Global Health Care Update

This bimonthly Update summarizes recent legislative developments and trends related to health care and highlights recently passed and pending legislation that may require employers to take action to comply with new rules or review existing plans.

Action May Be Required

China
The tax authority has rolled out a pilot program that encourages individuals to purchase health insurance policies. Circular 56, effective May 8, 2015, establishes a CNY 200 per month (CNY 2,400 per year) tax deduction for health insurance premiums paid. The pilot plan has been rolled out in Beijing, Shanghai, Tianjin, Chongqing, and in one large city in every province or region.

Recent Developments

U.S. Health Care Reform
The U.S. Departments of Labor, Health and Human Services, and the Treasury (the Departments) have published additional wellness program guidance. The Departments issued Frequently Asked Questions (FAQs) About Affordable Care Act Implementation Part XXV that focus on several issues that have been raised since the publication of final wellness program regulations in June 2013. In the preamble to these regulations, the Departments stated that they anticipated issuing future subregulatory guidance as necessary.

In the June regulations, the Departments addressed the requirements for wellness programs provided in connection with group health coverage. Among other things, these regulations set the maximum permissible reward under a health-contingent wellness program that is part of a group health plan (and any related health insurance coverage) at 30% of the cost of coverage (or 50% for wellness programs designed to prevent or reduce tobacco use). The wellness program regulations also address the reasonable design of health-contingent wellness programs and the reasonable alternatives that must be offered in order to avoid prohibited discrimination.

The latest guidance answers two questions: what does it mean that a health-contingent wellness program must be “reasonably designed,” and is compliance with the Departments’ wellness program regulations determinative of compliance with other laws?
The U.S. Equal Employment Opportunity Commission (EEOC) issued its much-anticipated proposed regulations addressing employer wellness programs under the Americans with Disabilities Act (ADA). These proposed regulations specifically address how employers may use and administer wellness program tools such as Health Risk Questionnaires (HRQs) and biometric screens that are permissible under the wellness rules under the Affordable Care Act and the Health Insurance Portability and Accountability Act (HIPAA), but had been questionable under the ADA.

These proposed regulations address when such programs are voluntary and therefore do not violate the ADA. They specifically address the following:

- Rewards or penalties are limited to 30% of the total cost of employee-only coverage;
- “Gating” or limiting benefits or options for employees who do not participate in an employee health program (wellness program), including an HRQ or biometric screen, are prohibited;
- Notice and confidentiality requirements apply with respect to the medical information obtained as part of these programs;
- Clarifies when smoking cessation programs are subject to these requirements; and
- Underscores that compliance with the EEOC rules concerning voluntary wellness programs does not ensure compliance with other antidiscrimination laws enforced by the EEOC.

The U.S. Internal Revenue Service (IRS) revised a set of questions and answers (Q&As) on large employer reporting required under the Affordable Care Act and also posted a new set of Q&As. According to the new guidance added to the revised set of Q&As, an “applicable large employer member” with no full-time employees in any month of a year does not have to file under Code Section 6056, but generally does have to file Form 1094-C (Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns) and Form 1095-C (Employer-Provided Health Insurance Offer and Coverage) if it sponsors a self-insured health plan and any employee or employee’s spouse or dependent is enrolled in the plan. The IRS also clarified required delivery methods for Form 1095-C and reporting requirements for an employee who has terminated employment. In the new set of Q&As, the IRS provided guidance on reporting offers of coverage for new hires, COBRA-related reporting, and other matters.

Recent guidance from the Department) calls into question the continued viability of opt-out credits that an employer offers to employees, where the employee chooses not to enroll in the employer’s medical plan and instead receives a cash payment contingent on enrolling in coverage in the individual market. Opt-out credits may adversely impact an employer’s affordability calculation for purposes of complying with the employer mandate to offer affordable, minimum value coverage. Employers need to review plan designs for potential issues if the employer offers employees a cash payment in lieu of coverage under its medical plan.

In Notice 2015–17, the Internal Revenue Service (IRS) reiterated previous guidance on an employer payment plan, which is a health plan that either reimburses employees for the premium expenses incurred for an individual health insurance policy or directly pays a premium for individual health insurance policy coverage on behalf of the employee. Under prior guidance, the IRS stated that an employer payment plan fails to comply with the group market reforms under the Affordable Care Act. Notice 2015–17 clarifies that an employer payment plan includes any reimbursements or payments made to an employee based on substantiated expenses for premiums under an individual market policy, regardless of whether the reimbursement is made on a pretax or an after-tax basis. In contrast, if an employer simply provides an employee with the payment of additional compensation that is not conditioned on the purchase of health insurance coverage, that arrangement is not an employer payment plan and will not be subject to the group market reforms under the Affordable Care Act for group health plans.

