

How Employers Twist the Affordable Care Act to Hurt Workers

06/07/2015 (Updated 09/21/2016)



The Affordable Care Act had its 5th anniversary this year and in that time it has transformed the US health care market. Doctors, hospitals, employers, insurance companies and patients are still adjusting to the new landscape. Rules are still being refined by the administration and some important provisions of the law are yet to be implemented.

As always, employers are looking for every opportunity in the transition to reduce their obligations to employees. In the research department, we've had many experiences with employers misrepresenting or selectively using the ACA to maximize their leverage in bargaining and hurt our members.

Your best weapon in these situations is a basic understanding of the law. Although the law contains lots of provisions with which CWA disagrees, the law's goals are broadly the same as our own: for everyone in the US to be able to access and afford health care. You should be skeptical when employers cite the law as an excuse to cut benefits or lower the standard of living for our members because that was not the intention of the law.

In this presentation I'll highlight the parts of the law that have been used most often by employers in my experience to hurt workers. You'll learn what the law actually says and you'll get tools to protect the benefits our members have fought so hard for over the years.

Overview of the ACA

- Three Legged Stool towards Universal Coverage:
 - No one can be denied coverage (Guaranteed Issue)
 - Everyone must have coverage (Individual Mandate)
 - Coverage must be affordable (Subsidies)
- Other Important Reforms
 - State-Based Exchanges
 - Medicaid Expansion
 - Benefit Regulations
 - Employer Mandate



2

The core of the ACA is three fundamental reforms that work together to achieve universal insurance coverage. First, insurance companies must sell coverage to anyone that applies for a fair price. This is called guaranteed issue. Before the law, insurance companies could deny coverage or charge exorbitant prices to sick customers and those with a history of illness.

However, people will have no reason to buy insurance when they're healthy if they can now wait to buy it after they get sick. Insurance relies on a balanced risk pool: healthy people pay premiums to cover the costs of sick people. Healthy people forgoing coverage would bankrupt the insurance market. To prevent this, the ACA mandates that everyone must have coverage.

To finish the three legs, the law provides income-based subsidies to make mandated insurance affordable for low-income customers. These three reforms make up the core of the law and are each necessary to it functioning.

The law contains many other reforms to control costs and improve care. Exchanges were created to help customers shop for coverage. Medicaid was expanded to cover low-income people at a reduced cost. Benefit regulations standardize coverage and the employer mandate ensures employers contribute their fair share.

ACA Effect on Insurance Coverage

Percentage Uninsured in the U.S., by Quarter

Do you have health insurance coverage?

Among adults aged 18 and older

■ % Uninsured



Quarter 1 2008-Quarter 1 2015

Gallup-Healthways Well-Being Index

3

Source: Jenna Levy. "In U.S., Uninsured Rate Dips to 11.9% in First Quarter" *Gallup* April 13, 2015
<http://www.gallup.com/poll/182348/uninsured-rate-dips-first-quarter.aspx>

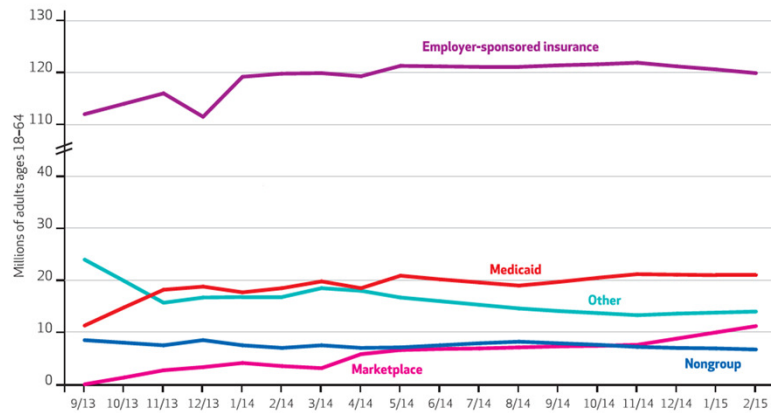
The effect of the law has been a drastic reduction in the uninsured. Gallup estimates the uninsured rate currently stands at 11.9% as of the first quarter of 2015 (down from 18% at the end of 2013).

17 million previously uninsured people gained coverage since the law came online in September 2013 while 26 million remain uninsured. [1]

[1] Source: Katherine G. Carman, Christine Eibner and Susan M. Paddock, "Trends In Health Insurance Enrollment, 2013–15." *Health Affairs* June 2015

ACA Effect on Insurance Coverage

Trends in Insurance Coverage Among US Adults Ages 18-64, By Type Of Coverage, September 2013-February 2015



4

Source: Katherine G. Carman, Christine Eibner and Susan M. Paddock, "Trends In Health Insurance Enrollment, 2013-15," *Health Affairs* June 2015

Expansion in coverage came predominantly through the new Marketplace exchanges (11.2 million), from Medicaid (9.6 million) and employer coverage (8 million). Approximately 12 million people lost coverage from individual non-group policies and "other" (state safety-net programs made redundant, Medicare and military coverage).

