PATTON BOGGS LLP

JULY 3, 2013

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For more information, contact your Patton Boggs LLP attorney or the authors listed below.

ROSEMARY BECCHI
rbecchi@pattonboggs.com
202.457.5255

GREGG BUKSBAUM
gbuksbaum@pattonboggs.com
202.457.6153

MICHAEL CURTO
mcurto@pattonboggs.com
202.457.5611

MARTIE KENDRICK
mkendrick@pattonboggs.com
202.457.6520

ERICA KRAUS
ekraus@pattonboggs.com
202.457.4132

LARRY MAKEL
lmakel@pattonboggs.com
214.758.1560

DAVID MCLEAN
dmcclean@pattonboggs.com
214.758.3553

KAREN THIEL
kthiel@pattonboggs.com
202.457.5229

TODD TUTEN
ttuten@pattonboggs.com
202.457.5215

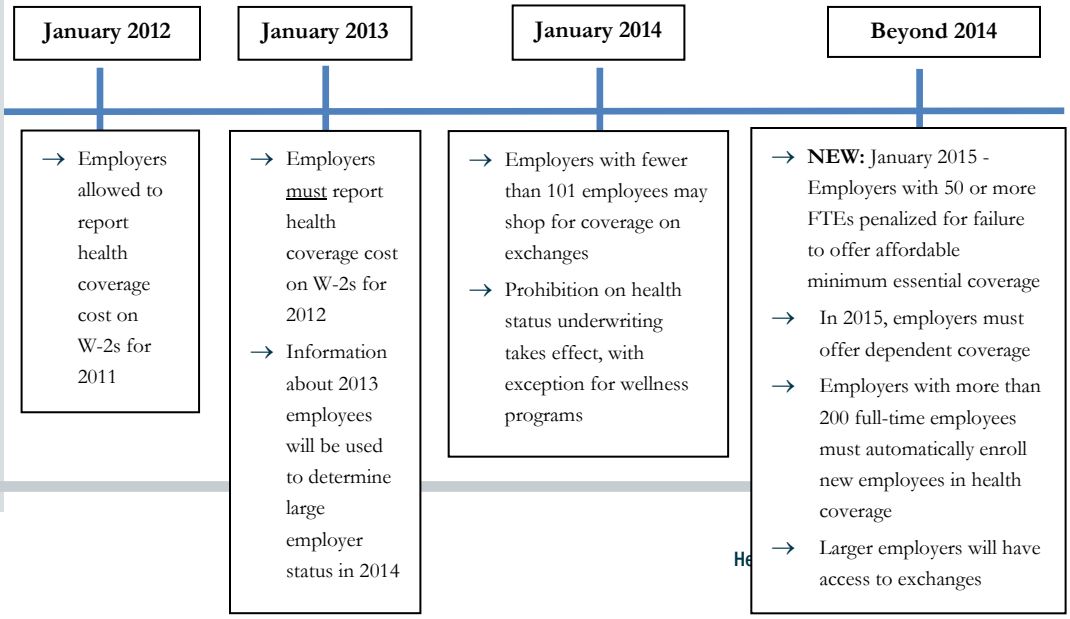
CLIENT ALERT

UPDATE: EMPLOYER RESPONSIBILITIES UNDER THE AFFORDABLE CARE ACT

ON JULY 2 THE OBAMA ADMINISTRATION ANNOUNCED A ONE YEAR DELAY OF REQUIREMENTS FOR LARGE EMPLOYERS (50 OR MORE FULL-TIME EMPLOYEES) TO REPORT THE HEALTH CARE COVERAGE THEY OFFER THEIR EMPLOYEES, AS WELL AS PENALTIES FOR FAILURE TO OFFER QUALIFIED INSURANCE. THE ADMINISTRATION ALSO ANNOUNCED A DELAY IN INFORMATION REPORTING REQUIREMENTS APPLICABLE TO INSURERS, SELF-INSURING EMPLOYERS, AND OTHER PARTIES THAT PROVIDE HEALTH COVERAGE.

