Affordable Care Act (ACA)
Employer Sponsored Group Health Plans
2016 and Beyond

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U.S. Health & Benefits
Presentation to FEI

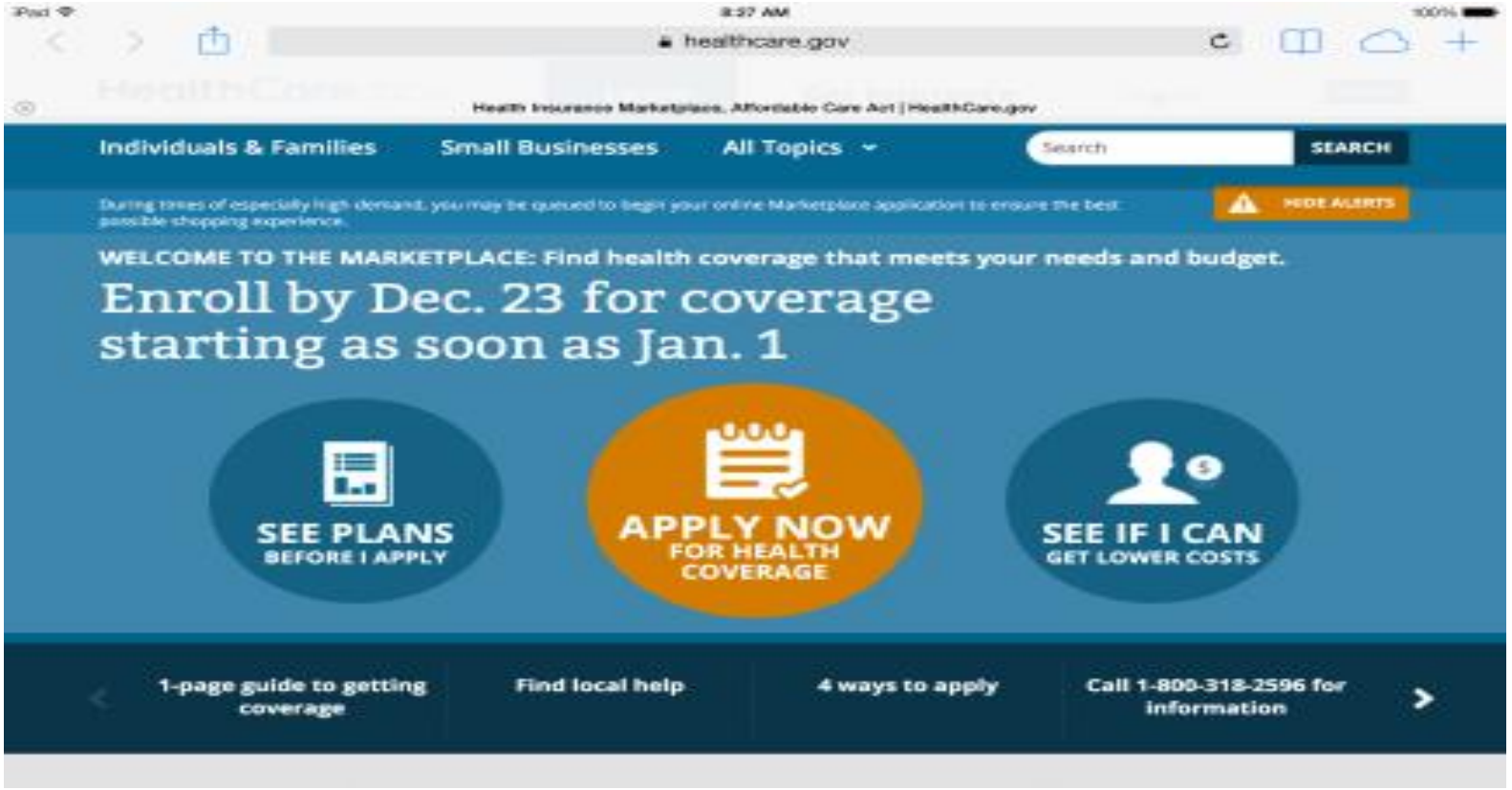
Empower Results®

Health Care Reform—From 1992 to 2015

Managed Healthcare

1992

… we have very different choices



2015

We have different choices for our phones…

1992

…than we did in 1992

2016

We have different choices for our entertainment…

1992

… than we did in 1992

2015

…and we even have different choices for President

1992

…almost

2015

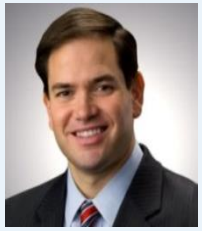
Democratic Candidates

Democratic Presidential Candidates	Approach	Details	Medicare/Medicaid
Hillary Clinton 	Build on the ACA	▪ Intends to slow the growth of overall health care costs (including Rx) ▪ Lower out-of-pocket costs like copays and deductibles ▪ Expand value and quality initiatives in ACA ▪ Expand access to rural areas, including focus on telemedicine licensing	▪ Opposes premium supports (what she calls “privatization of Medicare”) or phasing it out ▪ Advocates Medicare delivery reforms to improve value and quality of care
Bernie Sanders 	Single Payer Plan “Medicare for All”	▪ Includes vision and dental ▪ Cost $1.38T ▪ Savings of $6T from current system over 10 years ▪ Paid for by: ▪ 6.2% income based health care premium on employers ▪ 2.2% income based premium paid by households ▪ Progressive income tax rates ▪ Tax capital gains same as ordinary income for those above $250K ▪ Limit tax deductions for those above $250K ▪ Estate tax for inheritances over $3.5M ▪ Eliminate tax breaks that subsidize health care	Expand Medicare to all Americans

