U.P. Labor-Management Council

Affordable Care Act
2015 Bargaining and Beyond

Presented by:

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Working with Employers ®

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Affordable Care Act

The Affordable Care Act Was Signed into Law March 23, 2010

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Lots of Excitement and Celebration

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Now That Its Passed Let's See What We Have

Affordable Care Act at the Bargaining Table

Then We Started Reading the Law

Affordable Care Act at the Bargaining Table

WOW!

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Then The Real Fun Started

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF LABOR
UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH & HUMAN SERVICES
USA

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And The Fun Really Hasn't Stopped

Affordable Care Act

And The Fun Really Hasn't Stopped

Since the ACA was enacted, there have been approximately 50 significant changes/clarifications to the ACA.

- 32 unilateral changes from the President
- 17 passed by Congress
- 2 by the Supreme Court

- One of the most interesting was the President's 2013 rule clarifying that government contributions to Congress and their staff when they purchase insurance on the SHOP exchange…a subsidy the law doesn't provide for.
- Most of these changes were understandable and to be expected in light of the massive transition the law required. Some are simply realizations that the law didn't quite hit the mark on some issues.

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The Final Hurdle?

King v. Burwell, 135 S.Ct. 475 (2014)

- Could have potentially undermined the financial viability of the ACA by not permitting individuals who enroll in an insurance plan offered through a federally created exchange for a state that opted out, a subsidy.

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Ok, We're Here. Now What Do We Do?

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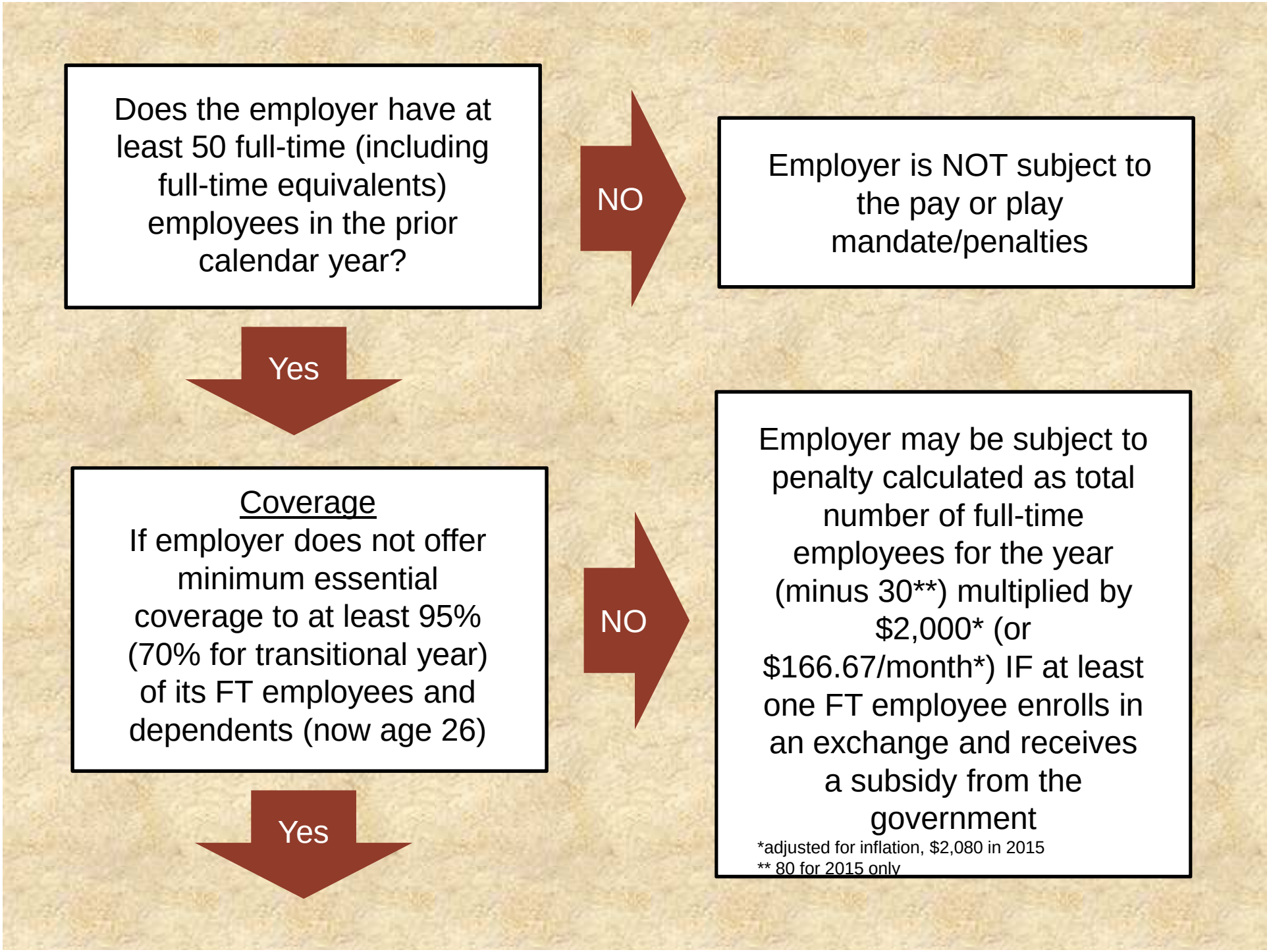
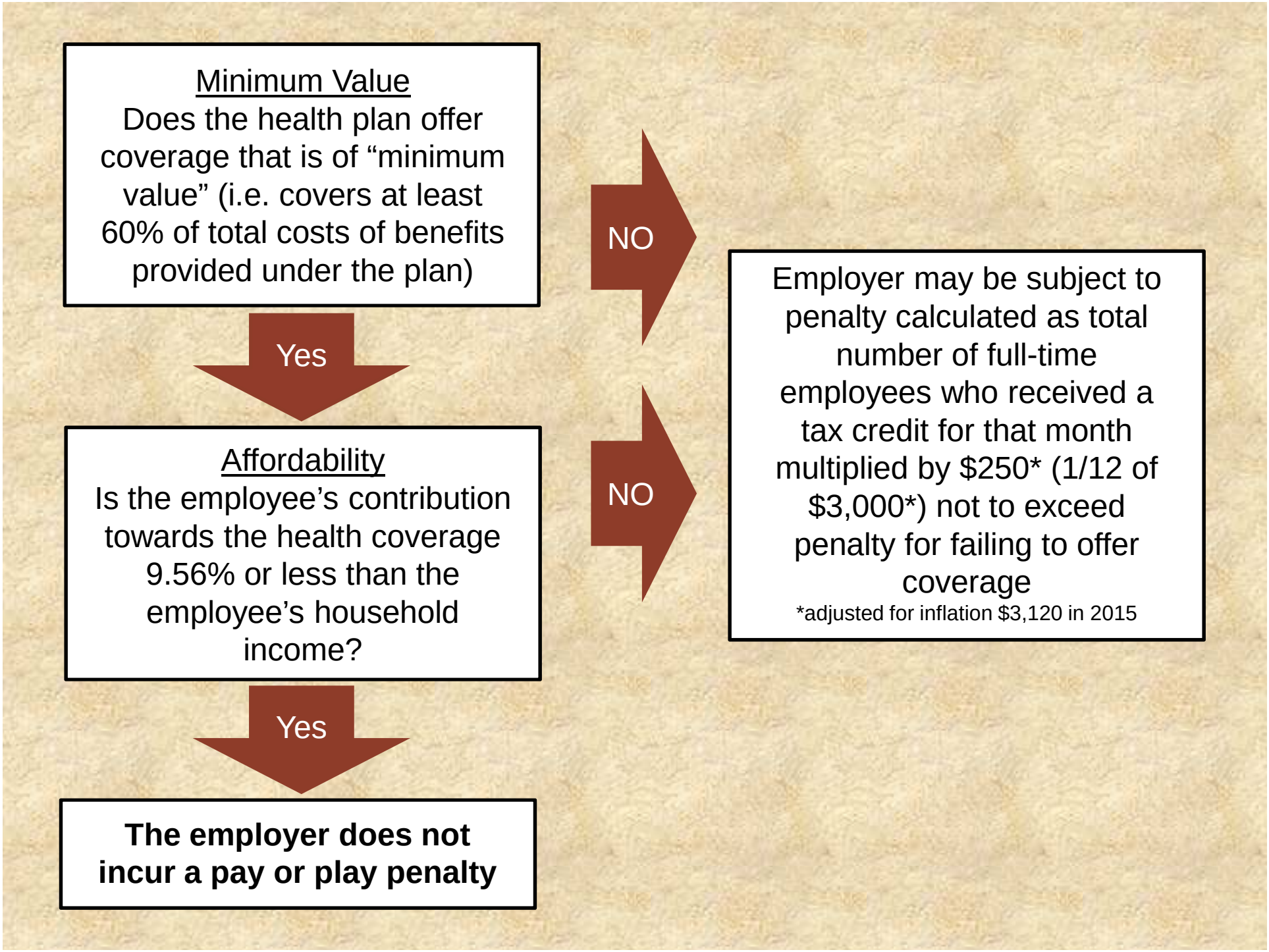
Let's Do Some Math

Obviously, a major factor in bargaining is the cost differentiation for employer sponsored healthcare versus the cost of not offering healthcare.


