

Affordable Care Act

The “Cadillac Tax”:
Excise Tax on High Cost Health Care

National Association of Pension Plan Attorneys
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I. Overview of the Law

A. Introduction

1. The Affordable Care Act (“ACA”) added § 4980I of the Internal Revenue Code (“Code”) to provide for an excise tax on so-called “high cost employer-sponsored health coverage”, otherwise known as the “Cadillac tax.”
2. The amount of the excise tax is 40% of the “excess benefit” over annual dollar limitations set by the statute.
3. The Cadillac tax is effective for tax years beginning on or after January 1, 2018.
4. Does the Cadillac tax apply to health insurance coverage under a governmental plan? The answer is yes.¹

B. Section 4980I Overview

1. Section 4980I(a) of the Code provides for the imposition of an excise tax, as follows:

If an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and there is any excess benefit with respect to the coverage, there is hereby imposed a tax equal to 40 percent of the excess benefit.²

2. “Excess benefit” means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts for months during the taxable period, calculated as
 - a) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month,
 - b) over an amount equal to 1/12 of the annual limitation for the calendar year in which the month occurs.
3. “The annual limitations are:
 - a) for self-only coverage for 2018, \$10,200 (as thereafter indexed), multiplied by the health cost adjustment percentage (determined by only taking into account self-only coverage);

¹ See 26 U.S.C. § 4980I(d)(E).

² See 26 U.S.C. § 4980I(b) for calculation of the excess benefit, including applicable dollar-limit adjustments.

- b) for other than self-only coverage, \$27,500 (as thereafter indexed), multiplied by the health cost adjustment percentage (determined by only taking into account coverage other than self-only coverage); and
- c) for multi-employer plans (as defined under Code section 414(f)) which are treated as other-than-self-only coverage, \$27,500 (as thereafter indexed), multiplied by the health cost adjustment percentage (determined by only taking into account coverage other than self-only coverage).

4. The health cost adjustment percentage is equal to 100 percent, plus the excess (if any) of the percentage by which the per-employee cost of providing coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010, over 55 percent. Section 4980I allows for other adjustments to increase the applicable dollar limit in certain specified circumstances, including:

- a) a cost of living adjustment;
- b) age and gender adjustments;
- c) adjustments for retirees; and
- d) adjustments for employees engaged in high-risk professions.

5. According to the IRS Notice 2015-16³ (the “Notice”), “applicable coverage” under § 4980I(d)(1)(A) means, with respect to any employee, coverage under any group health plan *made available* to the employee by an employer:

- a) which is excludable from the employee’s gross income under § 106 of the Internal Revenue Code, or
- b) would be so excludable if it were employer-provided coverage within the meaning of § 106 (detailing exclusion of certain employer-provided accident and health coverage from calculation of gross taxable income).

6. Per Section 4980I(d)(2)(A), the cost of applicable coverage shall be determined by “rules similar to the rules of § 4980B” (i.e., rules for determining the applicable premium for COBRA purposes) and shall be calculated separately for self-only coverage and other-than-self-only coverage.

7. Section 4980I(d) also sets out special rules for determining the cost of coverage for retirees, health FSAs, Archer MSAs, and HSAs.

³ Available at <http://www.irs.gov/pub/irs-drop/n-15-16.pdf>.

8. Under § 4980I(c), the entity that shall pay the tax is:
 - a) the health insurance issuer in the case of applicable coverage provided under an insured plan;
 - b) the employer if the coverage consists of coverage under which the employer makes contributions to an HSA or an Archer MSA; and
 - c) 3. the person that administers the plan in the case of any other applicable coverage (we expect the employer will fund the tax for self-insured plans, even if administrative functions are performed by another entity—i.e., a TPA).
 - d) The employer is responsible for calculating the tax and notifying the liable entity and the IRS of the amount of tax owed.
9. In the event of a failure to properly calculate the tax:
 - a) the amount of any unpaid tax shall be paid proportionately by each coverage provider, but without any penalty on the provider, and
 - b) the employer or plan sponsor⁴ shall pay a penalty equal to such additional excess amount, plus interest on the delinquent amount from the date the payment was due until the date it is paid, except that no penalty shall be imposed if:
 - i) the employer or plan sponsor proves that it neither knew, nor exercising reasonable diligence would have known, that such failure existed;
 - ii) the failure is corrected within 30 days, provided that the cause of the failure was due to reasonable cause and no to willful neglect; or
 - iii) the DOL waives the penalty in the event that the failure was due to reasonable cause and not to willful neglect, and paying the penalty would be excessive or otherwise inequitable relative to the failure involved.

⁴ Here, plan administrator is defined in ERISA §3(16) as the person specifically so designated by the terms of the plan; if no administrator is designated, the plan sponsor; or in the case of a plan for which no administrator has been designated and no sponsor identified, the entity prescribed by DOL regulations. With respect to a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

II. Potential Approaches

- A. The recent Notice describes potential approaches to three main topics within the Cadillac tax provision:
1. how to define “applicable coverage;”
 2. how to determine the cost of applicable coverage; and
 3. how to apply the annual statutory dollar limit to the cost of applicable coverage.
- B. Before releasing proposed regulations, the IRS anticipates issuing another request for comments to address the Cadillac tax issues not covered by the Notice.
- C. Defining “applicable coverage”
1. Under § 4980I(d)(1), “applicable employer-provided coverage” includes, with respect to any employee, coverage under any group health plan made available to the employee by an employer:
 - a) which is excludable from the employee’s gross income under § 106 of the Internal Revenue Code, or
 - b) would be so excludable if it were employer-provided coverage within the meaning of § 106.
 2. The following plans are included in the meaning “applicable employer-provided coverage”:
 - a) Health flexible spending accounts (FSAs);
 - b) Archer MSAs under §106(b);
 - c) Health Savings Accounts (HSAs);
 - d) Governmental plans, including as coverage under any group health plan established and maintained primarily for civilian employees of the federal government, state government, political subdivision, or an agency of the government;
 - e) Coverage for on-site medical clinics;
 - f) Retiree coverage;
 - g) Multiemployer plans; and
 - h) Coverage described in § 9832(c)(3) that covers a specified disease or illness and hospital indemnity or other fixed indemnity insurance if payment for the coverage is excluded from gross income or a deduction.
 3. According to the Notice, the IRS expects to issue future guidance including executive physical programs and HRAs.

4. The Cadillac tax provision explicitly excludes from applicable coverage:
 - a) Coverage only for accident or disability income;
 - b) Coverage issued as a supplement to liability insurance;
 - c) Liability insurance (including general liability and auto);
 - d) Workers' compensation or similar insurance;
 - e) Automobile medical payment insurance;
 - f) Credit-only insurance;
 - g) Other insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits;
 - h) Coverage for long-term care;
 - i) Coverage under a separate policy, certificate or contract of insurance which provides benefits substantially all of which are for treatment of the mouth or the eye;
 - j) Coverage described in § 9832(c)(3) that covers a specified disease or illness and hospital indemnity or other fixed indemnity insurance if payment for the coverage is not excluded from gross income or a deduction; and
 - k) A plan maintained primarily for members of the military or for members of the military and their families.
5. With respect to HSAs and Archer MSAs, the IRS anticipates issuing future proposed regulations providing that:
 - a) employer contributions to HSAs (including employee pre-tax salary reduction contributions) and Archer MSAs are included as applicable coverage, but
 - b) employee after-tax contributions to HSAs and Archer MSAs are excluded from applicable coverage.
6. The IRS also anticipates that future proposed regulations will exclude from applicable coverage on-site medical clinics that offer only *de minimis* medical care to employees.
7. With respect to the definition of "applicable coverage," the IRS in the Notice specifically requests comment on:

On-Site Medical Facilities.

How it should treat medical care in the case of on-site medical clinics, including whether the standard should be based on the

nature and scope of the benefits or denominated as a specific dollar limit on the cost of services provided, or some combination of the two, and how the cost of coverage provided by an on-site medical facility should be determined.

Limited Scope Dental and Vision.

Should self-insured limited scope dental and vision coverage that qualifies as an excepted benefit under § 9831 regulations be excluded from applicable coverage, and any reasons why it should not implement such an approach.

Employee Assistance Programs.

Similarly, the IRS is considering proposing that Employee Assistance Programs that qualify as excepted benefits under § 9831 regulations be excluded from applicable coverage and is seeking comment on reasons why it should not take that approach.

D. Determining the cost of applicable coverage:

1. Per the statute, any rules for determining the cost of applicable coverage will be “similar to” the rules for calculating COBRA applicable premiums (§ 4980B(f)(4)), which are discussed in more detail below.
2. Based on specific calculation rules for determining the applicable coverage cost (e.g., the Cadillac tax itself is not included in the cost, retirees under the age of 65 and over the age of 65 may be treated as similarly situated beneficiaries, specific rules for FSAs, HSAs, Archer MSAs, etc.).
3. “Made available” to an employee refers to the applicable coverage in which the employee is enrolled, not applicable coverage merely made available to the employee but in which the employee does not enroll.
4. Currently, there is some confusion surrounding computation of COBRA applicable premiums. Thus, Treasury and the IRS will consider whether, and to what extent, the potential approaches contained in the Notice could or should apply to both COBRA and Cadillac tax cost calculations. Under existing COBRA rules:
 - a) Section 4980B(f)(4)(A) bases the COBRA applicable premium on the average cost of providing coverage for those covered under the plan who are similarly situated (instead of basing the cost calculation on the characteristics of each individual).
 - b) Section 4980B(f)(4)(B) sets out a special rule for self-insured plans; specifically, it provides two options for self-insured plans to calculate their applicable premium: (i) the actuarial basis method; and (ii) the past cost method.

5. The Notice discusses the following potential approaches to determining applicable coverage cost and seeks comment on the feasibility and desirability of each option.

a) “Similarly situated individuals”

The IRS anticipates that a standard like COBRA’s “similarly situated” standard will apply in the Cadillac tax context. Under this approach,

(1) Start by considering as “similarly situated” each group of employees covered by a particular benefit package provided by the employer, and

(2) then subdivide that group based on proposed mandatory disaggregation rules, and

(3) further subdivide the group based on permissive disaggregation.

b) The specifics of the approach being considered by the IRS are as follows:

(1) Step 1 - Aggregation by Benefits Package: “Benefit packages” would be differentiated based upon “differences in health plan coverage.” According to the Notice, a group health plan may consist of more than one benefit package. Employees would be grouped by the benefit packages in which they enroll, not by the packages they are offered. For example, employees enrolled in a standard option and a high option would be treated as separate benefit packages, as would HMO options and PPO options, and options within HMO plans and PPO plans.

(2) Step 2 - Mandatory Disaggregation based on self-only and non-self-only coverage: After grouping employees by benefits package, the employer would be required to disaggregate based on self-only coverage and other-than-self-only coverage.

(3) Step 3 – Permissive Aggregation within other-than-self-only coverage: Employers would not be required to determine the cost of applicable coverage for employees receiving other-than-self-only coverage based on the number of individuals covered in addition to the employee (e.g, employee + 1, employee + 2, etc.), even if the actual cost of coverage varies on this basis. Presumably, an employer would be permitted to disaggregate these groups if desired.

(4) Step 4 – Permissive Disaggregation based on other factors: The IRS is considering permitting (but not requiring) further disaggregation based on distinctions that have traditionally been made in the group insurance market (e.g., bona fide

employment-related criteria like nature of compensation, job categories, etc.). The IRS is also considering identifying more specific standards for permissive disaggregation, such as: current and former employees, geographic distinctions, and number of individuals covered in addition to the employee (i.e., different rating units).

c) The IRS is particularly interested in comments on this topic (the mechanics of the substantially similar approach), such as:

- (1) Similarities and differences that should be considered in framing “benefits packages,”
- (2) Method of permissive disaggregation (e.g., broad standards v. specific standards)
- (3) Harmonizing with the COBRA rules.
- (4) Retirees under the age of 65 and over the age of 65 may be treated as similarly situated beneficiaries.

d) The IRS also seeks comments on the methods for calculating COBRA applicable premiums for self-insured plans.

- (1) Two methods available to self-insured plans for calculating COBRA applicable premiums will apply to self-insured plans for the Cadillac tax: the actuarial basis method (default method) and the past cost method (for which a plan must qualify and which must be elected by the plan administrator for a flexible 12-month determination period).
- (2) For both COBRA and the Cadillac tax, a plan should be required to use the same valuation method for at least five years, with limited exceptions for significant cost differences between periods of coverage (to avoid abuse if a plan switches between methods frequently).
- (3) With respect to the two self-insured options, the IRS requests comments on the following potential approaches and issues:

(a) Actuarial basis method: The IRS is considering whether to propose a broad standard under which the cost of applicable coverage for a group of similarly situated individuals would be equal to a reasonable estimate of the actual cost the plan would expect to incur for a determination period, instead of the minimum or maximum exposure the plan could have for that period. The IRS invites comments on all aspects of this approach, including whether a similar standard should apply for determining COBRA applicable premiums.

(b) Past cost method: The IRS is considering adopting rules for both COBRA and the Cadillac tax that would allow plans to use as the 12-month measurement period for a current determination period any 12-month period ending not more than 13 months before the beginning of the current determination period. The IRS is also considering regulations that would describe the costs that must be taken into account under this method, which could include: claims (submitted or incurred); premiums for stop-loss or reinsurance policies; administrative expenses; and reasonable overhead expenses of the employer ratably allocated to the cost of administering the plan. The IRS invites comments on all aspects of this approach (e.g., should claim costs be based on submitted or incurred claims and the maximum length of time for a run-out period).

(4) HRAs

(a) The IRS is also seeking comments on how the cost of coverage under an HRA should be determined, given that the IRS anticipates that future guidance will provide that HRAs are applicable coverage for Cadillac tax purposes.

(i) One approach under consideration is to determine the HRA coverage cost based on the amounts made newly available to a participant each year, but not take into account carry-over amounts or amounts made newly available before 2018 (except for non-calendar plan years beginning in 2017 and running over into 2018).

(ii) Another alternative under consideration is to allow employers to determine the cost of coverage by adding together all claims and administrative expenses attributable to HRAs for a particular period and dividing that sum by the number of employees covered for that period at that level of coverage.

(iii) The IRS is also considering whether to permit or require employers to use the actuarial basis method to determine the cost of HRA coverage.

(b) Some stakeholders have suggested that the cost of applicable coverage should not include an HRA that can be used only to fund the employee contribution toward coverage. Similarly, the IRS notes that some stakeholders have suggested that HRAs that can be used to cover a range of benefits (some of which are not applicable coverage) should be excluded. The IRS is seeking comments on these suggestions, particularly with respect to their administrability.

(5) Determination Period

(a) Under the COBRA rules, the determination of any applicable premium is made in advance for a 12-month period. If the same rule is applied to the Cadillac tax context, the amount of any liability for the tax would generally be known at the beginning of the taxable year generating the liability. The IRS invites comments on whether this rule should apply to § 4980I and whether additional guidance would be helpful on determination periods for COBRA and Cadillac tax purposes.

(6) Other methods for determining cost of applicable coverage

(a) Although § 4980I ties the cost determination for Cadillac tax purposes to the COBRA rules, some stakeholders have suggested that the cost of applicable coverage could be determined by the cost of similar coverage available elsewhere (e.g., through a Marketplace Exchange) or by reference to coverage available elsewhere based on actuarial values, metal levels (e.g., bronze, silver, etc.) or other metrics. The IRS requests comments on whether these suggestions are consistent with the Cadillac tax statute, and if so, whether these approaches would be useful.

E. Applying annual dollar limits to the cost of coverage

1. Section 4980I(b) provides two annual dollar limits—one for self-only coverage and one for other-than-self-only coverage, based on the employee’s enrollment status at the beginning of the month.

a) However, it is possible that an employer may offer a combination of both types of coverage (e.g., self-only major medical coverage and supplemental HRA coverage for the entire family). One of the IRS’s suggested approaches in this scenario is based on the employee’s “primary” or “major medical” coverage, which would account for the majority of the aggregate cost of the applicable coverage.

(1) So, for example, if an employee has applicable coverage costing \$12,000 per year, \$3,000 of which is self-only and \$9,000 of which is other-than-self-only, the IRS would apply the other-than-self-only dollar limit to the full \$12,000. If the self-only and other-than-self-only costs are split equally, the other-than-self-only limit would apply.

2. The other potential approach is to apply a composite dollar limit determined by prorating the cost of self-only applicable coverage and other-than-self-only applicable coverage. The IRS seeks comments on these approaches.

