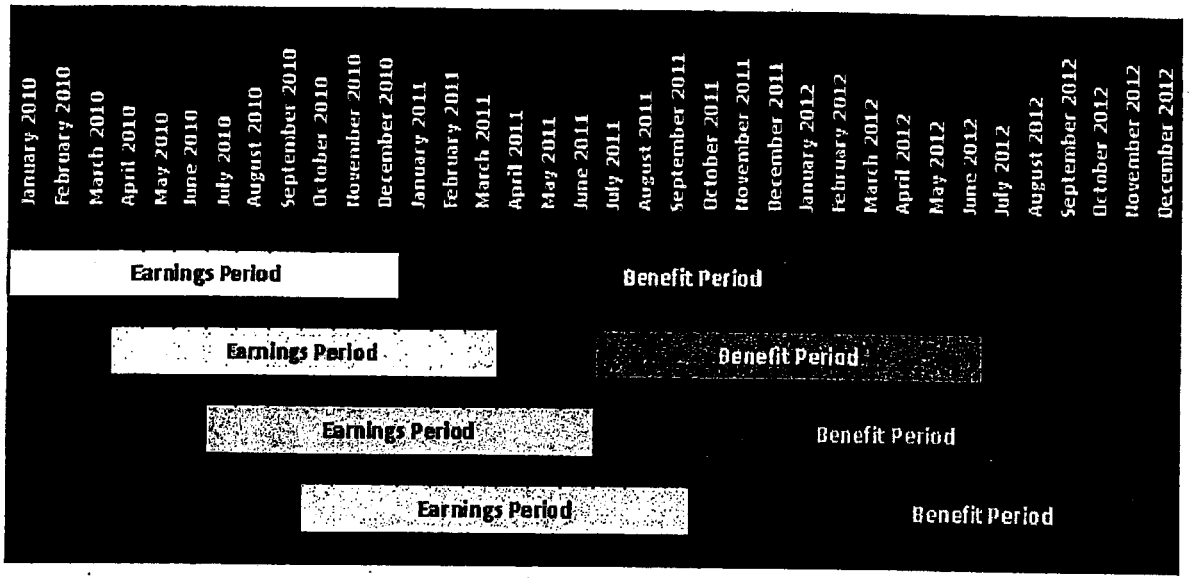
[5] The primary basis to establish eligibility under the Motion Picture Industry Health Plan is not compensation. Instead, eligibility is established if the employee performs at least 300 hours of covered services during a six month period.

March. Thus, for example, for the participant and his or her dependents to be eligible for one of the benefits packages that are available to Plans' participants, the Screen Actors Guild – Producers Health Plan requires that contributions be made based on earnings or certain residuals totaling at least $29,250 during the 12 month time period.[6]

- Although the earnings requirement must be met within 12 months (or six months, depending on the plan), the participant does not have to wait that full 12 month or six month period in order to qualify for benefits if the participant meets the earnings requirement more quickly. Instead, as soon as contributions are made that satisfy the minimum requirement, the participant is eligible for benefits beginning with the Plan's next benefit period. Thus, for example, if compensation of $29,250 is paid to an individual covered by a Screen Actors Guild contract in January and February, that individual will have satisfied the earnings requirement for the January – March quarter and will become eligible *for a full year of coverage* beginning on July 1. Once eligibility is established, the participant is eligible for continuous health benefits beginning with the next benefit period for six months to one year (depending on the Plan), without regard to the amount of any further employment generating contributions to the Plan. At the end of that benefit period, the participant will enjoy continuing benefits if the earnings in the previous appropriate six or 12 month earnings period are sufficient.

- This system of utilizing *earnings periods* and *benefit periods* is illustrated by the following chart that shows how a participant under the Directors Guild of America – Producer Health Plan would gain eligibility and the period of time that the participant would be entitled to health coverage:

[6] A participant in the Screen Actors Guild – Producers Health Plan can also establish eligibility in a lower tier of benefits by meeting a lower earnings threshold or by having contributions made for at least 74 days of coverage.



Most of the Plans have a similar structure for establishing eligibility and for the beginning date and duration of coverage once earned. Appendix A[7] to this letter provides charts for the Plans' earnings and benefits periods.

Issues arising under the ACA

Our Plans request clarification of the statutory requirements applied to the eligibility and benefits structure described above. In particular, these Plans are concerned with the application of the statutorily required employer shared responsibility, the waiting period, and the individual responsibility.