Therefore, under this guidance, a plan that provides for an opt-out credit (regardless of whether it’s pretax or after-tax) that conditions the receipt of the credit on the employee purchasing individual market coverage is an employer payment plan and does not meet the group market reforms under the Affordable Care Act. A group health plan that does not comply with the group market reform requirements is subject to a penalty of USD 100 per day (USD 36,500 per year) per impacted individual. Limited transition relief applies to small employers and S-Corporation health care arrangements for 2% shareholders.
The Departments issued the 27th set of Frequently Asked Questions (FAQs) About Affordable Care Act Implementation. Specifically, the five FAQs address limitations on cost-sharing and provider nondiscrimination.

The Departments answer the following questions:

- The 2016 Payment Notice clarified that under Section 1302(c)(1) of the Affordable Care Act, the self-only maximum annual limitation on cost-sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage or in coverage other than self-only. Does the Public Health Service (PHS) Act Section 2707(b) apply this requirement to all nongrandfathered group health plans?
- Does the clarification of Section 1302(c)(1) of the Affordable Care Act apply for plan or policy years that begin in 2015?
- Does the clarification of Section 1302(c)(1) of the Affordable Care Act apply to self-only coverage or other coverage that is not self-only coverage under a high-deductible health plan (HDHP) as defined at Section 223(c)(2) of the Internal Revenue Code?
- What is the Departments’ approach to PHS Act Section 2706(a)?
- Does Q2 in FAQs About Affordable Care Act Implementation Part XV continue to apply?

On the provider nondiscrimination issue, the Departments restated their current enforcement approach to PHS Act Section 2706(a). Until further guidance is issued, the Departments “will not take any enforcement action against a group health plan, or health insurance issuer offering group or individual coverage, with respect to implementing the requirements of PHS Act section 2706(a) as long as the plan or issuer is using a good faith, reasonable interpretation of the statutory provision.”

Regarding the cost-sharing issue, the Departments addressed a clarification provided in the final Notice and Benefits Parameters for 2016. That clarification stated that the Affordable Care Act provisions requiring that nongrandfathered group health plans not exceed cost-sharing limits laid out elsewhere in the health care law apply to each plan participant, regardless of whether the individual is enrolled in self-only coverage or in coverage other than self-only. In the latest FAQs, the Departments clarified that this applies to all nongrandfathered group health plans (self-insured or not) and to HDHPs. Additionally, the Departments will apply this clarification only for plan or policy years that begin in or after 2016.

The Department of Health and Human Services (HHS) published question-and-answer guidance applying the Affordable Care Act’s limits on out-of-pocket maximum amount to individuals enrolled in family coverage. The guidance reiterates the HHS’s position that the individual out-of-pocket maximum limit must apply to each individual, regardless of whether that individual is covered under a family tier of coverage. Subsequently, the Departments of Labor and Treasury joined HHS and confirmed that these limits apply to large group market and self-insured plans and do not prevent plans from complying with the requirements for health savings account-qualified high-deductible health plans. These requirements are effective starting with the first plan year beginning on or after January 1, 2016.

Americas

The U.S. Internal Revenue Service (IRS) issued inflation-adjusted limits for contributions to a health savings account (HSA) for calendar year 2016 and revised minimum deductible amounts and maximum out-of-pocket limits. The high-deductible health plan (HDHP) minimum annual deductible for singles and families will be USD 1,300 and USD 2,600 (no change from 2015), respectively. The HDHP out-of-pocket maximum will increase from USD 6,450 to USD 6,550 for singles and from USD 12,900 to USD 13,100 for families. The HSA maximum contribution limit for individuals remains USD 3,350; for families, it will increase from USD 6,650 to USD 6,750. The limit on HSA catch-up contributions remains USD 1,000.

In the Dominican Republic, disability coverage provided by pension fund administrators (AFPs) has been expanded. Under National Council of Social Security (CNSS) Resolution No. 369, AFPs must provide members with disability coverage until they reach age 65 (previously age 60). Members currently receiving a disability pension will continue to receive it until age 65. Individuals over age 60 who continue to work may qualify for a disability pension until they reach age 65.
Asia

Effective May 1, 2015, employers in China must provide employees working in hazardous conditions with health exams. The requirement is included in Occupational Health Check Regulations, recently issued by the National Health and Family Planning Commission. Health exams must be provided prior to the start of employment, during employment, and at the end of employment. Employers must cover the cost of the exams; employees have the right to select their own health care provided for the exam, subject to certain limitations.

In Beijing (China), effective June 1, 2015, workplaces must be smoke-free. Employers are required to establish a no-smoking policy and post no-smoking signs. Certain outdoor areas may be designated as smoking areas; however, they must be away from main walkways and from crowded areas. Signs must be posted indicating the health risks created by smoking. The Standing Committee of Beijing’s Municipal Peoples’ Congress issued a regulation on smoking control in November 2014.

Under the Australian government’s 2015 budget, the early withdrawal of superannuation benefits would be extended from 12 months to 24 months for individuals with a terminal illness.

Effective August 1, 2015, individuals in Hong Kong will be permitted to withdraw Mandatory Provident Funds (MPF) early in the event of terminal illness.

For More Information

For more information on the topic and countries in this newsletter, please refer to the Aon Hewitt Country Profiles eGuide. You can learn more about the Country Profiles eGuide here.

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