GOP Candidates

Republican Presidential Candidates	Repeal ACA	Expand HSAs	Coverage Across State Lines	Tax Credits to Buy Coverage	Limit Exclusion for Employer Health Insurance	Medicaid Block Grants to the States	Other
Jeb Bush 	X	X		X	X		▪ Tax breaks for small employers to make contributions for employees to buy individual plans ▪ Tort reform
Ben Carson 	X	X					▪ Utilize Health Empowerment Accounts ▪ Mental Health Reform
Ted Cruz 	X	X	X				▪ Health Care Choice Act as an alternative to ACA ▪ Allow insurance policies sold in one state to be sold in another

GOP Candidates

Republican Presidential Candidates	Repeal ACA	Expand HSAs	Coverage Across State Lines	Tax Credits to Buy Coverage	Limit Exclusion for Employer Health Insurance	Medicaid Block Grants to the States	Other
John Kasich 	X						▪ Improve primary care ▪ Reward value instead of volume
Marco Rubio 	X	X	X	X	X	X	▪ Reform Medicare by introducing choice between private plans and traditional Medicare ▪ Transition to premium support system for Medicare
Donald Trump 	X						

Agenda—Implementing Health Care Reform for 2016 and Beyond

ACA Employer Shared Responsibility

- *A Refresher*
- *Critical Nuances*

Health Reimbursement Arrangements—How Did A Simple “Account” become so Complicated?

- *It’s Minimum Essential Coverage*
- *Integration*

Excise Tax on High Cost Insurance—It’s Delayed But Not Forgotten

- *Overview*
- *Statutory Changes*
- *What’s Next?*

Wellness Programs – Staying Healthy with Complicated Rules

What is Health Care Reform?

Comprehensive health care reform legislation was passed in 2010 primarily to:

- Improve access to affordable health coverage for legal residents of the United States
  - Government Exchanges (aka Health Insurance Marketplace)—go to www.healthcare.gov
    - Different than Aon's "private" Exchange
  - Expansion of Medicaid
  - Employer Shared Responsibility (ESR)
  - Individual Shared Responsibility
- Require health coverage to include certain consumer protections (group market reforms)
- Health care reform legislation
  - Patient Protection and Affordable Care Act (PPACA or the ACA) passed on March 23, 2010
  - Amended by the Health Care and Education Reconciliation Act of 2010 passed on March 30, 2010

ACA Key Dates 2011–2014

2011	2012	2013	2014
▪ Lifetime dollar limits on Essential Health Benefits (EHBs) prohibited[1] ▪ Pre-existing condition exclusions prohibited for children under 19[1] ▪ Overly restrictive annual dollar limits on EHBs prohibited[1] ▪ Extension of adult child coverage to age 26[1] ▪ Prohibition against rescissions[1] ▪ Certain in-network preventive health care provided with no cost sharing2 ▪ Internal claims and appeals changes and external review2 ▪ Consumer/patient protections[2] ▪ Nondiscrimination requirements on fully insured plans[2] **(Delayed)** ▪ Certain retiree medical claims reimbursable [Early Retiree Reinsurance Program (ERRP)] ▪ Retiree drug plan flexible spending account (FSA) liability recognition ▪ Over-the-counter medicines not reimbursable under health FSA, health reimbursement accounts (HRAs), or health savings accounts (HSAs) without a prescription, except insulin ▪ HSA excise tax increase ▪ Public long-term care option (CLASS act)—no longer supported by the Department of Health and Human Services (HHS) ▪ Medicare Part D discounts for certain drugs in "donut hole"	▪ In-network women's preventive health care provided at no cost sharing (effective for PY beginning on or after August 1, 2012)[2] ▪ Employer distribution of summary of benefits and coverage to participants[1] ▪ Patient Centered Outcomes Research Institute (PCORI) fee based on average number of covered lives [applies to policy or plan years ending on or after October 1, 2012, and before October 1, 2019; report and pay the fee on Internal Revenue Service (IRS) Form 720 no later than July 31 of the calendar year immediately following the last day of the policy or plan year) (first payment due July 31, 2013) ▪ Employer quality of care report[2] **(Delayed)** ▪ Medical loss ratio rebates (insured plans only)[1] ▪ Employer reporting of health coverage on form W-2 (first filing due January 31, 2013)	▪ Notice to inform employees of coverage options in Exchange ▪ Limit health FSA salary-reduction contributions to $2,500 (indexed) ▪ Elimination of deduction for expenses allocable to retiree drug subsidy (RDS) ▪ Additional Medicare tax on high-income earners	▪ Individual mandate to purchase insurance or pay penalty ▪ State insurance Exchanges ▪ Pre-existing condition exclusions prohibited[1] ▪ Annual dollar limits on EHBs prohibited[1] ▪ Automatic enrollment **(Delayed)** ▪ Limit of 90-day waiting period for coverage[1] ▪ Increased cap on rewards for participation in health-contingent wellness program[1] ▪ Annual out-of-pocket (OOP) limits apply to group health plans[2] ▪ Coverage for individuals participating in approved clinical trials[2] ▪ No discrimination based on provider's license or certification[2] ▪ Information (transparency) reporting[2] **(Delayed)** ▪ Controlling health plans obtain unique Health Plan Identifier **(Enforcement Delayed)** ▪ Transitional reinsurance contributions for plans providing major medical coverage (applies to benefit years 2014–2016; in general, submit enrollment counts and payment dates each year by November 15) (first submission due by December 5, 2014)

