



Transforming Access to Health Care: How America's Restaurant and Foodservice Industry Can Lead the Way

November 21, 2013

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Acknowledgements

We are grateful to those who participated in the roundtable discussion for their contributions, ideas, and recommendations and to the subjects in the video interviews conducted by the Global Social Enterprise Initiative at the 2013 National Restaurant Association “Restaurant, Hotel-Motel Show” (NRA Show). Additionally, special thanks goes to Dawn Sweeney, Scott DeFife, Phil Kafarakis, Dave Matthews, James Balda, Randy Spicer, Angelo Amador, Michelle Neblett, Denise Roach, and Adrienne Weil of the National Restaurant Association and Ladan Manteghi and Bich Le of the Global Social Enterprise Initiative.

About the National Restaurant Association

NRA is the leading trade association for the restaurant and foodservice industry. Its mission is to help its members establish customer loyalty, build rewarding careers, and achieve financial success. The industry it serves is comprised of 980,000 restaurant and foodservice outlets employing 13.1 million people who service 130 million guests daily. NRA is involved in several issues at the federal and state levels, including food and nutrition, sustainability, labor and workforce, and taxes. Learn more at <http://www.restaurant.org> or [follow them on Twitter @WeRRestaurants](#).

About the Georgetown University Global Social Enterprise Initiative

The Global Social Enterprise Initiative at Georgetown’s McDonough School of Business aims to prepare current and future leaders to make responsible management decisions that yield both economic and social value. Through practical training for global business leaders, the initiative promotes transformative solutions to and impactful investments in the world’s significant challenges in health and well-being, economic growth, the environment, and international development. Learn more at <http://socialenterprise.georgetown.edu> or follow them on Twitter @GSEI_Georgetown.

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EXECUTIVE SUMMARY

Transforming Access to Health Care: How America's Restaurant and Foodservice Industry Can Lead the Way

The restaurant and foodservice industry employs 13.1 million individuals or ten percent of the U.S. workforce, making it the nation's second largest private sector employer. Its workforce is relatively young (43% of its workers are under age 26¹), an age segment which represents a disproportionately large share of uninsured Americans.² One out of three adults gets his/her first job experience in a restaurant.³ This welcoming training environment for all ages coupled with the availability of flexible work schedules translates to a large number of part-time workers, who typically are not eligible for insurance through their employer.

Given this employee profile, effective implementation of the Affordable Care Act (ACA) within the restaurant and foodservice industry appears to be a key opportunity to begin closing the gap among our nation's uninsured. Yet, there are unique characteristics of the restaurant and foodservice industry that make implementation of the ACA operationally challenging. This paper discusses the operational challenges, implications, and responses by the industry and identifies certain activities the National Restaurant Association might want to pursue in support its members and the industry as a whole with ACA implementation.

Situation

Under the ACA, the employer mandate or shared responsibility provision requires large employers – any company with 50 or more full-time equivalent employees – to offer health coverage or face possible penalties. Determining if a business qualifies as a large employer is complicated and even more so for the restaurant and foodservice industry due to its unique operating characteristics such as: 1) high number of part-time, seasonal and variable hour employees; 2) relatively high turnover; and 3) complex ownership structures. The ACA requires all individuals to obtain qualifying coverage through an employer, through the new health care exchanges (which opened on October 1, 2013), or through public programs, or face a tax penalty.

The interrelationship between the employer mandate and individual responsibility requirements makes it difficult for restaurant owners to predict how the new law will impact their businesses. Operators covered by

¹ Boucher, Tom, "Statement for the hearing 'Obamacare's Impact on Jobs', Before the Subcommittee on Health, Energy & Commerce Committee, U.S. House of Representatives, March 13, 2013.

² "The Uninsured, A Primer: Key Facts About Americans Without Health Insurance, The Kaiser Commission on Medicaid and the Uninsured, October 2012.

³ National Restaurant Association, "2013 Restaurant Industry Pocket Factbook, " restaurant.org.

the employer mandate report facing considerable uncertainty regarding the impact of the law, largely related to the choices their employees may make.

Options to Comply with the ACA

Details of the specific challenges and options to respond to them emerged during a September 6, 2013 roundtable discussion convened at Georgetown's McDonough School of Business by its Global Social Enterprise Initiative (GSEI) and the National Restaurant Association (NRA). The roundtable findings combined with interviews conducted at the National Restaurant Association's annual NRA Show (May 17-20, 2013), meetings with NRA members, research studies, media coverage and other reporting inform this discussion paper.

Restaurant owners want to do right by their employees, as they understand the clear linkage between satisfied employees who are their frontline in delivering quality service, and customer satisfaction. Restaurateurs who have offered health insurance to their employees well before the ACA recognize that providing this benefit correlates to lower turnover and a higher quality workforce.

To absorb the ACA's cost impact, many restaurateurs are coming up with solutions that do not involve cutting benefits or hours.⁴ However, for many other restaurateurs, offering health care coverage comes at a significant and in some cases unsustainable cost to their business. Some restaurant owners may find that they simply are not in a position to cover their employees, with others uncertain about whether they can even keep their operation open. They have to make tough choices as they find ways to comply with the ACA. It is important to note that at this stage, some of the options being discussed and implemented are anecdotal or in pilot phases. It is unclear how viable they are, how prevalent they are in practice, and if they are being used as a single response or in combination. Thus, monitoring, tracking, and reporting on them in the coming year will be critically important.

- **Managing hours:** Limiting part-time workers or new hires to below 30 hours a week to manage against the requirement to offer health care or limit potential penalties;
- **Offering "skinny" plans:** Providing a plan that meets the minimum essential coverage standard, which can avoid the \$2,000 penalty for not offering minimum essential health coverage, while letting employers risk the possibility of having to pay the \$3,000 penalty for not offering an affordable minimum plan and having an employee obtain coverage through an exchange;
- **Paying the penalties:** Not offering minimum essential coverage or not offering any health coverage and instead paying the \$2,000 penalty per year per full-time employee as a less expensive option than paying for health care coverage;
- **Raising menu prices:** Increasing prices on a restaurant menu to offset the cost of offering health care coverage;
- **Offering lump sum to employees:** Making a cash contribution to a savings account that employees can use to purchase health insurance through a private exchange⁵, thereby making health care costs somewhat more predictable and mitigating the difficulty in finding plans that are both affordable for everyone and meet the high bar for coverage demanded by even the bronze-level plans;
- **Arranging employee "job sharing":** Having workers work less than 30 hours a week at one franchise, yet above 30 hours a week in total for a single restaurant chain; and

⁴ Georgetown Social Enterprise Initiative –National Restaurant Association Roundtable event, September 6, 2013.

⁵ Private exchanges are emerging as marketplaces of health insurance and other products promoted by private industry stakeholders (e.g. payors, benefits consultants), generally with options for employers to administer defined contribution arrangements. "The Emergence of Private Health Insurance Exchanges: Fueling the 'Consumerization' of Employer-Sponsored Health Insurance, Booz & Company, 2012.

- **Doing nothing beyond notification:** Deciding not to offer health insurance coverage under the assumption that most employees will stay on their parents' or spouses' plans, will qualify for Medicaid (in the states expanding the program), or opt to pay the individual penalty.

Key Issues to Monitor

Throughout the roundtable event, participants identified several key issues that should be monitored in the coming months. Overall, much uncertainty was expressed even as the October 1st deadline for the exchanges to open approached. Widespread misinformation and lack of awareness among employees seemed to be prevalent across all restaurant segments. Many roundtable participants acknowledged that awareness-building efforts are not enough, and that it is a multi-step process to move from awareness to taking action to enroll in health care.

How leading providers (e.g. Aetna, UnitedHealth and Cigna) respond after seeing the pool of enrollees it gets over the coming months are a trend to watch. Will the providers expand their participation in the state exchanges or keep their involvement more limited?

Private exchanges are expected to grow from one million individuals enrolling in health care coverage through private exchanges in 2013, to 40 million enrolling through them by 2018.

