IRS Proposes Rules on Effect of Wellness Incentives on “Play or Pay” Obligations

A newly proposed IRS regulation provides additional guidance on how employers subject to the health reform law’s “play or pay” mandate can determine whether their health coverage offer to employees is considered adequate. The new rules discuss how to make these determinations for plans that offer wellness incentives, as well as for plans integrated with health reimbursement arrangements (HRAs) or coupled with health savings account (HSA) programs.

The regulation’s treatment of wellness program incentives seems complicated at first blush, but as a practical matter won’t have significant impact on most employer wellness programs.

Background – Offer of Qualifying and Affordable Coverage

Beginning in 2014, employers with an average of 50 or more full-time equivalent employees must offer at least 95 percent of their full-time employees (and children) at least some health insurance, or pay an annual, nondeductible penalty of $2,000 times all full-time employees, less the first 30.

If the employer offers coverage, the health plan--at least the “employee-only” level of coverage--must be both qualifying (i.e., must satisfy a “minimum value” requirement) and affordable to the full-time employee, or the employee is free to decline the employer’s offer and seek individual coverage in a public health insurance exchange. If the employee does so, and qualifies for federal subsidies to purchase the insurance, the employer will pay a $3,000 nondeductible annual penalty for that full-time employee, and any other full-time employee who does the same.

Affordability Issues

Affordability and Wellness Incentives

Prior IRS guidance indicates an employer’s coverage offer is “affordable” if an employer charges no more than 9.5 percent of an employee’s household income for employee-only coverage (the IRS allows for several “safe harbors” for complying with this standard, including W-2 pay, rate of pay and poverty level safe harbors; see our Alert of January 4, 2013). Left unanswered was the question of whether wellness rewards or penalties impact the affordability calculation.

For example, could a premium surcharge that applies to tobacco users or obese employees render the employer’s coverage “unaffordable”? If so, the affected individuals might be eligible to purchase subsidized coverage on a public health insurance exchange, possibly exposing their employer to the $3,000 penalty described above. That might not be a bad result for the employer, as the penalty might be less than the employer’s risk of covering the individual under the employer’s health plan.
The IRS has proposed that the affordability calculation must assume that all employees fail to meet the criteria for both outcomes-based wellness incentives, as well as participation-based incentives, such as incentives to complete health risk assessments, etc. In other words, affordability will be determined without taking into account any wellness-related incentives available to or even earned by the employees.

Interestingly, however, there is an exception for incentives for tobacco use. Discounts for non-tobacco users must be taken into account for all employees when determining affordability. That is, affordability will be determined by assuming that everyone—even tobacco users—receive the non-tobacco incentive (they won’t actually receive the incentive, of course; they’ll just be deemed to have received it, for purposes of the affordability calculation).

**Lockton Comment:** The relevant end result for tobacco users is this: If an employer’s coverage offer is so expensive as to be considered “unaffordable” under the play or pay mandate, but the cost is reduced to an affordable level for non-tobacco users, tobacco users will be deemed to have received the discount, for purposes of the affordability calculation. Thus, they will be deemed to have an offer of affordable coverage and will not be able to obtain subsidized insurance in a public health insurance exchange.

Interestingly then, under the proposed regulation an affordability calculation will never take into account incentives actually earned or forsaken under a wellness program. Rather, either everyone is deemed to have received the incentive or denied the incentive, depending on the nature of the wellness program. The scenario below, loosely based on an example in the proposed rules, illustrates operation of the rule.

**Example:** The XYZ Company’s wellness program reduces the employee’s premium for single coverage by $300 for employees who do not use tobacco products or who complete a smoking cessation course. The premium is reduced by another $200 if an employee completes a cholesterol screening within the first six months of the plan year. The annual employee cost for single coverage is $2,000, not taking into account the wellness discounts.

Two employees, Joe and Mary, complete the cholesterol screening and have their premium for single coverage reduced by $200, to $1,800 annually. Joe does not use tobacco and his premium is reduced by another $300. Mary uses tobacco and gets no additional discount.

Only the incentive related to tobacco use is considered in determining whether the coverage is affordable; the $200 incentive for completing the cholesterol screening is disregarded. Thus, neither Joe nor Mary is treated as having received the incentive for the cholesterol screening. But both Joe and Mary are treated as having earned the $300 “no tobacco” incentive. Their annual premium cost, for determining affordability under the play or pay mandate, is $1,700, even though Joe actually pays $1,500 and Mary pays $1,800.