Implementation of the Affordable Care Act (ACA) continues at an accelerated pace. Some of its most important provisions for employers are scheduled to take effect in January 2014. With the force of these provisions now less than a year away, employers need to understand their impact and begin to prepare now to comply with the new requirements. To assist in this effort, we have outlined some of the questions employers will face in preparing for January 2014 and how employers may approach these questions in light of the ACA's requirements. Note, however, that employers that self-insure are subject to an additional set of requirements not addressed here.

IMPORTANT ACA IMPLEMENTATION TIMELINES FOR EMPLOYERS



SHOULD MY COMPANY PROVIDE HEALTH INSURANCE COVERAGE TO EMPLOYEES?

In deciding whether to offer health insurance coverage, an employer must determine whether it is subject to the penalties imposed by ACA's employer responsibility provisions. If subject to the penalties, the employer should calculate the penalty it could face if it chooses not to offer coverage. An employer that is subject to penalties must take into account the potential penalty for not offering coverage, as compared to the cost of offering health coverage to employees, discounted by the value generated by providing the coverage in the form of its wage effects and its impact on employee health and satisfaction.

IS MY COMPANY SUBJECT TO PENALTIES?

The ACA imposes penalties only on large employers, defined to include employers with 50 or more full-time equivalent employees. To calculate full-time equivalent employees, use the following formula:

$$\text{Number of full–time employees} + \left[\frac{\text{Sum of the hours worked by each part-time employee in a month (up to 120 hours/employee)}}{120} \right]$$

Hours for part-time employees include both hours worked and hours paid while not working, for instance for paid vacation time. If this sum is equal to 50 or greater, your company will be subject to penalties if you do not offer health coverage AND any one of your full-time employees receives a federal premium tax credit to purchase coverage on an exchange. For example, for an employer with 45 full-time employees, and 20 part-time employees, each of whom works 110 hours per month, the number of full-time equivalent employees would be 45 + (2200/120), or 63.3. Because the employer's number of full-time equivalents exceeds 50, the employer would be an applicable large employer and would face penalties if any of its full-time employees receives a federal premium tax credit, even though it employs fewer than 50 full-time employees.

Some employees may be excluded from the calculation of full-time equivalent employees. These include seasonal employees - defined to include, but not limited to, agricultural workers who move from one seasonal activity to another - who work for 120 days or less, as well as retail employees who work only during the holidays. Further, an employer will not be considered a large employer if its number of full-time employees exceeds 50 for 120 days or less during the year. For instance, a student who works at a grocery store only during her school breaks, such that she works for the employer for 120 or fewer days during the year, would be excluded from the calculation of full-time equivalent employees for the purposes of determining large-employer status.

Further, only employees are included in determining large employer status. Self-employed owners, S-corp shareholders with ownership exceeding 2 percent, and independent contractors are all excluded from the calculation. Employers should be careful, however, to insure that independent contractors are correctly classified, as improperly excluding an employee from the large employer calculation adds risk to problems with independent contractor classification.

Employers that are not subject to penalties based on their number of full-time equivalent employees may still choose to offer health insurance to their employees. Employers should be aware, however, that their offer of affordable coverage may disqualify employees from receiving substantial federal subsidies to purchase health insurance on an Exchange.

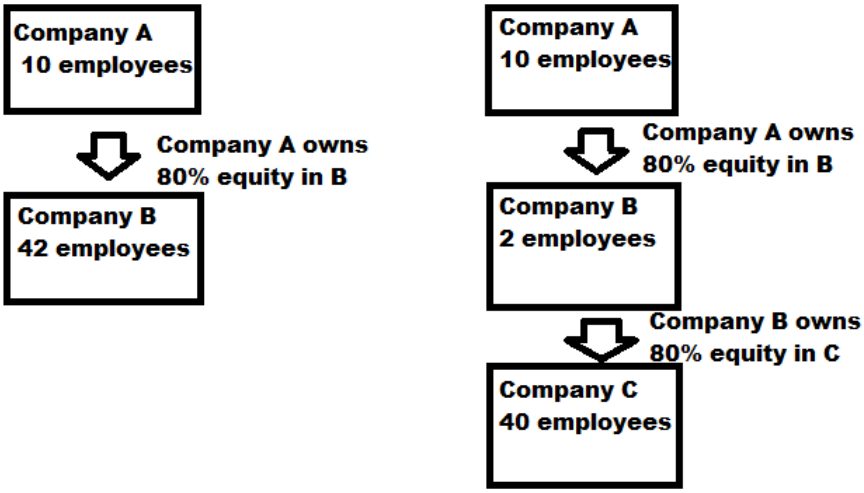
In calculating your number of full-time equivalent employees, be aware that the sum must include the employees of all entities in a "controlled group," as defined by Internal Revenue Code section 414. Your company may, therefore, be considered a large employer based on not only your employees but also the employees of your related entities. Section 414 defines controlled groups based on three types of relationships:

→ A controlled group exists based on a parent-subsidiary relationship when a parent organization owns 80 percent or more of the equity in a subsidiary. If your company owns 80 percent or more of the equity in another company, that company's employees will count toward your number of full-time equivalent employees for the purposes of determining large employer status. Further, if that subsidiary owns 80 percent or more of the equity in another company or companies, those companies' employees must also be included within your controlled group.

For example, consider the diagram on the next page. In the first structure, Company A has only 10 full-time equivalent employees. It owns 80 percent of the equity, however, in Company B, which has 42 full-time equivalent employees. Because A owns 80 percent of the equity in B, they are members of a controlled group and their full-time equivalent employees are combined for the purposes of determining whether they are large employers subject to penalties. Because their combined number of full-time equivalent employees is 52 and

therefore exceeds 50, each company may be subject to penalties if it does not provide qualifying health insurance for its full-time employees.

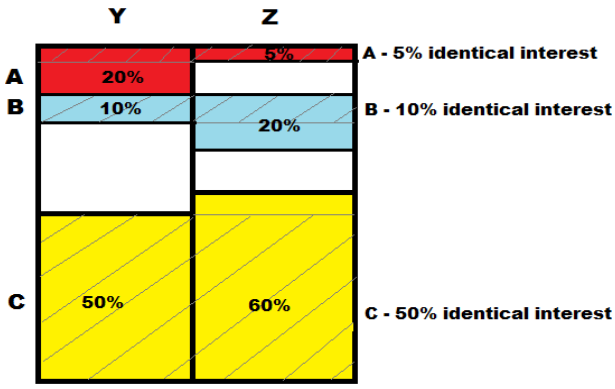
Similarly, in the second structure, Company A has only 10 full-time equivalent employees. Company B has only two full-time equivalent employees, so neither A nor B, nor A and B together as a controlled group, would qualify on their own as large employers. However, Company B owns 80 percent equity in Company C, which has 40 full-time equivalent employees. Because A owns 80 percent equity in B, which owns 80 percent equity in C, all three companies are members of a controlled group. Their employees, therefore, are added together when determining large employer status. Thus, although none of the three companies would qualify individually as an applicable large employer, each may be subject to a penalty if it does not offer qualifying health insurance because the controlled group has a combined total of 52 full-time equivalent employees. 26 USC 414(b), (c); 26 USC 1563(a).



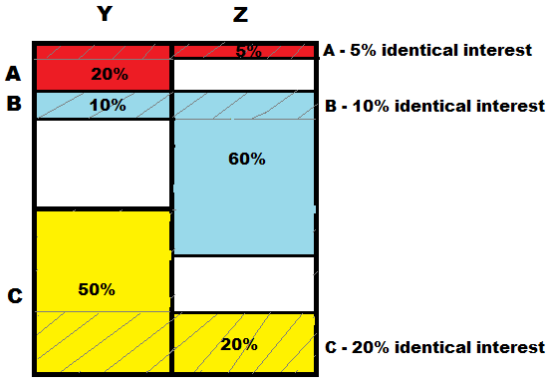
→ A controlled group exists based on a brother-sister relationship when the same five or fewer people, who must be individuals, trusts or estates, together own at least 80 percent of the equity in each of two organizations and at least 50 percent of the ownership of the organizations is identical. For instance, three individuals, A, B, and C, might own stock in two companies, Y and Z. Y and Z are members of a controlled group if A, B, and C collectively own 80 percent of each company and at least 50 percent of the ownership of the companies is identical. If A owns 20 percent of Y and five percent of Z, B owns 10 percent of Y and 20 percent of Z, and C owns 50 percent of Y and 60 percent of Z, Y and Z are members of a controlled group. A, B, and C collectively own 80 percent of Y and 85 percent of Z. Additionally, 65 percent of the ownership of Y and Z are identical – A's five percent interest in Z is mirrored in Y, B's 10 percent interest in Y is mirrored in Z, and C's 50 percent interest in Y is mirrored in Z. If, however, B and C's ownership interests are different, such

that B owns 10 percent of Y and 60 percent of Z and C owns 50 percent of Y and 20 percent of Z, Y and Z would not be members of a controlled group. Though A, B, and C would still collectively own 80 percent of both Y and Z, there would be only 35 percent identical ownership between the two companies. 26 USC 414(b), (c); 26 USC 1563(a).