3. The IRS also seeks comments on the various dollar-limit adjustments provided under § 4980I, including adjustments:

a) for qualified retirees (specifically, how employers determine that an employee is not eligible for Medicare enrollment);

b) adjustments for high-risk professions (specifically, how an employer determines if a majority of employees are engaged in a high-risk profession); and

c) age and gender adjustments (specifically, whether it would be possible and desirable to develop safe harbors that appropriately adjust dollar limits for employee populations with age and gender characteristics that are different from those of the national workforce).

III. Additional Issues

A. Collectively bargained “public sector” plans. As noted above, in calculating whether a high cost health cost coverage excise tax applies to a multiemployer plan, any coverage under the multiemployer plan is treated as other-than-self-only coverage. In other words, multiemployer plans have the benefit of the \$27,500 annual limit threshold for any coverage it offers, including self-only which would otherwise coverage under a multiemployer plan is not limited to \$10,200.

In the preamble to the employer shared responsibility regulations addressing employer penalties for failing to make sufficient offers of coverage (T.D. 9655, Feb.24, 2014), a commenter asked whether an exception to the rule for multiemployer plans (as defined under Code section 414(f)) could be applied to a non-federal governmental multiemployer plan.

The commenter noted that Code section 414(f)(1) defines a multiemployer plan as a plan (a) to which more than one employer is required to contribute; (b) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer; and (c) which satisfies such other requirements as the Secretary of Labor may prescribe by regulation. The commenter asked whether the exception applies to public sector multiemployer plans which are not subject to the jurisdiction of DOL. The Treasury indicated in the preamble that the exception could apply to collectively bargained public sector plans, provided that such plans satisfied the definition of Code section 414(f) of the Code.

Code section 414(f) does not require that a specific percentage of employees must be covered by a collective bargaining agreement. Conversely, DOL regulations provide that a plan is “established or maintained” under or pursuant to one or more collective bargaining agreements if the plan is an employee welfare benefit plan under section 3(1) of ERISA, at least 85% of the participants in the plan are employed under one or more agreements requiring plan contributions, and retirees and other individuals who satisfy certain criteria. DOL Reg. §2510.3-40 (b).

Arguably, if a state governmental plan is a multiemployer plan under the definition set forth in the Code, then a state governmental plan may be able to use the higher annual limitation as if all coverage provided under the plan were other-than-self-only coverage.

B. Certain “high risk” professions. Section 4980I(b)(3)(v) provides higher annual limits for certain “high risk” professions. The rule provides that, if an individual “participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines,” the annual dollar limit with respect to such individual for self-only coverage is increased by \$1,650, and the dollar amount for other-than-self-only coverage is increased by \$3,450.

For this purpose, a “high risk profession” is defined in the statute as law enforcement officers, employees in fire protection activities, individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), individuals whose primary work is longshore work, and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries, as well as those retired from a high-risk profession after not less than 20 years in such high risk profession.

It has been suggested that the “high risk profession” rule is the result of union lobbying. It should be noted, however, that high risk occupations such as steel work, manufacturing, railroad work and other high risk professions are not included. Treasury officials in informal conversations have suggested that they may not have the authority to expand the list because the categories are set forth in the statute, requiring legislative, rather than regulatory, action.

- C. Age and gender adjustments. It is unclear whether such adjustments should apply based on a particular plan's demographics (e.g., plans that skew more female than male) or based on national demographics.
- D. Annual limits apply regardless of region. Some commentators have suggested that the annual limits should be indexed according to regional health care costs.
- E. Effect of Wellness Plans. Some employers are attempting to reduce costs through the use of wellness plans.
- F. High Deductible Health Plans. Other employers may decide to make available a "high deductible health plan" to reduce costs.
- G. Repeal? Because the Cadillac tax is one of the major sources of funding for the ACA, repeal is unlikely, although a bill has been proposed.

ACA Employer Reporting Requirements

(as of April 29, 2015)



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New Reporting Requirements

- New tax reporting requirements are foundation of IRS enforcement of tax provisions of ACA:
 - Employer mandate (Code § 4980H) – which employers owe penalties for failing to offer affordable, minimum value coverage to full-time employees?
 - Individual mandate (Code § 5000A) – which individuals owe penalties for failing to maintain health coverage?
 - Premium tax credits (Code § 36B) – which individuals are eligible to receive premium assistance for coverage purchased on the Marketplace?
- **One year delay in reporting requirements - 2015**
- Calendar year reporting regardless of plan year
- Important to have systems in place to track required information early in 2015.

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New Reporting Requirements

- Penalties can be imposed for: (1) failing to timely file a return or provide statements; and/or (2) failing to provide a correct or complete statement.
 - Each failure has a penalty of \$100 per failure (\$250 for intentional failures), subject to a \$1.5 million cap annually.
 - Each employee's statement could be a single failure.
 - Example: If an employer fails to report a full-time employee on Form 1094-C and fails to provide that employee with a Form 1095-C, there are two failures for that single employee and there would be a \$200 penalty.
- No penalties for returns filed in 2016 (for 2015) if good faith effort is made to comply.
 - Available only for incorrect or incomplete information reported on the return or statement (including TINs and dates of birth).
 - No relief if fail to timely file an information return or furnish a statement.

Large Employer Reporting – IRC 6056

- **Large employers** must report the **terms and conditions** of the health care coverage provided to **full-time employees** for the year in a new annual return for IRS to determine whether **employer provides adequate** coverage to **avoid** shared employer responsibility penalties.
 - Certification as to whether the employer offered to its full-time employees and their dependents the opportunity to enroll in "minimum essential coverage" under an eligible employer-sponsored plan, by calendar month
 - The months during the calendar year for which coverage under the plan was available
 - Each full-time employee's share of the lowest cost monthly premium (self-only) for coverage providing minimum value offered to that full-time employee under an eligible employer sponsored plan, by calendar month
 - The number of full-time employees for each month during the calendar year
 - The name address and taxpayer ID for each full-time employee during the calendar year and the months, if any during which the employee was covered under the plan
- Two simplified alternative approaches

Large Employer Reporting – IRC 6056

- Simplified Approaches: Certification of Qualifying Offer
 - If an employer provides a "qualifying offer" to a full-time employee for all 12 months of a calendar year, simplified return can be filed.
 - Employee's name, SSN, address, and an indicator code that qualifying offer was made for all 12 months (employer does not have to track and report on a month-by-month basis).
 - Qualifying Offer: Offer to an FTE, spouse and dependents for all months during which employee was an FTE of MEC providing MV, affordable coverage.

Large Employer Reporting – IRC 6056

- Simplified Approaches: 98% Offer
 - Useful for employer who offer MEC to most of its employees.
 - Employer must certify that it offered MEC that is MV and affordable to at least 98% of its employees (regardless of whether they are FT or PT) and their dependent children.
 - Employer would then not be required to report on whether a particular employee is FT for one or more months in a calendar year or the total number of FT employees for the calendar year (still have to report identifying information on each employee).

Additional Employer Reporting – IRC 6055

- ✦ **Insurer if a fully insured group health plan, or plan sponsor** (generally, employer or trustees) **if a self-insured group health plan**, must report coverage information to IRS in a new annual return to ensure that individuals are complying with the **individual mandate** and obtaining **minimum essential coverage**
 - ✦ Name, address, and TIN of each "responsible individual" (primary insured)
 - ✦ Name and TIN of each individual covered under the policy or plan
 - ✦ For each covered individual, the months for which for at least one day the individual was enrolled in coverage and entitled to receive benefits

Timing of Filings

- ✦ Voluntary for 2014, mandatory for 2015
- ✦ C-Forms: Employers subject to both 6055 and 6056 reporting will report on new Form 1095-C **to employees** by January 31 and on new Form 1094-C to IRS by February 28 (March 31 if filing electronically).
- ✦ B- Forms: Employers not subject to 6056 reporting will report on a new Form 1095-B **to employees** by January 31 and on new Form 1094-B to IRS by February 28 (March 31 if filing electronically).
- ✦ Electronic reporting to IRS is mandatory if 250 or more returns are filed by the employer for that calendar year.

Using Third Parties – Designated Governmental Entities

- A governmental employer that maintains a self-insured group health plan is permitted to designate in writing another governmental unit, or an agency or instrumentality of another governmental unit, as the responsible reporting entity under Code Section 6055 and/or 6056 for some or all of the designating employer's employees.
- The designated governmental unit, agency or instrumentality must be part of or related to the same governmental unit as the designating governmental employer and must agree in writing to the designation
 - For example, a political subdivision of a state may designate the State or another political subdivision of the State.
- The governmental entity to which the reporting has been delegated must file a separate annual information return and transmittal for each governmental entity/ALE member for which it is reporting.
- The governmental employer must maintain a copy of the designation in its records.
- If these requirements are satisfied, the governmental employer will be treated as having transferred to the designated governmental unit, agency or instrumentality legal liability for filing the returns and furnishing the individual statements on behalf of the individuals for which it has been designated the responsible reporting entity.

Who Files What?

	Insured Health Plan	Self-Insured Health Plan
Small Employer (fewer than 50 full-time equivalent employees)	Small employer does not file anything. Insurer files form 1095-B.	An entity this small is not usually self-insured but, if so, would file 1095-B.
Applicable Large Employer (ALE) – 50 to 99 FTEs	ALE member files Form 1095-C Parts I and II (not Part III) (even though not subject to penalties in 2015). Insurer files Form 1095-B.	An entity this small is not usually self-insured but, if so, would file Form 1095-C Parts I, II, and III (even though not subject to penalties in 2015).
ALE – 100 or more FTEs	ALE member files Form 1095-C Parts I and II (not Part III). Insurer files Form 1095-B.	ALE member files Form 1095-C Parts I, II, and III

Reporting Eligibility and Enrollment

- ALE member with self-insured plan:
 - Employees and their family members
 - Form 1095-C for each employee who:
 - Was classified as FT for one or more months during the year; or
 - Was enrolled in health coverage, despite not being FT during any month of the year.
 - Non-employees (e.g., retirees, COBRA qualified beneficiaries)
 - Form 1095-B or Form 1095-C for each individual who:
 - Was enrolled one or more months during the year; but
 - Was not an employee (and was not enrolled through an employee) during any month of the year.



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VOID 600115
OMB No. 1545-0047

CORRECTED 2014

Form 1095-C **Employer-Provided Health Insurance Offer and Coverage**
Department of the Treasury
Internal Revenue Service

For information about Form 1095-C and its instructions, see www.irs.gov/1095c.

Part I **employee** **Applicable Large Employer Member (Employer)**

1. Name of employee _____ 2. Social Security number (SSN) _____ 7. Name of employer _____ 8. Employer identification number (EIN) _____

3. Street address (including apartment no.) _____ 9. Street address (including room or suite no.) _____ 10. Contact telephone number _____

4. City or town _____ 5. State or province _____ 6. Country and ZIP or foreign postal code _____ 11. City or town _____ 12. State or province _____ 13. Country and ZIP or foreign postal code _____

Part II **Employee Offer and Coverage**

14. Offer of Coverage or Enrollment Status

At 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15. Employee Share												
16. Lowest Cost Monthly Premium (Employee + Family)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
17. Minimum Monthly Premium (Employee Only)												
18. Minimum Monthly Premium (Employee + Family)												

Part III **Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(A) Name of covered individual	(B) SSN	(C) DOB (if SSN is not available)	(D) Covered all 12 months	(E) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 607094 Form 1095-C (01-14)



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Form 1095-C

Part II Line 14 Employee Offer and Coverage

- IA Qualifying Offer: Minimum Essential Coverage providing Minimum Value offered to full-time employee with employee contribution for self-only coverage equal to or less than 9.5% mainland single federal poverty line and Minimum Essential Coverage offered to spouse and dependent(s).
- IB Minimum Essential Coverage providing Minimum Value offered to employee only.
- IC Minimum Essential Coverage providing Minimum Value offered to employee and at least Minimum Essential Coverage offered to dependent(s) (not spouse).

Form 1095-C

Part II Line 14 Employee Offer and Coverage

- 1D Minimum Essential Coverage providing Minimum Value offer to employee and at least Minimum Essential Coverage offered to spouse (not dependent(s)).
- 1E Minimum Essential Coverage providing Minimum Value offered to employee and at least Minimum Essential Coverage offered to dependent(s) and spouse.
- 1F Minimum Essential Coverage not providing Minimum Value offered to employee, or employee and spouse or dependent(s), or employee, spouse and dependents.

Form 1095-C

Part II Line 14 Employee Offer and Coverage

- 1G Offer of coverage to employee who was not a full-time employee for any month of the calendar year and who enrolled in self-insured coverage for one or more months of the calendar year.
- 1H No offer of coverage (employee not offered any health coverage or employee offered coverage not providing Minimum Essential Coverage).
- 1I Qualifying Offer Transition Relief 2015: Employee (and spouse or dependents) received no offer of coverage, received an offer that is not a qualifying offer, or received a qualifying offer for less than 12 months.

Form 1095-C

Part II Line 16 Safe Harbor Codes, Other Relief

- 2A Employee not employed during the month.
- 2B Employee not a full-time employee.
- 2C Employee enrolled in coverage offered.
- 2D Employee in a section 4980H(b) limited non assessment period.
- 2E Multiemployer interim rule relief.
- 2F Section 4980H affordability Form W-2 safe harbor.
- 2G Section 4980H affordability federal poverty line safe harbor.
- 2H Section 4980H affordability rate of pay safe harbor.
- 2I Non-calendar year transition relief applies to this employee.

120115
OMB No. 1545-0047
2014

Form **1094-C** Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns CORRECTED

Department of the Treasury Internal Revenue Service
 Information about Form 1094-C and its separate instructions is at www.irs.gov/1094c.

Part I Applicable Law as Employer Member (ALE Member)

1. Name of ALE Member (required) _____ 2. EIN (required) (see instructions) _____

3. Street address (including room or suite no.) _____

4. City or town _____ 5. State or province _____ 6. County and ZIP or foreign postal code _____

7. Name of person to contact _____ 8. Contact telephone number _____

9. Name of Designated Government (if applicable) _____ 10. Employment Identification Number (EIN) _____

11. Street address (including room or suite no.) _____

12. City or town _____ 13. State or province _____ 14. County and ZIP or foreign postal code _____

15. Name of person to contact _____ 16. Contact telephone number _____

17. Reserved _____

18. Total number of Forms 1095-C submitted with this transmittal _____

Part II ALE Member Information

19. Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions. _____

20. Total number of Forms 1095-C filed by and/or on behalf of ALE Member _____

21. Is ALE Member a member of an Aggregated ALE Group? _____ Yes No
 If "No," do not complete Part IV.

22. Certifications of Eligibility (select all that apply):
 A. Qualifying Offer Method B. Qualifying Offer Method Transition Relief C. Section 4980H Transition Relief D. 98% Offer Method

Under penalties of perjury, I declare that I have examined this Form and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

 Signature _____ Title _____ Date _____

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 9197-A Form 1094-C (12-14)

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Page 2

Form 1094-C (2014)

Part III ALE Member Information—Monthly

		(a) Minimum Essential Coverage Offer Indicator		(b) Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Section 4980H Transition Relief Indicator
		Yes	No				
23	All 12 Months	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
24	Jan	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
25	Feb	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
26	Mar	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
27	Apr	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
28	May	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
29	June	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
30	July	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
31	Aug	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
32	Sept	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
33	Oct	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
34	Nov	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
35	Dec	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	

Form 1094-C (2014)

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Page 3

Form 1094-C (2014)
Part IV Other ALE Members of Aggregated ALE Group

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

Name	EIN	Name	EIN
36		51	
37		52	
38		53	
39		54	
40		55	
41		56	
42		57	
43		58	
44		59	
45		60	
46		61	
47		62	
48		63	
49		64	
50		65	

Form 1094-C (2014)

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540115
OMB No. 1545-2042
2014

Form **1095-B** Health Coverage

Department of the Treasury
Internal Revenue Service

Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.

VOID
 CORRECTED

Part I Responsible Individual (Policy Holder)

1 Name of responsible individual
2 Social security number (SSN)
3 Date of birth (if SSN is not available)

4 Street address (including apartment no.)
5 City or town
6 State or province
7 Country and ZIP or foreign postal code

8 Enter letter identifying Origin of the Policy (see instructions for codes)
9 Small Business Health Options Program (S-BOP) Marketplace identifier, if applicable

Part II Employer Sponsored Coverage (If Line 8 is A or B, complete this part.)