Health care decisions by employers are impacting other employee benefits such as sick leave and paid time off (typically benefits only offered to full-time employees) as companies face “competing” definitions of full-time employees. Under the ACA, full-time employees are those who average 30 or more hours a week in a given month, while for most restaurants and other industries, working 40 hours a week is the norm for full-time employment. Should employees now averaging 30 or more hours a week and deemed full-time under the ACA now qualify to receive sick leave and paid time off?

Federally qualified health centers⁶ have served low-income populations with relatively high levels of patient satisfaction. There may be opportunities for providing health care through these centers outside of Medicaid.

Lastly, the one-year transition relief for large employers on reporting requirements and enforcement of penalties creates some uncertainties for employers, particularly those on the “cusp” or bubble. Some employees who obtain coverage through an exchange in 2014 and receive a subsidy may find themselves with the choice to enroll in their employer’s coverage in subsequent years and pay more for that coverage or pay the individual mandate penalty. The same may be true for employees who start out in an exchange because they work for a small business, but then find they are working for a large employer as it expands beyond 50 full-time equivalent employees.

Role for National Restaurant Association

The National Restaurant Association has developed a member-exclusive Notification Tool (at Restaurant.org/Notify), which is an online solution to help restaurateurs provide the Fair Labor Standards Act (FLSA) notification about exchanges to employees and keep track of those whom they have notified. NRA’s Notification Tool leverages the Department of Labor’s templates, captures an employee’s e-signature confirming receipt of the notification, and creates a permanent record to verify which employees received the notice.

⁶ Federally qualified health centers are community-based organizations that provide comprehensive primary and preventative care to persons of all ages regardless of their ability to pay or health status.

Both roundtable participants and interviewees at the annual NRA show stated that the NRA has an important role to play in serving as a “trusted advisor” and “third party validator” to the entire industry. It has an opportunity to:

- **Support peer-to-peer learning:** Promote shared learning and best practices among restaurant and foodservice peer groups through online forums, webinars, seminars, etc.;
- **Develop consistent messaging:** Work with and among key stakeholders to develop uniform messaging tailored to specific segments of industry employees that conveys affordability and ease of access through the exchanges;
- **Build segmented awareness and engagement strategies:** Target priority segments such as young adults and utilize multiple touch points to reach them through social media and other tactics;
- **Become a one-stop, trusted resource:** Continue to invest in becoming the “go-to” education center for all things related to the ACA for the industry – both for employers and employees. This would include links to tools and information offered by federal agencies, such as Small Business Association’s: business.usa.gov/healthcare.
- **Use distribution partnerships for online Notification Tool:** Explore partnerships with providers along the entire restaurant supply chain to help get the message out to employers, especially small operators, about the tool and its capabilities.
- **Leverage reporting capabilities of online Notification Tool:** Develop a comprehensive strategy for the tool’s data collection capabilities; collect and analyze aggregated, non-identifiable data to serve as the “pulse” for how the restaurant and foodservice industry is complying with the ACA and flag areas that are working well or need to be addressed.
- **Partner to deliver industry-tailored offering:** Monitor for any market gaps in offerings and explore partnering with provider(s) to develop private exchange designed to meet the unique needs of the restaurant and foodservice industry.

The NRA also has an opportunity to establish itself as a leader among trade associations in many industries and sectors by potentially licensing its online Notification Tool to them to help with ACA implementation on an even larger scale.

Conclusion

With the public health care exchanges now open as of October 1, 2013 and employee enrollment underway, it is necessary to closely monitor and learn from the choices made by employees as well as measures taken by employers. Are eligible employees signing up for their employer plans, opting into exchanges, or paying the individual penalties? Similarly, how are employers responding in terms of labor scheduling, hiring, type of health benefits being offered, impact on other benefits offered, and business expansion? The one-year period of voluntary compliance and transition relief allows time for strategies to take root and other solutions to be shaped.

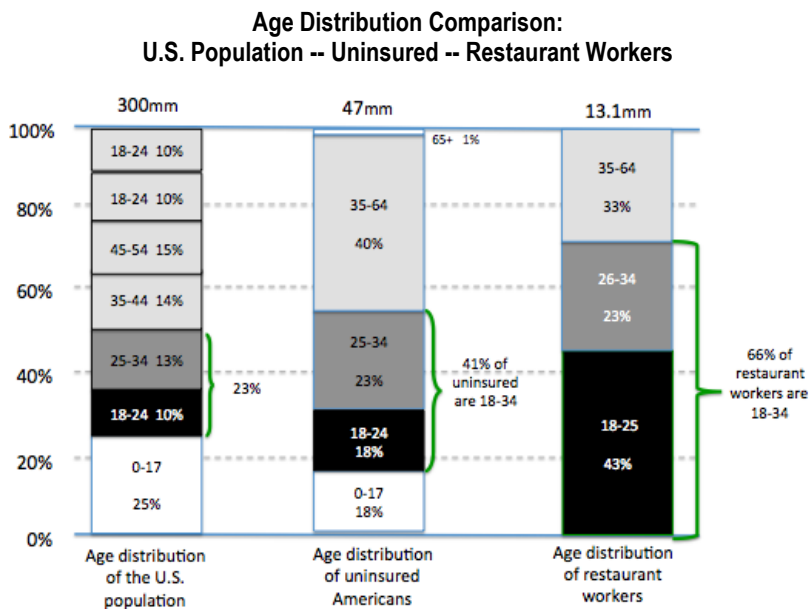
The National Restaurant Association has an opportunity as the industry’s leading trade association to leverage its online Notification Tool and content resources and report on trends concerning employee actions and employer responses, which will help inform policy and product offerings during the course of the next year. Sharing what is working, what continues to present challenges, and identifying what still needs to be done to comply would benefit the restaurant industry as well as its advisors, health care payors and providers, and policymakers alike.

Transforming Access to Health Care: How America’s Restaurant and Foodservice Industry Can Lead the Way

Overview

The restaurant and foodservice industry employs 13.1 million individuals or ten percent of the U.S. workforce, making it the nation’s second largest private sector employer. These employees staff a wide range of eating establishments, including full-service restaurants, quick-service restaurants, cafeterias and buffets, snack bars and catering services. The industry employs a relatively young workforce (43% of its workers are under age 26⁷; 2/3 are under 35⁸), representing a disproportionately large share of uninsured Americans.⁹ One out of three adults gets his/her first job experience in a restaurant.¹⁰ This welcoming training environment for all ages coupled with the availability of flexible work schedules translates to a large number of part-time workers, who typically are not eligible for insurance through their employer.

Given this employee profile, effective implementation of the Affordable Care Act (ACA) within the restaurant and foodservice industry appears to be a key opportunity to begin closing the gap among our nation’s uninsured.



Source: A Profile of Uninsured Persons in the United States, Pfizer 2008; National Restaurant Association, 2013.

⁷ Boucher, Tom, “Statement for the hearing ‘Obamacare’s Impact on Jobs’, Before the Subcommittee on Health, Energy & Commerce Committee, U.S. House of Representatives, March 13, 2013.

⁸ U.S. Census Bureau and U.S. Bureau of Labor Statistics, 2012.

⁹ “The Uninsured, A Primer: Key Facts About Americans Without Health Insurance, The Kaiser Commission on Medicaid and the Uninsured, October 2012.

¹⁰ National Restaurant Association, “2013 Restaurant Industry Pocket Factbook, “ restaurant.org.

Some believe that the ultimate success of the new health care law rests on the young adult segment, many of whom are “young invincibles” who believe they need coverage the least.¹¹

At the same time, there are some unique characteristics of the restaurant and foodservice industry that pose implementation challenges. Details of some of these challenges and strategies to respond to them emerged during a September 6, 2013 roundtable discussion¹² convened at Georgetown’s McDonough School of Business by its Global Social Enterprise Initiative (GSEI) and the National Restaurant Association (NRA). The roundtable findings combined with interviews conducted at the annual NRA Show (May 17-20, 2013), meetings with NRA members, research studies, media coverage and other reporting inform this discussion paper.

