Employee Benefits Report

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ACA Reminders

With just three months left until the health insurance exchanges open and six months until the Affordable Care Act (ACA) goes into full effect, employers have a lot to do. Some points to keep in mind as you review your health plans and make coverage determinations for 2014:

1. The ACA's shared responsibility requirements, otherwise known as "play or pay," apply only to employers with 50+ full-time equivalent employees. For specifics on counting employees, please see our February issue.
2. These "large employers" must offer "adequate" and "affordable" health coverage to at least 95 percent of their full-time employees and their dependents or face the possibility of a penalty.
3. Dependents include children up to age 26, regardless of their marital or student status, but not spouses.
4. "Adequate" plans must pay for at least 60 percent of expected medical expenses for a standard population.
5. "Affordable" plans can cost no more than 9.5 percent of an employee's annual household income for his/her share of premiums.

✹ Since employers realistically cannot know an employee's household income, the IRS has created a "safe harbor" that exempts employers from assessments if coverage offered to an employee

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Good news: Factors other than the recession helped slow healthcare cost inflation in recent years, say two studies published in the May issue of the journal *Health Affairs*. That means changes in our healthcare delivery systems could be working to control cost increases.

One study* attributed 37 percent of the healthcare spending slowdown between 2003 and 2012 to the recession, and 8 percent to a decline in private insurance coverage and Medicare payment rate cuts. That accounts for only 45 percent of the spending slowdown. The authors attribute the remainder to other trends.

The other study looked only at costs of large employers' health plans. It attributed about 20 percent of the spending slowdown in these plans to design changes—specifically, shifting more costs to employees. However, the author also observed "…a slowdown in spending growth even when we held benefit generos-**

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is affordable based on the employee's Form W-2 wages. If an employer offers multiple healthcare options, the affordability test applies to the lowest-cost option that meets the minimum value requirement.

- Employer contributions to health savings accounts (HSAs) do not affect affordability, since HSA funds generally cannot be used to pay health insurance premiums. Under the ACA, health reimbursement arrangements (HRAs) can only supplement a health plan, and also cannot be used in affordability calculations.
- The affordability standard applies to single-only coverage.

6 Penalties differ for employers that offer inadequate or unaffordable health coverage and those that offer no health coverage.

- Employers whose coverage fails to meet adequacy and affordability standards face a possible monthly penalty of one-twelfth of $3,000 per employee for any applicable month ($250). The total penalty cannot exceed the total number of the firm's full-time employees minus 30, multiplied by one-twelfth of $2,000 for any applicable month.
- Employers lacking coverage face a possible monthly penalty of one-twelfth of $2,000 ($166.67) per full-time employee, after the first 30 full-time employees.

The annual penalty will be $2,000 per full-time employee beyond the first 30 (penalties are waived for the first 30 workers).

- After 2014, a premium adjustment percentage will apply to penalty amounts.

7 Penalties will apply only if at least one full-time employee obtains coverage through an exchange and receives a premium tax credit. Is a possible penalty preferable to the certainty of paying for employee health benefits? Factors to consider:

- The overwhelming majority of your large employer competitors will be offering health benefits. Only 2 percent of large employers surveyed in April 2013 by the International Foundation of Employee Benefit Plans said they "definitely won't" or "are very unlikely" to continue providing health coverage after the ACA becomes effective. Will you be able to recruit and retain qualified employees without health benefits?
- Employers can deduct the costs of providing health coverage—whether premiums for a fully insured plan or self-insurance costs—as a business expense. Shared responsibility payments are taxes and not deductible. As a result, a $2,000 penalty would end up costing an employer in the 40 percent tax bracket (combined federal and state) approximately $3,300.

ity constant, which suggests that other factors, such as a reduction in the rate of introduction of new technology, were also at work."