The employer shared responsibility and the waiting period

As described above, employers that are signatory to collective bargaining agreements requiring contributions to these Plans do not establish the eligibility rules for their employees and, indeed, have no knowledge of whether any of their employees actually qualify for benefits. Instead, the employer's obligation is solely to make contributions to the applicable Plan. Thus, no employer can "mandate" any particular action by the trustees of the Plans, who have a fiduciary obligation to the participants of the Plans and not to any employer.

[7] As noted above in footnote 4, the Equity-League Health Trust Fund and the IATSE National Benefit Funds share many of the concerns expressed in this letter even though the eligibility designs of those two Plans differ from those of the other Plans that are described here. The eligibility structure of those two Plans is not referred to in Appendix A.

Furthermore, an individual's eligibility for benefits is only incidentally determined by the amount of time that the employee works for a *particular* employer. Instead, eligibility is established by the compensation paid to the employee by *any and all* signatory employers required to make contributions under the collective bargaining agreements.

Thus, employees who perform substantial work in the industry – *but who do not work "full-time" for any particular employer* – will obtain benefits because they will meet the covered earnings minimums. On the other hand, an employee with relatively little consistent work in the industry, but who works for 30 hours a week for one month for a single employer, might not meet the eligibility minimums of the Plan.

As is illustrated by the chart on page 6, the Plans provide that the *benefits period* (during which time benefits are provided) begins after the *earnings period* (the period of time during which the Plans calculate whether compensation to an employee has been sufficient to establish eligibility). Because of that structure, that coverage might not be provided within 90 days of the time that the employee was "full-time" for a particular employer.

Thus, for example, if sufficient contributions are made to the Directors Guild of America – Producer Health Plan for the earnings period that ends December 31, the participant would be eligible for benefits beginning on April 1 (the benefit period that begins one quarter after the end of the earnings period during which the participant established eligibility). It may be that part of that participant's employment during the earnings period ending December 31 was "full-time" for one particular employer in November. Thus, since that participant would not be covered until April 1, that participant would not be eligible for benefits for 120 days after the end of that "full-time employment" with that one particular employer that took place in November. Of course, once eligible, that participant would be eligible for 12 months of benefits, without regard to *any* further employment – "full-time" or otherwise.

The Plans' concerns in this regard are compounded by the fact that this employee, who had worked "full-time" for the employer in November on a freelance project, might very well not be employed at all by the employer on April 1.

Under these circumstances, the Plans request that the regulations clarify that an employer is not required to provide benefits to a "full-time" employee 90 days after that employment if that employee is no longer employed full time by that employer. The regulations should also clarify that these Plans would be in compliance with any statutorily defined "waiting period" if the benefits period begins within 90 days[8] of the end of the Plans' "earnings period,"[9] as opposed to the inception of employment (or of full-time employment).

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[8] Because certain of these Plans base eligibility on calendar quarters rather than days, the actual number of days necessary to establish eligibility in our plans after completion of the "earning period" is 92 or 93, rather than 90. Elimination of this two or three day difference will require costly systems changes and cause a great deal of ongoing confusion among plan

The individual responsibility

These concerns are compounded by uncertainty regarding the individual's statutory responsibility "for each month" to insure that the individual and any dependent "is covered under minimum essential coverage for such month."

If employers are required to provide coverage within 90 days for each month that the employee actually works an average of 30 hours per week, even if that employee does not continue to work full-time for that employer or otherwise qualify for benefits under current eligibility criteria, employees and employers might constantly be required to shift coverage depending on the work pattern of the employee.

For example, if an individual works an average of 30 hours per week for a single employer in January – but not in February, March or April – and if the employer were required to provide coverage for that employee 90 days after the January "full-time" employment, that employer would be required to provide health benefits to that employee in May. If that employee again works full-time for that employer in March, the employer might again be obligated to provide coverage 90 days later, in July. During the intervening months, the employee would have the obligation to obtain insurance – but that obligation would end every few months when the employer has the obligation. Thus, in April, the individual will have an obligation to obtain his or her own coverage, despite the fact that the individual will be covered under an entertainment industry plan the very next month.

This problem is perhaps best understood graphically. The following chart illustrates the problem and the contrasting predictable, and more comprehensive, coverage provided under the current eligibility rules of the Plans:

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participants (who, for the reasons discussed above, come in and out of eligibility for our Plans on a recurring basis). We understand that this quarterly system is not unique to the Entertainment Industry and could be addressed in the regulations through recognition of waiting periods not to exceed 90 days or a calendar quarter.

[9] Cf. Interim Final Rules and Proposed Rules, Nondiscrimination in Health Coverage in Group Market, published in Fed. Reg. Vol. 86, No. 5, pp. 1403 and 1404 (January 8, 2001) (providing that a health plan waiting period begins on the date that the individual first became "eligible" for coverage in the plan).

