

Top 10 Affordable Care Act Bargaining Issues for Unions

1. **Strategy:** What are the general interests and concerns of each party as to employer-provided health insurance and the Affordable Care Act (ACA)?

The Union's chief concern is to how to use ACA to build Union density, ensure relevancy of Union dues and preservation of Union sponsored plans in the context of the ACA. Unions must walk a fine line in ensuring that the ACA and the additional costs it imposes are not passed directly or indirectly onto the membership, or if some costs are passed through that there are appropriate and intelligent tradeoffs in the form of higher wages, more money in the pension plan, etc. Unions must assume for the immediate future that health care insurance costs will increase. In defining bargaining objectives, Unions must consider what is in the best interests of their membership (including part-timers, families, low income, unhealthy workers, etc.), including smart use of the subsidies for participating on the Exchanges. For low income workers, Exchanges may be the best option. The ACA offers communication opportunities for Unions to show the value of contributing to CBA-based health Plans and the safe harbor for both employers and the membership. Unions should plan as they would for regular benefits bargaining, i.e. send letters to the employer and the Plan requesting data, verify employer claims of required changes, etc.

2. **Bargainability:** What provisions, if any, of the ACA are subjects for midterm bargaining? Was the issue bargained? Is there a zipper clause? Is the decision a mandatory subject of bargaining? Does a savings clause apply? Does a national health insurance reopener make sense and, if so, what should it say? How far can an employer "go it alone" with its "broad" insurance language? Should it? What is the impact of the delay in implementation of the employer mandate? What impact will multiemployer Plan issues have on bargaining? What are the practical and/or legal concerns?

The term of the labor contract raises an immediate issue for negotiations, given the increasing length of collective bargaining agreements. The Union may resist reopening or take the position that the reopener is limited to ensure the compliance of the health Plan with the ACA rather than allowing a wholesale re-negotiation of the wages/benefits package. The Union will be concerned about a total renegotiation mid-term due to the "no strike" clause, and general unwillingness to assume responsibility for ACA compliance. The Union must closely review the terms of the savings and severability clauses, and ascertain what happens in the event that the contract and the law conflict. The Union must analyze the maintenance of benefits and management rights clauses. Are there letters of understanding regarding benefits?

This position of fighting a reopener may put Union-appointed trustees on Taft-Hartley Plans in a difficult position if the health Plan is unable to absorb the cost of the mandates and fees. If the reopener clause is ambiguous, mid-term bargaining may result in a stalemate where no progress is made. Regardless of the wording of reopener clauses, the Plan will seek to pressure both sides to reach an agreement on the costs of ACA compliance which will require tradeoffs by the parties. The one year delay on the

employer mandated coverage results in delaying hard decisions on health benefits, especially for Plans offering borderline health benefits. On the other hand, the delay gives the bargaining parties more time to take stock of how well the Exchanges will work in the states where located, and also will assist Unions with more time to lobby Washington for a “fix” for Taft-Hartley Plans, especially after the mid-term elections. The delay also allows more time to see if the PPA is re-authorized and its impact on Union defined benefit Plans.

3. **Extent of Coverage:** What are the practical and legal concerns of: (1) providing compliant (i.e. affordable, adequate value) coverage; (2) not providing coverage to take advantage of subsidies on the Exchanges; or (3) providing either unaffordable or inadequate value coverage? Providing employer-sponsored two-tier coverage, or reducing coverage to Bronze Level? What are the special cost and compliance concerns of providing coverage through a multiemployer health Plan?

Coverage issues offer skilled negotiators the best opportunity to make ACA a win-win. Unions must rely on legal counsel and the Plan consultants to open up all the possible ways to deliver high quality coverage for members and their families, while using subsidies to maximum effect. Under the ACA, employers are not required to provide coverage to any employee or dependent, but if an employee receives subsidized coverage in the Exchange, the employer may be subject to a penalty.

Wages and Benefits: Some Unions will face a decision about whether to bargain for increased wages instead of health benefits. If a large number of Union members are eligible for subsidized coverage in the Exchange, those workers may be better off receiving the amount an employer would have contributed to their health benefits in the form of higher wages and purchasing subsidized coverage in the Exchange. The suitability of this approach will be highly dependent on the specific circumstances of each workplace. In general, workers and employers may be better off forgoing group health insurance if the cost to the employer of providing group coverage is more than the cost of paying the penalty and providing wage increases sufficient to enable workers to purchase coverage through the Exchange after taxes.