Thus, to determine whether Joe and Mary have affordable coverage under the XYZ health plan, we would compare the deemed $1,700 premium to Joe’s and Mary’s household income (or W-2 pay, rate of pay or the federal poverty level, if the employer uses one of these safe harbors) to see if the premium cost is more than 9.5 percent of that number. This presents a thorny issue.
for Joe and Mary, if they intend to shop for insurance in a public health insurance exchange. Although Joe’s true premium cost is $1,500 and Mary’s is $1,800, they need to know and report their $1,700 *deemed* premium if they apply for coverage on a public health insurance exchange.

**Lockton Comment:** The model HHS-created application for health coverage and subsidies through a public health insurance exchange contemplates this issue. A question on an appendix to the application asks, “If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn’t receive any other discounts based on wellness programs.” Click to see the [model application](#).

**Effective Date of the Regulations**

The proposed regulation, when finalized, will apply for the 2014 and later calendar years, but to the extent the regulation as finalized differs from the proposed regulation, employers may rely on the proposed regulation for 2014.

However, the IRS has proposed a transition rule benefitting employers with existing wellness programs that provide incentives described as a flat dollar amount or percentage of premium. Until the plan year beginning in 2015, when making an “affordability” determination under the play or pay mandate, employers may assume that employees eligible for the wellness program (under the terms of the program as in effect on May 3, 2013) *satisfy* the wellness criteria. After that date, the affordability calculation must assume that all employees *fail* to meet the wellness criteria, except for tobacco use.

**Incentives versus Surcharges: Two Sides of the Same Coin?**

The proposed regulation speaks in terms of wellness “incentives,” but not penalties or surcharges. The examples in the proposed regulation focus on premium discounts, as opposed to surcharges. What are we to make of this?

We think that, if the IRS were asked, it would likely say that a surcharge is a form of incentive. Thus, if the employer’s wellness program sets a base employee contribution rate, and then imposes *surcharges* on those failing to meet wellness criteria, as opposed to granting *discounts* to those who meet the criteria, we think the IRS would likely say that the higher rate must be used in determining affordability. But if there’s a surcharge for tobacco use, that surcharge would be ignored, even for tobacco users.

**Impact of the Regulation**

The proposed rules won’t affect too many employers. Many employers don’t offer wellness incentives today, and those that do typically don’t offer incentives so large that they would affect an affordability calculation.

What about the employer toying with the idea of inviting unhealthy employees to seek subsidized coverage through a public health insurance exchange, by using wellness incentives to make the employee’s coverage offer “unaffordable”? Under the proposed regulation, except where the incentive is related to tobacco use, *no* employee is deemed to receive the incentive. Thus, if the unreduced premium is considered unaffordable for unhealthy employees, it’ll be
deemed unaffordable for similarly paid healthy employees as well, even though the actual premium they pay will be reduced by the wellness incentive.

Nevertheless, if the incentives are generous enough, the employer should be able to entice the healthy employees to “stay at home” and enroll in the employer’s plan, rather than leaping to the public health insurance exchanges for subsidized coverage there, and triggering a penalty against the employer.

*Lockton Comment:* Employers whose wellness incentives are so large as to affect an “affordability” calculation will want to isolate, for purposes of the calculation, incentives related to tobacco use from other incentives.

**Affordability and HRA Benefits**

The IRS has also hinted about how monies allocated to HRAs that are coupled with health plans (“integrated” HRAs) impact the affordability calculation. Newly available amounts under an integrated HRA will count towards affordability only if the HRA monies can be used 1) for premiums under the health plan with which the HRA is integrated, or 2) for premiums or cost-sharing.

This makes sense, as “affordability” is determined by assessing how much the employee must pay for employee-only coverage. Employers should be allowed to take credit, in making an affordability calculation, for HRA dollars they make available to employees to pay premiums under the employer’s group plan.

Stand-alone HRAs for employees (but not retirees) appear to be prohibited beginning in 2014. See our February 13, 2013, Alert for more information on stand-alone HRAs.

**Minimum Value (aka “Qualifying Coverage”)**

Recall that for employers subject to the play or pay mandate, the employer’s offer of employee-only coverage must not only be considered affordable, it must also be qualifying, or the employer risks penalties. Federal authorities describe qualifying coverage as coverage with a "minimum value" (MV) of 60 percent; that is, employee-only coverage must have at least a 60 percent actuarial value. This means the coverage must be actuarially designed to pay at least 60 percent of the insured's expected medical expenses. Per the IRS, the MV threshold is an all-or-nothing test with no exception for plans that miss the mark, even by a small amount.