Does the employer have at least 50 full-time (including full-time equivalents) employees in the prior calendar year?
NO
Employer is NOT subject to the pay or play mandate/penalties
Yes
Coverage
If employer does not offer minimum essential coverage to at least 95% (70% for transitional year) of its FT employees and dependents (now age 26)
NO
Employer may be subject to penalty calculated as total number of full-time employees for the year (minus 30**) multiplied by $2,000* (or $166.67/month*) IF at least one FT employee enrolls in an exchange and receives a subsidy from the government
*adjusted for inflation, $2,080 in 2015
** 80 for 2015 only
Yes


Minimum Value
Does the health plan offer coverage that is of "minimum value" (i.e. covers at least 60% of total costs of benefits provided under the plan)
NO
Yes
Employer may be subject to penalty calculated as total number of full-time employees who received a tax credit for that month multiplied by $250* (1/12 of $3,000*) not to exceed penalty for failing to offer coverage
*adjusted for inflation $3,120 in 2015
Affordability
Is the employee's contribution towards the health coverage 9.56% or less than the employee's household income?
NO
Yes
The employer does not incur a pay or play penalty

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HYPOTHETICAL (using standard baselines)

- Bargaining unit has 200 employees.
- All employees receive insurance from the employer.
- The employer's current contribution per employee is $4,000.
- Is it cheaper to provide insurance or to place the employees on the exchange?

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THE MATH

- How many employees do we have?
- Subtract the first 30. [Ignore the transitional 2015 rules]
- Multiply the remaining employees by $2000. [Actually a bit more each year as indexed by inflation]
- What's the difference between the fine and our cost?

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THE ANSWER

We don't know…yet

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THE ANSWER-CONTINUED

- The first question is “how many FTEs” do we have.
- The question is not how many union or bargaining unit FTE’s do we have.

- You have to include ***ALL*** of your FT employees into the calculation—not just the bargaining unit.

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THE ANSWER

- Let's assume we have 250 total employees and 200 bargaining unit employees.
- 250 – 30 = 220
- 220 x 2000 = $440,000/yr *pay or play* penalty.
- That is still significantly less than the $800,000—but everyone must go!

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PUBLIC SECTOR

- For Public Employers remember the 80/20 and hard cap rules in PA 54 of 2011.
- The ACA and PA 54 have to be analyzed concurrently.
- Even the addition of PA 322 of 2014 for police and fire require additional cost of healthcare to be passed on after expiration of contract. [other increases only apply to non police and fire]
- (See: *Schoolcraft County and The Schoolcraft County Sheriff, Public and Schoolcraft County Deputy Sheriff' s Association*, 28 MPER ¶ 47)

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PUBLIC SECTOR

- Remember that the Cadillac Tax and the affordability test, and all the other provisions of the ACA still apply irrespective of Michigan's law.

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KEEP FOCUSED

RED PURPLE GREEN YELLOW

BLUE ORANGE YELLOW

RED WHITE BLUE GREEN

ORANGE PURPLE RED YELLOW

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THE REST OF THE STORY

Platinum Plan

Gold Plan

Silver Plan

Bronze Plan

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THE REST OF THE STORY

Platinum Plan- 90%*

Gold Plan- 80%*

Silver Plan- 70%*

Bronze Plan- 60%

*% of the Actuarial value

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Actuarial Value

The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

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All Four Levels Cover These Types of Essential Health Benefits

- **(1) ambulatory patient services;**
- **(2) emergency services;**
- **(3) hospitalization;**
- **(4) maternity and newborn care;**
- **(5) mental health and substance use disorder services including behavioral health treatment;**
- **(6) prescription drugs;**
- **(7) rehabilitative and habilitative services and devices;**
- **(8) laboratory services;**
- **(9) preventive and wellness services and chronic disease management; and**
- **(10) pediatric services, including oral and vision care.**

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THE REST OF THE STORY

- The percentages in the “metal benefit” types are based on the expectation of healthcare usage. They are not guarantees.
- The remaining percentages are expected to be paid out of the pocket by the policy holder.
- There can still be a coinsurance or copay for Essential Benefits, and your insurance may not cover any other benefits and you could be responsible for all of those associated costs.

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EXAMPLE OF GOLD PLAN COSTS

Deductible for an individual enrollee	$1,198
Deductible for a family	$2,626
Doctor Visit	$23
Specialist visit	$45
Generic drugs	$11 (2014 data)
Preferred brand drugs	$39 (2014 data)
Non-preferred brand drugs	$85 (2014 data)
Specialty drugs	28% of specialty drug expense charged to patient as coinsurance fee (coinsurance fees used for specialty drugs in 52% of 2014 plans studied)
Annual cap on out-of-pocket costs for an individual	$4,298
Annual cap on out-of-pocket costs for a family	$8,986

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Plans Can Vary

	Gold Plan Example A	Gold Plan Example B
Consumer Out-of-Pocket Costs	20% of costs	20% of costs
Deductible	$250	$2,000
Coinsurance	20%	10%

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2014 Average Monthly Individual Plan Premiums By Age

Age 30	Age 40	Age 50	Age 60
$336	$378	$528	$801

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2014 Average Monthly Individual Plan Premiums By Age

- It is important to note that prior to the ACA, premiums for older beneficiaries were often 6 or 7 times more expensive than younger consumers.
- However, the ACA placed limits on aged based rating so that you cannot charge more than 3 times what is charged tot eh youngest, healthiest consumer.

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2014 Average Monthly Individual Plan Premiums By Age

- A good place to look to see what employee's rate and potential subsidy may be is: http://kff.org/interactive/subsidy-calculator/

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The Good News

In 2014, 35 of the 39 largest cities saw the lowest price gold plan was found in the exchange

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The Bad News

None of those 39 cities is located in the U.P.!

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A Tale of Two Cities

- Lets look at the estimated premium for a Silver family plan for a family of 4, consisting of two 40 year old non-smoker adults with 2 children under 20, making $40,000 in suburban Detroit v. Escanaba.
- Which city would you assume would provide more affordable healthcare?

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A Tale of Two Cities

Livonia

Total Premium: $687/month

Subsidy: $526/month

Ind. Premium: $161/month

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A Tale of Two Cities

Escanaba

Total Premium: $1,048/month

Subsidy: $887/month

Ind. Premium: $161/month

[4.84% of household income]

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A Tale of Two Cities

Same scenario in Escanaba– but the individual makes $70,000

Total Premium:	$1,048/month
Subsidy:	$502/month
Ind. Premium:	$547/month

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A Tale of Two Cities

Same scenario in Escanaba– but the individual makes $100,000

Total Premium:	$1,048/month
Subsidy:	$0
Ind. Premium:	$1,048/month

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A Tale of Two Cities

Same scenario in Escanaba– but the individual makes $100,000

Total Premium:	$1,048/month
Subsidy:	$0
Ind. Premium:	$1,048/month

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A Tale of Two Cities

The closer you are to the Federal Poverty Level the higher your subsidy.