10 Employer name
11 Employer identification number (EIN)
12 Street address (including room or suite no.)
13 City or town
14 State or province
15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider

16 Name
17 Employer identification number (EIN)
18 Contact telephone number
19 Street address (including room or suite no.)
20 City or town
21 State or province
22 Country and ZIP or foreign postal code

Part IV Covered Individuals (Enter the information for each covered individual.)

(a) Name of covered individual(s)	(b) SSN	(c) DOB if SSN is not available	(d) Covered all 12 months	(e) Months of coverage												
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
23			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notices, see separate instructions. Cal. No. 690611 Form 1095-B (2014)

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Thank you!

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Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

Information about Form 1094-C and its separate instructions is at www.irs.gov/1094c.

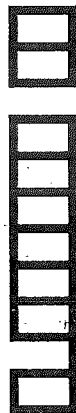
Form 1094-C

Department of the Treasury Internal Revenue Service

Part I Applicable Large Employer Member (ALE Member)

Form fields for Part I: 1 Name of ALE Member (Employer), 2 Employer identification number (EIN), 3 Street address, 4 City or town, 5 State or province, 6 Country and ZIP or foreign postal code, 7 Name of person to contact, 8 Contact telephone number, 9 Name of Designated Government Entity, 10 Employer identification number (EIN), 11 Street address, 12 City or town, 13 State or province, 14 Country and ZIP or foreign postal code, 15 Name of person to contact, 16 Contact telephone number.

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17 Reserved

18 Total number of Forms 1095-C submitted with this transmittal

Part II ALE Member Information

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member

21 Is ALE Member a member of an Aggregated ALE Group? If "No," do not complete Part IV.

22 Certifications of Eligibility (select all that apply):

- A. Qualifying Offer Method
B. Qualifying Offer Method Transition Relief
C. Section 4980H Transition Relief
D. 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

Signature, Title, Date

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 61571A

Form 1094-C (2014)

Part III ALE Member Information – Monthly

	(a) Minimum Essential Coverage Offer Indicator		(b) Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Section 4980H Transition Relief Indicator
	Yes	No				
23 All 12 Months	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
24 Jan	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
25 Feb	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
26 Mar	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
27 Apr	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
28 May	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
29 June	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
30 July	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
31 Aug	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
32 Sept	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
33 Oct	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
34 Nov	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
35 Dec	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	

Part IV Other ALE Members of Aggregated ALE Group

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

	Name	EIN	Name	EIN
36			51	
37			52	
38			53	
39			54	
40			55	
41			56	
42			57	
43			58	
44			59	
45			60	
46			61	
47			62	
48			63	
49			64	
50			65	

Employer-Provided Health Insurance Offer and Coverage
Information about Form 1095-C and its separate instructions is at www.irs.gov/ft1095c.

VOID
 CORRECTED

OMB No. 1545-2251
2014

Part I Employee

1 Name of employee: _____

2 Social security number (SSN): _____

3 Street address (including apartment no.): _____

4 City or town: _____ 5 State or province: _____ 6 Country and ZIP or foreign postal code: _____

7 Name of employer: _____ 8 Employer identification number (EIN): _____

9 Street address (including room or suite no.): _____ 10 Contact telephone number: _____

11 City or town: _____ 12 State or province: _____ 13 Country and ZIP or foreign postal code: _____

Part II Employee Offer and Coverage

14 Offer of Coverage (enter required code)	All 12 Months											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage													
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, the issuer of the insurance or the sponsor of the plan providing the coverage will furnish you information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, the provider of that coverage will furnish you information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.

Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.



Part I. Employee

Lines 1–6. Part I, lines 1–6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in Part I, a taxpayer identification number (TIN) may be provided instead of an SSN.

Part I. Applicable Large Employer Member (Employee)

Lines 7–13. Part I, lines 7–13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14–16

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage. If, for example, you chose to enroll in more expensive coverage such as family coverage, line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

Form 1094-B

Department of the Treasury
Internal Revenue Service

Transmittal of Health Coverage Information Returns

▶ Information about Form 1094-B and its separate instructions is at www.irs.gov/form1094b.

OMB No. 1545-2252

2014

1 Filer's name		2 Employer identification number (EIN)	
3 Name of person to contact		4 Contact telephone number	
5 Street address (including room or suite no.)		6 City or town	
7 State or province		8 Country and ZIP or foreign postal code	
9 Total number of Forms 1095-B submitted with this transmittal ▶			

For Official Use Only



Under penalties of perjury, I declare that I have examined this return and accompanying documents, and, to the best of my knowledge and belief, they are true, correct and complete.

▶ _____ Title

▶ _____ Date

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 61570P

Form 1094-B (2014)

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse, and individuals you claim as dependents had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who do not have minimum essential coverage and do not qualify for an exemption may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and miscellaneous coverage designated by the Department of Health and Human Services. For more information on minimum essential coverage, see Pub. 974, Premium Tax Credit (PTC).



Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to individuals covered under the policy if they request it for their records.

Part I. Responsible Individual, lines 1–9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.



If you don't provide your SSN and the SSNs of all covered individuals to the sponsor of the coverage, the IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Miscellaneous minimum essential coverage



If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange) that coverage will be reported on a Form 1095-A rather than a Form 1095-B.

Line 9. This line will be blank for 2014.

Part II. Employer-Sponsored Coverage, lines 10–15. This part will be completed by the insurance company if an insurance company provides your employer-sponsored health coverage. It provides information about the employer sponsoring the coverage. If your coverage is not insured employer coverage, this part will be blank.

Part III. Issuer or Other Coverage Provider, lines 16–22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.

Part IV. Covered Individuals, lines 23–28. This part reports the name, SSN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if an SSN is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, you will receive one or more additional Forms 1095-B that continue Part IV.

**LEGAL IMPLICATIONS OF EMPLOYEE WELLNESS PROGRAMS FOR
GOVERNMENTAL EMPLOYERS**

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As employer health plan costs continue to increase by double digits annually, more employers are recognizing that healthier employees produce lower medical claims. These employers are implementing company wellness programs that encourage employees to adopt and maintain healthy lifestyles. Employer wellness programs range from providing healthier alternatives to vending machine snacks, to subsidizing gym memberships, to providing reduced health plan premiums to employees who achieve stated health benchmarks. Some employers go even further by setting up onsite health clinics where employees can go for routine preventative care, health education classes, and disease management counseling.

The purpose of this paper is to outline the many legal requirements that impact employer wellness programs. These requirements are generally intended to ensure that such programs do not discriminate against employees on the basis of their medical condition or their genetic information and that they properly safeguard the employees' private medical data. Although there are several legal issues for an employer to consider, a properly implemented wellness program can go a long way in helping an employer control overall medical costs, maintain a healthy workforce, and stay competitive with other employers to attract the most sought after employees.

I.

HIPAA NONDISCRIMINATION

A. Statute

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires health benefits to be provided to participants in a nondiscriminatory manner. The HIPAA nondiscrimination rules prohibit a group health plan from establishing *eligibility* rules and requiring *premium contributions* based on any *health factor*.

Specifically, Section 2705(a) of the Public Health Service Act ("PHSA")² states that:

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

- (1) Health status.
- (2) Medical condition (including both physical and mental illnesses).
- (3) Claims experience.
- (4) Receipt of health care.
- (5) Medical history.
- (6) Genetic information.
- (7) Evidence of insurability (including conditions arising out of acts of domestic violence).

¹ This paper is intended for general information purposes only and does not and is not intended to constitute legal advice. The reader must consult with legal counsel to determine how laws or decisions discussed herein apply to the reader's specific circumstances.

² This paper focuses on governmental employers, thus it will refer to the HIPAA provisions in the PHSA. However, the reader should be aware of similar parallel provisions that apply to non-governmental employers in Section 702 of the Employee Retirement Income Security Act of 1974 ("ERISA") and Section 9802 of the Internal Revenue Code ("Code").

(8) Disability.³

In addition, Section 2705(b) states that:

A group health plan, and a health insurance issuer offering group or individual health insurance coverage may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.⁴

Thus, a group health plan may not generally charge an employee a higher premium than it charges to similarly situated employees, or otherwise penalize the employee, if the employee does not meet certain health benchmarks such as ideal body weight, normal blood pressure, or normal cholesterol levels.

Although PHSA Section 2705 prevents discrimination based on health status in charging premiums to individual employees, it goes on to state that the prohibition does *not* prevent a group health plan "from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention."⁵

B. Regulations

On December 13, 2006, the Department of Labor, the Department of the Treasury, and the Department of Health and Human Services issued final regulations that set standards for "wellness programs," described as health promotion and disease programs through which an employer may be able to require compliance to take advantage of premium discounts and rebates, consistent with PHSA Section 2705(b)(2)(B). On November 26, 2012, the Departments published proposed rules pursuant to the Patient Protection and Affordable Care Act of 2010 (the "ACA"), which proposed certain changes to the 2006 final HIPAA wellness program regulations (the "Proposed Wellness Program Regulations"). Under the Proposed Wellness Program Regulations, the Departments divided wellness programs into two categories: (1) participatory wellness programs; and (2) health-contingent wellness programs.

On June 3, 2013, the Departments issued final rules updating the 2006 HIPAA wellness program regulations, including for compliance with the ACA (the "Final Wellness Program Regulations").⁶ It is important to note that in the Final Wellness Program Regulations, the Departments made several material changes to the regulatory framework that had been proposed in the Proposed Wellness Program Regulations. The Final Wellness Program Regulations are effective for plan years beginning on or after January 1, 2014, and they apply both to grandfathered and non-grandfathered wellness programs (under the ACA).

The Final Wellness Program Regulations set forth the criteria for a program of health promotion or disease prevention offered or provided by a group health plan that must be satisfied in order for the plan to qualify for an exception to HIPAA's prohibition on discrimination based on health status. As noted in the Preamble to the Final Wellness Program Regulations, the Final Wellness Program Regulations set forth criteria for an affirmative defense that a plan can use in response to a claim that the plan discriminated against an individual under the HIPAA nondiscrimination provisions. However, the Final Wellness Program Regulations make clear that compliance with the requirements in the Final Wellness Program Regulations is not determinative of compliance with any other State or Federal law such as, for example, the Employee Retirement Income Security Act of 1974

³ PHSA § 2705(a).

⁴ PHSA § 2705(b).

⁵ PHSA § 2705(b)(2)(B).

⁶ 78 Fed. Reg. 33158 (June 3, 2013).

("ERISA") (generally not applicable to governmental employers), the Americans With Disabilities Act ("ADA"), or the Genetic Information Nondiscrimination Act ("GINA").⁷

Under the Final Wellness Program Regulations, a group health plan may offer premium discounts, impose surcharges, grant rebates, and otherwise create premium differentials between employees in exchange for adherence to a wellness program, provided that certain standards are satisfied.⁸ However, the framework under the Final Wellness Program Regulations for analyzing whether a wellness program complies with the applicable standards is fairly complex. The analysis depends on: (1) the type of activity; and (2) whether the plan offers a "reward" with respect to such activity. Furthermore, the analysis must be completed for each separate component or activity under a wellness program. In the following subsections 1, 2, and 3, we have outlined the framework and standards under the Final Wellness Program Regulations under three "steps," to help explain them.

1. Step One: What type of wellness program is the activity?

a. Participatory Wellness Programs

A "*participatory wellness program*" is a wellness program in which: (1) none of the conditions for obtaining a reward is based on an individual satisfying a standard that is related to a health factor; or (2) the program does not provide a reward. The Final Wellness Program Regulations list the following as examples of "participatory wellness programs:"

- A program that reimburses employees for all or part of the cost for membership in a fitness center.
- A diagnostic testing program that provides a reward for participation in that program and does not base any part of the reward on outcomes.
- A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits.
- A program that reimburses employees for the costs of participating, or otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking.
- A program that provides a reward to employees for attending a monthly no-cost health education seminar.
- A program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action (educational or otherwise) required by the employee with regard to the health issues identified as part of the assessment.⁹

b. Health-Contingent Wellness Programs

A "health-contingent wellness program" is a program that: (1) requires an individual to satisfy a standard related to a health factor to obtain a reward; or (2) requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward. This standard may be performing or completing an activity relating to a health factor, or it may be attaining or maintaining a specific health outcome.¹⁰

As discussed in more detail below, the Final Wellness Program Regulations divide "health-contingent wellness programs" into two types, each of which is subject to certain requirements in order to satisfy the Final Wellness Program Regulations: (1) activity-only wellness programs; and (2) outcome-based wellness programs.

⁷ 78 Fed. Reg. 33168.

⁸ 45 C.F.R. § 146.121(f).

⁹ 45 C.F.R. § 146.121(f)(1)(ii).

¹⁰ 45 C.F.R. § 146.121(f)(1)(iii).

(1) Activity-Only Wellness Programs

An "activity-only wellness program" is a program under which an individual is required to perform or complete an activity related to a health factor in order to obtain a reward.¹¹ Activity-only wellness programs do not require an individual to attain or maintain a specific health outcome (*i.e.*, such a program is an outcome-based wellness program, as discussed in subsection b(2) below).

Examples of activity-only wellness programs include walking, diet, or exercise programs, which some individuals may be unable to participate in or complete (or have difficulty participating in or completing) due to a health factor such as severe asthma, pregnancy, or a recent surgery.

(2) Outcome-Based Wellness Programs

An "outcome-based wellness program" is a program under which an individual must attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward. As noted under the Final Wellness Program Regulations, such programs generally have two tiers: (a) a measurement, test, or screening as part of an initial standard; and (b) a larger program that then targets individuals who do not meet the initial standards with wellness activities (for example, requiring such individuals to comply with an educational program or other activity as an alternative to achieve the same reward).¹²

The Final Wellness Program Regulations provide that an example of an outcome-based wellness program includes a program that tests individuals for specified medical conditions or risk factors (such as high cholesterol, high blood pressure, abnormal BMI, or high glucose level) and provides a reward to persons identified as within a "normal" or "healthy" range, or as being at "low risk" for certain medical conditions, while requiring persons who are identified as outside the normal or healthy range, or as being "at risk," to take additional steps (such as meeting with a health coach, taking a health or fitness course, adhering to a health improvement action plan, or complying with a health care provider's plan of action) to obtain the same reward.

2. Step Two: If the wellness activity is a "participatory wellness program," what standards must it satisfy under the Final Wellness Program Regulations?

If the wellness activity is a participatory wellness program, it must be made available to all similarly situated individuals, regardless of health status. Participatory wellness programs are not required to meet the requirements applicable to health-contingent wellness programs under the Final Wellness Program Regulations, as discussed in subsection 3 below.¹³

Furthermore, the Preamble to the Final Wellness Program Regulations clarifies that, if factors other than health status (such as scheduling limitations) limit an individual's ability to take part in a participatory wellness program, that does not mean that the program has violated the general rule prohibiting discrimination based on a health factor. This is because the program was not discriminatory under the HIPAA nondiscrimination rules to begin with.

Example: If a plan made available a premium discount in return for attendance at an educational seminar, and permitted all similarly situated persons to attend, but a particular individual could not attend because the seminar was held on a weekend and the individual was unavailable to attend, the program has not discriminated against that individual based on a health factor.¹⁴

¹¹ 45 C.F.R. § 146.121(f)(1)(iv).

¹² 45 C.F.R. § 146.121(f)(1)(v).

¹³ 45 C.F.R. § 146.121(f)(2).

¹⁴ 78 Fed. Reg. 33161.

3. Step Three: If the wellness activity is a "health-contingent wellness program," what standards must it satisfy under the Final Wellness Program Regulations?

Under the Final Wellness Program Regulations, there are five requirements that a health-contingent wellness program must satisfy in order to qualify as a compliant health-contingent wellness program under the Final Wellness Program Regulations. It is important to note the following: (a) the Departments have revised these requirements in several significant ways, from the requirements as set forth in the 2006 final regulations and in the Proposed Wellness Program Regulations; and (b) as described below, although some of these requirements apply in the same way both to activity-only and outcome-based wellness programs, others of these requirements apply in different ways depending upon whether the wellness program is activity-only or an outcome-based health-contingent wellness program.

a. Reward Limit

The Final Wellness Program Regulations provide that the "reward" can be in the form of a obtaining a reward or avoiding a penalty. A "reward" might include, for example: (a) a discount or rebate of a premium or contribution; (b) a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance); (c) an additional benefit; (d) any other financial or other incentive; (e) the absence of a surcharge; or (f) other financial or nonfinancial disincentive.¹⁵ Under the Final Wellness Program Regulations, effective for plan years beginning on or after January 1, 2014, the "applicable percentage" for the maximum reward is 30%¹⁶, with an increase of an additional 20% (to a total of 50%) to the extent that the additional percentage is in connection with a health-contingent wellness program designed to prevent or reduce tobacco use.¹⁷ Rewards offered in connection with a participatory wellness program are not counted for purposes of determining whether the applicable rewards percentage has been exceeded.

