ON-SITE HEALTH CENTERS

Policies to Preserve and Promote an Effective Employer Solution

National Business Group on Health

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The National Business Group on Health (the Business Group) is the nation's only non-profit organization devoted exclusively to representing large employers' perspective on national health policy issues and providing practical solutions to its members' most important health care and health benefits challenges.

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TABLE OF CONTENTS

I. Introduction 3

II. Summary of Policy Recommendations 5

III. Background on On-Site Health Centers 7

IV. Federal Issues 16

V. State Laws and On-Site Health Centers 31

VI. Policy Recommendations 33

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I. Introduction

Employers are investing in on-site health centers for a variety of reasons. Prominent among them are the desire for productivity enhancements, with less time away from work for minor problems; occupational health needs; improved access to more convenient care, especially primary and preventive care; an emphasis on wellness and health improvement; care coordination; cost savings, including direct health care cost savings;[1,2] frustration with the performance of the health care system; and employee recruitment and retention.

Employers began establishing on-site health centers decades ago with a focus on occupational health, safety and treatment for or protection against workplace injuries. "The recent resurgence" of on-site health centers, however, has "differed markedly from the first iteration of clinics."[3] This resurgence is driven by concern about time away from work for minor health problems, increased spending on employee health benefits, and a recognition that such centers could be used to promote wellness, health and productivity.[4,5]

On-site health centers are direct service providers, components of employee benefit plans, and typically part of a comprehensive health improvement strategy. As employers respond to needs in the marketplace, on-site health centers can no longer be neatly categorized, as they reflect a broad spectrum of approaches. These approaches include more traditional occupational health and safety clinics with treatment of workplace injuries; centers that provide both occupational health and safety and selected on-site medical care, including urgent care and some targeted wellness programs; and more comprehensive primary care services that may include some specialty care, management of chronic conditions, and wellness and health improvement programs. While the research cited throughout this report tends, of necessity, to characterize on-site health centers in particular ways, understanding this broad spectrum of evolving approaches to on-site health centers is critical in understanding employer health initiatives.

Employers sponsoring on-site health centers must comply with certain federal laws, including the Employee Retirement Income Security Act of 1974 (ERISA), continuation of coverage provisions under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and certain Internal Revenue Code (Code) provisions, particularly in regard to the interaction between on-site health centers

[1] National Business Group on Health. *The Value of On-Site Health Centers.* 2010.
[2] Center for Studying Health Systems Change. *Workplace Clinics: A Sign of Growing Employer Interest in Wellness.* Research Brief No. 17, December 2010.
[3] Center for Studying Health Systems Change, 2010.
[4] Mercer. *Worksite clinics: An old concept gets a new lease in the battle to control health care cost and improve workforce productivity*. Health & Benefits Perspective. 2009.
[5] Center for Studying Health Systems Change, 2010.

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and health savings accounts (HSAs). The Patient Protection and Affordable Care Act (PPACA)[6] will raise additional compliance issues for employers with on-site health centers, including W-2 reporting of the cost of health coverage and the new excise tax on high-cost health plans.

Employer interest in on-site health centers is expected to continue, and more employers are likely to offer them in the future.

> **"To help manage costs, 82% of employers in the 2008 *The Road Ahead* survey indicate they will focus on long-term solutions aimed at improving the health and productivity of their workers ... To that end, the thought by many employers is that an initial investment in on-site health clinics, combined with disease management and wellness initiatives, will help avert future, more costly employee health expenses. In addition to improving overall employee health, care at these clinics generally costs less for employers and employees than outside physicians' visits and health services, and also contributes to higher productivity."[7]**

Given the continuing evolution of on-site health centers in meeting critical needs in today's market and the changing regulatory framework under which they operate, it is a logical time to re-examine on-site health centers and review potential approaches for the appropriate regulatory environment for these centers.

