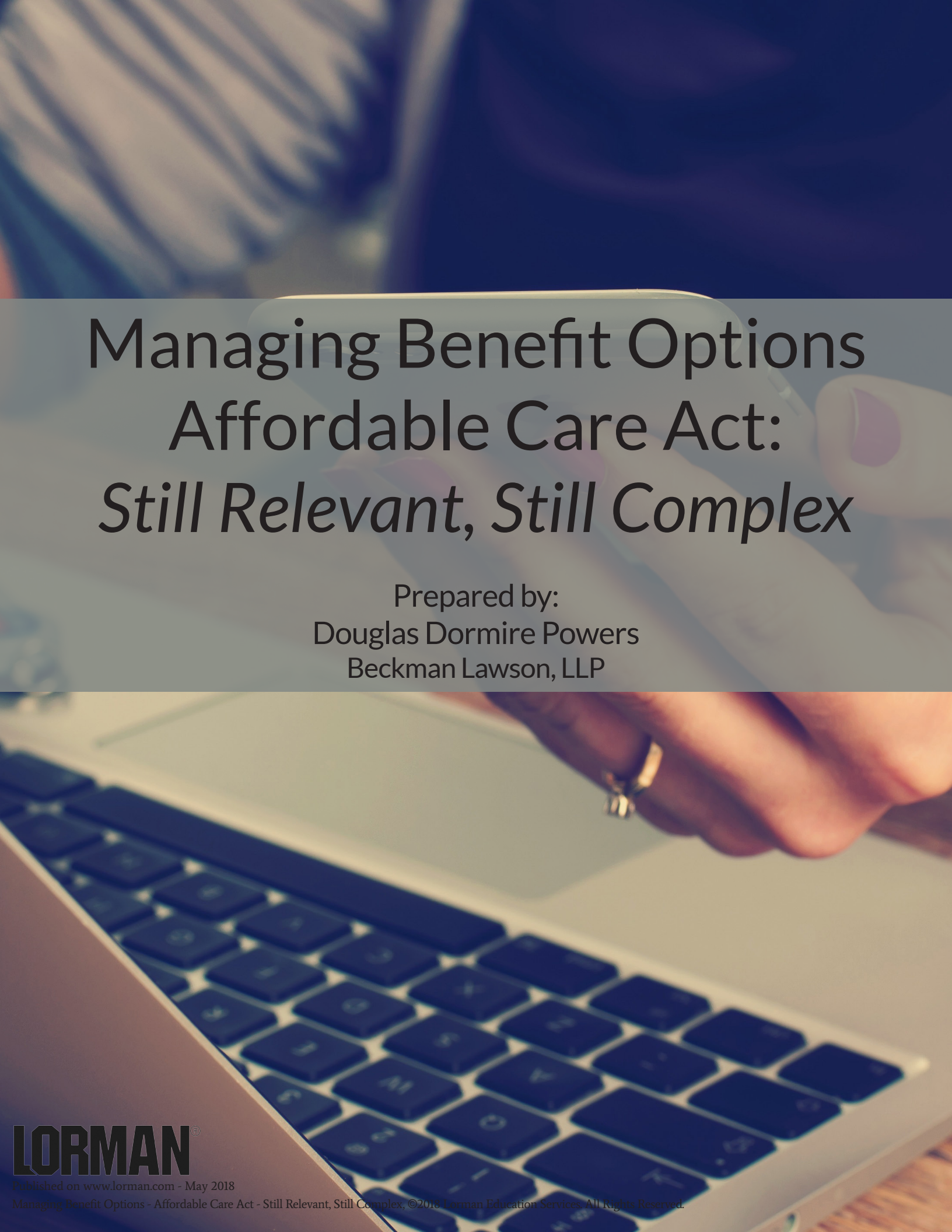

Managing Benefit Options Affordable Care Act: *Still Relevant, Still Complex*

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Managing Benefit Options
Affordable Care Act: Still Relevant, Still Complex

The Patient Protection and Affordable Care Act ("ACA" or "Obamacare") is the most ambitious and complex piece of federal legislation passed since Congress passed the Medicare Act in 1965. Depending on which printed version of the ACA you read, the legislation is between 900 and 2,000 pages long. It represents a complex, interdependent web of reforms of the American health care system.