Controlled Group



No Controlled Group



→ A controlled group also exists in the case of an "affiliated service group," where several service organizations regularly collaborate in the services they provide and are linked by at least 10 percent cross-ownership. 26 USC 414(m).

The IRS will offer a safe harbor from penalties to employers that offer coverage to at least 95 percent of their employees. An employer will still be subject to a penalty of $3,000, however, for each employee who is not offered coverage and receives a federal premium tax credit to purchase insurance on an exchange.

Given the complexity of the controlled group rules and the unique structure of every entity, including ownership arrangements, classes of stock and types of investors, fully understanding the implications of these controlled group rules may require employers to engage in additional research, analysis, and counsel.

HOW DO THE "CONTROLLED GROUP" TESTS IMPACT PRIVATE INVESTMENT FUNDS?

This "controlled group" analysis is especially critical when examining whether private investment funds and their individual portfolio company investments are subject to the penalties imposed by ACA. Based on the first of the above described relationship tests – the parent/subsidiary relationship – to the extent that any private investment fund owns at least 80 percent of the equity in a portfolio company, that private investment fund will technically be

aggregated with such portfolio company as part of a controlled group and prospectively subject to the penalties imposed by ACA. However, private investment funds, themselves (whether formed as limited partnerships, limited liability companies, offshore corporations or otherwise), generally do not actually have employees since they are only pools of capital, and those who manage (*i.e.,* "work for") a private investment fund are employed by the fund's sponsor and/or investment manager, which is a separate entity that does not, itself, have an ownership interest in the portfolio company under normal circumstances. Accordingly, to the extent a portfolio company has 50 or more full-time employees and a private investment fund with no employees owns at least 80 percent of the equity of that portfolio company, the private investment fund would be considered a large employer under the parent/subsidiary relationship test, but is not likely to be subject to penalties under ACA (the result may be different, however, in the rare case of a private investment fund that actually has employees). Nonetheless, there may be other consequences to a private investment fund that would impact its bottom line from an economic standpoint. For example, if any of its portfolio companies acquired other companies, the same controlled group analysis using the parent/subsidiary relationship test would be applied in connection with those acquisitions. As a result, a private investment fund could be aggregated with the subsidiaries of its portfolio companies if the 80 percent equity ownership threshold is met in relation to the acquired subsidiaries. Any penalties imposed on the portfolio companies and their subsidiaries under ACA could, therefore, have a negative impact on the private investment fund's returns.

Another important consideration occurs in the case of many different portfolio companies that are commonly owned by a single investment fund and whether these different portfolio companies would be aggregated to create a controlled group. In this case, the brother-sister relationship test may be applicable, depending on the ultimate ownership of the fund. The requirement for the brother-sister test is that the common owners must be individuals, trusts or estates and that the same five or fewer people own at least 80 percent of each organization (with at least 50 percent ownership being identical). The only way to trigger this test in the investment fund context would require a "look through" to the ultimate ownership of the investment fund. The rules are not abundantly clear in describing circumstances as to when such a look-through would be imposed. To the extent such a look-through were indeed prescribed, the nature and character of the investment fund's investors would need to be carefully examined. Accordingly, a private investment fund having an ownership structure that lines up with the test imposed by the brother-sister test *(i.e.*, 5 or fewer individuals holding greater than 80 percent of the investment fund with at least 50 percent ownership being identical) should carefully analyze this rule with its legal counsel. Alternatively, the typical private investment fund that has an investor base consisting of several public and private pensions and other institutional investors should not be captured by the brother-sister relationship test. Given the critical nature of this issue, however, it is highly recommended that all private investment funds consult with legal counsel in order to analyze the application of this rule to their unique circumstances.