This policy paper reviews:

- Background information on on-site health centers;[8]
- Federal regulatory requirements prior to the enactment of the Affordable Care Act (ACA) and additional requirements under the ACA;
- State regulatory issues; and
- Policy recommendations for consideration.

[6] The Patient Protection and Affordable Care Act (PL 111-148) and the health care related portions of the Health Care and Education Reconciliation Act of 2010 (PL 111-152) together comprise health reform, and the "Affordable Care Act" or ACA is a combined reference to those laws in this paper.

[7] Hewitt Associates, LLC. *Employers Implement On-Site Health Clinics to Manage Costs.* Trends in HR and Employee Benefits. August 2008.

[8] These centers are referred to in a variety of ways: as on-site health centers, work site clinics, employer health centers, and in some cases, when not on the employer's premises, near-site centers. This report will generally use "on-site" health centers.

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II. Summary of Policy Recommendations

While the context for these issues and challenges that employers face are important, we have put our policy recommendations up front to ensure these key changes will be taken very seriously by all, especially policymakers, legislators, and regulators who could unintentionally stifle innovation in an area that virtually all agree is a positive for employees and employers. With the decline in access to primary care, health improvement programs at the work site offer great benefits to all. Our policy recommendations are intended to recognize and encourage proven initiatives for on-site health centers while assuring appropriate protections for employees:

- **HIPAA Portability Recommendation: Clarify that on-site health centers will be considered "excepted benefits" under HIPAA as long as they are supplemental to major medical coverage.**

    o As an alternative, guidance could provide that on-site health centers will be considered "excepted benefits" if the costs of such centers do not exceed a certain percentage (e.g., 10%) of the costs of employer-sponsored health coverage.

- **Internal Revenue Code Recommendation: Establish a single, uniform standard for the application of Code requirements to on-site health centers.**

    o The simplest and most efficient standard would make the treatment of on-site health centers under the Code consistent with that under HIPAA, provided the HIPAA definition of "excepted benefit" includes any on-site health center that is supplemental to major medical coverage. Under this standard, on-site health centers would be exempt from the Code's requirements, provided they satisfy this definition of "excepted benefit."

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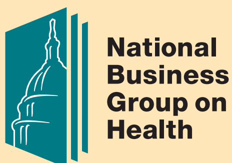
- o As an alternative, the IRS could adopt the HDHP/HSA standard under which on-site health centers would be exempt from the Code's requirements, provided the benefits provided through an on-site health center merely supplement coverage under a major medical plan.

- **COBRA Continuation Coverage Recommendation: Establish an exemption to COBRA's continuation of coverage requirements for on-site health centers.**

  - o The simplest and most efficient form of exemption would make the treatment of on-site health centers under COBRA consistent with that under HIPAA, provided the HIPAA definition of "excepted benefit" includes any on-site health center that is supplemental to major medical coverage. Under this standard, on-site health centers would be exempt from COBRA's continuation of coverage requirements, provided they satisfy this definition of "excepted benefit."

- **Patient-Centered Outcomes Research Trust Fund Fee (PCORTF) Recommendation: Clarify that all on-site health centers are excluded for purposes of the PCORTF fee.**



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III. Background on On-Site Health Centers

Evolution and rationale

Research on early adopters of on-site health centers (about two-thirds of centers were put in place prior to 2000) versus recent adopters (put in place in 2000 or later) highlights the changing motivations for establishing on-site health centers. As shown in Table 1 below, while some motivations have remained consistent, there has been a noticeable increase in the portion of recent adopters motivated by reducing medical costs, improving access to care, improving health care quality, offering the service as a "perk" and the desire to attract and retain the best workforce.

Table 1. Motivation for Adopting an On-Site Health Center[9]

	Early Adopters (before 2000)	Recent Adopters (2000 or after)
Enhance worker productivity	67%	67%
Reduce medical costs	49%	70%
Address occupational health and safety needs	54%	26%
Improve integration of health and productivity efforts	40%	37%
Improve access to care	33%	44%
Improve quality of care	12%	30%
Offer concierge service as a perk	7%	15%

Employers who have established primary care clinics as their on-site health centers are particularly focused on convenience for employees, access to preventive services, wellness and spending.

