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Peggy Scott

The eyes of the nation are on each year, the magazine recognizes talented and dynamic female executives working in commercial insurance, risk management, benefits management and related fields nationwide. All of us at Blue Cross congratulate Peggy for being honored alongside her exceptional peers. We believe Blue Cross members get the best of both worlds—local, community-based customer service and national-caliber talent like the expertise Peggy Scott brings to her position.

Learn more about Peggy in our Media Center at www.bcbsla.com.

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Since the passage of the Patient Protection and Affordable Care Act (commonly referred to as the PPACA or ACA) on March 23, 2010, how employers create and administer their health plans is dictated by a new set of rules. And yet, the rulemaking process has only just begun. The PPACA, or “health care reform,” will take years to become fully effective and requires thousands of pages of new regulations.

For employers, even health care reform’s simplest sounding concepts and computations can be confusing and complex. So with the deadlines of 2014 fast approaching, the sponsors are presenting the special advertising series Deciphering Health Care Reform, appearing in the March 5, May 28 and Aug. 6 issues of Business Report. All articles can also be found online at try.businessreport/hcr/.

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Measuring health care quality: What everyone should know

By Vindell Washington, M.D., MHCM
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Health care decisions matter. Each time you and your employees choose a physician or hospital for medical care, you want to know you are selecting and spending wisely. As health plan models are changing with higher deductibles, co-pays and premiums, employers and individuals alike are looking at their health care investment with fresh eyes. Today, in large part because of the capabilities of information technology, physicians and hospitals are sharing more information with patients, and that is welcome news. The ultimate goal is for patients to be in a position to make informed decisions about health care.

But how do you know where to look and what is important? How do you assess your health care options when the information you rely upon is often filled with industry jargon and complex calculations? It’s not an easy task because there are so many variables and different approaches to measuring quality.

This article is intended to help employers and individuals better understand the different ways health care is measured, the reasons behind variability in quality data and the information necessary to make informed decisions.

Quality care focuses on processes and outcomes

Quality in health care is measured in two ways: process and outcome. Process measures evaluate whether a provider (doctors and hospitals) follows each step of recommended national guidelines developed to more reliably lead to the best outcome when treating a patient for specific illnesses. For example, Core Measures from the Centers for Medicare and Medicaid (CMS) national standards are process measures because they provide step-by-step directions for caring for patients with certain illnesses or conditions. Taking every step in the core measure process is proven to reduce risk of complications, prevent recurrences and produce positive outcomes for patients admitted for four conditions: heart attack (acute myocardial infarction), congestive heart failure, community-acquired pneumonia and surgical infection prevention. CMS converts the data we submit quarterly into a rate or percentage that shows how well we adhered to the recommended processes in each of the four areas it measures.

The four key outcome measures by which hospitals evaluate commitment to the most positive patient experience possible are complication rates, mortality rates, patient satisfaction and readmission rates. Hospitals with good outcomes add tremendous value to the communities they serve because their patients are likely to recover...
faster and have fewer complications, getting them back on their feet and back to work faster.

Adhering to process and outcome measures is important, yet they do not tell the entire story about the care patients receive. Hospitals treat a variety of patients, and the best achievable outcome can be different for each patient. Two people may have the same condition, but that doesn’t necessarily mean the best treatment for each person is the same.

You can get the right care even if the process score is not perfect. For example, a hospital’s score could be lowered if someone failed to record a step that was taken or if the care team determined that the recommended step was not appropriate for a particular patient. Outcome measurements, on the other hand, evaluate the end result—from a patient perspective. Both measures are important since they combine to determine whether people get the right care. Above all else, the goal for every physician, nurse, health care professional and hospital is to deliver excellent care.

Multiple perspectives in quality assessment

When it comes to quality—as with many areas of health care—there are multiple perspectives of the value of care. A variety of industries and experts from providers to payors to companies have opinions about how quality should be measured, and many have elected to create their own scales or ratings that reflect their point of view or business goal. Today, there is no single national standard or benchmark rating system that is used by everyone. All this information can be confusing.

