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HEALTH CARE REFORM: Labor Relations Implications for Unionized and Union-Free Employers

The Patient Protection and Affordable Care Act (“PPACA”)\(^1\) enacted by Congress and signed by President Obama in March 2010 imposes significant new procedures and substantive changes on health insurance programs offered by all employers with more than 50 employees.\(^2\) The PPACA requirements are to be phased in over a multi-year period. The initial changes are in 2010-2011 and affect all insurance plans. The second major phase occurs in 2014, with the implementation of state run-insurance exchanges and the imposition of excise tax penalties on employers who either do not offer insurance at all or offer insurance which does not meet certain coverage and cost requirements. The final phase of changes is slated for 2018 when excise taxes are imposed on “Cadillac Plans.” Understanding the changes required by PPACA is a daunting task for any employer. For the unionized employer, this burden is even greater: A unionized employer must bargain regarding changes in insurance programs (or at least the effects of changes mandated by applicable law) or comply with provisions of collective bargaining agreements requiring that it bear the brunt of significant cost increases resulting from new federal mandates. In this paper, we will discuss the timing and requirements of the changes mandated by PPACA, as well as the collective bargaining implications of such changes.\(^3\)

I. The Initial Requirements of PPACA – Applicable Now to All Employers With More Than 50 Employees

A. All Plans

Effective the plan year commencing on or after September 23, 2010, all health insurance plans, including self-insured, fully-insured, and Taft-Hartley plans, are required to satisfy the following conditions:

1. Children up to age 26, even if married, must be considered eligible for coverage.\(^4\)

2. Lifetime dollar limits on essential benefits are prohibited.

3. Exclusions of pre-existing conditions for children are prohibited.

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\(^1\) The legislation is in fact a combination of two distinct pieces of legislation: PPACA, passed by the Senate on December 24, 2009 and signed by President Obama on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, signed into law by President Obama on March 30, 2010.

\(^2\) A full-time employee is defined as one who works more than 30 hours per week. In addition, an employer’s full-time equivalents must be considered. The number of full-time equivalents (“FTEs”) is determined by dividing the total number of hours worked by part-time employees by 120.

\(^3\) This paper does not address PPACA requirements that do not implicate terms and conditions of employment, such as reporting the value of employer provided health care benefits on W-2 forms, disclosure requirements, or other tax issues.

\(^4\) Grandfathered plans are not required to cover children up to age 26 who are eligible to participate in another employer’s plan.
4. Coverage cannot be rescinded except in cases of fraud.

In 2011, flexible spending accounts ("FSAs"), health care spending accounts ("HSAs"), and health reimbursement accounts ("HRAs") may no longer provide tax-free reimbursement for over-the-counter drugs.

B. Additional Requirements of PPACA Applicable as of the First Plan Year Following September 23, 2010 Unless the Plan Retains “Grandfathered” Status

Group health plans in existence as of March 23, 2010 are deemed “grandfathered,” and, thus, not subject to certain requirements of PPACA unless they lose such status. Specifically, grandfathered fully-insured plans are excluded from the law’s prohibition on discrimination in favor of highly compensated employees. (Self-funded plans already are subject to the nondiscrimination rule under the Internal Revenue Code.)

Whether fully-insured or fully-funded, grandfathered plans are also exempt from:

- Prohibitions on discrimination against potential plan participants based on health status.
- PPACA-established limits on out-of-pocket expenses and deductibles, co-insurance, co-payments and deductibles for certain “essential” screening and preventive care.
- Requirements allowing direct access to OB/GYNs.
- Prohibitions on pediatricians serving as primary care physicians.
- Restrictions on payment limitations for emergency services.
- Requirements that plans cover certain clinical trials and related costs.
- Requirements for expanded and more extensive appeal procedures.

Grandfathered status, however, can be easily lost, thus rendering the plan subject to the above requirements as of the first plan year following September 23, 2010. Grandfathered status will be lost for a number of reasons, including:

- Elimination of benefits for a particular condition, including procedures to diagnose or treat a particular condition.
- An increase in the co-insurance charged to employees.
- An increase in deductibles or out-of-pocket limits in excess of 15 percent of the overall medical inflation rate.
- An increase in co-payments for medical services in excess of $5.00 (adjusted for medical inflation) or in excess of 15 percent of the overall medical inflation rate.
- A decrease in the employer’s contribution rate by more than five percentage points below the contribution rate that existed during the period in March 23, 2010.

Fully-funded plans that are not grandfathered may not discriminate in favor of highly compensated employees with respect to eligibility requirements (i.e., waiting periods). Typical plans with stop-loss protections are considered funded plans.
Plans that lose grandfathered status are immediately subject to the various changes required by PPACA on the implementation dates established.