However, even when this approach benefits a workforce on average, some individual workers and their families could end up worse off because changes will impact workers unequally. Under the current employer-based health insurance system, single employees subsidize employees with families and younger workers subsidize older workers. Unions that bargain for wage increases in lieu of health benefits would likely bargain for a flat dollar amount increase or an increase as a percentage of wages, but workers’ premium contributions in the Exchange would also depend on their overall family income, the size of their family, and their age if they are not subsidy-eligible. Unions could also consider bargaining for other benefits, such as childcare, that would reach the workers who would be most affected by a non-offer of health benefits. Special consideration should be given in workforces that already have coverage, as a shift to the Exchange could create divisions among the workers.

Employer Responsibility: Coverage may be subsidized if the employee’s family income is less than 400 percent of the Federal Poverty Level (FPL) (\$44,680 for an individual and \$92,200 for a family of four in 2012). Employees below 133 percent of the FPL (approximately \$14,860 for an individual, \$30,660 for a family of four in 2012) may be eligible for Medicaid. Individuals are only eligible for subsidies in the Exchange if they

are not offered affordable coverage by their employer. Coverage is considered unaffordable if an employer requires a contribution greater than 9.5 percent of family income or offers a Plan that covers less than 60 percent of medical costs on average. Under proposed regulations, if self-only coverage costs less than 9.5 percent of income and an employer offers dependent coverage, then both employees and their family members are ineligible for subsidies regardless of whether or not family coverage is affordable. If the regulations are finalized as proposed, Union negotiators should consider that an offer of family coverage could prevent dependents' access to subsidized coverage in the Exchange. Typical Union-negotiated health Plans are not likely to fall below the actuarial value threshold of 60 percent as the average actuarial value for employer-based Plans was 80 percent in 2007 and even high-deductible health Plans in the group market had an average actuarial value of 67 percent.

Large employers not offering coverage to employees and their dependents with at least one full-time employee receiving subsidies in the Exchange are required to pay a penalty of \$2,000 multiplied by the number of full-time employees minus 30 employees. Large employers offering coverage with at least one full-time employee receiving subsidies in the Exchange pay the lesser of \$3,000 multiplied by the number of full-time employees receiving subsidies and \$2,000 multiplied by the total number of full-time employees minus 30 employees. Full-time is defined as an average of 30 hours or more with respect to any month and non-seasonal is defined as working 120 days or more in a taxable year. For existing employees, full-time status would be determined based on a look-back and stability period not exceeding 12 months. For newly-hired employees, in certain circumstances, employers would have six months to determine whether an employee is full-time and would not be subject to penalties during that time.

Below is a discussion of the factors that Unions may consider in weighing the trade-offs between negotiating for higher wages versus health benefits. (Some Unions may also want to consider bargaining to redirect the funds that the employer would have otherwise contributed towards health benefits towards pension contributions, training improvements, or other non-health care needs. In those cases, the factors considered would be similar.)

Medicaid and Subsidy Eligibility: Families with adjusted gross incomes under 133 percent of the FPL (approximately \$14,860 for an individual and \$30,660 for a family of four in 2012) will be eligible for Medicaid. Families with incomes between 133 percent and 400 percent FPL (\$44,680 for an individual and \$92,200 for a family of four in 2012) are eligible for subsidies in the Exchange. Subsidies are provided for premiums and cost sharing. Subsidies are designed to limit the cost of premiums to 3 percent of family income for a family at 133 percent FPL and 9.5 percent of family income for a family at 400 percent FPL. Undocumented workers are not eligible for Medicaid or purchasing coverage in the Exchange, whether subsidized or unsubsidized. Unions should take into account that increasing wages could make some workers ineligible for Exchange subsidies and Medicaid due to their higher income, and could reduce the amount that other workers receive in premium and cost sharing subsidies.

Tax Deductibility: In considering whether to pay increased wages instead of offering health benefits, the tax deductibility of health benefits is an important consideration. In order to compensate for \$100 in lost health benefits, an employer would spend roughly \$139 to \$193 in order to make workers whole after taxes and to pay the additional employer payroll taxes, depending on the tax brackets into which workers fall. If an

employer contributes to a Section 125 account for employees to use towards their premiums, the contributions will be considered employer-sponsored insurance and the employee will be ineligible for subsidies in the Exchange.

