

The Affordable Care Act (ACA) And Health Insurance Bargaining



Disclaimer: This ACA is not the health reform bill UE would pass. We have been consistent in our support for Single Payer (“Medicare For All”) going back to the 1940s. However, the ACA is the law of the land, so we need to minimize impacts and leverage the law to our own benefit where possible.

Every UE Workplace To See Changes In Next 1-5 Years

- Workplaces with good insurance gravely threatened by new “excise tax”
- Workplaces with poor insurance or low incomes may fare better on state exchanges
- Everyone else continues the fight to retain benefits in even tougher circumstances



The excise tax may eliminate health insurance plans that provide good coverage, forcing workers to pay a lot more out of pocket.

At the other extreme, workers who can't afford health insurance through their employer now might actually get better and cheaper health coverage through the new state exchanges.

For those in between, health insurance premiums will continue to become more and more unaffordable as the price exceeds the wage, high deductible plans will become more common as the industry gets away from HMO's and PPO's, and we will be forced to mount major campaigns to prevent the further discrimination of lower hourly wage earners paying the same percentage of insurance premiums as higher salaried earners.

UE Principles Regarding Healthcare Bargaining

- No changes in plan design, providers, or new limitations
- Medical care providers to determine treatment, not insurance bureaucrats
- Choice of medical providers, including hospitals
- No paperwork – easy to follow plan documents
- Oppose cost shifting onto workers
- No denial based on employment status, economic status, or immigration status
 - *Healthcare for All*, UE 73rd National Convention, Chicago, IL, August 2013



The Boss's Agenda?

- Drop insurance – make workers go on exchange
- Ratchet down coverage to 70% or less
- Slash benefits where excise tax is threat
- Convert jobs to under 30 hours per week
- Contract out work to temps



Polls of employers have found anywhere from 2%-20% plan to drop insurance, with small employers more likely

45% of employers concerned about excise tax

Employer mandate creates the incentives for increased numbers of under 30-hour positions, higher usage of temps

Until Now, the ACA Has...

- Provided tax credits to small employers for insuring workers
- Closed Medicare Part D “donut hole”
- Reduced cost to employers for pre-65 retirees
- Expanded family coverage to young adults under age 26
- Mandated free preventive care under new employer-provided plans
- As of October 1, 2013, enrollment in exchange plans has begun



The Affordable Care Act frontloaded many good but small changes over the last three years. But much bigger changes, some good and others bad, are now to come.

The ACA mandates that for individuals who have a new health insurance plan or insurance policy beginning on or after September 30, 2010, certain preventive services for adults, women, and children must be covered without having to pay a copayment or co-insurance to meet the deductible. This applies only when the services are provided by a network provider. Examples of preventive services that must be covered are immunizations and contraceptives. This is a link to a list of preventive services covered:

<http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforAdults>

How To Begin

1. Develop understanding of current health insurance
2. Shops with good insurance
 - Use [The Alliance excise tax calculator](#) to determine if insurance at risk of falling under excise tax
3. Shops with low wages and poor insurance
 - Undertake survey to see if members benefit from exchange subsidies
 - Use either the [UC Berkeley Labor Center ACA calculator](#), or a cell-based app like Obamacare411 to calculate membership's potential exchange subsidies



Considerations For All Workplaces:

- Ensure contracts set benefit threshold at 30 hours or less
- New restrictions on probationary periods for insurance
 - \$400 fine on employers for period over 30 days
 - \$600 fine if over 60 days
 - Insurance cannot set period longer than 90 days
- Illegal for bosses to retaliate for enrolling and getting subsidies on the exchanges
 - Add specific contractual protections (make it grievable)



Since the employer mandate kicks in at 30 hours, we want to ensure that no contracts set the threshold for benefits at a higher level. The employer may not care if a few people fall through the cracks (since they have 5% wiggle room), and some of them may be restricted due to income from getting exchange subsidies.

New fines provide financial incentives to employers to have probationary periods of 30 days or less regarding health insurance. In contracts with long probationary periods, we may wish to ensure the period is reduced.

We should add language regarding the ACA to all contracts – just as we have in the past with FMLA.