II. **Collective Bargaining Issues Applicable To Unionized Employers**

The unilateral implementation of new terms and conditions of employment to comply with legal mandates does not violate Section 8(a)(5) of the National Labor Relations Act. For example, the elimination of lifetime caps on essential medical benefits, or the extension of coverage for children to age 26, does not require bargaining with a union. However, these mandates add significantly to the cost of providing health care—an increase likely not anticipated by collective bargaining parties when today’s contracts were negotiated. As a result, employers—confronted with an unanticipated increase in labor costs—may seek to shift at least a portion of that increase to their employees. Such a shift in cost, however, cannot be effectuated unilaterally, absent an express waiver by the collective bargaining agent of its right to bargain over the effects of such changes. Thus, in many unionized settings, the costs associated with compliance with PPACA cannot be shifted to employees without the consent of the union or pursuant to a *bona fide* impasse in collective bargaining.

Of course, where a collective bargaining agreement is in place, the ability of the employer to shift costs will be determined by the terms of the collective bargaining agreement ("CBA") itself. For example, if the CBA expressly allows the employer to make unilateral changes in the costs incurred by employees for health insurance (i.e., deductibles, out-of-pocket limits, co-pays) or the level of benefits provided by the plan, the employer may mitigate its cost exposure without the consent of the union. Even in that setting, however, the employer must still comply with notice and other procedural requirements of the applicable contract provisions. On the other end of the spectrum are those collective bargaining agreements that require the employer to fund existing benefit levels regardless of the cost. In such situations, the employer may have no contractual right to pass any of the additional cost to its employees and may be required to absorb the full cost. (To be sure, a union recognizing the economic impact imposed by these changes may, in some cases, be amenable to bargaining over the effect of compliance with PPACA notwithstanding the terms of the collective bargaining agreement.) Between these extremes are collective bargaining provisions that limit the additional cost to be assumed by either the employer or employee or set forth specific cost sharing formulas. In all situations, the employer must have a clear understanding of the requirements imposed by the applicable collective bargaining agreement and comply with those provisions.

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6 The typical estimate is that these mandated benefits will add between one percent and four percent to health care costs over and above projected trends in health care costs.

7 On the flip side, an employer’s exercise of a contractual right to eliminate a particular insurance benefit to reduce costs may result in a request to bargain by a union. Similarly, if an employer provides contributions to an FSA in excess of $2,500.00, such benefit will be taxable to employees as of 2013. A union may seek bargaining over this issue as well.

8 One possible response to a collective bargaining agreement requiring an employer to fund the cost of existing benefit levels is to assert the additional cost applicable to new benefits mandated by the new law are beyond the requirements of the contract. Assuming the contract is both silent on the allocation of costs necessary to provide additional benefits and does not contain a “zipper” clause, an employer could assert that the issue is a mandatory subject of bargaining.
In those situations where the provisions of the CBA addressing health insurance do not provide any specific guidance to the parties, the employer should examine other provisions of the union contract. Specifically, an employer may try to rely on “reopener” language if it exists or a provision in the management rights clause. Even if these provisions do not clearly grant the employer the ability to impose additional costs on employees, they may provide enough language to induce the union to bargain over the issue.

Aside from ascertaining whether it has the right under its collective bargaining agreement to respond to the additional costs resulting from PPACA’s mandated benefits or coverage increases by raising employees’ share of health insurance costs or by reducing benefits, an employer must, at the outset, decide whether or not to do so. Whether an employer is unionized or union-free, as discussed earlier, raising employees’ deductibles, co-pays, out-of-pocket costs or eliminating entire classes of benefits may result in the loss of grandfathered status and the benefits derived from such status. Such cost shifting may also have a negative impact on employee morale and adversely affect employee relations. Accordingly, in determining whether or not to seek relief from the additional costs resulting from compliance with health care mandates by shifting all or a portion of those costs to employees, an employer should carefully consider the impact of such changes in the grandfathered status of its plan and its employee relations.

III. The Next Major Challenge for Employers – 2014

While PPACA presents immediate issues for employers, at their core, these issues generally relate to a common concern: How to address the ever increasing cost of providing health care to employees. Employers need to determine the best short and long-range approach to this issue. With that said, between 2012 and the end of 2013, most of the changes required by PPACA address taxation and reporting obligations, but as a general matter do not impose new substantive obligations on employers.9

The terrain shifts dramatically in 2014 when employers will confront tax penalties for failing to provide health benefit plans with minimum benefit levels at costs to employees below certain thresholds. Employers will be required to decide whether or not it is in their interest to continue to provide health insurance or discontinue employer-provided health insurance and pay the penalty. It is a gross understatement to say that any effort to discontinue health insurance benefits will likely be met with dissatisfaction among employees and strong union resistance.