One reason is that not all ratings measure the same indicators. Most of the measures that are publicly available are not risk-adjusted, meaning they do not take into account a critical set of individual risk factors such as age, severity of illness and additional medical problems that patients might have. This becomes problematic when comparisons between different institutions are made, because it can be an “apples-to-oranges” comparison. Hospitals treat a variety of patients, and the best achievable outcome can be different for each. In turn, the characteristics and health of one hospital’s population could be very different from another.

Due to the fact that measurements focus on different areas, looking at one indicator often is not enough. One-dimensional quality indicators can contribute to misleading conclusions regarding the overall quality of care and are often too narrow to assess the care for the vast majority of patients. When evaluating quality, it is important to remember that there is not one perfect measurement, and in order to make the most informed decision, decision-makers should look at several quality metrics.

Striving for perfection

We know patients rely on our physicians, nurses and hospitals to provide life-saving, quality care. Just like the many businesses with whom we partner, Franciscan Missionaries of Our Lady Health System strives for perfection and makes sure there’s a system in place to get as close to perfect as possible through continual process improvement. In the same way that businesses look to ensure their operations are running well and delivering the highest quality services and goods, we focus on achieving clinical excellence and advancing medicine for the communities we serve.

To meet our goals, we measure ourselves against national standards of best-in-class care. Our teams continuously strive to be better, which is why we do not hesitate to implement changes that will improve our results and processes and publish our data for public viewing. An important part of our quality efforts is a multidisciplinary group of professionals from each of our facilities that assesses areas of strength we can build upon and areas in which we must perform better. If a gap exists in our care approach, we implement solutions that rely upon evidence-based medicine and innovative thinking from our team. Every aspect of care can be analyzed to learn and improve.

Physicians and other clinicians are central to this process because they are the experts when it comes to patient care and finding solutions that work. “Our hospitals have the distinct advantage of operating as part of a health system instead of being stand-alone organizations,” says Dr. Richard Vath, Chief Medical Officer at Our Lady of the Lake Regional Medical Center. “My physician colleagues are committed to continually looking for areas where we can improve processes and outcomes in patient care. Those best practices for quality care can be shared across the system, and lessons learned in one of our hospitals are shared with all the others.”

Sometimes making a simple change can solve a complex problem. For example, precisely limiting the number of days a patient has an IV and removing a catheter as soon as possible can reduce the risk of infections. Using rigorous checklists as well as technology that sends reminders at certain intervals ensures nurses are removing catheters at the earliest and safest time. Also, before a patient leaves the hospital, a nurse or physician takes plenty of time to review discharge instructions with patients and their families in a detailed, clear way. This will improve the likelihood that patients will take their medications correctly once at home, which can contribute to a faster recovery and keep them from being readmitted to the hospital.

“The little things make a big difference when it comes to caring for our patients,” according to Dr. Stephen Hosea, Medical Director, Quality and Patient Safety, Our Lady of the Lake Regional Medical Center. “Training, discipline and constant system improvements transform small changes into important improvements. I think that kind of care environment is what everyone wants when it comes to care for their families.”

Look for yourself

Choosing a hospital or physician is a very personal decision, and each individual has different needs based on their specific illness or condition, potential side effects and even personal preference. Equally important, each hospital serves different medical needs and the degree of complexity and difficulty in treating patients can vary widely.

We encourage you and your employees to review the quality data on our website as well as other provider websites. There are a number of organizations, like Healthgrades and The Leapfrog Group, as well as government agencies, like The Joint Commission and National Quality Forum, that report quality data and evaluate a hospital’s performance. While transparency and the public availability of health care data is important, the amount of information can sometimes be overwhelming and hard to understand. At times, the criteria different organizations use are even in conflict with one another. When making decisions, it’s also important to remember there are other considerations you should take into account, such as matching the services and specialties of a hospital to your needs, selecting a facility that accepts your insurance and determining where your physician is able to admit patients. This information will enable you to have more informed conversations with your physicians and families.