The higher your wages are the lower your subsidy.

Those making 400% or more of the federal poverty level will be without any subsidy.

Age is still a factor in the price as well.

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Modified Adjusted Gross Income

- Adjusted Gross Income + Non-taxable Social Security Benefits+ Tax Exempt Interest + Excluded Foreign Income

= Modified Adjusted Gross Income

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Adjusted Gross Income

- Wages, salaries, tips, etc.
- Taxable interest
- Taxable amount of pension, annuity or IRA distributions and Social Security benefits
- Business income, farm income, capital gain, other gains (or loss)
- Unemployment compensation• Ordinary dividends
- Alimony received
- Rental real estate, royalties, partnerships, S corporations, trusts, Taxable refunds, credits, or offsets of state and local income taxes
- Other income

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You Can Deduct

- Self-employed expenses
- Student loan interest deduction
- IRA deduction (traditional IRAs)
- Moving expenses
- Penalty on early withdrawal of savings
- Health savings account deduction
- Alimony paid
- Domestic production activities deduction
- Certain business expenses of reservists, performing artists, and fee-basis government officials

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Calculating MAGI

- Make sure to add non-taxable Social Security
- Tax exempt interest
- Foreign earned income & housing expenses for Americans living abroad

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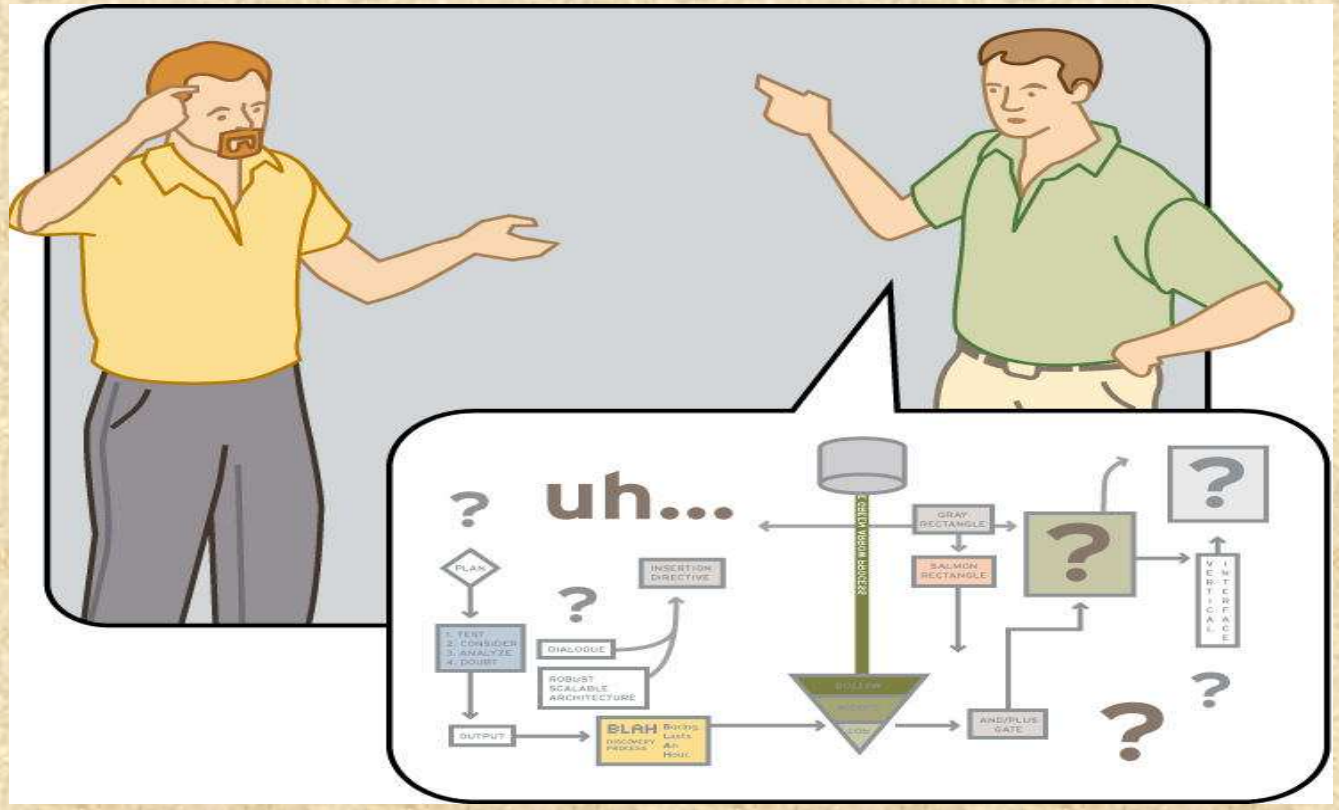
Pretty Simple



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- In 2014, the median Silver, Gold, and Platinum plans sold through the marketplaces were anywhere from $61 to $1377 cheaper than the average employer plan.
- The cheapest mid-level Silver plan — the most popular option— could be almost **$2500** cheaper than an employer sponsored plan.

Source: *PricewaterhouseCoopers*

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Beware of the Apples to Oranges Comparison

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Beware of the Apples to Oranges Comparison

- The main reasons for savings---Subsidies and design

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Beware of the Apples to Oranges Comparison

- The other major difference between most of the lower cost ACA Exchange programs and most labor represented employer plans are deductibles and out of pocket expenses.
- These types of deductibles and the benefits set the battleground for negotiations.

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Changes Required by Law

- Employer must comply with the law, BUT -> if statute itself does not mandate/direct how employers are to achieve compliance with its provisions then:
  - Duty to notify and bargain over effects of the changes before implementing

Quality Health Servs. of P.R., Inc. d/b/a Hosp. San Cristobal & Unidad Laboral De Enfermeras(Os) Y Empleados De La Salud, 358 NLRB No. 70 (June 25, 2012). See also, *Sheltering Pines Convalescent Hospital*, 255 NLRB 1195 (1981); *United Parcel Service*, 336 NLRB 1134, 1135 (2001); *Armour & Co.*, 280 NLRB 824, 827 (1986).

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Examples of ACA Requirements

- Age 26 dependent coverage
- No lifetime limits and restricted annual limits
- No rescissions
- No preexisting condition exclusions (under age 19)
- No reimbursement from FSAs/HSAs/HRAs for OTC drugs
- Uniform explanation of coverage (SBCs)
- 60 day advance notice of material modifications
- W-2 reporting of value of health coverage
- Cap on employee contributions to FSAs
- PCORI fee
- No preexisting condition exclusions
- No annual limits
- Employer reporting coverage to IRS
- Reinsurance fee
- Future—automatic enrollment, non-discrimination, Cadillac tax
- **NON-GRANDFATHERED PLANS**
  - No cost sharing for preventative care
  - Choice of primary care physician in-network
  - Direct OB/GYN services without referral
  - Internal and external claims-review procedures
  - Emergency services without pre-authorization at in-network rates
  - Limits on cost sharing/deductibles
  - Coverage required for clinical trials

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Key Questions

- What else do you want?

- How much will it cost?

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The Single Biggest Issue In Bargaining Should Not Be Cost

- There's no real magic about the insurance market.
- The key is to match the network and the total cost options.
- A recent study shows that many of what appear to be affordable plans on the Exchange are "narrow network" plans.
- Narrow network plans allow for controlled cost, with limits on the doctors and available doctors.
- Certain plans just say they will not pay, others charge higher co-pays.
- Less choice genrally means lower premiums.

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Cost Is Not The Only Issue

- Narrow networks are not new.
- Example, the average cost of an appendectomy can cost from $1529 up to $186,955.*
- Under ACA, there is a lack of competition for pricing from excluding sicker, older individuals, or just dropping benefits and raising deductibles through the roof. [The good old days?]
- So there are fewer choices.
- One major option left is narrowing options and approximately 70% of exchange plans are narrow or ultra narrow plans.

