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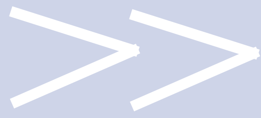

REPORT

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# Health Care Reform: Implications for Collective Bargaining in the Public Sector

By Andrew Malahowski

## I. Introduction

This article analyzes the key rules under federal health care reform which are most likely to impact collective bargaining negotiations in the public sector in the future (or which may already impact current negotiations and labor relations). Part II discusses the law and its enforcement. Part III provides an overview of six key reforms and an explanation of what they mean for public sector employer group health plans. Part IV provides strategies, options, and warnings about how each of these six reforms should be considered in the collective bargaining process.

The Patient Protection and Affordable Care Act ("PPACA") was signed by President Obama and became law on March 23, 2010.[1] One week later, the Health Care and Education Reconciliation Act of 2010 was signed and became law, providing additional modifications to PPACA.[2] Just over one year later, the entire landscape of employee benefits law has changed. PPACA provides a change to the world of employee benefits that is every bit as significant as the Employee Retirement Income Security Act of 1974 ("ERISA").[3] Further, as health care was already a key term in collective bargaining agreement negotiations even prior to the passage of PPACA – and in many negotiations, the key point of contention and cost item – it is not a stretch to state that PPACA is also the most significant labor statute passed by Congress in several decades.

The requirements of PPACA directly influence public sector labor negotiations. While many changes in PPACA are incorporated into ERISA (which does not apply to governmental employer plans), the key provisions of PPACA are also incorporated into the Internal Revenue Code, the Fair Labor Standards Act, and the Public Health Service Act ("PHSA"), all of which apply to public employers.[4] Section 2722(a)(1) of the PHSA, as amended by PPACA, specifically applies PPACA mandates to nonfederal governmental plans and health insurance offered in connection with such plans.[5] Further, while PPACA contains a number of statutory or regulatory mandates for group health plans which will force the hands of employers and unions alike, there are also a large number of choices presented by the law that are within the mandatory bargaining obligation for public employers in Illinois.[6] This article explores the most significant choices that public employers and unions will face under PPACA, and the major tension points that will influence negotiations.

## II. What Is Health Care Reform and Why Does It Matter?

PPACA is 906 pages in length. The Reconciliation Act is an additional 55 pages. Three agencies are responsible for promulgating regulations on health care reform – the Department of Health and Human Services (HHS), the Internal Revenue Service (IRS), and the Department of Labor (DOL). These agencies have jointly issued hundreds of additional pages of regulations, frequently asked questions, notices, and other guidance on health care reform. While the mandates of PPACA are phased in over time through 2018, several of the mandates for employers and group health plans are effective now, with the next "big wave" of regulations becoming effective in 2014. Health care reform compliance has become an all-consuming task for many insurers, health plan administrators, and multiemployer plan boards of trustees – and the mandates we've seen so far are, arguably, the "easy stuff."

While public employers are not

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subject to penalties under ERISA for failure to comply with PPACA, the PHSA applies to state and local governmental plans and imposes a penalty of $100 per day with respect to each individual affected by a failure to comply with PPACA.[7] The penalty applies with respect to any failure "to meet a provision" of PPACA, though mitigation of the penalty may occur where there is a previous record of compliance or based on the gravity of the violation.[8] The penalty does not apply where the failure would not have been discovered by the entity had it exercised reasonable diligence with respect to the issue.[9]

The silver lining of a law that is too voluminous to comply with perfectly, is that the law is too voluminous to be enforced perfectly as well. The first question under the agency FAQs for PPACA, notes that the agencies "are working together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and are working with families and individuals to help them understand the new law and benefit from it, as intended."[10] Therefore, the agencies' approach to implementation "is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law."[11] This approach includes "transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices."[12]

The ultimate constitutional fate of the law is far from settled. Since PPACA was enacted last year, several state attorneys general and private plaintiffs have filed lawsuits in an attempt to overturn it on constitutional grounds.[13] These lawsuits have challenged both the mandate under PPACA that individuals must purchase health insurance no later than 2014 or face fines, otherwise known as the "individual mandate," as well as the law as a whole. Some cases have found the individual mandate to be unconstitutional, but severable from the remainder of the legislation, thus preserving, for example, provisions affecting group health plans and employers.[14] Other cases have found PPACA to be unconstitutional as a whole, under the Commerce Clause.[15] Others have rejected constitutional challenges.[16] Most of the cases that have been decided have been appealed to federal circuit courts, and are awaiting argument or decision. Notwithstanding the foregoing, few if any health plan administrators, employers, and insurers are willing to rely on the decision of any court short of the U.S. Supreme Court to avoid compliance with PPACA.

Despite lingering hopes (or fears) concerning the law's constitutionality, employers are already engaged in collective bargaining for contracts that will extend into 2014 and beyond, critical years under PPACA. The time is now to grapple with the major elements of PPACA that will affect public sector employer collective bargaining in the future.

## III. Six Not-So-Easy Pieces

A large portion PPACA's 906 pages provides rules on public plans such as Medicare, the insurance market in general, and individual health coverage mandates for taxpayers. The rules for employers and employer group health plans are relatively minor in scope by comparison. However, the mandates for employers and employer group health plans create a sizeable "to do list" for employers that seek to bring their plans into compliance with the Act. The following is a discussion of the six rules under PPACA that are most likely to materially influence collective bargaining agreement negotiations.

