Health Care Reform Strategy: Your Next Move

Tami Simon, J.D.
Managing Director–Knowledge Resources
Buck Consultants
Washington, D.C.
The information contained in this presentation and any accompanying documents does not constitute legal advice; consult with your legal and tax advisors before applying this information to your specific situation.
Beltway and beyond
Beltway and beyond

- ACA delay
- Full ACA repeal: Unlikely
- Efforts to stall in the House will continue
- Technical corrections to the ACA
- More regulatory guidance forthcoming
- More lawsuits to follow
- October 1 is right around the corner
State *public* marketplaces

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
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<tbody>
<tr>
<td>Declaration Letter</td>
<td>11/16/2012</td>
</tr>
<tr>
<td>Deadline for blueprint</td>
<td>12/14/2012</td>
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<tr>
<td>Deadline for partnership exchange blueprint</td>
<td>2/15/2013</td>
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<tr>
<td>All exchanges must be ready to enroll</td>
<td>10/01/2013</td>
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<tr>
<td>All exchanges must be fully operational</td>
<td>01/01/2014</td>
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![State Action Towards Creating Health Insurance Exchanges](image_url)

*Updated February 25, 2013*

- Establishing State Exchange (17 + DC)
- Planning for Partnership Exchange (7)
- Federal Government Exchange (26)
Private exchanges

- Operated by for profit private companies (e.g., insurers, consulting firms, specialty firms)
- Some are already operational
- Vary in structure: single or multiple carrier, fully insured and/or self-funded, group or individual, actives and/or retirees
- Plans and services can extend beyond ACA-driven structure of public exchanges
  - Flexibility in plan offerings although many follow “metals” designs
  - Can also offer other forms of insurance and related services
- Federal subsidies and cost sharing are not available
Comparing private exchange apples to apples

- Fully insured/self funded?
- Employer control of plan design?
- What is included? Medical? Voluntary benefits? Other?
- Wellness? Incentives? Other?
- Help with enrollment? And other administrative bells and whistles?
- One/multiple carriers?
- Cost? Who is paid for what?
- Platform for employees?
- Vendor relationships? Contracting responsibility?
Strategic considerations
## Continuum of employer benefit delivery options

<table>
<thead>
<tr>
<th>Maintain</th>
<th>Manage</th>
<th>Sponsor</th>
<th>Facilitate</th>
<th>Exit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing plans and financing</td>
<td>Simplify and streamline plans</td>
<td>“Best-in-class” designs and partners</td>
<td>DC model with insurance focus</td>
<td>No benefit relationship with employees</td>
</tr>
<tr>
<td>Uncommon except for: • Labor contracts • Grandfathered plans</td>
<td>Insourced focus on cost management: • Vendor selection • Plan design • Communication • Engagement</td>
<td>Outsource functions: • Vendor partners • Quilted network • Portfolio of designs • Engagement resources • Self-funded or insured</td>
<td>Outsource functions and risk: • Insured choices • Fixed DC cost • Low focus on health engagement</td>
<td>“I am no longer in the benefits business”</td>
</tr>
<tr>
<td>“Status Quo is working for me”</td>
<td>“I will make the investment to improve performance”</td>
<td>“I believe better performance is achievable, but lack the resources on my own”</td>
<td>“I want to provide broad access to benefit programs while not having a role in day-to-day management”</td>
<td>“I am no longer in the benefits business”</td>
</tr>
<tr>
<td>“I am contractually obligated”</td>
<td>“Our unique benefits differentiate us”</td>
<td>“I will actively support the activities that have proven outcomes, and outsource wherever it makes sense”</td>
<td>“My CFO insists on a fixed cost model”</td>
<td></td>
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Note: The table outlines the various options for delivering employer benefits, ranging from maintaining existing plans to completely exiting the benefits business. Each option includes specific details and motivations for choosing that path.
Anticipating the “Cadillac” excise tax

Today…

• Keep an eye on the possibility of legislative and regulatory changes between now and 2018

• Consider implications in strategic planning for 2014+
  − Watch for impact of medical inflation and medical plan enhancements (some required by ACA) on cost
  − Consider role of wellness and other strategies to mitigate future cost increases and, therefore, plan cost
Anticipating the “Cadillac” excise tax

In 2018...

• Absorb the cost
• Offset another form of total rewards to cover the cost
• Reduce medical benefits to delay, reduce, or eliminate the tax
• Encourage migration to lower-value medical options
• Eliminate ancillary health care benefits such as the health FSA
• End health benefit sponsorship (subject to $2,000/full-time employee penalty)
The squeeze

Employer shared responsibility

Group health plan

Cadillac tax
Employer strategies

• How should an employer pick the right strategy?
  - Consider your workforce segment
  - Consider your obligations (e.g., nondiscrimination rules, wage and hour laws)
  - Consider your industry/competition
  - Consider the progress of the state exchanges
  - Consider all the options (rise of the private exchange)
  - Consider the administrative challenges of each option
  - Consider the corporate philosophy about being an employer of choice
  - Consider the costs

• How should employers address plan eligibility of particular populations?

• Should employers consider new workforce strategies?
Implications for human capital strategy

• **Avoid benefit obligations** by restructuring jobs
  - Re-organize, re-design, or re-deploy people/work/jobs/functions to avoid or mitigate employee benefit obligations

• **Reduce compensation costs** to offset increased benefit costs

• **Recalibrate** *Total Remuneration* to attract, retain & motivate

• **Drive higher profits** (or other strategic results) Reposition compensation and benefits
  FROM an *expense* to be minimized
  TO an *investment* to be managed for optimum return
Implications for retirement strategy

• Will increasing health care spend affect ability to contribute to retirement savings?

• What will the entire employee benefit portfolio look like after a health care strategy is chosen? Will it need realignment for consistency?

• As health care moves more toward a defined contribution approach, what will be the interplay with defined contribution retirement savings?

• How will employees need to adjust their planning for retirement readiness?

• Will executive retirement benefits need realignment?

• Will there be a reduction in balance sheet liabilities for post-employment benefits other than pensions?
Implications for communication strategy

Special ACA communication issues for 2013

- Confirm 2014 strategy and message regarding near-term benefits
- Based on anticipated longer-term strategy, consider positioning messages and implication for employee value proposition, total rewards, P.R.
- Proactively anticipate required exchange notices and the accompanying media barrage—explain:
  - Individual mandate and relevance
  - Current benefits meet ACA requirements (MEC, affordability, etc.)

Decide on your point of view, based on near-/long-term strategy

- Extent of education to provide on ACA: leaders, HR, employees
- Guidance/steering employee decisions (especially if eligible for subsidies)
- Education on cost-sharing impact of mandates and fees
Wellness program check-up
Buck’s Global Wellness Survey

Objective
Assess trends in employer-sponsored wellness strategies and practices

Participants
• 1,356 participating employers
• 11 languages
• 45 countries
• 17 million employees
• All industry categories
Buck’s Global Wellness Survey results— incentives

88% of US responding employers offer incentives for wellness—up from 62% three years ago in Buck’s 4th Global Wellness Survey

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<tbody>
<tr>
<td>Gifts and Merchandise</td>
<td>49%</td>
<td>39%</td>
</tr>
<tr>
<td>Raffles and Drawings</td>
<td>47%</td>
<td>34%</td>
</tr>
<tr>
<td>Cash</td>
<td>35%</td>
<td>33%</td>
</tr>
<tr>
<td>Premium Reductions</td>
<td>29%</td>
<td>24%</td>
</tr>
<tr>
<td>Contribution to FSA/HSA</td>
<td>15%</td>
<td>7%</td>
</tr>
<tr>
<td>Premium Increases</td>
<td>15%</td>
<td>38%</td>
</tr>
<tr>
<td>Mandatory Participation as condition of enrollment (such as HRA or screening)</td>
<td>4%</td>
<td>39%</td>
</tr>
</tbody>
</table>
Activities for which incentive rewards are offered

- Completing a health risk appraisal
  - Offered today: 57%
  - Plan to offer in next year: 18%
  - Plan to offer in next 2-3 years: 10%
  - Don't currently offer and no plans to offer: 14%

- Participation in workplace health "challenges"
  - Offered today: 50%
  - Plan to offer in next year: 16%
  - Plan to offer in next 2-3 years: 15%
  - Don't currently offer and no plans to offer: 19%

- Completing a biometric health screening
  - Offered today: 46%
  - Plan to offer in next year: 21%
  - Plan to offer in next 2-3 years: 15%
  - Don't currently offer and no plans to offer: 18%

- Obtaining regular preventive care examinations
  - Offered today: 37%
  - Plan to offer in next year: 15%
  - Plan to offer in next 2-3 years: 21%
  - Don't currently offer and no plans to offer: 26%

- Refraining from tobacco use
  - Offered today: 37%
  - Plan to offer in next year: 18%
  - Plan to offer in next 2-3 years: 18%
  - Don't currently offer and no plans to offer: 27%

- Tracking regular healthy living activities
  - Offered today: 33%
  - Plan to offer in next year: 18%
  - Plan to offer in next 2-3 years: 19%
  - Don't currently offer and no plans to offer: 30%

- Completing educational courses (live or online)
  - Offered today: 29%
  - Plan to offer in next year: 15%
  - Plan to offer in next 2-3 years: 21%
  - Don't currently offer and no plans to offer: 34%

- Contacting a health coach or advisor
  - Offered today: 30%
  - Plan to offer in next year: 14%
  - Plan to offer in next 2-3 years: 16%
  - Don't currently offer and no plans to offer: 39%

- Adherence to a disease management program
  - Offered today: 25%
  - Plan to offer in next year: 15%
  - Plan to offer in next 2-3 years: 23%
  - Don't currently offer and no plans to offer: 37%

- Achieving or maintaining measurable health status results
  - Offered today: 23%
  - Plan to offer in next year: 17%
  - Plan to offer in next 2-3 years: 26%
  - Don't currently offer and no plans to offer: 33%

- Adherence to a therapeutic regimen
  - Offered today: 13%
  - Plan to offer in next year: 14%
  - Plan to offer in next 2-3 years: 22%
  - Don't currently offer and no plans to offer: 51%
Incentive design considerations

- Legal compliance
- Risk tolerance
- Promoting corporate objectives of wellness investments
  - Manage or reduce health care costs
  - Reduce absence
  - Improve productivity
  - Improve health
  - Promote recruitment and retention
  - Other
Wellness programs

• What is a wellness program? *(what’s in a name?)*
  - Health promotion
  - Screening and preventive care
  - Disease management
  - Other

• Host of laws could apply
  - HIPAA nondiscrimination
  - ERISA
  - Tax rules
  - HIPAA privacy
  - GINA
  - ADA
  - COBRA
  - State non-smoking and nondiscrimination laws
HIPAA nondiscrimination requirements

- Prohibits discrimination based on health status
  - Applies to programs that are or related to a group health plan
  - Benign discrimination
  - Wellness programs are exception to the rule
    - Fall into two categories
      - Participatory wellness programs
      - Health-contingent wellness programs
  - Final regulations effective for plan years beginning on or after January 1, 2014

Wellness programs should be analyzed to confirm compliance with new regulations
A note about HIPAA
HIPAA privacy and security

• Final omnibus regulations
  - Generally effective September 23, 2013
  - To do list:
    - Review list of BAs
    - Update BAAs
    - Update privacy notice
    - Revise policies and procedures
    - Retrain workforce
    - Conduct risk analysis
    - Review/edit authorizations
    - Review/edit breach notification procedures

• Enforcement
  - Increasing
  - Audit program
Resources
Resources on Buckconsultants.com—free and available to the public!