[1] Denotes group/insurance market reforms applicable to all group health plans.
[2] Denotes group/insurance market reforms **not** applicable to grandfathered health plans.

ACA Key Dates 2015–2020

2015	2016	2017	2018	2019 and 2020
▪ Employer responsibility to offer affordable, minimum value (MV) health coverage to "full-time" employees (and their children) to avoid Code Sec. 4980H assessable payments ▪ Controlling health plans certify compliance with certain Health Insurance Portability and Accountability Act (HIPAA) standard transactions **(Delayed)** ▪ First transitional reinsurance contribution payment(s) due by January 15, 2015 and/or November 15, 2015 ▪ Additional nuances to group market reforms continue to be issued, plus updated regulations	▪ Annual employer reporting of health coverage information to IRS by February 28 (March 31 if filing electronically) of year immediately following calendar year coverage was offered (first electronic reporting due by March 31, 2016 to IRS) ▪ Annual employer statements to employees by January 31 of year immediately following calendar year coverage was offered (first reporting by February 1, 2016 to individuals) ▪ Second transitional reinsurance contribution payment(s) due by January 15, 2016 and/or November 15, 2016	▪ FINAL transitional reinsurance contribution payment(s) due by January 17, 2017 and/or November 15, 2017	▪ 2.3% excise tax on medical devices reinstated (effective in 2013 but suspended for 2016 and 2017) ▪ Health insurance providers fee reinstated (effective in 2014 but suspended for 2017)	▪ FINAL PCORI fee due by July 31, 2019 for calendar year plans and by July 31, 2020 for noncalendar year plans ending after December 31, 2018 and before October 1, 2019 ▪ Coverage providers subject to 40% excise tax on excess benefit of high-cost coverage ("Cadillac Tax" delayed from 2018 to 2020)

Employer Shared Responsibility—Background

Who Is Subject to the Employer Shared Responsibility Rules?

Answer: An Applicable Large Employer ("ALE")

- Employer that employed on average of at least 50 (for 2016 and beyond!)* or more full-time employees (including full-time equivalent employees) on business days during the preceding calendar year
  - **Full-Time Employees** are employed on *average at least **30 hours of service per week***
  - **Full-Time Equivalent Employees** *do not average at least 30 hours of service per week* but the employer must add up total hours per month in the preceding calendar year and divide by 120 hours to determine how many Full-Time Employees to "count"
- Calculation must include all Full-Time Employees (and Full-Time Equivalent Employees) of entities that are treated as a single employer under the controlled group rules (under Code Sec. 414(b), (c), (m) and (o))

The ALE threshold is decreased from 100 Full-Time Employees to 50 for 2016 and beyond!

*100 or more full-time employees (including FTEs) for 2015

Employer Shared Responsibility—Background

Corp. X
(ALE Member)
60 full time employees

Corp. Y
(ALE Member)
40 full time employees

Corp. Z
(ALE Member)
0 full time employees

Corp. Z owns 100% of Corp. X and Corp. Y = One ALE
> 50 full-time employees (FTEs)

Employer Shared Responsibility—Background

Who is an ALE Member?

- Determination of any potential assessable penalties under the ESR is made separately for each entity/company—for each ALE Member
  - Look at each company/subsidiary (ALE Member) in the controlled group
  - Each ALE Member needs to analyze which employees of that ALE Member qualify as Full-Time Employees
- Each ALE Member is liable for its 4980H assessable penalty
  - Is not liable for the 4980H assessable penalty of any other entity in the controlled group comprising the ALE

Employer Shared Responsibility—Background

What is the ESR Penalty/Mandate?

- An **ALE Member** may be subject to a penalty if it fails to comply with Internal Revenue Code section 4980H
- However, the stars must align to actually trigger the penalty

  - 1. Employer must be an ALE Member (a member of an ALE)
  - 2. Employee must be a Full-Time Employee
  - 3. [At least one] Full-Time Employee must go to a government Exchange (the Health Insurance Marketplace) and receive a Premium Tax Credit (a government subsidy)

Employer Shared Responsibility—Background

What is the Premium Tax Credit?