Future Major ACA Provisions:

January 1, 2014	Beginning of exchange subsidies
March 31, 2014	Beginning of individual mandate
January 1, 2015	Beginning of employer mandate
January 1, 2016	Small business exchanges in all states must cover employers with 50-100 employees
January 1, 2017	States may allow large employers on exchange, states may opt out (for example, Vermont single payer)
January 1, 2018	40% excise tax on “high value” health insurance plans begins



Employer **Penalty** / Mandate (50 or More Workers)

Employer Action	Annual Fine
Less than 95% of 30+ hour workers offered insurance	\$2,000 x (FT headcount-30)
Workers have unaffordable employer-based coverage, enroll on exchange and qualify for subsidies	\$3,000 per enrolled worker



There are two major penalties under the Act which apply to employers with more than 50 employees. One is potentially much bigger than the other.

Employers are mandated to offer qualified insurance to 95% of their full-time employees in 2014, and dependent children in 2015. If they do not, they pay a penalty based on their full-time workforce. This means there is no financial sense in the employer excluding certain classifications or groups of workers from having insurance. Employers would pay an identical penalty for offering insurance for 90% of the full-time workforce, or 0%, despite having significant costs insuring 90% of the workforce.

If an employer offers qualified insurance to 95%+ of the full-time workforce, but some full-time (30-hour+) workers enroll on the exchange and get subsidies (either because they are excluded from the group plan, or because it would cost more than 9.5% of employee income to purchase single coverage), then the employer is fined \$3,000 for each such worker, although the fine can be no greater than the first fine.

One note on hours for full-time status: Proposed IRS regulations would treat 130 hours of service (meaning any time an employee is entitled to be paid, not just hours actually worked) in a calendar month as the monthly equivalent of 30 hours of service per week $((52 \times 30) \div 12 = 130)$. This monthly standard takes into account that the average month consists of more than four weeks. These regulations have not been adopted, but will likely be, as the IRS has maintained a consistent position on this since 2011.

NOTE: The Employer Mandate has been delayed until January 1, 2015. That said, many employers appear to be enacting policies to minimize their own exposure to fines for 2014 regardless of this delay.

What Are Exchanges?

- Marketplace for private health insurance plans to be purchased by individuals and small businesses
- Costs/coverage transparent – no waiting for rates
- Plan comparison/enrollment online
- Pooling requirements should mean no difference in rates besides age/smoking status
- Every state has one or more exchanges
 - 27 federally-run exchanges
 - 7 federal-state partnerships
 - 17 state-run exchanges



There are two ways people will go into an exchange, buying a policy individually (either with or without subsidies) or through their employer buying in if they work for a small employer who is qualified.

No more differences to pricing based upon preexisting conditions with the exchanges

Coverage of Exchange

- Plans rated based upon the percent of medical expenses covered
 - Platinum (90%), Gold (80%), Silver (70%) and Bronze (60%)
 - Catastrophic plans for adults under 30
 - For a silver plan (baseline on exchange), 70% of expenses would be covered by insurance for a typical enrollee – the last 30% would be paid in some mix of coinsurance, copays, and deductibles



Average private insurance now covers 80% of cost

Average HSA-qualified high-deductible plan 67%

Within a tier of coverage, all plans should have the same total out-of-pocket costs, but the plan distribution between coinsurance, copays, and deductibles may differ

Who Can Get Exchange Plans?

● Individuals:

- Everyone who isn't an undocumented immigrant
- Some will pay 100% of premium cost
 - Income limits are fairly high (\$92,200 for family of four)

● Small businesses:

- Of under 50 employees in all states
- 50-100 in some states (all by 2016)



Additional Requirements:

Must not qualify for public insurance (Medicare, Medicaid, CHIP, TRICARE, etc)

Those with access to employer provided insurance excluded unless plan:

1. Covers less than 60% of medical expenses, or
2. Costs more than 9.5% of household income to pay for the cost of the single premium

Small Business Exchanges – Different Status Depending On Size

Employee Range	Access to exchange?	Special Tax Credits?	Mandate?
1-24	2014	Yes	No
25-49	2014	No	No
50-99	2014 or 2016, depending on state	No	Yes
100+	After 2017, if state decides to allow	No	Yes



The special tax benefits to the smallest employers which phased in in 2010 for providing health insurance rise in 2014. For-profit businesses see their maximum credit rise from 35% to 50% of the value of insurance, and tax-exempt small-employers see their credit rise from 25% to 35%. They can only get this credit for a maximum of two years, however. The maximum tax credit is earned by employers who have less than 10 workers, or those whose workforce has average taxable wages of \$25,000 or less.