Resources on www.buckconsultants.com. Go to:
- Research and insights > Publications > FYI
- Research and insights > Publications > Legislate
- Research and insights > Ideas > Health care reform
- Research and insights > Multimedia > On-demand webinars


Replays of recent webinars including wellness webinar
Questions?

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Appendix on wellness
Wellness programs: Participatory

Participatory wellness program

- Does not provide a reward or base the reward (incentives or penalties) on a specific health outcome
- Is available to all similarly situated individuals
- Must be provided at no cost
- Not required to satisfy five requirements applicable to health-contingent programs but may be affected by other laws
- Rewards not counted towards health-contingent program limits
Wellness programs: Participatory

Participatory wellness program

• Examples
  - Reimburse health club membership fees
  - Reward diagnostic testing regardless of outcome
  - Reward attendance at health education seminars
  - Reward completion of health risk assessment with no further action required
  - Reward participation in smoking-cessation program regardless of outcome
  - Waive copays or deductibles for preventive care
Wellness programs: Health-contingent

Health-contingent wellness program

• Requires individual to satisfy a standard related to a health factor in order to obtain reward

• Two categories
  - Activity-only
  - Outcome-based

• Must satisfy five requirements to be nondiscriminatory
Activity-only wellness programs

Require the individual to perform or complete an activity related to a health factor to receive a reward but does not require the attainment of a specific health outcome

- Examples
  - Walking, running, workout programs
  - Diet programs
  - Exercise programs

Concern is that some individuals may not be able to qualify for the reward due to a health factor such as severe asthma, pregnancy or recent surgery.
Outcome-based wellness programs

Require an individual to meet a specific health outcome or attain a specific health metric in order to qualify for a reward

- Examples
  - Reward non-tobacco users
  - Reward individuals who meet certain biometric or health standards
    - Can also include a requirement for those individuals who do not meet those standards to take additional steps to qualify
    - Specified BMI, cholesterol, blood pressure levels
Requirements for health-contingent programs: activity-only and outcome-based

1. Opportunity to qualify for reward
   • Individuals must be given the opportunity to qualify for the reward at least once a year
   • One, two, three strikes, you’re out—not allowed
   • Identical requirement for activity-only or outcome-based programs
Requirements for health-contingent programs: activity-only and outcome-based

2. Total reward cannot exceed specified percent of total cost of coverage

• Participation in a non-tobacco wellness program is 30% of the total cost of coverage

• Additional 20% can be applied to tobacco-use program (up to 50% total, including tobacco programs)

• Rewards for participatory wellness programs are not counted against limits

• Identical requirement for activity-only or outcome-based programs
Requirements for health-contingent programs: activity-only and outcome-based

3. Program must be reasonably designed to promote health or prevent disease

• Based on facts and circumstances
  - Reasonable chance of improving the health of participating individuals
  - Reasonable chance of preventing disease in participating individuals
  - Not overly burdensome
  - Not subterfuge for discriminating based on a health factor
  - Not highly suspect in the method chosen to promote health and prevent disease

• Identical requirement for activity-only or outcome-based programs
Requirements for health-contingent programs: activity-only and outcome-based

4. Full reward must be available to all similarly situated individuals

- **Activity-only**—reasonable alternative standard (or waiver) for obtaining the reward if requested by individual for whom it is:
  - Unreasonably difficult due to a medical condition to satisfy the standard
  - Medically inadvisable to attempt to satisfy the standard
    - Where appropriate, verification permitted
Requirements for health-contingent programs: activity-only and outcome-based

4. Full reward must be available to all similarly situated individuals (continued)

• **Outcome-based**—reasonable alternative standard (or waiver) for obtaining the reward for any individual who does not meet the initial standard based on the measurement, test, or screening
  
  – Must offer to any who do not meet the initial (healthy) standard, regardless of individual’s medical condition or other health status
    
    o No verification permitted
  
  – Special rule when reasonable alternative standard is outcome-based
Requirements for health-contingent programs: activity-only and outcome-based

5. Plan materials describing program must disclose availability of reasonable alternative standard to qualify for reward or waiver of standard

- Include contact information and statement that an individual’s personal physician will be accommodated
- For outcome-based programs, must disclose availability of reasonable alternative standard in any notice to individuals who did not satisfy an initial outcome-based standard
Where the rubber hits the road: Failure to comply with HIPAA

• Agency audit and enforcement actions
  - Excise taxes under Internal Revenue Code
    o Generally, $100 per day of noncompliance for each individual for whom the failure relates
    o Form 8928 filing requirement
  - Civil penalties for issuers subject to CMS enforcement
    o Generally, Up to $100 per day for each individual affected by the violation
  - Civil action to enforce requirements under ERISA
• Individual rights under ERISA
Supreme Court DOMA decision creates compliance conundrum for employers

The Supreme Court’s ruling that Section 3 of the Defense of Marriage Act, which had precluded recognition of a same-sex spouse as a spouse under federal law, was unconstitutional will affect the design and administration of employer benefit programs and HR policies. However, lack of clarity as to which states’ laws will determine spousal status and lack of guidance on when changes resulting from the Court’s ruling will become effective will hamper employers’ efforts to bring their programs into compliance. While awaiting guidance, the task for employers is to understand the questions created by the new paradigm, determine the optimum approach to providing benefits for their employee populations, and then assess the steps that can be implemented near term, versus the steps that must wait for agency guidance.

Background

The Defense of Marriage Act (DOMA), signed into law on September 21, 1996, contains two substantive provisions. Section 3 of DOMA defines the term “marriage” for all purposes under federal law, including the provision of federal benefits, as a legal union between one man and one woman. “Spouse” is defined as a person of the opposite sex who is a husband or a wife. Section 2 of DOMA allows states to refuse to recognize same-sex marriages entered into in other states.

Until the passage of DOMA, the federal government relied on the states to define marriage and recognized, for federal law purposes, marriages legally entered into under state law. After the adoption of DOMA, same-sex marriages were not recognized for purposes of more than 1,000 federal laws — including ERISA and the Internal Revenue Code (Code) — regardless of whether a state recognized same-sex marriage.
Employer-sponsored retirement and welfare benefits have been directly impacted by DOMA. For example, tax-qualified retirement plans were generally not permitted to recognize legally married same-sex spouses for purposes of QDROs and spousal consent rules and were not required to recognize such spouses for survivor annuities or death benefits. For welfare benefit plans, same-sex spouse coverage was generally taxable under federal tax rules, which most often resulted in the imputation of income for the employer’s cost of coverage. Similarly same-sex spouses were not eligible for COBRA benefits nor recognized for other purposes such as the Family Medical Leave Act (FMLA).

The varying treatment of same-sex spouses for state purposes complicated matters for employers. For example, in states that recognized same-sex spouses, it was not uncommon for same-sex spouse benefits to be taxable for federal income tax purposes but not taxable for state income taxes. Differences in tax treatment raised complex recordkeeping and reporting issues for employers.

**Supreme Court decision**

On June 26, 2013, in the case of United States v. Windsor (Windsor), the United States Supreme Court held that Section 3 of DOMA was unconstitutional because it violated the Fifth Amendment’s guarantee of equal protection of laws as applied to persons of the same sex who are legally married under the laws of their state. The Court’s decision does not affect the constitutionality of DOMA Section 2, which permits a state to refuse to recognize a same-sex marriage that was legally performed in another state.

The Windsor case involved a same-sex couple, Edith Windsor and Thea Spyer, who were married in Canada in 2007. The couple lived in New York, which recognized their marriage. When Ms. Spyer died in 2010, she left her entire estate to Ms. Windsor. Ms. Windsor sought the federal estate tax exemption afforded to opposite-sex spouses that had been denied to same-sex spouses as a result of Section 3 of DOMA. However, due to DOMA, Ms. Windsor was found not to be the spouse of Ms. Spyer for tax purposes and, therefore, was denied the federal tax benefit. Ms. Windsor subsequently challenged the constitutionality of DOMA under the Fifth Amendment guarantee of equal protection, claiming that DOMA treated same-sex legally married couples differently as compared to other similarly situated couples without justification.

The Court agreed. In its 5-4 decision, the Court found that DOMA’s principal effect is to “identify a subset of state-sanctioned marriages and make them unequal. The principal purpose is to impose inequality, not for other

| Currently the following states and the District of Columbia recognize the legal right of same-sex couples to marry: |

Thirty-five states have constitutional provisions or statutes that prohibit same-sex marriage.
reasons like governmental efficiency." The Court further found that DOMA "undermines both the public and private significance of state-sanctioned same-sex marriages."

The Court held that Section 3 of DOMA is invalid, "for no legitimate purpose overcomes the purpose and effect to disparage and to injure those whom the State, by its marriage laws, sought to protect in personhood and dignity. By seeking to displace this protection and treating those persons as living in marriages less respected than others, the federal statute is in violation of the Fifth Amendment."

**Buck Comment.** Striking Section 3 of DOMA effectively means that for purposes of federal law, the terms spouse and marriage can no longer be limited to spouses of the opposite sex. However, the ruling does not require employers to treat same-sex spouses the same as other spouses. But employers that provide disparate benefits to same-sex and opposite-sex spouses could face legal challenges as same-sex proponents seek to expand their rights.