Today’s excellent health care organization welcomes the re-review of quality and performance, as well as the candid dialogue with employers about the evolution of this all-important dimension of decision making. Measuring quality today is not that simple. The doctors and hospitals in our health system are pleased to be partners in their communities and advocates for understandable and relevant health care quality measurement that means better health for all. We look forward to your questions and conversa-

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**COMMON QUALITY TERMS**

- **SEVERITY:** stage or progression of disease (identified by the single chronic condition that has the greatest impact on resource consumption)
- **INTENSITY:** nonclinical factor (e.g., age of patient) that makes treatment require more resources
- **COMPLEXITY:** number and type of chronic conditions present when a patient is admitted that increase amount of care and services a patient receives (e.g., 2 chronic conditions vs. 6 substantial chronic conditions)
- **RISK:** patient characteristics that increase the probability for adverse clinical outcomes (e.g., mortality, complications, readmissions and patient safety events)

*Source: The Delta Group*
Health care reform is on the minds of all Americans, and by year end we will be talking about it all the time; it will be an unavoidable subject. Everyone will be impacted: employers, employees, providers, carriers, brokers and individuals. The decisions employers make and the work they do now will determine whether or not they will succeed in this new market environment. Employers have to fundamentally change the way they view health care to succeed in this new world.

The rising cost of health care is no longer a longer a human resources and benefits concern but an economic issue with far-reaching impact across the entire organization. It is time for employers to start taking control of their benefits programs, crossing your fingers and hoping for a good claims year is not a strategy. We have a broken and wasteful system and people are angry. It is time for employers to focus on their primary challenges, including complying with requirements of health care reform, improving workforce health and productivity, obtaining health care at the best value possible, and containing costs.

With the attention health care will be given, employers have an unparalleled opportunity for doing things that have never been done before for reducing costs and instilling accountability in their employees. There is no “one size fits all” approach. Every employer has strategic options on their table. The cards have been dealt— it is the employer’s decision how to play them and which path they take.

In this installment of “Health care reform: A clear path for employers,” we will discuss various strategies employers can implement in their organizations, as well as important factors to consider when deciding whether to play or pay.

Should I pay or play?
Many employers are grappling with the dilemma of deciding whether they will “play,” meaning continue offering employer-sponsored coverage, or if they will “pay,” meaning eliminating their employer-sponsored health care offering and paying the penalty for not offering coverage.

Eliminating coverage and paying the penalty may sound attractive to many employers, but it is necessary to carefully evaluate all available options and calculate the financial impact of each. Employers must be aware that there are new financial and social implications embedded in the law and there are options available for restructuring benefits beyond dropping or keeping coverage.

In this new world, as employers examine the implications of health care reform for their benefit and workforce strategies, there are many challenges, but there are also opportunities.

Here are some of the issues employers should weigh in their decision to play or pay:

Lost tax advantages. Employers eliminating health care coverage will be missing out on tax breaks (as will their employees). Employer contributions for health care coverage are not considered taxable income to the employee (and are deductible by the employer). Employee premiums that are paid through a Section 125 plan reduce the employee’s taxable income, which reduces both the employer’s and the employee’s FICA tax.

Reporting burdens remain. All employers will face new notification and reporting requirements whether or not they sponsor a group health plan. Employees who are not offered coverage are likely to go to an exchange for coverage. These exchanges will require a variety of employee data from employers, particularly for employees who may be eligible for the premium tax credit, meaning employers will potentially have to deal with a significant number of inquiries from exchanges (staff time, effort, costs). There will also be additional reporting to the IRS.

Loss of social contract between employers and employee. Employers could do long-term damage to their employment brand and reputation by not offering coverage, making it difficult for attracting and retaining top talent in the future. Employers could also lose current employees to organizations providing coverage. Health care reform fundamentally alters the social contract inherent in employer-sponsored health benefits and how employees view health benefits as a form of compensation. Employees who are forced to use exchanges—especially untested or insufficiently staffed exchanges—could feel undervalued or abandoned by their employers.

Penalty increases. Employers who have not properly budgeted for non-deductible penalties may compound their financial burdens, especially if they don’t make long-term plans for penalty increases.

Employers will have to balance remaining attractive to talented workers with the net economics of providing benefits—taking into consideration all the penalties and tax advantages of offering or not offering any given level of coverage.