Factors putting the brakes on healthcare cost inflation include:

- **Patient cost-sharing**
- **Slowdown in technological developments**
- **Greater provider efficiency**

The Slowdown In Health Care Spending In 2009–11 Reflected Factors Other Than The Weak Economy And Thus May Persist, by Alexander J. Ryu, Teresa B. Gibson, M. Richard McKellar, and Michael E. Chernew

****If Slow Rate Of Health Care Spending Growth Persists, Projections May Be Off By $770 Billion, by David M. Cutler and Nikhil R. Sahni***

8 Grandfathered health plans (those in effect continuously since March 23, 2010 or before) do not have to meet several of the ACA's requirements, including the requirement that plans cover specified preventive health services at no cost to insureds.

- Making "substantive" changes in your plan could cause it to lose grandfathered standards. "Substantive changes" include reducing covered benefits or increasing deductibles, co-payments or the share of premiums employees pay.
- You can increase employees' premiums without losing grandfathered status if your premium costs increase and employees continue to pay the same percentage of total premiums.

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9 Nondiscrimination provisions that previously applied to self-insured health plans will also apply to fully insured plans when the ACA becomes fully effective on January 1.

- Plans that provide richer benefits to executives and other highly compensated individuals will be subject to penalties. Penalties could add up quickly: an excise tax of $100 per individual per day of coverage will apply to a discriminatory plan.

10 Your employees are probably more confused about the ACA—and health benefits in general—than you are.

- The third annual Aflac WorkForces Report, released in April, found 76 percent of workers thought their employers would educate them about changes to their health coverage resulting from the ACA. However, only 13 percent of employers said educating employees about healthcare reform was important to their organization.
- The success of consumer-driven health plans depends on employees taking an active role in their health care decisions, yet 72 percent of employees surveyed had never even heard the phrase "consumer-driven health care."
- Education can help employees select the best health coverage options and make more informed health spending decisions. An experienced health insurance broker can help you select and implement education programs.

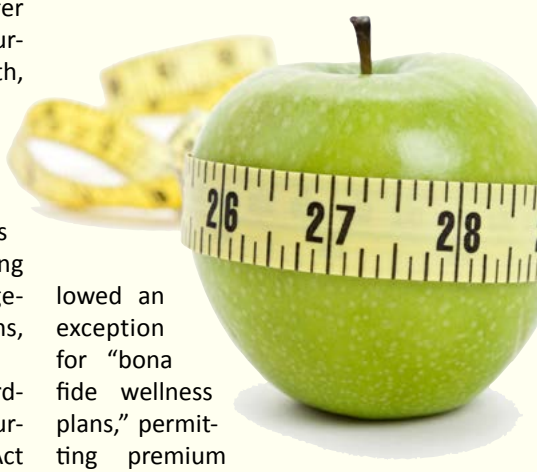
For more information on how the Affordable Care Act will affect your organization's health benefits, please contact our office.

Feds Release Wellness Program Nondiscrimination Regulations

In May, the U.S. Departments of Health and Human Services, Labor and the Treasury issued final rules on employment-based wellness programs. The final rules ensure "… that individuals are protected from unfair underwriting practices that could otherwise reduce benefits based on health status," said the official news release. Read on to find out what this means for your benefit programs.

About half of U.S. employers offer wellness programs, found a RAND employer survey. Employers offer wellness programs to reduce the burden of chronic illness, improve health, and limit growth of healthcare costs. Programs may include premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include smoking cessation programs, diabetes management programs, weight loss programs, and preventive health screenings.

Before the enactment of the Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act (HIPAA) prohibited group health insurance plans from discrimination based on a health factor. Group health plans could not charge "similarly situated individuals" different premiums or contributions based on a health factor, such as body mass index. However, HIPAA allowed an exception for "bona fide wellness plans," permitting premium discounts or rebates, or reductions to copayments or deductibles, in return for "adherence to programs of health promotion and dis-



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ease prevention." HIPAA capped such rewards to 20 percent of the total group health plan premium.

The ACA recognized the importance of wellness programs. Among other wellness-related provisions, it increased the maximum incentive for participating in wellness programs that make receipt of a reward contingent upon meeting a specified health standard to 30 percent of premiums. It boosted incentives for programs aimed toward eliminating or preventing tobacco use to 50 percent.