### A. Grandfathering

The two questions that must be asked first when analyzing an employer group health plan's compliance with PPACA are: (1) how much of PPACA applies to the plan; and (2) when do those rules begin to apply. Both of these questions are dependent on one inquiry in particular: whether the plan is "grandfathered." For many employers, this is an inquiry which should have been made already. For employers who wish to retain grandfathering status, it is an inquiry which must be kept in mind when making any changes to the

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plan.

Grandfathering rules are contained in PPACA Section 1251,[17] which provides, "With respect to a group health plan or health insurance coverage in which an individual was enrolled on [March 23, 2010], [subtitle C] and subtitle A . . . shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment."[18] Section 1251(d) provides a separate rule for "health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before [March 23, 2010]."[19] During the debates on health care reform, it appeared that the original intent behind these provisions was to fulfill a promise made by President Obama that "if you like your health plan, you can keep it."[20] On June 17, 2010, HHS, the IRS, and the DOL issued a joint regulatory interpretation of the grandfathering rules that attempted to keep this promise.[21] However, as the agency regulations made clear, grandfathering protection provides relatively minimal protection overall and can be difficult to maintain.

### 1. *When Is A Plan Grandfathered?*

PPACA Section 1251 has been interpreted by the agencies as containing a general grandfathering rule that applies to all group health plans and a more specific provision for collectively bargained fully-insured plans:

*General Plan Grandfathering*

As interpreted by the agency regulations, the general grandfathering rule requires group health plans to have had an individual enrolled in the plan on March 23, 2010.[22] Importantly, each different benefit package offered under a plan (for example, PPO or HMO options) is treated as a separate plan for grandfathering purposes.[23] While general grandfathering protection is easy to qualify for, it is difficult to maintain. General grandfathering protection is lost when certain changes are made to the plan.[24] The agency regulations provide that the following changes will result in a loss of grandfathered plan status under the general rule: (1) elimination of all or substantially all benefits to diagnose or treat a particular condition; (2) any increase in a participant's coinsurance requirement; (3) increases in deductibles or out-of-pocket limits above a certain percentage; (4) increases in co-payments above a particular amount or percentage; and (5) decreases in the employer's share of premiums by more than five percent; and (6) certain changes in annual limits.[25] Each of these "prohibited changes" is measured against the plan that was in effect on March 23, 2010.[26] This essentially means that the plan will only retain grandfathered status under the general rule if the plan design and premium sharing between the employer and employees remain essentially "frozen" (subject to some wiggle room to reflect permissible changes up to a specific percentage or amount) at the design and premium rules in effect on March 23, 2010.

*Collectively Bargained Plan Grandfathering*

The grandfather provision for collectively bargained plans simply requires the underlying collective bargaining agreement governing the plan to have been ratified before March 23, 2010.[27] Further, a plan subject to the collectively bargained plan grandfather rule is not prohibited from making the changes applicable to plans grandfathered under the general grandfathering rule.[28] A collectively bargained plan therefore retains its grandfathered status until the termination of the underlying collective bargaining agreement(s).[29] Importantly, the collectively bargained grandfather rule does not apply to self-insured plans (although the general grandfather rule may still apply).

While a self-insured plan can only be grandfathered under the general rule, a fully-insured plan subject to a collective bargaining agreement could gain the benefit of grandfathering under either rule (or both of them).[30] The regulations clarify that a collectively bargained plan that is fully insured and that loses its grandfathered status following the termination of the underlying collective bargaining agreement may then qualify under the general grandfather rule based on a comparison of the terms of the plan at the termination of such agreement and the terms that were effective on March 23, 2010.

### 2. *What Protection Does Grandfathering Provide?*

What provisions of PPACA are actually grandfathered? Unfortunately, the answer isn't particularly palatable to employers: only a few provisions are grandfathered. Grandfathering protection under Section 1251 is limited to Subtitles A and C from Title I of the Act.[31] To put this in perspective, out of the 12-page table of contents containing all of the provisions in PPACA, only approximately one and a quarter pages contain items that are grandfathered. To make matters worse, five additional provisions in Subtitles A and C were removed from grandfathering protection by the Reconciliation Act.[32] What employers and their unions must understand is that a grandfathered health plan does not avoid PPACA.

A grandfathered health plan simply avoids a few provisions of PPACA.

The DOL maintains a list of the PPACA mandates that are subject to grandfathering protection.[33] The full list is not discussed at length in this article. Most employers that have grappled with the grandfathering question have settled upon two provisions in particular as being the most important. First, as discussed in greater detail in Section III.B below, grandfathered health plans are exempt from certain mandatory claims and appeals procedures mandated by PPACA. Second, grandfathered health plans are not required to offer preventive coverage at 100 percent (i.e., with no co-pays, deductibles, or coinsurance). Many employers have found each of these mandates to be particularly burdensome and/or costly.

### 3. *Is Grandfathering Worth It or Not?*

Most employers have already answered the initial question of whether they would have a grandfathered plan quite simply, by realizing that they had no immediate intention to alter or amend existing plan terms. If that is the case, the employer's plan would be grandfathered (at least for the time being). The grandfathering question is more relevant for employers who are looking forward several years – especially those who are engaged in collective bargaining agreement negotiations for a multi-year contract. Employers sometimes take the position that the plan must qualify for and maintain grandfathering protection at all costs, as long as possible. However, the better view might be to conceive of grandfathering as a delay tactic. By keeping a grandfathered plan for at least 2010 and 2011, for example, the plan administrator is able to get a better handle on the first significant round of mandates under PPACA, while avoiding the immediate need to implement costly preventive care coverage and burdensome claims and appeals procedures. Further, by remaining open to losing grandfathered status eventually, an employer and its unions are given far more freedom to think critically about the plan's design, and whether premiums, copayments, deductibles, coinsurance, or other plan design changes are warranted in negotiations.