Taking back control
Employers must start approaching health care in the same manner they approach risk management, compliance and safety. Plan sponsors must take back control of their health care plans by managing eligibility, controlling costs and engaging employees. When employers take control of their health plan, they are able to tie health and productivity together. Employers can manage eligibility through a variety of scenarios, including a spousal carve-out, dependent audits, classifications of employees and restructuring of their workforce. They can control cost through various channels, such as plan design strategies, surcharges and/or incentives as well as utilizing analytics to make better, more informed decisions. They must engage employees through wellness, communication and education strategies.

Incentives
Employers have many opportunities to affect behavior change, with incentives being the most powerful tool in their toolkit. Incentives take on many forms, including educational and awareness-based, action-based, outcome-based and targeted incentives.

Educational and awareness incentives allow companies to offer rewards for completing activities such as health risk assessments (HRAs) and biometric screenings. This type of incentive is a good way to introduce employees to healthy behavior and educate them on their personal risk factors.

A clear path for employers: Part 2, Developing strategies
By Kerry Drake and Stephanie Pennington

PAY OR PLAY?

PLAY
Continue employer-sponsored health plan for all employees with employer contribution

PAY & SUPPORT
Discontinue employer-sponsored health plans, provide some financial support for employees and pay the penalty for not offering coverage

REDIRECT
Restructure contribution strategies for employee-sponsored plans and redirect ineligibles to the exchanges

PAY
Discontinue employer-sponsored health plans with no financial support and pay the penalty for not offering coverage
Action-based incentives allow employees to earn rewards and avoid penalties by taking action for improving their health, such as joining a gym or participating in a weight management or disease management program.

Some companies provide outcome-based incentives such as sorting workers into four premium tiers based on biometric screening performance. The healthiest people get the best rate and individuals with the riskiest health behavior get a higher premium rate.

Companies like Johnson & Johnson provide targeted incentives, giving employees $500 off their annual premium for submitting a health profile. They then use the data for tailoring activities to employees and offering an additional $100-$250 for participation in various activities. Their return on investment is up to $4 for every dollar they spend on their employee wellness program.

Every employer is different and has unique demographics that should be taken into consideration. Health care reform is here, so it is time for employers to get ready for their next steps. Employers should start reviewing and/or developing their compliance strategy. They must also determine how health care reform is going to financially impact their business and create and/or implement a suitable health plan strategy. Employers also need to review the administrative and reporting requirements for how they will affect their human resources and benefits departments. Once a plan is in place, it must be communicated to every employee. Employees will have to be engaged in and accountable for their own health care.

Health care reform calculator

How does an employer choose the appropriate path for their company? Using tools like our health care reform calculator, employers can calculate the financial impact of health care reform on their employer-sponsored medical plan. With this powerful tool, we can help employers project future medical plan costs through 2018. This tool also models the financial impact of various scenarios, including continuing to sponsor a plan for all employees, restructuring contribution strategies and discontinuing plan sponsorship. The tool also estimates the impact of medical inflation and the cost of mandates, taking into account penalties, taxes and other considerations. By understanding the financial impacts, employers are able to make informed decisions and choose the path best meeting their unique needs. Let's look at the fictional example of ABC Company (above).

In scenario 1, the employer has an employer with 300 full-time employees. Currently, 200 of those employees are enrolled in the medical plan, where the employer pays 60% of the total premium. In scenario 1, the employer makes no changes to enrollment, contributions or plan offerings. The projected total cost for the employer increased by 8% in 2014 for those same 200 enrollees, assuming an 8% rate increase.

If we factor in the individual mandate, scenario 2, we see participation has increased by 50 employees. If the employer continues paying 60% of the total premium, the employer's total cost increases over $160,000, or 25.5%, with the addition of those 50 employees.

In scenario 3, the employer decides to no longer offer health insurance and pays a nondeductible penalty of $540,000 for not offering coverage to employees. In this scenario, the employer's total cost increases by approximately 3%. In addition to the increased cost, employees are without coverage and will need to purchase coverage through an exchange.

In scenario 4, the most expensive option, the employer elects to discontinue coverage and pays the penalty for doing so, but it also increases the employees' salaries by the amount of their medical plan contribution. This option almost doubles the employer's total cost when compared with scenario 2.

The calculator makes very conservative assumptions for each scenario. Every employer is different and the scenarios will vary. Not all employers will reach the same outcome as that shown in this example.