Current Landscape

To understand the complexity faced by the restaurant and foodservice industry with regards to ACA implementation, the specifics of the Employer Mandate and Individual Responsibility Requirement are discussed along with the unique characteristics of the industry.

The Affordable Care Act

On March 23, 2010, the Affordable Care Act was signed into law with the goals of expanding access, increasing affordability, providing higher quality health care through a standardized set of essential benefits¹³ to all Americans, and slowing health care costs. The changes are designed to expand coverage to the nation’s nearly 50 million uninsured and improve protection to an estimated 25 million underinsured.¹⁴

Specifically, the ACA requires health care exchanges be established through which individuals (with premium and cost-sharing credits for eligible individuals and families¹⁵) and small businesses of up to 50 employees can purchase coverage.¹⁶ The law also expands Medicaid in states choosing to participate, includes the ability for an individual to join a parents’ plan until age 26, provides tax credits to help some small businesses pay for health insurance, imposes new responsibility on individuals to purchase insurance or face a penalty, and requires some employers to either offer insurance to their employees or face possible penalties.

The employer mandate, originally intended to go into full effect on January 1, 2014, includes some provisions that present compliance challenges to the business community, including the restaurant and foodservice industry. On July 2, 2013, the U.S. Treasury Department announced a one-year transition relief on the enforcement of penalties and various reporting requirements for large employers, making 2014 a year of voluntary compliance and transition relief. Large employers now have until January 1, 2015 to either

¹¹ Weaver, Christopher and Louise Radnofsky, “Health Law’s Success Rests on the Young”, *The Wall Street Journal*, July 31, 2013.

¹² The Roundtable was convened by Georgetown University’s Global Social Enterprise Initiative and the National Restaurant Association. Participants included executives from the restaurant and foodservice industry, accounting, health care consulting, insurance, university faculty, nonprofit and government leaders. See Appendix 1 for list.

¹³ Essential health benefits to include at a minimum: Doctor’s visits/outpatient services; emergency services; hospitalization; maternity/newborn care; mental health/substance use disorder services; prescription drugs; rehabilitative/habilitative services & devices; lab services; preventive/wellness services; and Pediatric services. Community Catalyst and Georgetown University Health Policy Initiative, 101.communitycatalyst.org, 2013.

¹⁴ Community Catalyst and Georgetown University Health Policy Institute, 101.communitycatalyst.org. McDonald, Margaret and Robin Hertz, “Profile of the Uninsured in the United States”, Pfizer, October 2008.

¹⁵ Premium credits and cost-sharing subsidies are available to individuals/families with income between 133%-400% of the federal poverty level according to: “Summary of the Affordable Care Act”, The Henry J. Kaiser Family Foundation, April 25, 2013.

¹⁶ “Summary of the Affordable Care Act”, The Henry J. Kaiser Family Foundation, April 25, 2013. Note: states have the option to limit participation to businesses with 50 employees or less until 2016; in 2017, states may opt to allow employers with 100 or more employees to be able to purchase their employee coverage through exchanges.

offer affordable and minimum value health care coverage to full-time (FT) employees and their dependents or face possible penalties. All employers, regardless of size, were required to provide written notice to all their employees by October 1, 2013 about how to access the new government-run health care exchanges.¹⁷

The Employer Mandate

How and whether employers are required to offer health care coverage to their employees is dictated by the company's size – not defined by revenue, but by their number of “full-time equivalent” (FTE) employees. Any company with 50 or more FTE employees is considered a “large employer.” The calculation is complex, requiring data on the number of full-time employees (defined under the law as those who average at least 30 hours of service a week during a calendar month), plus the hours worked by all non-full-time employees in a month. Establishments that are part of a business with multiple entities may be required to combine all their employees to determine whether they are considered one employer and hence covered by the employer mandate, which may sweep many businesses that consider themselves “small” into the employer mandate.

Technically, the ACA does not require employers to offer health insurance to their employees, but it does impose penalties on employers with more than 50 FTE employees if at least one of their full-time employees obtains a federal subsidy to buy a health plan through one of the new health care exchanges. These penalties are positioned as “employer shared responsibility” payments, with penalties for large employers generally falling into two categories: 1) those not offering minimum essential coverage; and 2) those offering unaffordable or inadequate (not of the minimum value) coverage. See Appendix 2 for explanation of calculations.

In addition, an employer with 200 or more full-time employees must automatically enroll full-time employees in a company health plan on day 91 of an employee's tenure, if he/she has not opted out of the health care plan.¹⁸ This provision of the law has not yet been explained or implemented.

Small businesses (those with fewer than 50 FTE employees) are exempt from penalties. Some small businesses may be eligible to receive tax credits to defray the cost of insurance if they pay a portion of their employees' premiums and purchase insurance through the exchanges.¹⁹ Employers with fewer than 25 FTE employees (based on 40 hours a week) can receive a tax break up to 50% for the cost of employee premiums if they pay at least 50% of the employee premium and average worker wages are below \$50,000 annually.²⁰

Individual Responsibility Requirement

Under the ACA, the individual (all citizens and legal residents) bears a new level of responsibility for ensuring that he/she has qualifying health coverage, or is subject to a tax penalty. Individuals can meet the requirement by obtaining insurance through an employer-sponsored plan, the new health care exchanges, in the individual market or through public plans.²¹ Beginning January 1, 2014, any person without qualifying health coverage must pay a tax penalty, either a flat rate or a share of household income, whichever amount is greater. The flat rate annual penalty for an individual is \$95 in 2014, and increases to \$325 in 2015 and \$695 in 2016, while the fee tied to household income will be 1% of taxable income in 2014, 2% in 2015, and 2.5% in 2016.²²

¹⁷ “Health Care Law Primer”, National Restaurant Association, July 2013.

¹⁸ Boucher Testimony, page 9.

¹⁹ Community Catalyst and Georgetown University Health Policy Initiative, 101.communitycatalyst.org.

²⁰ Community Catalyst and Georgetown University Health Policy Initiative, 101.communitycatalyst.org

²¹ Public plans include Medicare, Medicaid and the Children's Health Insurance Program, TRICARE, and the veteran's health care program, Community Catalyst and Georgetown University Health Policy Initiative, 101.communitycatalyst.org.

²² “Summary of the Affordable Care Act: Focus on Health Reform”, The Henry J. Kaiser Family Foundation, April 13, 2013.

The interrelationship between the employer mandate and individual responsibility requirements makes it difficult for owners to predict how the new law will impact their businesses. Operators report being faced with considerable uncertainty regarding the impact of the law, in large part based on what choices their employees may make. Will young workers opt to be on their parents' insurance, pay the individual penalty, or take their employers' coverage? How will the rise in penalty levels in 2015 and beyond affect their decision? Will coverage available through health care exchanges be less expensive than what operators can afford to offer?²³ Work has been underway within the restaurant and foodservice industry by operators and their advisors to identify effective pathways to comply with the new law, while also highlighting the challenges and implications arising from the industry's unique characteristics and business model.

Compliance Challenges Due to Unique Characteristics of the Industry

Restaurants have always been the employers of choice for those seeking flexible work schedules and the ability to select shifts in what is often a 24-hour, 7-day a week service operation.²⁴ With this flexibility and the number of entry-level positions comes relatively high turnover compared to other businesses. It is this dynamic of unpredictability and turnover coupled with the large use of part-time and seasonal workers that make the large employer determination – a critical gating factor regarding potential penalties – so challenging for the industry. Knowing which variable-hour and seasonal employees are considered “full-time” and thus eligible for offers of health care coverage also poses challenges for large employers trying to avoid penalties under the law.

Part-time, Variable-Hour and Seasonal Workers

Restaurants and foodservice companies rely heavily on large numbers of part-time and seasonal workers, who have fluctuating and unpredictable work hours. Part-time has been traditionally defined as anyone working fewer than 40 hours per week, but under the new law, working an average of 30 hours in a calendar month is now considered full-time. Catering services, in particular, generally staff up or down to accommodate the wedding season calendar. Restaurants with outdoor seating will have their busy season during the more temperate months and staff accordingly, while restaurants at ski resorts find their busy season during the winter months. This staffing dynamic means that planning and scheduling need to follow business needs. However, employers with variable-hour workforces and flexible scheduling must now be concerned about scheduling hours due to the potential penalties they may incur if employees who average 30 or more hours a week in a given month are not offered coverage.²⁵ These requirements may also push employers to make financial decisions that are not in the best interests of their businesses nor their employees.