At its most basic, the ACA can be characterized as a three-legged stool. First, it requires insurers to take on all comers, even those with serious health conditions. Ordinarily, insurers would take into account applicants' health conditions and charge premiums accordingly—sicker people have to pay more. But a related piece of Obamacare is community rating. That means that insurance rates depend on the health experience of all people. Standing alone, this feature would soon drive insurers out of business because healthy people will forgo insurance coverage until they get sick, then sign up for coverage. At that point, this feature looks more like welfare than insurance. In states that have tried this model without more, it has failed.

To counter the possibility of gaming the system in this way, a second feature of Obamacare is the requirement that everyone be covered by health insurance through the individual and employer mandates. That way, the risk of medical costs is spread equally among everyone—young and old, healthy and sick. Opponents of the ACA had high hopes that the Supreme Court would strike down the mandates as unconstitutional extensions of the Constitution's commerce clause. And, in fact, the Supreme Court did reach this conclusion on June 29, 2012. But in a surprise move, Chief Justice Roberts found the ACA's taxes—or

penalties, depending on your point of view—associated with the mandates represented a constitutional exercise of Congress's power to tax and spend.

But many people can't afford insurance, so in order for the individual mandate to work, poorer people need help paying for coverage. The Affordable Care Act solves this problem by providing the third leg of the stool with premium subsidies, cost sharing and expanded Medicaid eligibility. While the Supreme Court's 2012 decision did not result in invalidating the insurance mandates, it did hold that the Medicaid expansion went too far in its threat to yank all federal Medicaid support (typically about ten percent of a state's operating budget) if states "chose" not to participate in the expansion of that program designed to cover individuals whose income fell at or below 138% of the federal poverty level. Many Republican-led states immediately determined that they would not participate in the Medicare expansion because of their opposition to Obamacare as a whole, thereby walking away from federal support that under the ACA initially covered the entire cost of the expansion, and eventually ratcheting down to 90% after a few years.

a. A Word About Repeal, Replace, or Fix

This integrated three-legged stool approach makes sense in theory, but it is still fundamentally a market-based system, so the big issue becomes how to control costs. Under the ACA, cost containment was supposed to occur through enhanced competition among insurers for a huge new market of formerly uninsured people. Funding for government support of Obamacare was supposed to occur through an array of 23 new taxes. Early projections from the non-partisan Congressional Budget Office ("CBO") did not project a neutral cost for full implementation of the ACA, but it did predict substantial cost savings over national healthcare as it existed prior to the adoption of the legislation in 2010.

Unfortunately, both cost containment and revenue-raising features have not performed as expected. Lax enforcement and administrative complexity have induced many healthy young people to ignore the individual mandate, causing a skewed insured population of older, sicker participants and a corresponding increase in premiums. Many insurers have suffered huge losses and exited the exchanges as a result. So much for competition. And the federal government has yet to levy the first penalty against employers who have not complied with the employer mandate. Moreover, Congress has steadily chipped away at many of the taxes that were intended to offset Obamacare's costs, thereby encouraging a self-fulfilling prophecy of failure of the act as a whole.

The highly politicized environment surrounding the challenges of the American healthcare system and the ACA's efforts to address them have made progress difficult to come by. It is highly unlikely that Congress will approve a wholesale repeal of the ACA. Doing so would create a chaotic environment for all constituencies—consumers, providers, insurers, and employers. Whether the current Congress, with or without meaningful guidance and support from the Trump administration, can improve the state of healthcare in the United States is very much an open question. The dynamic of the debate changes almost daily.