Month	Jan	Feb	Mar	Apr	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Full Time	X		X			X						
90 day Employer Mandate*					X (for Jan.)		X (for Mar.)			X (for June)		
Individual Mandate	X	X	X	X		X		X	X		X	X
Plan Coverage under Current Plan Design							X	X	X	X	X	X**
Individual Mandate under Current Plan Design	X	X	X	X	X	X						

*Assumes that the individual did not perform work in the previous year that was sufficient to require employer-provided coverage; that two months of work (January and March in this example) are required to establish eligibility in the Plan; and that the Plan provides that eligibility begins in the following quarter (beginning in July in this example).

**For Plans providing 12 months of coverage after the establishment of eligibility, coverage will continue for six more months even if no further contributions are made based on compensation paid to that employee under the applicable collective bargaining agreement.

As this chart illustrates, the direct result of construing the Act to require a particular employer to provide insurance 90 days after full-time employment (even if that employee is no longer working for that employer) will be:

- a checkerboard of employer and employee mandates;
- lack of predictability; and
- the kind of complexity that will undoubtedly generate confusion and error, as well as potentially far less complete health care coverage for the individual at a greater cost.

Employers and employees would be required to pay attention on virtually a monthly basis to the enrollment, and re-enrollment in health plans. Each will also undoubtedly be required to calculate, and recalculate, his or her rights and obligations with regard to free choice vouchers, and premium tax credits, employer payment obligations and other mandates under the ACA. We do not believe Congress intended to complicate the work of the individual, to increase the potential of lost coverage, and to create a complex compliance structure for our health plans.

This complex scenario serves to underscore the wisdom of the current and longstanding eligibility system established by the trustees of each of these Plans that affords a predictable and reliable way for an employer to provide health benefits and coverage to employees in a multi-employer, freelance industry with unpredictable work patterns. It gives the individual the certainty of knowing whether his or her family will be covered, and the duration of that coverage.

Requested Regulatory Clarifications

We believe that the language of the Act provides sufficient leeway for the agencies to adopt clarifying regulations that provide the following:

1. An employer's responsibility with regard to the obligation to provide health benefits under the Act to employees is strictly limited to the payment of contributions as called for by the applicable collective bargaining agreements, and that nothing in the Regulations (or the statute) is intended to disrupt this existing arrangement or to require the payment of contributions or other amounts beyond what is required by those bargaining agreements.

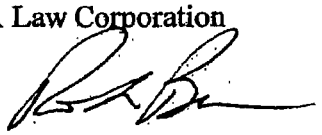
2. If an individual is no longer employed on a full time basis by a particular employer, the employer is not required to provide coverage to that individual even if that individual had been a "full-time" employee during some previous months.

3. An employer is not required to provide health benefits to employees who happen to work an average of 30 hours per week during a month for that employer, so long as that employer, pursuant to requirements in a collective bargaining agreement, contributes to a health plan that provides reasonable eligibility criteria, not related to the passage of time, that results in extended periods of health benefits coverage for employees.

4. These Plans would be in compliance with any applicable statutory waiting period if a benefits period begins within 90 days, or a calendar quarter, of the end of the Plans' earnings period.

Very truly yours,

Bush Gottlieb Singer López
Kohanski Adelstein & Dickinson
A Law Corporation



Robert A. Bush
On behalf of the following Health Plans:

AFTRA Health Fund
261 Madison Avenue, 7th floor
New York, NY 10016-2312

Directors Guild of America-
Producer Health Plan
8436 W. Third Street, Suite 900
P.O. Box 48127
Los Angeles, CA 90048-4189

Equity-League Health Trust Fund
165 West 46th St., 14th Floor
New York, NY 10036

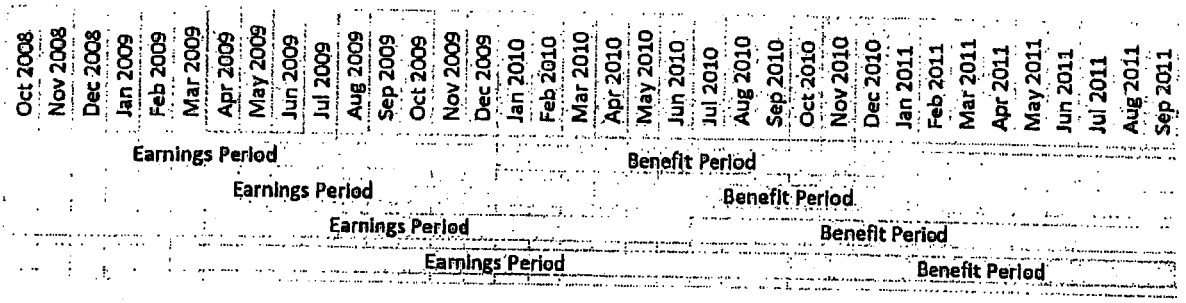
IATSE National Benefit Funds
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204

