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The Affordable Care Act: A Guide for Union Negotiators

The Affordable Care Act (ACA), the health reform law passed in March 2010, includes many provisions that will impact employer-based insurance and union health plans in particular. Some provisions are already effective, while others are not effective until 2014 or 2018. The ACA could potentially impact the next few rounds of contract negotiations for many unions depending on the specific contract expiration dates. This guide describes some of the key provisions of the ACA as they apply to union plans, outlines the implementation timeline, and discusses considerations for union negotiators.

This guide is based on our understanding of the law and related regulations as of March 2012. This guide will be updated as regulations implementing the law continue to be finalized and further information about the intent of the law becomes available.

1. Plan Requirements

The ACA introduces new standards for employer-sponsored health plans. The implementation dates for these requirements vary based on the plan's effective date, whether the plan is subject to a Collective Bargaining Agreement (CBA), and whether the plan is self-insured or fully-insured.

Plan Types

Grandfathered plans: Plans that had enrollees as of March 23, 2010, may be grandfathered. Some requirements will not apply to grandfathered plans, while other provisions apply to grandfathered plans on the same date they become effective for all plans. Certain changes to plan design will nullify a plan's grandfathered status, such as:

- elimination of benefits for certain conditions,
- certain increases in cost sharing (any increase in coinsurance percentage, an increase in deductible or out-of-pocket limit by more than 15 percent plus medical inflation, or an increase in co-payment by more than $5 adjusted for medical inflation or 15 percent plus medical inflation, whichever is greater),
- increases in employee share of premium by more than 5 percentage points, or
- certain changes in annual benefits limits.

These limits are applied on a cumulative basis, not an annual basis.

Changes to premiums, changes made to comply with federal or state laws, or changes in third party administrator will not cause a plan to lose its grandfathered status. Employers that change insurers can maintain grandfathered status as long as the new plan has similar cost sharing and benefits as the original plan.The grandfathering rules apply separately to each benefit package under a health plan. The White House predicts that between one- and two-thirds of large group plans will remain grandfathered by 2013.[1] For more information, see the grandfathering regulation.

Collectively bargained plans: Fully-insured plans pursuant to a CBA are grandfathered until the last expiration date of a CBA related to that coverage. Multi-employer plans are grandfathered until the last expiration date of a CBA related to that plan regardless of employer. Grandfathered status may be maintained upon the CBA expiration date if no changes were made since March 23, 2010, that would have otherwise caused the plan to lose its grandfathered status. For more information, see the grandfathering regulation.

Self-insured plans: Self-insured plans subject to a CBA are not eligible for the same delayed implementation as collectively bargained fully-insured plans. All self-insured plans are exempt from some plan requirements, as noted below. For more information, see the grandfathering regulation.

Plan Requirement Details

Grandfathered plans are exempt from the following requirements until the plan loses its grandfathered status:

Preventive services: Plans must offer first-dollar coverage (no co-payment or deductible) for certain preventive services effective now. Examples of preventive services covered under this provision include blood pressure, diabetes, and cholesterol tests; many cancer screenings; certain types of health counseling; certain routine vaccines; flu and pneumonia shots; pregnancy counseling, screening, and vaccines; and well-baby and well-child visits. The White House estimates that this provision will increase premiums by 1.5 percent, on average. See the list of covered preventive services. For more information, see the preventive services regulation.

Patient protections: Plans are prohibited from requiring a referral to see an obstetrician/gynecologist and from requiring prior authorization or higher cost sharing for out-of-network emergency services, effective now. These protections are already existing law in California. For more information, see the Patient's Bill of Rights regulation.

Out-of-pocket maximums: Group plans must limit out-of-pocket costs to $6,050 for single coverage and $12,100 for family coverage (2012 dollars) effective in 2014 for non-grandfathered plans. Self-insured plans are exempt.

Pricing: For small group plans (100 or fewer employees), medical underwriting is prohibited and rating variation is only allowed based on age (3:1 ratio), tobacco use (1.5:1.0),

family composition, and geography effective in 2014. In states permitting large group plans in the exchange in 2017, these pricing standards will apply to all fully-insured large group plans in and out of the exchange. Self-insured plans are exempt.

Deductibles: Small group plans (100 or fewer employees) must limit deductibles to $2,000 for single coverage and $4,000 for family coverage beginning in 2014 for non-grandfathered plans. Self-insured plans are exempt.

