Overview—Defined Contribution Health Plan

- “The term ‘defined contribution (DC) health plan’, in general, denotes a health plan in which the employer provides the participant a contribution of a fixed dollar amount, as opposed to a fixed benefit. In such a plan, any health care costs above the fixed dollar amount are the responsibility of the participant.

  DC plans can take many forms, from a plan in which the employer provides more dollars in the employee’s pay check that the employee can use to purchase health coverage on the open market, to a plan in which the employer provides a fixed dollar amount that can be spent by the employee on one of a variety of health plans selected and maintained by the employer. The role of the employer varies considerably in each of these designs, ranging from merely a variant of current employment-based plans to approaches in a completely different conceptual territory.”

  DOL ERISA Advisory Council

Overview—Defined Benefit Health Plan

“The term defined benefit employment-based health plan, in general, denotes a health plan in which the employer provides a determinable benefit which may be in the form of a reimbursement to the covered plan participant or a direct payment to providers or third-party insurers for the cost of specified services. This benefit can be self-insured (employees’ medical expenses are paid for by the employer), fully insured (benefits are paid through the direct payment of premiums to the insurance company by the employer) or a combination thereof.”

DOL ERISA Advisory Council
Overview—Consumer-directed health plans

- “Consumer-directed health plans (CDHP) are a hybrid type of defined contribution health and welfare plan virtually unknown until a few years ago…
  - Gaining acceptance as an interesting alternative health care product offered to employees.
  - Options vary widely, but, generally, the plans attempt to engage the participants more directly in the health care purchasing decisions by making them aware of the costs and providing them increased power to make decisions about their health care.”

  DOL ERISA Advisory Council

DC/CDHP Objectives

- In a consumer-directed plan, participants have more financial responsibility for the health care choices they make and are more involved in the selection of services and providers.
- Consumer-directed health plans attempt to shift greater responsibility for the cost and quality of services to the participant and away from the plan sponsor.
- The idea is that, if consumers are held financially responsible for the health care choices they make, they will increase their awareness of health care costs, and they will make cost-savvy choices for health care, thereby reducing the costs for the employee and, ultimately, the employer. This idea is also known as “health care consumerism”.

DC/CDHP Objectives (Cont.)

- In CDHC arrangements, incentives can be provided to employees to encourage awareness about consumption and accountability for their health care decisions.
- Both education and tools are provided to get consumers actively engaged.
- The concept behind CDHC plans is to promote greater self-reliance and use of self-service tools. CDHC plans attempt to encourage a healthier lifestyle and provide cost-saving benefits with the ability to accumulate savings for future health care needs.
- By providing the proper incentives, information, skills and tools, it is hoped that consumers will make informed decisions.
Comment from DOL Secretary

“The development of Consumer-Directed Health Care plans have the potential to impact the overall health care system. While CDHC arrangements may not ultimately be the “silver bullet” that some may hope they are as a vehicle for controlling health care costs, they do, they do have a potential to rearrange the incentives somewhat in the health care system. Employees eventually pay the cost for health care, either directly through higher premiums and cost sharing, or through lower wages offsetting higher premiums. There is, therefore, an incentive for employees to lower true health care costs, and rationalize health care spending. Engaging the consumer in health care decisions through more choice and providing more information should lead to better decision-making by participants.”
Phyllis Borzi, to ERISA Advisory Council
Donahue & Donahue, November 7, 2003

Barriers to Success Remain the Same Today

  - Dissatisfaction for those participants with chronic conditions;
  - Cost shifting to the less healthy employees
  - Participants may have out-of-pocket expenses that are difficult to budget;
  - Participants may not want the increased consumer role with decision-making responsibility;
  - Participants may skip necessary and/or preventive care in order to save money if personally responsible;
  - Participants may not have adequate sources from which to draw adequate information, or may not be able to use the available information due to inability to process information, illiteracy or language barriers.

The Point

- The issues and challenges regarding our current healthcare system remain the same as they have since the 1970’s.
- DC Health Plan models are just another method of trying to “bend the cost curve” to engage consumers to help control behavior and control costs.
- Medical FSA/Health reimbursement arrangement/health savings account arrangements have long been in place.
- The Patient Protection and Affordable Care Act of 2010 (“ACA”) hasn’t negated that need or concern, or the viability of DC/CDHP models as a preferred method of healthcare cost control.
  - **BUT, it HAS changed how DC health plan models can be utilized prospectively!!**
“Old” Defined Contribution Model

- Employer Contribution to Health Plan
- Health Reimbursement Arrangement (HRA)
- Health Savings Account (HSA)
- Individual Insurance Policy or Health Plan
- Medical FSA/Flex Credits to 125 Plan

ACA Changes to DC Plan Structures

- IRS Notice 2013-54 and EBSA FAQ XI eliminated the ability for employers to use an HRA or any other “employer payment plan” to pay for or reimburse the cost of individual insurance coverage, or make any employer contribution to any group health plan that is not compliant with the ACA.
  - Per the DOL guidance, an HRA will not satisfy the ACA mandates unless it is “integrated” with an ACA-compliant group health plan.