HOW LARGE IS THE PENALTY MY COMPANY FACES FOR NOT OFFERING COVERAGE?

The penalty for failing to offer health insurance is $167 per month, multiplied by the number of full-time employees minus 30.

$167	X	(Number of full-time employees – 30)	=	Monthly Penalty

Note that an employer that qualifies as large based on its number of part-time employee hours, but does not have more than 30 full-time employees, will not be subject to a penalty for failing to offer coverage. Though employees of all members of a controlled group are counted together for the purpose of determining whether they are subject to penalties as applicable large employers, the penalty to which each member of a controlled group is subject accrues only against that member. For the purposes of calculating each member's penalty, the 30 employee reduction must be shared ratably across members of a controlled group. For example, consider a controlled group including three companies, X, Y, and Z. X has 150 employees, Y has 100 employees, and Z has 50 employees. In calculating the penalties to which each company would be subject, the 30 employee reduction must be divided among the companies proportionally to the number of employees each retains. In this case, X would apply a 15 employee reduction, because it employs half of the controlled group's 300 total employees, so receives half of the 30 employee reduction. X's monthly penalty, therefore, would be $167x(150-15), or $22,545. Y would apply a 10 employee reduction, proportional to its third of the controlled group's employees, so that Y's monthly penalty would be $167x(100-10), or $15,030. Z would apply a five employee reduction because it employs one sixth of the controlled group's employees, so that Z's monthly penalty would be $167x(50-5), or $7,515. The penalty for failure to offer coverage will increase each year based on the growth of insurance premiums.

HOW MUCH COVERAGE SHOULD MY COMPANY OFFER?

Employers face penalties if the coverage they offer their employees is not affordable or does not meet the standard for minimum essential coverage.

Coverage is considered affordable for an employee if the cost of his or her least expensive option for self-only coverage is not greater than 9.5 percent of his or her household income. The IRS has created several affordability safe harbors. An employee's coverage will be considered affordable if his or her lowest cost option costs 9.5 percent or

less of his or her W-2 income, his or her hourly rate x 130 hours per month, or the federal poverty line for a single individual.

Minimum essential coverage is based on a plan's actuarial value. To qualify as minimum essential coverage, a plan must pay for at least 60 percent, on average, of covered health benefits. The percentage of health benefits paid for by a plan, for minimum value purposes, is equal to a plan's anticipated spending on covered health benefits, computed in accordance with a plan's cost-sharing, divided by the anticipated allowed charges for essential health benefits for a standard population. The standard population is specified by HHS-issued continuance tables.

According to HHS proposed regulations, a plan's covered spending includes spending on all benefits included in any essential health benefits benchmark plan, and may be adjusted to account for other benefits based on an actuarial analysis. In calculating a plan's anticipated spending, the proposed regulations specify that reduced beneficiary cost-sharing associated with wellness program compliance cannot be taken into account, with the exception of reduced cost-sharing associated with programs to prevent or reduce smoking. Employer contributions to health savings accounts, and employer contributions to health reimbursement accounts that can be used only for cost-sharing, will be taken into account.

The proposed regulations offer employers three options for determining whether their plans meet minimum value requirements. Employers may use a calculator provided by HHS, or they may offer a plan that fits into one of several specified safe harbors. Alternatively, employers who offer plans with non-standard benefits may obtain an actuarial certification that their plans meet minimum value requirements.

MUST MY COMPANY OFFER COVERAGE TO EMPLOYEES' DEPENDENTS?

The ACA does require employers to offer dependent coverage to avoid responsibility penalties. Notably, however, the IRS has not defined dependents to include spouses. Employers, therefore, must offer coverage to the children of their employees, but not the spouses of their employees. Children of employees are defined to include biological or adopted children, stepchildren, and foster children. Coverage must be offered to employees' children up to age 26.

WHAT PENALTY DOES MY COMPANY FACE FOR OFFERING INSUFFICIENT COVERAGE?

