



## Health Insurance Bargaining Guide April 15, 2024

This guide is for union leaders and negotiators who are bargaining health insurance coverage with their employer. It begins with the least complicated scenario, in which the plan type (health maintenance organization, preferred provider organization or high deductible health plan) and plan design (deductibles, copays, coinsurance and out-of-pocket maximums) are already determined, and the primary goal of bargaining is to set employee premium contributions. The guide expands from there to discuss negotiating plan design changes, plan type decisions and changes in health plans. A sample information request is included that the union may use to obtain the information necessary to bargain over health insurance benefits.

This is intended to be a brief, introductory guide that simplifies many concepts and factors that in the real world can become quite complex. If you have questions while you are bargaining health insurance coverage, don't hesitate to contact the Research and Collective Bargaining Services Department.

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### Types of Health Coverage Available

Health coverage by law generally must include **medical** coverage for doctor visits, hospital care and procedures as well as **prescription drug** coverage for an employer to avoid federal penalties. Some health plans bundle medical and prescription drug coverage into one premium, while other plans separate these costs. Other kinds of coverage, such as for **vision** and **dental** care, are also important benefits for members and their families. Vision and dental care coverage typically makes up a small share of overall health insurance costs.

### Bargaining Over Premium Costs

If the plan types and plan design have already been determined, then the primary economic factor to bargain is the **employee share of premium cost**. Key factors include:

- The employee premium contribution can be a percentage of the total premium, a flat monthly dollar amount or a percentage of salary.
- It's one of the largest paycheck withholdings an employee sees, and it can be costly, especially for family coverage.
- Employers may cite premium increases to justify seeking a higher premium contribution from employees. Health insurance premiums increased at higher rates in 2023 and 2024 than we have seen in recent years. However, the union should get documentation of actual, not just projected, premium increases before deciding on any employee premium cost increases.

- Compare members' premium contributions to those of other bargaining units with this employer and to similar employers in the surrounding area.
- Beware going along with the same employee premium contribution as management employees. Unless it's a percentage of *salary*, premium charges typically represent a greater share of pay for union members than for managers, who are often paid more. By this same logic, low-wage union members will pay a greater share of their paycheck toward health insurance than higher-paid members, unless you negotiate a percentage-of-salary payment.
- Health insurance proposals are often considered alongside the wage increase proposal. When considering these elements together, remember that for virtually all full-time employees, any given percentage of premium will be less than that same percentage of salary, so an employee who receives a 1% raise and pays an additional 1% of health insurance premiums will come out ahead economically. An example illustrates this:

	<b>Annual Amount</b>	<b>Value of 1%</b>
Employee salary	\$50,000	\$500
Health insurance premium – single	\$8,000	\$80
Health insurance premium – family	\$24,000	\$240

Note, an employer may contract with an insurance carrier to cover health costs in a fully insured plan, or instead pay for beneficiaries' health costs as they arise in a self-insured plan. If an employer states that it does not pay health insurance premiums because it is self-insured, you can determine the total premium by asking for the "COBRA rate," which is equivalent to the total premium (with a 2% administrative fee).

### **Bargaining Over Plan Design**

If the union is bargaining over the benefits and costs in a health insurance plan, what is known as plan design, these are the most important factors to consider:

- **Deductibles.** Deductibles are the amount that beneficiaries pay each year before insurance coverage kicks in, except for certain preventive treatments for which plans must pay 100% of the costs. There is usually an amount for each enrolled beneficiary and a total deductible for an entire family, after which insurance begins paying.
  - Higher deductibles mean more out-of-pocket expenses for employees and their families who need care, but lower premiums for everybody.
  - An example of a typical deductible in a Preferred Provider Organization (PPO) plan is \$500 for single coverage and \$1,000 for family coverage per year. Deductibles may be lower or higher than this amount.
- **Copays.** Copays are an amount the beneficiary is required to pay each time they visit a provider or fill a prescription. It is charged as a flat dollar amount.
  - Typical copay amounts are \$20-\$30 for a provider visit, or for a 30-day supply of medication. Better plans offer lower copays, and less generous plans charge higher copays.
  - Drug copays are often tiered between generic, preferred brand and non-preferred brand. For example, generic drugs may be \$10 for a 30-day supply, preferred brands (on the health insurance plan's formulary) may be \$25 and non-preferred brands may be \$50.
  - Specialist provider visits are sometimes higher than primary care copays.

