Up in Smoke?—IRS Filters Out Most Wellness Programs From Affordability and Minimum Value Tests and Clears the Air on COBRA and Retiree Medical Coverage

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Employers may only take into account whether a plan participant qualifies for an incentive or reward under a group health plan’s wellness program that is designed to prevent or reduce tobacco use when determining the plan’s affordability and minimum value under the Patient Protection and Affordable Care Act (Affordable Care Act), according to proposed regulations released by the Internal Revenue Service (IRS) on April 30, 2013. In calculating a plan’s affordability and minimum value, wellness program incentives and rewards that do not relate to tobacco use are not taken into account and are treated as not earned.

The proposed regulations, which become effective in plan years beginning after 2014, provide a transition rule for affordability and minimum value determinations made by plans with wellness programs in plan years beginning in 2014.

The proposed regulations also address contributions to health reimbursement arrangements (HRAs) and health savings accounts (HSAs) for purposes of determining affordability and minimum value and discuss the impact of COBRA coverage and retiree medical coverage on an individual’s ability to obtain a premium tax credit through an Exchange (marketplace).

In other Affordable Care Act developments, the Department of Health and Human Services (HHS) released new, shorter insurance applications for individuals and families that wish to purchase health coverage through an Exchange.

This Aon Hewitt bulletin discusses both of these releases.

Rules on Penalties, Affordability, and Minimum Value

Under the Affordable Care Act, an employer will be liable for a penalty under Internal Revenue Code Section 4980H if the employer fails to offer an affordable health care plan of minimum value to a full-time employee. An employer-sponsored health care plan is “affordable” only if an employee’s required contribution for self-only coverage does not exceed 9.5% of household income. An employer-sponsored health plan provides minimum value if the plan’s share of the total allowed costs is at least 60%. If an employer offers an employee an affordable employer-sponsored plan that provides minimum value, and the employee declines the offer, the employee will not be eligible for a premium tax credit to purchase health care coverage in an Exchange and the employer will not be liable for a penalty.

Under the proposed regulations, the minimum value of a plan is based on the anticipated spending for a standard population. The plan’s anticipated spending for benefits provided under any particular benchmark of essential health benefits (EHBs) for any state counts towards minimum value.
Smoking Out Wellness Programs

Under HIPAA, many employers offer nondiscriminatory wellness programs that provide employees with reduced cost sharing or lower premiums in exchange for the satisfaction of certain health and wellness goals. Previous comments offered divergent views on whether and to what extent these incentives should be taken into account in determining whether an employer’s health plan is affordable and provides minimum value.

Some commentators noted that HIPAA requires that wellness program incentives be nondiscriminatory and available to all similarly situated individuals. These commentators argued that employers should be permitted to calculate a plan’s affordability and minimum value assuming that employees satisfied the terms of the wellness program. Other commentators argued that, despite the HIPAA rules and because many individuals will face barriers to participation and fail to qualify for the incentives, employer plans should not be permitted to assume that individuals qualify for wellness program incentives and rewards when determining a health plan’s affordability and minimum value.

The proposed regulations adopt the rule that, in determining a health care plan’s affordability and minimum value, a plan may not assume that an individual qualifies for any incentives or rewards under a wellness program, other than a wellness program that is designed to prevent or reduce tobacco use. Therefore, the affordability of a plan that charges a higher premium for tobacco users will be determined based on the premium charged to non-tobacco users and to tobacco users who complete the related wellness program (e.g., by participating in a smoking cessation program).

Example: Employer offers a group health plan with a wellness program that reduces premiums by $300 for employees who are non-tobacco users or who complete a smoking cessation program. There is a $200 premium credit if an employee completes a cholesterol screening within the first six months of the plan year. Employee B does not use tobacco and his premium cost is $3,700. Employee C uses tobacco and his premium cost is $4,000. For purposes of affordability of the employer’s plan, only the incentives related to tobacco use are counted. Therefore, Employee C is treated as having earned the $300 incentive for attending a smoking cessation course. For both Employees B and C, the required contribution to premium for determining affordability is $3,700. The $200 incentive for cholesterol screening completion is not counted.

The IRS maintains that these rules regarding wellness incentives will have no practical impact on affordability under the employer shared responsibility payment, unless the required employee contribution for self-only coverage would exceed 9.5% of household income but for the wellness incentives. The IRS anticipates that similar rules regarding wellness incentives will be applied when determining whether an individual has affordable coverage for purposes of the individual shared responsibility payment.

