On October 1, 2013, the window opened on the largest expansion of health insurance for Americans since Lyndon Johnson signed Medicare in 1965. By April 2014, the end of the first open enrollment, eight million people had signed up for health insurance under the Affordable Care Act (ACA), President Barack Obama’s signature accomplishment. Eventually, it is estimated that up to 32 million of 45 million uninsured Americans may sign up for health insurance under ACA.

Is “Obamacare” good for multiemployer funds? That is a question many funds have asked over the last few years. Often, the answer has been an emphatic “no.”

ACA has been very disruptive to most, if not all, Taft-Hartley funds, given the raft of new regulations and fees, higher benefit costs and the constantly changing landscape. Having spent countless hours trying to understand and adapt to the new law, by the 2013 launch, many of us in the union benefits world were exhausted, frustrated, skeptical and feeling a bit unappreciated for our roles in already providing health insurance to many millions of union members and their families since the 1940s (with no direct taxpayer funding or federal assistance).

As the administrator of the SEIU Healthcare Illinois Benefits Office, which provides health coverage to about 22,000 union members who take care of children, the elderly, the disabled and others, I tried to approach the advent of ACA with an open mind. It helped that the union and employer association whose representatives governed our two boards of trustees “got it.” They were willing to try something new to take full advantage of the roughly $117 billion per year in new public funding for Medicaid expansion and subsidies to purchase coverage in the exchanges (now called the “marketplace”).

Although some unions lobbied to try to get direct subsidies for their Taft-Hartley funds, the effort gained little traction from an administration loath to be seen as doing “favors” for labor unions. But were there ways for funds to leverage federal funds indirectly, getting a “piece of the pie” to help our working families even though we had our own union-employer plans? Could that be done without marginalizing our own plans?

Support from the Service Employees International Union proved essential in this effort. SEIU represents health care workers and has long helped lead the fight for national solutions to cover the uninsured. SEIU created a small team led by advocate Kurt Edelman to work on ACA implementation and help locals and benefit plans figure out how best to help its members. SEIU had several national meetings to discuss ideas and followed up with regular conference calls, bargaining manuals and important updates.

In Illinois, our union for years had fought for expanded coverage under the federal State Children’s Health Insurance Program (SCHIP). Under Democratic governors, SEIU had expanded coverage to families above the poverty level, parents of children enrolled in Kid Care, and immigrants with green cards. For several years before the ACA launch, SEIU researchers and I met with Illinois health care officials to try to influence the direction of the state’s program to benefit working people and see whether there was a way to help our own members—and perhaps our own fund.

At the time, our fund provided employee-only coverage to about 20% of the union’s 100,000
dues-paying members—leaving some 200,000 members, spouses and children without coverage through the union.

We had two goals. The first was to use ACA—through the $100 billion per year federal expansion of Medicaid and estimated $17 billion per year in federal subsidies for coverage in the state and federal marketplaces—to help sign up some of the 78,000 SEIU health care members who did not qualify for our plan because of lack of hours, length of time on the job, layoff, disability, aging off of their parent’s plan or Consolidated Omnibus Budget Reconciliation Act (COBRA) expiration. We wanted to provide coverage to the thousands of uninsured family members.

A second—and critical—goal was to salvage our 5,500-member health plan for low- and moderate-income nursing home workers. The plan began in the 1960s when SEIU Local 4 organized nursing home workers in Chicago. The very modest plan had a $35,000 annual limit and other restrictions that would no longer fly under ACA. We calculated that eliminating the annual limit in 2014 and establishing an annual out-of-pocket maximum of no less than $6,350 would blow a $5 million hole in our budget. Employers and employees had no hope of increasing contributions and premiums by that much. Daunting, to say the least.

If we could not come up with a solution, 5,500 nursing home workers would lose the plan they had depended on for nearly 50 years.

I met with employer trustees to test the waters. They immediately made it clear they wanted to continue to provide health insurance to employees for moral reasons, to attract and retain a quality workforce, and to avoid future ACA
penalties. They were willing to help pay for the improved plan but could not or would not pay the entire freight. They also endorsed the idea of helping to move employees and dependents off of our plan to Medicaid and the marketplace, where appropriate, and to use state or federal grants to help do so, if possible.

Instituting a small, affordable monthly premium for all employees would help raise some revenue. The premium also would be an incentive for members who qualified for Medicaid to move to that no-cost federal plan, which charged virtually no out-of-pocket costs. For our plan, it was important to keep the premium affordable so members would still take coverage and also keep out-of-pocket costs low enough so they wouldn't be afraid to use their benefits. Experience had shown that if the costs were too high, employees would simply avoid going to the doctor.

