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THE AFFORDABLE CARE ACT: CONSIDERATIONS FOR EMPLOYERS WITH UNIONIZED WORKERS

The Affordable Care Act ("ACA") infuses new complexities into collective bargaining negotiations over health insurance benefits. In past years, the challenge for many employers at the bargaining table has been to control escalating health insurance costs and to shift an increasing share of those costs onto employees. Those challenges were hard enough. But now, with the advent of the ACA, employers face entirely new challenges as they develop their bargaining positions on health benefits. The ACA forces unionized employers to reassess the health benefits that they provide employees and determine which employees should be eligible to receive them. In addition, employers must develop new strategies for negotiating health benefits, with the goal of minimizing their exposure to ACA penalties, satisfying the ACA's coverage and benefit requirements, and preserving flexibility to make changes to comply with the ACA's complex and evolving requirements.

These challenges begin with fundamental decisions about the ACA's employer "play or pay" provision. These "play or pay" decisions implicate any number of mandatory bargaining issues, including whether to provide health insurance, what types and levels of health insurance to provide, how to address coverage of part-time employees, and how to deal with employee costs. The ACA's "Cadillac tax" also creates the potential for new costs that employers will need to take into account as they consider what health benefits they want to offer. Regardless of what employers have negotiated into past labor contracts, the landscape has dramatically changed. Employers need to take a fresh look at their health insurance provisions and prepare new strategies for negotiating future contracts in light of the ACA.

This *Commentary* gives an overview of the employer play or pay penalty and the Cadillac tax. It then lays out a variety of bargaining considerations for employers that flow from these provisions. Employers will want to have these in mind as they prepare themselves for negotiations.

THE EMPLOYER PLAY OR PAY PENALTY

Almost half of the American population gets health coverage through an employer. To keep that coverage in place and keep the new premium tax credit subsidy created by the ACA focused on those who do not currently have access to affordable insurance, the ACA creates adverse consequences for large employers who drop or fail to offer health coverage to their employees.[1]

The employer play or pay penalty (enacted as section 4980H of the Internal Revenue Code) goes into effect on January 1, 2015.[2] It requires large employers to offer health coverage to full-time employees and their children up to age 26 or risk paying a penalty. A large employer is an employer with an average of 50 or more full-time employees or full-time equivalents in the preceding year. Where an employer is part of a controlled group, all of the employees of the controlled group are counted for purposes of determining whether each member of the controlled group is a large employer.

Large employers will be forced to make a choice: to either "play" by offering affordable health coverage that provides minimum value or "pay" by potentially owing a penalty to the Internal Revenue Service if they fail to offer such coverage. This "play or pay" scheme, called "shared responsibility" in the statute, has become known as the Employer Mandate. Although the Employer Mandate generally will first be enforced on January 1, 2015, for employers with fiscal year plans that meet certain requirements, the effective date is deferred to the start of the plan year during 2015. To "play" under the Employer Mandate, a large employer must offer health coverage that is "minimum essential coverage," is "affordable," and satisfies a "minimum value" requirement to its full-time employees and certain of their dependents. "Minimum essential coverage" is defined in the same way for this penalty as it is for the individual coverage requirement. It includes coverage under an employer-sponsored group health plan, whether it be fully insured or self-insured, but does not include stand-alone dental or vision coverage, or flexible spending accounts. Coverage is "affordable" if an employee's required contribution for the lowest cost self-only coverage option offered by the employer does not exceed 9.5 percent of the employee's household income. Coverage provides "minimum value" if the plan's share of the actuarially projected cost of covered benefits is at least 60 percent. If a large employer does not "play" for some or all of its full-time employees, the employer will have to pay a penalty in two scenarios.

