Collective Bargaining Under the Affordable Care Act

by Anusha Rasalingam

Before ACA, unions and employers had far more flexibility in bargaining health care coverage, including how they defined *full-time employee* and when employees became eligible for coverage.
More than five years after its enactment, the Affordable Care Act (ACA) continues to pose challenges for both unions and employers in the collective bargaining process.

Prior to the passage of ACA, unions and employers had significant flexibility in determining which employees would be eligible for health care coverage, as well as the type of coverage they would receive. Now, employers, unions and multiemployer plans are subject to stricter requirements regarding eligibility, coverage and plan design.

While many ACA requirements have been phased in slowly, by the end of 2015, the act’s employer penalties for failure to provide coverage will be in effect. Both unions and employers must be prepared to fully address ACA requirements in collective bargaining.

Not only has ACA challenged unions and employers, but it has added significant complexity to collective bargaining. Prior to ACA, many of the complexities of the Employee Retirement Income Security Act (ERISA) and related health care laws could be handled by ben-
benefits professionals away from the bargaining table. ACA has created a need for greater expertise about its specific requirements on the part of unions, employers and their professional advisors.

The Decision to Provide Health Care Benefits

Unions and employers traditionally have included health coverage in collective bargaining. Under Section 8(a)(5) of the National Labor Relations Act, health and welfare benefits are a mandatory subject of bargaining between employers and unions. Nevertheless, prior to ACA, the decision of whether or not to provide health coverage to employees was left to the bargaining parties.

ACA has fundamentally changed bargaining over whether to provide health care coverage. ACA’s employer mandate requires large employers to offer coverage to at least 95% of their full-time workers. ACA defines a large employer as one with at least 50 full-time or full-time equivalent employees. While the original effective date for this requirement was January 1, 2014, Congress enacted transitional relief, delaying its implementation. For 2015, a large employer is an employer with 100 or more full-time equivalents, and coverage must be offered to at least 70% of employees under ACA. Barring further congressional action, the original requirement of offering coverage to 95% of full-time employees and the inclusion of employers with 50 or more full-time employees will be effective January 1, 2016. Thus, for large employers, there is less flexibility to decide whether to provide health care benefits for full-time employees than there was pre-ACA.

It is important to note that small employers—those employing fewer than 50 full-time employees (for 2015, fewer than 100 full-time employees)—are not affected by ACA. For small employers, collective bargaining over health care benefits is fundamentally the same as it was pre-ACA.

Who Is a Full-Time Employee?

One of the most significant changes to collective bargaining over health care benefits came from an unexpected place—the definition of a full-time employee. Prior to ACA, the definition of full-time employee status, and the wages and fringe benefits associated with full-time status, were negotiated between unions and employers. As many collective bargaining agreements (CBAs) limited certain fringe benefits, including pension and health care benefits, to full-time employees, the definition of a full-time employee—and, in particular, how many hours and which hours counted toward full-time status—was an important issue to be bargained. Frequently, different CBAs defined “full-time” in different ways.

However, ACA defines a full-time employee as an employee who works 30 hours per week on average or 120 hours per month and has required large employers to offer health care coverage to their employees. This has fundamentally shifted the course of collective bargaining for many unions and employers. Whereas before ACA, the definition of full-time was another tool for employers and unions to use in crafting a package of wages and benefits, now the compromises that had previously been struck by bargaining parties have come into question, requiring further adjustments to the total compensation package bargained.

Of particular note is the effect of ACA on part-time workers, especially in low-wage industries. As a general matter, unionized part-time workers have been more likely to have medical coverage than their nonunionized counterparts. Moreover, in many
CBAs, part-time status included individuals working over 30 hours per week, either by setting the threshold for full-time status above 30 hours or by excluding certain types of hours, such as overtime and holiday pay, from the determination of full-time status. ACA requires that all hours of compensation be included, so that the hours worked by these workers would qualify for full-time status. Not surprisingly, a frequent response to this change has been to reduce the hours of these workers to avoid triggering the ACA coverage requirement, resulting in a loss of income and, as discussed below, a loss of health care coverage for these workers.

**When Does Coverage Have to Begin?**

Another significant change is the elimination of waiting periods in excess of 90 days. Under ACA, a full-time employee must receive an offer of coverage no later than the 90th day after he or she meets the other eligibility requirements for coverage. However, these other eligibility requirements have to be more than the mere passage of time and cannot be used to evade the 90-day maximum waiting period requirement of ACA.

Many pre-ACA CBAs provided for much longer waiting periods for employee eligibility for health care coverage. These CBAs also allowed more time to elapse after an employee's date of hire before an employer would be required to make contributions on an employee's behalf. These waiting periods were often a means for employers to lower their costs by limiting their contribution obligation to employees who remained with the employer for longer periods of time.

Similarly, the health plans covering unionized workers—frequently, self-funded multiemployer plans—were designed to account for the particular arrangements in the CBAs between unions and employers. The plans often were structured with waiting periods in excess of 90 days to allow employer contributions to build up for a period before an employee becomes eligible for benefits, thus providing the plan with a stable funding base. ACA’s ban on such waiting periods not only increases employer costs but also cuts into the funding of multiemployer plan benefits.