We started running numbers internally and with the help of consultants. For hours we worked with a local SEIU researcher crunching census data to figure out how many members might qualify for the new Medicaid expansion. (The average nursing home employee makes less than $11 an hour, although many of the employees who enroll in the fund health insurance are at the higher end of the scale near $15.) We estimated family size, the number of earners and their wages to arrive at an educated guess that about 15% of members might shift to Medicaid. We guessed the new monthly premium would cause another 10% to drop coverage (while not desirable, that was inevitable given the low income levels). That would take us from 5,500 to 4,000 enrollees.¹

Among steps to reduce costs, we:

• Built on the strength of our patient-centered medical home (PCMH) model, where physician services are capitated (formerly a health maintenance organization). We:
  — Created a new brochure with quotes from patients and a more detailed description of services
  — Further improved the medical home benefits beyond the existing 10% difference in benefit levels between the preferred provider organization (PPO) and PCMH plans
  — Increased the premium differential between the PCMH and PPO plans to help shift enrollees to the much less expensive medical home plan. The PCMH premium was set at $9 per month, roughly the cost of the individual penalty in 2014 for not having insurance. This would allow premiums to rise with the penalty or for trustees to argue that the premiums were at a “hold-harmless” level for employees. The PPO premium was set at $36 per month.
  — Narrowed the hospital network for the medical home plan with newly negotiated low-cost agreements and engaged a new lower cost network for the PPO.
• Established a 50% penalty for nonemergency use of emergency rooms
• Eliminated the remaining small amount of dependent benefits, which would not have been ACA-compliant. Instead, we would help dependents sign up for marketplace coverage.

The next step was applying for state grant money allocated under ACA to pay for positions known as navigators or in-person counselors to help members sign up for Medicaid and find coverage for their family members. Grant applications were due several months before launch of the state and federal health care marketplaces in 2013. Despite a tight time line, we sought and secured an $800,000 grant for ourselves and a partner organization, a nonprofit citizens group, and hired a team of five navigators.

Obtaining the grant and putting together the navigator team greatly enhanced our work. Customer service reps were able to redirect phone calls about lost coverage to the navigators. We notified members by mail and phone and during inbound calls about the opportunity to sign family members up for health coverage under ACA. In 2014-15, navigators:

• Spoke at 100 public or union events
• Answered 5,000 inbound phone calls
• Contacted 14,000 members through mail and phone
what’s working

- Interacted with 4,000 union members and their families
- Enrolled 1,500 people in Medicaid and 500 in the marketplace.

Overall in Illinois, about 472,000 signed up for Medicaid and SCHIP and 347,000 signed up for the marketplace insurance.

Virgie Welch of Chicago is single with grown children. She is an SEIU member who works two jobs to make ends meet, taking care of the elderly and disabled through her employer, Help at Home. One job doesn’t offer health insurance, and she doesn’t work enough hours at Help at Home to qualify for the union insurance plan. She applied for Medicaid in 2013 but, after several months of waiting, was denied because her income was considered too high to qualify.

That’s when SEIU navigator Lisa Foreman came into her life. Foreman assisted Welch—who was very skeptical—to enroll in the Illinois Marketplace when it first opened and to choose a Blue Cross plan. Welch would have health insurance and would not owe any tax penalty. She had some difficulties with her coverage after she enrolled, but she trusted Foreman to assist her several times over the last two years.

The Illinois Association of Health Care Facilities and SEIU Healthcare Illinois sent this mailer to nursing home employees eligible for a new and improved health plan.
including when she had to reenroll in 2015. Without Foreman and the SEIU Navigator program, Welch said she never would have signed up for the ACA plan.

While the navigator team did its work, another team did a big launch of the brand-new “Gold-Plated” nursing home plan. We sent mailers encouraging members to “get behind the wheel of your new Cadillac health plan.” To these workers, the new plan certainly felt like a Cadillac, with a deductible of $100-$500, an out-of-pocket maximum of $3,500-$4,500 and no annual limit. Outreach counselors visited more than 100 nursing homes, explaining coverage options and signing up 4,200 new enrollees in about four months through one-on-one and group meetings, fax and mail.

At the end of the first year, the results were in. Improving benefits and reducing the number of enrollees kept our overall costs at about $15 million a year. We had to raise only $1.6 million—about 10% of our budget—in new income from employers and employees. Last but not least, our members had a “Cadillac plan” where in most cases their out-of-pocket costs were very low; a catastrophic illness wouldn’t push them into bankruptcy.

Given the Taft-Hartley world’s struggles with ACA, it is ironic that ACA—along with imagination and a lot of hard work—“saved” the nursing home plan for the SEIU health care union and long-term care employers.

Postscript

The following year we received an ACA grant of about $400,000 and partnered with the Chicago Federation of Labor. It is unclear whether state grants will continue to be offered under Illinois’ new Republican governor. We still plan to have several of our customer service staff maintain their state certification for counseling so that we can continue to assist members and their families whether or not we receive a grant.

Fund offices do not need a grant in order to train their customer service staff to become “certified application counselors.” There is no cost for the training, and the counselors can restrict their assistance to fund members.

ACA has greatly reduced the demand for COBRA coverage. Upon losing eligibility, all members can now be directed immediately to our navigator team, which will help them find other insurance options. In general, the only members who remain on COBRA are those who do not qualify for Medicaid or the marketplace because of immigration restrictions or a wish not to change physicians.

Endnote

1. In our plan, enrollment has always been required for coverage to take effect. To save money, we do not automatically enroll any eligible participants.

Zachary A. Nauth is administrator of the SEIU Healthcare Illinois Benefit Funds in Chicago, Illinois. He previously worked for SEIU locals and the international union in various capacities for 20 years. Nauth is a journalism graduate of the University of Illinois at Urbana-Champaign and has completed the International Foundation Administrators Masters Program (AMP®).