**Uncertainty about basis for determining spousal status**

The Court in *Windsor* based its decision in large part on the fact that the state in which Ms. Windsor and her spouse resided recognized same-sex marriages, and the IRS generally looks to the law of the state of residence to determine marital status. Accordingly, employees’ same-sex spouses who live and work in a state that recognizes the marriage should be recognized as spouses for federal purposes. However, the Court did not provide any framework for replacing the void left by the removal of DOMA Section 3. With Section 2 of DOMA still in place, questions remain about the marital status of employees who were married to same-sex spouses in a state that recognizes the marriage but are living or working in a state that does not recognize the marriage. Which state’s laws will control in determining marital status — the state of employment, the state of marriage celebration/certificate, the state of residence, or state of employer’s headquarters?

Although the general expectation is that the IRS will apply an expansive definition of spouse for federal individual income tax purposes (likely recognizing a legally married spouse as a spouse regardless of state of residence), it is less clear what approach will be used to define spouse for ERISA purposes. Employers may be obligated to provide certain benefit rights (for example, survivor benefits and spousal consent for various option choices) while having choices about providing — or paying for — other benefits. Approaches may vary based on the type of employer. Employers with ERISA plans, for example, may need to require spousal consent for various option choices; governmental and church plan employers might choose not to do so.

**Buck Comment.** Within days of the *Windsor* ruling, the Office of Personal Management (OPM), which administers benefit programs for federal employees, extended health and other benefits to federal employees and their same-sex spouses based on an expansive state of ceremony definition. Particularly noteworthy is that OPM will now permit federal employees in legal same-sex marriages to be reimbursed for health care expenses incurred by their spouses and newly acquired stepchildren from their flexible spending accounts. This indicates that the Administration will consider all legally-married spouses eligible for the spousal income tax exclusion of employer-provided health benefits, and that the children of these spouses will be treated as the employee’s stepchildren, regardless of their state of residence. Although it
may be too soon for private sector employers to act without a formal IRS pronouncement, the Administration’s actions suggest that the same rule may ultimately apply to them.

**Effective date?**

The Court did not address when its decision to repeal Section 3 of DOMA is effective. Due to Supreme Court rules that allow a 25 day period to request a rehearing of the Court’s decision, arguably the decision does not take effect until July 21, 2013. However, once the decision takes effect, will it take effect retroactively and, if so, to what date — the date of the decision (June 26, 2013) or some earlier date? The Court found Section 3 of DOMA to be unconstitutional, which arguably makes it invalid from its inception in 1996. A retroactive effective date raises numerous concerns for employer-sponsored plans. For example, will plans need to take corrective action for distributions made without spousal consent? How quickly must employers respond to implement any plan changes required by the ruling? Should the tax treatment of health plan contributions be adjusted retroactive to the beginning of 2013? Guidance from the IRS is needed to resolve these types of issues.

**Implications of Supreme Court decision for health and welfare plans**

Although the *Windsor* ruling will have its most immediate effect on employers that currently provide benefits to same-sex spouses, it may also affect employers who do not currently provide coverage. Some of the major implications are discussed below. In many instances, employer action may ultimately depend on yet-to-be-issued guidance from the IRS.

**Employers that currently provide health coverage to same-sex spouses**

For employers that currently provide health coverage to same-sex spouses, the repeal of DOMA changes the tax treatment of benefits and creates new COBRA rights.

**Change in tax treatment.** Because of DOMA, a same-sex spouse could not qualify for the income tax exclusion applicable to health coverage provided to an employee’s opposite-sex spouse. As a result, unless the same-sex spouse could qualify as the employee’s dependent for health coverage purposes, the value of benefits provided by the employer for spousal coverage were includable in the employee’s income and subject to federal income and FICA taxes.

The Court’s ruling means that the spousal health coverage exclusion will extend to coverage provided to employees’ same-sex spouses who are recognized as spouses for federal tax purposes. As a result, employers will no longer have to impute income to those employees, and employees who previously had to pay for same-sex spouse health coverage on an after-tax basis will be able to make those contributions on a pre-tax basis.

**Buck Comment.** Employers need IRS guidance on a number of issues related to the change in tax treatment. For example, employers need to know whether the spousal exclusion will apply to all health coverage provided during 2013 or only to coverage provided after the date of the ruling. This is important because payroll systems will need to be modified to ensure that income is not improperly imputed and that employees’ income is properly reported on their 2013 W-2 forms. Employers also need to know what impact the ruling will have on their FICA obligations for health coverage provided to same-sex spouses.
during 2013 as well as whether they and their employees will be able to file for refunds of taxes paid on
the income imputed on those benefits in 2010, 2011, and 2012, the years currently open for refund.

Effect on COBRA obligations. Only covered employees, spouses, and dependent children may be qualified
beneficiaries with independent COBRA election rights. Because same-sex spouses have not been considered
spouses under federal law, plans were not obligated to offer them COBRA. Although some plans currently provide
same-sex spouses with full COBRA-like coverage if they lose coverage as a result of a qualifying event, others
provide more limited coverage (for example, only offering COBRA if the same-sex spouse loses coverage on
account of the death of the employee). Many plans do not offer a same-sex spouse any type of continued
coverage after a qualifying event so that the same-sex spouse can only continue coverage as the employee’s
dependent.

The DOMA ruling means that plans will have to treat same-sex spouses who are recognized as spouses under
the Code as qualified beneficiaries for all purposes. This means, for example, that they will have to be given the
opportunity to elect COBRA coverage after the employee’s reduction in hours or termination of employment, even
if the employee does not elect coverage, and must be offered up to 36 months of COBRA coverage if they
experience a second qualifying event. They must also be offered up to 36 months of COBRA coverage when their
initial qualifying event is the dissolution of their marriage or the death of the employee. Same-sex spouses must
also be permitted to enroll new dependents on the same basis as active employees.

Buck Comment. Making necessary changes for same-sex spouses who currently have COBRA-like
coverage should not be that difficult. However, employers will have to determine how to deal with same-
sex spouses who lost coverage on account of a qualifying event but currently do not have COBRA
coverage — either because the employee did not elect or subsequently dropped COBRA coverage or
because the employee died or the marriage was dissolved while COBRA coverage was in effect.

Employers that currently do not provide health coverage to same-sex spouses
The Court’s ruling does not require employers to provide benefits to same-sex spouses, even in states that
recognize same-sex marriage. However, whether spousal coverage has to be extended to same-sex spouses
may be dictated by the terms of the plan document or insurance policy. For example, a plan document or
insurance policy that currently defines spouse as an individual who is of the opposite sex of the employee would
not have to permit employees to enroll their same-sex spouses. However, if a plan document or policy currently
defines spouse “as an individual who is recognized as a spouse under federal law,” eligibility for benefits will turn
on how the agencies define “spouse.”

Buck Comment. Employers should carefully review their plan’s definition of “spouse” to determine
whether it encompasses same-sex spouses and consult with counsel to determine how to proceed. For
insured plans, employers should also contact their insurance carriers. Typically, contracts base status on
the state in which the contract is issued, but some states may impose their own insurance laws on
policies affecting their residents.
Offering mid-year extensions of health coverage to same-sex spouses
Although additional guidance is needed, it appears that mid-year enrollment of same-sex spouses and their children may be permitted or required on several grounds.

HIPAA special enrollment. Previously ineligible same-sex spouses who become eligible for health coverage mid-year may have HIPAA special enrollment rights. This would mean that:

- An employee already enrolled in the plan would be able to enroll the spouse (and the spouse’s children if they are now eligible) and would have to be given the opportunity to change plan options (for example, may change from an HMO to a PPO).
- An employee who previously declined coverage would have to be permitted to enroll himself or herself and the same-sex spouse and children.

It does not appear that same-sex spouses who were eligible for coverage prior to the ruling but were not enrolled would have special enrollment rights; thus a plan would not have to permit their enrollment. However, enrollment may be permitted as described below.

Election changes permitted by Section 125. A change in legal marital status under federal law would arguably qualify as a change in status event that, if authorized by the plan document, would permit an employee who previously declined coverage for his or her same-sex spouse to now enroll the spouse.

Effect of ruling on health FSAs, HRAs, and HSAs
Until the Windsor ruling, health care expenses incurred by same-sex spouses were not eligible for reimbursement by a health FSA unless the spouse qualified as the employee’s dependent for health care purposes. Because of the ruling, an employee will be able to obtain reimbursement for the expenses of a same-sex spouse recognized as a spouse for federal tax purposes even if the spouse did not qualify as a dependent. The change in treatment would likely qualify as a change in legal marital status permitting an employee to increase his or her health FSA election.

Generally, health reimbursement arrangement (HRAs) cannot reimburse the expenses of same-sex spouses who are not dependents for health care purposes. However, some employers may have been permitting an HRA to reimburse expenses of a same-sex spouse by imputing the value of the coverage to the employee as additional income. Because of the ruling, they will no longer have to do so when the same-sex spouse is recognized as a spouse for federal tax purposes.

Buck Comment. As discussed above, guidance is needed about the effective date of the change in tax treatment and whether employers and employees will be able to recover taxes paid on income imputed in prior years.

Recognition as a spouse for federal tax purposes means that the expenses of a same-sex spouse may be reimbursed by a health savings account (HSA) without adverse tax consequences. It also means that the “special” rule limiting the contributions of married couples will apply. Under this rule, if one spouse has family high-deductible health plan (HDHP) coverage, the spouses’ combined annual HSA contribution limit is the applicable statutory maximum for family coverage, even if the other spouse has self-only coverage or each
spouse has family coverage not covering the other spouse. In contrast, similarly situated domestic partners may each contribute up to the applicable statutory maximum for family coverage.

**Treatment of spouse’s children**

Generally, a stepchild is the child of an individual’s spouse. Guidance issued by the IRS in 2011 stated that it would base its determination on whether a taxpayer was the stepparent of the child of a same-sex partner for federal tax purposes on the status of the individual under the laws of the state in which the parties resided. This meant that the tax treatment of health coverage provided to the child of a same-sex spouse could vary depending on the employee’s state of residence. For example, for employees living in a state that recognized status of the employee as a stepparent, coverage provided to the child up to age 26 would not result in imputed income to the employee, while coverage provided to a child in states that did not recognize the employee as a stepparent would be taxable to the employee unless the child could satisfy the definition of a “qualifying relative” for health care purposes.