ACA at the Bargaining Table

- Benefit Regulations
- Employer Mandate
- Tax on Health Benefits
- Increased Wellness Incentives and Penalties
- Popularization of Exchange Concept



5

The ACA is an enormous law that touches every aspect of the health care market. In this presentation I'll focus on the parts that may affect our members at the workplace.

The ACA has put new rules in place on what kinds of health benefits employers are allowed to offer on a pre-tax basis. Many of our plans will need to make changes to comply.

The employer mandate sets minimum requirement for employers that offer coverage and penalizes those that don't.

In **2018 [Note: Delayed to 2020]**, the Excise Tax on High Cost Employer-Sponsored Health Coverage goes into effect, which will likely require change to our plans over time.

The ACA permits larger plan incentives for wellness programs. These types of programs have become increasingly popular and may represent an opportunity for us to help our members get healthier and reduce health plan costs.

Finally, we'll look at the growing trend of employers creating their own health exchanges, a concept popularized by the state exchanges created under the ACA.

Benefit Regulations Overview

Effective	New Benefit Regulations
2010	<ul style="list-style-type: none"> • Dependent coverage to age 26. • No cost sharing for preventive care
2011	<ul style="list-style-type: none"> • No lifetime limits on benefits. • No annual limits on benefits. [Phased out by 2014] • Minimum “medical loss ratio” [85% large / 80% small]
2014	<ul style="list-style-type: none"> • Limits on out-of-pocket maximums. [\$6,850 single / \$13,700 family for 2016] • Maximum 90-day waiting period for new employees to be offered coverage.

6

Here is a chronology of the new benefit regulations that should now be applying to employer health plans which cover active employees (with the exception of free preventive care for grandfathered coverage). Plans must now:

1. Offer coverage to dependents up to their 26th birthday. As of 2014 this offer of coverage must be made whether or not the dependent has a plan available from their own employer.
2. Pay 100% for preventive services identified by organizations such as United States Preventive Services Task Force, Centers for Disease Control, and Health Resources and Services Administration.
3. Remove plan provisions that place annual or lifetime maxes on how much plans will pay toward coverage for an individual.
4. Report the percentage of premium dollars spent on care for members versus administration, executive salaries, and marketing. Fully-insured large employer plans that spend less than 85% of their premium revenue on care must rebate the difference to members.
5. Cap out-of-pocket spending for in-network services below \$6,850 for single coverage and \$13,700 for family coverage in 2016.
6. Employers can require that otherwise eligible employees wait no longer than 90-days after being hired before being offered coverage in the health plan.

It is important to emphasize that these rules are FLOORS for minimum coverage. Plans can always offer coverage more generous than the rules described here. Plans that fail to

comply with these rules will be fined \$100 per day of non-compliance, per affected individual.

The details of what these regulations mean in practice is still being clarified by regulators. For instance:

- Final regulations were issued in February of this year stating that, beginning in 2016, the individual out-of-maximum must apply to every individual enrolled in family coverage. [1]
- On May 11, HHS clarified that plans must provide at least one version of each FDA-approved contraceptive method. [2] This is separate from the Hobby Lobby Supreme Court decision which stated that “closely held” corporation were exempt from requirement to cover FDA-approved methods they object to on religious grounds. [3]

[1] FINAL REGULATIONS: <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>; FAQ: <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQs-Part-XXVII-MOOP-2706-FINAL.pdf>

[2] FAQ: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf

[3] <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/11/27/everything-you-need-to-know-about-the-supreme-court-birth-control-case/>

Regulations: Red Flags for Bargaining



RED FLAG #1: Employer demands cuts to pay for mandated benefit improvements

- Request data documenting changes in cost resulting from plan changes
- Cuts should be cost neutral; be mindful of how improvements and cuts are distributed in the unit



RED FLAG #2: Employers want unilateral ability to make future plan changes to comply with ACA

- Interpretation of ACA requirements can vary, union should have role in determining any plan changes
- Union also has valuable role to play in educating unit about plan changes

7

RED FLAG #1

Every employer is concerned with the cost of their benefits. When the ACA has required improvements to our members' plans, employers have demanded other cuts as compensation. These givebacks are not required by the law. If our members agree to allow for a cost neutral change, the union should request data that identifies the number of individuals affected and total cost of the change.

Changes should be cost neutral and, when possible, should be targeted to keep affected individuals whole. For instance: The benefit of free preventive services is likely to be broadly shared. Paying for this new benefit by increasing OOPMs will be a transfer of money from the sickest employees to the healthiest.