“...there are a lot of part-time people that work for us more than 30 hours a week, but it's only during those busy summer seasons. What happens to them in October, November and December when they're no longer those many hours?”

- NRA Show Interviewee

Employee Demographics

As mentioned earlier, 43% of all restaurant workers are under 26 years old. For many, this is their first real job experience. Employers are finding it hard to predict whether these workers will accept their offer of coverage, stay on their parents' health care plans, opt out and pay the individual penalty, quality for

²³ Settles, Kevin, “Implementation of the Affordable Care Act: Understanding Small Business Concerns”, before Committee on Small Business and Entrepreneurship, July 24, 2013.

²⁴ Boucher Testimony, page 5.

²⁵ Boucher Testimony, page 8.

Medicaid (in the states expanding the program), or go to an exchange where they might qualify for premium credits.

Relatively high turnover

Employee turnover rates vary depending on the dining segment, but average 50% to 60% annually across the industry.²⁶ They run higher than the retail and arts, entertainment and recreation industries, two other industries with relatively high turnover rates.²⁷ Turnover tends to be significantly higher among hourly employees than among salaried employees. Tracking an employee group with these levels of churn will be an added administrative burden for restaurant operators.

Low Profit Margins

The demand for and profitability of various eating establishments and services vary in this highly fragmented industry of over 980,000²⁸, where the 50 largest companies account for about 20% of the industry's revenue.²⁹ The business model of restaurants produces profit margins of only four to six percent before taxes, with labor costs being one of the most significant line items.³⁰ These low margins mean that businesses have little room for error when it comes to determining their strategies for complying with the ACA. Should they take on the added expense of offering coverage, or will it cost less to pay the penalties? Should they optimize employee scheduling of hours to stay below the large employer status and/or to minimize penalties? Will the cost of offering health coverage be offset by higher employee satisfaction, loyalty, and better customer service? For owners and operators on the 50 FTE employee cusp, will the new mandate become a deterrent for business expansion?

Complex Ownership Structures

Owners often have multiple restaurant entities with various partners. They consider each restaurant to be a separate small business with its own set of employees. However, many are finding that under the ACA, application of the Common Control Clause in the Internal Revenue Code may translate to all of their businesses potentially being considered a single employer – in some cases, bumping smaller restaurants into the “large employer” designation and subjecting them to a whole new set of regulations.³¹

Many restaurant operators or conglomerates have locations in multiple states, with each state having the authority to decide if it will offer its own health care exchange or participate in the federal one. Each state is also allowed to make its own decision about whether or not it will expand Medicaid as part of the ACA. Human Resource professionals must in some cases become familiar with the details of their own health care offerings, that of multiple state exchanges, and the federal exchange in order to communicate options to their employee base.

Employees working in the same job class or category for the same employer may find themselves with entirely different coverage options and costs simply because of where they reside. Employees who might otherwise be eligible to receive Medicaid benefits, but who reside in states not expanding the program, could find themselves unable to afford their employer's coverage, ineligible for federal subsidies, and ineligible for Medicaid coverage. Another employee with a similar income and household profile and residing in a state with an expanded Medicaid program may find themselves now receiving health care benefits through Medicaid. Does the employer make any accommodations to the employees living in the non-Medicaid expansion states?

²⁶ “Restaurant Industry Operations Report”, 2010 Edition. National Restaurant Association.

²⁷ Jacobs, Eliza, “Executive Brief: Differences in Employee Turnover Across Key Industries, Society for Human Resource Management, December 5, 2011.

²⁸ National Restaurant Association, “2013 Restaurant Industry Pocket Factbook, “ restaurant.org.

²⁹ Hoovers, Restaurant Industry Review

³⁰ Boucher testimony.

³¹ Settles Testimony, page 5.

Some smaller restaurants turn to management companies to help with lease negotiation, financing, day-to-day operations and more. They may increasingly turn to these management companies for assistance in handling reporting and compliance required with the implementation of the ACA. Questions have arisen, however, as these restaurateurs are unclear if their affiliation with restaurant management companies could lead to being defined collectively as a large employer. The service providers do not feel that they can confidently assure their clients that this will not be the case.

Options to Comply With and Mitigate Potential Negative Impact of the ACA

Restaurant owners want to do right by their employees, as they understand the clear linkage between satisfied employees who are their frontline in delivering quality service, and customer satisfaction. Restaurateurs who have offered health insurance to their employees well before the ACA recognize that providing this benefit correlates to lower turnover and a higher quality workforce. Starbucks' coffee chain, well known for its practice of offering health insurance to even part-time employees, cites a turnover rate of less than half of the industry average as proof that its commitment to generous health care benefits is a sound business practice.³²

However, for many restaurateurs, offering health care coverage comes at a significant and in some cases, unsustainable cost to their business. Some restaurant owners may find that they simply are not in a position to cover their employees, with some uncertain about whether they can even keep their operation open. They have to make tough choices as they find ways to comply with the ACA. It is important to note that at this stage, some of the options being discussed and implemented are anecdotal or in pilot phases. It is unclear if they are viable, how prevalent they are in practice, or if they are being used as a single response or in combination. Thus, monitoring, tracking and reporting in the coming year will be critically important.

To reduce or not to reduce hours

Almost all employers have had to ask themselves whether or not they would cut employee hours to below 30 hours a week to sidestep the requirement to offer health care and avoid or limit negative impact on their business with potential penalties. For some, "it wasn't even something we considered." For others, it is potentially a necessary solution as a way to stay in business. Still, for other operators, it is not something they will pursue with their current employees, but may be a practice implemented with new hires. Whether they should trim hours, hire more part-timers or leave things unchanged seems to vary by restaurant type.

At the September 6th roundtable, it was clear that restaurateurs want to help their employees obtain health care coverage. As one participant characterized, "It's not a question of consciously keeping employees out of health care; it's about struggling with how to afford it." Employers understand that cutting hours or other workarounds could create ill will among employees with potentially negative impact on their businesses. According to some roundtable participants, early comments widely covered by the media about some restaurateurs having to reduce hours to comply with the ACA may have unfortunately created a sense that the industry was trying to avoid compliance when in fact owners are striving both to comply *and* to compete. Another participant commented that if employers cut back on hours, there would likely be a legislative response, citing that elected members are very focused on potential issues related to employment.

"It's not a question of consciously keeping employees out of health care; it's about struggling with how to afford it."

- Roundtable participant

³² Hammers, Maryann. "Starbucks is Pleasing Employees and Pouring Profits", Workforce.com, October 3, 2013.

One restaurateur told how one of his long-time, older employees literally hugged him when the employee learned that his hours would remain intact and not be cut back due to the ACA. In another example, some employees are being moved to just under 30 hours per week in order to avoid having to offer coverage. Employees in this case who may lose on benefits such as paid vacation (which accrue based on number of hours worked) may in turn be compensated with a higher hourly rate to make them whole.

Responses have been varied and reflect corporate cultures and the segment in which they operate. Fast food chains appeared to be feeling the most pressure to explore the reduction of hours due to their relatively slimmer margins.³³ White Castle has decided it will not fire full-time employees or cut benefits as a result of the ACA. But, as the firm considers what will happen after the new law takes effect, Vice President Jamie Richardson, said in a NPR interview that the company is considering hiring only part-time workers. With profit per employee at only \$750 per year, says Richardson, which is much lower than other industries, adding health insurance as a benefit for all employees over 30 hours simply isn't feasible.³⁴

Jeff Benjamin, a restaurateur in Philadelphia with four restaurants and three more in the planning stages, stated in the same NPR interview that adding more part-time workers is not an option he and several others he has spoken to intend to pursue. The reason is there are simply too many fixed costs, in some cases doubling the cost of such items as training, uniforms, and scheduling "to make it worthwhile to go the part-time route." He also adds, "And sometimes as you lower people's hours, they may not be as committed."³⁵

Still, staffing with mainly part-time workers is a viable strategy and may be reflected in the 2013 U.S. workforce data. Employers have added far more part-time employees in 2013 – averaging a seasonably adjusted 93,000 a month – compared to full-time workers, which averaged 22,000 per month. Last year, the trend was reversed, with 31,000 part-time positions created monthly versus 171,000 full-time ones.³⁶ While other factors such as business expansion and post-recession recovery may be driving the hiring, many believe the shift is largely due to the new health care law and need to minimize its cost impact³⁷.