*Please note that our health care reform calculator is designed for employers with 50 or more full-time employees based on federal guidance.

Conclusion

The discussion to date has largely focused on dropping versus keeping coverage. Many employers will continue sponsoring group health plans, not making many changes. In fact, some small employers may even be eligible for receiving a tax credit as an incentive for continuing to offer coverage. Other employers will decide to discontinue or not to offer a group health plan and refuse to provide any financial incentives to their employees.

However, for many employers the most value-creating path lies in between. For example, employers may decide to continue to sponsor a group health plan but to make major changes, including restructuring contribution strategies, implementing a wellness program or limiting eligibility and directing certain employees to exchanges. Other employers may discontinue plan sponsorship but decide to provide some form of financial support to their employees as a substitute. Some employers may decide to drop group coverage but begin funding a health reimbursement arrangement (HRA) or increase wages. In many instances, these intermediate options produce the best possible results for the employer and its employees.

Whether a company is poised for shifting from employer-sponsored health coverage or continuing to offer the same benefit package it does now, health care reform will change the economics of its workforce and benefits, as well as how employees value coverage. Understanding these changes at a granular level will enable companies to gain or defend a competitive advantage in the increasingly dynamic market for talent.

In the next installment (Aug. 6) we will focus on how employers can achieve success in this new market environment. We will address steps for achieving an administratively and financially healthy plan, as well as best practices for achieving behavior change—an employer's primary ally for impacting costs—including compliant wellness programs, communication and engagement.

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Why reform will drive up costs and what you can do

By Mike Reitz
CEO & President

Blue Cross Blue Shield of Louisiana

there are large costs connected to having a system in which every person can get health insurance, no matter their age or health issue.

Pre-existing conditions. There are large costs connected to having a system in which every person can get health insurance, no matter their age or health issue. In 2014, there will be no underwriting, so health insurance will be issued to every person. Insurers may no longer exclude or restrict people with pre-existing conditions. This is great news for many who will get the coverage and care they need, but will come at a price to other policyholders, who will be absorbing the cost of this added risk.

Weak mandate. One might argue that the mandate requiring all people to buy health insurance starting in 2014 will help offset the cost of no underwriting. In theory, it was supposed to help, but the mandate is too weak. The fine for not buying health insurance under the law is $95 per person in 2014 (or 1% of taxable income, whichever is greater), $325 in 2015 (or 2%), and $695 in 2016 (or 2.5%). Let’s face it, the size of the fine is small compared to the cost of health insurance.

Essential benefits. Starting in 2014, all health insurance policies sold to individuals and small businesses must offer the same minimum essential health benefits. These policies will contain items and services within at least 10 categories of benefits (ambulatory patient services, emergency room services, hospital services, lab services, maternity and newborn care, mental health and drug abuse disorders, pediatric services, prescription drugs; no cost sharing for preventive care; no annual or lifetime limits on coverage; and a minimum actuarial value of 60%). These extra benefits add to the cost of the policies, as you would expect. Now, individuals and businesses will be forced to buy policies much broader and more costly than what they usually buy. At the same time, the reform law bans certain kinds of more affordable health care plans—like those with very high deductibles.

Age rating. The law sets new limits on how much the cost of health insurance premiums can differ based on a person’s age. As a result, younger, presumably healthier people may be charged a lot more for their health coverage than they pay now, while older people might pay less. The law also says males cannot be charged less than females. These new restrictions on age rating will result in an overnight increase in health insurance costs for people in their 20s and 30s. This increases the chance that younger, healthier people will delay buying insurance until they are sick, and if this happens, costs will go up for everybody.

It seems counterintuitive, but likely, that the healthiest groups may see the largest increases, while the less healthy groups’ premiums may decrease, because health status will no longer be a factor in how they are rated.

New taxes. The new reform law contains a new premium tax on health plans and insurers that will make health insurance more costly for small businesses and individuals. The tax starts at $8 billion in 2014 and rises to $14.3 billion in 2018, increasing annually after that based on premium growth. The Congressional Joint Committee on Taxation has predicted that the tax will add $350-$400 a year to family premiums.