While recognizing the value of workplace wellness programs, the ACA's authors also recognized that workplace wellness programs, particularly those involving incentives, could be applied in a discriminatory fashion. Discrimination—intentional or unintentional—can occur when wellness programs require medical exams or ask questions about disabilities, health conditions or family history. In some instance, these questions could violate the Americans with Disabilties Act (ADA), the Pregnancy Discrimination Act (PDA) or the Genetic Information Nondiscrimination Act (GINA). Additionally, because women and older people generally have more health conditions than men and younger people, and many chronic conditions affect a disproportionate number of racial minorities, wellness programs could potentially discriminate against women, older employees and minorities.

The final rules define two major types of wellness programs: "participatory wellness programs," which are a majority of wellness programs, and "health-contingent wellness programs." Participatory wellness programs either do not provide a reward or do not require an individual to satisfy a health standard to obtain a reward. Participatory wellness programs would include a program that reimburses employees for all or part of the cost of membership in a fitness center, a diagnostic testing program that does not base any part of the reward on outcomes, and a program that rewards employees for attending a no-cost health education seminar.

In contrast, health-contingent wellness programs require an individual to satisfy a standard related to a health factor to obtain a reward. Final regulations subdivide this category into: (1) activity-only wellness programs, and (2) outcome-based wellness programs, which require the achievement of some health-related standard, such as body mass index or cholesterol level.

Activity-only wellness programs must offer a "reasonable alternative standard" or waive the standard for individuals whose medical condition makes it unreasonably difficult or medically inadvisable to attempt to satisfy the standard. Because outcome-based programs condition receipt of a reward on meeting specific health standards, they must offer alternatives to a broader group of individuals than activity-only wellness programs. They must provide a "reasonable alternative standard" to all individuals who do not meet the initial standard, with or without a physician's note. The rules require this to ensure that wellness programs are reasonably designed to improve health and not a subterfuge for underwriting or reducing benefits based on health status.

Takeaway Points

The new wellness program rules:

- Become effective January 1, 2014.
- Apply to fully insured and self-insured plans.
- Apply to grandfathered plans.
- Require health plans or issuers to ensure that a wellness program: is reasonably designed to promote health or prevent disease; has a reasonable chance of improving the health of, or preventing disease in, participating individuals; is not overly burdensome; is not a subterfuge for discriminating based on a health factor; and is not highly suspect in the method chosen to promote health or prevent disease.
- Require the availability of a reasonable alternative standard for certain wellness programs.
- Increase the maximum permissible reward under a health-contingent wellness program offered with a group health plan from 20 percent to 30 percent of the cost of coverage.
- Increase maximum rewards for wellness programs designed to prevent or reduce tobacco use to 50 percent of premiums.

For more information on wellness programs and/or the Affordable Care Act, please contact us.

The Cost of Cancer

Cancer is the second leading killer in the U.S., accounting for 25 percent of all deaths. Half of all men and a third of all women will receive a cancer diagnosis at some point in their lives. Employers can take several positive steps to reduce the impact and cost of cancer.

Cancer care costs $157 billion annually (2010 dollars). Since employers provide coverage for nearly half of all Americans, employers bear much of this burden. A 2007 study, Cost of Cancer to Employers, found that cancer-related claims accounted for only one percent of employers' medical claims, but 10 percent of their employee medical costs.

Cancer also costs billions in disability losses. Unum, a disability insurance company, recently announced that for the 12th year in a row, cancer topped the reasons for claims filed under its long-term disability policies. Cancer claims comprised nearly 16 percent of the company's long-term disability claims, while back disorders, the next leading cause, accounted for 15.1 percent of claims.

Cancer also has many indirect costs. The Cost of Cancer to Employers study estimated that more than one-third of employees undergoing cancer treatment never return to work. Productivity also suffers. A University of Arizona study found that cancer is responsible for approximately $7.5 billion in lost productivity every year.

So what can employers do?