[9] Towers Watson. *Realizing the Potential of Onsite Health Centers.* 2008

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Table 2. Most Important Objectives for Establishing Primary Care Clinic[10]

	Percent of employers rating important or very important
Convenience: time and effort for employees	86%
Better access to preventive care	77%
Encouraging employees to make better use of health/wellness programs	75%
Control over overall health spending	74%
Health/wellness leadership image	65%
Means of attracting talented employees	51%

Prevalence of On-Site Health Centers

There is a continuum of arrangements for on-site health centers, but the research generally recognizes two categories of on-site health centers: occupational health and primary care. The occupational health category focuses on care related to health, safety and injury on the job and typically includes immunizations, treatment for minor conditions and first aid. The primary care category goes beyond those services to include other forms of urgent care, chronic disease management and wellness services. Just under one-third (30%) of large employers offer occupational health centers, and 15% offer primary care clinics, which are most typically intended to complement, not supplant, primary care available in the community.

- The largest employers (20,000+ employees) are more likely to offer the clinics and, in particular, are nearly twice as likely as other large employers to offer primary care clinics (27% v. 15%).
- The health care sector is by far the most likely to offer both occupational health and primary care at the work site, a logical practice as this is the business of that sector.
- Service industries are least likely to offer on-site health centers.

Table 3 summarizes these findings.

[10] Mercer. *Survey on Worksite Medical Clinics.* 2008.

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Table 3. Prevalence of On-Site Clinics, 2010 Survey[11]

	Occupational health	Primary care
BY EMPLOYER SIZE		
Large employers (500+ employees)		
Currently offer	30%	15%
Don't offer, but considering	8%	10%
Don't offer, not considering	62%	75%
Jumbo employers (20,000+ employees)		
Currently offer	37%	27%
Don't offer, but considering	10%	17%
Don't offer, not considering	53%	56%
CURRENTLY OFFER, BY INDUSTRY		
Large employers (500+ employees)	30%	15%
Health Care	63%	36%
Wholesale/Retail	24%	9%
Manufacturing	31%	13%
Government	27%	17%
Transportation/Communication/Utility	35%	11%
Services	17%	10%
Financial Services	9%	2%

Recent trends indicate increasing attention to on-site health centers by public employers, including municipal government and school systems, and to multiple employers joining together to use or establish on-site health centers. The latter can include one employer making its on-site health center available to another or several employers jointly forming an on-site or "near-site" health center (such as one for multiple employers in an office park.)[12]

[11] Mercer. *2010 National Survey of Employer-Sponsored Health Plans,* 2011.
[12] Center for Studying Health System Change, 2010

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Services

The range of services offered at on-site health centers can be categorized in a number of ways. Services include occupational health, acute care, chronic disease management, primary care, specialty care, pharmacy services, employee assistance programs and health improvement programs.[13]

Recent adopters of on-site health centers (2000 or later) are more likely than earlier adopters to focus on wellness centers with clinical services.[14] The priority for wellness activities stems from:

> **"... growing recognition that face-to-face wellness activities - in particular, health coaching and lifestyle management programs - generally are more effective than alternatives, such as Web-based and telephonic coaching."[15]**

The most common services in primary care settings are screenings and immunizations, followed by treatment of workplace injuries, urgent care and chronic disease management.

Table 4. Services Offered at Primary Care Clinics[16]

Services	Percent of Employers		Services	Percent of Employers
Screenings	83%		Pharmacy	32%
Immunizations	81%		Mental health/EAP counseling	23%
Treatment of workplace injuries	64%		Physical therapy	23%
Urgent care	62%		Dental	6%
Chronic disease management	40%		Vision	2%
Lab/X-ray	36%			

Employers are turning to the primary care approach, in part, due to dissatisfaction with care models available in their communities. In some cases, on-site health centers aim to transform primary care, but in most cases employers intend to supplement community-based primary care and use on-site health centers to fill gaps in care.