The premium tax credit is a refundable credit that helps eligible individuals and families with low or moderate income afford health insurance purchased through a Health Insurance Marketplace (a government Exchange). (Cost sharing reduction(s) are also available.)

Who is Eligible for the Premium Tax Credit?

To be eligible for the Premium Tax Credit, an applicable taxpayer or a member of the taxpayer's family

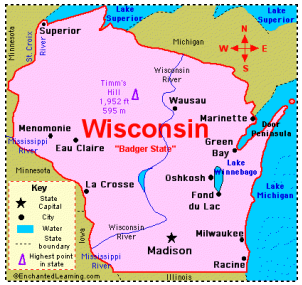
- 1. Must be enrolled in Qualified Health Plan through a government Exchange; and
- 2. Cannot be:
  - Eligible for employer-sponsored Minimum Essential medical Coverage (MEC) that is Affordable and provides Minimum Value; or,
  - Enrolled in MEC other than coverage in the individual market
- Further, the applicable taxpayer is eligible for the premium tax credit only if his/her household income is at least 100% but not more than 400% of the Federal Poverty Level (FPL) for the taxpayer's family size for the taxable year
  - For example, for a family of four in the continental U.S., the income is $24,250–$97,000 for 2015

Employer Shared Responsibility—Background

- Ethan Engineer works at least 30 hours per week
- Ethan works for Wisconsin Widget Corp.
- Ethan is married with two kids and his household income is $75,000 per year
- Ethan "feels" that his coverage is too expensive – caution: IRS reporting should reconcile overpayments/determine whether or not ESR is triggered
- Wisconsin Widget Corp. offered Ethan medical coverage at annual enrollment, but Ethan declined the coverage

$ to Ethan's insurer through government Exchange (or Ethan can claim credit on tax return)

Ethan works for Wisconsin Widget Corp.



Healthcare.gov

Ethan tells Exchange he's employed and employer did not offer him affordable coverage

Employer Shared Responsibility Payment: General Rule

How Does a Full-Time Employee's Enrollment in the Health Insurance Marketplace Affect an ALE Member?

An ALE Member, i.e., a "large employer" will be required to make an assessable payment to the IRS if it fails one of two tests under the Internal Revenue Code (IRC):

- Test # 1: IRC section 4980H(a) – Sledgehammer Penalty
- Test # 2: IRC section 4980H(b) – Tack Hammer Penalty

What's New for 2016?

Test # 1 is a lot more difficult to pass …

Test #2's determination of Affordability has updates (and more to come!) …

Test # 1: IRC §4980H(a)—Employer Shared Responsibility Payment

Sledgehammer Penalty under § 4980H(a):

- **MEC must be offered to 95% [70% in 2015] of all Full-Time Employees (and their eligible non-spouse dependents) or sledgehammer penalty will apply**

What's New in 2016! Threshold is 95% and penalty amount increased

# of Full-Time Employees employed by the ALE Member (**minus 30** [minus 80 for 2015])* x **$180** per month in 2016 (indexed)

Annualized the penalty is
($180 x 12 months = $2,160)

Notes:

- The penalty does not include employees in a limited non-assessment period
- Applies separately to each ALE Member
- *Minus **30** (or 80 for 2015) is allocated ratably among ALE Members

Test # 1: IRC §4980H(a)—Employer Shared Responsibility Payment

Sledgehammer Penalty under §4980H(a):

Action Steps to Consider

due to Increase from 70% to 95%:

- **Employers should confirm that they have captured all "common law" Full-Time Employees and document with staffing agencies/PEOs**
  - Complicated requirements by IRS
  - Staffing agencies and PEOs further complicate – employers should analyze whether individuals who work for staffing agency or PEO are (or are not) a common law employee of the employer – regulations provide for a safe harbor; document with your service providers
- **If currently using Monthly Measurement Method for determining who is a Full-Time Employee, may want to consider the Look-Back Measurement Method—complicated transition rules IRS Notice 2014-49**
- **Revisit analysis to ensure that the 95% threshold can be satisfied in 2016 before it's too late—penalty is month to month**

Test # 2: IRC §4980H(b)—Employer Shared Responsibility Payment

Tack Hammer Penalty under §4980H(b):

- **MEC must be Affordable and Provide Minimum Value or "Tack Hammer Penalty" may apply**

# of Full-Time Employees who enroll in government Exchange and receive a premium tax credit and were **not** offered Affordable MEC that meets MV x **$270** per month in 2016 (indexed)

Annualized penalty is

($270 X 12 months = $3,240)

Notes:

- Does not include Full-Time Employees who are in a permissible waiting period
- Tack Hammer Penalty may still apply if an employer offers coverage to at least 95% (but less than 100%) of Full-Time Employees and one or more of those employees who are not offered coverage receive a premium tax credit or cost sharing reduction

Test # 2: IRC §4980H(b)—Employer Shared Responsibility Payment

Tack Hammer Penalty under §4980H(b):

When is coverage Affordable?