There is some hope here. Congressman Charles Boustany (R-La.), believes the tax threatens to stifle small business growth and has introduced legislation, H.R. 763, to repeal this tax. The ACA limits what health insurers are legally allowed to spend on administration and make in profits. So, it’s vital to know that when rates go up, it’s not because insurance companies are making large profits. It’s because costs are going up. Or because the new law is requiring that the cost of care be shared differently among different groups and those with different health issues.

While we expect challenges ahead, there are some things we can do. Blue Cross and Blue Shield of Louisiana is working with policymakers and regulators to make some changes to the health care laws. We are committed to working with all stakeholders—legislators, providers, businesses, individuals—to find solutions for affordable, high-quality coverage for everybody. We’re also working with our customers to find affordable plans that still meet their needs. We want to make sure that their health insurance works for them and their families, providing them with the safety and security they’ve come to expect from us.

This is key new in this time of uncertainty. That’s why we founded the Louisiana Healthcare Education Coalition, a civic group committed to providing neutral health care and wellness news to the people of our state. The coalition is made of health care providers, small businesses, community leaders and advocacy groups who are devoted to helping people understand health care reform.

So what can businesses do?
• Join LHEC, get involved and learn more about the things that drive up health care costs.
• Focus on wellness. Claims costs drive health insurance premiums; and 70% of all illnesses are preventable. Healthier people need less medical attention.
• Tax credits are available to help offset costs of insurance for some small businesses.

Check with the IRS to see what you might be eligible to get.

• Contact your representative and try to help repeal the premium tax. This will help address at least one of the major factors that will cause premiums to rise in 2014.

We are now just a few months away from the opening of the exchanges or the Health Insurance Marketplace. On Oct. 1, 2014, small businesses and individuals can start to shop on the exchanges (for coverage to begin Jan. 1, 2014). It will be a time of change. But as an insurer with more than 75 years in the marketplace, we will be a resource and support system for our members and community. We have hundreds of authorized Blue Cross brokers around the state standing by ready to answer any of your questions and help guide you.

Our mission is clear and it always has been: to provide affordable access to quality care. We will continue to do this, now and in the future.
Worker classification, workforce restructuring and other problem employees under the ACA

Steve Mehaffey, CPA, JD, and Brandon Lagarde, CPA, JD, LLM

Starting in 2014, the ACA requires employers with at least 50 full-time employees and/or their equivalents (referred to in the ACA as a “large employer”) to offer affordable health insurance that provides a minimum level of coverage or they must pay an excise tax penalty. The ACA adopts the common law definition of an employee. A full-time employee is an employee who performs an average of 30 or more hours of service per week.

For “large employers,” if the employee is not offered health insurance or is offered health insurance that is unaffordable to the employee and the employee receives subsidized coverage through an exchange, the employer will be assessed a penalty.

Many employers are beginning to evaluate the use of “alternative employee arrangements,” such as independent contractors, leased employees, and part-time employees, as a strategy to contain the cost associated with the ACA.

Buyers beware: The use of alternative arrangements may invite scrutiny and the potential for large monetary penalties if these individuals are determined to be employees by the Department of Labor (DOL) or the IRS.

Employers have routinely relied on both independent contractors and temporary staffing to meet their personnel needs. For decades, employers have struggled to classify their workers correctly under federal employment tax law. In recent years, the IRS has made worker misclassification an audit priority. With the addition of the shared responsibility penalties, the financial consequences of worker misclassification have increased significantly. If one independent contractor is misclassified for one year and should have been determined to be an employee by the Department of Labor (DOL) or the IRS, the remedies have been expanded to include compensatory and punitive damages.

The Affordable Care Act raises the service per week. This tactic seems to be particularly popular with governmental employers, colleges and universities, and restaurant employers. Before you consider reducing your employee’s hours, consider ERISA Section 510, which states: “It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against the participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan ... Or for the purpose of interfering with the attainment of any right to which such participant may become entitled to under the plan ...”

While these are fact-specific cases, with many defenses, employers dislike getting tied up in unnecessary litigation. In addition, in some situations the remedies have been expanded to include compensatory and punitive damages.

