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Employee Benefits | Life Insurance | Risk Management

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INSURANCE BRIEF

INSIDE THIS ISSUE:

Summary of Benefits and Coverage (SBC)

The Departments of Labor, Health and Human Services and Treasury issued another set of health care reform FAQs (Part XIV in the series) addressing changes to the SBC. An updated SBC and sample completed SBC have also been issued.

Effective: For coverage beginning on or after January 1, 2014 and before January 1, 2015.

Key Provisions: The SBC will need to state whether the plan provides "minimum essential coverage" (MEC) as required by the individual mandate. It will also need to state whether the plan meets the "minimum value" (MV) requirement. MV means the plan pays at least 60% of allowed charges for covered services. To the extent that it would be administratively burdensome for a plan or insurer to modify its SBCs to add this new information, the agencies indicate that no enforcement action will be taken for using the previous template, provided that the necessary minimum essential coverage and minimum value information is set forth in a cover letter or similar disclosure furnished with the SBC. Model language is provided for this purpose.

In an effort to ensure a smooth transition to new market changes in 2014, the Departments have extended existing enforcement relief relating to various facets of SBC compliance (e.g., the circumstances in which the SBC may be provided electronically, penalties for failure to provide the SBC or uniform glossary) through the end of the second year of applicability. The agencies also emphasize their continued focus on assistance with implementation, rather than enforcement through penalties.

Action Items: Fully-insured policy holders will have SBCs provided by the carrier. Those with self-insured policies will want to coordinate with their administrators to update their SBC.

2014 HSA Limits

The IRS released the new Health Savings Account (HSA) index figures for 2014. The index includes increases of approximately 1.5% to both the individual and family contribution limits as well as the maximum out-of-pocket expenses. The minimum annual deductible for both individuals and families remains the same.

The overall limits are the following:

- Maximum HSA Contribution: $3300 for individual, $6550 for families
- Minimum HDHP Deductible: $1250 self-only coverage, $2500 family coverage
- Out of Pocket Maximum: $6350 self-only coverage, $12700 family coverage

The catch-up contribution allowed for those 55 and over remains $1000.

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Wellness Program Final Regulations *courtesy of Alfred B. Fowler, Attorney at Law*

On May 29, 2013, the Agencies (Internal Revenue Service, Department of Labor, and Health and Human Services) published final regulations regarding nondiscriminatory wellness programs offered in connection with a group health plan. But first, here are the basic rules, mostly unchanged from the proposed rules.

- **Effective Date**. Plan sponsors will be subject to the final regulations for plan years beginning on or after January 1, 2014.
- **Applicability.** Applies to both grandfathered and non-grandfathered plans.
- **Transitional Relief**. For wellness programs beginning before January 1, 2015 for fiscal year plans (January 1, 2014 for calendar year plans), plans can determine affordability and minimum value and can assume all employees satisfy the wellness program terms and incentives in effect as of May 3, 2013 for employees eligible for the program on that date.

Affordability

In light of the fact that many plan sponsors are considering the implementation of a wellness plan while also entering into the Patient Protection and Affordable Care Act (ACA) pay or play arena for 2014, a question has arisen about the ability to include rewards when calculating "affordability" for purposes of the ACA affordability test (the safe harbor: 9.5% of wages for a single employee). We discuss this issue in this Memorandum in the "Other Considerations" section of this Benefits Alert.

Discussion

The final regulations cover two major categories of wellness programs permitted under the law:

1. **Participatory Wellness Programs.** These programs provide rewards without regard to health status. They must be made available to all similarly situated individuals to be treated as nondiscriminatory. These types of programs include reimbursement for dues paid to fitness centers, reimbursement for diagnostic tests without regard to outcome, and rewards for attending no-cost health education seminars.
2. **Health-Contingent Wellness Programs**. A "health-contingent wellness program" requires an individual to satisfy a standard related to a health factor to obtain an award. The final regulations subdivide these programs into two categories:
   - Activity-Only Wellness Programs. Under an "activity-only wellness program," an individual is required to perform or complete an activity related to a health factor in order to obtain a reward. Examples include walking, weight loss, or exercise programs.
   - Outcome-Based Wellness Programs. Under an "outcome-based wellness program," an individual must attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward. Generally, these programs have two tiers:
     - A measurement, test, or screening as part of an initial standard; and
     - A larger program that targets individuals who do not meet the initial standard by just engaging in wellness activities (such as meeting with a health coach, taking a health or fitness course, or adhering to a health improvement action plan).

Requirements for Health-Contingent Wellness Programs: Health-contingent wellness programs must satisfy the following requirements to avoid discrimination:

- Frequency of Opportunity to Qualify: An individual must be given the opportunity to qualify for the reward at least once per year.
- Size of the Reward: The total reward (whether offered alone or coupled with another reward) cannot exceed 30% (or 50% if the program is designed to prevent or reduce tobacco use) of the total cost of employee-

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PCORI Fees

The long-awaited revised IRS Form 720 and Instructions are now available.

Background: Health care reform imposes patient-centered outcomes research institute (PCORI) fees on certain health insurers and self-insured health plan sponsors for policy or plan years ending on or after October 1, 2012 and before October 1, 2019 to help fund clinical effectiveness research. The IRS issued final regulations implementing the fees in December 2012. (See our SML Update from December 7, 2012).

Key Provisions: Although Form 720 is filed quarterly for numerous other federal excise taxes, the PCORI fee reporting and payment are only required annually, on the second-quarter filing. The annual PCORI fee deadline is July 31 of the year following the calendar year in which the applicable policy or plan year ended. For example, the Form 720 that reports the liability for the fee imposed for a plan year ending on December 31, 2012 must be filed by July 31, 2013.