Under the Final Wellness Program Regulations, the total reward offered to an individual under all health-contingent wellness programs (whether activity-only or outcome-based) with respect to a plan cannot exceed the applicable percentage (discussed above) of the total cost of employee-only coverage under the related health plan. This employee-only cost is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee or any dependents are) receiving coverage.¹⁸

However, if, in addition to employees, any class of dependents (such as spouses, or spouses and dependent children) may participate in the health-contingent wellness program, the reward must not exceed the applicable percentage of the total cost of the coverage in which the employee and any dependents are enrolled (such as family coverage or employee-plus-one coverage).¹⁹ Notably, the Final Wellness Program Regulations do not set forth detailed rules governing apportionment of the reward among family members under a health-contingent wellness program available to employees and their dependents. Instead, the Preamble to the Final Wellness Program Regulations notes that the Departments are allowing plans to have flexibility to determine the apportionment of the reward among family members, as long as the method chosen is reasonable. However, the Preamble also notes that additional subregulatory guidance may be provided by the Departments if questions regarding apportionment persist, or if the Departments become aware of apportionment designs that seem unreasonable.²⁰

b. Reasonably Designed

Under the Final Wellness Program Regulations, a health-contingent wellness program (whether activity-only or outcome-based) must be "reasonably designed" to promote good health or prevent disease. A program

¹⁵ 45 C.F.R. § 146.121(f)(1)(i).

¹⁶ Under PPACA, the Departments have the authority to increase the maximum 30% reward percentage to as much as 50% if the Departments determine, in the future, that such an increase is appropriate.

¹⁷ 45 C.F.R. § 146.121(f)(5).

¹⁸ 45 C.F.R. §§ 146.121(f)(3)(ii) and 146.121(f)(4)(ii).

¹⁹ *Id.*

²⁰ 78 Fed. Reg. 33162.

satisfies this standard if it: (a) has a reasonable chance of improving the health of or preventing disease in participating individuals and it is not overly burdensome; (b) is not a subterfuge for discrimination based on a health factor; and (c) is not highly suspect in the method chosen to promote health or prevent disease.²¹

This "reasonably designed" standard is based on all the relevant facts and circumstances. However, the Final Wellness Program Regulations require that, to ensure that an outcome-based health contingent wellness program is "reasonably designed to improve health" and does not act as a subterfuge for underwriting or reducing benefits based on a health factor, a reasonable alternative standard to qualify for the reward must be provided to any individual who does not meet the initial standard based on a measurement, test, or screening that is related to a health factor, as explained in subsection d. below.²²

c. Available Annually

For both activity-only and outcome-based programs, the program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year. The purpose of this standard is to ensure that individuals have the ability to improve their health or wellness compliance over time and ultimately become eligible for the reward. Otherwise, the program could simply be a subterfuge for rewarding individuals who meet the standard at the time the program is implemented and discriminating on an ongoing basis against individuals who cannot meet the program's standards.²³

d. Uniform Availability and Reasonable Alternative Standards

As noted in the Preamble to the Final Wellness Program Regulations, an important element of the Final Wellness Program Regulations is the requirement that the full reward under a health-contingent wellness program, whether activity-only or outcome-based, must be available to all similarly situated individuals.²⁴ As noted in subsections (2) and (3) below, this requirement applies differently to activity-only wellness programs vs. outcome-based wellness programs.

(1) Requirements Applicable to Both Activity-only and Outcome-Based Programs:

The Preamble to the Final Wellness Program Regulations indicates that the full reward must be available under a health-contingent wellness program (whether activity-only or outcome-based) to those individuals who qualify by satisfying a reasonable alternative standard. This is the case even though it may take some time for an individual to request, establish, and satisfy a reasonable alternative standard.²⁵

- **Example:** If a calendar year plan offers a health-contingent wellness program with a premium discount and an individual who qualifies for a reasonable alternative satisfies that alternative on April 1, the plan must provide the premium discounts for January, February, and March to that individual.

The Preamble also states that plans have flexibility to determine how to provide the portion of the reward corresponding to the period before an alternative was satisfied (such as payment for the retroactive period or *pro rata* over the remainder of the year), as long as the method is reasonable and the individual receives the full amount of the reward. In circumstances where an individual may not satisfy the reasonable alternative standard until the end of the year, the plan may provide a retroactive payment of the reward for that year within a reasonable time after the end of the year, but may not provide pro rata payments over the following year (a year after the year to which the reward corresponds).²⁶

²¹ 45 C.F.R. §§ 146.121(f)(3)(iii) and 146.121(f)(4)(iii).

²² 45 C.F.R. § 146.121(f)(4)(iii).

²³ 45 C.F.R. §§ 146.121(f)(3)(i) and 146.121(f)(4)(i).

²⁴ 45 C.F.R. §§ 146.121(f)(3)(iv) and 146.121(f)(4)(iv).

²⁵ 78 Fed. Reg. 33163.

²⁶ *Id.*

In lieu of providing a reasonable alternative standard, the plan may instead waive the otherwise applicable standard. Furthermore, plans are not required to establish a particular reasonable alternative standard in advance of an individual's specific request for one, as long as the plan provides a reasonable alternative standard upon an individual's request.²⁷ The Preamble also notes that plans and issuers have flexibility to determine whether to provide the same reasonable alternative standard for an entire class of individuals (provided that it is reasonable for that class) or to provide the reasonable alternative standard on an individual-by-individual basis based on the facts and circumstances presented.²⁸

Whether the program is activity-only or outcome-based, all the facts and circumstances will be taken into account in determining whether the plan has furnished a reasonable alternative standard, including, but not limited to, the following:²⁹

- If the reasonable alternative standard is completion of an educational program, the plan 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 the plan may not require an individual to pay for the cost of the program.
- The time commitment required must be reasonable. For example, requiring attendance nightly at a one-hour class would be unreasonable.
- If the reasonable alternative standard is a diet program, the plan is not required to pay for the cost of food, but must pay for any membership or participation fee.
- 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 that individual, the plan must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. As the Preamble clarifies, this requirement is not limited to a situation where the personal physician disagrees with the specific recommendations of a medical professional or other agent of the plan with respect to the individual. A plan may impose standard cost-sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

Based on the foregoing, if an individual is unable to meet or maintain a metric as required under a wellness program and the individual requests an alternative standard in order to obtain the reward, an employer will need to be prepared to provide to the individual a reasonable alternative standard (which could be outcome-based, activity-only, or participatory) that complies with all of the applicable requirements described above (the requirements listed below will depend upon whether the reasonable alternative standard is outcome-based, activity-only, or participatory). In the alternative, an employer may simply waive the applicable standard and provide the reward to the individual.

(2) Requirements for Activity-Only Health Contingent Wellness Programs

For an activity-only program to satisfy this requirement, the program must allow a reasonable alternative standard (or a waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is either: (a) unreasonably difficult due to a medical condition to satisfy; or (b) medically inadvisable to attempt to satisfy, the otherwise applicable standard.³⁰ Plans are not required to determine a particular reasonable alternative standard in advance of such an individual's request for one. However, a

²⁷ 45 C.F.R. §§ 146.121(f)(3)(iv)(B) and 146.121(f)(4)(iv)(B).

²⁸ *Id.*

²⁹ *Id.* at 33163-33164; 45 C.F.R. §§ 146.121(f)(3)(iv)(C) and 146.121(f)(4)(iv)(C).

³⁰ 45 C.F.R. § 146.121(f)(3)(iv)(A).

reasonable alternative standard must be furnished upon the request of such an individual, or the condition for obtaining the reward must be waived.³¹

To the extent that a reasonable alternative under an activity-only wellness program is, itself, an activity-only wellness program, it must comply with all of the Final Wellness Program Regulations' requirements that are applicable to activity-only wellness programs, in the same manner as if it were an initial program standard. To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an outcome-based wellness program, it must comply with all of the Final Wellness Program Regulations' requirements applicable to outcome-based wellness programs.³²

For activity-only wellness programs, a plan may seek verification (*e.g.*, a statement from a participant's physician) that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard of an activity-only wellness program.³³ A plan may seek verification with respect to requests for a reasonable alternative standard for which it is reasonable to determine that medical judgment is required to evaluate the validity of the request. In short, it will not always be reasonable for a plan to seek such verification. In contrast, however, outcome-based wellness programs may not seek such verification (see discussion in subsection (3) below).

As noted in the Preamble, the Final Wellness Program Regulations do not expressly prohibit plan provisions that require verification to be provided by a physician in clinically appropriate circumstances, nor do the Final Wellness Program Regulations expressly require that medical professionals other than a physician be permitted to provide verification in specific circumstances if a physician's expertise would be required to evaluate the validity of the request.³⁴ The Preamble explains that the Departments generally view any plan requirement for verification to be subject to the broader standards for reasonable design, and the Departments intend to examine verification requirements in light of all relevant facts and circumstances. The Departments may provide future guidance on this issue.

(3) Requirements for Outcome-Based Health Contingent Wellness Programs

For an *outcome-based program* to satisfy this requirement, the program must allow a reasonable alternative standard (or must waive the otherwise applicable standard) for obtaining the reward for any individual who does not meet the initial standard based on the measurement, test, or screening.³⁵ Plans are not required to determine a particular reasonable alternative standard in advance of such an individual's request for one. However, a reasonable alternative standard must be furnished upon the request of such an individual, or the condition for obtaining the reward must be waived.³⁶

To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, a participatory or activity-only wellness program, it must comply with all of the Final Wellness Program Regulations' requirements that are applicable to participatory or activity-only wellness programs, as applicable, in the same manner as if it were an initial program standard. To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, another outcome-based wellness program, it must comply with all of the Final Wellness Program Regulations' requirements applicable to outcome-based wellness programs, subject to the following special rules:³⁷

- The reasonable alternative standard cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual's circumstances. For example, if the program's initial standard is to achieve a BMI less than 30, the reasonable alternative standard cannot

³¹ 45 C.F.R. § 146.121(f)(3)(iv)(B).

³² 45 C.F.R. § 146.121(f)(3)(iv)(D).

³³ 45 C.F.R. § 146.121(f)(3)(iv)(E).

³⁴ 78 Fed. Reg. 33165.

³⁵ 45 C.F.R. § 146.121(f)(4)(iv)(A).

³⁶ 45 C.F.R. § 146.121(f)(4)(iv)(B).

³⁷ 45 C.F.R. § 146.121(f)(4)(iv)(D).

be to achieve a BMI less than 31 on that same date. However, a reasonable alternative standard for the individual could be to reduce the individual's BMI by a small amount or small percentage, over a realistic period of time, such as within a year.

- An individual must be given the opportunity to comply with the recommendations of his or her personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the plan or issuer, but only if the physician joins in the request. The individual can make a request to involve a personal physician's recommendations at any time and the personal physician can adjust the physician's recommendations at any time, consistent with medical appropriateness.

In contrast to activity-only wellness programs, it is not reasonable, with respect to an *outcome-based wellness program*, for the plan to seek verification, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard as a condition of providing a reasonable alternative to the initial standard.³⁸ However, if the plan provides an activity-only wellness program as the alternative standard, then the Final Wellness Program Regulations' provisions governing activity-only wellness programs will apply to that alternative standard and, as permitted under those provisions, the plan may, if reasonable under the circumstances, seek verification that it either is unreasonably difficult due to a medical condition for the individual to perform or complete the activity or is medically inadvisable for the individual to attempt to perform or complete the activity.³⁹

Example: If an outcome-based wellness program requires participants to maintain a certain healthy weight and provides a diet and exercise program for individuals who do not meet the targeted weight, a plan or issuer may seek verification, as described in the Final Wellness Program Regulations' provisions applicable to activity-only wellness programs, if reasonable under the circumstances, that a second reasonable alternative standard is needed for certain individuals because, for those individuals, it would be unreasonably difficult due to a medical condition to comply, or medically inadvisable to attempt to comply, with the diet and exercise program, due to a medical condition.

In Attachment A to this article we have provided some examples from the Final Wellness Program Regulations, which illustrate how the "uniform availability and reasonable alternative standard" requirement works, in practice, for outcome-based health-contingent wellness programs.

e. Disclosure Requirement

All plan materials describing the terms of the health-contingent wellness program (whether activity-only or outcome-based) must disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of a waiver of the otherwise-applicable wellness program standard), including the contact information for obtaining a reasonable alternative standard and a statement that the recommendation of an individual's personal physician will be accommodated. This disclosure also must be provided in any disclosure that an individual did not satisfy an initial outcome-based standard.⁴⁰

Plan materials are not required to describe specific reasonable alternative standards. It is sufficient to disclose that some reasonable alternative standard will be made available. However, if the plan materials merely mention that such a program is available, without describing its terms, this detailed disclosure is not required.⁴¹

³⁸ 45 C.F.R. 146.121(f)(4)(iv)(E).

³⁹ *Id.*

⁴⁰ 45 C.F.R. §§ 146.121(f)(3)(v) and 146.121(f)(4)(v).

⁴¹ *Id.*

The Final Wellness Program Regulations provide the following model language that may be used to satisfy this disclosure requirement (note: this disclosure language differs from the model language previously provided by the Departments in the 2006 final regulations and in the Proposed Wellness Program Regulations):

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.⁴²

C. HIPAA Opt-Out

Prior to the enactment of PPACA, sponsors of self-funded nonfederal governmental health plans were permitted to elect an exemption from (or "opt-out" of) certain provisions of HIPAA. Specifically, these plans were able to opt out of compliance with the following requirements:

- (1) Limitations on pre-existing condition exclusion periods;
- (2) Requirements for special enrollment periods;
- (3) Prohibitions against discriminating against individual participants and beneficiaries based on health status (except for provisions added by the Genetic Information Nondiscrimination Act of 2008);
- (4) Standards relating to benefits for newborns and mothers;
- (5) Parity in the application of certain limits to mental health and substance use disorder benefits (including the requirements imposed by the Mental Health Parity and Addiction Equity Act of 2008);
- (6) Required coverage for reconstructive surgery following mastectomies; and
- (7) Coverage of dependent students on a medically necessary leave of absence.

As a result of this opt-out opportunity, self-funded nonfederal governmental employees were able to opt-out of the HIPAA non-discrimination rules and had much more flexibility in designing wellness programs because they did not have to follow either the HIPAA non-discrimination rules or the wellness rules.

PPACA amended the HIPAA opt-out provisions of the Public Health Service Act so that self-funded nonfederal governmental health plans are no longer able to opt-out of the first three requirements listed above, including the HIPAA non-discrimination rules. This change was effective for plan years beginning on or after September 23, 2010 (special effective date rules apply to collectively bargained plans ratified before March 23, 2010, as described in the guidance).

Guidance⁴³ makes clear that self-funded nonfederal governmental plans will still be able to opt-out of the standards relating to benefits for newborns and mothers, parity in the application of certain limits to mental health and substance use disorder benefits, required coverage for reconstructive surgery following mastectomies, and coverage of dependent students on a medically necessary leave of absence. However, self-funded nonfederal governmental employers will have to fully comply with the HIPAA non-discrimination and wellness rules in the future when designing wellness programs.

⁴² 45 C.F.R. § 146.121(f)(6).

⁴³ Memo from Steve Larson, Director, Office of Oversight, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, September 21, 2010 (available at: http://www.hhs.gov/ociio/regulations/opt_out_memo.pdf).

II. AMERICANS WITH DISABILITIES ACT

Medical questionnaires and medical examinations often make up a large part of an employer's wellness program. However, the Americans with Disabilities Act ("ADA") places significant limits on an employer's ability to make disability-related inquiries or to require medical examinations. In fact, after employment begins, an employer may generally only make disability-related inquiries and require medical examinations if they are "job-related and consistent with business necessity."⁴⁴

While wellness programs may be beneficial to both the employer and its employees, they have never been interpreted in any official guidance or in case law as satisfying the "job-related and consistent with business necessity" requirement under the ADA. Therefore, a wellness program that makes disability-related inquiries or requires medical examinations will violate the ADA *unless* it meets an exception under the ADA.