If the IRS extends spousal recognition to all legally married same-sex spouses, regardless of the state of residence, it appears that the children of same-sex spouses will likely be treated as an employee’s stepchildren for federal tax purposes. As the stepchild of the employee, the child would be eligible for coverage under the terms of a plan that covered stepchildren. In addition, the child would likely qualify as the employee’s dependent for purposes of the income tax exclusion of the value of health coverage and his or her expenses would be eligible for reimbursement by a health FSA or HRA (but not HSA) up to age 26. Expenses would be eligible for tax-free reimbursement from an HSA only if the child qualifies as the employee’s qualifying child or qualifying relative for health purposes.

**Buck Comment.** Employers should review their plan’s definition of child and/or stepchild to determine whether it would encompass the children of an employee’s same-sex spouse living in a state that recognizes the employee’s stepchild (which is likely the case in states that recognize same-sex marriage). If it does, the employer should determine whether there are HIPAA special enrollment implications. Also, employers should be aware that under current guidance, the Affordable Care Act will require plans to cover employees’ stepchildren in 2015 to avoid the $2,000 pay or play penalty.

**Change under Medicare rules if recognized as spouse**

The Medicare Secondary Payer rules generally will require an employer plan to pay primary to Medicare for the same-sex spouse of an active employee when the spouse is age 65 or disabled. They are not required to do so for domestic partners. In addition, employers may find that individuals recognized as spouses may be less likely to drop coverage at age 65 because they will now qualify for the waiver of the Medicare Part B late-enrollment penalty (available to individuals who have employer-sponsored coverage due to their spouse’s active employment).

**Implications for dependent care flexible spending accounts**

Recognition of a same-sex partner as a spouse may affect employees currently participating in a dependent care flexible spending account in several ways. First, the employee may not be reimbursed for payments to the partner caring for the employee’s child. Second, if the employee and spouse file jointly, the employee will not incur any
eligible expenses unless his or her spouse is working, looking for work, a full-time student, or incapable of self-care.

Buck Comment. Employers should review their plan documents to determine whether they would permit employees to change their dependent FSA elections. Also, guidance is needed to determine what retroactive effect, if any, the Windsor ruling will have on the reimbursement of expenses that were eligible expenses prior to the ruling but may not be eligible expenses now.

Implications for other benefit programs
The Windsor ruling may affect the tax treatment of other benefits provided to same-sex spouses and their children. For example, the exclusion for de minimis amounts of dependent life insurance and the exclusion for tuition reimbursement benefits may permit employers to provide these benefits to employees’ same-sex spouses and their children without having to impute income to the employee. Adoption assistance programs may also be affected because although they can reimburse expenses that the employee incurs to adopt the child of his or her domestic partner, they cannot reimburse expenses incurred to adopt the child of a spouse.

Buck Comment. Employers should review all of their benefit programs to identify areas in which recognition of a same-sex partner as a spouse may affect program administration.

Implications of Supreme Court decision for tax-favored retirement plans
The effect of the Court’s ruling on retirement plans will vary based on whether or not the plan is an ERISA plan and the degree to which the plan sponsor seeks to provide parity between same-sex and opposite-sex spouses. The issues for ERISA plans primarily involve survivor benefits, spousal consent, and qualified domestic relations order requirements. All retirement plans are potentially affected by the rollover and minimum distribution rules. As noted above, how the term “spouse” is defined for purposes of ERISA and the Code will significantly impact how these issues must be addressed and what discretion, if any, is available to plan sponsors in harmonizing their treatment of same-sex spouses. If a more expansive definition of spouse is required for federal purposes (for example, spouse is determined based on state of celebration and not residency) then virtually all same-sex spouses will be considered spouses for retirement plan purposes in ERISA plans.

Effect of ruling on survivor benefit requirements
Retirement plans that are subject to ERISA have several obligations to the spouse of the plan participant. These include providing survivor benefits under the plan, together with the requirement to obtain the consent of the spouse when the participant endeavors to waive those survivor benefits by choosing other forms of benefit payment or other beneficiaries. Spousal consent rights can apply to plan loans and withdrawals, the commencement of retirement benefits, and preretirement death benefit rights. These rules will now be applicable to a same-sex spouse who meets the definition of spouse based on how spouse is defined for federal tax and ERISA purposes.

Pension plans (including money purchase plans and defined contribution plans offering annuity forms of benefits) must provide that married participants are entitled to receive their benefits in the form of a Qualified Joint and Survivor Annuity (QJSA) (including the qualified optional survivor annuity and other survivor annuity forms).
unless the participant's spouse consents to a different form of payment. Legally recognized same-sex spouses will be entitled to receive such benefits unless an alternate form of payment is elected with the spouse’s consent. In addition, these types of plans must also provide a Qualified Preretirement Survivor Annuity (QPSA) for legally recognized same-sex spouses. Similarly, participants in defined contribution plans that do not offer annuity forms of benefit must obtain the consent of their legally recognized same-sex spouse to name a nonspouse beneficiary.

Plan sponsors can provide the survivor benefits described above to other beneficiaries such as domestic partners who are not legally recognized same-sex spouses. However, if the plan also extends consent rights to a domestic partner or person other than a legal spouse, the restriction on the participant’s unfettered right to select distribution options and name beneficiaries could be considered an assignment or alienation of plan benefits that would endanger the plan’s tax-qualified status. Providing consent authority to such an individual may be acceptable if the extension is voluntary and subject to disclosure.

**Buck Comment.** This presents a conundrum for the employer that wishes to harmonize the treatment of all same-sex spouses (including those who may not be recognized as spouses for federal purposes) and, perhaps, same-sex domestic partners. Guidance on who is a spouse for ERISA purposes will be needed before plan sponsors can make these types of decisions. Employers exempt from the ERISA spousal protection and anti-alienation rules, such as governmental and church employers, have greater flexibility and will need to observe the requirements of their own state or doctrine.

**Effect of ruling on defined contribution plan hardship withdrawals**
An employee's elective contributions under a cash or deferred arrangement (for example, elective deferrals under a 401(k) or 403(b) plan) can only be distributed upon the occurrence of certain events, one of which is the employee's hardship. Hardship distribution regulations enumerate various reasons that are deemed to satisfy the hardship criteria — some of which include expenses of the participant’s spouse. With the removal of Section 3 of DOMA, expenses of legally recognized same-sex spouses (based on the criteria defined by IRS) can be included.

**Buck Comment.** The 2006 Pension Protection Act (PPA) expanded the hardship distribution rules to permit a 401(k) or 403(b) plan to offer hardship distributions to cover the medical, tuition, and funeral expenses of a primary beneficiary. If the same-sex spouse is one of the participant’s primary beneficiaries, and if the plan has been amended to include the expanded PPA definition of expenses, the Court’s decision will not change administration on this score.

**Effect of ruling on QDRO administration**
It appears that same-sex marriages will be treated the same as opposite-sex marriages for QDRO purposes. Prior to the Windsor decision, a domestic relations order assigning a benefit to other than a child, dependent, or opposite-sex spouse or former opposite-sex spouse of the participant (for example, an assignment on behalf of a same-sex spouse or domestic partner) would not be valid under ERISA or the Code.

**Free QJSA coverage with 415 limitation**
Code Section 415 limits the amount of retirement benefits that can be provided from a defined benefit plan, but the value of a QJSA benefit is not taken into account. This rule is expected to be applied based on how the IRS defines spouse for federal tax purposes.
**Code Section 401(a)(9) minimum required distribution period**

Certain minimum distributions required by the tax rules in Code Section 401(a)(9) are determined using the life expectancy of the participant and his or her spouse and certain deferral options are not available to nonspouse beneficiaries. Guidance on what rules must or may be applied for determining access to these options will be needed.

The payment deferral rules for beneficiaries will be impacted for defined benefit and defined contribution plans. Nonspouse beneficiaries are required to draw down plan benefits by the end of the calendar year that contains the fifth anniversary of the death of the participant or start a lifetime benefit by the end of the calendar year following the year in which participant’s death occurred. Contrast this with the rule for a spouse that permits the spouse to defer to the end of the calendar year in which the participant would have been age 70 ½. A same-sex spouse who meets the definition of spouse as defined under federal law will now be able to defer distribution commencement until the end of the calendar year in which the participant would have attained age 70 ½, and their benefits payments will no longer be subject to the incidental death benefit rules requiring a restricted payment schedule when the age difference between the participant and beneficiary exceeds 10 years.

The life expectancy rule used for determining minimum distributions is generally of interest to defined contribution plans that permit installment payments and to defined benefit plans that allow period certain, or certain and life, options. Plans that limit period certain options to just 10 or 15 years generally do not cross the line with this rule unless they have participants retiring beyond age 84 when the single life limit is 15.5 years. Longer payout periods are permitted based on the life expectancy of the participant and legally recognized spouse.

**Rollovers**

The spouse of a plan participant currently has more rollover options than a nonspouse beneficiary. A spouse is permitted to roll over death benefit proceeds to his or her IRA or another eligible retirement plan. A nonspouse beneficiary can only roll over to an “inherited” IRA and distribution restrictions limit prolonged deferral. Same-sex spouses who are recognized as spouses for federal purposes will now have access to the more flexible IRA and other eligible retirement plan alternatives.

**Retroactivity for retirement plans?**

The Court did not set an effective date for the change to DOMA. By declaring Section 3 of DOMA to be unconstitutional, it is possible that claims will be asserted for benefits back to the enactment date. Under such an interpretation, retirement plans could face a host of negative consequences. The same-sex spouses of participants who had died during the intervening period might assert claims for QJSA and QPSA survivor benefits under defined benefit plans even though benefits had been paid to other beneficiaries. Same-sex spouses of participants in 401(k) and other defined contribution plans might assert claims for death benefits that had long ago been distributed from the plan. Plans that give the administrator or fiduciary discretionary authority to determine eligibility for benefits and to construe the terms of the plan are often accorded deference by courts. Under this standard, it is hoped that the courts will find that interpreting the plan in accordance with DOMA was reasonable and within in the scope of the administrator or fiduciary’s authority.