“Skinny Plans”

Another compliance option that appears to be gaining more awareness among employers is to offer a “skinny plan” (a plan that meets minimum essential coverage, but is not of minimum value, meaning it provides less than the 60% minimum benefit level), which can avoid the \$2,000 penalty for not offering minimum essential coverage. Employers take a chance on whether or not they might have to pay the \$3,000 penalty for not offering an affordable or minimum value plan and having their employee obtain coverage through an exchange. Restaurateurs, along with other industries that employ a large number of low-wage workers, are weighing whether their employees will opt to pay the individual penalty against how many might seek to obtain coverage through an exchange. The \$3,000 penalty is only levied on those employees who obtain coverage through an exchange and claim a tax credit.

Many companies and benefits advisors had wrongly assumed that the ACA required that *all* coverage meet the minimum set of essential benefits (see footnote 6 for definition). However, it is now understood that the mandate only applies to plans sold by insurers to small businesses or individuals. At issue is the very definition of “minimum essential coverage” and what this clause means in terms of plans that are compliant. According to Section 5000(A)(f) of the Internal Revenue Code (IRC), minimum essential coverage is: 1) either government-sponsored coverage such as Medicare or Medicaid; 2) an “eligible employer-sponsored

³³ Jargon, Julie, Louise Radnofsky and Alexandra Berzon, “Health Care Law Spurs a Shift to Part-Time Workers”, *Wall Street Journal*, November 4, 2012.

³⁴ Ydstie, John, “Full-Time Vs. Part-Time Workers: Restaurants Weigh Obamacare”, National Public Radio, July 24, 2013.

³⁵ Ydstie, John, “Full-Time Vs. Part-Time Workers: Restaurants Weigh Obamacare”, National Public Radio, July 24, 2013.

³⁶ Jargon, Julie, Brenda Cronin & Sarah E. Needham, “Restaurant Shift: Sorry, Just Part-Time”, *Wall Street Journal*, July 14, 2013.

³⁷ Jargon, Julie, Brenda Cronin & Sarah E. Needham, “Restaurant Shift: Sorry, Just Part-Time”, *Wall Street Journal*, July 14, 2013.

plan”; 3) a plan “offered in the individual market within a State”; 4) a “grandfathered” health plan; or 5) anything else that the Secretary of Health and Human Services deems appropriate.³⁸

Paragraph 2 of Section 5000(A)(f) defines an “eligible employer-sponsored plan” as “a group health plan or group health insurance coverage offered by an employer to a employee” which is [either a government-sponsored plan] or “any other plan or coverage offered in the small or large group market within a State.”³⁹ So, this means that *any* health insurance plan that is legally sold within a state’s boundaries can be considered an “eligible employer-sponsored plan.” In several states, insurers offer inexpensive plans with limited services, and some employers are finding they can offer these “skinny” plans and avoid the \$2,000 per year, per full-time employee (minus the first 30).⁴⁰

By making decisions that minimize their potential penalties, employers may in effect be causing their employees to receive lower benefits if employees enroll in their employer’s minimum essential coverage and not seek other coverage options through the new health care exchanges where they could get more benefits and might qualify for a subsidy. Steve Wojcik, Vice President of Public Policy of the National Business Group on Health, an association of 364 large companies, sums it up with his comment that retail, restaurant, and hospitality companies face “a tough dilemma” because “they know their employees are unlikely to be able to afford the full-blown coverage, even if it’s within the affordability requirements of the [ACA].”⁴¹ While employees can seek higher coverage levels through the exchanges, some employers are counting on their employees not doing so; and for those few that do, employers will only have to pay the \$3,000 penalty on those few employees.

Going the Penalty Route

Another potential option is for companies to not provide insurance at all. Restaurants would instead pay the \$2,000 per year, per full-time employee (minus first 30) penalty for not providing coverage. For some companies, the start-up costs associated with offering a health plan are significant, and/or the costs for providing health coverage to all employees now defined as full-time under the ACA add up to more than the penalty expense. One accounting firm reported advising a client that most scenarios showed it would cost less to pay the penalty than to provide coverage.⁴² Indeed, straight cost comparisons and analyses by some benefits consultants, tax attorneys, and health policy professors have illustrated that for some companies, paying the penalty is a less expensive option than offering health coverage to employees.⁴³

However, cost alone is not the sole driving factor for most companies. In a sample of 400 large employers surveyed by the National Small Business Association, only 3% said they plan to pay the penalty, while 71% said they plan to continue offering health insurance. One possible drawback to simply going the penalty route is the tax consequence. Employers can deduct health insurance premiums they pay for their employees, whereas penalty payments are not deductible.⁴⁴ Another drawback is the concern that the employer would be considered a less attractive place to work, especially if competitors are able to offer benefits.

³⁸ Roy, Avik, “Employers Can Minimize Their Exposure to Obamacare’s Penalties by Offering Low-Cost ‘Skinny’ Coverage”, *Forbes*, May 21, 2013.

³⁹ Roy, Avik, “Employers Can Minimize Their Exposure to Obamacare’s Penalties by Offering Low-Cost ‘Skinny’ Coverage”, *Forbes*, May 21, 2013. Weaver, Christopher and Anna Wilde Matthews, “Employers Eye Bare-Bones Health Plans Under New Law”, *Wall Street Journal*, May 20, 2013.

⁴⁰ Roy, Avik, “Employers Can Minimize Their Exposure to Obamacare’s Penalties by Offering Low-Cost ‘Skinny’ Coverage”, *Forbes*, May 21, 2013.

⁴¹ McCann, David, “Obamacare Delay Poses Legal Risk to Employers”, CFO.com, July 9, 2013.

⁴² Maze, Jonathan, “Obamacare Confounds the Restaurant Industry”, *Restaurant Finance Monitor*, November 13, 2013.

⁴³ Tully, Shawn, “Documents Reveal AT&T, Verizon and Others Thought About Dropping Employer-Sponsored Benefits”, *Fortune*, May 6, 2010.

⁴⁴ Maltby, Emily and Sarah E. Needleman, “Small Businesses Opt for the Health-Care Penalty”, *Wall Street Journal*, April 8, 2013.

Passing on Costs to Customers

Some restaurateurs are raising their prices to bring in revenue to cover the additional costs associated with the ACA. This is often a decision that is not made lightly and done with the bottom line in mind, weighing several factors such as remaining competitively priced and ensuring customer loyalty. Those who were initially vocal about this practice have seemingly backed off from their public stance as sales dipped and company headquarters admonished franchisees for tainting the brand reputation⁴⁵. But, for some companies that are committed to offering health coverage and doing so without reducing hours or other benefits, price increases may be one of their only viable options.

“On the financial end, we’re going to have to raise prices; we’re not going to be able to absorb it. So it’s going to make our P&L statements less profitable.”