Minimum services covered: Fully-insured small group plans (100 or fewer employees) in and out of the exchange and large group plans in the exchange must cover preventive and primary care, emergency, hospital, physician, outpatient, maternity and newborn care, pediatric (including dental and vision), medical/surgical care, prescription drugs, lab, and mental health and substance abuse, effective in 2014 for non-grandfathered plans. States have the flexibility to set the benchmarks within each category. For more information see the HHS news release.

Some requirements are implemented on the same date for all plans, regardless of plan effective date or whether the plan is collectively bargained:

No lifetime or annual limits: Plans are prohibited from limiting the lifetime dollar value of benefits effective the first day of the next plan year beginning after September 23, 2010. Annual limits are restricted to no less than $750,000 beginning September 23, 2010, $1.25 million beginning September 23, 2011, and $2 million beginning September 23, 2012, and are banned completely beginning January 1, 2014. The annual limit requirements do not apply to grandfathered individual plans. To ensure that individuals with limited benefit plans continue to have access to affordable insurance, some plans received temporary waivers of the annual limit restrictions through 2013. See the current list of approved waivers. The White House predicts that the ban on lifetime limits will increase premiums by 0.5 percent or less and the annual limit restrictions will increase premiums by 0.1 percent or less.[2] For more information, see the Patient's Bill of Rights regulation.

Dependents under age 26: Plans must allow adult children under age 26 to enroll in a parent's plan effective now. Adult children are eligible without regard to financial dependency, residence, student status or employment. Married children are eligible to enroll in a parent's plan, though their spouses are not. Coverage is exempt from taxes through the end of the tax year in which the adult child turns 26. Through 2013, grandfathered group plans do not need to provide coverage to dependents that have health insurance available through their employer no matter the price or quality of the employer's insurance. For more information, see the Dependent Coverage regulation and IRS guidance.

Plan administrative costs: Plans must provide rebates to consumers if the percentage of premiums spent on medical services and activities to improve health care quality falls below 85 percent for large group plans or 80 percent for small group plans (or higher standard set by state, if applicable) beginning in 2011. Self-insured plans are exempt. For more information, see the Medical Loss Ratio regulation.

2. Automatic Enrollment

Employers with more than 200 full-time employees[3] must automatically enroll employees into a plan unless they opt out of coverage. The law does not specify which plan employers offering multiple plans should automatically enroll employees in, making this a potential subject for collective bargaining. Unions and employers are also likely to want to negotiate over the specific way in which employees are notified and given the opportunity to opt out of coverage. This provision will be effective once final regulations are issued, which the Department of Labor does not expect to happen in time to take effect in 2014.

3. Eligibility

Waiting periods of more than 90 days are banned in 2014 for all plans, including grandfathered plans and self-insured plans. Employers that currently require waiting periods that are significantly longer than 90 days may face increased costs in order to bring the plan into compliance. An initial federal notice suggests that employers that offer coverage would not be subject to penalties during the first three months after an employee's date of hire if the waiting period applies during that time. The notice indicates that employers could require a specified number of cumulative hours for eligibility for coverage below a to-be-determined limit, after which the 90-day waiting period would begin.

4. Employer Responsibility

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, beginning in 2014. An employee is eligible for the exchange if they are lawfully present in the U.S. That coverage may be subsidized if the employee's family income is less than 400 percent of the Federal Poverty Level ($44,680 for an individual and $92,200 for a family of four in 2012). Employees below 133 percent of the Federal Poverty Level (approximately $14,860 for an individual, $30,660 for a family of four in 2012) may be eligible for Medicaid. Employees 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.[4]

Employers with fewer than 50 full-time equivalent non-seasonal exmployees are exempt from the employer responsibility penalties.

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, an initial federal notice suggests that 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, according to an initial federal notice.

Examples

Employer 1: 100 full-time employees, does not offer coverage, at least one employee enrolled in subsidized coverage through the exchange

Penalty = $140,000 = $2,000 x (100-30)

Employer 2: 100 full-time employees, offers coverage, but coverage is unaffordable for 20 employees who are enrolled in subsidized coverage through the exchange

Penalty = $60,000 = $3,000 x 20

No employer penalties shall apply for employees enrolled in Medicaid or for employees' dependents who receive subsidized coverage in the exchange.

5. Worker Share of Premium

Although the ACA does not require that employers contribute towards health plan premiums, the employer's contribution level has several important implications. The less the employer contributes towards coverage, the greater the number of workers that would be potentially eligible for the exchange and the greater the number of employees for which the employer would potentially pay a $3,000 penalty. Secondly, increasing the worker share of the premium by more than 5 cumulative percentage points would cause the loss of grandfathering status after the CBA expires. Finally, the less the employer contributes towards coverage, the more likely it is that worker contributions to premiums exceed 8 percent of family income, making workers exempt from the individual mandate.