Employer size is based upon common ownership, meaning separately incorporated branches are not separate small businesses for purposes of the ACA. If there are 40 employees at one location and 70 at another, the count is over 100 and the employer does not qualify as a small business. The only exception is when a larger global company employs less than 50-100 employees within the U.S.

Public employers can enroll in an exchange, if they meet the above requirements, as can nonprofits.

Premiums are billed to employers as if they are unsubsidized individual exchange premiums, meaning the oldest workers (64) cost three times what the youngest workers (20) cost, and there is up to a 50% premium surcharge for smoking. Employers do not need to pass on these costs without modification to workers however.

Employers don't pay a group rate – instead, they get a “shopping list” totaling the cost for each individual plan a worker chooses.

Due to delays, federal-run exchanges (and some state exchanges) won't offer multiple plan choices to small employers until 2015. In these cases, if the employer picks a plan in the first year, everyone is enrolled on it. In future years, however, employees will be given a lump of cash which they can use to purchase any “small employer” plan at any coverage level.

Bargaining for a Small Employer Exchange Plan

- ◎ Push for employer to offer access to gold or platinum plans rather than silver
- ◎ Don't agree to pay a percentage of premium, due to the oldest workers potentially having premium shares three times greater than the youngest
- ◎ Instead, bargain to establish either a flat dollar amount for the premium share, or a percentage of total monthly wages



If we have a small employer plan, bargaining is a much simpler process, coming down to essentially three questions: what tier or tiers the contract provides for the members, whether members can enroll in any plan within a tier, and the structure and level of premium cost sharing.

Remember that most insured workforces currently have coverage similar to gold, but silver is the new default, so in most cases, gold or platinum should be our goal.

When it comes to cost sharing, keep in mind that small employer plans are unsubsidized by the government, and thus can vary up to 300% between the youngest and oldest workers. Thus if we have contract language specifying employees pay 10% of the premium, workers of different ages could pay anywhere from \$50 to \$150 per month for identical coverage. This is a very bad idea – not just for shop solidarity, but for the employer, as it sets up a payment system which discriminates against older workers.

Summary Of Individual Exchange Subsidies

Income Level As % of FPL	Max % of Household Income for Premium	% of Medical Expenses Covered	Reduction of OOP Max
100%-133%	2%	94%	66%
133%-150%	3%-4%	94%	66%
150%-200%	4%-6.3%	87%	66%
200%-250%	6.3%-8.05%	73%	50%
250%-300%	8.05%-9.5%	70%	50%
300%-400%	9.5%	70%	33%



There are three different subsidies you get based upon income on the exchange.

The first, for those under 400% of the poverty line, limits the maximum you can pay annually for premiums to a percentage of your income on a sliding scale. Any costs above this are paid for through the government providing a tax credit, which is either given as part of the annual tax refund or, if preferred, in monthly installments. Please note that this is based upon the second cheapest “silver” plan on the exchange, so if you want better coverage than this, you must pay for the difference yourself.

The second subsidy, available to the lowest-income people, reduces the total cost of deductibles, coinsurance, and copays. While for most people a baseline silver plan would result in roughly 30% cost sharing, for some low income people cost sharing could be as low as 6%. These subsidies are only available if you enroll in a silver plan. The federal government directly pays the insurer for the cost of this subsidy, so if your income is below 250% of the FPL, when the plan is offered to you you’ll see much higher levels of coverage for “baseline” plans.

The final subsidy is a reduction of the annual out-of-pocket (OOP) maximum. Similar to the second subsidy, this is paid for through direct payments to insurers. As an example, a family at the 250% threshold enrolling in a plan with an out-of-pocket max which would normally be \$8000 would see their annual limit reduced to \$4,000.