- Emergency room copays are typically \$100 to \$150 but may be waived if admitted to the hospital.
- **Coinsurance.** Coinsurance is a share of the cost of care or a prescription that the beneficiary is required to pay. It is charged instead of a copay.
  - Coinsurance may be charged for particular medical services, such as a 10% coinsurance for radiology (CT or MRI).
  - Coinsurance may also be charged for out-of-network providers in a PPO plan. The same visit may be covered at 100% for an in-network provider (after copay), but 80% at an out-of-network provider.
- **Out-of-pocket maximum (OOPM) or OOP limits.** The OOPM is the maximum amount that a beneficiary may be required to pay for covered medical costs in a year.
  - OOPMs do not affect most beneficiaries, but they can be very important to a few members with high medical costs. Once a beneficiary reaches the OOPM, covered health care is paid 100% by the plan for the rest of the plan year.
  - OOPMs range from approximately \$1,000 for single coverage at the very lowest up to the government cap, which in 2024 is \$9,450 for single coverage and \$18,900 for family coverage.
  - Some plans with significant coinsurance charges have a second, lower OOPM for coinsurance. Beneficiaries who reach this lower OOPM are no longer required to pay coinsurance but continue to be charged copays and prescription drug cost sharing until reaching the full OOPM.

Details about plan design can be found in the summary of benefits and coverage (SBC) for your plan. Note that some plans have separate deductibles and OOP limits for different kinds of care and treatment. For example, some plans have separate deductibles for prescription drugs than for other care.

### **Bargaining Over Plan Choices**

If you are bargaining for a choice of plans, there are usually three plan types that may be available to choose from. The availability and cost of these plan types vary greatly by geographic region, and not all plan types are available in any given location. The most common plan types today are:

- **Health Maintenance Organizations (HMOs)** are plans that generally have a closed network of providers that enrollees must use in order to have medical costs covered. Kaiser Permanente is a well-known example of an HMO.
- **Preferred Provider Organizations (PPOs)** are plans that typically have in-network providers where care is covered at a preferential rate. If enrollees get care from providers outside the network, the PPO may not cover the cost, or may cover it but at a lower percentage.
- **High Deductible Health Plans (HDHPs)** have been gaining in popularity in recent years. These plans require enrollees to meet very high deductibles. In exchange, premiums may be much lower than a traditional PPO or HMO plan. Employers may choose to contribute to an employee **health savings account (HSA)** to offset all or a portion of this high deductible if the HDHP is “HSA-eligible.” To be HSA-eligible, a plan must have at least a \$1,600 deductible for single coverage and \$3,200 for family coverage and cannot have an OOPM greater than \$8,050 for single coverage and \$16,100 for family coverage in 2024. (Note that this OOPM is lower than the federal OOPM that applies to other plans.) Aside from the higher deductible, a HDHP may be structured as a PPO, HMO or another type of plan.

Decisions over plan type offerings can have a significant impact on the health care received by members and how much they pay for that care. Balancing the tradeoffs between lower premiums, access to care and members' out-of-pocket costs requires keen attention to the preferences of the membership.