The first scenario occurs when an employer does not offer health coverage to "substantially all" of its full-time employees and any one of its full-time employees both enrolls in health coverage offered through an insurance exchange, which is also being called a marketplace (an "exchange"), and receives a premium tax credit. "Substantially all" means 95 percent or more of the full-time employees. (For 2015, transition relief is provided so that substantially all means 70 percent or more.) In this scenario, the employer will owe a "no coverage penalty." The no coverage penalty is $2,000 per year (although projected to be $2,120 for 2015 after adjusting for inflation) for each of the employer's full-time employees (excluding the first 30). The penalty is actually computed month by month for each calendar year, taking account of changes in full-time headcount from month to month and changes in what may be offered during the calendar year.

The second scenario occurs when an employer does offer health coverage to its employees, but such coverage is deemed inadequate for Employer Mandate purposes, either because it is not "affordable," does not provide at least "minimum value," or the employer offers coverage to substantially all (but not all) of its full-time employees and one or more of its full-time employees both enrolls in exchange coverage and receives an exchange subsidy. In this second scenario, the employer will owe an "inadequate coverage penalty." The inadequate coverage penalty is $3,000 per person (projected to be $3,180 in 2015 after adjusting for inflation) and is calculated not based on the employer's total number of full-time employees but based on each full-time employee who receives a premium tax credit. (Furthermore, the penalty is capped each month by the maximum potential "no coverage penalty" discussed above). Again, the penalty is actually computed month by month, taking account of changes in who is a full-time employee and who is receiving the premium credit in a given month.

Exchange subsidies will not be available to any employee whose employer offers the employee affordable coverage that provides minimum value. Thus, by "playing" for employees who would otherwise be eligible for an exchange subsidy, employers can ensure they are not subject to any penalty, even if they don't "play" for all employees. However, employers will want to take care to avoid any impermissible discrimination in setting rules for eligibility.[3]

Who is a Full-Time Employee? Managing compliance for an employer depends on being able to identify who is a full-time employee. For purposes of the play or pay penalty, an employee is full-time if he works an average of 30 hours per week or 130 hours per month. An employer may use one of two available methods to determine whether an employee is full time: the monthly measurement method, which depends on an employee's actual hours of service, and the look-back measurement method, which depends on measuring an employee's hours of service over a measurement period of anywhere from three to 12 months, determining whether the employee is full-time based on the hours of service in that period, and then labeling the employee as full-time or part-time for a subsequent stability period based on the results in the measurement period. Under either method, the employer must track hours of service, which are defined as hours for which an employee is paid, or entitled to payment, including vacation, holidays, illness, incapacity, and military duty.

Is Coverage Affordable? Under the statute, coverage is affordable if the employee's share for self-only coverage under the lowest cost employer-sponsored health plan is no more than 9.5 percent of the employee's household income. Employers do not know their employees' household incomes, making it impossible to know whether they are offering affordable coverage. In response to this dilemma, the Treasury regulations provide employers with three safe harbors they may use to determine whether the coverage they offer is affordable. Employer coverage is considered affordable for purposes of the employer play or pay penalty if the employee's share for self-only coverage under the lowest cost employer-sponsored health plan is (i) no more than 9.5 percent of the wages shown on Box 1 of the employee's W-2; (ii) no more than 9.5 percent of the employee's wages if the employee were assumed to work 30 hours per week at the applicable rate of pay; and (iii) no more than 9.5 percent of the amount that is 100 percent of the federal poverty level.

Multiemployer Plans. Employers who have unionized employees can know whether the employees are offered coverage if it is provided through a single employer plan with terms of eligibility that the employer negotiates. However, an employer may not know whether any particular employee will be offered coverage if it is provided through a multiemployer plan to which the employer contributes. Furthermore, even if the multiemployer plan does offer coverage to the employee, the employer itself is not offering the coverage. Treasury and IRS have addressed each of these issues in the final regulations implementing the employer play or pay penalty. First, the final regulations offer interim relief in the preamble to employers that are required to make contributions to multiemployer plans under their collective bargaining agreements. As long as the multiemployer plan offers coverage that is affordable and provides minimum value and is offered to the children of individuals who are otherwise eligible, the employer will not be penalized, regardless of whether the employer's employee is in fact eligible for the coverage under the multiemployer plan. The interim relief will remain in effect until at least six months after superseding guidance is published. Second, the Treasury regulations implementing the play or pay penalty provide that coverage offered by a multiemployer plan to which the employer contributes that is affordable and provides minimum value is considered coverage offered "on behalf of" the employer. Employers may use the same safe harbors that are available for coverage they offer themselves in determining whether the multiemployer plan's coverage is affordable.