When Members Might Do Better On The Individual Exchanges

- Workers in lower-wage shops may gain enough exchange subsidies to make eliminating employer-provided insurance and going to exchange sensible
 - Particularly true for older workers and smaller employers
 - May need some additional compensation to make going to an exchange worthwhile
- Resist employer demands to eliminate insurance and go to exchange **in all cases where wage is over \$16.00 per hour**



Where does it make sense to consider eliminating employer coverage entirely and going over to the individual exchange? First, the workplace must have fairly low wages. With wages over \$16 per hour, a substantial number of members will likely be over the 400% FPL threshold, be ineligible for subsidies, and thus really be harmed with any plan to eliminate employer-provided insurance. We should keep in mind that even in lower-paid shops there may be some individuals – particularly those who have working spouses and don't have dependent children at home – who may fall over the limit if their wages are substantially higher than the workplace average.

In addition, we'd want to focus on smaller employers for several reasons. First, employers of under 50 don't have an employer mandate, hence pay no fine if they choose not to insure us. Secondly, the deduction of the first 30 workers for all firms means that even those in the small to medium-sized range (50-200) get a substantial fine reduction compared to large employers. Perhaps most important, however, is the mandate that 95%+ of employees must be insured means it's cost prohibitive for a larger employer to drop coverage for us unless they can drop it for everyone at once. This also goes for employers which are not particularly large, but have several bargaining units. Imagine a school district, for example, which eliminated coverage for support staff. The teacher's contract isn't up for two years, during which time the district would pay a fine on insured teachers as if they were uninsured. Further, many teachers would make too much to qualify for subsidies, and they'd thus be very unlikely to wish to follow support staff into the exchange.

Generally speaking, the older the workforce of an employer, the better off employees will be with exchange coverage, as the value of subsidies is so much greater than the tax benefits that both the employer and employee gets for having insurance. On the other hand, for small employers with young workforces, the small employer exchange may be a more attractive option, because premiums are so much cheaper.

Keep in mind that if the boss is willing to eliminate our coverage, he must be willing to eliminate his as well – and he'll have to pay out of pocket.

Nibbling Around the Edges

- Not covered by employer mandate:
 - Spouses
 - Pre-65 retirees
 - Part timers (under 30 hours)
- If 50%-100% of cost is picked up by employee, dropping coverage may be better



Some groups are offered insurance under a union contract, but not subject to employer mandates. The largest group are spouses – employers must provide employee + child coverage, but they don't need to cover spouses at all under the ACA. Certain contracts also allow part-timers or pre-65 retirees into the group plan, often under pretty bad cost-sharing arrangements.

We certainly shouldn't eliminate benefits for these people willy-nilly. We need to carefully consider if the cost sharing under contract for these people is worse than what people would pay on the exchange, and if plans with comparable benefit levels exist. For some people, particularly those who are required to pay 50%-100% of the cost to take part, the exchange will be a godsend, but only if we eliminate the contractual obligation to insure these groups.

Annual Individual Tax Penalties Due To Individual Mandate

	2014	2015	2016
Charge per Adult	\$95	\$325	\$695
Charge per Child	\$47.50	\$162.50	\$347.50
Family Max	\$285	\$975	\$2,085
Or % of Income If Higher	1%	2%	2.5%



Beginning on January 1, 2014, most people must have health insurance or pay a tax penalty. Exceptions are those with religious exceptions, prisoners, members of Indian tribes, and people uninsured for less than three months. Another exemption is for undocumented workers – however their children are covered by the mandate if they are citizens or documented immigrants. Presumably in most cases they will qualify for Medicaid/CHIP. There is also a rule that you cannot be forced to buy insurance if the cheapest regular plan on your exchange costs more than 8% of your income. Due to this rule few people who make too much money to qualify for subsidies (more than 400% of the poverty line) but make less than \$150,000 annually will be forced to buy health insurance.

The tax penalties that individuals pay annually for not having health insurance are based upon one of two measures – either a fixed amount for each adult and child in the family, or a percentage of your income, with the HIGHER of the two numbers being your annual fine. In practical terms this means that lower-income households will usually face the annual flat fee, while higher-income households will instead get a percentage of their gross income deducted. The fine phases in in 2014 and 2015. By 2016 it reaches its max as a percent of income, but the per-person charges will still increase with inflation. The tax penalty cannot be greater than cost of cheapest bronze coverage on the exchange.