The ADA includes an exception for "voluntary wellness programs," under which an employer does not have to show that the disability-related inquiries or medical examinations are job-related and consistent with business necessity if the wellness program is "voluntary" and records under the program are kept confidential and separate from personnel records.⁴⁵ Voluntary wellness programs can include such medical examinations as blood pressure screening, cholesterol testing, glaucoma testing, and cancer detection screening.⁴⁶ The preamble to the Final HIPAA Wellness Program Regulations states, however, that compliance with the HIPAA nondiscrimination rules and the final wellness regulations does not mean that the wellness program is "voluntary" within the meaning of this exception under the ADA.⁴⁷

The ADA also provides an insurance safe harbor that may apply to wellness programs if the program is a "bona fide benefit plan." This safe harbor states that the ADA is not to be construed to prohibit or restrict "a person or organization covered by this chapter from establishing, sponsoring, observing, or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law. . . ."⁴⁸

While the boundaries of the voluntary wellness program exception and the insurance safe harbor provisions have been tested in the courts, employers and benefits practitioners eagerly awaited anticipated guidance from the Equal Employment Opportunity Commission ("EEOC") on how employer wellness programs can be designed in compliance with the ADA. That guidance finally came in the form of a proposed regulation on April 20, 2015 ("EEOC Proposed Rule").⁴⁹ This section of the paper discusses the issues that arise under the ADA, the history of the EEOC's enforcement, and the EEOC Proposed Rule.

A. Disability-Related Inquiries and Medical Examinations Defined

The ADA only applies to wellness programs if such programs make *disability-related inquiries* or conduct or request *medical examinations*.

1. **Disability-Related Inquiry.** The EEOC defines a "disability-related inquiry" to mean a question (or series of questions) that is likely to elicit information about a disability. A disability-related inquiry includes obvious questions, such as asking an employee whether he or she has (or ever had) a disability or how he or she became disabled. However, a disability-related inquiry also includes asking

⁴⁴ 42 U.S.C. § 12112(d); 29 C.F.R. §§ 1630.13 and 1630.14.

⁴⁵ 42 U.S.C. § 12112(d)(4)(B); *see also* EEOC Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees under the ADA, 8 Fair Empl. Prac. Man. (BNA) 405:7701 (hereinafter, "Enforcement Guidance").

⁴⁶ Enforcement Guidance.

⁴⁷ *See* 78 Fed. Reg. 33158, 33168 (June 3, 2013).

⁴⁸ 42 U.S.C. § 12201(c).

⁴⁹ 80 Fed. Reg. 21659 (April 20, 2015).

questions relating to an employee's genetic information (including the employee's family medical history), asking whether the employee is currently taking any prescription drugs or medications, and asking broadly worded questions about an employee's impairments that are likely to elicit information about a disability.⁵⁰ On the other hand, general questions regarding an employee's well-being, whether the employee has been drinking, the employee's current illegal use of drugs, or a request for contact information for the employee in the case of a medical emergency are not disability-related inquiries.⁵¹

2. Medical Examination. The EEOC defines a "medical examination" as a procedure or test that seeks information about an individual's physical or mental impairments or health. Whether a particular test or procedure is a medical examination will be determined based on several factors,⁵² but the EEOC has determined that certain tests, including blood pressure screenings and cholesterol tests, are medical examinations for purposes of the ADA.

The broad range of questions and tests covered under the EEOC's definitions of "disability-related inquiry" and "medical examinations" makes it very unlikely that a health risk assessment (provided as part of a wellness program) would not be subject to the ADA's requirements concerning these restrictions. An example of a program that would not be considered to ask any disability-related questions or conduct any medical examinations is a smoking cessation program that is available to any employee who smokes and only asks employees to disclose how much they smoke.⁵³

B. The EEOC Informal Discussion Letters' Interpretation of a "Voluntary Wellness Program" Under the ADA

The ADA states that an employer "may conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site" even though such examinations are not job-related and consistent with business necessity.⁵⁴ The regulations repeat this provision almost verbatim, without providing any further interpretation of what it means to conduct a "voluntary" medical examination.⁵⁵ However, in guidance issued prior to the EEOC Proposed Rule, the EEOC has stated that a "wellness program is 'voluntary' as long as an employer neither requires participation nor penalizes employees who do not participate."⁵⁶ On March 6, 2009, and again on August 10, 2009, the EEOC addressed the issue more directly, although *informally*, by stating its view that if an employee's eligibility in an employer's health care plan is conditioned upon completion of a health risk assessment that makes disability-related inquiries and requires medical examinations, such health risk assessment does not qualify as a "voluntary wellness program," and therefore violates the ADA.

1. First EEOC Letter

On March 6, 2009, the EEOC issued an Informal Discussion Letter⁵⁷ ("Letter 1") in which it provided its informal opinion as to whether certain wellness programs were in fact "voluntary" for purposes of the exception.⁵⁸

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.* The EEOC lists the following factors in the Enforcement Guidance: (1) whether the test is administered by a health care professional; (2) whether the test is interpreted by a health care professional; (3) whether the test is designed to reveal an impairment of physical or mental health; (4) whether the test is invasive; (5) whether the test measures an employee's performance of a task or measures his or her physiological responses to performing the task; (6) whether the test normally is given in a medical setting; and (7) whether medical equipment is used.

⁵³ *Id.* at n.78.

⁵⁴ 42 U.S.C. § 12112(d)(4)(B).

⁵⁵ 29 C.F.R. § 1630.14(d) ("A covered entity may conduct voluntary medical examinations and activities, including voluntary medical histories, which are part of an employee health program available to employees at the work site.").

⁵⁶ Enforcement Guidance.

⁵⁷ EEOC Informal Discussion Letter, "ADA: Disability-Related Inquiries and Medical Examinations; Health Risk Assessment," Mar. 6, 2009 (hereinafter, "Letter 1").

The employer seeking Letter 1 was a county that required county employees to participate in a health risk assessment as a condition for participating in its health insurance plan. The health risk assessment included answering a short, health-related questionnaire, taking a blood pressure test, and providing blood for use in a blood panel screen. Results from the assessment went directly and exclusively to the employee, and the county only received information in the aggregate.

In Letter 1, the EEOC first states that requiring completion of the health risk assessment "does not appear to be job-related and consistent with business necessity, and therefore would violate the ADA." The EEOC next discusses the exception provided when disability-related inquiries and medical examinations are part of a voluntary wellness program. On this point, Letter 1 states:

A wellness program is voluntary if employees are neither required to participate nor penalized for non-participation. In this instance, however, an employee's decision not to participate in the health risk assessment results in the loss of the opportunity to obtain health coverage through the employer's plan. Thus, even if the health risk assessment could be considered part of a wellness program, the program would not be voluntary, because individuals who do not participate in the assessment are denied a benefit (*i.e.*, penalized for non-participation) as compared to employees who participate in the assessment.⁵⁹

As an additional consideration, the EEOC retracted its original response to the county, which had stated that a wellness program that uses inducements to encourage participation in a wellness program (*e.g.*, premium discounts) would be considered voluntary under the ADA if it met the HIPAA Final Wellness Program Regulations. Because the county did not specifically ask this question, the EEOC withdrew that portion of the March 2009 Letter, and in doing so stated: "The Commission is continuing to examine what level, if any, of financial inducement to participate in a wellness program would be permissible under the ADA." Thus, the EEOC left open the question of whether a wellness program with disability-related inquires and/or medical examinations, which offers rewards or penalties based on participation, would pass muster when reviewed under the ADA, even if the rewards or penalties are in accordance with the HIPAA Final Wellness Program Regulations.

2. Second EEOC Letter

On August 10, 2009, the EEOC issued a second Informal Discussion Letter ("Letter 2") on the topic.⁶⁰ The employer seeking Letter 2 required its employees to complete a health risk assessment containing over 100 questions in order to receive monies from an employer-funded health reimbursement arrangement (but did not require medical examinations). The EEOC was consistent with the position it took in Letter 1 and found the employer's policy violated the ADA because the health risk assessment was not voluntary insofar as employees were penalized for nonparticipation with respect to their eligibility to receive reimbursement for health expenses. The EEOC did note, however, that only the disability-related inquiries on the health risk assessment appeared to violate the ADA. It specifically noted that questions about lifestyle, such as whether an employee sees a personal doctor for routine care or has a health care directive, and questions relating to personal nutrition and exercise are not likely, in its view, to elicit information about a disability, and are therefore *not* subject to the ADA's restrictions.

Until recently, these Letters were the only statements from the EEOC on its position. While they do not constitute an official opinion, the Letters were construed by many in the benefits community as a warning shot from the EEOC of its position if it were to directly challenge an employer in court.

⁵⁸ This is not the first time that the EEOC has stated – even if informally – its possible position on this topic. EEOC representatives did informally indicate in response to questions presented on May 4, 2006 by the ABA Joint Committee on Employee Benefits that conditioning the availability of employer-provided health insurance on an employee's participation in a health risk assessment might well render participation in the assessment involuntary, making unlawful any disability-related inquiries or medical examinations that are part of the assessment. *See* <http://www.abanet.org/jceb/2006/EEOC2006final.pdf>.

⁵⁹ Letter 1 (internal citations omitted).

⁶⁰ EEOC Informal Discussion Letter, "ADA: Health Risk Assessments," Aug. 10, 2009 (hereinafter, "Letter 2").

C. Support for Wellness Programs: *Seff v. Broward County*

On April 11, 2011, the United States District Court for the Southern District of Florida provided employers with some additional support for their wellness programs under the ADA. In *Seff v. Broward County*,⁶¹ the plaintiff, Bradley Seff, and a class of individuals who were similarly situated, alleged that Broward County, Florida violated the ADA because it charged \$20 on a bi-weekly basis to employees who declined to participate in a health questionnaire and biometric screening as a part of a wellness program. Broward County, like many employers, instituted this wellness program because of rapidly escalating health care costs. The wellness program was designed to encourage employees to become active in managing their own health care. Employees who did not wish to incur the \$20 surcharge completed an online health risk assessment and a biometric screening to test glucose and cholesterol levels. Personal information related to the program was held by a third-party wellness vendor and was not released to the County.

U.S. Federal District Court Judge K. Michael Moore granted summary judgment in favor of Broward County, thus denying any relief to the class of employees complaining in the lawsuit. Judge Moore did not analyze Broward County's program under the voluntary wellness program provisions of the ADA (as the EEOC had done in its informal letters discussed above). Instead, Judge Moore upheld the program under the ADA's insurance safe harbor provisions. This safe harbor states that the ADA is not to be construed to prohibit or restrict:

a person or organization covered by this chapter from establishing, sponsoring, observing, or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; .

..

The safe harbor further provides that it is not to be used as subterfuge to evade the overall purposes of the ADA.⁶² Judge Moore found that the wellness program was a part of Broward County's group health plan structure and, using the bona fide benefit plan safe harbor of the ADA, he upheld the wellness program because it was designed to develop and administer present and future benefits using accepted principles of risk assessment. Broward County used the aggregate data it received from the health risk assessments and biometric screenings to classify risks and to assist it in developing future benefit plan designs. Judge Moore further found that the program was designed as an initiative to mitigate future risks in the benefit plans because it encourages employees to get involved in their own health care, thus leading to a healthier employee population and less future costs to the benefit plan. Thus, the program was held to fall within the safe harbor because it was a part of a bona fide benefit plan and was designed to assist in the underwriting, classifying, and administration of risks related to the plan.

Judge Moore's decision was affirmed by the United States Court of Appeals for the Eleventh Circuit on August 20, 2012.⁶³ This decision gives an additional potential defense to an employer sponsoring a wellness program that is part of its group health plan, and that is intended to help reduce costs under that health plan. The EEOC has made clear, however, that it does not agree with the outcome in the *Broward County* case.⁶⁴

⁶¹ *Seff v. Broward County*, Case No. 10-61437-CIV-MOORE/SIMONTON, N. Dist. Fl. (April 11, 2011).

⁶² 42 U.S.C. § 12201(c).

⁶³ *Seff v. Broward County*, 691 F.3d 1221 (11th Cir. 2012).

⁶⁴ See Memorandum in Support of EEOC's Application For Temporary Restraining Order and an Expedited Preliminary Injunction, *EEOC v. Honeywell* (filed Oct. 27, 2014); See also Preamble, EEOC Proposed Rule, 80 Fed. Reg. 21662 n. 24.

D. EEOC Litigation

The EEOC initiated lawsuits in late 2014 against three separate employers, alleging that their employer wellness programs violated the ADA.

1. EEOC v. Orion Energy Systems

The EEOC filed its first complaint against Orion Energy Systems on August 20, 2014, alleging that Orion's wellness program violated the ADA, and that Orion's employment practices also violated the ADA.⁶⁵ Orion's wellness program required employees to complete a health risk assessment which included a fitness component, disclosure of medical history, and a blood draw. Orion paid the entire premium for employee-only coverage under the health plan. However, if an employee failed to participate in the wellness program, the employee was required to pay the entire premium for self-only coverage, plus a \$50 per month penalty for failure to participate in the fitness component. According to the EEOC's complaint, Orion fired the only employee who complained about, and refused to participate in, the wellness program.⁶⁶ Although not stated in the court documents, it appears that the wellness program did not comply with the HIPAA Final Wellness Program Regulations.

The EEOC's complaint alleged that the blood draw is a medical exam and that it and the disability related inquiries were not job-related or consistent with business necessity, and were not voluntary because there was a significant financial penalty imposed for not participating (100% of self-only premium surcharge plus \$50 per month penalty), and at least one employee was fired for not participating.⁶⁷

2. EEOC v. Flambeau

The EEOC filed its second complaint alleging that a wellness program violated the ADA against Flambeau, Inc. on September 30, 2014.⁶⁸ Flambeau's wellness program required biometric testing and a health risk assessment that included disability related inquiries. Employees completing the wellness program had 75% of their self-only premium subsidized. Employees who failed to complete the wellness program had their coverage terminated and had to pay the entire premium for self-only coverage under COBRA to reinstate coverage. Although not stated in the court documents, it appears that the wellness program did not comply with the HIPAA Final Wellness Program regulations. An employee was unable to complete the wellness program on the day the company designated due to the employee's medical leave. When the employee returned to employment, he tried to complete the wellness program, but his request for additional time was denied and his health insurance was terminated.⁶⁹

The EEOC's complaint alleges that the wellness program was not voluntary due to the penalty of termination of coverage and having to pay the entire premium cost under COBRA to reinstate that coverage.⁷⁰

3. EEOC v. Honeywell International

The third lawsuit filed by the EEOC was a petition for a temporary restraining order and preliminary injunction against Honeywell on October 27, 2014.⁷¹ Honeywell's wellness program consisted of a free biometric screening (including a blood draw) that employees and spouses (if covered under the health plan) were required to take for the 2015 plan year. The biometric screening tested for blood pressure, cholesterol, glucose, BMI, and nicotine. If an employee did not do the biometric screening:

⁶⁵ Complaint, *EEOC v. Orion Energy Systems, Inc.*, No. 1:14-cv-01019 (E.D. Wis. Aug. 20, 2014).

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ Complaint, *EEOC v. Flambeau, Inc.*, No. 3:14-cv-00638 (W.D. Wis. Sep. 30, 2014).

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ Petition for a Temporary Restraining Order and Preliminary Injunction, *EEOC v. Honeywell Int'l Inc.*, No. 0:14-cv-04517 (D. Minn. Oct. 27, 2014).

- (i) the employee would not receive Honeywell's health savings account ("HSA") seed dollars (up to \$1,500) (a reward for the employee's participation);
- (ii) an annual \$500 surcharge was added to the employee's health premiums (a penalty for the employee's failure to participate); and
- (iii) an annual \$1,000 tobacco surcharge was added to the employee's health premiums (a penalty for the employee's failure to participate).

Additionally, if the employee's spouse did not do the biometric screening, the employee was charged another \$1,000 tobacco surcharge for his or her spouse (if covered by the plan) (a penalty for failure of the spouse to participate). However, the tobacco surcharge did not apply if the employee and/or spouse enrolled in a tobacco cessation program, submitted a biomedical screening report from their physician that showed that they do not use tobacco, or worked with a health advocate to establish that they were nicotine free. Additionally, there were waivers from participation for employees with illnesses or pregnancy that precluded participation, and employees and spouses could submit a form from their personal physician if they had already had an annual exam in 2014 that included a biometric screening.⁷²

This case has received significantly more attention than the prior two cases because it involves a fairly common wellness program design – even if slightly more aggressive in the size of the rewards and penalties than many – that satisfies the HIPAA Final Wellness Program Regulations.