**Buck Comment.** Although it is not possible to predict what guidance the IRS and other agencies will provide on retroactive or prospective requirements, or what the courts will do even if the agencies declare
prospective application is permitted, employers can take some steps currently to protect their plans from disputes. For example, it’s always wise to remind participants to keep their written beneficiary designations up to date to avoid having to apply the plan defaults. A written designation naming the same-sex spouse would not need consent from any other party and yet would go a long way in assuring that the spouse gets the participant’s benefits if that’s what the parties intend.

Implications of Supreme Court decision for ownership attribution determinations

In addition to affecting various types of retirement and other benefit plans, as a general matter, the *Windsor* decision can change an individual’s status as a spouse for determining ownership of business entities when evaluating controlled and affiliated group status, nondiscrimination requirements, ERISA disclosures, and party-in-interest or disqualified person status.

Implications of Supreme Court decision for employment-related policies and executive compensation

Although future guidance will clarify what employers can and cannot do, they should begin to consider what, if any, policy changes they may have to make to facilitate personnel administration that may vary based on location.

Effect of ruling on leave laws

Because of DOMA, same-sex married couples were not entitled to leave to care for a seriously ill spouse or for certain military family leaves available to opposite-sex spouses under the FMLA. (See our March 29, 2013 For Your Information.) The *Windsor* decision increases the availability of FMLA leave and likely the complexity of leave administration by eliminating the distinction between same-sex and opposite-sex marriages for FMLA purposes while allowing states to retain the distinction under state leave laws.

DOL regulations. Because current DOL regulations look to the employee’s state of residence to determine whether his or her partner is a spouse for FMLA purposes, employers may have to provide job-protected leave for some — but not for other — employees to care for a same-sex spouse. Lawfully married same-sex couples who live in a state where same-sex marriage is recognized will be entitled to up to 12 weeks in a 12-month period of leave to care for a seriously ill spouse or for activities that arise in connection with a military spouse’s deployment, and up to 26 weeks of caregiver leave for a military spouse who is seriously injured or ill. However, under current regulations, an employer would not have to provide same-sex spousal leave for an employee who lives in a non-recognition state.

Buck Comment. Whether the DOL will amend its regulations to recognize spousal status based on the state of celebration rather than state of residence remains to be seen.

While the *Windsor* decision generally expands FMLA protections for same-sex married couples, it may also reduce leave entitlement in at least one circumstance. Under DOL regulations, spouses who work for the same employer are limited to a combined total of 12 workweeks off when the leave is for bonding with a new child or caring for a sick parent. When they were not considered spouses under DOMA, each one could take 12 weeks for either purpose.
Civil unions and domestic partnerships. Some states permit same-sex civil unions or domestic partnerships, but employees in those relationships — even those designed to be marriage-equivalent for state law purposes — have not had spousal standing under the FMLA. It appears that spousal leave under the FMLA will continue to be unavailable to an employee to care for a civil union or domestic partner under existing regulations.

Coordination with state leave laws. Whether the Windsor decision complicates or eases administrative burdens for employers largely depends on where they have operations and the state leave laws that apply to their workforce. Because California employers, for example, will be able to extend FMLA, as well as the California Family Rights Act (CFRA), to married same-sex spouses, FMLA and CFRA leave administration for those employees will be simplified. The complexities of administering FMLA and CFRA leave for same-sex and opposite-sex registered domestic partnerships will not change. In states that recognize civil unions or domestic partnerships but not same-sex marriage, the rules have not changed and leave entitlements under state and federal laws will still differ.

Employers will want to review their current leave policies and revise them as needed to reflect the new legal landscape. Policies, forms, and procedures should be evaluated to ensure that employees and those responsible for administering leave clearly understand under what circumstances leave may be permitted.

Effect of ruling on executive compensation
The Court’s decision may have a variety of executive compensation implications. For example, the survivor rights and income and estate tax effects pertaining to equity-based compensation, deferred compensation, and supplemental executive retirement plans are among the areas that may be impacted. Employers should determine whether the term “spouse” is defined in their executive compensation plans and contracts and how the Court’s ruling may affect their executive compensation and benefit arrangements.

Payroll and withholding issues
Because same-sex married couples will be eligible for the same federal benefits and tax treatment as opposite-sex couples, payroll tax and withholding practices will have to be revised. Employers will want to make sure their payroll administrators and/or vendors are aware of system changes that may be needed and are preparing for them. As the IRS releases guidance on past and future tax treatment, employers can expect an uptick in requests to change W-4s as well as for amended W-2s in connection with refund claims for currently open tax years. For those employees who will be able to use pre-tax dollars to pay for same-sex spousal coverage, employers should get ready to put new voluntary salary reduction arrangements in place and reset payroll deductions pending further guidance.

Effect of ruling on immigration
The decision invalidating DOMA Section 3 opened the door for the extension of federal immigration benefits to legally married same-sex couples. Secretary of Homeland Security Janet Napolitano has already announced that U.S. Citizenship and Immigration Services (USCIS) will now review immigrant visa petitions (i.e., green card sponsorship petitions) filed on behalf of same-sex spouses in the same manner as petitions filed on behalf of opposite-sex spouses.
In determining whether to extend marriage-related benefits at the visa application or adjustment of status stage to a same-sex spouse, USCIS generally will look to the state or country where the marriage occurred to determine its validity. Whether USCIS intends to extend immigration benefits to same-sex spouses of non-immigrant visa holders (such as H-1B holders) remains to be seen.

**Buck Comment.** Because federal immigration agencies have also considered the law of the state of residence in certain limited circumstances, USCIS has indicated that it may provide future guidance.

While these issues are being worked through, employers must make certain that appropriate work authorizations are on file and visas they may have sponsored are adjusted for any status changes. (See our April 25, 2013 For Your Information.)

**In closing — action steps**

Buck recommends employers identify plans, benefits, and polices impacted by the *Windsor* ruling, review current plan terms and/or policies and practices defining spouses, review existing domestic partner provisions, if any, and determine a preferred compliance approach (for example, inclusive or restrictive). This preparation will allow the employer to understand what impact the change will have on benefits at both the federal and state levels as guidance is issued.

**Buck Comment.** As the number of states recognizing same-sex marriage grows, employers who take an inclusive approach to providing plan benefits may decide to roll back coverage for domestic partners — a benefit that had been extended in the days when state-sanctioned marriage was not possible. If an employer has been grossing up employees to compensate them for the denial of federal tax preferences, they may wish to re-evaluate whether to continue the practice and for what groups of employees. Whether an employer will be able to seek a refund of payroll tax paid on gross-up is unclear, but it appears employers may be able to claim refunds for any open years of federal payroll taxes paid on imputed income for health care benefits for same-sex spouses. Employers should factor in the size of the expected refund in determining whether to seek one.

Using multiple definitions of spouse, in addition to complicating the administration of employer plans and uniform application of various employment policies, may inadvertently create employee relations issues. For that reason, employers may want to consider a uniform definition of spouse for as many plans and policies as possible.

As a practical matter, employers may not know which of their employees, if any, are in a same-sex marriage. Although there appears to be no requirement for employers to clarify marital status, they may want to consider asking employees to self-identify or sending a reminder to all employees to keep their employee information current.

All changes in plans and policies merit communication to employees. Employees will want to know how they will be impacted. Employers should take time to think through the many legal issues surrounding the *Windsor* decision, and be prepared to adjust employee communications in light of expected guidance. Company culture and business considerations should be factored into these decisions.
Final wellness regulations mean health plans need a checkup

The Departments of Labor, Treasury, and Health & Human Services (the Departments) issued final regulations, which, among other things, reflect changes made by the Affordable Care Act to wellness programs subject to the HIPAA nondiscrimination rules. While the regulations retain the same general principles and framework as prior guidance, the Departments modified some of the concepts first introduced in the proposed regulations issued late last year. Specifically, the Departments subtly reworked the definition and analysis for participatory and health-contingent programs. These changes could have a significant impact on some wellness programs. As a result, all group health plans offering wellness programs will need to consider those programs in light of these final regulations and make any necessary design changes. The regulations are effective for plan years beginning on or after January 1, 2014.

In this article: Background | HIPAA wellness programs | Participatory wellness programs | Health-contingent wellness programs | Activity-only programs | Outcome-based programs | Wellness plan checkup |

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), which amended the Internal Revenue Code (Code), ERISA, and the Public Health Service Act (PHSA), generally prohibits group health plans and insurers from discriminating against individual participants and beneficiaries with respect to eligibility, benefits, or premiums based on a health factor. However, HIPAA does not prevent a group health plan from establishing rewards (e.g., premium discounts, rebates, or modifying copayments or deductibles) under a wellness program that promotes health and prevents disease.

Final regulations issued in 2006 addressed wellness programs, permitting group health plans to provide a reward (or penalty) for participants who satisfy (or fail to satisfy) a health standard, as long as the program satisfies certain conditions. The regulations established five requirements to which standard-based (currently known as “health-contingent”) wellness programs must adhere. (See sidebar on page 2.)

In 2010, the Affordable Care Act (ACA) modified the HIPAA nondiscrimination and wellness program provisions, essentially codifying the 2006 regulations (i.e., the five requirements are now statutory) and increasing the maximum reward available to participants in wellness programs to 30% of the total cost of coverage. In addition, the ACA authorized the Departments to increase the reward to up to 50% of the cost of coverage.
In November 2012, the Departments issued proposed regulations, adjusting the 2006 wellness regulations to accommodate the ACA changes and modifying them. Retaining core principles from the 2006 regulations, the proposed regulations increased the maximum reward available to participants in wellness programs to 30% of the cost of coverage and allow a 50% limit for certain tobacco-related programs. The proposed regulations also introduced some new concepts. For example, the regulations significantly changed the "reasonable alternative standard" for health-contingent wellness programs. (See our December 13, 2012 For Your Information.)

In early May, the Departments issued proposed regulations generally addressing affordability and the minimum value of eligible employer-sponsored plans for purposes of the shared responsibility penalty. (See our May 24, 2013 For Your Information.) Among other things, those proposed regulations address the impact of wellness programs on minimum value and affordability. Those regulations have not yet been finalized and should not be confused with these final wellness regulations.

Note that many other laws regulate plans and issuers in their provision of benefits to participants and beneficiaries. Compliance with these wellness final regulations is not determinative of compliance with other applicable requirements such as the Americans with Disabilities Act, Title VII of the Civil Rights Act of 1964, the Genetic Information Nondiscrimination Act, the Code, privacy and state law. To confirm compliance in all areas of the law, it's important to consult legal counsel for a full analysis of any wellness program.