The insurer or plan sponsor filing Form 720 must report the average number of covered lives under health insurance policies and self-insured health plans subject to the PCORI fee. The instructions briefly explain the alternative methods for calculating the average number of covered lives, which include special transition rules for first-year reporting. The instructions refer to the final regulations for more detailed information about the alternative counting methods. Final HHS regulations issued in March 2013 provide several methods for counting a self-insured plan's covered lives: the actual method, snapshot method, and Form 5500 method.

Our clients with wrap plans will find that they will owe less if they utilized the actual count method instead of the 5500 method. This is because the 5500 method looks at total employee participants in the wrap plan, not just your self-insured policy.

The average number of covered lives is multiplied by the rate per covered life ($1.00 for a policy or plan year ending before October 1, 2013; $2.00 as adjusted periodically thereafter) to determine the amount of the fee. If the health insurer or plan sponsor files Form 720 only to report PCORI fees, the instructions clarify that a Form 720 should not be filed for the first, third, or fourth quarter. The instructions also note that deposits are not required for PCORI fees (that is, the fees are paid when the Form 720 is filed), so insurers and plan sponsors are not required to use the IRS's electronic tax payment service to pay these fees.

Action Items: Clients with self-insured health plans should make best efforts to determine the average number of covered lives and remit payment with the Form 720 by July 31st.

Please contact your SML Account Team if you have any questions about how this applies to your policies.

Wellness Programs *cont'd*

only coverage under the plan, taking into account both employer and employee contributions. If dependents are included in the health-contingent wellness program, the reward cannot exceed 30% (or 50% if the program is designed to prevent or reduce tobacco use) of the total cost of coverage in which the employee and the dependents are enrolled.

- Reasonable Design: The health-contingent wellness program must be reasonably designed to promote health or prevent disease. An outcome-based wellness program must provide a reasonable alternative standard to qualify for a reward – for all individuals who do not meet the initial standard that is related to a health factor – in order to be reasonably designed.
- Uniform Availability: The full reward must be available to all similarly situated individuals.
- Reasonable Alternative Standards: The same, full reward must be available to individuals who satisfy a reasonable alternative standard that is provided to individuals who satisfy the program's applicable standard. *Example*: If a calendar year plan offers a health-contingent wellness program with a premium discount and an individual satisfies a reasonable alternative standard on April 1, the plan or issuer must provide the individual with the premium discounts for January, February and March.
- Notice of Availability of Reasonable Alternative Standard: Plans and issuers must disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of a waiver of the otherwise applicable standard) in all plan materials describing the terms of the health-contingent wellness program. For outcome-based wellness programs, this notice must also be included in any disclosure that an individual did not satisfy the initial standard.

More Guidance on Reasonable Alternative Standards:

- In lieu of providing a reasonable alternative standard, a plan or issuer may waive the health-contingent wellness program's applicable standard and provide the reward.
- All the facts and circumstances are taking into account in determining whether a plan or issuer has provided a reasonable alternative standard, including but not limited to the following factors:
    - If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program and may not require the employee to pay for the cost of the program.
    - The time commitment required must be reasonable. For example, requiring attendance nightly at a one-hour class would be unreasonable.
    - If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay for any membership or participation fee.
    - If an individual's personal physician states that a standard is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the physician.
- Plans or issuers with an activity-only wellness program may request verification, such as a statement from the individual's physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard.
- If an individual does not meet the target biometrics under an outcome-based wellness program, the individual must be provided with a reasonable alternative standard regardless of any medical condition or other health status, to ensure that the standards are not a "subterfuge" for discrimination or underwriting based on a health factor. It is not reasonable to request verification for an outcome-based wellness program. To the extent the reasonable alternative standard is:
    - An activity-only wellness program: The alternative standard must comply with the requirements for activity-only programs as if it were an initial program standard. *Example*: If a walking program is provided as an alternative to a running program, the plan or issuer must provide reasonable alternatives to individuals who cannot complete the walking program because of a medical condition (such as pregnancy or recent surgery).
    - Another outcome-based wellness program: The alternative standard must comply with the requirements for outcome-based programs, subject to the following rules:

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Wellness Programs *cont'd*

- *Rule One:* The alternative standard cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual's circumstances. *Example*: If the initial standard is to achieve a BMI less than 30, the alternative standard cannot be to achieve a BMI less than 31 on that same date. However, a reasonable alternative standard could be to reduce the individual's BMI by a small amount or a small percentage over a realistic period of time.
- *Rule Two:* An individual must be given the opportunity to comply with the recommendations of the individual's physician as a second reasonable alternative standard, but only if the physician joins in the request.

Other Considerations

Wellness Rewards and ACA's Affordability Provisions. The final regulations make it clear that premium reduction (non-tobacco) awards (30%) are not to be used in calculating affordability minimum value. The rules assume no employee earns the reward. ***Exception:*** A tobacco-related premium reduction can be counted toward affordability and minimum value under ACA.

Written Plan Requirement. If the wellness program affects premiums, cost-sharing, or benefits under the employer's group health plan, then the terms of the wellness program are considered to be health plans and are required to be in writing and disclosed in the summary plan description (SPD), as well as in its own plan documents.

Compliance with Other Laws. Compliance with the final regulations does not mean the wellness program is in compliance with any other provision of ERISA, or any other state or federal law, including the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act of 2008 (GINA). In addition, other state and federal laws may apply with respect to privacy, disclosure and confidentiality of information maintained by the wellness program.

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