[13] National Business Group on Health. *The Value of On-Site Health Centers.* 2010.
[14] Towers Watson, 2008.
[15] Center for Studying Health System Change, 2010.
[16] Mercer, 2008.

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On-site health centers not only provide convenient access for employees, but also shorter appointment and in-office waits and longer encounters with health care practitioners than are typically available in the primary care community. This is partly because on-site health center practitioners are salaried rather than reimbursed on a fee-for-service basis. Longer visits allow a physician to listen, diagnose, discuss options, and screen for other problems that are not part of a patient's initial presenting concern. On-site health centers use evidence-based guidelines and electronic health records (EHRs) more than in typical primary care practices, which facilitate internal care coordination. The lack of EHR penetration in the broader health community hinders communication with employees' regular physicians.[17]

Staffing at on-site health centers can take several forms. Nurse practitioners or physician assistants are often the service providers, with the level of physician supervision dependent on state regulations and the scope of services provided by the center. The nurse practitioner/physician assistant model is particularly attractive in states that allow such clinicians to prescribe certain medications. The physician role can range from oversight to direct staffing where the clinic offers a more comprehensive range of services, either along with nurse practitioners/physician assistants or instead of those providers. Finally, centers with an even broader scope of services may include a staff with general practitioners, specialists, physical therapists, pharmacists, lab technicians, nutrition counselors and others.[18]

On-site health centers typically account for just a small portion of an employer's total spending for employee health benefits. Just over half of the employers spend less than 2% of their total health budget on their primary care centers. For some employers, especially those in the manufacturing sector, the centers are a more substantial investment, reaching 20% or more of health spending, as shown in Table 5.

Table 5. Portion of Total Health Budget Spent on Primary Care Clinic[19]

Percentage of total health budget	Percentage of employers
Less than 2%	52%
2% – 5%	19%
5% – 9.9%	17%
10% – 19.9%	4%
20% or more*	7%

* Note: Almost one-fifth of manufacturing employers with a primary care clinic spend 20% or more of their total health budget on the clinic.

[17] Center for Studying Health System Change, 2010.
[18] Hewitt, 2008.
[19] Mercer, 2008.

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Models

Three general models exist for operating on-site health centers: an employer-owned and operated health center, a center outsourced to a vendor, and a hybrid model in which the employer contracts with local health care providers.

A summary of how these models typically work is provided in Table 6.

Table 6. Models of On-Site Clinics[20]

Employer-managed	Hybrid	Outsourced
Employer owns clinic	Employer contracts with local clinic/health institution	Employer contracts with third-party vendor
Employer controls all clinic operations, personnel and decisions about vendor integration	Employer influences scope of services and vendor integration	Vendor controls all clinic operations, personnel and decisions about vendor integration
Result: High control, somewhat high risk, higher barrier to exit	Result: Moderate control, lower risk, easy exit	Result: Low control, lower risk, easy exit

Most employers outsource on-site health center functions in some way, in part because of liability and privacy concerns, and in part because running on-site health centers is not a core competency for most employers. However, there are clear tradeoffs involved with these three models.[21,22] The employer-managed approach can help ensure that the center is integrated with the company's culture but may raise concerns about confidentiality for employees seeking care. Contracting with community-based providers may address the confidentiality concerns and could allow for an expanded array of services, but those providers are unlikely to make the center their highest priority and may not be culturally aligned or fully in sync with the employer's goals. Outsourced vendors bring a breadth of expertise in managing all aspects of an on-site health center, but, as with contracted physicians, may not be aligned with the company's culture or goals.[23]

[20] Mercer, 2008.
[21] Center for Studying Health System Change, 2010.
[22] Hewitt, 2008.
[23] National Business Group on Health. *The Value of On-Site Health Centers.* 2010.