Impact of IRS Notice 2013-54

- Effective as of January 1, 2014 (or by July 1, 2015 for employers with less than 50 FTEs), any “employer payment plan” that facilitates the payment or reimbursement of premiums for major medical coverage in the individual market OR such other group health plan arrangement that is not ACA-compliant is prohibited.
  - Fine is $100 per violation/day.
- Exceptions:
  - Arrangements that qualify as ACA “excepted benefits”;
  - Arrangements limited to “non-employees” (e.g., retiree-only HRA plans are allowed).
Viability of DC Plan Models

- DC Plan models that provide a fixed dollar contribution to fund an HRA for retirees are still acceptable and growing in popularity.
  - Cannot benefit current employees, but can be prefunded for use only upon retirement.
- DC plan models that provide a fixed dollar contribution for “integrated” group medical coverage for actively enrolled participants in an HRA or other similar pre-funding arrangement.
  - Limited to copays and deductibles, generally.
  - Can be through a stand-alone, employer-managed plan OR through a separate private exchange arrangement.

Private Exchange Alternatives

- Employer “sponsors” group health plan coverage by agreeing to participate in a “private exchange” model.
- Employer provide employees with a fixed “defined contribution” amount to let the employees “purchase” group health coverage from a menu of several different plan options (similar to federal “Healthcare Marketplace” but usually with fewer options and without public subsidies).
- ACA-compliant coverage is provided through a private insurance carrier, or through a consulting organization or through other third parties who contract with insurance carriers to provide different coverages and medical provider networks for usage.
Design Options Vary by Product/Program

### Advantages

- Streamlined “one stop shopping” arrangement that allows employees to purchase health insurance and other voluntary benefit products through an online portal without employer involvement.
- Employer fixes its cost of healthcare spending with lower upfront costs of operation.
- Private exchange providers have comprehensive communication tools to educate consumers.
- Employee buys up or buys down from different health plan offerings that meet individual coverage responsibilities.

![Diagram showing number of medical plan choices recommended (and offered)]
BUT, Compliance is Still Required

- Pay/play impact still exists on an employer by employer basis
- Fiduciary oversight responsibility
- COBRA, HIPAA, ADEA age based limitations
- ERISA Requirements:
  - Plan Document/SPD
  - 5500, plan asset requirements
  - Notices – Medicare Part D, ACA notices
  - Potential Cadillac Tax Impact
  - Fiduciary oversight responsibility

Disadvantages

- Even though compliance burden remains, employers lose autonomy in plan design and carrier selection.
- Employee education is largely done online without employer involvement.
- Wellness initiatives can be “lost” without employer involvement.
- Cost “savings” may be short-lived based on adverse selection in plan design.

Popularity is Mixed
CDHP’s are Still an Option

- Even if Private Exchanges (or public exchanges) don’t succeed in the long-term, consumer-driven healthcare models remain available and a viable alternative.
- High deductible health plans and health savings account arrangements continue to be supported by the ACA and are still gaining in popularity.
  - Paired wellness and other cost-containment strategies still can succeed in engaging consumers in “bending the curve” in the manner intended over a decade ago.

Update on Wellness

- Background: HIPAA generally prohibits group health plans from discriminating against persons based on their health status:
  - A Plan cannot deny individuals eligibility for benefits because of a health factor
  - A Plan cannot charge individuals more for coverage because of a health factor

Wellness Program Exception to HIPAA Nondiscrimination Rules

- As a general rule, the HIPAA nondiscrimination rules do not prevent group health plans from establishing incentive-based wellness programs
- Two categories of wellness programs under HIPAA (and the level of compliance under each differs):
  1. Participation-Based Wellness Programs (no special restrictions on incentives)
  2. Health Contingent Wellness Programs (Add'l Reqmts)
    1. Activity-Based vs. Outcomes-Based
Participation-Based Wellness

- Participation-based programs do not condition a reward upon satisfaction of a standard related to a health factor
- Examples:
  - Program that reimburses costs of fitness center membership
  - Diagnostic testing program that provides reward for participation
  - Program that encourages preventive care through waiver of copayment/deductible for certain activities
  - Program that reimburses employees for the costs of smoking cessation programs without regard to whether employees quit smoking.

