Labor and Employment Alert: Is Your Health Plan 'Affordable?'

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Summary: Under the pay-or-play penalties going into effect next year, an employer is subject to penalties if it does not offer "affordable" health coverage to its full-time employees (using the new 30-hour federal standard). The IRS has now proposed that premium discounts and other rewards for participation in an employer-sponsored wellness program not be taken into account in determining whether the health coverage offered by your company is affordable.

What companies are subject to the pay-or-play penalties?

The pay-or-play penalties only apply to "applicable large employers." An "applicable large employer" is, generally, an employer with at least 50 full-time and full-time equivalent employees in the preceding calendar year. See our January 8, 2013 *Client Alert*: Roadmap to Health Care Reform Pay-or-Play Penalties for details.

What is affordable health coverage and why does it matter?

If your company is an applicable large employer and your health coverage is not "affordable," you may incur an unaffordable/inadequate coverage penalty. The penalty is $250 per month ($3,000 per year) times the number of full-time employees receiving federal premium assistance to buy health insurance on an exchange.

To determine "affordability," you divide a numerator by a denominator:

Numerator:

The employee contribution for single health coverage

Denominator:

The employee's actual household income, or one of three proxies for household income:

1. The employee's hourly rate of pay times 1,560 hours (or annual salary);
2. The federal poverty level (currently, $11,490); or
3. Box 1 of Form W-2.

A result that does not exceed 9.5% is deemed to be "affordable" for purposes of the unaffordable/ inadequate coverage penalty.

Wellness programs and affordability

Wellness programs are subject to a myriad of requirements but, if you have a compliant wellness program, you may provide a discounted rate of employee contributions to those benefits-eligible employees who choose to participate in your wellness program. Up to now, we did not know which employee contribution rate would be used in the numerator of the affordability fraction (the contribution rate for employees who participate in the wellness program or the contribution rate for employees who decline to participate in the wellness program). The IRS recently proposed regulations providing that, for purposes of determining affordability, you must use the contribution rate applicable to employees who decline participation in any wellness programs. In other words, you must ignore any premium discount that employees may get when they participate in your wellness program. Two notes:

- The regulations, if finalized as proposed, would apply in 2015. Therefore, if you currently have a wellness program with premium discounts, you may use the discounted employee contribution rate in the numerator of the affordability fraction in 2014.
- Although the affordability test would disregard most wellness premium discounts after 2014, you are permitted to use the employee contribution for non-tobacco users in the numerator of the affordability fraction. However, this exception is likely to be less useful than it appears. Read on for an explanation.

Tobacco use and wellness programs

The Department of Health and Human Services (HHS) published final regulations defining "tobacco use" for purposes of premiums for health insurance to be sold on the public exchanges. "Tobacco use" is defined as the use of tobacco on average of four or more times per week within no longer than the past six months. Needless to say, this definition is not consistent with what is typically used in wellness programs today. The problem is that HHS, IRS, and DOL previously indicated the intention to coordinate provisions applicable to tobacco users for purposes of premiums in the public exchanges and employer-sponsored wellness programs. Therefore, it is possible that you will have to use the same definition of tobacco use (i.e., use of tobacco products four or more times per week) in order to use the non-tobacco user's employee contribution rate in the numerator of the affordability fraction.

In addition, remember that you must offer an alternative option (such as completion of a tobacco cessation class) for tobacco users to qualify for the non-tobacco user's employee contribution rate. Therefore, even a tobacco user must be permitted to pay the non-tobacco user's employee contribution rate if he or she meets your alternative option.

OTHER EMPLOYEE BENEFIT NEWS

Summaries of Benefits and Coverage (SBCs) and Minimum Value

The government released a template for 2014 SBCs (available at http://www.dol.gov/ebsa/healthreform/). The only change from the 2013 SBC template is the addition of two statements:

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy [does/does not] provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage [does/does not] meet the minimum value standard for the benefits it provides.**

Medical plans subject to the health care reform mandates will count as "minimum essential coverage" so the first question is easily answered.

A plan provides minimum value if it would cover at least 60% of estimated medical expenses for a standard population. In other words, a plan provides minimum value if, on average, a covered individual is expected to pay no more than 40% of his or her medical expenses in the way of deductibles, copays and coinsurance. Unfortunately, the government proposes to ignore any cost sharing enhancements (such as a reduced deductible or waiver of copays) available only to individuals who participate in wellness programs (except those related to tobacco use).

Minimum value is calculated in one of three methods:

1. **HHS Minimum Value Calculator**: The Minimum Value Calculator permits an employer to enter information about covered benefits and cost-sharing to determine whether the plan provides minimum value.
2. **Checklists**: HHS and the IRS will publish designed-based safe harbor checklists. If your plan's design is the same as – or more generous than – one of the checklists, your plan will be treated as providing minimum value. The checklists have not yet been published. This method would not involve calculations.
3. **Actuarial certification**: If your plan has nonstandard features that preclude the use of the Minimum Value Calculator and safe harbor checklists, you may engage an actuary to determine if your plan nonetheless provides minimum value.

If your plan is insured, your insurer will be able to tell you whether your plan provides minimum value.

The right to decline health coverage

If you have a group health coverage that does not provide minimum value or is potentially unaffordable for one or more full-time employees, it is important that you give employees an effective opportunity to decline such coverage (and that you are able to document that you gave employees an effective opportunity to decline such coverage). Mandatory (or stealth) enrollment in coverage that does not meet minimum value and affordability standards could result in a no-offer penalty under Code §4980H and violation of employees' rights to access federal premium assistance as protected by the Fair Labor Standards Act.

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This alert is a summary and cannot include all details that may be relevant to your situation. As always, please contact us if you want more information on these developments or other employee benefits matters.