Thus, post-ACA, bargaining parties must be careful to review not only the CBA provisions governing eligibility for health care coverage but also the plan eligibility requirements to ensure compliance with the 90-day maximum waiting period.

**What Coverage Must Be Provided?**

Perhaps the most striking change ACA has made to collective bargaining is its regulation of the scope of health care coverage provided to employees. Under ACA, employers that are required to provide health care coverage must provide coverage that is “affordable” and provides “minimum value.” An employee’s health care coverage is considered affordable if his or her share for single-only coverage is less than 9.5% of household income. Also, providing minimum value means that the plan must pay for at least 60% of the total allowed costs of benefits provided under the plan. Often, in the collective bargaining context, employers will seek confirmation that the benefit plan offered meets the minimum value standard.

In addition to the obligations placed on employers, ACA also sets minimum standards for group health plans. These reforms include requirements to cover dependent children until the age of 26 and 100% of certain preventive services, as well as prohibitions on lifetime limits, annual limits and waiting periods in excess of 90 days. These new requirements have increased benefit costs significantly. Thus, the imposition of these substantive mandates and, in particular, the elimination of annual limits upset the carefully struck balance made by employers, unions and multiemployer plans in providing meaningful benefits to their participants. This change is particularly striking in the collective bargaining context, as many unionized industries provide health care coverage via self-funded multiemployer plans, which, prior to ACA, had significant flexibility in tailoring their plans of benefits to the contributions provided by employers and the needs of their participant base.

The effect of this change is evident particularly with respect to part-time workers. Pre-ACA, many part-time unionized workers participated in limited scope medical plans known as mini med plans, which no longer are permissible under ACA’s minimum standards. In response, some observers have championed the idea of “skinny plans”—i.e., plans that do not meet all of ACA’s minimum coverage standards, specifically the prohibitions on lifetime and annual limits—as a way for employers to avoid the larger penalties under ACA. Even if employers can avoid penalties in this manner, it is clear that the health insurance coverage or group health plan would still violate ACA and trigger penalties for any applicable violations.

Another consideration for unions and employers is the effect of requiring employee copremiums for coverage. Tradi-
tionally, many unionized groups have not included employee copremiums for health care coverage, and many employers with unionized employees have not set up appropriate mechanisms for employees to make pretax contributions for health care coverage. As a general matter, a cafeteria plan, set up under Section 125 of the Internal Revenue Code, is the appropriate vehicle for collecting and transmitting pretax contributions from employees and is easily set up by most payroll companies. But for unions and employers already grappling with significant change in this arena, it’s an important detail to be remembered.

Who Is Responsible for Penalties?

A large employer that fails to offer affordable, minimum value coverage to at least 95% of its full-time employees faces potential penalties under ACA. If an employer fails to offer health coverage to at least 95% of its full-time employees and at least one full-time employee obtains subsidized coverage in the health insurance marketplace, the penalty is $2,000 times the total number of full-time employees employed by the employer, excluding the first 30 employees. Employers must pay this penalty for every employee, even the ones who were offered coverage.

If the coverage an employer offers to its full-time employees and their dependents is not affordable or does not provide minimum value and at least one full-time employee obtains subsidized coverage in the marketplace, then the employer will be assessed a penalty equal to $3,000 times each full-time employee who receives subsidized coverage in the marketplace (with a maximum of the penalty amount that would have been due if the employer did not offer coverage).

Predictably, the potential for these penalties has left many employers concerned about their liability for coverage negotiated in collective bargaining. As a result, employers, unions and health care plans (multiemployer plans in particular) have engaged in greater information sharing regarding the type of coverage provided and data required for ACA compliance. While providing information in the context of collective bargaining is to be expected, it is useful to remember that the obligation to provide benefits and liability for the attendant penalties for failure to do so rest solely upon the employer.

Final Checklist for Bargaining Parties

When bargaining health care benefits, there are a number of new questions and concerns that unions, employers and their professional advisors must review. When considering CBA provisions regarding health care coverage, the parties should ask the following questions:

- Is the employer a large employer?
- Is coverage being offered to 95% of full-time employees?
- Does the definition of full-time employee match ACA?
- Are all hours counted toward determining full-time status?
- Is there a waiting period in excess of 90 days in the CBA?
- Does the health plan have a waiting period of more than 90 days for coverage to start?
- Is the coverage affordable and does it provide minimum value?
- Does the health care coverage comply with ACA’s minimum standards?
- Are employee pretax contributions being made through a cafeteria plan?
- Who is responsible for ACA penalties?

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Alson R. Martin, J.D., LL.M. National Underwriter. 2015.

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Endnotes


3. Specifically, the argument is that by offering a skinny plan, an employer can avoid the larger penalty of $2,000 multiplied by all of its full-time employees for failure to offer coverage. In this case employers would risk a penalty only if a full-time employee sought coverage in the health insurance marketplace and received a premium subsidy. Even then, the penalty would be only $2,000 multiplied by the number of employees who seek coverage in the marketplace and receive a premium subsidy.


5. Under ACA, if health coverage is funded solely through employer contributions, the coverage will be considered affordable under ACA. If employees pay a portion of the cost of their health care coverage, the coverage will be affordable if the employee’s contribution for employee-only coverage is less than 9.5% of the employee’s household income.