6. Cost of Coverage

The Congressional Budget Office projects that average large group premiums in 2016 would be 0 to 3 percent lower under the ACA compared to under current law,[5] while a recent Commonwealth Fund study estimated that private coverage premiums would be 9 percent lower in 2019 compared to under current law.[6] Over the longer-term, the ACA could potentially decrease premiums even more, in part due to delivery system reforms and a reduction in the cost-shift from uncompensated care. While the average cost per enrollee may decrease, the total cost for some employers may increase to the degree that higher take-up rates result from the individual mandate and the automatic enrollment requirement.

Small Business Tax Credit

Small businesses with 25 or fewer full-time equivalent employees with average annual wages of no more than $50,000 are eligible for tax credits towards the purchase of coverage. These credits currently reduce the employer cost of providing coverage by as much as 25 percent for eligible tax-exempt businesses and 35 percent for all other eligible businesses. In 2014, the credits increase to as much as 35 percent for eligible tax-exempt businesses and 50 percent for all other eligible businesses. Credits are greatest for those firms with ten or fewer employees and wages of less than $25,000, and phase out as average wage and firm size increases. Starting in 2014, the tax credits will only be available for insurance purchased through the exchange. For more information, see the IRS guidance.

Excise Tax

Insurers will be taxed at 40 percent of the aggregate value of plans above a high-cost threshold beginning in 2018. In the case of self-insured plans, the tax will be paid by plan administrators. The cost of this tax will likely be passed on to employers and enrollees through higher premiums.

The aggregate value of a plan includes the combined worker and employer contributions to premiums, in addition to employer contributions to a Health Savings Account (HSA), Medical Savings Account (MSA), or a Flexible Spending Arrangement. The value will be calculated excluding dental and vision benefits. Employers are responsible for paying any tax on the HSA or MSA amounts and for notifying the insurer of the full cost of coverage.

In 2018, the high-cost thresholds will be $10,200 for individual coverage and $27,500 for family coverage. The thresholds will be adjusted for firm-specific age and gender and increased by $1,650/$3,450 for retirees aged 55 and over who are not Medicare-eligible, electrical and telecommunications installation/repair workers and individuals in high-risk jobs (including longshore work, emergency response, firefighting, law enforcement, construction, mining, agriculture, forestry, and fishing). The thresholds may be adjusted upwards initially to the degree that Federal Employee Health Benefits Program premiums rise more than expected between 2010 and 2018 and will be indexed by inflation in 2020 and subsequent years (inflation plus 1 percent in 2019).

To avoid the tax, some employers and unions will want to make changes to their plans, such as changing the plan type offered (e.g., PPO to HMO), making changes to benefits or cost sharing, or improving provider networks by eliminating high-cost low-value providers.

7. Early Retiree Reinsurance Program

Employers that provide health insurance coverage to retirees aged 55–64 were eligible to receive reimbursement for 80 percent of claims between $15,000 and $90,000. The program stopped accepting new applications as of May 6, 2011 and received requests for reimbursement that exceeded the $5 billion in funding appropriated as of February 17, 2012. For more information, see the Early Retiree Reinsurance Program website.

8. Wellness Programs

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.

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."

9. Tax Changes Related to Health Insurance

The law makes several tax changes that will affect some employer-sponsored plans:

- Contributions to a Flexible Spending Arrangement for medical expenses are limited to $2,500 beginning in 2013.
- Funds from a Health Reimbursement Arrangement, Flexible Spending Arrangement, Health Savings Account, or Medical Savings Account cannot be used as reimbursement for over-the-counter medications not prescribed by a doctor beginning in 2011.
- Distributions from a Health Savings Account or a Medical Savings Account that are not used for qualified medical expenses will be taxed at an increased rate of 20 percent beginning in 2011.
- The law eliminates the tax deduction for employers who subsidize Medicare Part D retiree drug payments effective in 2013.

10. Considerations for Taft-Hartley Trust Funds

All Taft-Hartley fund plans are subject to a CBA and many are self-insured, making the rules for those plan types especially important for trust funds. A few additional special considerations for Taft-Hartley funds are worth noting.