Figuring HSAs and HRAs Into Affordability and Minimum Value

The proposed regulations also provide guidance on whether, and to what extent, an employer may consider contributions to HSAs and HRAs in determining whether a health plan is affordable and provides minimum value.
HSAs—All employer contributions to an HSA for the current plan year will be taken into account in determining whether the plan provides minimum value and are treated as amounts available for first dollar coverage.

HRAs—The proposed regulations also state that amounts newly made available under an HRA that is integrated with an eligible employer-sponsored plan for the current plan year will count in determining the plan’s minimum value if the amounts may be used only for cost sharing and not for paying premiums. Conversely, such amounts will count in determining whether a plan is affordable if the employee may use the amounts only for premiums or if the employee may choose to use the amounts for either premiums or cost sharing. The preamble states that counting such HRA amounts in the affordability test if those amounts may be used either for premiums or cost sharing prevents double counting of HRA amounts when assessing the minimum value and affordability of employer-sponsored coverage.

Wellness Program Transition Rule for 2014

For plan years beginning before January 1, 2015, the employer will not be liable for the “targeted penalty” under Code Section 4980H(b) if a group health plan’s self-only coverage would have been affordable and provided minimum value, taking into account all wellness program incentives (whether related to tobacco or not) and regardless of whether the employee receives a federal subsidy. This transition rule applies only:

- To the extent of the wellness program reward as of May 3, 2013, expressed either as a dollar amount or a fraction of the total required employee contribution to the premium or employee cost sharing, as applicable;
- Under the terms of a wellness program as in effect on May 3, 2013; and
- With respect to an employee who is in a category of employees eligible under the terms of the wellness program as in effect on May 3, 2013 (regardless of whether the employee was hired before or after that date).

Any required employee contribution to premium determined based on assumed satisfaction of any wellness program under this transition relief may be applied to the use of an affordability safe harbor.

Impact of COBRA and Retiree Medical Coverage on Eligibility for the Premium Tax Credit

The final regulations governing eligibility for the premium tax credit provide that an individual who may enroll in COBRA coverage or retiree medical coverage is eligible for minimum essential coverage only for the months that the individual is actually enrolled in COBRA coverage or retiree medical coverage. The proposed regulations apply this rule only to former employees. Active employees eligible for COBRA coverage because of reduced hours will be subject to the same rules for eligibility of affordable, minimum value employer-sponsored coverage as other active employees.

As a result, a former employee who is eligible for COBRA coverage, and a retiree who is entitled to retiree medical coverage, will be considered eligible for minimum essential coverage only for the months in which they are actually enrolled in such coverage. Thus, a former employee who waives COBRA
coverage or retiree medical coverage from a former employer remains eligible for federally subsidized health insurance coverage in an Exchange.

In contrast, an active employee who is eligible for COBRA coverage as the result of a reduction in hours will be considered eligible for minimum essential coverage, even if the individual does not actually enroll in COBRA coverage. Thus, if the employee waives an offer of affordable, minimum value health care coverage from an employer, the employee will not be entitled to federally subsidized health insurance coverage in an Exchange.

Application for Coverage in an Exchange

HHS released three health insurance applications to be used by individuals and families to apply for health care coverage in an Exchange, Medicaid, and the Children’s Health Insurance Program and for premium tax credits beginning October 1, 2013.

The family application includes an Employer Coverage Tool, which an individual may request an employer to complete if any member of the household is eligible for employer-sponsored coverage. The Employer Coverage Tool requires information about the employer such as an address, employer identification number (EIN), and contact information regarding employee health coverage. If the employee is eligible for employer-sponsored coverage or will be in the next three months, the tool requests information about whether the employer-sponsored coverage covers dependents and/or a spouse and whether the plan’s self-only coverage provides minimum value and is affordable (including information on wellness programs for premium incentives related to tobacco cessation programs, if applicable). The tool also asks for information about any changes to the plan in the following plan year, including whether the employer will stop offering coverage, or whether the employer will begin offering coverage or will change the premium amount for self-only coverage and what the premium will be.

Resources


The updated Exchange consumer applications are available at: http://cciio.cms.gov/resources/other/index.html#hie

Aon Hewitt's Regulatory Guidance Under the Affordable Care Act page, which provides links to Aon Hewitt bulletins on Affordable Care Act guidance and regulations, is available at: http://www.aon.com/human-capital-consulting/thought-leadership/leg_updates/healthcare/index_regulatory_guidance_affordable_care.jsp
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