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Approaches by employers in the health care and retail industries reflect the unique characteristics and business opportunities of these employers.

- As noted earlier, employers operating within the health care community are the most likely to offer the on-site health centers; they are already in the business of providing health care and thus have the delivery capacity in-house. Such organizations may seek to expand the model to other employers as a new line of business.
- The retail-based health center reflects a different business approach and response to concerns about access to primary care in the community. Mass retailers, including pharmacies and other retailers (CVS/Caremark, Walgreens, Wal-Mart, and Target) are establishing retail-based clinics that can serve their own employees as on-site health centers and serve as a new line of business as primary care access points (retail clinics) for the customers that they otherwise serve. Further, these retail clinics can serve as "near-site" workplace clinics for local employers, including those who do not have the workforce size needed to justify their own clinics.[24]

Charges for Services

A majority of on-site health centers do not charge for their services. About 60% do not charge and 40% charge. Early adopters (founded before 2000) are more likely not to charge (70%); 56% of more recent adopters (founded in 2000 or later) do not charge.[25]

The typical charge, when imposed, is a relatively nominal copay of $5 or $10 per visit. This provides a revenue stream for on-site health centers and a potential deterrent to excess utilization. In some cases when such charges are imposed, they are waived for screening and preventive care.[26]

The design of the copayment structure depends on the goals of the employer. For example, a limited number of employers forming comprehensive on-site health centers may seek to substitute for other sources of care. Quad/Graphics, one of the long-term leaders in providing on-site health centers for its own employees and as a vendor (through QuadMed) to other employers, offers substantial cost-sharing incentives to its employees to use its clinics. These incentives include much lower deductibles and cost sharing for employees using the clinics and a lower premium if employees identify the clinic as their primary care provider.[27]

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[24] Hewitt, 2008.
[25] Towers Watson, 2008.
[26] Mercer, 2008.
[27] Center for Studying Health Systems Change, 2010.

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There are obvious tradeoffs in the copayment structure. Providing complimentary services nurtures the culture of health that employers seek, reduces complexity, and drives utilization to the on-site health center. However, imposing no charge does not sensitize employees to the costs of care and increases the employer's costs. Alternatively, requiring some copayment, but less than what the employee would pay for using a community provider, helps steer employees to the center and sensitizes them somewhat to the cost of care. Copayments impose administrative complexity for the employer, however. Finally, if cost sharing is equal under the employer's health plan to that imposed for use of providers in the community, the cost sharing emphasizes employee responsibility and positions the center as another delivery site but does not drive utilization to the on-site health center or assure alignment with other goals, such as wellness.[28]

Eligibility and Use of On-Site Health Centers

Eligibility for on-site health centers is generally limited to employees. While including dependents is seen as a way to address a larger base of employer spending and wellness priorities, doing so raises capacity, convenience, security and safety issues. Extending eligibility to retirees is increasingly rare.[29] Two of the major consulting studies document the predominance of eligibility for regular employees for on-site health programs and specifically for primary care clinics, as seen in Tables 7 and 8.

Table 7. Eligibility for Services Among Employers Offering Work Site Programs[30]

	Percent of employers
Regular employees covered under health plan	96%
Regular employees not covered under health plan	87%
Part-time employees	71%
Temporary employees	44%
Contract employees	25%
Covered dependents	25%
Retirees	20%

[28] National Business Group on Health. *The Value of On-Site Health Centers.* 2010.
[29] Center for Studying Health System Change, 2010.
[30] Towers Watson, 2008.