## B. Claims and Appeals Procedures

PPACA provides significant new rules regarding benefit claim and appeal rights for benefit participants, and these rules are generally effective for plan years beginning on or after September 23, 2010.[34] As noted above, the claims and appeals procedures do not apply to grandfathered health plans (until they lose their grandfathered status). Most importantly for public employers, PPACA appears to make the detailed claims and appeals procedures required under ERISA applicable to all non-grandfathered group health plans that are subject to PHSA, including governmental plans.[35] Section 2719(a)(2)(A) provides that "a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503-1 of title 29, Code of Federal Regulations, as published on November 21, 2000."[36] This single sentence of PHSA is loaded with meaning and obligations for employers who were not previously subject to ERISA.

The rules provided under Section 2560.503-1 of the DOL Regulations are familiar to all employers governed by ERISA, but likely not as familiar to public employers. Public sector group health plans are not subject to ERISA directly because ERISA does not apply to governmental plans.[37] A governmental plan is one which is established or maintained for employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing.[38] This rule has long provided a safe haven for public employers from the wide range of reporting and disclosure requirements provided under ERISA, including the claims and appeals procedures provided under Section 2560.503-1 of the DOL Regulations. However, given the incorporation of Section 2560.503-1 into PHSA Section 2719, public employers are now faced with a new universe of regulation governing *all* claims for benefits under their group health plans.

The detailed rules associated with the ERISA claims appeal regulations are beyond the scope of this article. To make a very long story short, the ERISA claims appeal regulations govern both the timing and content of benefit claims decisions.[39] Initial decisions, appeals, urgent care claims, pre-service claims, and post-service claims are subject to differing time limits for initial review and appeals, as well as rights to extend those time limits. If the claim is denied, the plan administrator must send the participant a notice, either in writing or electronically, with a detailed explanation of why the claim was denied and a description of the appeal process. In addition, the plan must include the plan rules, guidelines, protocols, or exclusions (such as medical necessity or experimental treatment)

used in the decision or provide the participant with instructions on how he can request a copy from the plan. The notice may also include a specific request for the participant to provide the plan with additional information in case the participant wishes to appeal the denial.[40] In addition, it is worth noting that PPACA adds certain external review requirements to the existing claims procedures.[41] This cumbersome process creates an additional expense, takes administrative time, and has numerous procedural hurdles that lead to frequent errors in plan administration.

Even though the ERISA claims procedures impose substantial requirements on the plan administrator, they do have advantages for employers if they are adhered to correctly. One advantage is that the claims process provides an efficient vehicle for developing the facts in a case. Additionally, parties get their "day in court" long before any suits are filed. Indeed, in some cases, claimants may be barred from pursuing a civil action if they have not exhausted their remedies under the plan's claims provision. Further, if the plan itself provides for discretion to determine claims and the claims procedures are followed correctly, then the plan's claim decision is typically reviewed under an "arbitrary and capricious" standard of review.[42] In its heyday, the standard was described by defense attorneys with the following often quoted passage from the Seventh Circuit: "Although it is an overstatement to say that a decision is not arbitrary or capricious whenever a court can review the reasons stated for the decision without a loud guffaw, it is not much of an overstatement. The arbitrary or capricious standard is the least demanding form of judicial review of administrative action."[43] Effective use of internal claims procedures can provide a substantial benefit for the constantly vigilant, detail oriented plan administrator.

One final practical point must be noted. Many public sector employers already voluntarily follow the claims procedures applicable under ERISA – either because they maintain an insured plan and the insurance carrier employs such procedures automatically, or because they run all claims through a third party administrator that is familiar with and utilizes such procedures. Therefore, the claims and appeals requirements of PPACA will present the biggest issue for public employers that are self-insured and which self-administer claims to some extent (and this is a small universe of employers). For most employers, even public employers, existing insurers and third party administrators are well-equipped to provide claims procedures that comply with PPACA (and ERISA).

### C. Automatic Enrollment

Under PPACA, employers with more than 200 full-time employees who offer health coverage will be required to enroll all employees automatically in their plan.[44] This mandate actually comes as an amendment to the Fair Labor Standards Act (FLSA).[45] While PPACA itself does not provide an effective date for this rule, the DOL later issued an FAQ explaining that employers will not be required to comply with Section 18A of the FLSA until the DOL issues explanatory regulations.[46] Further, the DOL explained that it intends to complete this rulemaking by 2014.[47] Importantly, plans must comply with the automatic enrollment rules whether they are grandfathered or not.[48]

In the absence of agency regulations on this provision, we only know what the statute and minimal additional guidance tell us. Section 18A does not require an employer to maintain a group health plan for its employees – it only requires automatic enrollment for large employers who actually offer a plan.[49] Further, Section 18A still permits employers to impose a plan waiting period (though that period may be shorter now, as explained in Section III.D, below). The process of providing automatic enrollment involves notice and the opportunity for employees to opt out of coverage. The mandate only requires the automatic enrollment of "new full-time employees" and requires the employer to "continue the enrollment of current employees"[50] (presumably, all subject to opt-out rights on a periodic basis, such as through open enrollment).

The answers to many questions remain unclear in the absence of final agency regulations. Who are "full-time employees"? Which benefit package must be extended to automatically enrolled employees? May the employer create a new (less expensive) benefit package specifically for automatic enrollees? What are the content and timing requirements for any automatic enrollment or opt-out notices? It would be foolish to attempt to bargain all of the specifics concerning automatic enrollment without answers to these questions. Nevertheless, employers with more than 200 full-time employees must consider this rule during negotiations, and how it is likely to impact (and increase) plan participation.