RED FLAG #2

As the regulations governing these new rules have continued to evolve, employers have often demanded contract language allowing them to make unilateral changes to the health plan to comply with the law. The union should not allow the employer to interpret and implement these rules on their own. Employers, especially small ones, have misinterpreted these rules in the past and often there are multiple ways to comply with the law.

Reopener language can be written that gives the union a role in plan changes. The union can ensure that all changes are done in a way that minimizes disruption and harm to the members. The union will also be able to educate the membership about the changes.

Regulations: Red Flags for Bargaining



RED FLAG #3: Employer demands unnecessary changes

- Rx and Medical OOPMS can be separate, but together can't exceed legal limits
- Plan design can vary under legal limits



RED FLAG #4: Employer drops payments for individual coverage

- Consider new SHOP exchanges for small business
- Compare coverage available on new state-based exchanges
- Consider improvements to other benefits (PTO, 401k) in lieu of wage increases to preserve subsidy eligibility on the exchange

8

RED FLAG #3

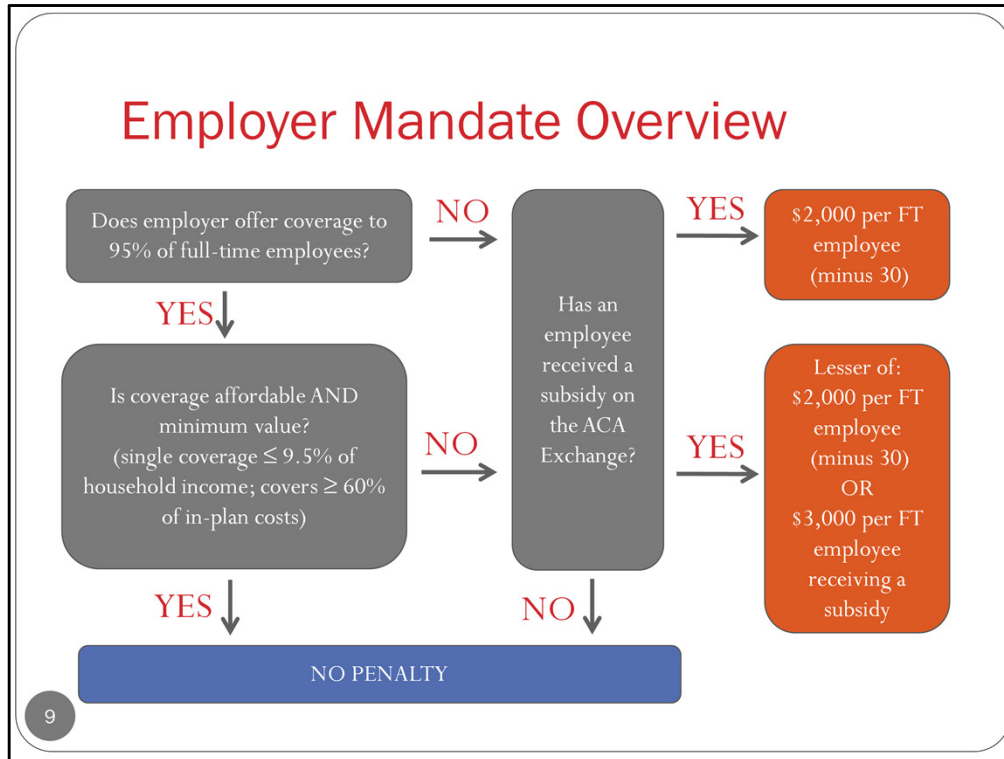
In bargaining, employers may use the ACA to demand lots of changes to the plan that benefits the employer. Employers may be confused about the law or may be knowingly misrepresenting it to make gains in bargaining. In our experience, employers have used the law as a reason to combine medical a prescription drug out-of-pocket maximums. Combining these limits hurts members and is not required by the law.

Employers have also made demands to change the way plans are structured, such as deductibles counting towards out-of-pocket maximums or copays be changed to coinsurance which applies to out-of-pocket maximums. The law only requires that employee payments be limited to the annual dollar amounts mentioned before, regardless of whether paid as deductibles, copays or coinsurance. Plans can remain unchanged with these amounts added as “global maximums.”

RED FLAG #4

The IRS has stated that the ban on annual benefit limits means that stand-alone HRAs and other pre-tax payments towards individual coverage are no longer permissible for active employees (retiree plans are exempt from these rules). For some of our smallest employers, this means that current benefit arrangements need to change drastically. For these employers, the SHOP state-based exchange for small business will allow them to provide access to job-based, tax advantage coverage without undertaking the administrative burden of beginning their own health plan.

The union should compare the employer's payment for coverage to subsidies that may be available to the employee on the individual exchange. Small employers (under 50 full-time equivalent employees) are exempt from the employer mandate, so the union should consider allowing employees access to the individual exchange and securing cost neutral improvements to other benefits. Wage increases will affect subsidy levels on the exchange.