Prevailing wage employees

One last group of problematic employees that we will discuss is employees subject to the prevailing wage laws of the Service Contract Act, Davis-Bacon Act, or similar law. The prevailing health and welfare fringe benefits under the Service Contract Act can be around $3.71 per hour (or $643.07 per month). The shared responsibility provisions are silent as to how employers may treat this mandated fringe benefit payment when determining whether coverage is affordable. Employers should not have to pay twice for the cost of health care coverage for their prevailing wage employees—once under the fringe benefit payment provisions of the prevailing wage law, and again under the shared responsibility penalties because the worker declines not to use the funds to pay for employer-provided health coverage.

The Affordable Care Act raises the service provider/service recipient relationship to a new level of scrutiny with the potential for significant penalties and the potential for increased litigation. Whether you are hiring a new individual or considering other personnel matters, bear in mind that the ACA presents new traps for the unwary.
An applicable large employer (ALE) can be subject to a penalty for not providing health insurance coverage to certain employees. As was previously discussed in this series, determining whether an employer is an ALE is not a matter of merely counting to 50. In a similar vein, the employer shared responsibility payment (the “penalty”) makes a seemingly straightforward computation—counting the number of full-time employees and multiplying the resulting number by a statutorily designated amount—an exercise in complexity.

The following is not a comprehensive discussion on computing penalties under the PPACA, but is rather to provide employers with an overview of the applicable rules and highlight matters that employers should begin considering to avoid the penalty.

The amount of the penalty differs depending on whether 1) the employer offers any health insurance coverage to its employees or 2) the employer offers coverage, but such coverage is deemed to be either unaffordable or fails to provide minimum value. An ALE that fails to offer health insurance coverage becomes subject to a penalty when at least one of its full-time employees purchases insurance through an exchange and receives a premium tax credit to offset a portion of the cost. The penalty in this case is equal to: (x) the number of the employer’s full-time employees less 30, multiplied by (y) one-twelfth of $2,000 (“failure-to-cover penalty”). Therefore, for a particular month, the penalty is $166.67 for each full-time employee in excess of 30 full-time employees.

An ALE that offers health insurance coverage, but such coverage is unequal or does not provide minimum value, is subject to a penalty when at least one of its full-time employees purchases insurance through an exchange and receives a premium tax credit to offset a portion of the cost. The penalty in this case is equal to: (x) the number of the employer’s full-time employees less 30, multiplied by (y) one-twelfth of $2,000 (“failure-to-cover penalty”). Therefore, for a particular month, the penalty is $166.67 for each full-time employee in excess of 30 full-time employees.

Determining who is a full-time employee

The key analysis for employers computing their PPACA penalty liability is determining the number of full-time employees. To complicate matters, the number of full-time employees used to calculate the penalty is not equivalent to the number of full-time employees used to initially determine whether an employer is an ALE (i.e., the sum of full-time and full-time equivalent employees determined on a controlled group basis).

For the penalty calculation, a full-time employee is any employee that averages at least 30 hours of service per week or 130 hours of service per month. An employer may determine the number of its full-time employees on a month-to-month basis. However, determining whether an employee is full-time on a monthly basis would be administratively challenging for many employers, particularly those without a static workforce. To assist employers with projecting which employees would need to be offered coverage to avoid the penalty or, alternatively, to calculate the penalty liability, the IRS issued safe harbor methods that allows employers to rely on the look-back period on which employers can determine their number of full-time employees.

Overview of safe harbor approach

The safe harbor methods refer to the look-back period used to determine the number of employees that are full-time as the “measurement period.” Every measurement period may have an associated administrative period, but must have a stability period related to it. Once the measurement period ends, an employer has an optional administrative period to determine the number of full-time employees and enroll them in health coverage. Immediately following the administrative period, the stability period begins. During the stability period, any employee that was determined to be full-time during the prior measurement period is treated as a full-time employee in calculating the penalty regardless of how many hours the employee actually works during the stability period.

As represented in Chart 1, these methods set up a recurring cycle of measurement periods that have the basis for calculating penalties. Subject to certain statutory parameters, employers are permitted to choose the length of time for each period. The applicable parameters depend on whether the employee is classified as a) an ongoing employee, b) a new full-time employee, or c) a new variable hour or seasonal employee.