### D. Maximum Waiting Periods

Prior to PPACA, group health plans frequently imposed waiting periods ranging from thirty days to as long as two years. Health plan waiting periods frequently permit employ-

ers to maintain a group health plan for their permanent workforce while giving the employer the flexibility to hire temporary workers at a much lower total cost (i.e., without insurance premium costs or, for self-insured plans, the health costs for such workers themselves). In addition, it is common for employers to tie a probationary employment period with the period necessary to gain coverage under the group health plan. However, for plan years beginning on or after January 1, 2014, waiting periods as a condition for eligibility to participate in a group health plan may not exceed 90 days.[51] The rule prohibiting excessive waiting periods applies equally to grandfathered health plans.[52]

### E. Pay or Play

Contrary to many discussions overheard concerning PPACA, there is no mandate for employers to provide employee health coverage. Employers remain free to offer health coverage for their employees or not. Employees who work for an employer that does not offer a group health plan will be permitted to participate in the state health insurance exchange beginning in 2014.[53] By January 1, 2014, each state must establish an "American Health Benefit Exchange" - a government agency or nonprofit entity, which acts as a government supervised (but not truly government-sponsored) marketplace for insurance products.[54] Further, beginning in 2014 employers with 100 or fewer employees will be permitted to offer employee health coverage directly through an exchange, and in 2017 states may permit larger employers to offer do so.[55]

Therefore, PPACA simply creates insurance opportunities for employers - but a decision not to take any opportunity (i.e., sponsor a group health plan, or offer coverage through an exchange) will come with a price. Instead of forcing employers to provide group health insurance to employees, PPACA taxes employers if they don't offer coverage, or don't offer coverage meeting certain conditions.[56] This tax is commonly referred to as the "pay or play" tax, and is memorialized in a new Section 4980H of the Internal Revenue Code.[57] The tax will begin to apply in 2014.[58] While public employers are exempt from income taxes, we expect that this tax (actually referred to in the Code as an "assessable payment") will apply to public employers. The history behind PPACA does not suggest any removal of public employers from the pay or play tax rules (or the Cadillac plan excise tax, discussed below in Part II.F). Further, where Congress has provided an exemption from taxes for governmental plans or employers under the same Subtitle D of the Code, it has done so explicitly.[59]

An "applicable large employer" (i.e., an employer with at least 50 full-time employees during the preceding calendar year counting all full- and part-time equivalencies), will be subject to pay or play rules.[60] Taxes will apply to such employers if they either offer no coverage at all, or offer coverage that isn't "minimum essential coverage."[61] Further, applicable large employers who offer minimum essential coverage to their employees may still be subject to penalties if any employees decline coverage under the employer-sponsored plan and opt to participate individually in the state health insurance exchange instead.[62] Importantly, the pay or play rules apply regardless of whether the plan is grandfathered or not. The amounts of the penalties depend on the type of coverage offered by the employer, if any, and are as follows:

#### *1. Employers Not Offering Minimum Essential Coverage*

If an applicable large employer does not offer employee health coverage at all, or the coverage offered is not "minimum essential coverage," the employer will be subject to a tax of $2,000 per year for each full-time employee.[63] The first 30 full-time employees are not counted for purposes of the penalty. Technically, the tax only applies if "at least one" full-time employee receives federal health coverage assistance, but that is likely to occur if the employer does not provide any health coverage (or to a lesser degree, coverage that isn't regarded as "minimum essential coverage"). Stated simply, the failure to offer minimum essential coverage results in a "headcount tax," calculated based on the number of employees in excess of 30. The applicable tax amount per employee will be adjusted for inflation after 2014.[64] While the statutory definition of "minimum essential coverage" appears to encompass broadly most employer-provided group health plans, further regulations may add parameters or qualifications to this definition.

#### *2. Employers Offering Minimum Essential Coverage*

If the employer offers minimum essential coverage, but this coverage is either (a) unaffordable (i.e., the premium to be paid by the employee is more than 9.5 percent of the employee's household income); or (b) consists of a plan under which the plan's share of the total allowed costs of benefits is less than 60 percent, then the employer will be subject to a different tax.[65]

The annual tax amount of $3,000 will apply with respect to each employee who opts out of the employer's group health plan and elects subsidized coverage under a state health exchange instead. This penalty is capped at an amount equal to $2,000 per year times the total number of full-time employees in excess of 30.

Obviously, a great deal more information is needed to fully understand the pay or play tax, and whether and to what extent it might apply. For example, how will an employer know its employee's household income? Employers only know how much they pay the employee, not other sources of household income. How is the "60 percent of costs" measurement performed to determine whether the plan is sufficient to avoid a tax? Until regulations are issued, it is extremely difficult to know whether a group health plan will completely avoid the pay or play tax with respect to all employees. Perhaps the only clear rules now, in the absence of regulations, are: (1) employers with fewer than 50 full-time equivalencies are not covered by the pay or play tax; (2) an applicable large employer who offers no health insurance at all will pay the $2,000 headcount tax discussed above; (3) an applicable large employer who offers a rich plan of benefits with low employee premium contributions is likely safe from paying any tax; and (4) an applicable large employer who offers either a limited benefit or charges high employee premium contributions will likely pay a $3,000 tax for a number of its employees that opt out of its group health plan.