The “Shared Responsibility” employer mandate has been a controversial aspect of the law that has seen numerous delays. It was originally written to go into effect January of 2014. It was delayed by the Obama administration and phased-in through 2015. The full provision, as written, will go into full effect January 2016. This flow chart shows the steps an employer must take to comply with the mandate.

The law requires that employers do two things: (1) offer coverage to nearly all (95%) of their workforce, and (2) provide coverage that is considered affordable and covers a large enough portion of participants’ health care costs, called “minimum value”. For the purposes of the law, “affordable” means that it costs employees less than 9.5% of their income to enroll and “minimum value” means that the plan is expected to cover 60% of employee’s health care costs. If an employer offers a plan that meets these requirements, they are protected from any penalties.

If the employer does not coverage or if provided coverage is not affordable or of minimum value, the employer mandate penalty is only triggered if an employee goes to the public exchange and gains a subsidy for coverage. If one employee qualifies for a subsidy on the exchange, penalties kick-in for the employer. The amount of penalty is determined by whether or not any coverage is offered. If an employer doesn’t offer coverage at all, they must pay \$2,000 per year for every full-time employee minus the first thirty. If they offer inadequate coverage, they pay the lesser of the previous penalty or \$3,000 for each employee that gains a subsidy. This means that employers have an incentive inadequate coverage as opposed to none at all.

Note: For 2015 the mandate was suspended for employers between with between 50 and 99 FTE and the offer requirement was reduced from 95% to 70%. [1]

[1] FACT SHEET: <http://www.treasury.gov/press-center/press-releases/Documents/Fact%20Sheet%20021014.pdf>

Employer Mandate Overview

- Applies only to “large employers” who have more than 50 full-time equivalent employees
- Affordability standard ($\leq 9.5\%$ of income) applies to INDIVIDUAL coverage and HOUSEHOLD income
- Employer mandate criteria are also used to determine if an employee can go to ACA exchange and gain a subsidy for coverage
 - Small employers are free to allow employees access to subsidy
 - Large employers can only give employees access to subsidies if they pay the Employer Mandate penalty

10

It is important to remember that the mandate only applies to “large” employers with over 50 full-time equivalent employees. For 2015, the mandate was phased in to exempt employers with less than 100 FTE. Multiple part-time employees can together be considered a “full-time” equivalent if they work more than 30 hours per week combined.

Under the law, affordability has been defined as employee-only coverage offered at a cost of no more than 9.5% of household income. This inconsistency (household income vs. individual coverage) creates a couple of important issues. For our members, the problem is that the cost of dependent coverage is not considered at all. Employers are required to offer coverage to dependents up to age 26 but are not required to make it affordable. Under the law coverage for spouses is not required at all. Many employers are taking advantage of this loophole by shifting money away from family coverage and onto single coverage. This makes maintaining coverage for children and spouses increasingly difficult for workers.

For employers, the problem is that they have no way of knowing what an employee’s household income is. The IRS has provided them with “safe harbor” rules that say as long as they make coverage affordable based on the employee pay information they have available, they will not be liable for penalties. For employees, the household standard still applies when applying for coverage on the exchange.

It is also important to remember that employer mandate rules and employee options for gaining subsidies on the new exchanges are inextricably linked. Employees are blocked

from exchange coverage if their employer offers coverage that meets the qualification of the employer mandate. This means that at large employers, employees may only gain a subsidy if their employer has agreed to pay penalties. Employers can hurt employees by blocking them from more affordable coverage available on the exchange.

Mandate: Red Flags in Bargaining



RED FLAG #1: Employer caps hours below 30/week

- Define distribution of work hours and benefit availability in the contract
- Document increase costs associated with changing work hours



RED FLAG #2: Dependent coverage is unaffordable

- Create separate tiers for child and adult dependents.
- “Working spouse surcharge” allows access for spouses without another option for coverage



RED FLAG #3: Employer introduces “Skinny Plans”

- Compare to plans available on ACA exchange
- Check if employees qualify for expanded Medicaid

11

RED FLAG #1

Employers that have flexibility over employee work hours may try to avoid the mandate by capping hours below the 30 hour/week definition for full-time. Under the mandate employers have no responsibility to provide coverage for employees that work part-time. This hurts workers twice over: they are denied access to coverage and their take-home pay is reduced.

The first line of defense for this type of employer malfeasance is our contract. Rules for how hours are assigned or shift bidding processes are often defined there. The 30hrs/week limit is tied to hours actually worked, not hours assigned. Employers will likely need to institute new rules for employees that pick up and drop hours, which may require new contract language.