**HIPAA wellness programs**

Wellness programs come in all shapes and sizes and have had a variety of names over the years. Some programs reward certain behaviors, biometrics, and/or participation in certain activities. Wellness programs have been referred to as health and productivity, wellness, disease management programs, etc. These programs attempt to address body, mind, and pocketbook — helping employers reduce benefit costs and lost work time, while increasing employee productivity and satisfaction. For example, a wellness program might create incentives to encourage employees to adhere to a particular course of treatment or to otherwise better manage their health. A program that relates to an employer group health plan must comply with HIPAA protections. The final regulations divide wellness programs into two categories — participatory and health-contingent. Programs that
reward individuals who participate in certain activities or who meet certain standards based on results of tests, measurements, or screenings are subject to a heightened scrutiny under the regulations.

**Participatory wellness programs**
A program is participatory if none of the conditions for obtaining a reward are based on an individual satisfying a standard that is related to a health factor. A participatory wellness program must be available to all similarly situated individuals. Such programs are not considered discriminatory and need not meet the five wellness requirements set out in the regulations.

Examples of participatory programs include those that:

- Reimburse some or all of the cost of fitness center memberships (e.g., free or discounted health club membership)
- Reward individuals who receive diagnostic testing — not based on outcomes (e.g., biometric screening)
- Waive copays or deductibles under a group health plan for receiving preventive care (such as prenatal care or well-baby visits). Note that the ACA requires non-grandfathered plans to cover certain preventive health care at 100%. Thus, this would only be relevant for grandfathered plans. Note that some plans provide rewards (other than waiving copays or deductibles) for individuals who receive preventive care services and presumably these too would be considered participatory programs
- Reward participation in a smoking cessation program, regardless of whether the individual quits smoking (e.g., listed among health education seminars offered under the wellness program)
- Reward attendance at free health education seminars (e.g., course on nutrition)
- Reward the completion of a health risk assessment (HRA) — not based on outcomes (e.g., no follow-up action on any identified health issues required)

**Buck Comment.** While the language is consistent with the 2006 regulations, the notion of participatory programs expressed in the final (and proposed) regulations differs from that commonly known in the wellness community as a “participatory program.” Commonly understood, a participatory program was a program available to all similarly situated employees, regardless of a health condition. For example, a “Get Healthy” walking program, not targeted at those with a specific health issue, but available to the entire employee population, had been considered participatory. Under the final regulations, however, such a program would not be participatory, but rather an activity-only program in the health-contingent category and subject to the wellness requirements. Under the final regulations, participatory programs appear to be more passive and don’t generally include a physical activity.

**Health-contingent wellness programs**
A health-contingent program requires an individual to satisfy a standard related to a health factor in order to obtain a reward. Such programs fall into two categories — activity-only and outcome-based. Both programs are required to comply with the newly restructured five requirements for wellness plans, but the requirements differ slightly depending on whether the program is activity-only or outcome-based.
Activity-only programs

Activity-only programs require an individual to perform or complete an activity related to a health factor in order to obtain a reward. For example, these include walking, diet, and exercise programs. Activity-only programs are subject to the five requirements for wellness plans.

Buck Comment. Why are activity-based programs, like exercise or walking programs, available to all employees regardless of health, now considered health-contingent? Concerned that a wellness reward could be unavailable to some individuals because of a health factor (e.g., recent surgery prevents the person from exercising), the Departments provided safeguards in the regulations to ensure that these individuals would be given a reasonable alternative standard to qualify for the reward.

Requirements for activity-only wellness programs

1. **Opportunity to qualify for reward.** Individuals must be given the opportunity to qualify for the reward at least once a year.

2. **Size of reward.** As described under the proposed regulations, the maximum reward for participation in a non-tobacco wellness program is 30% of the total cost of coverage. An additional 20% can be applied to wellness programs designed to prevent or reduce tobacco use (up to 50% total, including tobacco programs). The total cost of coverage is the sum of employer and employee contributions, generally the COBRA rate minus the 2% administrative fee. If any employee dependents are also eligible to participate in the wellness program, the reward limit cannot exceed the applicable percentage of the coverage category (e.g., employee plus one, family) in which the employee and any dependents are enrolled. In the case where family members are eligible for a reward and not all members participate or qualify for the reward, the regulations allow plans to apportion the reward among family members, as long as the method is reasonable. The Departments note that additional subregulatory guidance could be issued if questions arise.

A reward includes not only financial incentives — such as lower contributions, reductions in cost-sharing, but also includes the avoidance of a penalty — such as the absence of a premium surcharge or other financial or nonfinancial disincentives.

Buck Comment. Rewards offered in conjunction with participatory wellness programs do not count toward the limit for health-contingent programs. Any rewards provided for participatory programs, such as attending health education seminars or taking a health risk assessment or biometric screening (not health outcome related), would not be included in the applicable percentage for health-contingent programs.
3. **Reasonable design.** Programs must be reasonably designed to promote health or prevent disease. Based on the facts and circumstances, a program will satisfy this standard if it:

- Has a reasonable chance of improving the health of participating individuals
- Has a reasonable chance of preventing disease in participating individuals
- Is not overly burdensome
- Is not subterfuge for discriminating based on a health factor
- Is not highly suspect in the method chosen to promote health and prevent disease

The preamble to the regulations provides a safe harbor of sorts for identifying if a program is reasonably designed. The Departments state that “[w]hile programs are not required to be accredited or based on particular evidence-based clinical standards, these practices, such as those found in the CDC’s [Guide to Community Preventive Services](https://www.cdc.gov/).” may increase the likelihood of wellness program success and are encouraged as a best practice.

4. **Uniform availability and reasonable alternative standards.** The full reward must be available to all similarly situated individuals. For an activity-only program, a reward will be deemed available to all similarly situated individuals for a period if it allows a reasonable alternative standard (or waiver) for obtaining the reward for any individual for whom, for that period, it is:

- Unreasonably difficult due to a medical condition to satisfy the standard
- Medically inadvisable to attempt to satisfy the standard

The plan or issuer must furnish a reasonable alternative standard to these individuals, if requested, or the condition for obtaining the reward must be waived.

**What’s reasonable?** Whether an alternative standard is reasonable depends on all the facts and circumstances, including but not limited to the following:

- 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 (instead of requiring an individual to find such a program unassisted) and may not require an individual to pay for the cost of the program.
- The time commitment required must be reasonable (e.g., requiring nightly attendance at a one-hour class would be unreasonable).
- If the reasonable alternative standard is a diet program, the plan or issuer must pay any membership or participation fee associated with the program (but not the cost of food).
- If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for the individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Nothing in the regulations appears to require the plan or issuer to cover 100% of the office visit (or consultation) from which the physician's personalized recommendations result. The regulations do provide that plans and issuers may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.
Example. In the summer months, Romeo's Rugs Inc. implements a “Get Moving” walking program, which is available to all employees. The employer communicates to employees that if it is unreasonably difficult due to a medical condition for an individual to participate (or it is medically inadvisable for an individual to attempt to participate), the plan will waive the walking program requirement and provide the reward. All materials describing the terms of the walking program disclose the availability of the waiver.

Juliet is pregnant during the period that the program is offered. Her doctor verifies that it is unreasonably difficult and medically inadvisable for her to attempt to participate in the walking program. The standard is waived for her and she receives the reward. Romeo's Rugs' wellness program is a health-contingent, activity-based program that satisfies the HIPAA requirements.

Buck Comment. For activity-only programs, plans and issuers can seek physician verification when it is reasonable to believe that requests for an alternative standard require a medical judgment to evaluate the validity of the request. With regard to whether the verification must be made by a physician or other medical professional, for now, the regulations permit the plan, in light of all the facts and circumstances and subject to the broader standards for reasonable design, to determine whether a physician or other medical professional should provide the opinion. Further guidance could be issued on this subject.

Identifying an alternative standard. Plans have the flexibility to determine whether to provide the same alternative to those who request it or on an individual-by-individual basis. Plans do not have to determine the alternative in advance.

Right to earn full reward. Individuals who are given an alternative standard to an activity-only wellness program must be able to earn the same reward as those who meet the initial activity, even if it takes some time to satisfy the standard. The plan has the flexibility to determine how to provide the reward, such as retroactive or pro rata payments for the remainder of the year, as long as the method is reasonable and the individual is made whole (e.g., receives the full amount of the reward). In the case where an individual does not satisfy the alternative until the end of the year (e.g., complete a smoking cessation class), the plan can provide retroactive payment for the reward within a reasonable time after the end of the year. But, pro rata payments may not be made over the following year (the year after the year in which the reward was earned). A plan can always waive the otherwise applicable standard (and provide the reward) for an individual who cannot meet it.

Buck Comment. The Departments do not describe how the retroactive payments would be made and what the impact might be on cafeteria plan (also called pretax or salary reduction plan) elections. Additionally, except as noted above, individuals generally cannot satisfy a reasonable alternative standard applicable to one year and be rewarded in the subsequent year. Those plans will need to be changed to be ready for 2014. Under the cafeteria plan change in election rules, a mid-year contribution to a health FSA, an HRA, or an HSA by an employer is permissible, but will not trigger an opportunity for employees to change existing health FSA or major medical elections under a cafeteria plan. An employee
may prospectively change a major medical election only in limited circumstances, one of them appropriate for this situation being a change in cost or coverage terms of the medical coverage (such as a premium reduction, deductible decrease, or increase of major medical coverage). Plans should seek legal advice for how best to comply with the cafeteria plan and the wellness regulations when a standard is satisfied late in the year.

The flowchart on the following page provides a useful overview of the analysis involved with offering a reasonable alternative standard (RAS):
Health-Contingent

Activity-Only

Comply with 5 wellness requirements

Offer RAS if unreasonably difficult or medically inadvisable due to medical condition

MD verification permitted to prove health condition

Outcome-Based

Comply with 5 wellness requirements

Offer RAS if can’t meet initial measurement, test, or screening (regardless of health condition)

MD verification of health condition not permitted

Participatory

No need to offer 5 wellness requirements

Plan not required to provide RAS

If RAS is participation-only

If RAS is activity-only

If RAS is outcome-based
5. **Notice of reasonable alternative standard.** A plan must disclose in all plan materials describing the program the availability of the reasonable alternative standard to qualify for the reward (and if applicable, the possibility of a waiver). The regulations also require that this disclosure include contact information and a statement that an individual’s personal physician will be accommodated.