THE CADILLAC TAX

In addition to the penalty associated with whether health coverage is offered and to whom, the ACA imposes new taxes and fees on employers that will affect bargaining over health benefits. Some of these new costs, such as the Patient-Centered Outcomes Research Institute Fee and the Transitional Reinsurance Program applicable to plan issuers and sponsors, are already effective or will be in 2014.

Starting in 2018, the ACA imposes another new tax, often called the "Cadillac tax." It is a nondeductible 40 percent excise tax on any excess in the cost of employer-sponsored health care coverage provided to an enrollee over specified dollar thresholds. For purposes of the Cadillac tax, employer-sponsored coverage includes major medical coverage and pharmaceutical coverage but excludes separate dental and vision plans. Where an enrollee participates in more than one type of employer-sponsored coverage, the cost of those plans is aggregated for purposes of calculating the Cadillac tax. As employers prepare for labor contract negotiations, they need a strategy for bargaining over health benefits with the looming Cadillac tax in mind.

Insurance companies are liable for the excise tax for insured plans. Plan administrators—who may be the employers themselves—are liable for the excise tax for self-insured plans. Employers are likely to bear the cost regardless of who is liable for paying the tax because insurers or outside plan administrators are highly likely to pass along the costs imposed by the excise tax to the employer sponsors of the plan through higher rates and fees. Employers will also face administrative costs because the plan sponsor (usually, the employer) is responsible for calculating the excess benefit subject to the tax and allocating the excess among the insurers and plan administrators. Employers are subject to penalties if they fail to make these computations accurately. Given all this, employers and insurers have a significant incentive to keep the costs of employer-sponsored health plans below the trigger point for the excise tax.

All employer-sponsored health care plans are potentially subject to the excise tax; there is no exception for plans negotiated as part of a collective bargaining agreement. In fact, unionized employers must address the excise tax earlier than nonunion employers. While nonunion employers may have the flexibility to adjust benefits anywhere between now and 2018 to get the cost below the threshold and avoid the excise tax (even though waiting may be inadvisable), unionized employers need to address the potential excise tax in their upcoming rounds of bargaining in order to ensure that the contractual changes necessary to avoid the excise tax are in place before 2018.

The excise tax is expected to have the most significant impact on the type of rich health care plans that labor unions have fought to obtain and protect over the years. Even though the government has yet to issue regulations giving specific details on how to compute the cost of coverage, employers can project the problem they will be facing by using their COBRA premiums, which must be computed to reflect the cost of coverage. The ACA imposes the tax on the portion of the annual value of health plan costs for employees that exceed in 2018 the following amounts: $10,200 for single coverage and $27,500 for family coverage, with higher amounts for certain retirees and employees in high-risk professions. These thresholds for 2018 will increase if the cost of coverage in a specified option in the Federal Employee Health Benefits Program goes up by more than 55 percent between 2010 and 2018.