In short, care must be taken to not blindly assume a Union-sponsored Plan is always in the members' best interest since some low income members may do better with a subsidized Plan on the Exchange, especially if it means more money in their pocket as the tradeoff for the employer reducing or dropping the employer-sponsored Plan. Employers may welcome the ability to walk away from the cost, hassle and uncertainty of providing coverage. The coverage issues concerning multi-employer health Plans are: the difficulty in obtaining information concerning the nature of the coverage, eligibility rules, and determination of minimum value and affordability. All of these questions are also important to the employers in considering how they will be able to continue to participate in a multi-employer Plan. In general, Unions want to ensure the viability of a multi-employer Plan, even though employers will be increasingly be skeptical of such Plans and the loss of control by agreeing to participate in them.

4. **Who to Cover:** For each of the parties, what are the practical and legal concerns when employees are designated full-time, part-time, seasonal or intermittent? Who is a part-time employee under the law? Who controls which employees are full-time both from a scheduling perspective and from a "determining eligibility" perspective (look-back period)? Who pays and what is offered for less than 40 hour full-timers? Are these employees better off with no or unaffordable coverage? What about coverage for part-time employees? What are the legal and practical concerns of the part-time/full-time dilemma for Union duty of fair representation exposure, fair treatment issues, ERISA Section 510 issues for employers, representational/unit appropriateness issues? Should spouses and/or dependents be covered?

While the Union would prefer to have full-time, year round workers, modern alternative employment reflects the variable employee nature of industry and workforce. While all employees are able to participate in the Exchanges, the employer's obligation is limited to full-time employees working more than 30 hours a week or 130 hours per month. For non-hourly employees, employers can (1) count actual hours, or (2) give 8 hours credit if at least one hour is worked, or (3) use 40 hours per week. Different methods can be used for different employees. The mandate invites employers to bargain to reduce hours, and thereby reduce their mandate (the Walmart solution).

The incentive for employers to reduce workers to part time leaves the issue up to the Union to decide whether to push to cover part-timers at the bargaining table, and how hard to push. Because the ACA does not require that employers cover part-time employees under the Plan, a Union could bargain for their coverage. A Union may believe that bargaining for part-time employees may not be the most cost-effective strategy. The Union could experience two issues with part-time employees: (1) part-time employees may be less likely to be members of the Union and therefore submit a disparate treatment allegation, and/or (2) part-time employee members of the Union may argue that the Union negotiated in bad faith. It would be unwise for a Union to expressly state that no part-time workers would get health benefits, as part-time workers may allege a Union who fails to bargain for part-time insurance coverage fails to meet its legal obligation as the sole bargaining representative. Part-time employees may attempt to pursue a duty of fair representation claim against the Union based on disparate treatment or bad faith.

Disparate Treatment: Part-time employees may allege the Union decided to concede part-time employees coverage because they are less likely to join the Union. In this case the Union would have to make an explicit statement about its reasoning for allowing the removal of part-time employees from coverage (specifically, the Union may choose to make the argument excluding part-time employees, for their employment status, could result in cost-savings and higher wages). The Union may choose to bargain for an objective test for health care eligibility, i.e. employees who work more than 1,000 hours rather than a statement that part-timers will not be covered to minimize disparate treatment claims.

Bad Faith Bargaining: While a Union's decision to exclude part-time employees from coverage is deliberate, it is not unjustified. Here, the Union would have to prove that part-time employees may benefit from receiving coverage in the Exchange. In particular, the Union may demonstrate that part-time employees may qualify for Exchange, Medicaid or other subsidized coverage that will meet the needs of employees and result in cost-savings. Subsidies under the Exchanges are determined based on income, rather than classification of part-time or full-time status. If the Union is able to prove its coverage negotiations will result in tangible victories for workers (increase in wages, better pension Plans, etc.), then the Union will likely survive a bad faith allegation. The Union may argue it did not act in bad faith because it has met its obligations to employees that are covered by the ACA. Part-time employees are not covered. While this seems a bit harsh, the Union has sufficient grounding to argue that it has met its duty.