The penalty is $3,000 annually for each full-time employee that receives a federal premium tax credit. An employer's total penalty is capped at $2,000 times its number of full-time employees reduced by 30. For example, an employer with 100 employees that offered insufficient coverage would have its penalty for insufficient coverage capped at (100-30) x $2,000, or $140,000. If one of its employees received a federal premium tax credit, the employer would be assessed a $3,000 annual penalty; if two of its employees received federal premium tax credits, its penalty would be $6,000; if three of its employees received federal premium tax credits it would be assessed a $9,000 annual penalty, and

so forth, until accrued penalties reached $140,000. The penalty for offering insufficient coverage will increase each year based on the growth of insurance premiums. Notably, federal premium tax credits are available only to households under 400 percent of the federal poverty line. Employers will not be penalized, therefore, for offering insufficient coverage to employees with household incomes exceeding 400 percent of the federal poverty line.

CAN MY COMPANY OFFER DIFFERENT COVERAGE OPTIONS TO DIFFERENT EMPLOYEES?

Employers are prohibited from offering coverage that favors highly compensated employees. Highly compensated employees are defined as the five highest paid officers in a company or anyone among the highest paid 25 percent of employees.

To avoid illegally favoring highly compensated employees, an employer's plan must benefit at least 70 percent of employees. The plan must also offer the same benefits provided to highly compensated employees to non-highly compensated participants in the plan. Further, this non-discrimination rule applies across an entire controlled group. Some plans that were in existence on March 23, 2010, however, may be grandfathered out of complying with these requirements.

An insured group health plan that fails to comply with these requirements will generally be subject to an excise tax of $100 per day of non-compliance for each employee who receives less favorable benefits (or an equivalent civil money penalty in the case of non-federal governmental group health plans), capped at the lesser of 10 percent of the cost of the group health plan or $500,000.

TO WHOM MUST I OFFER COVERAGE?

To avoid responsibility penalties, an employer must offer coverage to its full-time employees.

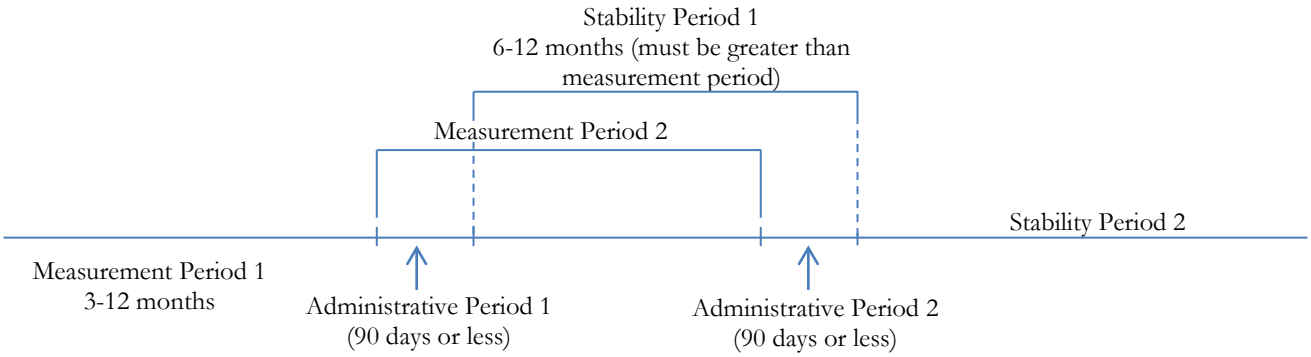
HOW DO I DETERMINE WHO IS AN EMPLOYEE?

Whether a worker is considered a company's employee will be determined based on common law standards. Though this determination is fact-specific, the IRS has issued guidance on employees hired through temporary employment or employee leasing agencies. Temporary employees hired through an agency may sometimes be considered employees of the temporary agency and sometimes employees of the client employer, depending on a 20 point test used by the IRS to determine the common law employer. Leased employees will be considered employees of the leasing company.

HOW DO I DETERMINE WHICH OF MY COMPANY'S EMPLOYEES WORK FULL TIME?

The ACA requires employers to offer coverage to their full-time employees, defined as employees who work 30 or more hours per week. The 30 hours includes both time worked and paid hours when no work is performed, including vacation, holidays, or paid leave. For employees not paid on an hourly basis, an employer may calculate hours based on actual hours of service, days worked times eight hours, or weeks worked times 40 hours.