Until Obamacare with all its constituent parts, including the employer mandate, either is modified or done away with altogether, it remains the law of the land. Employers, therefore, must continue to configure their healthcare offerings to employees consistent with the ACA's requirements. One of the thorniest problems for employers is how to deal with part-time, seasonal and temporary employees, primarily in two dimensions. First, how does an employer count these workers for purposes of determining whether the employer is an "applicable large employer" ("ALE") subject to the ACA's employer mandate? Second, how does an ALE

determine who among these employees is a "full-time employee" who must be offered healthcare coverage that is affordable and offers minimum value or face the possibility of penalties?

b. Determining "Applicable Large Employer" Status

If an employer has at least 50 full-time employees, including full-time equivalent ("FTE") employees, on average during the prior year, the employer is an ALE for the current calendar year, and is therefore subject to the employer shared responsibility provisions and the employer information reporting provisions, commonly referred to as the ACA's employer mandate. The question is how to count an employer's workforce to make this determination. Under the ACA, an employer must determine the number of FTE employees it has. And here is where things can get complicated right off the bat. Why? Because the ACA contains different definitions for "seasonal workers" and "seasonal employees."

"Seasonal workers" are relevant for determining whether an employer is an ALE. That term is defined as "an employee who performs labor or services on a seasonal basis as defined by the Secretary of Labor." That definition, of course, is found in a different regulation, but can be summarized as an employee who is employed for not more than four months (or 120 days) during the prior calendar year. The ACA regulation further muddies the waters, maybe in a helpful way, by also saying that an employer "may apply a reasonable, good faith interpretation of *seasonal worker."*

Why does any of this matter in determining whether an employer is an ALE? Initially, determining the number of FTEs is a fairly simple mathematical exercise, bearing in mind that under the ACA, "full-time" means an employee who works 30 or more hours per week, rather than the more standard notion of 40 hours per week. To determine its full-time workforce size

for a year an employer adds its total number of full-time employees to the total number of full-time equivalent employees for each month of the prior calendar year and divides that total number by 12. So, for example, if for each month of the prior year an employer has 30 employees who work an average of 30 hours per week, and another 30 who work an average of 20 hours per week, the employer has 50 FTEs, comprised of the 30 full-time employees and 20 more FTEs from its part-time workforce (30 PT employees x 20 hours = 600 hours/30 hours = 20 FTEs).

There is, however, one additional wrinkle in this ALE calculation. An employer is not considered an ALE if (1) the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year and (2) the employees in excess of 50 during such 120-day period are seasonal workers. This is the area where an employer's permissible good faith definition of "seasonal worker" could have an impact on ALE status.

c. Determining Who Is Entitled to Coverage

On February 14, 2014, the Internal Revenue Service (the "IRS") issued final regulations under Section 4980H of the Internal Revenue Code (the "Code"), which establishes the employer "shared responsibility" mandate under the ACA. ALEs are subject to penalties if they do not offer minimum value healthcare coverage that is affordable to their full-time employees and their dependents. Regulations establish which employers are subject to the penalties, which employees and dependents must be offered coverage, and what constitutes affordable and minimum value healthcare coverage.

An ALE is subject to penalties if it (i) fails to offer major medical coverage to at least 95% of its full-time employees and their dependents or (ii) offers coverage that fails to meet affordability and "minimum value" tests and one or more full-time employees obtain subsidized

coverage on a public health insurance exchange. In general, if an employer fails to offer coverage to substantially all of its full-time employees and their dependents and one or more full-time employees obtain subsidized coverage on an exchange, the employer is subject to a monthly penalty equal to the total number of its full-time employees (reduced by 30), multiplied by 1/12th of $2,000 (adjusted for inflation). For employers who do provide coverage but don't provide coverage meeting minimum value and affordability requirements, the fee is the lesser of $3,000 per full-time employee receiving subsidies, or $2,000 per full-time employee (minus the first 30).