In the meantime, the thresholds are a valuable point of reference. According to the Kaiser Family Foundation annual survey, the average annual premium cost in 2012 for single coverage at employers with at least some unionized workers was $5,734 per year (or $4,466 below the threshold) and $16,073 for family coverage (or $11,427 below the threshold). These average amounts, which remain significantly below the trigger for the excise tax, are somewhat misleading, due to the tremendous variation in the costs of health benefit programs across the country. Employers in the Northeast and West often pay significantly more for health care plans than employers in the South. In addition, employers in certain industries, such as health care and in the public sector, usually pay health benefit costs that are significantly above the average. In fact, for certain unionized employers, the current cost of health benefits already exceeds the value that would trigger the excise tax in 2018. Based on a study conducted by SEIU regarding the likely application of the excise tax on the most commonly offered health plans among its represented members, eight out of 14 health plans are expected to trigger the excise tax in 2018.[4]

BARGAINING CONSIDERATIONS

The ACA adds new consequences to some fundamental decisions about providing employee health coverage, directly affecting bargaining strategies. While providing

health insurance benefits to unionized employees has been a fundamental term of most labor contracts for decades, the ACA forces employers to reconsider and readjust their arrangements if they want to avoid penalties and account for new costs imposed under the law. The threshold questions that employers must answer include:

The "Play Or Pay" Decision. Whether to offer health coverage or drop health coverage for employees and their dependents is a complicated economic, practical, and policy decision that unionized employers must make, taking into account the economic impact of that decision, the structure of their health benefit programs (e.g., existing coverage of union and non-union employees under the same plans), the employers' bargaining leverage, and the effect of the decision on employee morale, recruitment, and retention. In making the economic analysis of the ACA's penalties and costs for bargaining purposes, employers should:

- **Evaluate the costs of continuing coverage versus the costs of dropping coverage for employees, including all employees averaging 30 or more hours a week.** Employers that drop coverage may face a substantial penalty under the ACA. If the employees who both work full-time (i.e., on average 30 hours per week or 130 hours per month) and are not offered health coverage constitute more than 5 percent of the employer's work force, the employer is subject to the "no coverage penalty" equal to $2,000 multiplied by the number of the employer's full-time employees (less the first 30) if any full-time employee enrolls in health coverage through an exchange and receives a premium tax credit.

- **Evaluate the costs of making coverage "affordable" for lower-wage employees.** In many instances, to make coverage affordable and avoid penalties under the ACA, employers may have to bear a significant part of the coverage costs for their lower-wage employees.

- **Evaluate the costs of making the ACA's required changes in health plans.** Employers need to account for the cost of making changes to comply with ACA rules for group health plans. These changes affect the design of the plan. Many, such as the requirement to cover children up to age 26, have been in effect since 2010. For 2014, changes newly in effect include review of annual dollar limits on benefits in light of recent guidance defining essential health benefits that cannot have annual limits, the maximum 90-day waiting period for coverage, and the cap on out-of-pocket maximums.[5]

- **Consider the cost of providing coverage to children and providing (or not providing) coverage to spouses.** The ACA as implemented by the Treasury regulations does not require employers to provide coverage for spouses and does not penalize employers for excluding spouses from coverage, so employers will need to evaluate the potential savings from excluding spouses from eligibility for health coverage. The ACA, however, treats children differently: employers face a penalty under the ACA if they do not offer coverage to their full-time employees' children, including adult children up to age 26.

- **Consider the added cost of the ACA's various fees.** Self-insured employers will owe a "transitional reinsurance fee" in 2015, 2016, and 2017; for the first year, the fee is at the rate of $63 per covered life. For the second year, the fee is at the rate of $44 per covered life. In addition, for a single-employer plan, the employer must pay a "patient-centered outcomes research institute fee," which is $2 per covered life payable in the years 2014–2020.