To determine whether or not an employee works full time, an employer may look back at a standard measurement period of 3-12 consecutive months. If an employee has worked full time during the standard measurement period, he or she must then be offered health coverage for a stability period of 6-12 months that is at least as long as the standard measurement period. If the employee did not work full time during the standard measurement period, he or she need not be offered health coverage as a full-time employee during the stability period. Employers may use an administrative period of no more than 90 days after the end of the standard measurement period to identify full-time employees, but the period must overlap with the prior stability period



The IRS has made special provisions for employers who plan to adopt a 12-month measurement period followed by a 12-month stability period, because of the difficulty involved in establishing the first measurement period. These employers may use a transition measurement period of 6-12 months, beginning no later than July 1, 2013, and ending no earlier than January 1, 2014.

IF I HIRE A NEW EMPLOYEE, WHEN MUST I OFFER HIM OR HER COVERAGE?

An eligible employee who is reasonably expected to work full time when hired must generally be offered health coverage within ninety (90) days of his or her start date. All calendar days beginning on the enrollment date are counted, including weekends and holidays. If the 91st day is a weekend or holiday, the plan or issuer may choose to provide coverage earlier than the 91st day, but cannot provide an effective date of coverage later than the 91st day.

Different rules apply to hires who are variable hour or seasonal employees. An employee is considered a variable hour employee when it cannot be determined at the date of hire whether he or she can reasonably be expected to work an average of 30 hours per week or more. The term "seasonal employee" has not yet been defined for the purposes of determining whether an employee can reasonably be expected to work fulltime when he or she is hired. For the purposes of determining large employer status, the ACA refers to Department of Labor (DOL) regulations defining 'on a seasonal or other temporary basis' to describe an agricultural worker who moves from one seasonal activity to another, and also explicitly includes retail workers employed only during the holiday season. In the context of determining obligations to new employees, however, the IRS has provided that, at least through 2014, employers may use a reasonable good faith interpretation of seasonal employee.

For variable hour and seasonal employees, an employer may use an initial measurement period of 3-12 months to determine if a new employee averages 30 hours of work or more per week. If the employee works full time during the initial measurement period, he or she must be offered health coverage as a full-time employee for a subsequent stability period of the same length as or longer than the initial measurement period, but no shorter than six months. The employer may use an administrative period of no more than 12 months after the end of the measurement period to determine whether or not the employee has worked full time. The length of the measurement period and the administrative period combined, however, cannot extend beyond the final day of the first calendar month beginning on or after the one-year anniversary of the employee's start date.

BEYOND THE EMPLOYER RESPONSIBILITY PENALTIES, WHAT DOES THE ACA MEAN FOR MY COMPANY'S TAXES?

EXCHANGE NOTICE

No later than October 1, 2013, employers must provide notice to all employees, both full-time and part-time, explaining the State Exchanges, tax consequences of purchasing Exchange benefits, eligibility for premium assistance, and if the employer's plan is affordable and provides minimum value. The Department of Labor has published model notices for both employers that do and do not offer health coverage.

W-2 REPORTING

Beginning in January 2012 for the 2011 tax year, employers are allowed to report the cost of an employee's coverage under an employer-sponsored group health plan on the employee's W-2 form. Employers are required to report the cost of an employee's coverage under an employer-sponsored group health plan beginning with the W-2s issued in January 2013 for the 2012 tax year, although transition relief is available for some employers and for certain types of

coverage. For employers that filed fewer than 250 W-2s in the previous calendar year, employers furnishing W-2s to employees who terminate before the end of a calendar year and request early W-2s, and for reporting multi-employer plans, Health Reimbursement Arrangements, certain dental and vision plans, some self-insured plans, and employee assistance programs, the requirement to report coverage will not apply for the 2012 Forms, or for future calendar years until the IRS publishes guidance giving at least six months-notice of the change. The coverage cost information is provided for information purposes only, to help employees be better informed consumers of health coverage.

PAYROLL TAX

Beginning in 2013, an additional Medicare tax of 0.9 percent is being applied to wages for taxpayers with household incomes exceeding $250,000 for married taxpayers filing jointly, $125,000 for married taxpayers filing separately, and $200,000 for other taxpayers. Employers must withhold this additional tax from wages paid in excess of $200,000 in a calendar year. An individual who is expected to owe more should decrease his or her withholding exemptions or pay estimated taxes. An employee will determine the amount owed (or any refund or credit due) when the employee completes his or her income tax return. The additional Medicare tax also applies to self-employment income.