### F. Cadillac Plan Excise Tax

Beginning in 2018, group health plans with total premium levels above a specified threshold (e.g., $10,200 for individual coverage, $27,500 for family coverage, both subject to adjustments for inflation) will be subject to a 40 percent excise tax.[66] This tax is commonly referred to as the "Cadillac plan excise tax," and is memorialized in a new Section 4980I of the Internal Revenue Code. The tax expressly applies to governmental plans, pursuant to Code Section 4980I(d)(1)(E).[67] Grandfathered plans are not exempt from the tax. The tax will apply to the total dollar amount of health coverage premium costs which exceed the thresholds above for all covered employees of the employer. While the employer is subject to the tax in the case of a self-insured plan, and the insurer is subject to the tax in the case of an insured plan, it is expected that insurers will pass on any excise taxes directly to employers, or won't offer Cadillac-level coverage in the first place. Obviously, the magnitude of the tax alone makes this a key negotiations subject.

Of particular importance to the public sector is that the dollar thresholds are increased with respect to employers where a "majority of employees covered by the plan are engaged in a high-risk profession."[68] This group of employees includes law enforcement and fire protection employees. The increased threshold amounts are $11,850 for individual coverage and $30,950 for family coverage, both subject to adjustments for inflation.

## IV. What Does PPACA Mean For Collective Bargaining?

The statutory rules and regulatory guidance that are currently available concerning PPACA provide discussion points for – but not all the answers to – collective bargaining agreement negotiations. As of the date of this article, we have no agency regulations at all on the two most significant mandates (the pay or play tax, and the Cadillac plan excise tax) and we have no experience as to how well the State exchanges will be able to deliver health coverage to individuals and small employers who elect to participate. There is also a possibility (perhaps a slim one) that constitutional challenges to PPACA may be successful. Further, there is a possibility (likely a substantial one) that further regulatory developments or even congressional action will change the rules that we think we know now. Therefore, what employers know about PPACA can and should influence collective bargaining, but it is important not to forget Plato's caveat, "I know that I know nothing." Attempting to bargain all of the potential effects and rules of health care reform now could lead to unforeseen and unforeseeable consequences.

What this means in legal terms is that for collective bargaining agreements that extend to 2014, a reopener on health care may be important and useful. Employers and unions will need the flexibility to evaluate the State exchanges to determine whether it would be appropriate to have the employer (if it is a small employer) offer coverage through the exchange. The effectiveness and costs of the State exchanges for individuals will also be relevant in determining whether it is a real option for the employer to not provide group health insurance coverage to employees at all. Employers and unions will need the flexibility to react to the pay or play tax regulations, whenever they are released, so they can determine whether the existing group health plan remains an effective and tax-free way of delivering group health coverage. Both employers and

their unions may decide that offering group health coverage through an employer-sponsored plan is no longer the most effective way to provide benefits to employees. It is possible that the State exchanges will provide a less expensive, quality product. Notwithstanding the foregoing, it is our impression that few employers want to be a "first mover" on the decision to shut down their group health plan and pay the pay or play tax instead. Further, even fewer unions seem amenable to this proposal, especially in the absence of information about the quality of the State exchange system, which would become the primary option for their members to receive health care.

Even if the employer and union wish to continue an employer-sponsored group health plan indefinitely, a reopener would have utility. There are several ways to draft a reopener, but we expect that public employers will want to have some flexibility to react to PPACA mandates. It would not make much sense to continue to provide a group health plan that is deemed "unaffordable" under the pay or play rules (thus triggering an assessment against the employer or its insurer), or is excessively expensive under the Cadillac plan excise tax rules. We expect that employers will ask for the flexibility to avoid this result through language similar to the following: "If additional costs or taxes may be imposed on the Employer as a result of federal health care reform legislation or accompanying regulations, then the contract may be reopened at the request of the Employer to negotiate plan design changes or other health plan terms which will be sufficient to avoid such additional costs or taxes." On the other hand, unions will be interested in protecting the benefits of their members, so other language may be appropriate which accommodates this concern. In either case, it seems reasonable to leave room for plan design changes to avoid taxes and assessments under PPACA that, in the end, will benefit neither the employer nor the union members. If the employer will continue to provide group health coverage to its employees, the bargaining parties should be able to engage in the worthy, collective endeavor of tax avoidance.

Besides determining whether a reopener would be useful, public employers and their unions must weigh the advantages and disadvantages of retaining grandfathering status. As noted above in Section III.A.3, most employers and unions are interested in retaining grandfathered status for a period of time so that the effective date of the more burdensome or expensive PPACA mandates can be delayed as long as possible. However, as long as grandfathering remains a goal of the bargaining parties, the parties must keep in mind the six "prohibited changes" that will spoil grandfathering status for self-insured plans under the general grandfathering rule. These limitations will often force the hand of the bargaining parties. For example, since grandfathering protection is lost if the employer's share of premiums is decreased by more than 5 percent, the range of potential bargaining proposals with respect to employee premiums will be quite small. This may have the effect of driving negotiations towards other economic items over which the parties may have little flexibility. In short, the decision to retain grandfathering status indefinitely may hamstring negotiations over health care considerably.

With respect to waiting periods and automatic enrollment, these mandates may affect an employer's hiring expectations, use of part-time labor, as well as negotiations concerning probationary periods or seasonal work. Before agency regulations are released, there will be a number of unanswered questions on these rules, including whether existing collective bargaining agreement terms will be "grandfathered" from applying these rules during their term, whether and how seasonal employees may be subject to automatic enrollment, and whether employers will still be free to maintain a probationary period for employees with no benefits for longer than 90 days notwithstanding PPACA's maximum 90-day waiting period. However, employers must prepare for the reality that a larger percentage of their workforce will be entitled to coverage under their group health plan.