The EEOC alleged that Honeywell's wellness program violated the ADA and the Genetic Information Nondiscrimination Act of 2008 ("GINA"), and requested that the court enjoin Honeywell from penalizing employees and spouses who do not participate in the wellness program. First, the EEOC's petition alleged that the biometric testing is a medical examination within the meaning of ADA that was not job-related or consistent with business necessity. The EEOC further stated that the substantial financial inducement imposed upon employees to make them participate in the biometric testing was a penalty that made the testing involuntary, and it was, therefore, an unlawful medical examination under the ADA. Second, the EEOC's petition alleged that the imposition of penalties on employees if spouses fail to undergo biometric testing is an unlawful inducement to acquire family medical history (genetic information) that is a violation of Title II of GINA.⁷³

Honeywell responded that encouraging participation in its wellness program through surcharges does not make it involuntary, particularly in that the surcharges complied with the HIPAA Final Wellness Program Regulations. Honeywell argued that the EEOC's Enforcement Guidance is not entitled to any deference in light of Congress's express approval of rewards and penalties in connection with wellness programs, as expressed in these rules and regulations. Honeywell alternatively argued that its wellness program was a bona fide benefit plan that qualified for the ADA insurance safe harbor for covered entities "establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with state law."⁷⁴ With respect to the GINA allegation, Honeywell argued that its wellness program did not request genetic information within the meaning of that term as defined under GINA. Even if it did request genetic information, Honeywell argued that Title I of GINA, which applies to group health plans, controlled, and that the EEOC has no jurisdiction over Title I claims. Finally, Honeywell argued that even if Title II of GINA applies, Title II contains an exception for voluntary wellness programs.⁷⁵

In short, the issue in *Honeywell* was whether a wellness program that fully complies with the HIPAA Final Wellness Program Regulations could nonetheless violate the ADA and GINA. The Court in *Honeywell* issued an order on November 6, 2014, denying the EEOC's petition for a temporary restraining order on the

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *See Seff v. Broward County*, 691 F.3d 1221 (11th Cir. 2012).

⁷⁵ For additional discussion on wellness programs under GINA, *see supra* Section III.

grounds that there was no threat of irreparable harm since employees could be made whole through monetary damages if the EEOC were to ultimately prevail. The court also noted that it could not determine the likelihood of success on the merits given the great uncertainty in how the ACA, ADA and GINA are intended to interact, and the need for clarity under the laws.

E. EEOC Proposed Rule

On April 20, 2015, the EEOC released much anticipated proposed regulations to provide group health plan sponsors with guidance on designing wellness programs that would comply with the ADA.⁷⁶ The EEOC Proposed Rule is not yet effective. However, the EEOC has stated that, "[i]t is unlikely that a court or the EEOC would find that an employer violated the ADA if the employer complied with the [proposed rule] until a final rule is issued."⁷⁷ Importantly, the EEOC Proposed Rule tracks the HIPAA Final Wellness Program Regulations (with some notable exceptions). Therefore, employers with wellness programs that already comply with the HIPAA Final Wellness Program Regulations may, in some cases, only need to make minor modifications to their programs. However, the EEOC Proposed Rule is quite clear that an employer's ADA obligations and HIPAA obligations are distinct and compliance with one of the rules does not constitute compliance with the other rule. Specifically, the EEOC Proposed Rule states:

Compliance with the requirements of paragraph (d) of this section, including the limit on incentives under the ADA, does not relieve a covered entity from the obligation to comply in all respects with the nondiscrimination provisions of Title VII of the Civil Rights Act of 1964, 42 U.S.C. 2000e et seq., the Equal Pay Act of 1963, 29 U.S.C. 206(d), the Age Discrimination in Employment Act of 1967, 29 U.S.C. 621 et seq., Title II of the Genetic Information Nondiscrimination Act of 2008, 42 U.S.C. 2000ff, et seq., or other sections of Title I of the ADA.⁷⁸

The EEOC Proposed Rule has five essential elements.

First, an employee health program, including any disability-related inquiries or medical examinations that are part of such programs, must be reasonably designed to promote health or prevent disease. This is similar to the requirement under the HIPAA Final Wellness Program Regulations that a wellness program be "reasonably designed." To comply with this element, a wellness program must have a reasonable chance of improving the health of, or preventing disease in, participating employees and must not be overly burdensome. In addition, the program must not be a subterfuge for violating the ADA or other laws preventing employment discrimination, or highly suspect in the method chosen to promote health or prevent disease. The EEOC provided examples of wellness programs that would meet this standard and some that would not:

Acceptable: Conducting a health risk assessment and/or a biometric screening of employees for the purpose of alerting them to health risks of which they may have been unaware would meet this standard.

Acceptable: Use of aggregate information from employee health risk assessments by an employer to design and offer health programs aimed at specific conditions that are prevalent in the workplace would meet this standard.

Not Acceptable: Collecting medical information on a health questionnaire without providing employees follow-up information or advice, such as providing feedback about risk factors or using aggregate information to design programs or treat any specific conditions would not be reasonably designed to promote health.

⁷⁶ 80 Fed. Reg. 21659 (April 20, 2015).

⁷⁷ "Questions and Answers about the EEOC's Notice of Proposed Rulemaking on Employer Wellness Programs," published on the EEOC's website at http://www.eeoc.gov/laws/regulations/qanda_nprm_wellness.cfm (last visited on April 29, 2015).

⁷⁸ 80 Fed. Reg. 21667.

Not Acceptable: A program is not reasonably designed to promote health or prevent disease if it imposes, as a condition to obtaining a reward, an overly burdensome amount of time for participation, requires unreasonably intrusive procedures, or places significant costs related to medical examinations on employees. It is also not acceptable if the program exists mainly to shift costs from the covered entity to targeted employees based on their health.

The second element of the EEOC Proposed Rule is that the wellness program must be voluntary. Consistent with past guidance from the EEOC on this topic, the EEOC Proposed Rule states that a wellness program is not voluntary if an employee is required to participate. Furthermore, an employee cannot be denied coverage under any group health plan or particular benefit packages within a group health plan for non-participation, nor can benefits be limited for employees who do not participate. This requirement would clearly make programs that condition eligibility on whether an employee completes a health risk assessment or undergoes biometric screenings impermissible. It would also appear to prohibit programs that prevent employees from enrolling in particular plan options if they do not undergo a medical examination or a disability-related inquiry (e.g., employee can enroll in the employer's high deductible health plan without completing a health risk assessment, but would be prohibited from enrolling in the health maintenance organization option without completing a health risk assessment). Finally, an employer cannot take any adverse employment action or retaliate against, interfere with, coerce, intimidate, or threaten employees for not participating. Note that the kinds of programs that would now be prohibited under this element would have likely been allowed under the HIPAA Final Wellness Program Regulations as a "participatory" wellness program. In this way, the EEOC Proposed Rule goes further to regulate wellness programs than the HIPAA Final Wellness Program Regulations.

The foregoing requirements of the "voluntariness" element of the EEOC Proposed Rule are consistent with the EEOC's prior informal guidance and litigation positions. However, the EEOC Proposed Rule goes further and requires an employer to provide employees a written notice that: (a) is written so that the employee from whom medical information is being obtained is reasonably likely to understand it; (b) describes the type of medical information that will be obtained and the specific purposes for which the medical information will be used; and (c) describes the restrictions on the disclosure of the employee's medical information, the employer representatives or other parties with whom the information will be shared, and the methods that the covered entity will use to ensure that medical information is not improperly disclosed (including whether it complies with the HIPAA Privacy Rule). This new notice requirement adds to the various notices that employers must provide in connection with their group health plans. It is not yet clear whether this notice can be provided in connection with the HIPAA Final Wellness Program Regulations' required disclosure about the availability of a reasonable alternative standard and/or whether this notice might be integrated in a group health plan's HIPAA Notice of Privacy Practices.

The third element of the EEOC Proposed Rule requires that incentives (financial or in-kind) connected with the wellness program must not exceed a 30 percent limit of the total cost of employee-only coverage. An incentive can be in the form of a reward or a penalty, but all rewards for all wellness programs connected with the group health plan must be combined and may not exceed the 30 percent limit. This element roughly aligns with the HIPAA Final Wellness Program Regulations' limits; however, HIPAA's allowance to extend the limit to 30 percent of the cost of family coverage if family members are eligible to participate is conspicuously absent from the EEOC Proposed Rule. It is not yet clear why the EEOC did not extend the limit to dependent coverage if dependents participate in the program; however, the EEOC may be reserving on this point until it provides further guidance with regard to whether the collection of a spouse's health information is considered to be the collection of "family history" under the Genetic Information Nondiscrimination Act (the position that the EEOC took in *Honeywell*, discussed above).

The EEOC limit also diverges from the HIPAA Final Wellness Program Regulations' limit because it can apply to both participatory and health-contingent programs, or any combination of the two. The HIPAA Final Wellness Program Regulations do not impose a limit on rewards connected with a participatory wellness program because such programs do not implicate a "health status factor" under HIPAA. However, the EEOC's concern is whether a wellness program requires medical examinations or makes disability-related inquiries. Although completing a health risk assessment or undergoing a biometric screening, alone, is a participatory program under

the HIPAA Final Wellness Program Regulations, these activities involve disability-related inquiries and medical examinations and thus are subject to the EEOC's reward limit. This could require some wellness programs to adjust their reward limits. Many wellness programs take advantage of the full 30 percent limit on their health-contingent components because that is all the HIPAA Final Wellness Program Regulations require. However, if those wellness programs provide an additional incentive for completion of a participatory component involving a health risk assessment or a biometric screening, the EEOC Proposed Rule would require that the amount of that incentive be included in the 30 percent limit.

The EEOC Proposed Rule notes that not all participatory wellness programs require disability-related inquiries or medical examinations such as attending nutrition, weight loss, or smoking cessation classes. These kinds of participatory wellness programs would not be subject to the EEOC's limit on incentives, nor would they be subject to the HIPAA Final Wellness Program Regulations' limit. It should also be noted that the EEOC Proposed Rule would not prevent employers from taking advantage of the HIPAA Final Wellness Program Regulations' allowance of a 50 percent incentive for tobacco-related wellness programs as long as the program did not involve disability-related inquiries or medical examinations. For example, a wellness program that merely asks employees whether or not they use tobacco (or whether or not they ceased using tobacco upon completion of the program) is not an employee health program that includes disability-related inquiries or a medical examination. Thus, this program could still utilize the HIPAA rules' allowance of an incentive up to 50 percent of the cost of the coverage. However, a program that requires employees to undergo a blood test or other medical examination to conclusively demonstrate the absence of tobacco use would involve a medical examination and would have to confine the reward to the 30 percent limit (even though the HIPAA Final Wellness Program Regulations might have otherwise allowed an incentive of up to 50 percent).

Under the fourth element of the EEOC Proposed Rule, reasonable accommodations must be provided, absent undue hardship, to enable employees with disabilities to earn whatever financial incentive an employer offers (regardless of whether a wellness program includes disability-related inquiries or a medical examination). This element is similar to the HIPAA Final Wellness Program Regulations' requirement to provide a reasonable alternative. Compliance with one will likely constitute compliance with the other. However, note that the ADA would require a reasonable accommodation under a participatory wellness program, even though the HIPAA Final Wellness Program Regulations do not require reasonable alternatives for participatory wellness programs. For example, an employer that offers a financial incentive to attend a nutrition class, regardless of whether the employee reaches a healthy weight as a result, would have to provide a sign language interpreter so that an employee who is deaf and who needs an interpreter to understand the information could earn the incentive, as long as providing the interpreter would not result in an undue hardship to the employer. Furthermore, an employer would, absent undue hardship, have to provide written materials that are part of a wellness program in alternate format, such as in large print or on computer disk, for someone with a vision impairment. Moreover, an employer that offers a reward for completing a biometric screening that includes a blood draw would have to provide an alternative test so that an employee with a disability that makes drawing blood dangerous can participate and earn the incentive.

The final element of the EEOC Proposed Rule requires that confidentiality be observed with regard to the medical information collected in connection with the wellness program. In general, information obtained from disability-related inquiries and medical examinations may only be provided to an employer in aggregate terms that do not disclose, or are not reasonably likely to disclose, the identity of an employee. An exception exists for the administration of a health plan, in which case the group health plan administrator must comply with the HIPAA Privacy Rule (discussed in more detail in Section V).

F. ADA Conclusion

The EEOC has faced a considerable amount of negative press and Congressional reaction in bringing the *Honeywell* case, particularly given the fact that it delayed issuing a rule on wellness programs before bringing lawsuits enforcing standards that were not clear. However, with the issuance of the EEOC Proposed Rule, sponsors of wellness programs have much more concrete guidance when designing their wellness programs. Employers should begin to evaluate their wellness programs in light of the EEOC Proposed Rule and monitor the issuance of a final rule.

III. GENETIC INFORMATION NONDISCRIMINATION ACT

The Genetic Information and Nondiscrimination Act of 2008 ("GINA") prohibits group health plans from doing three main things with respect to genetic information:

- (1) Group health plans may not adjust premiums or contribution amounts of individuals in a group coverage plan on the basis of genetic information;
- (2) Group health plans are extremely limited in their ability to request or require an individual or family member of the individual to undergo a genetic test; and
- (3) Group health plans may not collect genetic information for underwriting purposes and also may not collect genetic information with respect to an individual prior to enrollment.⁷⁹

GINA defines "genetic information" broadly to mean, with respect to an individual, information about: (a) the individual's genetic tests; (b) the genetic tests of family members of that individual; (c) the manifestation of a disease or disorder in family members of the individual; or (d) any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the individual or any family member of the individual.⁸⁰ A "genetic test" is "an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes."⁸¹ Lastly, "underwriting purposes" is defined to include, among other things, rules for eligibility, computation of premiums, application of pre-existing condition exclusions, and "other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits."⁸²

Of special concern to many employers is how GINA will impact their implementation of wellness programs and health risk assessments. This is because many health risk assessments ask a wide range of health-related questions that often include questions about an employee's family health history. Such information constitutes "genetic information" under GINA. Under GINA, a group health plan may not collect genetic information for underwriting purposes, nor may it collect genetic information with respect to any individual prior to that individual's effective date of coverage under the plan.⁸³ The interim regulations set forth numerous examples of how this prohibition impacts health risk assessments. In sum, if a health risk assessment seeks information about an individual's family history, *and* if completing the health risk assessment will result in a premium reduction, then the group health plan is impermissibly collecting genetic information for underwriting purposes. On the other hand, if completing the health risk assessment has *no* impact on premiums (or any other underwriting purpose) and its completion is not required prior to or as a condition for enrollment in the group health plan, then collecting the family history would not be prohibited by GINA.⁸⁴ At the end of this paper in Appendix B, we have set forth the examples in the regulations related to the use of genetic information in relation to health risk assessments.

⁷⁹ PHSA § 2705.

⁸⁰ 45 C.F.R. § 146.122(a)(3).

⁸¹ 45 C.F.R. § 146.122(a)(5).

⁸² 45 C.F.R. § 146.122 (d)(1)(ii).

⁸³ 45 C.F.R. § 146.122(d).

⁸⁴ 45 C.F.R. § 146.122 (d)(3).

The EEOC recently challenged a wellness program that imposed a tobacco surcharge on employees whose spouses did not participate in a wellness program as violating GINA. See the discussion of the *Honeywell* litigation in the preceding section for a discussion of these allegations.