A. The 2014 Changes

PPACA fundamentally alters the health insurance landscape in 2014. Among other things, states are required to establish insurance exchanges in which individuals and small

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9 In 2013, PPACA imposes some substantive changes that will result in bargaining obligations for unionized employers. Specifically, salary deferred contributions to flexible spending accounts are limited to $2,500.00 annually. The limit is indexed for inflation as of 2014. Employers with FSA programs should be prepared to address this cap in negotiations.
employers can purchase insurance. Although PPACA does not require an employer to provide health insurance for employees, there are tax penalties for large employers who do not provide any health insurance or who provide health benefits to employees that do not meet certain minimum standards. Excise taxes may also be triggered if employees are eligible for tax subsidies based on their income.

1. **Which Employers Must be Concerned**

   Employers who employ an average of 50 full-time employees over the prior calendar year are potentially subject to penalties under PPACA.

2. **Covered Employers Who Offer No Health Insurance**

   A covered employer that offers no health insurance and employs at least one employee who is eligible for a tax credit will be subject to an excise tax penalty equal to $2,000 per full-time employee per year, exclusive of the first 30 full-time employees. Employers are required to pay the penalty on a monthly basis. For example, an employer with 100 full-time employees, one of whom is eligible for a tax credit, will be assessed a penalty of $140,000 ($2,000 x 70 full-time employees) payable in monthly installments of $11,667.00. No excise tax penalty is due on part-time employees.

3. **Covered Employers Who Offer Health Insurance**

   Employers with more than 50 FTEs offering health coverage that meets “minimal essential coverage” requirements may also be required to pay an excise tax penalty if at least one employee has enrolled in an insurance exchange and is eligible for a tax credit. The penalty is $3,000.00 per year per employee eligible for the tax credit. However, the total penalty may not exceed the penalty the employer would have paid if it offered no insurance at all. An employer who offers employer-sponsored coverage will also be subject to the excise tax if the employee’s share of the premium exceeds 9.5 percent of his or her total household income or if the plan fails to cover at least 60 percent of the cost of covered claims.

   As of 2014, employers offering health plans that provide minimal essential coverage must also offer a “free choice” voucher to each employee who opts out of the employer’s plan and whose share of the premium costs of the employer’s plan is more than 8 but less than 9.8 percent of household income and whose household income is less than 400 percent of the federal poverty level. The amount of the voucher must be equal to the largest portion of the employer’s share of health insurance premium costs. Unlike excise penalties,

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10 Employees eligible for a tax credit are those whose family incomes are less than 400 percent of the federal poverty guidelines (currently equal to $88,200 for a family of four).

11 For purposes of calculating the penalty, a full-time employee is one who averages 30 hours of work per week. Since the penalty is paid monthly, the calculation of full-time status is calculated monthly as well.

12 Calculated on a per capita basis, the penalty is $167.00 per month for each full-time employee on behalf of whom the penalty is paid. Since the penalty is not paid for the first 30 full time employees, the effective penalty per full-time employee is even less. In this example (100 full-time employees), the effective penalty per full-time employee is $117.00 per month – significantly less than the typical premium for health insurance.

13 The method for determining this actuarial value will be subject to future regulations.
voucher costs are tax deductible to employers and excluded from employees’ taxable income. Additionally, employees may keep the difference between the amount of a free choice voucher and the amount they spend to purchase insurance coverage in an exchange or elsewhere. However, this difference is taxable income for the employee.

4. **Other Mandates**

Effective 2014, PPACA mandates other changes in health care coverage which will likely further increase the cost of insurance. Specifically, effective 2014 health insurance plans:

- May not have waiting periods in excess of 90 days.
- May not impose annual dollar amounts on essential benefits.
- May not exclude coverage for any pre-existing condition.
- Must provide coverage for participating in clinical trials.

In addition, health insurance plans must provide an “essential health benefits” package that covers ambulances, emergency room care, hospitalization, maternity and newborn care, mental health and substance abuse care, prescription drugs, rehabilitation services, laboratory services, preventive care (including wellness services and chronic disease management) and pediatric services, including oral and vision care. Moreover, a qualified health plan must pay for at least 60 percent of the actuarial value of the benefits provided.\(^{14}\)

**B. Labor Relations Implications for Employers**

The mandates applicable to employers that provide health care coverage in 2014 and the penalties imposed on employers who decide not to offer health care coverage at all may set the stage for a significant confrontation between employers and their employees, both unionized and non-unionized. As shown above, the excise tax imposed on employers opting to end all health insurance coverage is substantially less than the cost of the typical health insurance premium for an individual. Consequently, employers may seriously consider terminating health insurance coverage.