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Table 8. Eligibility For and Use of Primary Care Clinics[31]

Eligibility for primary care clinic	Percent of employers
On-site employees	94%
Employees from other locations	68%
Retirees	34%
Covered dependent adults	34%
Covered dependent children	32%
Employees from other companies	15%

Among companies with primary care clinics, use by eligible employees varies substantially. For about half the employers with primary care clinics, fewer than 25% of employees used the clinic in the past year, while for one-fourth of the employers, more than 50% of employees used the clinic.[32]

The use of primary care clinics, however, is relatively high compared with other employer-sponsored health initiatives. For example, use of the on-site clinics (percent of eligible employees participating) ranked in the top five of employee participation rates among 20 employer health initiatives, which ranged from flu shots to nurselines, weight management, disease management and stress reduction. The only higher participation rates were for flu shots and health assessments.[33]

Impact

Studies point to a relatively substantial return for on-site health centers of $2 in savings for every $1 invested, and some studies indicate levels of $3 to $6 for every $1 invested.[34,35] Those amounts include direct health care cost savings and productivity savings. But isolating the measure of return on investment is difficult and is seen as a current measurement priority for employers and benefit consultants. Some researchers feel that the higher return figures are unrealistic, with a return between $1 and $2 more realistic for the long term.[36]

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[31] Mercer, 2008.
[32] Mercer, 2008.
[33] Hewitt. *The Road Ahead: Under Construction with Increasing Tolls.* Survey Findings, 2010.
[34] Hewitt, 2008.
[35] National Business Group on Health. *The Value of On-Site Health Centers.* 2010.
[36] Center for Studying Health System Change, 2010.

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Employers and employees generally report high levels of satisfaction with on-site health centers. Three-fourths of employers offering primary care clinics rate them as successful or very successful, and only 2% as not successful.[37] Employees using on-site clinics rate satisfaction with those clinics among the top five of 20 employer health initiatives, with 85% satisfied or highly satisfied.[38]

On-site health centers are expected to remain a focus of attention for employers given the shortage of primary care providers and an environment that supports wellness and lends itself to innovation:

> **"... employers have never been more interested in workforce health and well-being as a business value that can be measured, managed and turned into a competitive advantage. There have never been more creative opportunities to use technology — to support new ways of engaging the workforce in managing their physical and financial health and increasing the efficiency and quality of health care delivery. In fact, there has never been a better time for 'disruptive' innovation..."[39]**

IV. Federal Issues

Overview

Federal laws applicable to employer-sponsored health plans may present challenges to companies that seek to implement effective on-site health centers. These laws include the Employee Retirement Income Security Act of 1974 (ERISA), the continuation of coverage requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA),[40] the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its subsequent amendments, and the Patient Protection and Affordable Care Act (ACA) of 2010. Certain provisions of the Internal Revenue Code (Code) may also be of concern.

The application of federal law to an on-site health center depends largely on the services it provides, who is eligible for those services, and whether the on-site health center is offered as a part of the employer's health benefit plan (sometimes referred to as a "major medical plan") or as an entirely separate service. To the extent that these features can be clearly defined, an on-site health center's regulatory status will be more certain.

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[37] Mercer, 2008

[38] Hewitt, 2010.

[39] Towers Watson. *Workforce Health 2010: New Deal, New Dividend.* 2010 Health Care Cost Survey. 21st Annual U.S. Results Report. 2010.

[40] COBRA was enacted in April 1986; title X providing for continuation of coverage requirements was subsequently amended a number of times.

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In general, employer-sponsored on-site health centers that are limited in their purpose to providing first aid or treatment for minor work site injuries or illnesses, referred to in some federal statutes as “on-premises facilities” or “on-site medical clinics,” tend to be exempt from some but not all of these federal laws. On-site health centers that offer more in the way of medical services may be subject to these laws. Making such a determination can be difficult because a particular law and its implementing regulations may lack clarity on the criteria that an on-site health center must meet to qualify for an exemption.

Discerning the application of federal requirements to on-site health centers has been made more challenging by the enactment in 2010 of the ACA. Because the ACA adds a layer of complexity to this discussion, the following discussion is arranged in terms of pre- and post-ACA requirements.