If the employer has the ability to make these changes unilaterally, it's up to the union to make the case against it. Employers often won't consider other costs associated with changing work rules. How many employees will leave to find other work if their hours are limited? What are the training costs associated with this turnover? Will the company need to bring on more workers to make up the difference? How much will this new shift tracking system cost to implement? The research department can help you make the case that employers will end up worse off by hurting their employees with new limits on their work hours.

RED FLAG #2

As noted before, the definition of “affordable” coverage is tied to employee-only coverage. Employers may require exorbitant contributions for any other level of coverage as long as employee-only coverage is reasonably priced. This places a burden on our members with families.

Unfortunately, our best defense against this is to minimize the damage. Typically coverage for children is much cheaper than for spouses and adults. Consider bargaining for an affordable “Employee + Child(ren)” tier that will cost the employer less to subsidize. Working spouse surcharges can allow for spouse coverage contributions to be more targeted. These surcharges only apply to spouses with coverage available from their employer. They can be written to apply only to employees making above a certain income level. These can be compromise steps to reduce costs for the employer without hurting children and low income members.

A last ditch approach may be to convince the employer to drop spouse coverage entirely. This will allow spouses to go to the exchange for subsidized coverage. This approach is only beneficial if employee incomes are low enough to make subsidized coverage on the exchange affordable. A survey and some analysis will be required to assess this option.

RED FLAG #3

Large employer plans must meet the benefit requirements listed above (free preventive care, no annual/lifetime benefits) but aren’t required to cover “essential health benefits” required for small group and individual plans. This means that large plans aren’t required to cover things like hospital stays, surgery, or drugs. “Skinny Plans” have been created in response to this loophole. These plans fulfill the employer’s requirement to offer coverage under the mandate and (surprisingly!) also allows enrolled employees to avoid penalty payments under the individual mandate. The employer may do one of two things:

- (1) Offer only the “skinny” plan at a very cheap rate. Low-income employees may prefer this bare-bones bones coverage to more comprehensive coverage they can find on the exchange. The employer won’t pay penalties if no employees go to the exchange for subsidized coverage.
- (2) Offer the skinny plan along with a plan that just qualifies as affordable and minimum value. Employees will be blocked from subsidized coverage on the exchange but will have access to the low-cost “skinny” plan.

This is a difficult situation for our low-wage members. It is important that health plans protect employees from catastrophic incidents, which skinny plans do not. However, skinny plans are affordable (\$40 - \$100/month [1]), which may be attractive for low-income employees. The union must look for new options to save the employer money which can be applied to more generous coverage. Low-income employees may qualify for Medicaid which is expanded to 133% of the poverty line in many states. Anyone qualified for Medicaid may enroll regardless of available employer coverage without incurring penalties to the employer. Members moved to Medicaid generate savings for the employer that can be applied to

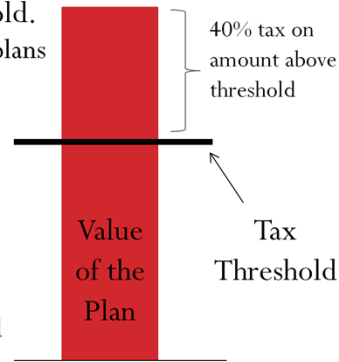
better coverage for the remaining workers. Healthcare.gov will help you find “Navigator” organizations in your area which receive federal grants to go to worksites and sign people up for Medicaid. They’ll be more than happy to help your members determine eligibility.

You should also compare any penalties that the employer might pay for dropping coverage altogether with their costs for “skinny plans.” A case could be made that allowing workers access to subsidized coverage can make both sides better off.

[1] Crawford Advisors “Innovative MEC & Skinny Plans How to Avoid Employer Penalties” September 09, 2014 http://www.crawfordadvisors.com/wp-content/uploads/2014/09/Sept_Webinar_MEC_and_SkinnyPlans_v3.pdf

Health Benefit Tax Overview

- 40% tax on “high cost” health plans starting in ~~2018~~ **2020**.
- Tax will apply to plan value above threshold.
 - Defined for 2018 at for active employees plans at \$10,200 single / \$27,500 family.
 - Retirees: \$11,850 / \$30,950
- Threshold increases annually by CPI
- All contributions count – employer and employee
 - All contributions to health accounts are included
 - Stand-alone dental and vision are excluded
 - Out-of-pocket costs are excluded
- Tax is paid by employer (self-insured) or insurance company (fully-insured)