Excise Tax Begins in 2018

- All health plans above an annual limit subject to a 40% tax on all benefits exceeding that limit
- Benefit value includes sum of:
 - Total premium (employer & employee share)
 - Employer contributions to HSAs, HRAs, MSAs, and FSAs
 - Likely employee contributions to HSAs, MSAs, and FSAs
 - Supplemental health benefits, like onsite medical clinics
- Insurance companies plan to pass cost along in higher premiums, and employers plan to pass it along to their workers



Vision & dental plan benefit values NOT INCLUDED!

Insurance companies pay tax on premiums over limits for fully-insured plans. Will try to convert tax into increased premiums, or refuse to offer good plans

Employer pays tax on HSA, HRA, and FSA contributions, along with self-insured plan. Employers will try to slash benefits or pass costs to employees

Excise Tax Thresholds: 2018 -2020

40% Tax Above Annual Limits	2018	2019	2020+
Single – Regular Limit	\$10,200	CPI+1%	CPI
Single – High Risk/Retiree	\$11,850	CPI+1%	CPI
Family – Regular Limit	\$27,500	CPI+1%	CPI
Family – High Risk/Retiree	\$30,950	CPI+1%	CPI



Certain groups may get higher limits set, if they have unfavorable age/gender spreads. High risk include electrical and telecommunications installation/repair workers, longshoreman, emergency response, firefighting, law enforcement, construction, mining, agriculture, forestry, and fishing.

If the costs for benefits to federal employees exceed certain level, limits may be pushed upward.

Assuming annual premium increases of 6%, a family plan which costs \$1,750 per month today will be above the excise tax threshold in 2018. Assuming the same cost escalation, a plan which now has a monthly premium cost for family of \$1,500 per month would hit the excise tax threshold by 2023

Potential Changes Due to Excise Tax

- Insurers may no longer offer good plans
- More options in self-insured workplaces to reduce costs without increasing out-of-pocket costs
 - Eliminating high-cost, low value providers from network, HMOs, wellness, eliminating FSAs, etc
- Experience may be similar to Pension Protection Act – negative change to federal law that we are limited to bargaining over the effects of



Unions fought tooth and nail against excise tax – it ultimately didn't end up as bad as it initially was, and the phase in was delayed by several years as a result of the labor movement. But it will still have a bad impact.

If you can't stop reductions in the value of the health plan due to the excise tax, demand pay increases to make up the difference. If we have new out-of-pocket costs, the employer should provide additional wages (even if they aren't pre-tax) to pay for them.

It is also possible that members may want to consider other pre-tax benefits, such as increased pension/401(k) contributions, or a child-care Flexible Spending Account. These allow for us to replace pre-tax dollars with other pre-tax dollars.

Finally, despite HRAs also coming under the excise tax, we should consider them in the near period as a possible means to lower premium costs while not substantially affecting member's total costs.

When the ACA Has No Direct Impact

- If workplace's insurance isn't in danger of hitting excise tax, and wages are too high for exchange subsidies, it's the same fight as always
- Keep in mind it's now more expensive for the boss to eliminate our insurance
- Don't let the employer use confusion to push through new massive concessions
- Healthcare bargaining remains difficult, but not too different until all employers are allowed on exchanges



In 2017, some states may begin to allow large employers onto their exchanges

Mounting A Fight

- Educate and involve the membership
- Challenge employers to sign on to Medicare for All/Single Payer
- Mobilize allies by framing contract fight as part of a broader fight for healthcare for all
- Publicly blow the whistle on employers trying to dump workers off coverage
- Talk to members about real solutions to the healthcare crisis



Where to Go For More Information

- [UE Website](#)

- This presentation, along with other materials and links to ACA-related documents, to be available

- [UC Berkeley Labor Center](#)

- Best guide available with unions online

- [Kaiser State Premium Watch](#)

- Tracking all state actions – keep watch for your own exchange

- [Kaiser Family Foundation](#)

- General accessible information regarding healthcare reform



We didn't ask for this —
We want single payer!