The proposed rules contain a number of alternatives self-insured employers may use to establish MV (if the employer purchases group insurance, the insurer will determine the actuarial value of its coverage).

1. **MV Calculator**

   Earlier this year, the Department of Health and Human Services (HHS) and the IRS released an Excel-based MV calculator built on continuance tables and a standard population reflecting claims data of typical self-insured employer plans. The calculator and accompanying instructions are posted on HHS's website. The rules allow an adjustment in plan value based on features that are outside the parameters of the calculator. Click for more information on the calculator.
2. **Plan Design Safe Harbor**

Although the IRS has not officially designated any safe harbor plan designs (i.e., plan designs that would automatically be deemed to offer MV), the preamble to the regulations indicates the following three plan designs might qualify:

- $3,500 integrated medical and drug deductible, 80 percent plan cost-sharing, and a $6,000 maximum out-of-pocket limit for employee cost-sharing;

- $4,500 integrated medical and drug deductible, 70 percent plan cost-sharing, a $6,400 maximum out-of-pocket limit, and a $500 employer contribution to an HSA; and

- $3,500 medical deductible, $0 drug deductible, 60 percent plan medical expense cost-sharing, 75 percent plan drug cost-sharing, a $6,400 maximum out-of-pocket limit, and drug co-pays of $10/$20/$50 for the first, second and third prescription drug tiers, with 75 percent coinsurance for specialty drugs.

3. **Actuarial Certification**

Alternatively, the employer may seek an actuarial certification that its plan design provides MV. A member of the American Academy of Actuaries must perform the analysis. Future guidance may address the additional standards.

**Account-Based Plans and MV**

An employer may consider its contributions to employees’ HSAs, when assessing MV.

*Lockton Comment:* This makes sense, because an employee may use an employer’s HSA contribution to pay out-of-pocket medical expenses, such as deductibles and other cost-sharing under the medical plan. Thus, the HSA contribution may be viewed as “shrinking” the employee’s deductible or cost-sharing requirements under the plan, thus increasing the plan’s actuarial value.

Newly available amounts under an integrated HRA will also count towards MV if the HRA monies can be used only for cost-sharing (not premiums).

*Lockton Comment:* This also makes sense. While HRA dollars that may be used to pay premium should be considered in assessing the *affordability* of the employer’s coverage, dollars that may only be used to reduce cost-sharing expenses under the plan should be viewed as “shrinking” the plan’s deductible or other cost-sharing requirements.

**Wellness Incentives and MV**

Similar to the rules that apply to affordability, when assessing a plan’s actuarial value any reduced cost-sharing that applies based on wellness activities is ignored, with the exception for tobacco use.
Forced Enrollment Issues

The IRS has reiterated its earlier position that full-time employees cannot be forced to enroll in an employer plan that is either non-qualifying (MV less than 60 percent) or is unaffordable (costs more than 9.5 percent of pay for single coverage). According to the IRS, forcing an employee into a health plan would be impermissible interference with the employee’s ability to access subsidized coverage in a public health insurance exchange.

Lockton Comment: An employee would be viewed as “forced” to enroll in an employer plan if the employee were unilaterally enrolled in the plan without an opportunity to opt out. For example, an employer might have contemplated unilaterally enrolling employees in a skimpy, non-qualifying (non-MV) plan for which the employer would pay the entire, though modest, premium.

The advantage to the employer would be that, under the health reform law, once the employee is enrolled in any employer-based medical plan more robust than a health flexible spending account, the employee is disqualified from receiving subsidies in a public health insurance exchange. Without those subsidies, the employee would not be able to trigger a play or pay penalty against the employer.

Presumably, offering a skinny, non-qualifying plan in conjunction with an offer of qualifying and affordable coverage will be permitted.

Retirees and COBRA Beneficiaries

On a positive note, the IRS indicated that retirees and COBRA beneficiaries may qualify for subsidized coverage through a public health insurance exchange, even if they are offered COBRA or retiree coverage that is both affordable and meets the MV standard, if they do not enroll in the coverage. This rule will allow former employees to compare the cost of coverage from their former employer to the cost of purchasing (likely subsidized) coverage through a public health insurance exchange.

Employers may want to consider communicating this rule in conjunction with COBRA and retiree coverage election materials so former employees can comparison shop for coverage. In many instances, exchange-based coverage may be cheaper than COBRA or retiree medical.

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