### Health Care Spending Accounts

In addition to the main health plans outlined above, many employers have introduced special spending accounts for health care into their benefit offerings. Examples include:

- **Health reimbursement accounts (HRAs)** allow an employer to provide an amount it decides upon that employees may draw from to be reimbursed for qualified medical expenses that the employer wants to cover. HRAs can be used to cover a benefit not covered by the health plan, to offset employee out-of-pocket expenses or even pay for premiums in another employer's plan, such as coverage through a spouse's employer. There are also special types of limited purpose HRAs, such as Excepted Benefit HRAs (EBHRAs) to pay for specific types of care and Individual Coverage HRAs (ICHRAs) that allow an employer to pay for premiums to purchase individual coverage on the Affordable Care Act marketplace.
- **Flexible spending accounts (FSAs)** allow the employer or employee to contribute up to a total of \$3,200 in 2024 to cover out-of-pocket health care costs. Employees are allowed to contribute pre-tax dollars to FSAs. Generally, FSA contributions must be used within the plan year, however, an employer may offer a grace period of up to two and a half extra months to use remaining funds or to carry over up to \$640 per year to use the following year.
- **Health savings accounts (HSAs)**, as mentioned above, are funds used by employees enrolled in high deductible health plans to offset out-of-pocket health costs, such as the high deductibles that employees must pay before coverage starts each plan year. The money in HSAs comes from employer contributions, employee contributions or both, plus investment earnings on accumulated account balances. In 2024, HSA contributions are limited to \$4,150 for single coverage and \$8,300 for family coverage. Contributions to HSAs are made on a pre-tax basis and any unused funds can be carried over year to year. HSAs are "portable," meaning that individuals can keep their HSAs even if they change employers or leave the workforce.

HRAs, FSAs and HSAs have many similarities, but one type of account may be more appropriate or more advantageous for any given situation.

### Changes in Health Insurance Plans

If you are bargaining over a change in health insurance plan, then in addition to the factors above, consider the impact of the change on employees' access to health care.

- A new plan will have different providers. Moving from an HMO to a PPO, or vice versa, often requires members and their families to find new primary care providers, specialists, pharmacies and other providers.
- Even if both the old and the new plan are PPOs, the provider network will be different, and members may find the new network does not include their current providers. This forces members to choose between finding new providers and paying more for care.
- When a change in plan is under discussion, the union should review the **network access report** (sometimes known as the provider access report) and the **disruption analysis**. These analyses are

produced by the prospective health insurance carrier based on claims data showing how employees utilized health care services under the existing plan.

- The provider access report compares employees' home locations and in-network provider office locations to identify how many employees may lose convenient access to in-network providers.
- The disruption report calculates how many employees would have to find new providers in order to remain within the new network.

### **Health Insurance Information Request**

The following information request can be used to obtain the information needed for most health insurance bargaining situations.

Please provide the following requested items for each medical, prescription drug, vision and dental plan offered to represented employees.

We request all items be provided in an electronic format. For data tables, Excel spreadsheets or compatible formats are requested.

1. Summary plan description (SPD) and summaries of benefits and coverage (SBC).
2. The plan document, certificate of insurance and contract.
3. Plan brochures, enrollment materials and other distributed documents.
4. Enrollment counts for each plan and each coverage option (employee only, employee and spouse, employee and family, etc.), along with counts of employees that have opted out of coverage.
5. Total monthly premium rate (or COBRA rate if the plan is self-insured).
6. Employee and employer premium contribution rates.

For any plan where the union is negotiating plan design changes or a change in plan, add:

7. Calculated actuarial value.
8. Total employer contributions paid by plan and coverage tier, with a breakout of any premium rebate or discount provided by the insurance carrier or administrator.
9. Total employee contributions paid by plan and coverage tier.
10. For the past year, total employee out-of-pocket payments (deductible, coinsurance, copays) paid by the plan and coverage tier.
11. Any additional utilization studies, cost experience analyses, rate development reports or other evaluative reports regarding the cost and usage of company-sponsored benefits.

If the union is negotiating a change in plan, add:

12. The network access report or provider access report and disruption analysis.

If you have any questions regarding this guide or have specific questions as you bargain health insurance benefits for your members, contact the Research and Collective Bargaining Services Department.