Regulations establish two methods an ALE may use to determine who is a full-time employee entitled to coverage: (1) the monthly measurement method, and (2) the look-back measurement method. The monthly measurement method, while simpler to administer, is rarely used because it can cause employees who hover around the 30-hour per week threshold for full-time employment to bounce in and out of coverage monthly. This simple calculation can result in a massive administrative headache as employees.

Here is how the monthly measurement method works: full-time employees are identified based on the hours of service for each calendar month. Once an employee is first eligible under this method, an employee must be offered coverage no later than the first day of the first calendar month after three full calendar months following the employee's eligibility (similar, but not identical to the permissible three-month waiting period for full-time employees).

Thereafter, the employee must be offered coverage for any month during which the employee works 130 or more hours. The problem with this approach is that an employer has to know in advance for any given month whether an employee will meet the full-time threshold,

making the monthly measurement method impractical for variable-hour or otherwise unpredictable employee workloads.

Therefore, aside from a couple of unique scenarios, the monthly measurement method is largely impractical. It might avoid the $2,000-per full-time employee penalty if the number of employees subject to moving in and out of coverage is less that the permissible 5% of full-time employees who may be excluded from coverage without penalty, but the employer would still be subject to a monthly fraction of the annual $3,000 penalty for each employee improperly excluded who receives a subsidy on the ACA exchange. Overall, however, the administrative headaches that the monthly measurement period risks make it a poor choice for most employers in determining its full-time workforce that must be offered coverage.

The alternative is the look-back measurement method for determining full-time employees. While more practical, it is still administratively complex, but is especially relevant with respect to an employer's part-time, variable hour, and seasonal workforce.

In applying the look-back measurement method, the first issue is whether an employee is hired as a full-time employee or not. If so, then an employer must offer all such employees the opportunity to enroll in affordable coverage that offers minimum value. Application of the look-back method is relevant only when the employer in good faith cannot determine whether an employee will meet the full-time threshold, either because the employee is part-time (but perhaps expected to be close to full-time), variable-hour, or seasonal. Each of these categories is treated somewhat differently with respect to the application of the look-back measurement method.

The basic structure of the look-back measurement method consists of three periods: (1) a measurement period, (2) a stability period, and (3) an administrative period. The measurement period may be any length between three and twelve months. During the measurement period, the

employer tracks the hours an employee works. If the average hours worked over the entire measurement period equals or exceeds the 30-hour full-time threshold, then the employee must be offered coverage for the following stability period.

New employees are subject to an initial measurement period that corresponds with the beginning of their employment. Following the completion of the initial measurement period, the employee will be folded into the employer's measurement period for ongoing employees. So, for example, if an employer uses a twelve-month measurement period that corresponds with the calendar year, a new employee hired mid-year will be subject to an initial twelve-month measurement period beginning around the date of hire, followed by an initial twelve-month stability period. At end of the initial measurement period, the employee, as now an ongoing employee, will be in the middle of the employer's standard measurement period, and the employee's hours for the first half of the calendar year will be counted for both the initial measurement period and the first standard measurement period. If at the end of the first standard measurement period the employee falls below the 30-hour threshold, the employer must keep the employee on the plan until the expiration of the initial stability period (in this example, near the second anniversary of the employee's date of hire in the middle of the calendar year).

The stability period is the same length as the measurement period, except that it may be no shorter than six months. Thus, regardless of the employee's hours during the stability period, including months during which hours may fall below full-time, the employee is entitled to coverage for the entire period. However, the employer may begin another measurement period during the stability period that may bear on the employee's eligibility for the next stability period.