Coverage Levels and Plan Design. Employers who decide, for economic and other reasons, to "play" and offer health insurance to employees must determine the level of benefits that they want to offer their union-covered employees. Employers need to meet the "minimum value" threshold to avoid ACA penalties but also should stay under the cost threshold to avoid triggering the Cadillac tax in the future. For many large employers, given the complexity of the ACA and its penalties, what the employer plans to provide all employees, whether unionized or not, on a company-wide basis will drive its proposals on benefit levels at the bargaining table, which makes preserving the right to make company-wide plan design changes a high priority. Some considerations include:

- **Consider using the minimum value standard and the Cadillac plan threshold as points of reference for the overall richness of the proposed plan.** Many if not most existing employer health plans generously exceed the "minimum value" standard (i.e., the standard that requires that the plan's share of the actuarially projected cost of covered benefits is at least 60 percent). On the other end of the spectrum, however, some employer plans, if not trimmed, risk triggering the Cadillac tax given their current cost and historic rate of growth. While unions may resist efforts to curtail employee benefits in the near term, employers should consider the leverage that avoiding the Cadillac tax provides at the bargaining table. Failure to address this problem could result in diverting economic resources to substantial taxes in 2018 that could otherwise be added to the economic package at the bargaining table or used for other business purposes.

- **Consider using one of the essential health benefits package benchmarks (e.g., the federal employee plan) as a point of reference for what benefits the employer will cover.** Under the ACA, all qualified health plans offered through the state exchanges must offer the essential health benefits package, and each state has a benchmark plan that is used to define the package of benefits. While employers are not required to offer an essential health benefits package in their group health plans, they need to be familiar with at least one benchmark plan for purposes of ensuring they do not impose impermissible annual limits on benefits. Employers can evaluate any benefits that unions may demand against one or more state benchmark plans, since those plans set the standard for comprehensive sound coverage that an individual is guaranteed to be able to purchase on the exchanges. The comparison gives employers an opportunity to identify particular benefit requests as exceeding a norm and either reject them or bargain for concessions in other areas in return for providing them.

- **Consider what additional benefits to offer employees, like dental, vision, disability, and long-term care.** The ACA requires employers to provide minimum essential coverage, meaning the core major medical coverage, but they can certainly offer more options. Offering these additional health benefits will not help the employer avoid a play or pay penalty, as they do not count toward the computation of minimum value; nor would they constitute minimum essential coverage if offered by themselves. These types of added benefits may be useful leverage in negotiations, since they do not contribute to the cost of coverage that can trigger the Cadillac tax if they are offered through separate fully insured policies. However, the same is not true for dental and vision coverage that is self-insured. Both employers and unions may see strategic value in negotiating over these added benefits.

- **Consider strategies for including wellness programs and related surcharges and incentives, including tobacco surcharges**. ACA regulations have reaffirmed that employers may attach economic rewards and penalties to wellness programs without violating the group health plan nondiscrimination rules that originated in HIPAA.[6] Wellness programs can include economic incentives that are based on achieving certain health outcomes, provided that the employer makes a reasonable alternative available. The regulations specifically permit an employer to impose a tobacco surcharge; however, certain state laws may limit an employer's ability to impose a tobacco surcharge. In addition, the EEOC has yet to give clear assurance that wellness program economic incentives are permissible under federal law, including the Americans with Disabilities Act, for wellness programs involving a medical examination or disability-related inquiry. Particularly if an employer is making wellness programs available to non-union employees, the employer will want a strategy for how to handle wellness programs when negotiating over health benefits for union-covered employees.

Part-Time Employees. The ACA's "full-time employee" definition sweeps in many workers who have long been considered part-time employees for purposes of providing health coverage. For those employers that currently provide insurance only to employees who work 40 hour per week, their covered populations will expand, potentially dramatically, when they treat part-time employees averaging 30 hours a week as full-time employees in order to avoid the ACA play or pay penalty. Bargaining priorities include:

- **Ensuring that part-time employees who meet the ACA's test of "full-time employees" are eligible for coverage.**

- **Addressing the look-back and stability method for determining who is a full-time employee under the ACA.** Employers should preserve the ability to take advantage of this method to determine whether variable-hour employees or seasonal employees are treated as full-time employees, particularly if they do not want to offer coverage to part-time employees or want to offer them different coverage. Employers should consider retaining discretion not only to use the method but also to adjust the length of the measurement periods and stability periods that are used for determining whether an employee is full-time for purposes of the play or pay penalty.