Employees that have been continuously employed by the employer for one complete measurement period are considered ongoing employees. For these employees, an employer may choose a standard measurement period of between three and 12 consecutive months for measuring whether an employee averaged 30 hours of service per week.

At the end of the measurement period, the employer may use a period of up to 90 days as an administrative period. Employers are prevented from dropping coverage during the administrative period for any employee that is covered because he or she was a full-time employee in a prior measurement period. For example, an employer that is determined to be a full-time employee during a measurement period (First Measurement Period), which is the measurement period preceding the current measurement period (Second Measurement Period), to which the current administrative period (Second Administrative Period) relates, must remain covered throughout the entire Second Administrative Period even if the employer determines that the employee was not full-time during the Second Measurement Period.

Again, see Chart 1 to visualize the succession of measurement periods.

An employer would not incur a penalty liability for failing to offer coverage to this employee once the stability period following the Second Administrative Period begins.
The length of the stability period for ongoing employees must be at least six consecutive calendar months and may not exceed 12 months, but may not be less than the length of the measurement period chosen by the employer. Therefore, if an employer chooses a nine-month measurement period, the associated stability period may not be less than nine months.

In contrast to the determination of the stability period that employers are subject to the penalty.

If the employer determines that an ongoing employee averaged at least 30 hours of service per week (i.e., was full-time) during the measurement period, the employer must treat the employee as a full-time employee during the stability period that follows. Employers can change the length of the measurement period and stability period on a go-forward basis, but may not do so once a measurement period has started.

Generally, an employer must use the same length of measurement, administrative and stability periods for all employees. However, employers are permitted to treat the following categories of employees as having different measurement, administration and stability periods:

- collectively bargained employees and noncollectively bargained employees
- each group of collectively bargained employees covered by a separate collective bargaining agreement
- salaried employees and hourly employees
- employees whose primary place of employment are located in different states

New full-time employees

An employer must offer health insurance coverage within three months of hiring a new employee that is expected to be full-time. The IRS identified two factors to consider when deciding whether an employee “is expected” to be full-time: 1) whether the employee is expected to be full-time, and 2) whether the number of hours worked by the employee during the standard measurement period does not exceed 12 months, 2) it begins on or before July 1, 2013, and 3) the measurement period ends no sooner than 90 days before the beginning of the employer’s 2014 plan year.

The effect of the transitional relief is to delay the first date on which an employer with a fiscal year plan may be subject to the penalty. For example, an employer with a plan whose fiscal year begins on July 1, 2013, may use transitional relief under the safe harbors to follow:

- a three-month administrative period beginning on April 1, 2014 and ending on June 30, 2014; and
- a 12-month stability period beginning on July 1, 2014, and ending on July 1, 2015.

As employers are not subject to the penalty until the beginning of the stability period, the employer would have no exposure for the penalty from Jan. 1, 2014, through June 30, 2014.

Employers with a calendar-year plan year will need to determine their penalty liability beginning on Jan. 1, 2014. If an employer elects to take full advantage of the safe harbor regulations and transitional relief, the measurement period has already begun. It could start on April 15, 2013, and end on Oct. 14, 2013. The administrative period could begin on Oct. 15, 2013, and end on December 31, 2013, and the stability period would cover the entire 2014 calendar year.

Whether or not an ALE is ultimately subject to a penalty, they will be required to remit monthly reports to the IRS. Accordingly, an ALE will need to determine the number of its full-time employees in order to ensure such employees are offered coverage and avoid the penalty.

The most important step that ALEs can take at this time is to work with the payroll department to ensure an appropriate system is in place to track the numbers of hours for determining and substantiating employees’ status as full-time or less than full-time. If the employer currently has no mechanism in place to track hours for the PPACA, then the employer needs to immediately begin implementing a system.

Next, an ALE should begin considering which timelines they would like to adopt for the first measurement period, subsequent measurement periods for ongoing employees, and initial measurement periods for variable or seasonal employees. This will allow the employer to project when they would become liable for a failure to comply with the employer mandate to offer health insurance coverage to full-time employees and either avoid such exposure or prepare for it.

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