- Affordability Test for purposes of the premium tax credit is based on the cost of self-only coverage, even if the employee elects family coverage
- An employer-sponsored plan is **Affordable** if the Full-Time Employee's required contribution for self-only coverage under the plan does not exceed **9.66%** (**in 2016**) of the Applicable Taxpayer's household income for the taxable year
- While the **Affordability** Test for purposes of an individual's premium tax credit will continue to be based on **household income**, the IRS issued three optional safe harbors that allow employers to calculate the Affordability Test for the Employer's Shared Responsibility Payment
  - W-2
  - Rate of Pay
  - Federal Poverty Line – using 9.66% and $11,770 as FPL for an individual = $94.75
- **New! Safe harbors also may use the 9.66% for 2016, 9.56% for 2015 (indexed) in lieu of 9.5%**

Test # 2: IRC §4980H(b)—Employer Shared Responsibility Payment

Tack Hammer Penalty under §4980H(b):

Additional "New" Affordability Nuances for 2016 and Beyond

- **Employers may take into account a "health flex contribution" when determining if coverage is affordable**
  - A health flex contribution may not be taken as cash, may be used to pay for MEC (medical coverage), and may be used only to pay for medical care
  - If a cafeteria plan contribution can be used to pay for health care benefits and also for non-health care (for example, a dependent care spending account or group term life) benefits, it does not qualify as health flex contributions and will not lower employee's contribution
  - Transition rule for plan years beginning before January 1, 2017: Employers may take into account any employer flex contribution (whether a health flex contribution or not) to determine affordability
- **Opt-Out Credits—watch out!**
  - While transition rules currently apply and not effective until final rules are issued, the IRS is **likely** going to count opt-out credits as a lost opportunity which makes passing the Affordability test a LOT more difficult
  - Example: Employees required to contribute $200 toward the cost of coverage but if the employee opts-out, s/he are eligible for $100 in additional compensation → result: IRS will consider this a $300 employee contribution for medical coverage

What Method to Use for Purposes of Determining Who is a Full-Time Employee?

Monthly Measurement Method	Look-Back Measurement Method
▪ Employer is comfortable that it will absolutely meet the 4980H(a) 95% test (70% in 2015) for each ALE member	▪ Employer does not have a "good picture" or accurate data regarding their true common law employee workforce and/or hours
▪ Employer has a **small**, identifiable number of variable hour, seasonal, or part-time employees (**or none**) who are not offered MEC, or are not offered MEC that is Affordable coverage that meets Minimum Value	▪ Employer has a **large** number of variable hour, seasonal or part-time employees who are not offered MEC that is Affordable and meets Minimum Value
▪ Employer has a **small**, identifiable number of full-time employees (**or none**) who are not offered MEC, or are not offered MEC that is Affordable or provides Minimum Value (e.g., interns)	▪ Employer does not have an effective mechanism to manage actual hours worked v. scheduled hours worked for its common-law employee workforce
▪ Employer is comfortable with the exposure on 4980H(b) penalty—full-time employees or part-time, variable hour, or seasonal who might be deemed full-time during a month(s) using the monthly measurement method who are not offered MEC, or not offered MEC that is Affordable or provides Minimum Value	▪ Employer is concerned about adverse publicity (both internally and externally) regarding liability for the 4980H(b) penalty, even if the number of variable hour, seasonal, and part-time employees is relatively small
▪ Employer's cost of implementing and administering the look-back measurement method may exceed any anticipated exposure under the 4980H(b) penalty	▪ Employer's potential exposure under 4980H(b) exceeds the cost of implementing and administering the look-back measurement method

Health Reimbursement Arrangements—How Did a Simple Account Become So Complicated?

Health Reimbursement Arrangements—An Overview

- A Health Reimbursement Arrangement (HRA) is:
  - Funded solely by an employer
  - Reimburses an employee for medical expenses by the employee or his dependents
  - Up to a maximum dollar amount for a coverage period
- After the Affordable Care Act was passed, employers began wondering whether they could offer an HRA and let employees and/or retirees purchase coverage through a government Exchange
  - This question was answered on Friday, September 13, 2013 and then, clarified on December 16, 2015

Friday the 13th Guidance

- An HRA is a group health plan, so it must comply with the consumer protections (also known as group market reforms) that apply to all employer-sponsored group health plans
  - Two of the reforms are particularly problematic:
    - No annual dollar limits on essential health benefits (EHBs) and
    - No cost sharing for certain in-network preventive health services

Friday the 13th Guidance

- IRS Solution—Integration with another group health plan
- 2 methods of integration but *general* requirements are:
  - Employee covered by HRA must actually ***be enrolled*** in a group health plan, e.g., an HDHP
    - Does not have to be sponsored by employer
  - HRA is available only to employees also enrolled in non-HRA group health coverage
  - HRA provides that employees (or former employees) can permanently opt out of and waive future reimbursements from the HRA at least annually, and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt-out of and waive future reimbursements from the HRA
  - Method 1 does not require that the group health plan provide minimum value as long as it does not consist solely of excepted benefits (e.g., dental/vision); however, it is limited to reimbursement of copays, coinsurance, deductibles, premiums under the non-HRA group coverage, as well as medical care that does not constitute EHBs
  - Method 2 requires that the non-HRA group health plan provides minimum value