- NRA Show Interviewee

At a seminar held at Southern New Hampshire University on the impact of the ACA on small businesses, Tom Boucher of Great New Hampshire Restaurants referred to price increases as the “fifth option”, after considering cuts in benefits to managers, eliminating bonus pay, eliminating longevity incentives, and reducing hours to create more part-time positions not eligible for coverage. In this example, small price increases over what would ordinarily take place each year, along with some small cuts in operating expenses such as marketing, provided the resources needed to offer expanded coverage and comply with the law. Boucher made the decision to embrace the opportunity to become what he believes is an “employer of choice” in the restaurant industry by expanding his company’s health care offerings to the newly eligible employees. “We are not going to cut benefits or hours.”⁴⁶

Lump Sum for Health Care

During the roundtable, one restaurant was given as an example of a company providing its employees a lump sum with which to purchase health insurance through a private exchange⁴⁷. This option is partly due to the difficulty in finding plans that are affordable for everyone and meets the high bar for coverage demanded by even the bronze-level plans. It is also a way for employers to mitigate the uncertainty over their health care costs as they can more readily budget and plan with this lump sum approach. It is similar to the transition from defined benefit to defined contribution retirement plans. Instead of designing and offering a defined set of health benefits, companies are essentially getting out of the business of health care and making cash contributions to savings accounts that employees use to purchase insurance on a private exchange. While the approach allows companies to cap health care costs and gives employees more choice in plans, risk shifts from the employer to employee, as was the case with retirement plans.

The lump sum option may offer a near-term pathway. However, transferring risk and unpredictability to the employee has some worried about the potential for employee coverage problems and potential backlash. Early indications are that many workers enrolling in private exchanges are choosing less expensive coverage than they previously had, and questions remain as to whether or not it leaves employers open to penalty liability.⁴⁸

⁴⁵ GSEI-NRA Roundtable Participant, September 6, 2013. Ungar, Rick, “Papa John’s, Applebee’s Pay Huge Price for Anti-Obamacare Politicking”, *Forbes*, December 4, 2012.

⁴⁶ Solomon, Dave, “Small business on Obamacare: ‘We need to know what the laws are’”, New Hampshire Union Leader, September 2013.

⁴⁷ Private exchanges are emerging as marketplaces of health insurance and other products promoted by private industry stakeholders (e.g. payors, benefits consultants), generally with options for employers to administer defined contribution arrangements. “The Emergence of Private Health Insurance Exchanges: Fueling the ‘Consumerization’ of Employer-Sponsored Health Insurance, Booz & Company, 2012.

⁴⁸ GSEI-NRA Roundtable participant, September 6, 2013.

A New Kind of “Job Sharing”

Another potential way to manage costs associated with the ACA, is the practice of part-time “job sharing.” Some franchise owners are reportedly sharing workers who work fewer than 30 hours a week at one franchise, but above that in total for the restaurant chain⁴⁹. By working fewer than 30 hours at each location, the franchise can avoid being required to offer its employees health care. As long as the franchises have different owners, this job sharing practice is entirely legal⁵⁰. In another flavor of this job sharing practice, the Wall Street Journal reports that a McDonalds franchise has hired workers to be cashiers or cooks for 20 hours a week, and then the workers log hours at a nearby Burger King or Wendy’s with another set of workers taking the opposite shifts. Both franchise chains keep these workers’ hours under 30 hours per week.⁵¹ Naturally, this option is only potentially feasible for operations in close proximity of each other. The tracking and managing across separate franchise owners may be too onerous to make it practical.

Status Quo

Finally, while doing nothing might seem a risky option, some restaurant owners may find themselves doing just that - maintaining the status quo. They may choose to do nothing more beyond the required employee notification about the ability to obtain coverage through an exchange. With 43% of restaurant workers under the age of 26, employers with disproportionately large number of young adult workers may find that taking no action may be the most cost effective option. Many young workers will choose to stay on their parents’ plan until age 26, obtain health care through their spouse’s employer, find they qualify for Medicaid (in the states expanding the program), or opt-out and pay the individual penalty of \$95 a year or 1% of income, whichever is greater.

Key Areas to Monitor

One roundtable participant explained that although the industry has weathered major changes before such as reporting tip income, the scope and breadth of the ACA is on a level never before seen and will have lasting impact on restaurant and foodservice businesses. Just a few weeks before the October 1st deadline for employee notification about options available at public health care exchanges, participants at the September 6th roundtable swapped information about situations they were facing or observing. They seemed to find comfort in knowing that they were not alone in not feeling 100% ready. Several themes and insights emerged during the roundtable that are amplified and supplemented by articles in the mainstream press.

Employees are unpredictable

Employers were unified in the assertion that the biggest cause for uncertainty and “sleepless nights” is the inability to predict what employees will do. Some employees are completely unaware of the new level of individual responsibility that faces them. Others are opting into plans offered by employers in order to avoid the unknown that other options carry. Still others seem to be delaying decisions until more is known, potentially setting themselves up for a situation where open enrollment at work has closed and other options are not affordable to them. These delays have been exacerbated by the problematic roll-out of the federal and some state exchanges.

With employees slow to make commitments in this environment, business leaders are forced to make “best guess” projections and assumptions. One participant described the process at his company, which included a mailed survey, an interview with every single employee, and mandatory group meetings. With just weeks

⁴⁹ Berman, Julian, “Fatburger Franchises Sharing Employees to Skirt Obamacare, CEO Says”, [Huffington Post](#), July 10, 2013.

⁵⁰ 29 CFR 791.2 – Joint Employment, Legal Information Institute Cornell University Law School, [www.law.cornell.edu](#).

⁵¹ “Obamacare and the ‘29ers’: How the new mandates are already reducing full-time employment”, Wall Street Journal, February 22, 2013.

to go before the October 1st employee notification deadline, 40% of his 250 employees were still unsure of whether or not they would enroll in their employer's health care offering, which meant a \$200,000 expense swing in either direction.

Another restaurateur described the "total shock" over an unexpected \$2 million expense that his company is having to absorb, as their company's September 1, 2013 renewal yielded 800 new enrollees. The company thought it had a full year to deal with the expense given the one-year transition relief. One of the roundtable participants attributed this unexpected increase in enrollees to the fact that premium information was not yet available from the exchanges, so employees were likely signing up for what was known. Anticipating this dynamic, the proactive employer with the new \$2 million expense had already planned to take advantage of a part of the regulation that he hopes will be a lifeline for his company. In previous years, once an employee enrolled in a company health care plan, they could not later opt-out. However, this time around, once employees learn what they can get through an exchange, they will have the option to opt-out or un-enroll from their employer-sponsored coverage that was offered on a non-calendar year basis (September 2013 to September 2014 in this example).

Finally, another participant added to the lively exchange that what happened in Massachusetts could be a relevant test case, where an unexpectedly large number of employees opted for insurance⁵².

Misinformation and lack of awareness

A poll conducted in April 2013 by the Kaiser Family Foundation showed that conversation with family and friends and the news media has provided the greatest amount of information about the ACA, with the employer as one of the least sought out sources.⁵³ Yet, employers are responsible for notification and are an important distribution channel for building awareness about the ACA. The restaurant industry is not alone in its concern about employee education gaps and their role in helping to close them.

According to the same poll, 4 in 10 Americans were still unaware the ACA had been fully implemented as law. Research conducted for Enroll America found that nearly 80 percent of the uninsured were unaware of their upcoming coverage options.⁵⁴ Nearly half of all Americans (49%) say they do not have enough information about the ACA to understand how it will impact their family. When looking at uninsured and low income Americans, that share rises to 58% of uninsured and 56% of low-income households.

While millions of dollars are being spent in states and their navigator programs to support education efforts about the exchanges, most businesses appear to be relying on traditional broker relationships to guide them. At the same time, the health insurance broker industry is going through tremendous upheaval, with many lacking the capacity and capability to lead clients through the changes required by the ACA. Consolidation is underway as smaller operations are being absorbed by large enterprises⁵⁵. All this flux is adding to the already complex operating environment. Several examples were shared at the roundtable about the lack of reliable information and questions concerning whom to trust. Restaurateurs are wary about receiving wrong information, which could in turn result in a bad decision that could damage their businesses.

All roundtable participants expressed concern for their many colleagues, especially small business owners, who are too busy running their daily operations to even think about the requirements of the ACA and "who may only find out about them when told they are not compliant. October 1st was the notification deadline and

⁵² This was a result of the Massachusetts Health Reform Act of 2006 that required all adults 18 and over to have health insurance and all employers with 11 or more full-time employees to offer a group health plan to their employees (and pay a fair share of the monthly premium), or pay an Employer Fair Share Contribution. Source: <http://www.massresources.org/health-reform.html>

⁵³ Kaiser Family Health Tracking, April 2013.