* Renee Y. Hsia, MD, MSc; Abbas H. Kothari, BA; Tanja Srebotnjak, PhD; Judy Maselli, MSPH, Health Care as a 'Market God'? Appendicitis as a case Study *JAMA Internal Medicine*, May 28, 2012, Vol 172, No. 10

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Reality

- Most employer based plans were and are “Affordable” as defined by the ACA.
- Most employer sponsored plans were and are robust compared to ACA Exchange Plans.
- Most employer sponsored plans were and are expensive for employers.
- The ACA is not an insurance plan, it’s a law. There is no such thing as Obamacare and insurance is not free.
- Lower paying jobs offering insurance prevent individuals from receiving subsidies.

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Average Cost Continues To Rise

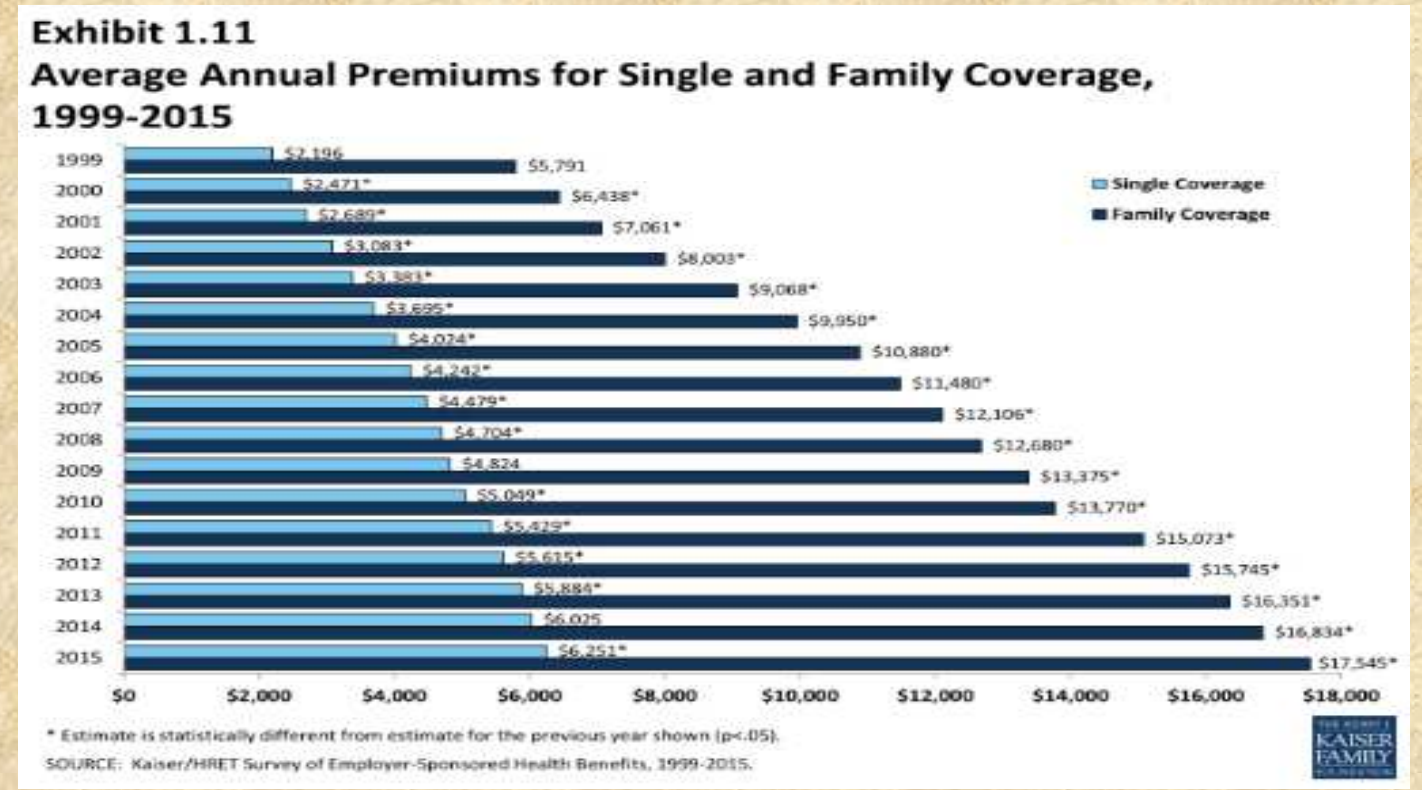

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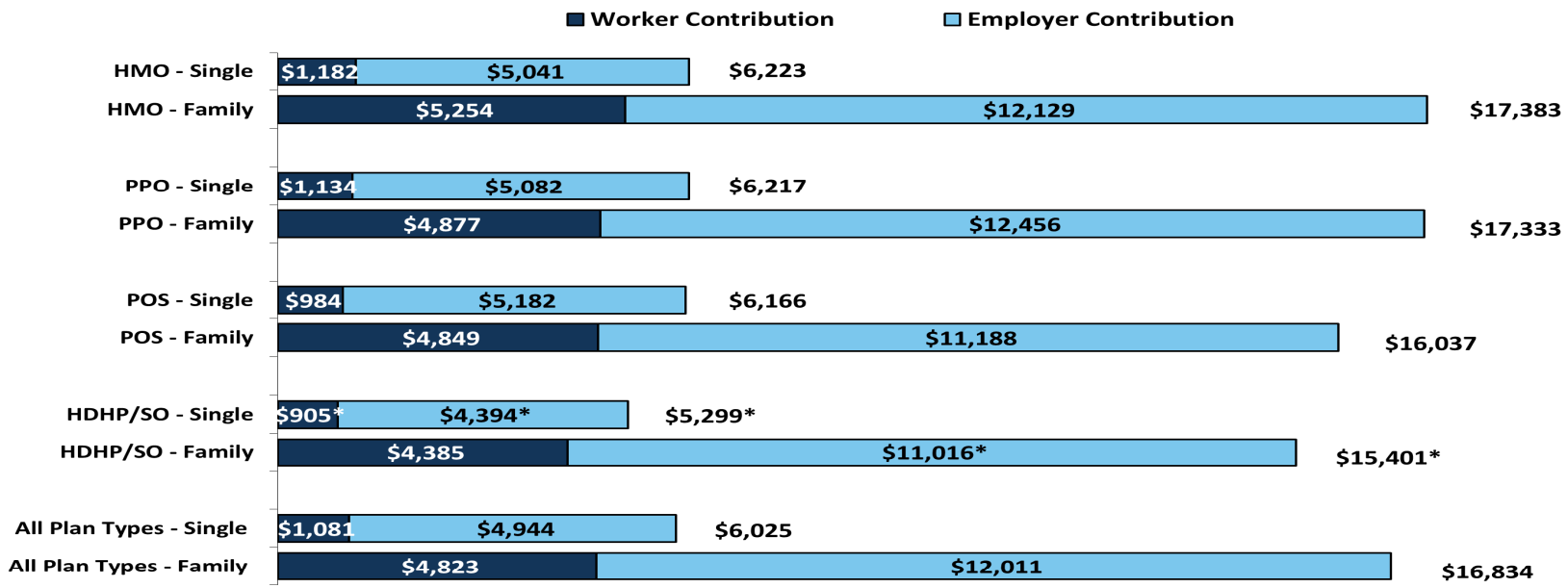
Exhibit B:
Average Annual Firm and Worker Premium Contributions and Total Premiums for Covered Workers for Single and Family Coverage, by Plan Type, 2014



* Estimate is statistically different from All Plans estimate by coverage type (p<.05).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014.

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But the Rise Seems to Have Slowed Down

- The $17,545 average annual family premium in 2015 is 27% higher than the average family premium in 2010 and 61% higher than the average family premium in 2005.

- The 27% premium growth in the last five years (2010 to 2015) **is significantly smaller** than the 69% premium growth seen between 2000 and 2005

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Interesting Difference in Premiums In Relation To Income

- Covered workers in firms with a large percentage of lower-wage workers (at least 35% of workers earn $23,000 per year or less) have lower average single and family premiums ($5,606 and $16,182) than covered workers in firms with a smaller percentage of lower-wage workers ($6,307 and $17,665).