The one truth that seems crystal clear, even in the absence of regulations, is that health care isn't getting any cheaper for employers. One mechanism within the power of the bargaining parties which may alleviate health care cost increases is to agree upon plan design changes (including increasing co-pays and deductibles, or moving away from 100 percent coverage plans to 90/10 or 80/20 coinsurance levels instead). However, if the bargaining parties are unable to agree upon significant plan design changes, either due to the need to preserve grandfathering or because of member resistance to higher out of pocket costs, the bargaining parties have another option: wellness programs designed to increase the quality of care and decrease the long-term health costs for the plan as a whole. The HIPAA wellness regulations permit incentive-based (or disincentive-based)

wellness programs with precisely this goal in mind.[69] The HIPAA wellness regulations already permit employers to "nudge" participants towards better health by instituting standard-based and other incentivized wellness programs. The use of health risk assessments, diabetes management programs, smoking cessation programs, and maternity management programs are already common in the private sector and are gaining traction in the public sector as well. The HIPAA wellness regulations already permit such programs to reward (or penalize) participants to encourage their participation and adherence to such programs (for example, with dollar incentives, increases in co-pays, increases or decreases in premiums, or the like). The dollar limit on incentives (or disincentives) is currently 20 percent of the cost of coverage.[70] Under PPACA, the dollar limit on incentives (or disincentives) under a standard-based wellness program is increased to 30 percent of the cost of coverage in 2014.[71] This limit may be increased in the future to 50 percent of the cost of coverage, if deemed appropriate by DOL, HHS and IRS. Health plans without any wellness components contain an inherent choice architecture that fosters poor decision making and waste of resources, and therefore increased costs over time. Health plans with wellness programs can begin to influence choice in a legally permissible manner to encourage intelligent participant use of an employer's group health plan. Such programs can decrease participant out of pocket costs as well.

The structure of PPACA creates both winners and losers – through taxes and assessments on employers and insurers which are ultimately used to fund State health care exchanges to be used by individuals and small employers, and through plan mandates that are beneficial for some participants but which may increase health costs for everyone. Employers and unions should seek common ground in negotiations so that they can achieve as many joint victories as possible. ♦

**NOTES**

1. Pub. L. No. 111-148, 124 Stat. 119 (codified in scattered sections of 42, 26, and 29 U.S.C.), *available at* <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>.
2. Pub. L. No. 111-152, 124 Stat. 1029, *available at* http://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf.
3. 29 U.S.C. §§ 1001-1461 (2006).
4. *See* Internal Revenue Code, 26 U.S.C. §§ 1-9834; FLSA, 29 U.S.C. §§ 201-19; PHSA, 42 U.S.C. §§ 201 to 300mm-61.
5. 42 U.S.C.A. § 300gg-21 (West 2011).
6. *Decatur v. AFSCM*E, Local 268, 122 Ill. 2d 353, 364-65,522 N.E.2d 1219, 1224 (1988) ("the mere existence of a statute on a subject does not, without more, remove that subject from the scope of the bargaining duty").
7. PHSA § 2723(b)(2)(C)(i), 42 U.S.C.A. § 300gg-22(b)(2)(C)(i) (West 2011).
8. PHSA § 2723(b)(2)(A), 42 U.S.C.A. § 300gg-22(b)(2)(A) (West 2011).
9. PHSA § 2723(b)(2)(C)(iii), 42 U.S.C.A. § 300gg-22(b)(2)(C)(iii) (West 2011).
10. United States Dept. of Labor, Employee Benefits Security Admin., FAQs About the Affordable Care Act Implementation, Part I, Q1, *at* <http://www. dol.gov/ebsa/faqs/faq-aca.html>.
11. *Id.*
12. *Id.*
13. *See* www.next.westlaw.com (search "Patient Protection and Affordable Care Act" under "All Federal")(last accessed June 20, 2011).
14. *Virginia ex. Rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010).
15. *Florida v. U.S. Dept. of Health and Human Servs.*, Case No. 3:10-cv-91-RV/EMT, 2011 WL 285683 (N.D. Fla, Jan. 31, 2011), *clarified,* 2011 WL 723117 (N.D. Fla. Mar. 3, 2011).
16. *Thomas More Law Center v. Obama*, 720 F. Supp. 2d 882 (E.D. Mich. 2010), *aff'd*, No. 10-2388, 2011 WL 2556039 (6th Cir. June 29, 2011).
17. 42 U.S.C.A. § 18011 (West 2011).
18. *Id.* § 18011(a)(2).
19. *Id.* § 18011(d).
20. *Fact Sheet: Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans*, Health reform. Gov, (no longer updated), http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html.
21. *Id.*
22. 45 C.F.R. § 147.140(a)(1)(i) (2010).
23. *Id.*
24. *Id.* § 147.140(a)(1)(ii).
25. *Id.* § 147.140(g)(1)(i)-(vi).
26. *Id.*
27. 45 C.F.R. § 147.140(f) (2010).
28. *Id.*
29. *Id.*
30. *Id.*
31. 42 U.S.C.A. § 18011(a)(2) (West 2011).
32. 42 U.S.C.A. § 18011 (West 2011 as amended by Pub. L. No. 111-152 24 Stat. 1029 § 2301(a)).
33. The list can be found at: http://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf (last visited June 20, 2011).
34. 42 U.S.C.A. § 300gg-19 (West 2011).
35. *Id.*
36. *Id.*
37. *See* ERISA 29 U.S.C. § 1003(b)(1) (2006). (exempting governmental plans from Title I of ERISA).
38. *Id.*
39. 29 C.F.R. § 2560.503-1 (2010).
40. *Id.*
41. 42 U.S.C.A. § 300gg-19 (West 2011).
42. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).
43. *Pokratz v. Jones Dairy Farm*, 771 F.2d 206, 209 (7th Cir. 1985).
44. FLSA, 29 U.S.C.A.§ 218A (West 2011).
45. *Id.*
46. U.S. Dept. of Labor, FAQS About Affordable Care Pt. V (2011), *available at* <http://www.dol.gov/ebsa/faqs/faq-aca5.html.>.
47. *Id.*
48. 42 U.S.C.A. § 18011(a)(2) (West 2011).
49. FLSA, 29 U.S.C.A.§ 218A (West 2011).
50. *Id.*
51. PHSA, 42 U.S.C.A. § 300gg-7 (West 2011).
52. 42 U.S.C.A. § 18011(a)(4)(A)(i) (West 2011).
53. 42 U.S.C.A. § 18032 (West 2011).
54. *Id.* § 18031(b)(1).
55. Pub. L. No. 111-148, § 1312(f).
56. 26 U.S.C.A. § 4980H (as amended by Pub. L. No. 111-148 124 Stat. 119)(West 2011).
57. *Id.*
58. *Id.*
59. *See, e.g.*, I.R.C. § 4980F(f)(2) (exempting governmental plans).
60. *Id.* § 4980H(c)(2)(A).
61. *Id.* § 4980H(a)(1).
62. *Id.* § 4980H(b)(1).
63. *Id.* § 4980H(c)(1).
64. *Id.* § 4980H(c)(5).
65. *Id.* § 4980H(b)(1); *see also Id.* § 36B(c)(2)(C) (providing the "60% of costs" and "9.5% of household income" rules for premium assistance).
66. *Id.* § 4980I(a).
67. Note also that Internal Revenue Code § 4980I already applies to any group health plan as defined by reference to Section 5000(b)(1). Section 5000(b)(1) itself would include governmental plans, which are only exempt from being considered "group health plans" by virtue of Section 5000(b)(4). Therefore, the express inclusion of governmental plans in Section 4980I(d)(1)(E) is likely a belt-and-suspenders addition by Congress. It is curious that the same addition was not made for the pay or play tax under Section 4980H, through it is probably wishful thinking (and against the plain language of the statute) to conclude that public employers are exempt from pay or play rules.
68. I.R.C. § 4980I(b)(3)(C)(iv).
69. 45 C.F.R. § 146.121(f) (2010).
70. *Id.* § 146.121(f)(2).
71. 42 U.S.C.A. § 300gg-4(j)(3)(A) (West 2011). ♦