⁵⁴ "New national campaign aims to boost ACA awareness", ACA Watch, National Insurance Services of Wisconsin, June 25, 2013.

⁵⁵ GSEI-NRA Roundtable, September 6, 2013.

most do not know what to notify about.”⁵⁶ Employers in other industry sectors also appear to be experiencing similar issues of uncertainty and misinformation and are looking to their trade associations for answers.

There is a genuine desire and interest in providing quality health insurance options; however, some employers appeared to be unclear about the following:

- Impending deadlines around notification;
- What information to provide to employees; and
- Belief that if not defined as a large employer, no action was needed.⁵⁷

Many expressed misgivings about the state of readiness among their employees. There is a massive need for consumer education and awareness building. The employers at the trade show and roundtable feel the pressure of being on the frontline for providing this education to their employees and doing so credibly. Misinformation, or absence of information, could lead to inefficient implementation of the new health care law and/or unexpected penalties. Some of the commonly held misconceptions among employees include:

- Not knowing whether one has access to insurance exchanges;
- Unclear understanding about the ability to stay on parents’ plans;
- Belief that all elements of the ACA have been postponed by one year;
- Lack of clarity about the costs of insurance exchange products; and
- Lack of awareness of individual penalties and their escalation.

Awareness building alone is not enough

Building awareness of the ACA requirements is a major challenge, but another major step is to get employers to take action and in turn, encourage their employees to take action. There is a need for a consistent set of messages not only to inform, but also to motivate people to use available tools and resources. One roundtable

The uncertainty that still exists around cost appears to be a significant hurdle for many smaller operators.

participant stated that the starting premise for most operators in the industry is that they cannot afford to offer health care. “We (the NRA, brokers, accountants, consultants and other advisors) can educate, but the key is in being able to tell owners what it will cost them.” The uncertainty that still exists around cost appears to be a significant hurdle for many smaller operators.

Impact on Hiring and Expansion

Some business owners who currently have fewer than 50 FTE employees are putting their plans of expansion and hiring on hold to avoid crossing the 50-FTE employee threshold, which would require them to participate in the Employer Shared Responsibility and Large Employer Reporting Requirement(s) part of the law as a large employer. As one operator expressed at the NRA Show, “I can tell you we’re not hiring more, and I know this is across the board where we operate. I know people aren’t opening second restaurants because of this.”⁵⁸

Lump Sums and Private Exchanges

As mentioned earlier, there are a few examples of companies offering their employees a lump sum payment with which to buy health care coverage through private exchanges. According to Accenture, about 1 million individuals will enroll in health insurance through a private exchange in 2014; that figure is projected to reach 40 million by 2018.⁵⁹ Darden Restaurant Group (Red Lobster, Olive Garden, Longhorn Steakhouse,

⁵⁶ GSEI-NRA Roundtable, September 6, 2013.

⁵⁷ Excerpts from NRA Trade Show 2013, video highlights.

⁵⁸ Interview #9, Restaurant, Hotel-Motel Show, May 2013.

⁵⁹ Hamett, Carol, “Is the Time Right for Private Exchanges”, HR Executive Online, July 1, 2013.

etc.) along with Sears Holding and Walgreen's is offering a lump sum to its employees to purchase their own plans on exchanges.⁶⁰ Darden's employer contribution will be benchmarked to inflation and will rise accordingly. Other companies in their respective industries will watch these early adopters closely.

The ACA and costs associated with it appear to be a catalyst for employers to transition from a system in which they select benefit plans and qualify employees to participate in it, to one where employers give funds to employees to buy their own coverage. For employers, costs become fixed, predictable and controllable; for employees, they receive more choice and gain portability, with the ability to maintain their coverage even if they switch employers. Dual income households may be able to take contributions from different employers to purchase a single coverage plan for their whole family.⁶¹

Health care exchanges now open for business

Much has been reported about the lack of readiness when the health care exchanges opened on October 1, 2013. Technical difficulties have kept many people from setting up accounts or enrolling although improvements in wait time and site availability are reported to be underway. Some of the leading insurance providers – UnitedHealth, Aetna, and Cigna – are limiting their participation in the state-run exchanges, apparently out of concern that unhealthy Americans who previously were unable to receive coverage will flood the exchanges. They are adopting a “wait and see” approach, testing the waters and determining what their risk pools look like before entering too far into the state exchange programs.⁶²

Health care decisions impact other employee benefits

A roundtable participant talked about the challenges her company is facing with the change in definition of the full-time employee. Her concern is over how to track benefits for the 30-hour a week full-time employees and benefits (e.g. sick leave, vacation pay, paid time off, life insurance) for the regular full-time employees who work 40 hours a week. From the employee perspective, some of their decisions related to health care benefits such as self-imposed cutback of hours to qualify for exchange credits, might cause reduction in contributions to their retirement plans. This theme was also shared by an owner at the NRA Show, “To figure out 250 employees – who's full-time, who's not full time; when they're considered full-time on payroll at 40 hours and according to this healthcare (law), they're 30 hours . . . it's an administrative nightmare.”⁶³

Medicaid expansion opportunity

For the states that are expanding Medicaid eligibility as part of the ACA, questions remain as to whether those eligible will enroll for benefits. There may be a stigma to being eligible for Medicaid among people who typically do not think of themselves as low income. Most states apparently consider targeting young, healthy men for coverage as a vital part of their expansion strategy. Federally qualified health centers⁶⁴ have served lower income populations with relatively high satisfaction levels among patients they serve. There may be opportunities for providing health care through these centers outside of Medicaid.

Impact of One-Year Delay

With the one-year transition relief and voluntary compliance for the employer reporting requirements and penalty enforcement for large employers, there may be some individuals who purchase coverage through a health care exchange and qualify for a subsidy in 2014. Consider a “young invincible” earning \$24,000 a year who signs up for a silver plan at 70% coverage and who receives a government subsidy, effectively making this an 87% benefit plan. Once he/she receives his/her employer's plan for 2015, it would be

⁶⁰ Rogers, Kate, “Walgreens to Move 160K Workers to Private Health Care Exchanges”, Fox Business, September 18, 2013.

⁶¹ Scandlen, Greg. “Private Health Insurance Exchanges: The Emerging Marketplace”, Policy Insights, Citizen's Council for Health Freedom, November 2012.

⁶² Luhby, Tami, “Big Insurers Ditch Obamacare Exchanges”, CNN Money, September 10, 2013.

⁶³ Interview #9, Restaurant, Hotel-Motel Show, May 2013.

⁶⁴ Federally qualified health centers are community-based organizations that provide comprehensive primary and preventative care to persons of all ages regardless of their ability to pay or health status.

necessary to give up their health exchange coverage that could provide better benefits at a lower price. Individuals do not qualify for a subsidy if their employer's plan is deemed affordable and of minimum value, and they could end up in a plan that provides less coverage for a higher price even with the employer subsidizing the premium.

The same dynamic could happen with employees who work for a small business (any business with fewer than 50 FTEs). Individuals could purchase health insurance through an exchange and potentially receive a subsidized premium, but then be offered an opportunity to enroll in their employer's offering and receive an employer contribution in the following year if the employer grows to more than 50 FTEs. In this scenario, if an individual decides to enroll in his/her employer-sponsored plan, he/she may end up paying more for a plan that provides less coverage depending on what the individual enrolled in on the exchange and what the employer offers.

Potential Innovation Opportunities

Now that public health care exchanges are open and employee enrollment is in effect, it is important to closely monitor and learn from the choices employees make. Are employees signing up for their employer plans, opting into exchanges, or paying penalties? Similarly, how are employers responding in terms of labor scheduling, hiring, type of health benefits being offered, impact on other benefits offered, communication with employees and exchanges, and business expansion? Employee actions and employer responses will help inform policy and product offerings during the course of the next year.