The regulations update and provide sample notice/disclosure language as follows:

*Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.*

Additionally, an example in the regulations addressing an activity-only program uses this notice language:

*Fitness Is Easy! Start Walking! Your health plan cares about your health. If you are considered overweight because you have a BMI of over 26, our Start Walking program will help you lose weight and feel better. We will help you enroll. (If your doctor says that walking isn't right for you, that's okay, too. We will work with you [and, if you wish, your own doctor] to develop a wellness program that is.)*

**Outcome-based programs**

Unlike activity-only programs, outcome-based programs require an individual to attain or maintain a specific health outcome in order to receive a reward. Programs that reward nonsmokers; those who attain certain results on biometric screenings (e.g., BMI of 30 or under); or those who test within a healthy range for biometric screening tests of certain risk factors (e.g., high cholesterol or glucose level) and require those who test outside the range or who are at risk to take additional steps (like meeting with a health coach) to obtain the reward are outcome-based programs. Much like the activity-only program requirements, outcome-based programs must satisfy five conditions to be compliant with HIPAA, however, some differences exist.

**Requirements for outcome-based wellness programs**

1. **Opportunity to qualify for the reward.** As required for activity-only programs, individuals must be given the opportunity to qualify for the reward at least once a year.

2. **Size of reward.** As with activity-only programs, the maximum reward for participation in a non-tobacco wellness program is 30% of the total cost of coverage. An additional 20% can be applied to wellness programs designed to prevent or reduce tobacco use (up to 50% total, including tobacco programs). See information above for more details on the size of the reward.

**Example.** Macbeth’s Musical Instruments’ wellness program consists exclusively of a tobacco prevention offering. The total annual cost of employee-only coverage under Macbeth’s group health plan is $6,000. Employees who have used tobacco in the last 12 months and who are not enrolled in the tobacco cessation program are charged a $1,000 premium surcharge in addition to their employee contribution of
$6,000. Employees who participate in the plan’s tobacco cessation program are not assessed the $1,000 surcharge. The program satisfies the maximum reward limitation because the reward for the wellness program (absence of a $1,000 surcharge) does not exceed 50% of the total annual cost of employee-only coverage, $3,000 ($6,000 x 50% = $3,000).

Example. Same facts as above, but the wellness program contains other health-contingent components in addition to a tobacco prevention offering. In addition to a $2,000 group health plan premium surcharge imposed on employees who do not participate in the smoking cessation program, employees can earn a $600 premium reduction if they meet certain health-related numerical scores related to blood sugar, weight, cholesterol, and blood pressure. The program satisfies the maximum reward limitation because (1) the total of all rewards (including absence of a surcharge for participating in the tobacco program) is $2,600 ($600 + $2,000 = $2,600), which does not exceed 50% of the total annual cost of employee-only coverage ($3,000); and (2) tested separately, the $600 reward for the wellness program unrelated to tobacco use does not exceed 30% of the total annual cost of employee-only coverage, $1,800 ($6,000 x 30% = $1,800).

3. Reasonable design. Duplicating the rule from the activity-based program requirements, wellness plans must be reasonably designed to promote health or prevent disease. Based on the facts and circumstances, a program will satisfy this standard if it:
   - Has a reasonable chance of improving the health of participating individuals
   - Has a reasonable chance of preventing disease in participating individuals
   - Is not overly burdensome
   - Is not subterfuge for discriminating based on a health factor
   - Is not highly suspect in the method chosen to promote health and prevent disease

4. Uniform availability and reasonable alternative standards. The full reward under an outcome-based program must be available to all similarly situated individuals. A reward will be deemed available to all similarly situated individuals for a period if the program allows a reasonable alternative standard (or waiver) for obtaining the reward for any individuals who do not meet the initial standard based on the measurement, test, or screening. As opposed to an activity-only program where an alternative standard must be generally offered when it is medically inadvisable for the individual to meet the initial standard (and, if reasonable, the plan can request physician verification), for an outcome-based program, the plan must offer a reasonable alternative standard to any individual who does not meet the initial (healthy) standard, regardless of the individual’s medical condition or other health status. To ensure that an initial standard is not subterfuge for discrimination or underwriting based on a health factor, the plan must offer a reasonable alternative standard to receive the reward to any individuals who do not meet the target biometric (e.g., nonsmoking status, cholesterol level, BMI, blood pressure). Under an outcome-based program, doctor verification of the health condition is not permitted.

Example. Richard’s Roses Inc. offers a wellness program reward for employees who have a healthy cholesterol level below 200 mg/dl. The group health plan provides the screening free of charge.
Employee Henry Bolingbroke’s test results indicate a level of 237 mg/dl. Regardless of any medical condition or other health status that might cause the cholesterol level to be high, Henry has not met the initial standard (e.g., target biometric) and he must be given a reasonable alternative standard to obtain the wellness program reward.

**What’s reasonable?** Whether an alternative standard is reasonable depends on the facts and circumstances. The Departments use the same facts and circumstances to define a reasonable program that are used for activity-only programs. (See details above.)

**Standards to meet if the alternative is activity-only.** To the extent that a reasonable alternative standard under an outcome-based program is itself an activity-only program, it must comply with the activity-only requirements as if it were the initial program standard. If the reasonable alternative is an activity-only program, then the plan may need to offer a second alternative to any individual who can’t satisfy the standard for a medical reason.

**Standards to meet if the alternative is outcome-based.** If the reasonable alternative is an outcome-based program, the plan may need to provide a second alternative to anyone who fails the standard. A special rule related to outcome-based programs requires that when the reasonable alternative standard is outcome-based, the individual must be allowed to request to follow his or her doctor’s recommendations to earn the reward.

**Identifying an alternative standard.** As for activity-only programs, plans have the flexibility to determine whether to provide the same alternative to those who request it or to provide an alternative on an individual-by-individual basis. Plans do not have to determine the alternative in advance. (See details above.)

Refer to the flowchart above for an overview of the reasonable alternative standard analysis.

5. **Notice of reasonable alternative standard.** Like activity-only programs, a plan must disclose in all plan materials describing the program the availability of the reasonable alternative standard to qualify for the reward (and if applicable, the possibility of a waiver). The regulations also require that this disclosure include contact information and a statement that an individual’s personal physician will be accommodated.

The regulations update and provide sample notice/disclosure language. The regulations state that the requirements for an outcome-based program will be satisfied if this language or substantially similar language is used:

> Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.
Additionally, an example in the regulations addressing an outcome-based program uses this notice language:

*Your health plan wants to help you take charge of your health. Rewards are available to all employees who participate in our Cholesterol Awareness Wellness Program. If your total cholesterol count is under 200, you will receive the reward. If not, you will still have an opportunity to qualify for the reward. We will work with you and your doctor to find a Health Smart program that is right for you.*

**Wellness plan checkup — it’s going to be a busy summer**

Under the ACA, programs that are noncompliant could be subject to penalties under the Code and the PHSA of up to $100 per day. Wellness programs are also subject to audit from the DOL and could be subject to enforcement under ERISA. The Departments state that these wellness regulations provide “criteria for an affirmative defense that can be used by plans and issuers in response to a claim that the plan or issuer discriminated under the HIPAA nondiscrimination provisions.” A careful review of any program of health promotion and disease prevention is required before 2014. Each component of a wellness program should be carefully analyzed to determine whether the piece is participatory (not subject to a maximum reward) or health-contingent (subject to the 30% — 50% for tobacco use programs — maximum reward).

So, this summer is the ideal time for all wellness programs to have a checkup to ensure compliance. In examining wellness arrangements for 2014, consider the following:

**Is the program participatory?**

- Participatory program
  - Reward can be financial or nonfinancial (e.g., education, fitness, no reward at all)
    - Health education seminars
    - Discounted health club membership (taxable benefit)
    - Smoking cessation program
    - Health risk assessments
    - Biometric screenings
  - Program is participatory if the reward is not conditioned on an individual satisfying a standard that is related to a health factor
  - Program must be available to all similarly situated individuals, regardless of health status
  - Need not meet the five requirements for health-contingent programs

**Is the program health-contingent?**

- Health contingent program

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*Looking at the big picture*

Keep in mind that the Departments continue to send the same message: wellness program rewards should be available to all — not just those who are healthy.*
To receive the reward, the program requires an individual to satisfy a standard related to a health factor.

Program is either an activity-only or outcome-based.

Must meet the five requirements:

□ Activity-only program

- To receive the reward, the individual has to perform or complete an activity related to a health factor (e.g., health factor of the individual)
  - Walking program
  - Diet program
  - Exercise program

- Program does not require a measurement, test, or screening

- Program must meet the five requirements for activity-only arrangements
  - Individuals must be allowed to qualify for the reward at least once a year
  - Amount of the reward must be limited to the requirements for tobacco use and non-tobacco use programs
  - Program must be reasonably designed to promote health or prevent disease — design would not be considered subterfuge for discrimination
  - Program is uniformly obtainable and reasonable alternative standards are available
    - Is it reasonably foreseeable that an individual won’t qualify for the reward because of a health standard?
    - If it’s unreasonably difficult for an individual to meet the standard due to a medical condition or medically inadvisable to attempt to satisfy the standard, program must offer a reasonable alternative or waive the standard if requested
      - Physician verification is permitted where a medical judgment is necessary to evaluate the validity of the request
    - Alternative standard offered must be reasonable, manageable, practical
    - Activity-based alternative standards must meet the activity-based requirements; outcome-based alternative standards must meet outcome-based requirements
    - Individual using alternative standard must be made whole and receives the full amount of the reward if alternative is satisfied
  - Documentation must meet disclosure requirements

□ Outcome-based program

- To receive the reward, the individual must meet a specific health outcome or attain a specific health metric
  - Reward for nonsmokers
  - Reward for meeting certain biometrics or health standard (e.g., BMI, cholesterol)

- Program must meet the five requirements for outcome-based arrangements
- Individuals must be allowed to qualify for the reward at least once a year
- Amount of the reward is limited to the requirements for tobacco use and non-tobacco use programs
- Program is reasonably designed to promote health or prevent disease — design would not be considered subterfuge for discrimination
- Reasonable alternative standard offered to those who do not meet the initial standard (based on the measurement, test, or screening)
  - Program offers reasonable alternative standard to anyone who doesn’t meet the initial standard, regardless of medical condition or health status
  - Physician verification of the validity of the request for an alternative is not permitted
  - Alternative standard offered is reasonable, manageable, practical
  - Activity-based alternative standards must meet the activity based requirements; outcome-based alternative standards must meet outcome-based requirements
  - Individual using alternative standard must be made whole and receives the full amount of the reward if alternative is satisfied
- Documentation meets disclosure requirements

Some other considerations:

- Compliance with the tax code
  - Taxability of reward
    - Cash or reward with a face value is always taxable
  - Premium or cost sharing reductions are nontaxable
  - Compliance with specific Code requirements
    - Contribution to an HSA or health FSA
    - Employee elections under a cafeteria plan

- Compliance with ADA
  - Would the program be considered voluntary?
  - Does the program accommodate those who — because of a disability — can’t meet a requirement?