5. **Cost Sharing:** How are the various costs shared? For premiums? To bring noncompliant Plans into compliance? For preventative services? For spouses (will they even be covered)? Dependents? Part time employees? For the new taxes? For possible penalties? For Cadillac taxes? How does an employer cost out health care before knowing what Plan and competing Exchange rates will be? How does employer know if Plan is affordable and providing minimum value for full-time employees? What are the practical and/or legal concerns?

The consultants will provide the data. The two issues of major concern to the Union here are (1) is the consultant's data reliable? and (2) how to prevent ACA compliance costs from dominating the other economic issues at the bargaining table. By pressuring the Plan to cost out the various options prior to bargaining, the Union will have time to decide if it wants to retain its own consultant to review those projections, and avoid ACA compliance from being an undefined specter haunting the negotiations. The employer will likely take the lead on presenting the options, since ACA is fundamentally an opportunity for employers to compel the Union to seek to bargain for maintaining the status quo.

6. **Timing and Notices:** What if an existing CBA requires an employer to contribute to the Plan on behalf of a covered employee only after the employee has completed six months of employment? How do the parties deal with the ACA new limits on waiting periods? What are the practical and/or legal implications of each party?

The difficulty with the ACA 90-day rule relates to the fact that many health Plans use a three month, or quarterly eligibility period. The solution in most cases is to set a rule for becoming eligible which does not rely solely on the passage of time, and use that period

for becoming eligible in lieu of a rule which requires more than 90 days from the date of eligibility. The employer will insist on clarity of the 90-day rule because of the risk that the employer may be found to be contributing to a Plan which does not comply with the ACA. The recent FAQ suggests finally a possible softening of the agency position that it is 90 days because the FAQ refers to “quarterly” periods and to the aggregation of work by multiemployer Plans. Any change in the SPD or the annual summary requires 60 days advance notice to the participants.

7. **Certifications, Indemnification and Reopeners:** What assurances should an employer seek to confirm that the multiemployer Plan in which it participates fully complies with the ACA? Or that the contract language as written will permit full compliance? Or that the Plan will not become subject to the Cadillac tax? Who should provide such assurances? The Union? The Plan? Does the Plan care if the Union makes assurances such as indemnifying the employer for any additional costs or fees imposed as a result of the ACA? Should an employer agree to Plan participation without assurances of ACA compliance? Who pays if it turns out an employee is able to obtain subsidized insurance on the Exchange despite those assurances? Who should pay if a Cadillac tax is imposed? What assurances might the Union want if it is an employer sponsored Plan? What if anything should be added to the contract to address future changes to the ACA or its implementing regulations? What are the practical and/or legal concerns?

Employers should require written assurance of ACA compliance; however, a Plan will refuse to indemnify the employer on account of the changing state of the law. Unions should likewise refuse to provide such assurance. It is premature to include the 2018 Cadillac tax in negotiations.

8. **Grandfathered Status:** What are the costs and consequences of losing grandfathered if the Plan is changed? What are the practical and/or legal implications of each party?

The principal cost for loss of grandfathering is the requirement for covering preventative care. This is largely an analytic exercise in comparing the cost of maintain grandfathering (limiting participant costs) versus the cost of providing ACA preventative care. The following is a list of changes required following a loss of grandfathered status:

- *Adult Child Coverage:* Non-grandfathered Plans must offer coverage to all dependent children to age 26 (regardless of access to other employer-provided coverage).
- *Free Preventive Services:* Non-grandfathered Plans must offer 100% coverage for all in-network preventive care services (see our separate email addressing this item in greater detail).
- *Emergency Services:* Emergency care must be covered at same benefit level (both in and out-of-network). Balance billing is permitted for out-of-network emergency services, but the reimbursement rate for out-of-network preventive services must be the greater of (1) the Medicare reimbursement rate, (2) the in-network reimbursement rate, or (3) the UCR reimbursement rate.
- *Choice of Provider:* Non-grandfathered Plans that require participants to designate a primary care provider must allow participants to choose among

any available provider in the network. Women must be able to designate an OB/GYN as their primary care provider (and visit an OB/GYN without a referral) and parents with children must be able to designate a pediatrician as the child's primary care provider. Plans that require a primary care provider designation will be required to disclose these rights in all participant communication materials describing Plan benefits.