The administrative period is designed as a buffer between the end of a measurement period and the beginning of the corresponding stability period. This permits the employer to confirm eligibility, offer a reasonable enrollment period and otherwise attend to necessary administrative details. This period can be no longer than 90 days. In addition, the administrative period cannot have the effect of shortening a stability period. In other words, an administrative period must overlap with the prior stability period so that it will not cause a gap in coverage for ongoing employees during their second and subsequent measurement periods. One way to ensure a compliant administrative period is to stagger measurement periods and stability periods.

An example taken from the regulation may help clarify the operation and interaction of these look-back measurement method periods. Assume an employer establishes a twelve-month measurement period that runs from October 15 through October 14 of the next year, and a twelve-month stability period that corresponds with the calendar year. The employer also establishes an administrative period between October 15 and December 31.

Ongoing employees A and B have worked full-time and have participated in the employer's healthcare plan. During the measurement period between October 15, 2015, and October 14, 2016, Employee A continued to be full-time. That employee's coverage continues uninterrupted for the balance of the 2016 calendar year stability period, and all of the 2017 stability period.

Employee B, however, no longer qualifies as a full-time employee based on the same measurement period ending on October 14, 2016. That employee continues to be covered for the balance of the 2016 calendar year stability period, but will not be covered for the 2017 stability period.

d. Planning Opportunities

The look-back measurement method operates the same way for all potentially non-full-time employees, whether they are classified as part-time, variable-hour, or seasonal. Seasonal employees, however, present some unique considerations and planning opportunities. This is where the distinction between a "seasonal worker" and a "seasonal employee" mentioned earlier comes into play. A seasonal employee for purposes of coverage under the employer mandate is defined as one who: (1) fills a position that typically lasts for six months or less, and that (2) begins in roughly the same part of the calendar year each year. An employee who meets these criteria can work any number of hours, including hours above 30 per week, and still be classified as a seasonal employee.

Thus, instead of becoming eligible for coverage after a 90-day waiting period as other non-seasonal employees working full-time hours, a seasonal employee is treated the same way as part-time and variable-hours employees with respect to the application of the look-back measurement method. As long as a seasonal employee's hours do not meet the full-time threshold for a measurement period, the employee need not be offered coverage.

Employers who want to minimize their obligation to offer coverage to seasonal employees should typically use the maximum twelve-month measurement period so that the average number of hours worked will be as low as possible after taking into account the non-seasonal time period during which the seasonal employee is not working.

Under the final regulations, a returning employee may be treated as a new employee if his or her break in service was 13 weeks or longer. Therefore, if a seasonal employee returns to work the next year, the employee's service during the prior year is not counted for purposes of the measurement period. Instead, the employee would begin a new initial measurement period upon commencement of work the next season.

One potential planning opportunity that may involve significant legal risk is manipulating work hours so as to maximize the number of employees who fall below the 30-hour full-time threshold for required coverage. From a very early point in the life of the ACA, the establishment of a 30-hour work week as being the benchmark for full-time employment has been controversial. Part of that conversation has been the concern that employers would shorten work hours to avoid the mandate, causing employees to lose income.

However, doing so has always presented a risk of running afoul of the Employee Retirement Income Security Act of 1974 ("ERISA"). That federal law governs all employer-sponsored retirement and welfare benefit plans. While many of its provisions deal with technical aspects of setting up and operating benefit plans, one aspect has a parallel with garden variety employment discrimination claims.

Section 510 of ERISA prohibits discrimination against an employee in the exercise of the employee's rights under employer-sponsored benefit plans. Intentionally restricting the hours of existing employees to avoid the obligation to provide health care coverage arguably presents such a case of discrimination, although cases raising this theory of liability have had a mixed record. The key seems to be whether the employer has a legitimate, nondiscriminatory reason for any such reduction in hours.

The risk of a section 510 violation is reduced or eliminated in the case of new employees, who presumably have no existing rights regarding benefits prior to being hired. As to existing employees, employers should exercise great care to avoid even the appearance of such discrimination, even if it occurs quite innocently. Weak facts have seldom deterred a determined plaintiff.