- Covered workers in firms with a large percentage of higher-wage workers (at least 35% of workers earn $58,000 per year or more) have higher average family premiums ($18,130) than covered workers in firms with a smaller percentage of higher-wage workers ($16,923)

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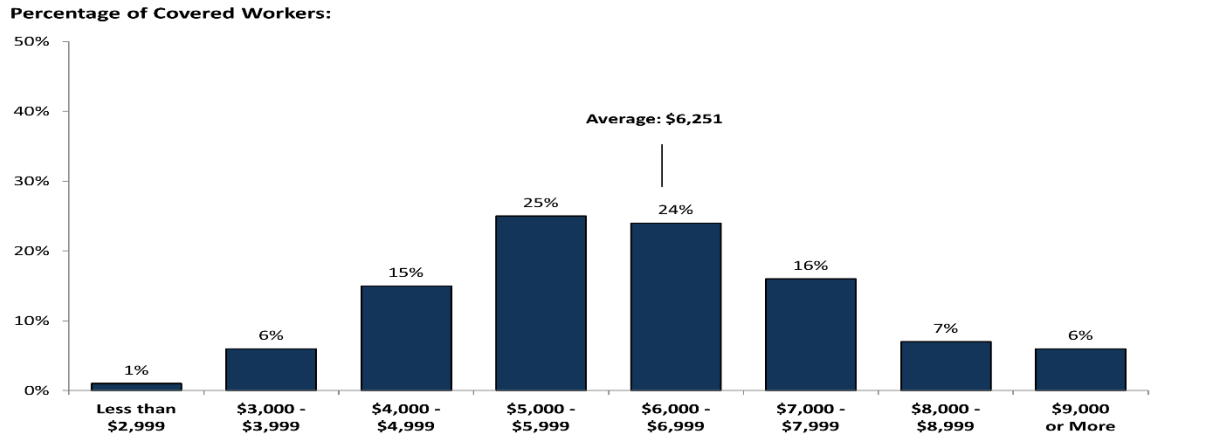
Comparing Cost of Plans- Single Coverage

Exhibit 1.9
Distribution of Annual Premiums for Covered Workers with Single Coverage, 2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

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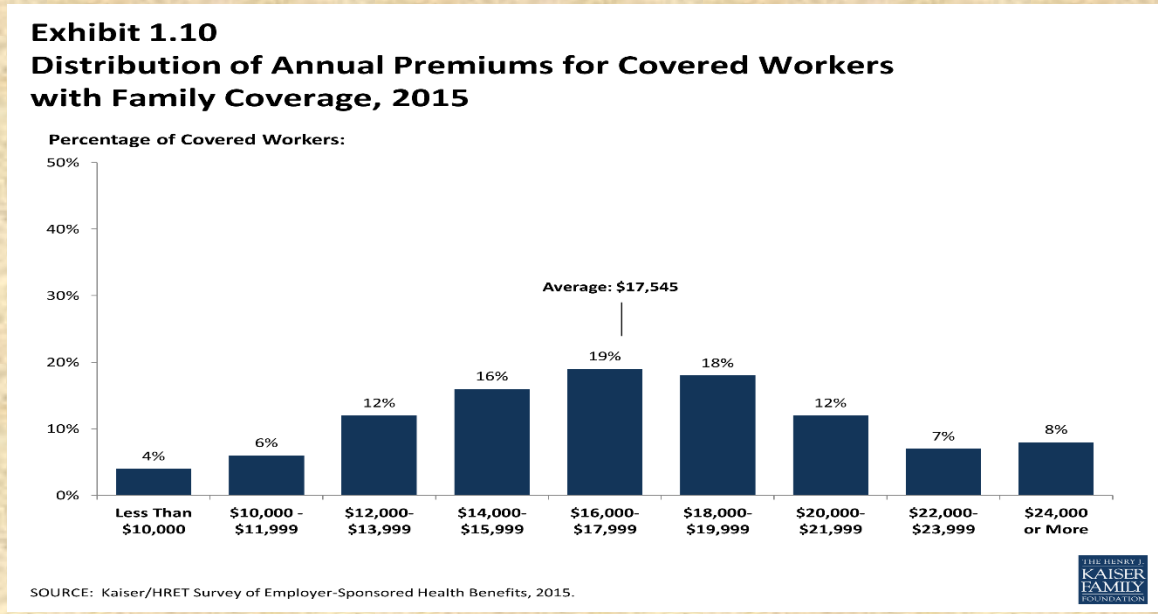
Comparing Cost of Plans- Family Coverage



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Comparing Cost of Plans- Family Coverage

- In 2015, approximately 19% of employers offered benefits to part-time workers
- However, larger employers (over 200 employees) were nearly twice as likely to offer insurance to part-time employees

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Play or Pay Mandate – Employer Penalties

- Still being phased in: applies to employers with 100 or more full-time employees starting in 2015
  - ✓ Employers with 50 or more full-time employees starting in 2016
- Additional transitional relief:
  - ✓ Employers that are subject to the employer responsibility provisions in 2015 must offer coverage to at least 70 percent of full-time employees as one of the conditions for avoiding an assessable payment, rather than 95 percent which will begin in 2016.

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Play or Pay Mandate – Employer Penalties

Remember, your contract's definition of Full Time and Part Time employees does not define Full Time and Part Time under the ACA.

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Number of FT Employees

- IRS Control Group (control aggregation rules)
  - Employees of businesses that are under common control are added together to determine if an employer employs the equivalent of at least 50 (or 100 under the 2015 transition rule) full-time employees (including full-time equivalents
  - Control group number is not used for calculation of actual penalty

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Full or Part Time Employee?

- Full-time employee ≥30 hours per week OR ≥130 hours of service in a calendar month.

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FTE Calculation

- First, an employer calculates the number of full-time employees. Again, a full-time employee is defined as working on average at least 30 hours of service per week in a given month.

- Next, the employer factors in part-time employees. To calculate the full-time equivalent of part-time employees, add the number of hours worked by part-time employees in a given month and divide the total by 120.

- Finally, the sum of the full-time employees and the full-time equivalent of the part-time employees is the number used to determine whether an employer is subject to the ESR.

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Full or Part Time Employee?

Bargaining issues: 1) change in size of workforce; 2) use of subcontract work to reduce number of full time employees; 3) reduction of hours worked/shifts/schedules; 4) greater use of OT for FT employees

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Seasonal Employees?

- Seasonal Employees actually count toward an employer's FTE.
- However, while the seasonal workers' hours are counted toward the hours of service in determining whether an employer is subject to the ESR – if seasonal employees who worked less than 120 days were the cause of the employer pushing the FTE threshold, the employer would not be subject to the ESR.

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Seasonal Employee?

- *A seasonal worker* is a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including (but not limited to) workers covered by 29 CFR 500.20(s)(1) and retail workers employed exclusively during holiday seasons.

- Employers may apply a reasonable, good faith interpretation of the term *seasonal worker* and a reasonable good faith interpretation of 29 CFR.20(s)(1) (including as applied by analogy to workers and employment positions not otherwise covered under 29 CFR 500.20(s)(1)).

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Seasonal Employee?

29 CFR 500.20(s)(1)- (1) Labor is performed on a seasonal basis where, ordinarily, the employment pertains to or is of the kind exclusively performed at certain seasons or periods of the year and which, from its nature, may not be continuous or carried on throughout the year. A worker who moves from one seasonal activity to another, while employed in agriculture or performing agricultural labor, is employed on a seasonal basis even though he may continue to be employed during a major portion of the year.

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Minimum Essential Coverage (i.e. any plan)

- Employer sponsored coverage: Group health insurance coverage for employees under –
  - A governmental plan, such as the Federal Employees Health Benefit program
  - A plan or coverage offered in the small or large group market within a state
  - A grandfathered health plan offered in a group market
  - A self-insured group health plan for employees
- But NOT:
  - Stand-alone dental or vision benefits
  - Workers' compensation insurance
  - coverage only for a specified disease or illness

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Minimum Value

- NOT the same as minimum essential coverage
- Generally: A plan provides minimum value if it covers at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan.
- Minimum value calculator: http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html

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Affordability

- Requires that employee's share of premium is less than 9.56% of household income
- Three safe harbors:
  - W-2 Safe Harbor: No more than 9.56% of the wages reported in W-2
  - ROP Safe Harbor: No more than 9.56% of the employee's wages if the employee were assumed to work 30 hours per week at the applicable ROP
  - Federal Poverty Line Safe Harbor: No more than 9.56% of the amount equal to the federal poverty line

❖ Issue: safe harbor method subject to bargaining?