- *Revised Appeals Procedures:* Plans must revise its internal appeals procedures to expand the notice provided to participants upon claim denial and adhere to stricter claim review requirements. Plans must also offer an external review by an independent review organization (IRO) for certain denied claims. Plans will be required to contract with at least three IROs.
- *Participant Notice:* There is no formal requirement to notify participants that a Plan has lost grandfathered status, but the Plan may choose to do so. Of course, the Plan is required to notify participants of the additional Plan changes resulting from the loss of grandfathered status (as described above and below).
- *Cost-Sharing Limitations:* Starting in 2014, there are limits on the amount of deductible and out-of-pocket maximums a Plan may impose on participants. There's still some question whether this will apply to a self-funded group health Plan or only to those Plans offered through the Exchanges, but we believe the best interpretation is that it will apply to all Plans. There's also some question whether these limits will apply only to in-network services or to all services, regardless of whether they are provided in-network or out-of-network. The specific limits (indexed to inflation) are \$2,000 (individual), \$4,000 (family) for deductibles, and approximately \$6,000 (individual) and \$12,000 (family) for out-of-pocket maximums.
- *Coverage for Experimental Treatments:* Starting in 2014, a Plan will be required to cover any Phase I-IV clinical trial for a life-threatening condition.
- *Transparency Disclosures:* Non-grandfathered Plans must report on claims payment policies, disenrollment claims denied, cost-sharing for out of network coverage, and "other information." Note that this information is submitted to HHS and to the state insurance commissioner and will be made available to the public. This provision was originally to be effective in 2011, but subsequent guidance indicated it will not be effective until further guidance is issued.
- *Quality of Care Report:* Non-grandfathered Plans must submit reports providing details on (1) provider reimbursement structures that improve health care quality; and (2) incentives for case management, care coordination, chronic disease management, and activities to prevent hospital readmission. The effective date of this provision is not clear from the Act, but the report must be submitted to HHS, so presumably the requirement won't become effective until HHS tells Plans how to submit the report.

9. **Wellness Programs:** Which bargaining party wants a wellness program? Whose decision should it be? How do the parties measure and share the saving? What are the practical and legal (EEO, ADA) implications for each party?

Over the next several years, and beyond, there will be increased emphasis on Plan design changes relating to preventative care and wellness. Unions will likely support wellness programs although focusing more on carrots than sticks, and seek appropriate

privacy protections for their members. Wellness programs may become a more frequent topic of bargaining in coming years, as the use of such programs is already growing and the ACA increases employers' flexibility in offering wellness incentives. Beginning in 2014, employers can provide rewards to employees of up to 30 percent of the total Plan premium as part of a wellness program incentive, up from the current limit of 20 percent. Under the law, the Secretary of Health and Human Services may increase this limit to 50 percent if deemed appropriate. Rewards may be in the form of a premium discount, reduced cost-sharing, the absence of a surcharge, or a benefit that would not otherwise be provided under the Plan. It is likely there will be more arrangements for on-site employee gyms, payment of health club dues, weight control classes, blood pressure classes, cancer detection programs, etc.

The ACA also sets new standards for wellness programs. For example, rewards must be made available to all similarly situated individuals and a reasonable alternative standard must be made available to individuals for whom it is difficult or inadvisable to meet the standard due to a medical condition. Additionally, wellness programs must be "reasonably designed to promote health or prevent disease."

10. **Two Trust Approach:** The parties wish to take advantage of the subsidies, while still maintaining Union-represented employees' association with the Plan as their "Union benefit Plan." They propose that the Plan provide staff to determine whether employees would be eligible for premium subsidies and, for those who are eligible, the parties would negotiate a termination of coverage by the Plan. Instead, the employer would contribute to a common law trust that would enroll these employees in a designated Silver Qualified Health Plan (QHP) on the Exchange, which would be open to the public, but would have a contract with the multi-employer Plan to administer benefits for the subsidized bargaining unit employees. From the subsidies, the employer would pay the \$2000 per full-time employee (minus 30) penalty and the taxes and a bump up from the Silver Plan to the multi-employer Plan benefit level. Assuming the bargaining parties agree to this, what should the Plan trustees do? What are the practical and/or legal implications?

This is a possible way to harmonize the ACA Exchange with employer provided health insurance, for low income workers. The bargaining parties should seek Plan input on the costs and administrative burden on pursuing such an option. Additionally, further regulatory guidance should be sought.