- A trust fund may have some plans with grandfathered status and some plans that do not have grandfathered status.
- The regulations do not indicate that a Taft-Hartley plan will lose its grandfathered status if a new employer joins, but the impact may be subject to interpretation.
- Trust funds are likely to be especially attentive to the increased costs related to the new plan requirements as they have a set amount of assets to use to pay out benefits.
- It is not yet clear what impact the ban on waiting periods of more than 90 days will have on trust funds that require a minimum number of initial hours worked for eligibility. This may be clarified through regulations.

11. Wages or 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.

Below is a discussion of the factors that employers may consider in deciding whether or not to offer coverage and 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 Federal Poverty Level (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.[7]

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.

Coverage Offered to Non-Bargaining Unit Staff

Some employers may want to offer coverage to certain employees but not others. The ACA extends existing Internal Revenue Code Section 105(h) non-discrimination rules, which currently apply only to self-insured plans, to non-grandfathered fully-insured plans, effective six months after enactment. These rules require that plans benefit a significant portion of all employees in order for benefits to be excludable from taxable income. Eligibility for coverage may not discriminate in favor of highly-compensated individuals. Under these provisions, employers may offer coverage to full-time workers but not part-time workers, except in certain situations in which part-time workers constitute a significant percentage of the workforce. Workers covered under a collective bargaining agreement may be excluded from consideration under the non-discrimination rules if benefits were a subject of good faith bargaining.

Employee Demographics

In workplaces in which many workers have low family incomes and are citizens or permanent residents, union members may generally be better off purchasing subsidized coverage in the exchange and receiving increased wages from their employer in lieu of health benefits. Similarly, older workforces who are subsidy-eligible may be better off in the exchange because their premium contribution is limited to a set percentage of income regardless of their age, while large group plans outside the exchange will be allowed to continue to set premiums based on the age of the workforce. Those seeking family coverage may also be better off in the exchange. Finally, undocumented workers will not be able to purchase coverage in the exchange, with or without subsidies.

For bargaining units with primarily low-wage workers, unions may want to survey members prior to bargaining to understand family income, family size, age, and current source of coverage, in order to make informed decisions about whether the union would be better off negotiating for wages in lieu of health benefits for some or all of the members in the unit. See a sample survey of workers.

12. Take-Up of Coverage

The percentage of workers currently enrolled in coverage will also have an effect on employer and union decisions. The employer cost of continuing to offer job-based coverage for workforces with low take-up rates (whether due to limited eligiblity or other sources of coverage) will be relatively lower than the cost for other employers, altering their calculations about whether to offer coverage. However, employers with low take-up rates could experience an increase in costs if take-up increases due to the individual mandate and auto-enrollment requirement.

13. Large Employers and the Exchange

Beginning in 2017, states have the option to expand the exchange to large employers. Unions and employers in states where that choice becomes available will face a decision about whether it is better to purchase a plan in the exchange or maintain the existing health plan outside the exchange. Whether or not it is advantageous for large employers to enter the exchange is partly dependent on how the exchange is structured. In addition, unions and employers are likely to compare the premium, plan type, provider network, and design of exchange plans to their current plan, in order to determine whether exchange plans will meet the needs of their members or employees. They may also consider that purchasing coverage in the exchange could put undocumented workers at risk. It is not yet clear what documentation will be required for employees enrolling in coverage in the exchange through their employer, but if Social Security is used for verification there is a potential that undocumented workers could be identified and face enforcement actions.

Endnotes

[1] U.S. Department of Health and Human Services, "Fact Sheet: Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans," http://www.healthcare.gov/news/fact-sheets/keeping_the_health_plan_you_have_grandfathered.html.

[2] U.S. Department of Health and Human Services, http://www.healthcare.gov/law/provisions/billofright/patient_bill_of_rights.html.

[3] Full-time is defined as an average of 30 hours or more per week with respect to any month.

[4] Roland McDevitt, Jon Gabel, Ryan Lore, Jeremy Pickreign, Heidi Whitmore, and Tina Brust, "Group Insurance: A Better Deal for Most People than Individual Plans," *Health Affairs* 29, No. 1 (2010): p. 1-9.

[5] Congressional Budget Office, Letter to Senator Bayh, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act," November 30, 2009.

[6] David M. Cutler, Karen Davis, and Kristof Stremikis, "Issue Brief: The Impact of Health Reform on Health System Spending," Commonwealth Fund Publication 1405, Vol. 88, May 2010.

[7] Estimated taxes include Social Security, Medicare, federal income tax, California state disability insurance, California income tax , and California workers' compensation.

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