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Complicating the Equation

THE ACA does not leave the penalty static. It is adjusted for inflation.

Inflation adjustment

(A) In general

In the case of any calendar year after 2014, each of the dollar amounts in subsection (b) and paragraph (1) shall be increased by an amount equal to the product of—

(i) such dollar amount, and

(ii) the premium adjustment percentage (as defined in section 1302(c)(4) of the Patient Protection and Affordable Care Act) for the calendar year.

(B) Rounding

If the amount of any increase under subparagraph (A) is not a multiple of $10, such increase shall be rounded to the next lowest multiple of $10.

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Multiemployer Plans

- Interim guidance -> applicable large employer that is required by CBA to contribute to multiemployer plan will not be subject to penalty if coverage is of minimum value, affordable and offers coverage to dependents
- # of employees dependent not on plan participant or union size

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Note: an employer is treated as offering coverage for all employees for whom it is required to contribute to the multiemployer plan…*even full-time employees that never satisfy the plan's eligibility rules* (and thus aren't offered coverage under the plan)

Bargaining Issues: 1) ability to require plan to guarantee necessary coverage; 2) indemnity language; 3) reporting requirements

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Safe Harbor For Variable Hour Employees

- MEASUREMENT PERIOD
- STABILITY PERIOD
- DUTY TO BARGAIN?????

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Grandfathered Plans

- Grandfathered plans are certain plans that were purchased before March 23, 2010. These plans have a grandfathered status and don't have to follow some of the ACA's rules and regulations or offer the same benefits, rights and protections as new plans.

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Grandfathered Plans

- On many old plans you can still be dropped form coverage for reasons other than fraud, be denied treatment for preexisting conditions, face annual and lifetime dollar limits and more.

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Loss of Grandfathered Plan Status

GENERALLY, THESE ACTS WILL RESULT IN A LOSS OF GRANDFATHERED STATUS:

- A significant cut or reduction in benefits by eliminating all or substantially all of the benefits to diagnose or treat a condition, or any necessary element to diagnose or treat a condition.
- Raising coinsurance charges.
- Significantly raising fixed cost-sharing (i.e., deductibles and out-of-pocket limits) by more than medical inflation (as measured from March 23, 2010) plus 15 percentage points.
- Significantly raising copayment charges by more than the greater of: (i) medical inflation (as measured from March 23, 2010) plus 15 percentage points or (ii) $5 (adjusted for medical inflation).
- Significantly lowering the rate of employer contributions by 5 percentage points for any coverage tier.
- Adding or tightening an annual limit (with one exception).
- Reclassifying employees so that the reclassified employees are eligible for a different plan (even if it's a grandfathered plan), without a bona fide employment reason.
- Failing to continuously maintain at least one covered individual (not necessarily the same individual).

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Affordable Care Act at the Bargaining Table

HSA/FSA

- Generally paired with high-deductible plan to allow funds to be used pretax basis for out-of-pocket health expenses
  - Offers lower monthly premiums
- Changes: 1) prohibits use of funds to buy over-the-counter drugs without a prescription, and 2) [HSA] increased penalty from 10% to 20% on early withdrawal of funds (before age 65)
- 2015 contributions will be
  - Single $3,350 ($4,500 for 55+)
  - Family $6,650 ($7,500 for 55+)

Affordable Care Act

Beware of the Smart Ideas

- Skinny Plans

Health insurance plan that appears to be cost-efficient alternative to providing minimum essential coverage for employees under the ACA – but are significantly cheaper because they are stripped down.

Affordable Care Act

Beware of the Smart Ideas

- Skinny Plans

  - Remember, Minimal Essential Coverage: Employer sponsored coverage: Group health insurance coverage for employees under –
    - A governmental plan, such as the Federal Employees Health Benefit program
    - A plan or coverage offered in the small or large group market within a state
    - A grandfathered health plan offered in a group market
    - A self-insured group health plan for employees

Affordable Care Act

Beware of the Smart Ideas

- Skinny Plans

  - Some smart guys, started thinking, if we offer coverage, that doesn't cover in-patient hospitalization or physician services or both, we're still offering a plan and if its affordable.

  - The skinny plans then barely meet the minimum value calculations on a minimum value calculator through he HHS and IRS—some come at 59.5 and round up!

Affordable Care Act

Beware of the Smart Ideas

- Skinny Plans

BUT…guidance from the IRS indicate that these type of plans would not meet minimum value standards because they do not include hospitalization services or physician services. [Notice 2014-69]

Basically, they said you can't rely on the online calculator!!

Affordable Care Act

Beware of the Smart Ideas

- Skinny Plans

- In 2015, the HHS published a final Notice of Benefit and Payment parameters [80 FR 10749]

- Consistent with Notice 2014-69, the final rule provides that, in order to provide MV, a plan must not only cover a predicted 60 percent of the allowed costs under the plan, but it must also provide a benefits package that reflects benefits historically provided under **"major medical"** employer coverage.

Affordable Care Act

Beware of the Smart Ideas

- Skinny Plans

Major Benefits:

Specifically, to satisfy the MV requirement, coverage must include substantial coverage of both inpatient hospital services and physician services.

Affordable Care Act

Out of Pocket Expenses

The ACA requires that the out-of-pocket maximum be updated annually, based on the percent increase in average premiums per person for health insurance coverage:

- For 2015, the out-of-pocket maximum is **$6,600 for self-only coverage** and **$13,200 for family coverage**.

- Under the final rule, [80 FR 10749] the out-of-pocket maximum increased for 2016 to **$6,850 for self-only coverage** and **$13,700 for family coverage**.

* To be calculated for plan year, not calendar year.

Affordable Care Act

Reinsurance rate

The ACA also established a transitional fee called the annual contribution rate applicable to health insurance issuers and self-insured groups.

- 2014 - $63/enrollee
- 2015 - $44/enrollee
- 2016 - $27/enrollee

- Beware your contract language regarding apportionment of “cost of insurance”.

Affordable Care Act

ACA Open Enrollment

- The decision to go to the ACA should be determined in conjunction with ACA open enrollment periods:
  - For 2016 – November 1, 2015 through January 31, 2015

Affordable Care Act

Cash-in-lieu of Benefits

- Technically still permissible—but some indicate that it may not be for long.

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Affordable Care Act

Cadillac®

Tax On High-Cost Insurance

- **Currently scheduled to take effect in 2018**
- **Imposes an excise tax (40%) on health plans with aggregate expenses that exceed $10,200 for individual coverage and $27,500 for family coverage**
- **Purpose ->** reduce healthcare usage and costs by encouraging employers to offer plans that are cost-effective and engage employees in sharing in the cost of care.

Affordable Care Act

The Great Leveler

- Understand the purpose of the ACA and the Cadillac Tax
- Reduce tax preferred treatment of employer provided healthcare
- Reduce excess health care spending by employees and employers
- Help finance the expansion of health coverage under the ACA

The Great Leveler

- 40% tax on the cost of health coverage that exceeds threshold amounts
- Cost of coverage includes the total contributiosn paid by both the employer and employees, but not cost sharing amounts such as deductibles, coinsurance and coays when care is received.