IV. TAXATION OF WELLNESS PROGRAM REWARDS

Providing rewards to participants in a wellness program may result in the requirement to include the value of those rewards in the participants' income. This will be a very fact sensitive question depending on the reward provided. Following are some guidelines based on various examples of wellness program rewards:

- Premium reductions or holidays: To the extent that the costs paid by the employer for an employee's or retiree's health coverage are excluded from income by Internal Revenue Code ("Code") Section 106, and to the extent that an employee's or retiree's own contributions toward health coverage are excluded by Code Section 104, any premium reduction or holiday should not result in taxable income to the employee or the retiree.
- Contributions to a health care flexible spending account ("FSA"), a health reimbursement arrangement ("HRA"), or a health savings account ("HSA"): Contributions to a health care FSA, an HRA, or an HSA by an employer are regarded as providing health care coverage; thus, contributions made as a reward in the context of a wellness program should not be included in income under Code Section 106. However, before an employer chooses to make wellness program reward contributions to an FSA, HRA, or HSA, it should carefully consider the potential nondiscrimination issues associated with making such contributions to some employees, but not others. Those rules are beyond the scope of this paper, but in general, can be found at Code Section 125 (for FSAs and HSAs), Code Section 105(h) (for HRAs), and Code Section 4980G (for HSAs).
- Discounted gym/fitness club memberships, prizes from rewards catalogues, extra vacation days, cash, airline tickets, theater tickets, and similar rewards: Unless an exception can be found in the Code (such as the exception under Code Section 106 for health coverage), an employee's gross income includes "all income from whatever source derived, including . . . (1) Compensation for services, including fees, commissions, fringe benefits, and similar items."⁸⁵ The provision of an incentive or reward for complying with certain personal health goals in a wellness program would most likely be considered a taxable fringe benefit of employment. Fringe benefits that enjoy tax-preferred status include: working condition fringes, no-additional-cost services, qualified employee discounts, line of business limitations, *de minimis* fringes, employer-operated eating facilities, and qualified transportation fringes.⁸⁶ To qualify for the tax-preferred status, each of these fringe benefits must meet a number of requirements.

The "*de minimis*" fringe benefit exclusion is often used (and misused) to exclude rewards to employees from income. According to Treasury Regulations governing fringe benefits:

Gross income does not include the value of a *de minimis* fringe provided to an employee. The term "*de minimis* fringe" means any property or service the value of which is (after taking into account the frequency with which similar fringes are provided by the employer to the employer's employees) so small as to make accounting for it unreasonable or administratively impracticable.⁸⁷

In general, if a fringe benefit is provided to a single employee frequently, but not to other employees, the benefit is taxable to that employee. Similarly, if a benefit is not necessarily utilized by an employee very often,

⁸⁵ 26 U.S.C. § 61(a).

⁸⁶ See generally 26 U.S.C. § 132.

⁸⁷ 26 C.F.R. § 1.132-6(a).

but is made available to a large percentage of the employee population as a whole, the benefit would be taxable to the entire employee population, even if a given single employee uses the benefit only infrequently.⁸⁸

The ability of an employer to account for, or value, the benefit is also an important factor in whether a fringe benefit is taxable. In general, if a benefit is reasonably susceptible to an accounting, it is taxable. Relevant Treasury Regulations state:

Unless excluded by a provision of chapter 1 of the Internal Revenue Code of 1986 other than section 132(a)(4), the value of any fringe benefit that would not be unreasonable or administratively impracticable to account for is includible in the employee's gross income. Thus, except as provided in paragraph (d)(2) of this section [relating to occasional meal money or local transportation fare], the provision of any cash fringe benefit is never excludable under section 132(a) as a *de minimis* fringe benefit. Similarly except as otherwise provided in paragraph (d) of this section, a cash equivalent fringe benefit (such as a fringe benefit provided to an employee through the use of a gift certificate or charge or credit card) is generally not excludable under section 132(a) even if the same property or service acquired (if provided in kind) would be excludable as a *de minimis* fringe benefit. For example, the provision of cash to an employee for a theatre ticket that would itself be excludable as a *de minimis* fringe (see paragraph (e)(1) of this section) is not excludable as a *de minimis* fringe.⁸⁹

The Treasury Regulations go on to provide a number of examples of items that are taxable fringe benefits, and those that are not:

(1) Benefits excludable from income. Examples of *de minimis* fringe benefits are occasional typing of personal letters by a company secretary; occasional personal use of an employer's copying machine, provided that the employer exercises sufficient control and imposes significant restrictions on the personal use of the machine so that at least 85 percent of the use of the machine is for business purposes; occasional cocktail parties, group meals, or picnics for employees and their guests; traditional birthday or holiday gifts of property (not cash) with a low fair market value; occasional theater or sporting event tickets; coffee, doughnuts, and soft drinks; local telephone calls; and flowers, fruit, books, or similar property provided to employees under special circumstances (*e.g.*, on account of illness, outstanding performance, or family crisis).

(2) Benefits not excludable as *de minimis* fringes. Examples of fringe benefits that are not excludable from gross income as *de minimis* fringes are: season tickets to sporting or theatrical events; the commuting use of an employer-provided automobile or other vehicle more than one day a month; membership in a private country club or athletic facility, regardless of the frequency with which the employee uses the facility; employer-provided group-term life insurance on the life of the spouse or child of an employee; and use of employer-owned or leased facilities (such as an apartment, hunting lodge, boat, etc.) for a weekend. . . .⁹⁰

Thus, many rewards that an employer might consider for compliance with a wellness program (such as gift cards, frequent flier miles, and tickets) would be taxable to the recipient employee. On the other hand, premium discounts, premium holidays, and reductions in deductibles should not result in taxable income.

⁸⁸ 26 C.F.R. § 1.132-6(b).

⁸⁹ 26 C.F.R. § 1.132-6(c).

⁹⁰ 26 C.F.R. § 1.132-6(e)(1) – (2).

V. PRIVACY ISSUES

A. Health Information Privacy

The Privacy Rule issued under HIPAA⁹¹ governs how a health plan may use and disclose protected health information ("PHI"). The information provided via a wellness program should be treated like any other PHI received by a health plan and should be protected under the Privacy Rule. For example, the information should only be used and disclosed for purposes related to operating the wellness program. This means that access to the PHI should be restricted to the people who are directly related to administering the program. Similarly, the information should not be used for any employment-related decisions or any other benefit-related decisions. Any use or disclosure of the PHI outside of the program should be disclosed and authorized by the participant. All employers who maintain health plans and/or wellness programs should undergo an analysis of their use and disclosure of PHI from the plan or program and they also need to have in place a HIPAA compliance program. Employers sponsoring wellness programs should also consult with state law to determine whether state laws restrict the uses and disclosures of health information in connection with wellness programs.

Employers also need to be aware of privacy obligations they may have under the ADA. To the extent that the wellness program is not subject to HIPAA, it must still comply with the ADA requirement to keep employees' medical information confidential. In general, the ADA requires that any information obtained "regarding the medical condition or history of any employee shall be collected and maintained on separate forms and in separate medical files and be treated as a confidential medical record."⁹² Exceptions apply when there is a need to provide accommodations to an employee, when emergency medical care may be required, and in the case of governmental investigations.⁹³ In the normal course of business, however, an employer needs to have the procedures in place to keep information obtained through its wellness program confidential and completely separate from employee personnel files.

B. Smokers' Rights Laws

When designing a wellness program, an employer may also need to take into consideration state laws, notably state "lifestyle" laws. These laws have been passed in a number of states and prevent employers from penalizing employees for their lifestyle choices and their behavior outside of the workplace. The most common of these kinds of laws are those that prevent employers from discriminating against employees with regard to the terms and conditions of their employment (including in benefit plans) because of employees' off-duty use of tobacco products. A wellness program that imposes penalties for individuals who smoke could run afoul of such a law. Employee benefit plans that are subject to ERISA would likely enjoy preemption from such laws. Plans exempt from ERISA, however, such as governmental plans, must be aware of state law prohibitions on these types of programs.

VI. ONSITE HEALTH CLINICS

Fifty years ago, a sick or injured worker in a manufacturing plant did not have to leave work to get health care – the worker simply went to the plant clinic and saw the company doctor. Today, the idea of the company clinic is making a come back, but with a new emphasis on wellness and prevention. In addition to simply implementing wellness programs, an increasing number of large employers also maintain onsite medical clinics for their employees.

Staffed by physicians, nurse practitioners, and health advocates, an onsite clinic's convenience can increase the likelihood of an employee seeing a health care provider for his or her medical needs. Maintaining the

⁹¹ See 45 C.F.R. Parts 160 and 164.

⁹² 29 C.F.R. § 1630.14.

⁹³ *Id.*

clinic can reduce the employer's health plan costs for physician and emergency room visits, while reducing absenteeism associated with minor illnesses that go untreated. In addition, patient loads in onsite clinics are usually lower than in a family doctor's office, allowing onsite clinic providers to spend more time with their patients discussing health recommendations and concerns. For these reasons, the convenience of onsite clinics to employees can promote the prevention, detection, and early treatment of serious conditions.

A. The Integration of Onsite Clinics with an Employer's Wellness Initiatives

Today's onsite clinics are often an integral part of employers' larger wellness initiatives. These clinics can provide wellness screenings, administer tobacco cessation programs, develop personalized health coaching plans, and might even offer lunchtime seminars on diabetes management or stress reduction. Employees at high risk for disease can receive onsite preventative coaching and have their health conveniently monitored. For example, a diabetic employee could have a standing weekly appointment during her break to have her blood sugar checked. An employer might even offer a premium discount to employees who visit the clinic once per quarter for regular cholesterol, blood pressure, or other wellness screenings, or charge a lower co-pay to employees under the employer's health plan for onsite clinic visits than for visits to their family physician's office.

B. General Legal Risks

When setting up onsite clinics, employers should be aware of potential legal risks. First – and foremost in many employees' minds – is the privacy of employee health information. The privacy and security regulations of HIPAA may apply to the onsite clinic's health data, as well as confidentiality restrictions under the ADA. Extreme care must be taken to ensure that the clinic's health data is confidentially maintained, is used only for clinic and wellness program purposes, and is not disclosed to the employer to make employment-related decisions such as hiring, termination, and promotion decisions.

Second, the employer must determine how to staff the clinic. If the employer intends to employ the clinic staff, it must be aware of the medical malpractice liabilities and regulatory burdens it might face. Often employers will contractually engage a clinic vendor or independent health care provider to staff and manage the clinic and to take the risk for these liabilities. Ensuring that the clinic's providers are properly licensed and credentialed, are screened, and maintain appropriate medical malpractice insurance are critical issues. In addition, the employer must ensure that non-physicians are properly supervised by a physician medical director and that a physician is on-call to handle emergencies. The agreement must also clearly address how medical records are created, maintained, stored, and secured in compliance with HIPAA. Furthermore, any agreement should clearly set forth hours of operation, the scope of services to be provided at the clinic, whether medications and controlled substances will be distributed at the clinic and with procedures in place to comply with all regulatory requirements pertaining to such substances, and the health care providers' indemnification obligations to the employer in the event the employer is liable for the providers' negligence.

C. Effect of Onsite Clinic Services on HSA Eligibility

If an employer offers its employees a high deductible health plan ("HDHP"), those employees who participate in the HDHP may generally make contributions to a health savings account ("HSA") to help pay for their medical expenses on a tax-favorable basis. However, participation in an HDHP is not the only criterion for being an "eligible individual" for purposes of making HSA contributions.⁹⁴ An individual not only must be enrolled in an HDHP, but such individual may not be covered under any other health plan that is not an HDHP and that provides coverage for any benefit that is covered under the HDHP. This requirement raises questions as to an individual's HSA eligibility in the context of an employer offering coverage to its employees at an onsite clinic.

Through a series of guidance documents, the Internal Revenue Service ("IRS") has fine-tuned the definition of "eligible individual" and the kinds of non-HDHP coverage in which an eligible individual may or

⁹⁴ See 26 U.S.C. § 223.

may not participate. Specifically with respect to onsite clinics, Notice 2008-59 states that if free or discounted health care services are available to employees at such clinics, the availability of such care might render the individual ineligible to make HSA contributions. The guidance specifically states:

Q-10. Is an otherwise eligible individual who has access to free health care or health care at charges below fair market value from a clinic on an employer's premises an eligible individual under § 223(c)(1)?

A-10. An individual will not fail to be an eligible individual under § 223(c)(1)(A) merely because the individual has access to free health care or health care at charges below fair market value from an employer's on-site clinic if the clinic does not provide significant benefits in the nature of medical care (in addition to disregarded coverage or preventive care).

Example 1. A manufacturing plant operates an on-site clinic that provides the following free health care for employees: (1) physicals and immunizations; (2) injecting antigens provided by employees (e.g., performing allergy injections); (3) a variety of aspirin and other nonprescription pain relievers; and (4) treatment for injuries caused by accidents at the plant.

The clinic does not provide significant benefits in the nature of medical care in addition to disregarded coverage or preventive care.

Example 2. A hospital permits its employees to receive care at its facilities for all of their medical needs. For employees without health insurance, the hospital provides medical care at no charge. For employees who have health insurance, the hospital waives all deductibles and co-pays.

Because the hospital provides significant care in the nature of medical services, the hospital's employees are not eligible individuals under § 223(c)(1)(A).⁹⁵

As illustrated by these examples, if an onsite health clinic provides care beyond very routine insignificant services at rates below fair market value, the availability of that coverage to an employee will make that employee ineligible for HSA contributions.

VII. **CONCLUSION**

As the growth of health care costs continues to outpace inflation, employers must search for new and innovative ways to control costs in order to be able to continue offering their employees health care coverage. Wellness programs can be a useful tool in this endeavor by aiming to reduce overall claims costs while promoting wellness and encouraging healthy lifestyles amongst employees. By providing rewards to employees for achieving certain health goals or participating in health promotion activities, employers can contribute to the quality of life of their employees and enjoy greater productivity and lower costs at the same time. Larger employers who choose to establish an onsite medical clinic may see even more positive results. By complying with the legal requirements described in this paper, such as HIPAA nondiscrimination and privacy rules, GINA, and the ADA, an employer can be on its way to a healthier and hopefully more affordable workforce.

⁹⁵ IRS Notice 2008-59.

APPENDIX A

EXAMPLES FROM FINAL WELLNESS PROGRAM REGULATIONS

(See 45 C.F.R. § 146.121(f))

Activity-Only Wellness Programs

The provisions of the regulations governing activity-only wellness programs are illustrated by the following example:

Example. (i) **Facts.** A group health plan provides a reward to individuals who participate in a reasonable specified walking program. If it is unreasonably difficult due to a medical condition for an individual to participate (or if 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.

(ii) **Conclusion.** In this Example, the program satisfies the requirements of paragraph (f)(3)(iii) of this section because the walking program is reasonably designed to promote health and prevent disease. The program satisfies the requirements of paragraph (f)(3)(iv) of this section because the reward under the program is available to all similarly situated individuals. It accommodates individuals for whom it is unreasonably difficult to participate in the walking program due to a medical condition (or for whom it would be medically inadvisable to attempt to participate) by providing them with the reward even if they do not participate in the walking program (that is, by waiving the condition). The plan also complies with the disclosure requirement of paragraph (f)(3)(v) of this section. Thus, the plan satisfies paragraphs (f)(3)(iii), (iv), and (v) of this section.

Outcome-Based Wellness Programs

The provisions of the regulations governing outcome-based wellness programs are illustrated by the following examples:

Example 1. Cholesterol screening with reasonable alternative standard to work with personal physician.

(i) **Facts.** A group health plan offers a reward to participants who achieve a count under 200 on a total cholesterol test. If a participant does not achieve the targeted cholesterol count, the plan allows the participant to develop an alternative cholesterol action plan in conjunction with the participant's personal physician that may include recommendations for medication and additional screening. The plan allows the physician to modify the standards, as medically necessary, over the year. (For example, if a participant develops asthma or depression, requires surgery and convalescence, or some other medical condition or consideration makes completion of the original action plan inadvisable or unreasonably difficult, the physician may modify the original action plan.) All plan materials describing the terms of the program include the following statement: "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." In addition, when any individual participant receives notification that his or her cholesterol count is 200 or higher, the notification includes the following statement: "Your plan offers a Health Smart program under which we will work with you and your doctor to try to lower your cholesterol. If you complete this program, you will qualify for a reward. Please contact us at [contact information] to get started."

(ii) **Conclusion.** In this Example 1, the program is an outcome-based wellness program because the initial standard requires an individual to attain or maintain a specific health outcome (a certain cholesterol level) to

obtain a reward. The program satisfies the requirements of paragraph (f)(4)(iii) of this section because the cholesterol program is reasonably designed to promote health and prevent disease. The program satisfies the requirements of paragraph (f)(4)(iv) of this section because it makes available to all participants who do not meet the cholesterol standard a reasonable alternative standard to qualify for the reward. Lastly, the plan also discloses in all materials describing the terms of the program and in any disclosure that an individual did not satisfy the initial outcome-based standard the availability of a reasonable alternative standard (including contact information and the individual's ability to involve his or her personal physician), as required by paragraph (f)(4)(v) of this section. Thus, the program satisfies the requirements of paragraphs (f)(4)(iii), (iv), and (v) of this section.