Friday the 13th Guidance

- Neither an employer-sponsored HRA nor similar arrangements can be integrated with individual market coverage (e.g., the government Exchange)
  - Ouch!
- But wait! If the HRA is limited to retirees and are part of a stand-alone retiree medical plan that are not subject to the group market reforms, it does not have to be integrated
  - Remains a solution for moving retiree medical to the individual market
    - Private Exchange
    - Government Exchange (Health Insurance Marketplace)
  - Section 732(a) of ERISA—fewer than two current employees on the IRS Form 5500 on the first day of the plan year
    - Plan document structure
    - IRS Form 5500

Friday the 13th Guidance Clarified and Backed Up by IRS Notice 2015-87

In December, 2015, IRS issued additional clarifications:

- Retiree only HRA remains workable
  - Does not have to comply with the group market reforms
- However, it's important to note that the HRA is MEC for any month in which the funds are retained in the HRA (even for months in which the employer no longer contributes to the HRA)
  - If funds remain in the HRA, retiree/former employee is NOT eligible for a premium tax credit through the government Exchange
- If HRA is also part of a plan with two or more current employees, it cannot be used to purchase individual market coverage even after the employee covered by the HRA ceases to be covered by other "integrated" group health plan coverage
  - HRA balance can be used to reimburse medical expenses
  - Individual cannot purchase individual coverage

Friday the 13th Guidance Clarified and Backed Up by IRS Notice 2015-87

In December, 2015, IRS issued additional clarifications

- Transition rules from Friday the 13th generally remains unchanged but were clarified
  - Specifically, unused amounts credited before January 1, 2014, including any amounts credited before January 1, 2013 and any amounts that were credited during 2013 under the terms of the HRA as in effect on January 1, 2013, may be used after December 31, 2013 to reimburse medical expenses **even if the HRA is not integrated (or retiree only)**
  - **New! If the HRA terms on January 1, 2013 did not prescribe a set amount to be credited during 2013, then the amounts credited during 2013 may not exceed the amounts credited for 2012**
- **New! Family integration rules**
  - If HRA reimburses medical expenses of an employee's spouse and/or dependents (family HRA), to satisfy the integration requirement, the spouse and/or dependents also must be enrolled in the "other" group health plan for the HRA to meet the group market reforms
  - Transition rules available since new

Friday the 13th Guidance Clarified and Backed Up by IRS Notice 2015-87

And don't forget employer payment plans

- An employer payment plan typically refers to an employer who reimburses an employee's substantiated premiums for non-employer sponsored hospital and medical insurance
  - Historically excluded from an employee's (or retiree's) gross income under Code section 106
    - Exclusion also applies if the employer pays the premiums directly to the insurance company
  - It's a group health plan and cannot be integrated with the individual market coverage (like an HRA) to satisfy the group market reform(s)
- An employer arrangement reimbursing the cost of individual market coverage (whether or not funded solely by salary reduction or also including other employer contributions) also does not work
  - It cannot be integrated with individual market coverage (unless the coverage consists solely of excepted benefits)
  - Violates group market reform(s)
- Employer payment plan is compliant if the individual market coverage covers **only** excepted benefits

Excise Tax—It's Delayed But Not Forgotten

Excise Tax—It's Delayed But Not Forgotten

On December 18, 2015, President Barack Obama signed a significant year-end spending and tax package (H.R. 2029), referred to as the Consolidated Appropriations Act, 2016

- The Consolidated Appropriations Act, 2016, combined a $1.1 trillion omnibus appropriations and $680 billion tax extenders package
- The legislation contains a freeze on taxes used to pay for the Affordable Care Act (the "ACA")
  - **The 40% excise tax on high-cost health care plans (often referred to as the "Cadillac tax") will be delayed for two years, effective date delayed from 2018 to 2020**
    - **Excise tax is now deductible following the Consolidated Appropriations Act**
  - The 2.3% excise tax on the sale of medical devices, which took effect in 2013, will be suspended for 2016 and 2017
  - The health insurance providers fee, which took effect in 2014, will be suspended for 2017