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Affordable Care Act

The Great Leveler

- **Thresholds for high-cost plans are currently $10,200 for individual coverage, and $27,500 for family coverage**
- **The thresholds will be updated for 2018 when final regulations are issued and thereafter indexed for inflation**
- **The thresholds will also be increased for high risk professions such as law enforcement and construction and**
- **For group demographics including age and gender**

The Great Leveler

- **Who calculates?**
  - **Insured: Employers calculate and insurers pay**
  - **Self-funded: Employers calculate and "the person who administers the plan benefits" pays**
  - **HAS and Archer MSAs: Employers calculate and employers pay**

The Great Leveler

Applicable types of coverage

- Insured and self-insured group health plans (including behavioral, and prescription drug coverage)
- Wellness programs that are group health plans (most wellness programs)
- Health Flexible Spending Accounts (FSAs)
- Health Savings Accounts (HSAs), employer and employee pre-tax contributions*
- Health Reimbursement Accounts (HRAs)*
- Archer Medical Savings Accounts (MSAs), all pre-tax contributions*
- On-site medical clinics providing more than de minimis care*

The Great Leveler

Applicable types of coverage

- Executive Physical Programs*
- Pre-tax coverage for a specified disease or illness
- Hospital indemnity or other fixed indemnity insurance
- Federal/State/Local government-sponsored plans for its employees
- Retiree coverage
- Multi-employer (Taft-Hartley) plans

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Affordable Care Act

The Great Leveler

Excluded types of coverage

U.S.-issued expatriate plans for most categories of expatriates
Coverage for accident only, or disability income insurance, or any combination thereof
Supplemental liability insurance
Liability insurance, including general liability insurance and automobile liability insurance
Worker's compensation or similar insurance
Automobile medical payment insurance
Credit-only insurance
Other insurance coverage as specified in regulations under which benefits for medical care are secondary or incidental to other insurance benefits

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Affordable Care Act

The Great Leveler

Excluded types of coverage

Long Term Care

Standalone dental and vision*

Coverage for the military sponsored by federal, state or local governments*

Employee Assistance Programs*

Employee After-Tax Contributions to HSAs and MSAs*

Coverage for a specified disease or illness and hospital indemnity or other fixed indemnity insurance if payment is not excluded from gross income

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Affordable Care Act

The Great Leveler

Self-only coverage
A $12,000 individual plan would pay an excise tax of $720 per covered employee:
$12,000 - $10,200 = $1,800 above the $10,200 threshold
$1,800 x 40% = $720

Family coverage
A $32,000 family plan would pay an excise tax of $1,800 per covered employee:
$32,000 - $27,500 = $4,500 above the $27,500 threshold
$4,500 x 40% = $1,800

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Affordable Care Act

The Great Leveler

Self-only coverage

Plan Cost	$11,000	$12,000	$13,000	$14,000	$15,000
Tax	$320	$720	$1,120	$1,520	$1,920

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Affordable Care Act

The Great Leveler

Family coverage

Plan Cost	$28,000	$30,000	$32,000	$34,000	$36,000
Tax	$200	$1,000	$1,800	$2,600	$3,400

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Affordable Care Act

Who Pays?

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Affordable Care Act

Who Pays?

- The International Longshore and Warehouse Union and the 29 west coast ports in the Pacific Maritime Association ultimately reached a tentative agreement after slowdowns and several major ports ceased weekend work and before a lockout or strike took place with the.

- Ultimately who pays the Cadillac tax?

- It is believed the continuation of H&W Plan may result in $100 million or more in Cadillac tax liability.

Affordable Care Act at the Bargaining Table

Who Pays?

- The Employer pays the penalties
  - BEWARE OF THE PLAN YOU DO NOT KNOW

Affordable Care Act

ERISA Section 510

"[i]t shall be unlawful for any person to…discriminate against a participant or beneficiary…for the purpose of interfering with the attainment of any right to which such participant may become entitled under the provisions of an employee benefit plan."

ERISA Section 3(7) defines "participant" as "any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan."

Health and welfare plans are covered by Section 510.

Affordable Care Act

ERISA Section 510

Part-time employee hired with intent that she move into full-time position when job became available was "participant" in benefit plan under ERISA, as it was not disputed that she would have become eligible for health insurance benefits upon moving to full-time position.

Hired with intent that employee would become full-time = a participant under ERISA Section 3(7) and for purposes of Section 510

Fleming v. Ayers & Associates, 948 F.2d 993, 998 (6th Cir. 1991).

Affordable Care Act

Part-time employee who had reasonable expectation of becoming employed full-time when job became available **was a "participant" in employer's group health plan under ERISA**; employee would have become eligible for health insurance benefits upon moving to full-time position, employee received good performance reviews, employee complied with employer's recommendations regarding certification needed for full-time employment, and employer specifically told employee he would be considered for full-time position that would soon become available.

Sanders v. Amerimed, Inc., No. 1:13-CV-813, 2014 WL 1664472 (S.D. Ohio Apr. 25, 2014).

Affordable Care Act

Wellness Plan

- More than half of large employers using HRAs provide incentives for their completion, and more than a third of these incentives equaled or exceeded $500. A federally commissioned report prepared by RAND suggests that incentives are effective in increasing HRA completion.

- Employers may use incentives in other ways as well. About 12 percent of large firms reported tying incentives to wellness program completion, while about 8 percent of large firms with biometric screening programs reported tying incentives to biometric outcomes, not including smoking Studies have shown that appropriately structured incentives can influence health behaviors.

Affordable Care Act

Wellness Plan

- HIPAA (1996) prohibited discrimination based on health factors
- However, there was an exception for programs of health promotion and disease prevention.
- HIPAA imposed a limit on wellness incentives tied to health factors of 20 percent of the total cost of coverage, a level thought to avoid rewards or penalties so large as to deny coverage or create too heavy a penalty on individuals not meeting the requisite standards

Affordable Care Act

Wellness Plan

- The ACA actually lifted the ceiling on health contingent wellness incentives to 30% (close to $1,800 annually for an average employee-only plan)
- Even invited regulations to potentially increase the ceiling to 50% if appropriate and in 2013 allowed for up to 50 if the program was targeted at tobacco use.

Affordable Care Act

Wellness Plan

- However, In April of 2015 the EEOC issued proposed regulations on the Application of the ADA to Wellness programs. [29 CFR Part 1630]

- Wellness programs can be offered by employers as part of an insured or self-insured group health plan, or outside of a group health plan. The provisions of the proposed rules dealing with notice and incentives apply to group health plans; the remaining provisions apply to all workplace wellness programs. The proposed rule applies to all "covered entities," which are referred to here as employers, but also include employment agencies, labor organizations, and joint labor-management committees.

Affordable Care Act

Wellness Plan

- The ACA/HIPAA wellness program regulations recognize three different types of wellness programs.

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Affordable Care Act

Wellness Plan

- Participatory wellness programs either do not offer a reward or do not make a reward contingent on an individual satisfying a condition related to a health status factor. A participatory program might simply pay for a gym membership or a smoking cessation program or reward an employee who completes a health risk assessment. Participatory programs must be offered to all similarly situated employees on a nondiscriminatory basis.

- Activity-only health contingent wellness programs require an employee to perform or complete an activity related to a health factor to obtain an award.

- Outcome-based health contingent wellness programs further require a participant to achieve a certain health based outcome, such as cessation of smoking or achieving a certain biometric measure, to obtain a reward.

Affordable Care Act

Wellness Plan

Activity-only or outcome-based health contingent programs must meet five requirements under the ACA:

1) All eligible individuals must be given the opportunity to qualify for the reward at least once per year.
2) The total reward offered under health contingent programs cannot exceed 30 percent of the total cost of employee-only coverage under the plan (50 percent for tobacco prevention and reduction programs), including both employer and employee contributions.
3) Health-contingent wellness programs must be reasonably designed to promote health or prevent disease.

Affordable Care Act

Wellness Plan

Activity-only (Cont.):

4) The full reward must be available to all similarly situated individuals. Activity-only programs must thus allow a reasonable alternative standard or waive of an otherwise applicable standard for individuals for whom it is unreasonably difficult or medically inadvisable to achieve a program standard. An outcome-based program must allow a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward to any individual who does not meet the initial standard based on a measurement, test, or screening.

5) plans and issuers must disclose the availability of reasonable alternatives for meeting standards in any plan materials and at the time individuals are notified that they did not achieve program standards.

Affordable Care Act

Wellness Plan

"Voluntary"

The ADA prohibits discrimination by employers against employees in the terms and conditions of employment, including fringe benefits, on the basis of disability, and requires employers to make reasonable accommodations for disabilities.

Affordable Care Act

Wellness Plan

"Voluntary"

The ADA prohibits discrimination by employers against employees in the terms and conditions of employment, including fringe benefits, on the basis of disability, and requires employers to make reasonable accommodations for disabilities.