## Recent Developments

Recent Developments is a regular feature of The Illinois Public Employee Relations Report. It highlights recent legal developments of interest to the public employment relations community. This issue focuses on developments under the collective bargaining statutes and the equal employment opportunity laws.

## IELRA Developments

### Education Reform Act

On June 13, 2011, Governor Quinn signed into law the Education Reform Act (ERA) of 2011. The ERA consists of two acts, Il. Pub. Act. 097-0008 (also known as SB 7) and Ill. Pub. Act 097-0007 (also known as HB 1197, the "trailer bill"). The Acts contain different provisions for the Chicago Public Schools and all other school districts.

For non-Chicago districts, the ERA amends IELRA § 12(a) to permit either party to petition for mandatory mediation within 90 days of the scheduled start of the school year, as opposed to the previous 45-day window. Newly added § 12(a-5)(1) allows a party to declare impasse, "any time 15 days after mediation has commenced." If, seven days following the impasse declaration, the parties have not reached agreement, each party is required to submit its final offer that includes a cost summary. If there is no agreement seven days later, the mediator must post the parties' final offers and cost summaries on the IELRB's website. In addition, the school district "shall" notify the news media. Fourteen days must elapse following publication of the final offers before the union may lawfully strike.

The ERA amends IELRA § 4.5 which applies to the Chicago Public Schools, to define the length of the school day and the length of the school year as permissive subjects of bargaining.

The ERA establishes separate impasse procedures for the Chicago Public Schools. Under newly added § 12(a-10), following a reasonable period of negotiation, either party may invoke a fact-finding process before a panel of three, one member appointed by each party, and a jointly selected neutral member. Should the bargaining dispute not settle within 75 days from the appointment of the panel, the panel shall issue a private report to the parties containing advisory findings and recommended terms of settlement. Each party has 15 days to submit a notice of rejection, including a rationale for the rejection. If neither party rejects the fact-finding panel's report, the recommended settlement becomes incorporated into the parties' collective bargaining agreement. If there is a rejection of the panel's recommended settlement, the report and notice of rejection shall be made public to Chicago's newspapers. Thirty days following publication, the Union may strike. However, the Union's strike authorization vote must meet the requirements established by § 13(b)(2.10). The final language of § 13(b)(2.10) requires three-fourths of the bargaining unit's employees who are "members of the exclusive bargaining representative have affirmatively voted to authorize the strike; provided, however, that all members of the exclusive bargaining representative at the time of a strike authorization vote shall be eligible to vote . . . "

## IPLRA Developments

### Protected Concerted Activity

In *Joseph and Mitchner and County of Cook*, Case Nos. L-CA-09-046 and L-CA-09-099 (ILRB Local Panel, 2011), the Local Panel held that refusing to submit to a background check in protest of the employer's failure to bargain did not constitute protected concerted activity. The employees were registered nurses working at a hospital that provided medical services for juvenile detainees. The employer instituted a policy requiring all staff having contact with juvenile detainees to undergo general and child abuse and neglect background checks. The employees refused to sign the background check authorization forms until the parties had bargained over the requirement. This refusal ultimately led to the nurses' terminations.