For unionized employers, the decision to terminate health insurance benefits is a mandatory subject of bargaining. Any proposal to do away with health benefits will surely be met with intense opposition from unions. Even if a union is willing to consider the elimination of employer-sponsored health insurance, it will likely seek to capture a part, if not all, of the savings realized for bargaining unit members. Of course, whether unionized or union-free, an employer may be willing to share the cost-savings with its employees so they may purchase insurance on an exchange. In addition, all employers (whether union or non-union) must seriously analyze the impact of the elimination of employer-sponsored health insurance on their ability to recruit and retain qualified employees, morale among the workforce, and other labor-related issues.

\(^{14}\) See note 13 above.
Unionized employers who continue to offer health insurance as of 2014 will also face new bargaining pressures. The continuing rise in health insurance costs will intensify cost sharing issues. Unions will demand that employers accept a larger share of premiums and employers will try to hold the line or reduce their costs. Of course, this discussion will be further complicated by the inability to predict an employer’s exposure to penalties because an employee’s eligibility for tax credits or premium penalties will be predicated not on the employee’s earnings from the employer, but on the employee’s total household income. Moreover, if employees eligible for free choice vouchers abandon an employer’s plan to take advantage of lower cost options on an exchange, the employer may lose discounts predicated on the number of employees participating in the employer’s plan.

Employers participating in Taft-Hartley plans will likely experience even greater resistance from unions as they try to reduce costs. For example, if employees have the option of participating in state exchanges with premium costs lower than the contribution rate paid by an employer to a union welfare fund, employers may reasonably seek to exit the plan. Even if an employer is willing to pay an amount equal to 100 percent of a comparable exchange-sponsored health insurance plan, unions are unlikely to freely give up the institutional dependency employees have on union-sponsored health plans or risk the loss of participants which could threaten the viability of the union plan and its existing infrastructure. Moreover, an employer’s willingness to provide additional compensation for the purchase of insurance on an exchange will not necessarily avoid the payment of excise taxes.

IV. Recommendations and Conclusion

Whether unionized or union-free, employers need to develop a short and long-range approach to health care costs in light of the recent changes in the law. For unionized employers, contracts bargained in 2011 will likely extend into 2014, so planning for the 2014 PPACA-mandated changes should begin now. All employers should analyze their plans to ensure they meet minimum benefit and coverage levels to avoid excise taxes. Employers should also review employee premium costs in an effort to anticipate if employee co-premiums will trigger excise taxes. Finally, employers should estimate the cost of excise taxes should they decide to terminate employer-sponsored health insurance.

To be sure, it may be very difficult to estimate with any degree of accuracy the costs of complying with PPACA. Accordingly, employers should also consider the inclusion of reopener clauses in new union contracts to permit bargaining over health insurance programs in advance of the 2014 changes. While any contract language needs to be suited to the particular situation, sample language may be as follows:

The parties agree that the establishment of state sponsored insurance exchanges pursuant to the Patient Protection and Affordable Care Act (“PPACA”) in 2014 may create an opportunity to provide quality affordable health care coverage to employees on a more cost effective basis for the Employer than has
previously existed. Accordingly, at any time prior to December 31, 2014, either party may reopen this Agreement upon sixty (60) days written notice for the purpose of negotiating changes to Employer’s health insurance plan or the establishment of mechanisms and procedures to provide health insurance to employees through the exchanges in lieu of the Employer’s health insurance plan [or as appropriate, in the case of employers participating in multi-employer health plan, insert the name of the multi-employer plan]. If the parties are unable to reach an agreement on the foregoing, either party, with [insert number of days] days’ written notice may terminate this Agreement in its entirety.

Other options to consider if the parties are unable to agree on new health insurance terms are submissions of the dispute to binding interest arbitration. If this option is agreed upon, the standards for the arbitration should be outlined. Employers may also consider broad language to allow it to unilaterally amend, modify, or terminate its insurance plans.

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PPACA imposes new obligations on employers that will have a significant cost impact on an employer’s health insurance plans. Efforts to shift some portion of the increased costs to employees or exit the health insurance business will likely meet significant resistance. Unions and employees long accustomed to employer-provided or subsidized health insurance are likely to insist employers continue to provide or fund health insurance coverage whether through employer sponsored plans, Taft-Hartley plans, or (as of 2014) state-sponsored insurance coverage. From both a practical and strategic standpoint, all employers should explore their options with labor counsel now. Whether unionized (in which case an employer should get started well in advance of the next round of negotiations) or union-free (where there still are significant labor ramifications with any approach), employers should develop a plan that suits their situation far in advance so that they can make the best long-range decisions for their organization.

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