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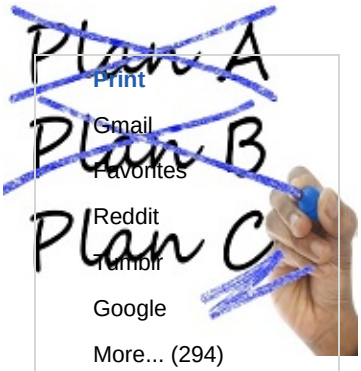
Impact of wellness incentives, flex credits and cash in lieu on affordability

Thursday, April 30, 2015 - David Flotten, JD, SPHR



Applicable large employers (ALEs) may be subject to “play or pay” penalties if the health coverage they offer to their full-time employees is not “affordable.” Coverage is affordable if the cost of single coverage on the lowest-cost, minimum-value (MV) plan available to that employee (“cost of coverage”) is less than 9.56% (2015) of the employee’s household income. Alternatively, the coverage will be deemed affordable if the cost of coverage meets one of three affordability safe harbors.

In this blog post, we want to focus on how an employer determines the “cost of coverage.” Not only does the cost of coverage determine whether the coverage is affordable, but the employer must also typically report this cost of coverage on employees’ 1095Cs (register for an upcoming webcast on this topic) at the end of the year. That cost of coverage will also often be relevant when appealing any §1411 certifications the employer may receive.

A couple of key points to start with. The cost of coverage is:

1. The cost the employee **would** pay if the employee enrolled in single coverage on the lowest cost MV plan available to the employee
   - **Not** the amount the employee actually pays for whatever coverage they enroll in
2. The employee cost only
   - Not the total cost or the employer cost
3. A monthly cost
   - Per pay period contributions must be converted to a monthly amount
4. Specific to each employee based on the lowest cost single MV coverage available to that particular employee
   - If all employees are eligible for the same health plans at the same cost, then the cost of coverage will be the same for all employees – the lowest cost single MV coverage is the same for everyone. But if different employees are eligible for different health plans or are charged different amounts for health coverage, then the lowest cost single MV coverage will vary from one employee to the next.

Certain premium contribution structures raise unique issues when determining the cost of coverage.

Wellness incentives

Some employers offer wellness plans with premium incentives. The amount an employee pays for health coverage varies depending on whether the employee participated in certain wellness activities or achieved certain wellness-related outcomes (tobacco usage, body mass index, blood pressure, cholesterol, etc.).

When determining the cost of coverage, the employer may only take into account tobacco-related premium incentives (assume the employee is a non-tobacco user) and must disregard any non-tobacco related incentive (assume the employee did not participate in any other wellness activity or had the worst possible outcome). Because wellness incentives take many forms, applying these rules to specific plan designs is sometimes tricky. Contact your benefits consultant to discuss the specifics for your particular plan structure.

Defined contribution, total compensation and flex credit plans

Some employers offer a plan whereby employees are given a fixed amount of money (often referred to as flex credits) that can be applied towards the cost of some or all benefits, with the employee paying the balance of the cost for whichever benefits they elect. Employees may even be able to cash out any leftover flex credits.

The problem when it comes to cost of coverage is: How do you determine the **employee cost of single health coverage**? The employee cost is determined only after you apply the flex credit – but how much credit do you apply towards single health coverage as opposed to other available benefits?

There is no specific guidance under the premium subsidy or play or pay rules – but the issue is addressed under the individual mandate regulations ("§5000A regulations"). Under the §5000A regs, flex credits are only applied towards the cost of coverage if those flex credits:

1. Can be used to purchase minimum essential coverage (major medical coverage)
2. Can **only** be used to purchase benefits that pay for medical care as defined by §213 of the tax code
3. Cannot be received as taxable compensation (cash wages or additional PTO days)

Many flex credit plans will fail the last two requirements – for example, because the flex credits can be used to purchase non-medical benefits like disability or life insurance; or because unused credits can be cashed out. In that case, the cost of coverage will typically be the **total** cost of single health coverage on the lowest cost MV plan available – which may very well be unaffordable.

Employers with flex credit plans have to decide whether to take the conservative approach and apply the §5000A regulations or take the chance of branching out on their own to come up with some alternative method to apply the flex credits when reporting the cost of coverage.

Cash in lieu benefits

Finally, some employers offer employees a cash payment if they waive coverage under the health plan (cash in lieu). Here's the thing - a cash in lieu payment is a form of flex credit under the cafeteria plan. This has to be true or, for technical reasons, all eligible employees would be taxed on the cash in lieu payment, even if they enrolled in health insurance and didn't receive the cash.

But if a cash in lieu payment is really a flex credit, which by definition can be received as cash, then (applying the §5000A rules literally) that flex credit cannot be taken into account when determining the cost of coverage. In other words, the cash in lieu payment must be **added** to the employee premium cost when determining the cost of single coverage.

This isn't quite as crazy as it first seems. For example, assume Edna earns $3,000 per month. Single coverage on her employer's lowest cost MV health plan costs $100 a month paid through pre-tax payroll deductions. Employees who waive coverage receive a $75 per month cash in lieu payment.

- If Edna waives coverage, then her gross pay for the month is $3,075 ($3,000 + $75 cash in lieu payment)
- If Edna enrolls in single health coverage, then her gross pay for the month is $2,900 ($3,000 - $100 pretax premium deduction) – $175 **less** than she would earn if she waived coverage

In other words, the real cost to Edna of enrolling in single coverage is not just the $100 premium cost, but the $75 in additional compensation she has to forgo in order to do so.

Is this really what the agencies intended when they issued the §5000A regulations? No one is sure – additional clarification would be welcome. But it is a technically correct application of the §5000A rules. The most conservative course of action for an employer with a cash in lieu option is to add that cash in lieu amount to the single premium cost when reporting the cost of coverage.

For more information, contact us.