The ADA generally prohibits employers from obtaining medical information from employees through disability-related inquiries or medical examinations. It does, however, allow employers to conduct voluntary medical examinations as part of an employee health program, including a workplace wellness program.

Affordable Care Act

Wellness Plan

"Voluntary"

- The proposed rule clarifies when disability-related inquiries and medical examinations conducted under workplace wellness programs are voluntary.
- The proposed rule provides that an employee health program, including any disability-related inquiries and medical examinations, must be reasonably designed to promote health or prevent disease. It must have a reasonable chance of improving health of or preventing disease in participating employees and must not be overly burdensome, a subterfuge for violating the ADA or other employment discrimination laws, or use a highly suspect method to promote health or prevent disease.

Affordable Care Act

Wellness Plan

"Voluntary"

- Collecting biometric information from employees, for example, without providing employees with follow-up information or advice or without using aggregate information to design programs to treat specific conditions, would not reasonably promote health.

- A program is not reasonably designed to promote health if it imposes, as a condition to obtaining a reward, an overly burdensome amount of time for participation, requires unreasonably intrusive procedures, or places significant costs on employees. Programs should not simply shift costs from employers to targeted employees based on their health.

Affordable Care Act

Wellness Plan

"Voluntary"

- For a wellness program to be deemed voluntary, an employer **may not require an employee to participate in a wellness program**, deny coverage under its group health plans or particular group health plan benefits, or take any adverse action against an employee who refuses to participate in a wellness program or achieve certain outcomes under such a program. An employer may not retaliate against, interfere with, coerce, intimidate, or threaten an employee who does not participate in a wellness program.

Affordable Care Act

Wellness Plan

"Voluntary"

- For an employee's participation in a wellness program to be considered voluntary, an employer must provide a notice clearly explaining what medical information will be obtained, how the medical information will be used, who will receive the medical information, how its disclosure will be restricted, and how the employer will prevent improper disclosure of the medical information.
- wellness programs that include disability-related inquiries or medical examinations will be considered voluntary if they offer incentives that do not exceed the 30 percent of total cost of employee coverage maximum imposed by the ACA/HIPPA rules. The proposed rule would, however, extend the 30 percent maximum, which under the ACA/HIPAA rules only applies to health contingent wellness programs, to participation wellness programs that include disability-related inquiries or medical examinations.

Affordable Care Act

Wellness Plan

"Voluntary"

- The proposed rule clarifies that medical information collected through a wellness program may only be provided to an employer in aggregate terms that do not disclose and are not reasonably likely to disclose the identity of specific individuals, except as needed to administer the health plan and as otherwise permitted under EEOC rules for necessary work restrictions or accommodations.

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Affordable Care Act

What Kind of Plan Do You Want?

The ACA plans include programs such as:

- **Exclusive Provider Organization (EPO):** A managed care plan where services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency).
- **Health Maintenance Organization (HMO):** A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.
- **Point of Service (POS):** A type of plan where you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans require you to get a referral from your primary care doctor in order to see a specialist.
- **Preferred Provider Organization (PPO):** A type of health plan where you pay less if you use providers in the plan's network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.

Affordable Care Act

What Kind of Plan Do You Want?

Most employers have many more options on their own and they can bargain to meet their needs.

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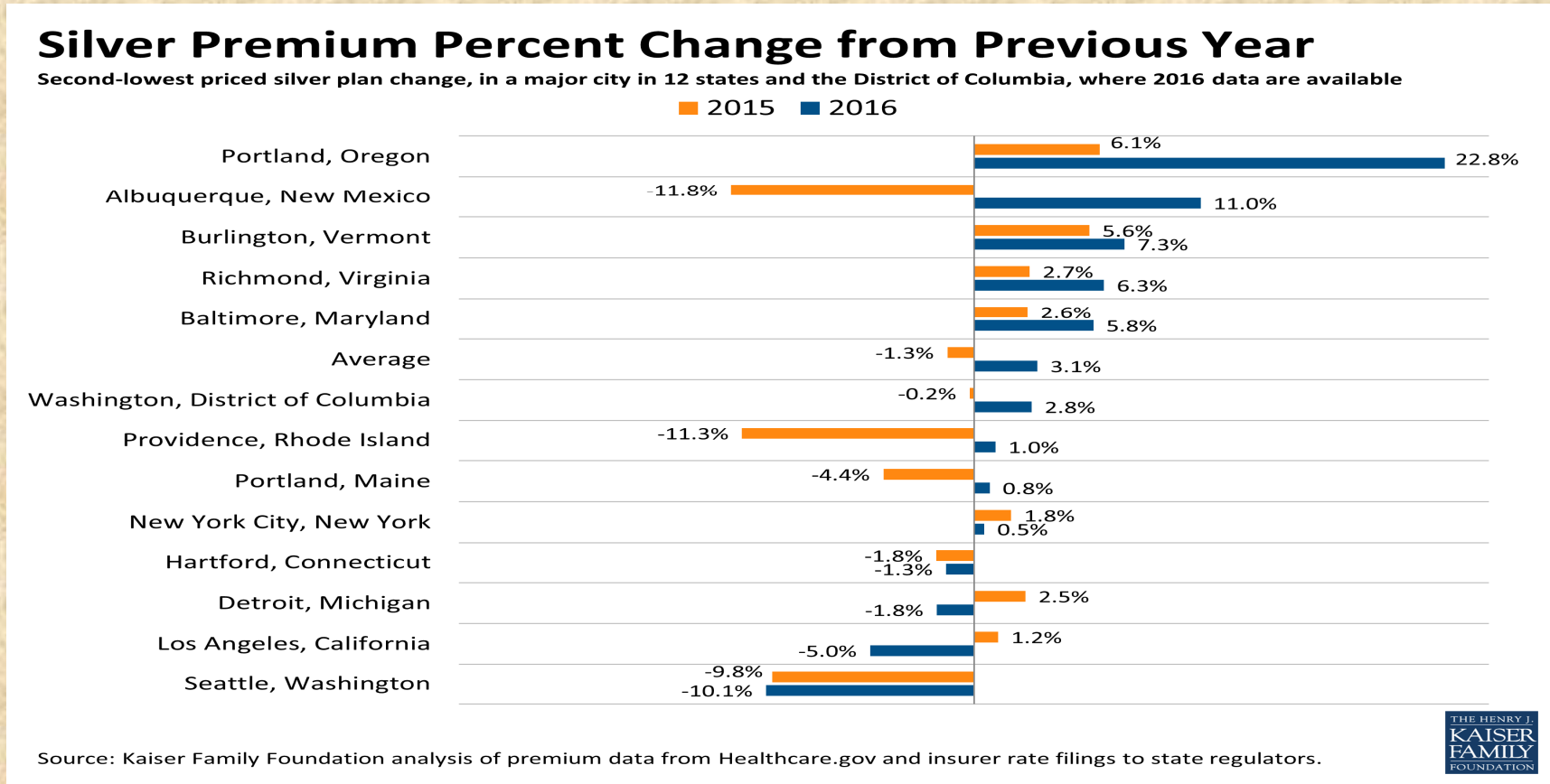
Affordable Care Act

Reopener?



Affordable Care Act

Re-opener?

- Healthcare only.
- Full negotiations.
- Pitfalls of open-endedness.
- Healthcare committee.

Affordable Care Act

Issues

- Waiver -- must be *clear and unmistakable.*
- Impasse -- highly scrutinized by NLRB
- Management Rights Clause
- Zipper clauses/Contract re-openers
- Grievance and arbitration process
- Permissive v. mandatory subjects of bargaining
- Permissive v. Mandatory Subjects -- Employer must bargain over ACA discretionary requirements.
- Even where mandated, Employers are still required to bargain over *effects* of any changes.
- Changes mandated by law must be mandated (*non-discretionary*) or must be bargained--ACA *mandatory* requirements trump CBA provisions

Affordable Care Act

Additional Factors to Remember

RETENTION?

NON-DISCRIMINATION RULES?

PENALTY 2 YEARS FROM NOW?

WHAT WILL YOUR GOALS BE 2 YEARS FROM NOW?

Thank You

U.P. Labor-Management Council 2015:
Affordable Care Act 2015 Bargaining and Beyond

Thank you for attending!