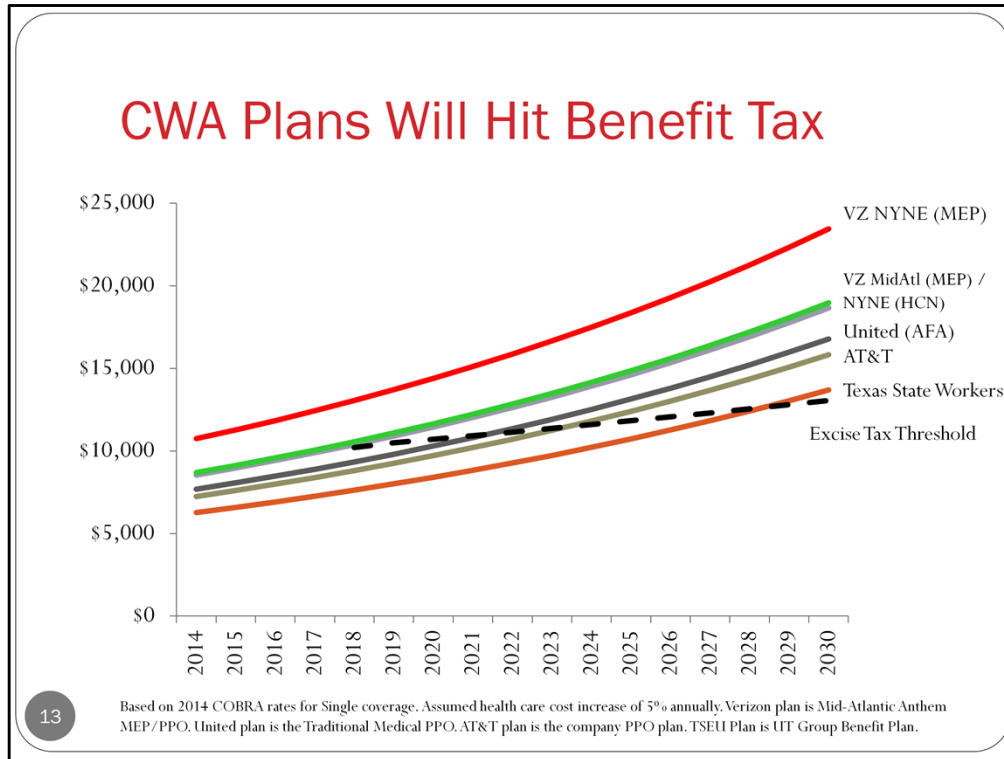


12

The employer mandate is the most important issue for low-wage workers that struggle to receive any kind of health plan from their employer. For workers at the other end of the scale, higher wages and a solid history of generous health coverage, the Health Benefit Tax is the biggest concern.

Beginning in ~~2018~~ **2020** a 40% tax will be levied on any amount of plan value that exceeds thresholds established under the law. For active employees, those thresholds are \$10,200 for single coverage and \$27,500 for family coverage. Retirees are subject to higher thresholds. These thresholds increase annually according to the government’s measure of inflation.

“Plan value” under the law is the equivalent of the total premium paid for fully insured coverage, what the employer and employee together pay for coverage. For self-insured coverage this is equivalent to the amount charged for COBRA coverage . Plan value also includes any amounts contributed to a health account by either the employee or employer. A rule of thumb is that all tax-advantaged funds used by the employee or employer to pay for health care is counted for the tax. Dental and vision coverage is excluded. Out-of-pocket costs paid by employees is also excluded as long as its paid with post-tax money and doesn’t come from a tax-advantaged health account.



The tax thresholds grows by general inflation (CPI) over time. Historically general inflation has been considerably less than the growth in health care costs. This means that more plans will be hit year over year. Researchers have estimated that while only 16% of plans will be hit by the tax in 2018, that number will increase to 75% within 10 years. [1]

This chart shows projections for CWA plans out until 2030. Assuming a moderate level of cost growth (5% per year) even our lowest cost plans are projected to hit the tax at some point. These amounts do not include assumption about health account funds, which would increase the likelihood of hitting the tax.

Company (Plan)	Year Hit	10 Year Tax Liability Per Employee (2018 - 2027)
Verizon NYNE - (MEP)	2018	\$51,578
Verizon MidAtl (MEP)	2018	\$20,190
Verizon NYNE (HCN)	2018	\$18,004
United (AFA)	2022	\$6,926
AT&T	2024	\$3,101
Texas State Employees	2029	\$0

[1] Bradley Herring and Lisa Korin Lentz, "What Can We Expect from the "Cadillac Tax" in 2018 and Beyond?" Inquiry 48: 322–337 (Winter 2011/2012)

Benefit Tax: Red Flags in Bargaining



RED FLAG #1: Employers want ability to make unilateral changes to avoid the tax.

- Reopener language can allow for negotiations to avoid tax
- All cuts to avoid tax should be redistributed to employees in wages or other benefits



RED FLAG #2: Employer is demanding cuts right now to avoid tax in 2018

- Final regulations have not been written
- Age and gender adjustment may change calculation
- Improving health of the workforce will also lower plan cost

14

RED FLAG #1

No employer is planning to pay this tax. Because there are many details about the tax that have not yet been released by the IRS, employers are doing what they can now to give themselves flexibility to avoid the tax in ~~2018~~ **2020**. This means that employers are pushing for language in our CBAs that allows them to unilaterally cut our health benefits to stay under the tax thresholds.