CHANGES TO FSAs, HSAs, AND MSAs

Beginning in 2011, the cost of an over-the-counter medicine purchased without a physician's prescription was excluded from reimbursement from a Flexible Spending Arrangement, Health Savings Account, or Archer Medical Savings Account. Additionally, beginning in 2013, salary reduction contributions to health flexible spending arrangements are limited to $2,500.

SMALL BUSINESS TAX CREDIT

The ACA created a tax credit for employers that have fewer than 25 full-time equivalent employees (calculated as described in the penalty section above), pay an average wage of less than $50,000 a year, and pay at least half of their employee health insurance premiums. Multiple entities may be treated as a single employer under the controlled group rules, as discussed above.

The maximum credit available is 35 percent of the cost of employer-paid health care premiums for small business employers and 25 percent of the cost of employer-paid health care premiums for tax-exempt employers for 2010 through 2013. These rates will increase to 50 percent and 35 percent on January 1, 2014. The amount of the credit is on a sliding scale, such that smaller employers and employers with lower average wages will receive a larger credit.

The credit can be carried back or forward to other tax years. Additionally, the credit is refundable, so that employers with no taxable income may receive the credit as a refund, as long as it does not exceed their income tax withholding

and Medicare tax liability. Eligible employers may also claim a business expense deduction for premiums paid in excess of the credit.

Eligible employers can calculate their credit using IRS Form 8941. Employers should evaluate their eligibility for the credit. If an employer can benefit from the credit for a year but did not claim the credit on its tax return, it may consider filing an amended return for the year.

SHOULD I CONSIDER OFFERING A WELLNESS PROGRAM?

To encourage employers to offer workplace wellness programs, the ACA creates an exception from its general prohibition on health underwriting, which will take effect in 2014 and will apply to group health plans and group health insurance issuers. Group health plans include both insured and self-insured group health plans. This exception allows employers to adopt "health-contingent wellness programs," which may allow rewards or surcharges of up to 30 percent of the total cost of plan coverage based on whether an employee satisfies a standard related to a health factor. Standards may include attaining a certain health outcome or participating in an activity related to a health factor. For instance, a program might offer a premium discount, reduction in cost-sharing, or waive a surcharge for employees who have a specified body mass index or refrain from smoking. Such programs may create opportunities for employers to reduce health care costs by encouraging employees to adopt healthier lifestyles.

Plans must meet five requirements to fall within the exception:

- → Available to all similarly situated individuals, who must be given a chance to qualify at least once annually; and
- → Size of reward is not more than 30 percent of the cost of coverage, including both employer and employee contributions, but
    - → If dependents may participate, the limit is 30 percent of the cost of family coverage, and
    - → Programs may be designed to allow a 20 percent additional maximum for smoking cessation or reduction; and
- → "Reasonable alternative standard" or waiver available for individuals for whom it is unreasonably difficult or medically inadvisable to meet the health-contingent standard, such that

→ If the alternative standard is outcome-based, an employer cannot require verification that a health factor makes it unreasonably difficult to satisfy the otherwise applicable standard; and

→ If the alternative standard is activity-based, an employer may seek verification that it is unreasonably difficult for the employee to complete the activity; and

→ Notification given to employees of the terms of the program and the opportunity to seek alternative qualification standards or waiver of the standard; and

→ Reasonably designed to promote health or prevent disease, not overly burdensome, and not a subterfuge for health status discrimination, such that

→ If a plan's initial standard for obtaining a reward is based on results of a test or screening related to a health factor, the plan is not reasonably designed unless it makes a different, reasonable means of qualifying for the reward available to all individuals who do not meet the initial standards.

Participatory wellness programs, which do not provide a reward or do not include any conditions for obtaining a Reward that are based on satisfying a standard relating to a health factor, are not required to meet these requirements, although they must be made available to all similarly situated individuals, regardless of health status.

With the publication of the Final Rule, however, the Departments of Health, Labor and Treasury announced they recognize that each employer's wellness program is unique and that employers may have questions regarding the application of these requirements. The Departments anticipate issuing subregulatory guidance in order to provide additional clarity, and that they may propose modification to these requirements, as necessary.

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