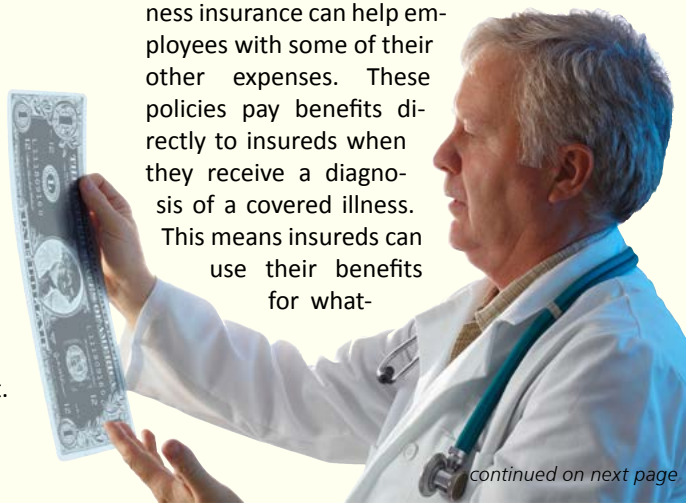
1. **Encourage Prevention.** Under the Affordable Care Act, health plans must provide certain preventive services, including cancer screenings, with no out-of-pocket costs to participants. Employers can encourage employees to take advantage of these services, which can often catch cancers in their earlier, more treatable, stages.
2. **Encourage Wellness.** The National Cancer Institute identifies the most common risk factors for cancer as:

- Growing older
- Tobacco
- Sunlight
- Ionizing radiation
- Certain chemicals and other substances
- Some viruses and bacteria
- Certain hormones
- Family history of cancer
- Alcohol
- Poor diet, lack of physical activity, or being overweight.

We can't change our age and family history, but we can change our habits. Targeted wellness programs can encourage and help employees modify their behaviors to reduce lifestyle choices that lead to increased risk of cancer.

3. **Offer Appropriate Coverage.** Employees dealing with cancer incur many expenses, even if they have a good health insurance plan. A recent study of patients at Duke Cancer Institute and three affiliated rural clinics found patients had median out-of-pocket costs of nearly $600 a month for their treatment.

Cancer patients can also have expenses that aren't limited to medical bills. They might miss work, require additional help around the house and have extra transportation expenses. Disability insurance can replace a portion of an employee's income when he or she cannot work due to a covered illness. And cancer or critical illness insurance can help employees with some of their other expenses. These policies pay benefits directly to insureds when they receive a diagnosis of a covered illness. This means insureds can use their benefits for what-



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ever they need—whether covering deductibles and copayments, paying for transportation expenses or covering the income of a spouse who leaves work to provide care.

Employers can provide both disability and critical illness insurance on an employer-paid or entirely employee-paid (voluntary) basis. For more information, please contact us. ■

Legislation Would Amend Overtime Rules

The Working Families Flexibility Act of 2013(H.R. 1406) would allow private-sector employers to offer employees the opportunity to accrue paid time off or 'comp time' for working overtime hours. Workers in the public sector have had this option for years. The House of Representatives approved the bill in May; at press time the Senate had not yet voted.

As approved by the House, H.R. 1406 would:

- **Allow employers to offer employees a choice between cash wages and accruing comp time for overtime hours worked. Employees who want to receive cash wages would continue to do so. No employee can be forced to take comp time instead of receiving overtime pay.**
- **Protect employees by requiring the employer and the employee to complete a written agreement to use comp time, entered into knowingly and voluntarily by the employee. Where the employee is represented by a union, the agreement to take comp time must be part of the collective bargaining agreement negotiated between the union and the employer.**
- **Retain all existing employee protections in current law, including the 40-hour work week and how overtime compensation is accrued. The bill adds additional safeguards for workers to ensure the choice and use of comp time are truly voluntary.**
- **Allow employees to accrue up to 160 hours of comp time each year. An employer would be required to pay cash wages for any unused time at the end of the year. Workers are free to 'cash out' their accrued comp time whenever they choose to do so.**
- **Require the nonpartisan Government Accountability Office to report to Congress on the extent private-sector employers and employees are using comp time, as well as the number of complaints filed with and enforcement actions taken by the U.S. Department of Labor.** ■

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