Repeal faces an uphill battle

- "Cadillac Tax" raises $91 billion over 10 years

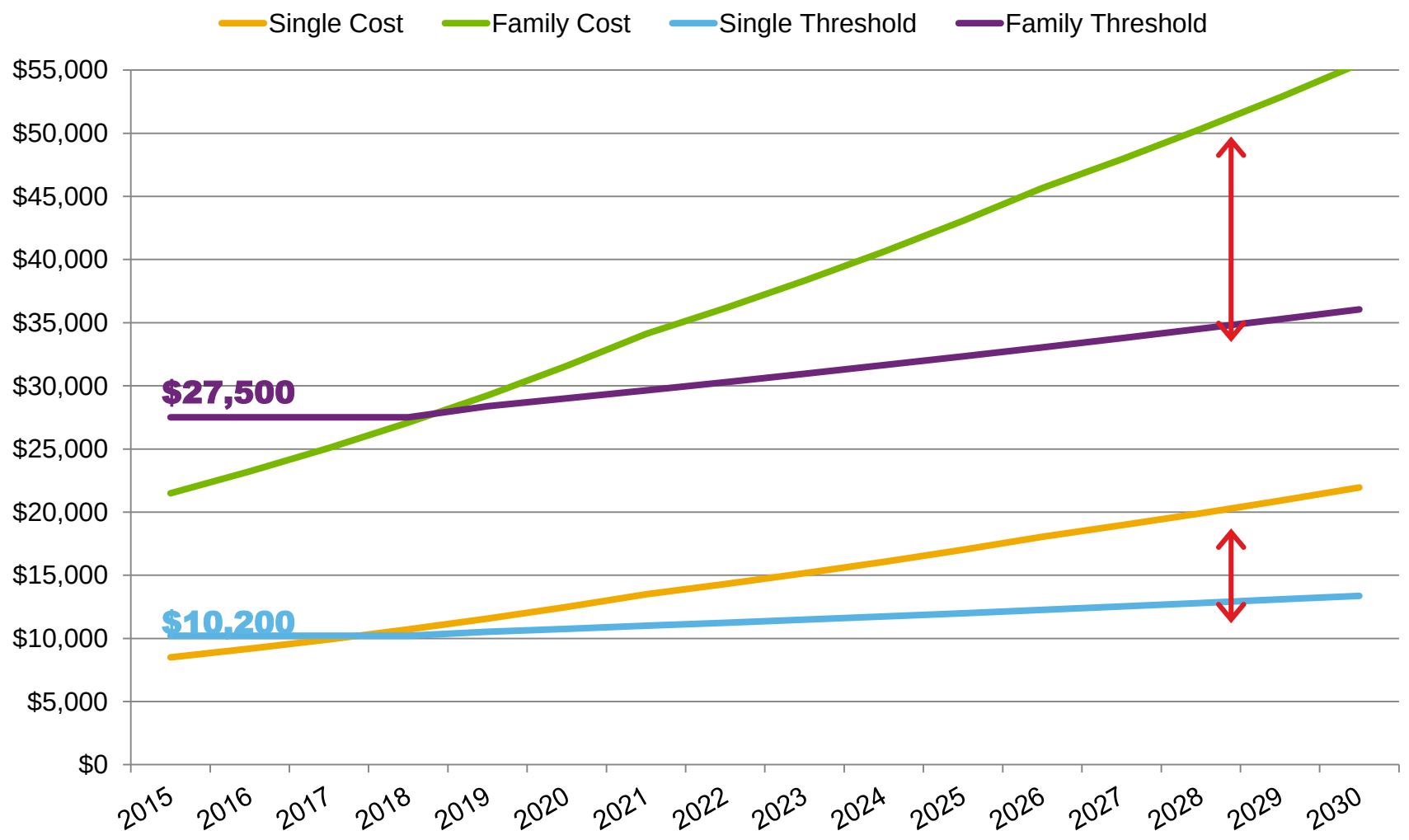
Employer groups support repeal of "Cadillac Tax"

- Many predict FSAs will be one of the first casualties if "Cadillac Tax" goes into effect

2020—Excise Tax on High-Cost Employer-Sponsored Health Coverage

- Excise tax thresholds are indexed and vary based on different circumstances
  - Self-Only Coverage: $10,200
    - $11,850 for “qualified retirees” and high risk professions/installation of electrical or telecommunications lines
  - Other than Self-Only Coverage: $27,500
    - $30,950 for “qualified retirees” and high risk professions/installation of electrical or telecommunications lines
- **The initial dollar thresholds in 2020 will be indexed from 2018**
- **Qualified Retiree** means any individual who:
  - Is receiving coverage by reason of being a retiree;
  - Has attained age 55; and
  - Is not entitled to Medicare benefits
- Historically generous group health plans are at risk of being taxed, such as collectively bargained plans
- **Employee** means current employee, former employee, surviving spouse, or other primary insured individual

The Impact of the Excise Tax



IRS Asks Industry for Input Before Issuing Regulations on Excise Tax

- IRS issued request for comments in Notice 2015–16
  - Notice provides first insights on approaches being considered by IRS regarding
    - Definition of "applicable coverage" under Code Section 4980I
    - Determination of cost of applicable coverage
    - Application of annual statutory dollar limit to cost of applicable coverage
- **Applicable coverage—Current IRS musings**
  - Employer HSA contributions (including employee pretax contributions) will be included
    - But not employee after-tax contributions
  - Coverage for on-site medical clinic
    - Proposed regulations will provide that applicable coverage does not include on-site medical clinics that offer only *de minimis* medical care
      - How to calculate *de minimis* medical care? Services provided? Dollar limit? Both?
  - IRS considering excluding
    - *Self-insured* limited scope dental and vision coverage that qualifies as an excepted benefit
      - Fully insured dental and vision already excluded
    - Value of EAPs that qualify as an excepted benefit