Motion Picture Industry Health Plan
11365 Ventura Boulevard
Studio City, CA 91604-3148

Screen Actors Guild –
Producers Health Plan
3601 West Olive Avenue
Burbank, CA 91505-4662

APPENDIX A

Three of the entertainment industry multi-employer health plans (AFTRA Health Fund, DGA-Producer Health Plan, and SAG-Producers Health Plan) feature 12-month earnings periods (beginning on a calendar quarter) that correspond to 12-month benefit periods. As reflected in the following chart, once a participant has reached the minimum earnings threshold during an earnings period, there is a three-month waiting period before the beginning of their 12-month benefit period.



For example, in 2010, the minimum earnings levels to establish eligibility in *one* of the benefit packages[10] made available to participants were:

AFTRA Health Fund: $30,000
DGA-Producer Health Plan: $32,400
SAG-Producers Health Plan: $29,250

As reflected in the chart at the end of this Appendix, the Motion Picture Industry Health Plan features 26- or 27-week earnings periods that correspond to six-month benefit periods beginning on the calendar month. Once a participant has reached the minimum hours threshold during an earnings period, their six-month benefit period begins on the first day of the third month following the month in which their earnings period ended (e.g. if the earnings period ended in January, the benefit period would begin April 1).

For initial coverage under the Motion Picture Industry Health Plan, a participant must work a minimum of 600 hours during one earnings period or two consecutive earnings periods. For continuing coverage, a participant must work a minimum of 300 hours during one earnings period.

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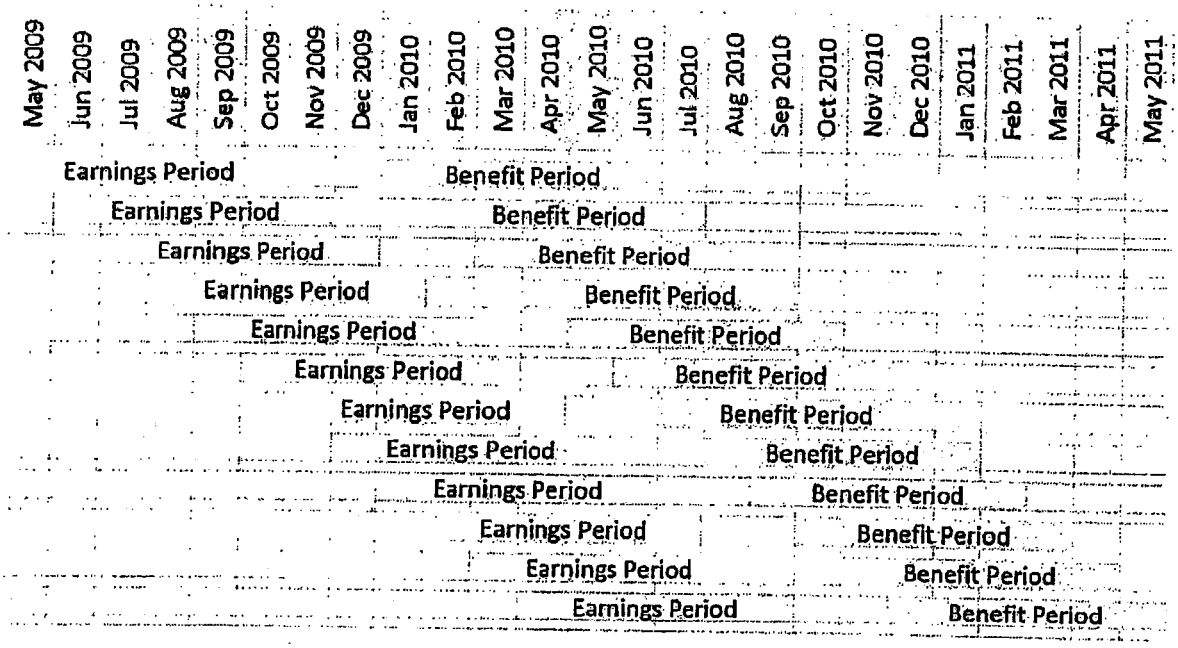
[10] Certain of these Plans provide a different schedule of benefits for participants who have lower, or higher, minimum earnings levels. Those different eligibility requirements are not relevant to the operation of the earnings period and benefit periods that are addressed in this Appendix.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