Example 2. Cholesterol screening with plan alternative and no opportunity for personal physician involvement.

(i) Facts. Same facts as Example 1, except that the wellness program's physician or nurse practitioner (rather than the individual's personal physician) determines the alternative cholesterol action plan. The plan does not provide an opportunity for a participant's personal physician to modify the action plan if it is not medically appropriate for that individual.

(ii) Conclusion. In this Example 2, the wellness program does not satisfy the requirements of paragraph (f)(4)(iii) of this section because the program does not accommodate the recommendations of the participant's personal physician with regard to medical appropriateness, as required under paragraph (f)(4)(iv)(C)(3) of this section. Thus, the program is not reasonably designed under paragraph (f)(4)(iii) of this section and is not available to all similarly situated individuals under paragraph (f)(4)(iv) of this section. The notice also does not provide all the content required under paragraph (f)(4)(v) of this section.

Example 3. Cholesterol screening with plan alternative that can be modified by personal physician.

(i) Facts. Same facts as Example 2, except that if a participant's personal physician disagrees with any part of the action plan, the personal physician may modify the action plan at any time, and the plan discloses this to participants.

(ii) Conclusion. In this Example 3, the wellness program satisfies the requirements of paragraph (f)(4)(iii) of this section because the participant's personal physician may modify the action plan determined by the wellness program's physician or nurse practitioner at any time if the physician states that the recommendations are not medically appropriate, as required under paragraph (f)(4)(iv)(C)(3) of this section. Thus, the program is reasonably designed under paragraph (f)(4)(iii) of this section and is available to all similarly situated individuals under paragraph (f)(4)(iv) of this section. The notice, which includes a statement that recommendations of an individual's personal physician will be accommodated, also complies with paragraph (f)(4)(v) of this section.

Example 4. BMI screening with walking program alternative.

(i) Facts. A group health plan will provide a reward to participants who have a body mass index (BMI) that is 26 or lower, determined shortly before the beginning of the year. Any participant who does not meet the target BMI is given the same discount if the participant complies with an exercise program that consists of walking 150 minutes a week. Any participant for whom it is unreasonably difficult due to a medical condition to comply with this walking program (and any participant for whom it is medically inadvisable to attempt to comply with the walking program) during the year is given the same discount if the participant satisfies an alternative standard that is reasonable taking into consideration the participant's medical situation, is not unreasonably burdensome or impractical to comply with, and is otherwise reasonably designed based on all the relevant facts and circumstances. All plan materials describing the terms of the wellness program include the following statement: "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.)" Participant E is unable to achieve a BMI that is 26 or lower within the plan's timeframe and receives notification that complies with

paragraph (f)(4)(v) of this section. Nevertheless, it is unreasonably difficult due to a medical condition for E to comply with the walking program. E proposes a program based on the recommendations of E's physician. The plan agrees to make the same discount available to E that is available to other participants in the BMI program or the alternative walking program, but only if E actually follows the physician's recommendations.

(ii) Conclusion. In this Example 4, the program is an outcome-based wellness program because the initial standard requires an individual to attain or maintain a specific health outcome (a certain BMI level) to obtain a reward. The program satisfies the requirements of paragraph (f)(4)(iii) of this section because it is reasonably designed to promote health and prevent disease. The program also satisfies the requirements of paragraph (f)(4)(iv) of this section because it makes available to all individuals who do not satisfy the BMI standard a reasonable alternative standard to qualify for the reward (in this case, a walking program that is not unreasonably burdensome or impractical for individuals to comply with and that is otherwise reasonably designed based on all the relevant facts and circumstances). In addition, the walking program is, itself, an activity-only standard and the plan complies with the requirements of paragraph (f)(3) of this section (including the requirement of paragraph (f)(3)(iv) that, if there are individuals for whom it is unreasonably difficult due to a medical condition to comply, or for whom it is medically inadvisable to attempt to comply, with the walking program, the plan provide a reasonable alternative to those individuals). Moreover, the plan satisfies the requirements of paragraph (f)(4)(v) of this section because it discloses, in all materials describing the terms of the program and in any disclosure that an individual did not satisfy the initial outcome-based standard, the availability of a reasonable alternative standard (including contact information and the individual's option to involve his or her personal physician) to qualify for the reward or the possibility of waiver of the otherwise applicable standard. Thus, the program satisfies the requirements of paragraphs (f)(4)(iii), (iv), and (v) of this section.

Example 5. BMI screening with alternatives available to either lower BMI or meet personal physician's recommendations.

(i) Facts. Same facts as Example 4 except that, with respect to any participant who does not meet the target BMI, instead of a walking program, the participant is expected to reduce BMI by one point. At any point during the year upon request, any individual can obtain a second reasonable alternative standard, which is compliance with the recommendations of the participant's personal physician regarding weight, diet, and exercise as set forth in a treatment plan that the physician recommends or to which the physician agrees. The participant's personal physician is permitted to change or adjust the treatment plan at any time and the option of following the participant's personal physician's recommendations is clearly disclosed.

(ii) Conclusion. In this Example 5, the reasonable alternative standard to qualify for the reward (the alternative BMI standard requiring a one-point reduction) does not make the program unreasonable under paragraph (f)(4)(iii) or (iv) of this section because the program complies with paragraph (f)(4)(iv)(C)(4) of this section by allowing a second reasonable alternative standard to qualify for the reward (compliance with the recommendations of the participant's personal physician, which can be changed or adjusted at any time). Accordingly, the program continues to satisfy the applicable requirements of paragraph (f) of this section.

Example 6. Tobacco use surcharge with smoking cessation program alternative.

(i) Facts. In conjunction with an annual open enrollment period, a group health plan provides a premium differential based on tobacco use, determined using a health risk assessment. The following statement is included in all plan materials describing the tobacco premium differential: "Stop smoking today! We can help! If you are a smoker, we offer a smoking cessation program. If you complete the program, you can avoid this surcharge." The plan accommodates participants who smoke by facilitating their enrollment in a smoking cessation program that requires participation at a time and place that are not unreasonably burdensome or impractical for participants, and that is otherwise reasonably designed based on all the relevant facts and circumstances, and discloses contact information and the individual's option to involve his or her personal physician. The plan pays for the cost of participation in the smoking cessation program. Any participant can avoid the surcharge for the plan year by participating in the program, regardless of whether the participant stops smoking, but the plan can require a participant who wants to avoid the surcharge in a subsequent year to complete the smoking cessation program

again.

(ii) Conclusion. In this Example 6, the premium differential satisfies the requirements of paragraphs (f)(4)(iii), (iv), and (v). The program is an outcome-based wellness program because the initial standard for obtaining a reward is dependent on the results of a health risk assessment (a measurement, test, or screening). The program is reasonably designed under paragraph (f)(4)(iii) because the plan provides a reasonable alternative standard (as required under paragraph (f)(4)(iv) of this section) to qualify for the reward to all tobacco users (a smoking cessation program). The plan discloses, in all materials describing the terms of the program, the availability of the reasonable alternative standard (including contact information and the individual's option to involve his or her personal physician). Thus, the program satisfies the requirements of paragraphs (f)(4)(iii), (iv), and (v) of this section.

Example 7. Tobacco use surcharge with alternative program requiring actual cessation.

(i) Facts. Same facts as Example 6, except the plan does not provide participant F with the reward in subsequent years unless F actually stops smoking after participating in the tobacco cessation program.

(ii) Conclusion. In this Example 7, the program is not reasonably designed under paragraph (f)(4)(iii) of this section and does not provide a reasonable alternative standard as required under paragraph (f)(4)(iv) of this section. The plan cannot cease to provide a reasonable alternative standard merely because the participant did not stop smoking after participating in a smoking cessation program. The plan must continue to offer a reasonable alternative standard whether it is the same or different (such as a new recommendation from F's personal physician or a new nicotine replacement therapy).

Example 8. Tobacco use surcharge with smoking cessation program alternative that is not reasonable.

(i) Facts. Same facts as Example 6, except the plan does not facilitate participant F's enrollment in a smoking cessation program. Instead the plan advises F to find a program, pay for it, and provide a certificate of completion to the plan.

(ii) Conclusion. In this Example 8, the requirement for F to find and pay for F's own smoking cessation program means that the alternative program is not reasonable. Accordingly, the plan has not offered a reasonable alternative standard that complies with paragraphs (f)(4)(iii) and (iv) of this section and the program fails to satisfy the requirements of paragraph (f) of this section.

Size of Reward

The provisions of the regulations which limit the size of the reward for health-contingent wellness programs are illustrated in the following examples:

Example 1. (i) Facts. An employer sponsors a group health plan. The annual premium for employee-only coverage is \$6,000 (of which the employer pays \$4,500 per year and the employee pays \$1,500 per year). The plan offers employees a health-contingent wellness program with several components, focused on exercise, blood sugar, weight, cholesterol, and blood pressure. The reward for compliance is an annual premium rebate of \$600.

(ii) Conclusion. In this Example 1, the reward for the wellness program, \$600, does not exceed the applicable percentage of 30 percent of the total annual cost of employee-only coverage, \$1,800. ($\$6,000 \times 30\% = \$1,800$.)

Example 2. (i) Facts. Same facts as Example 1, except the wellness program is exclusively a tobacco prevention program. Employees who have used tobacco in the last 12 months and who are not enrolled in the plan's tobacco cessation program are charged a \$1,000 premium surcharge (in addition to their employee

contribution towards the *33192 coverage). (Those who participate in the plan's tobacco cessation program are not assessed the \$1,000 surcharge.)

(ii) Conclusion. In this Example 2, the reward for the wellness program (absence of a \$1,000 surcharge), does not exceed the applicable percentage of 50 percent of the total annual cost of employee-only coverage, \$3,000. ($\$6,000 \times 50\% = \$3,000$.)

Example 3. (i) Facts. Same facts as Example 1, except that, in addition to the \$600 reward for compliance with the health-contingent wellness program, the plan also imposes an additional \$2,000 tobacco premium surcharge on employees who have used tobacco in the last 12 months and who are not enrolled in the plan's tobacco cessation program. (Those who participate in the plan's tobacco cessation program are not assessed the \$2,000 surcharge.)

(ii) Conclusion. In this Example 3, 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 the applicable percentage of 50 percent of the total annual cost of employee-only coverage (\$3,000); and, tested separately, the \$600 reward for the wellness program unrelated to tobacco use does not exceed the applicable percentage of 30 percent of the total annual cost of employee-only coverage (\$1,800).

Example 4. (i) Facts. An employer sponsors a group health plan. The total annual premium for employee-only coverage (including both employer and employee contributions towards the coverage) is \$5,000. The plan provides a \$250 reward to employees who complete a health risk assessment, without regard to the health issues identified as part of the assessment. The plan also offers a Healthy Heart program, which is a health-contingent wellness program, with an opportunity to earn a \$1,500 reward.

(ii) Conclusion. In this Example 4, even though the total reward for all wellness programs under the plan is \$1,750 ($\$250 + \$1,500 = \$1,750$, which exceeds the applicable percentage of 30 percent of the cost of the annual premium for employee-only coverage ($\$5,000 \times 30\% = \$1,500$)), only the reward offered for compliance with the health-contingent wellness program (\$1,500) is taken into account in determining whether the rules of this paragraph (f)(5) are met. (The \$250 reward is offered in connection with a participatory wellness program and therefore is not taken into account.) Accordingly, the health-contingent wellness program offers a reward that does not exceed the applicable percentage of 30 percent of the total annual cost of employee-only coverage.

APPENDIX B

EXAMPLES FROM GINA REGULATIONS RELATED TO COLLECTING GENETIC INFORMATION IN CONNECTION WITH HEALTH RISK ASSESSMENTS

(See 45 C.F.R. § 146.121-1(d)(3))

Example 1. (i) Facts. A group health plan provides a premium reduction to enrollees who complete a health risk assessment. The health risk assessment is requested to be completed after enrollment. Whether or not it is completed or what responses are given on it has no effect on an individual's enrollment status, or on the enrollment status of members of the individual's family. The health risk assessment includes questions about the individual's family medical history.

(ii) Conclusion. In this Example 1, the health risk assessment includes a request for genetic information (that is, the individual's family medical history). Because completing the health risk assessment results in a premium reduction, the request for genetic information is for underwriting purposes. Consequently, the request violates the prohibition on the collection of genetic information in paragraph (d)(1) of this section.

Example 2. (i) Facts. The same facts as Example 1, except there is no premium reduction or any other reward for completing the health risk assessment.

(ii) Conclusion. In this Example 2, the request is not for underwriting purposes, nor is it prior to or in connection with enrollment. Therefore, it does not violate the prohibition on the collection of genetic information in this paragraph (d).

Example 3. (i) Facts. A group health plan requests that enrollees complete a health risk assessment prior to enrollment, and includes questions about the individual's family medical history. There is no reward or penalty for completing the health risk assessment.

(ii) Conclusion. In this Example 3, because the health risk assessment includes a request for genetic information (that is, the individual's family medical history), and requests the information prior to enrollment, the request violates the prohibition on the collection of genetic information in paragraph (d)(2) of this section. Moreover, because it is a request for genetic information, it is not an incidental collection under paragraph (d)(2)(ii) of this section.

Example 4. (i) Facts. The facts are the same as in Example 1, except there is no premium reduction or any other reward given for completion of the health risk assessment. However, certain people completing the health risk assessment may become eligible for additional benefits under the plan by being enrolled in a disease management program based on their answers to questions about family medical history. Other people may become eligible for the disease management program based solely on their answers to questions about their individual medical history.

(ii) Conclusion. In this Example 4, the request for information about an individual's family medical history could result in the individual being eligible for benefits for which the individual would not otherwise be eligible. Therefore, the questions about family medical history on the health risk assessment are a request for genetic information for underwriting purposes and are prohibited under this paragraph (d). Although the plan conditions eligibility for the disease management program based on

determinations of medical appropriateness, the exception for determinations of medical appropriateness does not apply because the individual is not seeking benefits.

Example 5. (i) Facts. A group health plan requests enrollees to complete two distinct health risk assessments (HRAs) after and unrelated to enrollment. The first HRA instructs the individual to answer only for the individual and not for the individual's family. The first HRA does not ask about any genetic tests the individual has undergone or any genetic services the individual has received. The plan offers a reward for completing the first HRA. The second HRA asks about family medical history and the results of genetic tests the individual has undergone. The plan offers no reward for completing the second HRA and the instructions make clear that completion of the second HRA is wholly voluntary and will not affect the reward given for completion of the first HRA.

(ii) Conclusion. In this Example 5, no genetic information is collected in connection with the first HRA, which offers a reward, and no benefits or other rewards are conditioned on the request for genetic information in the second HRA. Consequently, the request for genetic information in the second HRA is not for underwriting purposes, and the two HRAs do not violate the prohibition on the collection of genetic information in this paragraph (d).

Example 6. (i) Facts. A group health plan waives its annual deductible for enrollees who complete an HRA. The HRA is requested to be completed after enrollment. Whether or not the HRA is completed or what responses are given on it has no effect on an individual's enrollment status, or on the enrollment status of members of the individual's family. The HRA does not include any direct questions about the individual's genetic information (including family medical history). However, the last question reads, "Is there anything else relevant to your health that you would like us to know or discuss with you?"

(ii) Conclusion. In this Example 6, the plan's request for medical information does not explicitly state that genetic information should not be provided. Therefore, any genetic information collected in response to the question is not within the incidental collection exception and is prohibited under this paragraph (d).

Example 7. (i) Facts. Same facts as Example 6, except that the last question goes on to state, "In answering this question, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk."

(ii) Conclusion. In this Example 7, the plan's request for medical information explicitly states that genetic information should not be provided. Therefore, any genetic information collected in response to the question is within the incidental collection exception. However, the plan may not use any genetic information it obtains incidentally for underwriting purposes.

Example 8. (i) Facts. Issuer M acquires Issuer N. M requests N's records, stating that N should not provide genetic information and should review the records to excise any genetic information. N assembles the data requested by M and, although N reviews it to delete genetic information, the data from a specific region included some individuals' family medical history. Consequently, M receives genetic information about some of N's covered individuals.

(ii) Conclusion. In this Example 8, M's request for health information explicitly stated that genetic information should not be provided. Therefore, the collection of genetic information was within

the incidental collection exception. However, M may not use the genetic information it obtained incidentally for underwriting purposes.