IRS Asks Industry for Input Before Issuing Regulations on Excise Tax

- IRS request for comments in Notice 2015-52
- Who will pay the “Cadillac Tax” for self-insured plan? IRS is considering either
  - Person responsible for performing the daily plan administration functions (receiving and processing claims for benefits, responding to inquiries, or providing a technology platform for benefits information), the TPA; OR
  - Person with ultimate authority or responsibility for plan administration, regardless of whether that person routinely exercises that authority or responsibility
- How to allocate contributions to HRAs, Health FSAs, and HSAs
- **Impact of the Excise Tax on the Employer Shared Responsibility rules**
  - Employers that are subject to the excise tax will begin to cut back on the value of benefits
  - Result—some employers could ultimately have a risk of an ESR Tack Hammer penalty, because the plan might not meet Minimum Value
    - Sick population
    - Safe harbor requested

Wellness Programs—Staying Healthy with Complicated Rules

Federal Laws Regulating Wellness Programs

HIPAA (DOL, IRS, HHS)

- Comprehensive regulatory scheme for implementing wellness programs under ERISA
- Permits "participatory wellness programs" and "health contingent wellness programs," with latter further divided into "activity-only wellness programs" and "outcome-based wellness programs"
  - Under HIPAA, **only health contingent wellness programs** must limit size of reward to 30% of total cost of elected coverage (50% for tobacco cessation programs) and make available reasonable alternatives for rewards contingent on outcomes

GINA (EEOC)

- Prohibits employers from offering rewards or incentives to employees to provide health plans with "genetic information," a term that is broadly defined to include employee's family medical history
- The term "family" includes relatives by blood and marriage (e.g., spouse)

ADA (EEOC)

- Prohibits employers from medical inquiries of employees unless job-related and for business necessity
- Medical inquiries can be part of health risk questionnaire only if HRQ is "voluntary"
  - Common practice for employers to argue that a wellness program that offers HIPAA-compliant incentive designs should be deemed to satisfy ADA's definition of "voluntary"

Recent Challenges to Employer Wellness Programs

- EEOC alleged in three separate claims that employer-based wellness programs violate ADA because programs are not "voluntary"
  - Orion Industries and Flambeau, Inc.
    - Employees who do not participate in biometric screenings/medical exams and health status questionnaires forfeit employer health care subsidy and must pay entire cost of health care coverage
    - In the case of Orion Industries, the EEOC alleges the employer later fired an employee for refusal to participate and raising objections to the program
    - **Employers recently received good news in *EEOC v. Flambeau, Inc.***
      - **On December 31, 2015, the U.S. District Court for the Western District of Wisconsin determined that Flambeau, Inc. could condition participation in its group health plan, upon the completion of a health risk assessment and biometric screening, since it falls within ADA's "safe harbor" which provides an exemption for activities related to the administration of a bona fide insurance benefit plan**
  - Honeywell International
    - Employees who do not take biometric screenings pay a $500 surcharge and forfeit eligibility for a $1,500 HSA contribution
    - Employees and spouses are assessed $1,000 each if tobacco screenings are not completed (alleged ADA and GINA violations)

EEOC Issues Wellness Program Regulations Under the ADA

EEOC's proposed regulations define a "voluntary" wellness program under the ADA

- Prohibit wellness programs from "gating" benefits
  - Wellness program cannot deny health care coverage to employee or limit benefits if an employee refuses to answer a disability-related inquiry or take a medical examination
    - Includes inquiries or examinations that are part of a health risk assessment
- Outline permissible financial incentives that an employer may offer in "voluntary" wellness program
  - Limits rewards and penalties, including those rewards and penalties under a participation-only program, to 30% of the cost of employee-only coverage, which is more restrictive than under the HIPAA wellness rules
- Set forth the rules regarding notice and confidentiality of medical information obtained as part of voluntary employee health programs
- Notifies employers that compliance with the EEOC rules concerning voluntary wellness programs does not ensure compliance with all the antidiscrimination laws that the EEOC enforces

EEOC Issues Wellness Program Regulations Under GINA

EEOC's proposed regulations define a "voluntary" wellness program under GINA

- Employers may obtain genetic information (i.e., family medical history) as part of health or genetic services only when those services are reasonably designed to promote health or prevent disease
- An employer may offer an inducement to an employee whose spouse:
  - Is covered under the employee's health plan;
  - Receives health or genetic services offered by employer, including as part of wellness program; and
  - Provides information about his or her current or past health status as part of a health risk assessment

EEOC Issues Wellness Program Regulations Under GINA

EEOC's proposed regulations define a "voluntary" wellness program under GINA

- Total inducement to employee and spouse under GINA and ADA may not exceed 30% of total annual cost of coverage for plan in which employee and any dependents are enrolled
  - Maximum share of inducement attributable to employee's participation in wellness program equals 30% of cost of self-only coverage
  - Remainder may be provided in exchange for spouse providing information to wellness program about current or past health status
  - Remainder =
    - [30% of total cost of coverage for plan in which employee and dependents are enrolled] **minus**
    - [30 percent of total cost of self-only coverage]

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