For the union, this is not a process that we can afford to leave to the employer's discretion. Benefit changes motivated by the tax should not be exempted from the bargaining process. Reopener language should give the union access to data that confirms the company's tax concerns and input into plan changes. Provisions we've bargained typically include a bargaining timeline and a process by which a third-party mediator or actuary makes a final decision on benefit changes in case the two parties can't agree.

It's also important that the benefit tax isn't an opportunity for the employer to pocket savings gained from plan cuts. All value lost to members from plan changes should be distributed back in higher wages or other benefit improvements.

RED FLAG #2

Worse than contract language allowing for future cuts are employers that are demanding cuts now to prevent tax payments that are years away. There is too much uncertainty about final regulations on the tax for any current projection of tax liability to be reliable. Important provisions like rules about adjustments to the tax threshold based on the age

and gender of your unit haven't been described by the IRS at all. Any proposal for benefits designed to avoid the tax in ~~2018~~ **2020** is a guess at best.

More importantly, cost shifting in the plan is not the only way to avoid the tax. Plan value is also affected by the health of the population, the way utilization is controlled by the network and the prices paid to providers. Tackling these issues in bargaining can yield savings to the plan without affecting benefit levels. Now is the time, with years remaining until the tax will hit, to tackle these underlying drivers of cost. Benefit reductions should be considered a option of last-resort after other reforms have been attempted.

Wellness Programs Overview

- Two kinds of wellness programs: Health-Contingent and Participatory
 - Health-Contingent programs may be (1) Activity-Only or (2) Outcome-Based
- The value of reward/penalty for health-contingent program can equal 30 percent of the coverage cost
 - 50 percent for programs to prevent or reduce tobacco use
 - Reasonable alternatives have to be offered to individuals who cannot meet specified health-related standard.

15

Due to the potential for health cost savings from improving health, the ACA included provisions that give employers more leeway to offer rewards and penalties for participation in programs that are designed to make enrollees healthier. These programs can take two forms,

- 1) Participatory programs either don't provide a reward or have no conditions for employees to obtain the reward (reduced price for gym memberships, healthy cooking demonstration, etc.)
- 2) Health-contingent programs make an award available and require employees to meet some requirement (steps taken, lower BMI, classes attended etc.) to earn the reward or avoid the penalty

Health-contingent programs can be

- 1) Activity-only, meaning that completion of the program only requires that you complete an activity (attend a class, complete a questionnaire)
- 2) Outcome-based, meaning that you need to achieve some kind of health goal (lower BMI, tobacco free, blood glucose level)

Under the ACA the employers may now increase the size of the reward or penalty they play on health-contingent programs from 20 percent to 30 percent of the cost of coverage. If the program is only available to employees, the limit is 30 percent of the cost of individual coverage. If the program is also available to spouses and dependents, the limit is 30 percent of the cost of whatever coverage in which the employee and dependent are enrolled. And additional 20 percent is allowed (total of 50 percent) for programs aimed at

reducing tobacco use.

HIPAA requires the wellness programs also meet anti-discrimination standards, in that its available to all similarly situated employees and a waiver or alternative program is offered to any employees that cannot complete the requirement.

Wellness: Red Flags in Bargaining

- Well designed wellness programs can reduce costs and improve health for our members
 - Programs that reduce barriers to care and improve medication adherence for those who already have a costly condition (diabetes, heart disease, etc) have the most potential for savings.
 - Programs aimed at already healthy employees that promote preventive care or fitness have less potential for savings



RED FLAG #1: Employer proposes burdensome penalty for wellness participation

- Organizational commitment and responsiveness to employee feedback more likely to increase participation

16

CWA is a proponent of innovative programs that reduce health costs by helping employees improve their health and get the right, cost-effective treatment for their condition. A recent study by the RAND corporation found that disease management program targeting conditions that drive costs (diabetes, heart disease, asthma) were shown to yield a savings of \$3.80 for every \$1 spent on these programs. On the other hand, lifestyle management programs aim at improving fitness and nutrition yielded savings of only \$0.50 for every \$1 spent. [1]

For these programs, employee commitment and participation are the most important drivers of success. Financial rewards or penalties can be a part of encouraging employee participation. There are in our experience, however, more important obstacles that need to be considered. Employers often do not effectively educate workers about program options and benefits. Employees are often suspicious of providing the employer or insurance company with personal health information, despite privacy laws. The local unions can and should be a partner in these efforts to get employees involved in wellness programs.

[1] Rand Corporation. “Do Workplace Wellness Programs Save Employers Money?” Research Brief. (2014).