The Administrative Law Judge held that these terminations violated IPLRA §§ 10(a)(2) and (1) but the Local Panel disagreed, stating that while refusing to sign the authorization forms was concerted activity, not all concerted activity is protected. The Local Panel distinguished between protected concerted activity and unprotected insubordination, stating that "[e]mployees' rights to engage in concerted activities must be balanced against the employer's right to maintain order and respect." Because the charging parties' refusal to sign the authorization forms "threatened Respondent's right to maintain discipline in the

workplace," it was not protected under the IPLRA.

### Duty of Fair Representation

In *Chicago Joint Board, Local 200, Retail, Wholesale and Department Store Union v. ILRB*, No. 1-10-1497, 2011 WL 2520139 (Ill. App. 1st Dist. June 22, 2011), the First District Appellate Court upheld the Local Panel's finding that Local 200 breached its duty of fair representation. Local 200 represented a bargaining unit of pharmacists at Stroger and Provident Hospitals. The union grieved the employer's use of an independent management group to perform bargaining unit work at Provident. An arbitrator sustained the grievance and remanded the matter to the parties to negotiate the remedy. The local president, a Stroger pharmacist, negotiated a remedy that paid most of the monetary relief to Stroger pharmacists. The court upheld the Local Panel's findings that the local president manipulated the remedy against Provident pharmacists in retaliation for their having supported his opponent, a Provident pharmacist, in the prior union election; for having opposed ratification of the collective bargaining agreement because they believed it treated Stroger pharmacists more favorably than Provident pharmacists; and for complaining about Stroger pharmacists performing overtime at Provident. The court, thus, concluded that the charging parties had established that the union engaged in intentional misconduct directed at the charging parties in retaliation for their activities.

## EEO Developments

### Class Actions

In *Dukes v. Wal-Mart Stores, Inc.*, 131 S. Ct. 2541 (2011), the United States Supreme Court reversed lower court rulings which had certified a nationwide class action for 1.5 million current and former female employees at Wal-Mart's 3,400 stores. Rule 23(a) of the Federal Rules of Civil Procedure requires that for a class to be certified, the claimants must be so numerous that joinder of individuals is impracticable, the claims raise common questions of law or fact, the claims of the class representatives are typical of those of the class as a whole and the class representatives will fairly and adequately protect the class. Additionally, the class must meet one of the sections of Rule 23(b). In this case, the lower courts certified the class under Rule 23(b)(2) which requires that the defendant's actions be generally applicable to the class so that final injunctive or declaratory relief is appropriate to the class as a whole. Rule 23(b)(2) is the only provision within Rule 23(b) that does not require notice and an opportunity to opt out to all individual members of the class.

The Court held unanimously that Rule 23(b)(2) does not authorized certification when each class member would be entitled to an individualized award of monetary damages, in this case back pay. Written by Justice Scalia, the opinion looked to the history of the rule and noted that none of the cases cited by the Federal Rules Advisory Committee as forerunners of the rule supported combining any claim of individualized relief with a classwide injunction. The court reasoned that the structure of Rule 23(b) also does not allow for the combination of classwide injunctive and individualized monetary relief under Rule 23(b)(2). Such claims must be brought under Rule 23(b)(3) which allows for certification in much wider circumstances and with greater procedural protections, including mandatory to class members and the right to opt out.

The Court divided over whether the class could be certified under Rule 23(a). The Court's ruling heavily stressed the commonality requirement of class action claims. Each plaintiff must show, at the outset, that the claimed bias was targeted at each of them. The Court said that the women's claims did not demonstrate sufficient commonality. The women could not point to a common reason behind each of the decisions affecting them. Their allegation that a corporate culture allowed for bias to be institutionalized in the individual managers' decisions regarding promotion and pay was not sufficient.

The Court opined that the gap between individual work place bias claims and the existence of a class of persons suffering the same injury was largely due to the size of the company, both geographically and in sheer numbers. To overcome this gap, the plaintiffs would need to show "significant proof" that Wal-Mart had a general policy of discrimination. The Court said that the women's statistical proof, anecdotal evidence from employees and a sociologist's testimony that Wal-Mart's corporate culture left them vulnerable to discrimination did not meet this burden. Wal-Mart's announced and enforced anti-sex-bias policy and the decentralized decision making that took place at the local level is the exact opposite of a

general policy of discrimination. In a company of Wal-Mart's size and geographic scope, the Court said, it was "quite unbelievable" that all managers would exercise their discretion in the same way without a common directive. The Court opined that the plaintiff's evidence fell short of proving such common directive.

Justice Ginsburg, joined by Justices Breyer, Sotomayor, and Kagan, dissented. The dissent argued that the evidence offered by the plaintiffs did support a finding that a corporate culture at Wal-Mart was permeated with gender bias. This corporate culture bolstered decision making at the store level that resulted in large discrepancies in promotion and pay for men and women. According to the dissent, such discrepancies could not be explained by "natural variables." The dissent argued that the majority's focus on the dissimilarities of the class overlooked this evidence. Such focus results in Rule 23(a)(2)'s requirement of commonality being no longer easily satisfied. Instead, the Court has subjected it to the rigors of Rule 23(b)(3) and becomes a question of whether a class action is superior to any other mode of adjudication. ♦

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