- **Preserving the flexibility to modify the definition of who is considered full-time under the ACA, in case there is a legislative change.** Bipartisan legislation has been introduced that would raise the full-time standard for purposes of the play or pay penalty from 30 hours per week to 40 hours per week.

Cadillac Tax. It is critical for employers to assess now whether they are likely to trigger the excise tax, based on the current costs of their benefit plans as well as the projected rate of increase for the cost of those plans through 2018. Absent a significant legislative change to the ACA, it is unlikely that these thresholds for the excise tax will increase before 2018 other than by the adjustment that corresponds to the increase in rates for federal employees. After 2018, the dollar thresholds will be indexed for inflation as follows—for 2019: the consumer price index, plus one percentage point; for 2020 and after, by the consumer price index.

Trim Now in Anticipation of Cadillac Tax. Absent waiver language, employers with open or soon-to-open contracts need to consider trimming their plans, as necessary, now. Most existing employer health plans generously exceed the minimum value standard. Some employer plans, if not trimmed, risk triggering the excise tax given their current cost and the historic rate of growth of coverage costs. Unions are likely to resist efforts to curtail employee benefits in the near term, but unions (one hopes) will understand that a failure to address the excise tax could divert resources that otherwise might be available to be added to the economic package at the bargaining table.

Cost Trigger to Protect Against Cadillac Tax. Even if employers are able to achieve health plan cost containment measures during contract negotiations, employers should also seek to include a provision in their labor contracts that would trigger cost reductions necessary to avoid the excise tax. The specifics of this provision would need to be addressed between the parties, such as the benefits that would be reduced or the process by which the union and the employer would agree on such changes. Such a provision would help employers avoid the worst-case scenario regarding the excise tax, i.e., an obligation to pay a 40 percent nondeductible tax with no way to avoid it due to restrictions imposed by the labor contract.

LAWYER CONTACTS

For further information, please contact your principal Firm representative or one of the lawyers listed below. General email messages may be sent using our "Contact Us" form, which can be found at www.jonesday.com.

Patricia A. Dunn
Washington
+1.202.879.5425
pdunn@jonesday.com

F. Curt Kirschner Jr.
San Francisco
+1.415.875.5769
ckirschner@jonesday.com

Catherine E. Livingston
Washington
+1.202.879.3756
clivingston@jonesday.com

ENDNOTES

1 The premium tax credit is available under Internal Revenue Code (IRC) §36B. To be eligible, an individual must be enrolled in coverage through an exchange, have household income between 100% and 400% of the federal poverty level, and not be eligible for or enrolled in government-sponsored minimum essential coverage or employer-sponsored minimum essential coverage.

2 The statutory effective date for the penalty is January 1, 2014. The government elected to defer enforcement until 2015.

3 Self-insured plans are subject to rules that prohibit discrimination against highly compensated employees under IRC §105(h). Failure to comply with the rules can result in loss of the tax exclusion for excess benefits provided to highly compensated employees.

4 *See* SEIU, "FAQs: Excise Tax on High-Cost Health Plans", *available at* http://www.seiu.org/images/pdfs/NHCR__FAQ%20Excise%20Tax-1.pdf (last visited March 20, 2014).

5 For an explanation of how these provisions apply to self-insured plans, *see* "FAQs on the Affordable Care Act, Part XII," Questions 1 and 2, *available at* http://www.dol.gov/ebsa/faqs/faq-aca12.html (last visited March 20, 2014).

6 For more information on requirements applicable to wellness programs, *see Jones Day Commentary*, "Employer Wellness Programs: What Financial Incentives Are Permitted Under the Law?" *available at* http://www.jonesday.com/employer-wellness-programs-what-financial-incentives-are-permitted-under-the-law-08-01-2013/.