- Compliance with other anti-discrimination laws, such as Title VII, the Pregnancy Discrimination Act and the Age Discrimination and Employment Act
  - Does the program affect a benefit offered in an employment situation? Does it stem from an employer-provided benefit?
  - Under the plan design, would an individual in a protected class receive less of a benefit than individuals not in the protected class? Regardless of the official name, the program may not impose any sort of “take-away” penalty if such an individual does not take certain steps, such as respond to an incentive
Does the program single out pregnant women for a lesser benefit unless they take certain actions?

Does a program incentive relate to the age of the individual?

To confirm compliance in all areas of the law, it’s important to consult legal counsel for a full analysis of any wellness program.
IRS issues guidance on the delay in the employer shared responsibility and reporting requirements

The IRS has released formal guidance on the previously announced one-year delay in the employer shared responsibility and reporting requirements. Importantly, the guidance confirms that the delay does not apply to any other health reform provisions, including the individual mandate. The delay provides employers additional time to develop a compliance strategy and to establish a process to track hours and classify employees.

In this article: Background | Notice 2013-45 | Marketplace verification of individual income and employer coverage | In closing

Background

The ACA includes two significant new reporting requirements under the Internal Revenue Code (Code) to help the IRS enforce the individual and employer mandates. Both of these reporting requirements originally applied to coverage provided on or after January 1, 2014, with the first information returns to be filed in early 2015:

- **Code section 6055 reporting** — Insurers, sponsors of self-insured plans, government agencies, and other parties must report information to the IRS for each individual for whom minimum essential coverage (MEC) was provided. A statement would also be provided to the individual. This reporting is intended to support the IRS enforcement of the individual mandate.

- **Code section 6056 reporting** — Large employers subject to the “shared responsibility” provisions of ACA must report information to the IRS on the health care coverage provided to full-time employees. As with the Code section 6055 reporting, a statement is also provided to the individual. This reporting is intended to support the IRS enforcement of the employer mandate.

On July 2, in postings on the White House and U.S. Treasury Department websites, federal officials announced that these two reporting requirements would be delayed by one year, with the first information returns to be filed in 2016 for the 2015 year. (See our July 2, 2013 For Your Information.)

The White House and Treasury postings also announced that because of the delay in these reporting requirements, the IRS would not have the information needed to enforce the employer shared responsibility penalties for failing to offer health coverage or for offering coverage that is not affordable or fails to provide minimum value. Therefore, the employer obligation to comply with the shared responsibility requirements was also delayed by one year, until 2015.
On July 9, the IRS published Notice 2013-45 that provides formal guidance on the transition relief for the one-year delay of the reporting and employer shared responsibility requirements. Importantly, this Notice confirms that the delay does not apply to any other ACA provisions, including the individual mandate provision.

The delay in the Code section 6055 reporting requirement has raised questions about how an individual’s eligibility for premium tax credits will be determined. The Department of Health and Human Services (HHS) published final regulations on July 15 that finalize the approach Marketplaces (Exchanges) will use to verify an individual’s household income and availability of employer-sponsored coverage. On July 9, Marilyn Tavenner, administrator of the Center for Medicare & Medicaid Services (CMS), posted a blog titled Myth vs. Fact: Health Insurance Marketplace on Track that further addressed how the Marketplaces will determine eligibility for Marketplace subsidies for 2014.

**Notice 2013-45**

Notice 2013-45 provides guidance on the one-year delay of the reporting and employer shared responsibility requirements in four key areas:

- **Information reporting requirements** — The Notice confirms that the IRS expects to publish proposed rules this summer on the reporting requirements. The one-year transition relief will provide additional time for input from employers, insurers, and other reporting entities to help simplify the reporting requirements, as well as more time to develop systems for collecting and reporting the required information.

- **Employer shared responsibility requirements** — Large employers must offer affordable, minimum value health coverage to full-time employees or be subject to a shared responsibility penalty (excise tax) if one or more full-time employees receive a premium tax credit to purchase Marketplace coverage. After receiving an employer’s Code section 6056 information return and information about employees claiming the premium tax credit, the IRS will determine whether an assessable payment is due. Before any penalties are assessed, the IRS will contact the employer, and the employer can appeal the penalty. Because the Code section 6056 reporting has been delayed one year, the Notice states that it would be impractical to determine if an employer owed any shared responsibility penalties for 2014. As a result, the employer shared responsibility was delayed to 2015.

  **Buck Comment.** The proposed shared responsibility regulations issued earlier this year included special transition relief rules for 2014, applicable to non-calendar year plans and multiemployer plans. (See our January 30, 2013 For Your Information.) The regulations also permitted employers to use a shorter measurement period in connection with stability periods beginning in 2014. The Notice does not address how the delay affects the availability of these special rules. If new transition rules are not provided in future guidance, employers who plan to use a 12-month measurement period for identifying full-time employees for 2015 will need to start tracking hours as soon as October 2013.
**Buck Comment.** Even though the employer shared responsibility requirements are delayed until 2015, employers will still need to determine whether their plans provide minimum essential coverage and minimum value for reporting in the Marketplace notice and Summary of Benefits and Coverage (SBCs).

- **Employee access to premium tax credits** — Employees will still be eligible for the premium tax credit through the Marketplaces if their household income is within a specified range and if they are not eligible for employer-sponsored coverage that is affordable and provides minimum value.

- **Impact of delay on other ACA provisions** — The Notice confirms that the transition relief has no impact on the effective dates or application of other ACA provisions, including the individual shared responsibility (mandate) provision. Buck Consultants' [Health Care Reform Timeline](#) includes a summary of all the various requirements by date.

**Marketplace verification of individual income and employer coverage for determining subsidies**

Generally, an individual who is eligible for employer-sponsored coverage that is affordable and provides minimum value will not be eligible for premium tax credits to purchase health coverage in the Marketplaces, even if their household income is between 100% and 400% of the federal poverty level. This rule is not affected by the delay in the employer reporting requirements and application of the employer shared responsibility penalty. A July 9 blog posting by CMS administrator Tavenner addressed the process that will be used by the Marketplaces to determine eligibility for Marketplace subsidies.

Based in part on the CMS blog, summarized below is the application and subsidy process for 2014:

- By October 1 employers will provide employees with a Marketplace notice. Employers can, but are not required to, include information about whether the employer offers a plan that satisfies the minimum value and affordability requirements.

**Employers must still comply with the following ACA requirements in 2013:**

- PCORI fee (due by July 31 for calendar year plans)
- Marketplace notice required by October 1
- SBC by beginning of annual enrollment period

And the following beginning in 2014:

- Prohibition on waiting periods in excess of 90 days
- Prohibition of annual dollar limits on essential health benefits
- Prohibition on pre-existing condition exclusions
- New HIPAA wellness rules
- Child coverage to age 26, even if eligible for other coverage
- Transitional reinsurance assessment
- For non-grandfathered plans:
  - Limits on out-of-pocket maximums must include deductibles and copayments
  - Coverage of routine costs related to clinical trials
  - Provider non-discrimination
**Buck Comment.** Including information on minimum value and affordability in the Marketplace notice may prevent an employee from receiving a premium tax credit and having to pay it back. Also, although employers do not have to provide the Marketplace notice to pre-Medicare retirees, information in the notice may help retirees in making the most appropriate decision, particularly if the employer wants to encourage retirees to enroll in the Marketplaces.

- An individual will complete a Marketplace [application](#) for coverage and will attest to his or her income level and the availability of any employer health coverage in 2014. The individual must attest to the accuracy of the information in the application under penalty of perjury under federal law.
  - The income information will be used to estimate the individual’s 2014 household income for determining the Marketplace subsidies.
  - The employer health coverage information will be used to determine if the individual is eligible for affordable, minimum value coverage from the employer. The employer can also include the employer plan information required in the application in the Marketplace notice.

- The Marketplace will verify the individual’s income information from the application against electronic income data sources such as tax filings, Social Security data, and current wage data. In some cases additional documentation may be requested. The Marketplace will also request additional income information from a random sampling of individuals where:
  - Current income information is not available
  - There is a significant discrepancy between the income reported on an available tax return and the income provided by the individual, and
  - The individual cannot provide an acceptable explanation for this discrepancy

- The Marketplace will verify the employer coverage information from the application based on a random sample of applications. The final regulations released on July 5 allow state-based Marketplaces to defer this random sampling of employer coverage for the first year. Federally-facilitated Marketplaces will conduct this random sampling for 2014.

- If an individual is eligible for the premium tax credit, the Marketplace will pay those credits directly to the insurance carrier for the plan selected by the individual. The individual will pay the balance of the premium, net of the premium tax credit, to the insurer.

- When the individual files his or her 2014 federal income tax return, the IRS will reconcile the advance payments of the premium tax credit based on the individual’s actual household income for 2014. The IRS will recoup overpayments and provide refunds through federal income tax filings. The amount that the IRS can recoup will be capped for lower income households.

- After the end of the year, the Code sections 6055 and 6056 reporting would be used to determine individual and employer shared responsibility penalties. That process will be delayed by one year to 2015.
Buck Comment. With the one-year delay in the Code section 6055 reporting, it is not clear how the IRS will enforce the individual shared responsibility penalty for 2014.

In closing
The one-year delay in the employer shared responsibility mandate and reporting requirements provides employers with additional time to develop a compliance strategy for 2015. It will also provide an opportunity to determine how effective the Marketplaces will be for individuals. The Marketplace notices and other employer communication efforts can fill an important role in helping employees and retirees make the most appropriate benefit decision in 2014.

Authors
Richard Stover, FSA, MAAA
Leslye Laderman, JD, LLM

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