Health Contingent Wellness Programs

- Under HIPAA, “Health Contingent” wellness programs must:
  1. Be reasonably designed to promote health or prevent disease
  2. Provide an opportunity to qualify at least once per year
  3. Provide the award opportunity to all “similarly situated individuals”
  4. Limit the financial reward opportunity:
     - The reward must generally not exceed 30% of cost of coverage (if dependents may participate, reward limit can be measured as 30% of the cost of the family coverage)—can be up to 50% for tobacco use prevention.
  5. Permit individuals to achieve the reward through a “reasonable alternative standard”

Health Contingent Programs (Add'l Rqmts)

- For an “activity-based” wellness program (i.e., requires the completion of an activity related to a health factor to receive an award, such as smoking cessation), the Plan may seek verification from the individual's physician that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the applicable standard
- "Outcomes-based" wellness programs (those that require achievement of a specific health outcome) must accommodate for circumstances where actual results were not achieved, which cannot be conditioned on medical condition for any failure.
- In all plan materials describing the wellness program, the availability of the reasonable alternative standard must be disclosed (see Model Notice of Availability)
Other Non-HIPAA Requirements

- The Patient Protection and Affordable Care Act (PPACA) contains several provisions specifically relating to wellness programs.
- Other laws also apply to wellness programs:
  - Americans with Disabilities Act (ADA)
    - EEOC provides oversight and enforcement
  - Genetic Information Nondiscrimination Act (GINA)
  - Other Laws
    - Title VII (age, sex, race, religion), ADEA, FLSA, FMLA
    - ERISA (as an "employee benefit plan"), Internal Revenue Code

ADA Considerations

- Wellness programs often involve disability-related inquiries and medical examinations
- General Rule: Under the Americans with Disabilities Act (ADA), disability-related inquiries and medical examinations must be job-related and consistent with business necessity.
  - The employer must have a reasonable belief based on objective evidence that either:
    - an employee’s ability to perform an essential job function will be impaired by a medical condition; or
    - an employee will pose a direct threat due to a medical condition.
- ADA Considerations
  - Wellness programs tend to be implemented “across the board” without regard to an employer’s belief based on objective evidence.
    - EEOC believes that wellness programs do not typically meet the “job-related and consistent with business necessity standard.”
  - The ADA permits disability-related inquiries or medical examinations that are not job-related and consistent with business necessity provided they are voluntary.
    - Employer may not require participation nor penalize employees who choose not participate.
    - EEOC considered it a ADA violation to require an employee to complete an HRA as a condition of participation in an employer’s group health plan, or as a condition of receiving medical expense reimbursements from employer’s health reimbursement account.
**ADA: What Incentives Can be Considered?**

- Despite PPACA and other administrative support for wellness programs, EEOC is still unwilling to shift from its current position that the only way a wellness program can be utilized is when the program is truly voluntary:
  - EEOC generally accepts the premise of a "reward" based system (e.g., a premium discount) vs. a "penalty" (e.g., premium surcharge)
  - Questions remain as to whether the amount of any award vs. penalty has any impact over the "voluntary" nature of such rewards/penalties

---

**EEOC Wellness Update**

- On April 16, 2015, EEOC issued proposed rules in an effort to clarify its position on wellness:
  - Wellness programs can offer incentives of up to 30% of the cost of coverage (for employee-only coverage) and still be "voluntary";
    - Can’t require participation and can’t deny access or limit health coverage
- On December 31, 2015, one court struck down EEOC’s regulatory efforts, in EEOC v. Flambeau, Inc., Case No. 3:14-cv-00638-bbc (W.D. Wis. Dec. 31, 2015), by ruling that wellness programs that are part of a bona fide health plan are protected from ADA application. Stay Tuned!

---

**“Cadillac” Tax—Factory Recall Ahead?**

- As it stands now, beginning in 2020 (extended from 2018), any “high-cost plan” will be subject to a 40% excise tax if the cost of coverage under that group health plan exceeds the following thresholds:
  - Single: $10,200/year (i.e. >$850/mo.)
  - Family: $27,500/year (> $2,291/mo.)
- IRS has now issued two rounds of proposed guidance to clarify the plans and costs to be included (most recent issued July 31, 2015, with more feedback requested).
Summary of Current Guidance

- Health Plan “Costs”
  - Average cost for the health insurance plan (insured or self-insured)
  - Employer contribution to an HSA or HRA
  - **ALL contributions (including EE payroll deducted amounts) to a Flexible Spending Account (FSA)**
  - The value of (most) onsite clinics
  - Cost of tax-preferred “limited benefit” plans (e.g., dental and vision, etc.)

More Details from Current Guidance

- “Costs” are determined on an employee by employee basis (e.g., one employee with max’d FSA contributions could hit the threshold but another employee who didn’t elect FSA contributions may not);
- “Costs” are calculated on a monthly basis but “tax” is paid annually.
- Tax is paid on IRS Form 720

The Future

- Effective Date is still 4+ years away
- Bi-partisan support exists for amending/changing current law (2017 Budget Bill proposes immediate changes/revisions)
- If no changes were to be made, or an employer wishes to prepare today:
  - Increase deductibles/copays/coinsurance to reduce “cost”;
  - Cease employer HSA contributions, or phase out by 2018.
QUESTIONS?

Brian M. Johnston
(816)360-4319
bjohnston@polsinelli.com