Health Plan Exchanges Overview

- Employers starting private exchanges that mimic ACA state-based exchanges
- 9 million active employees receive coverage through a private exchange in 2015, 40 million projected by 2018

Active Employees	Medicare Retirees
Walgreens Darden Restaurants Sears Holdings Hilton Worldwide	CenturyLink AT&T General Electric IBM Caterpillar DuPont

17

Accenture estimate of private exchange growth:

<http://newsroom.accenture.com/news/three-million-employees-enrolled-in-private-health-insurance-exchanges-in-2014-according-to-accenture.htm>

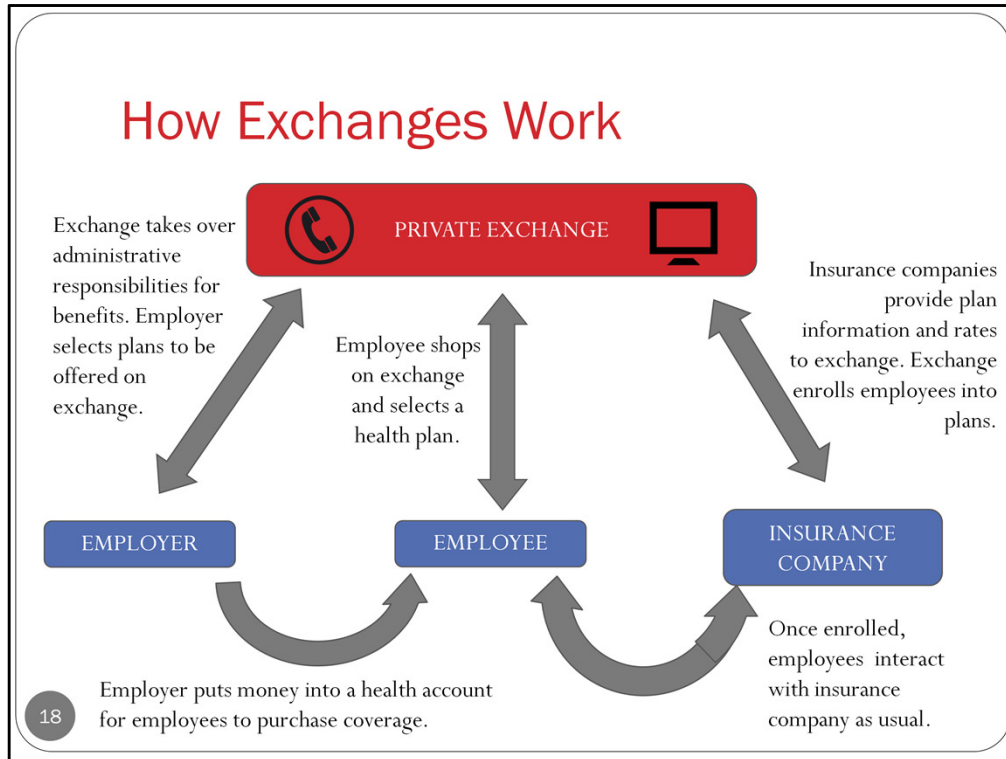
Walgreens, Darden, Sears:

<http://www.forbes.com/sites/brucejapsen/2013/09/17/walgreen-joins-rush-to-employer-exchanges-an-alternative-to-obamacare-marketplace/>

Hilton: <http://aishealth.com/archive/nhex0315-03>

IBM, General Electric, Time Warner: <http://www.bloomberg.com/news/articles/2013-09-09/ge-to-ibm-ending-retiree-health-plans-in-historic-shift>

Caterpillar, Dupont: <http://www.benefitspro.com/2013/09/25/retirees-fear-shift-into-exchanges>



Exchanges are marketplaces where participants can comparison shop for health coverage.

Employers will discontinue their benefit plans and place employees onto a private exchange in order to offload administrative responsibilities and cost. Typically an employer will choose the benefit plans available for employees and designate a certain amount of money each employee will receive to defray the cost of coverage. Employers may place this money into individual health accounts for employees or pay it directly to the exchange once and employee selects a plan.

Employees usually interact with a website and a call center setup by the exchange for help in choosing a plan.

Exchanges: Red Flags in Bargaining



RED FLAG #1: No accountability for benefits administration

- Union should have input in selection process for exchange administrator
- Ongoing oversight established with a joint committee or retiree representative



RED FLAG #2: No increases in employer contributions

- Health care costs will rise every year, employer payments toward coverage must rise as well to prevent gradual cost shift



RED FLAG #3: Employer contributions not portable outside the exchange

Conclusion

- The law creates challenges and new opportunities for our members.
- Don't leave ACA compliance to the employer's discretion
- Focus on “standard-of-living” – health benefits in context of retirement, wages, leave and work rules. Embracing change on health benefits may allow for improvements elsewhere.
- The CWA Research Department is always available to help.