Now that public health care exchanges are open and employee enrollment is in effect, it is important to monitor and learn from the choices employees make.

The National Restaurant Association has developed a member-exclusive Notification Tool (at [Restaurant.org/Notify](https://www.restaurant.org/Notify)), which is an online solution to help restaurateurs provide the Fair Labor Standards Act (FLSA) notification about exchanges to employees and keep track of those whom they have notified. The NRA's Notification Tool leverages the Department of Labor's templates, captures an employee's e-signature confirming receipt of the notification, and creates a permanent record to verify which employees received the notice. Participants view the Notification Tool as a "tremendous value", offering "one central source" and providing a third party trusted brand – the National Restaurant Association – to supplement their own company's communication efforts.

Both roundtable participants and interviewees at the annual NRA show stated that the National Restaurant Association has an important role to play in serving as a "trusted advisor" and "third party validator" to the entire industry and has an opportunity to:

- **Support peer-to-peer learning:** Promote shared learning and best practices among restaurant and foodservice peer groups through online forums, webinars, seminars, etc.;
- **Develop consistent messaging:** Work across key stakeholders to develop uniform messaging (yet tailored to specific segments of industry employees) that conveys affordability and ease of access through the exchanges;
- **Build segmented awareness and engagement strategies:** Target priority segments such as young adults and utilize multiple touch points to reach them through social media and other tactics such as engaging a star chef from the Food Network to do a PSA, or handing out NRA-branded

- stickers or a hat with an “I’m covered” message (similar to the “I voted” stickers handed out on election days);
- ***Become one-stop, trusted resource:*** Continue to invest in becoming the education center for all things related to the ACA for the industry – both for employers and employees. From expert content, to real-time updates to ACA modifications, to tools like the online Notification Tool and more, being the “go-to” destination for the industry would have a positive ripple effect for the brand as the NRA expands its own suite of benefits offerings. Available tools and information should include those offered by federal agencies, such as the Small Business Association’s: business.usa.gov/healthcare.
 - ***Use distribution partnerships for online Notification Tool:*** Explore partnerships with providers along the entire restaurant supply chain to help get the message out to employers, especially small operators, about the Tool and its capabilities. Ensure State Restaurant Associations are letting their respective membership companies know about the tool. Position it as supporting not only the October 1st notification requirements, but also as part of their ongoing commitment to notifying employees and for the onboarding process of new employees.
 - ***Leverage reporting capabilities of online Notification Tool:*** Develop a comprehensive strategy for the tool’s data collection capabilities; collect and analyze aggregated, non-identifiable data to serve as the “pulse” for how the restaurant and foodservice industry is complying with the ACA and flag areas that are working well or need to be addressed.
 - ***Partner to deliver industry-tailored offering:*** Monitor for any market gaps in offerings and explore partnering with provider(s) to develop a private exchange designed to meet the unique needs of the restaurant and foodservice industry.

The NRA also has an opportunity to lead among trade associations of other sectors, by potentially licensing its online Notification Tool to help them with ACA implementation on an even larger scale.

Summary

Solutions at the tactical and strategic levels to ensure the industry’s ACA compliance have been developed and are being tested by restaurateurs representing all segments of the industry. Much still remains to be learned and decided as the notification deadline has only recently passed. The industry will continue to evolve its need for information and refine its resources and product and service solutions. The one-year period of voluntary compliance and transition relief allows time for the strategies to take root and shape other solutions.

The Global Social Enterprise Initiative at Georgetown’s McDonough School of Business and National Restaurant Association will continue to collaborate in monitoring industry developments and responses to the ACA. Most roundtable participants said it would be useful to convene again in six to nine months to see if/how their assumptions have played out and to assess the changing landscape. Sharing what is working, what continues to present challenges, and identifying what still needs to be done to comply with the ACA would benefit the restaurant industry as well as its advisors, health care payors and providers, and policymakers alike.

Appendix 1: September 6, 2013 Roundtable Participant List

- **Tom Boucher, Owner and CEO** of Great NH Restaurants, Inc.
- **Scott DeFife**, Executive Vice President of Policy & Government Affairs, National Restaurant Association
- **Rusty Field**, National Vice President, Distribution Strategy and Channel Development, UnitedHealthcare
- **Phillip (Phil) Kafarakis**, Chief Innovation & Member Advancement Officer, National Restaurant Association
- **Stephen Lagarde**, Senior Manager, Deloitte Tax
- **Howard Lapsley**, Partner, Health & Life Sciences Practice, Oliver Wyman
- **Rosalyn (Roz) Mallet**, Co-Founder, PhaseNext Hospitality
- **Ladan Manteghi**, Executive Director, Global Social Enterprise Initiative, Georgetown University's McDonough School of Business
- **William (Bill) Novelli**, Professor, McDonough School of Business at Georgetown University
- **Jason Ormsby**, Senior Vice President and Chair of the Health Quality and Information Technology Group, Atlas Research and Executive Faculty Member in Georgetown University's Department of Health Systems Administration
- **John Rother**, President and CEO, National Coalition on Health Care and Adjunct Professor, Georgetown University
- **Christopher (Chris) Shand**, Vice President, Human Resources, Recruiting and Training, Silver Diner, Inc.
- **Jay Stieber**, Executive Vice President and General Counsel, Lettuce Entertain You Enterprises, Inc.
- **Michael Sternberg**, Principal and Chief Executive Officer, Star Restaurant Group, LLC
- **Dawn Sweeney**, President & CEO, National Restaurant Association and National Restaurant Association Educational Foundation
- **Lauri Tomlins**, Vice President of Human Resources, Sodexo
- **Diane Ty**, Project Director, Global Social Enterprise Initiative, Georgetown University's McDonough School of Business
- **Joy Johnson Wilson**, Director of Health and Human Services Policy and Senior Federal Affairs Counsel, National Conference of State Legislatures

Appendix 2: Large Employer Calculations

- A large employer who does not offer coverage to its employees will be subject to a penalty if at least one full-time employee obtains coverage through an exchange and receives a premium tax credit. The annual penalty that is assessed is equal to the number of its full-time employees minus 30 and multiplied \$2,000 or $\$2,000 * (\# \text{ of FTs} - 30) / 12$ to calculate the monthly penalty. It is important to note that part-time workers are included in what is the FTE calculation to determine if an employer has at least 50 FTEs and therefore a large employer; however, the penalty is only levied based only on the number of full-time workers (those working an average of at least 30 hours a week in a calendar month).⁶⁵
- Individuals who are offered coverage through their employers can only obtain premium credits for exchange coverage if their employer's coverage is deemed unaffordable or inadequate. To qualify as affordable, the individual's contribution toward the premium for the lowest cost self-only coverage cannot exceed 9.5% of his/her household income.⁶⁶ Adequate coverage is defined as a health plan that must pay at least 60%, on average, of covered health care expenses. If at least one full-time employee declines his/her employer's coverage and obtains coverage through an exchange with a premium credit, the employer will be subject to the penalty.⁶⁷ This annual calculation is $\$3,000 * \# \text{FT claiming tax credit}$.

⁶⁵ Mulvey, Janemarie, "Potential Employer Penalties Under the Patient Protection and Affordable Care Act", Congressional Research Service, July 22, 2013.

⁶⁶ "Health Care Law Primer", National Restaurant Association, July 2013, edition. The IRS allows for three "affordability safe harbors" for wage-based tests. These include: 1) W-2 Safe Harbor where a health plan is considered affordable if a full-time employee's share of the premium for self-only coverage during a year is less than 9.5% of the wages the employer pays, as reported in Box 1 of Form W-2; 2) Rate-of-Pay Safe Harbor, where this method is used prospectively, applying it broadly to its group of employees or on an employee-by-employee basis. Employer can apply the premium contribution based on the rate of pay for the lowest-paid employee; 3) Federal Poverty Safe Harbor, where the employee's share for self-only coverage cannot exceed \$1,091.55 for the year, which is 9.5% of \$11,490, the federal poverty level for an individual in 2013), or not more than \$90.96/month.

⁶⁷ Mulvey, Janemarie.