Employee Retirement Income Security Act of 1974 (ERISA)

ERISA establishes federal standards for most non-governmental group health plans. The Department of Labor defines a group health plan as “an employee welfare benefit plan established or maintained by an employer or by an employee organization (such as a union), or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement, or otherwise.”[41] To the extent that an employer’s on-site health center provides such “medical care” (or is part of an employer-sponsored major medical plan), the center would likely be regarded as an “ERISA plan” (or part of an ERISA plan) and thus subject to ERISA’s requirements. As discussed below, these requirements include reporting and disclosure and benefit standards. However, ERISA plans are protected from the application of state laws as a result of ERISA’s preemption provision (section 514), which preempts state laws that relate to employee welfare benefit plans.

ERISA explicitly exempts certain employer-sponsored arrangements from the definition of a group health plan. These arrangements include the “maintenance on the premises of an employer of facilities for the treatment of minor injuries or illness or rendering first aid in case of accidents occurring during working hours.”[42] It follows that if an employer operates a center that provides for this limited set of workplace-related services, that center does not have to comply with ERISA’s requirements. On the other hand, such facilities and services may be subject to state health insurance and benefit laws because ERISA’s preemption provision would not apply.

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[41] An ERISA-covered group health plan is a type of “employee welfare benefit plan,” which is defined under ERISA to include a broad range of non retirement benefits, including medical, surgical, hospital care, sickness, accident, disability, death, unemployment, vacation, apprenticeship, daycare, scholarship and legal benefits. 29 C.F.R. § 2510.3-1(a)(2).

[42] 29 C.F.R. § 2510.3-1(c)(2).

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Employee benefit consultants have advised that ERISA's exemption from "group health plan" status for on-site health centers for "treatment of minor injuries or illness or rendering first aid in case of accidents occurring during working hours" would likely extend to clinics that provide very minor care to employees. Clinics that offer a broader range of services, such as those that provide primary care for employees and their dependents, diagnostic tests and lab work, would more likely be regarded by regulators as ERISA plans.[43]

On-site health centers that are ERISA group health plans (or part of group health plans) must comply with ERISA's notice, reporting, disclosure and claims procedure requirements as well as other federal laws that apply to ERISA plans, including COBRA's continuation of coverage provisions, HIPAA, the Code and the ACA unless they fall within an exemption in the laws.[44]

Making an employer-sponsored on-site health center (or centers) part of the employer's overall group health plan can ease the burden of complying with these federal requirements. For example, ERISA-required reporting to the Department of Labor related to on-site health center benefits and services can be subsumed under the overall group health plan's reporting. This also is likely to be the case for some but not all federal notice and disclosure requirements. As discussed below, however, federal requirements related to coverage and benefits may present more of a compliance challenge.

ERISA's Disclosure, Notice and Reporting Requirements

If an on-site health center is an ERISA plan, the plan sponsor must prepare and maintain a plan document that sets forth rules for operation, administration and amendment of the plan. The plan sponsor must provide this plan document to participants and beneficiaries upon request. In addition, the plan sponsor must provide to participants a summary plan description (SPD) that summarizes the plan's benefits, claims and appeals procedures, and other plan rules, which must be updated for material modifications. Often the plan document and SPD are combined into one document. The plan sponsor must file a disclosure form (5500) with the Department of Labor annually. The plan sponsor also must provide certain notices to participants related to medical child support orders.

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[43] An additional exemption under ERISA is for a group or group-type insurance program offered by an insurer to employees who meet certain conditions. These are the types of arrangements in which an insurer is simply promoting a product for voluntary purchase by employees through the workplace, with neither the employer nor an employee organization making any contribution to that purchase. Such conditions are generally not met by on-site health centers. Towers Watson, *Welfare Benefit Compliance for Employer-Provided Onsite Health Care Facilities, Insight: 2008*. http://www.watsonwyatt.com/research/pdfs/2008-WT-0032.pdf.

[44] See sections 1563(2)(e) and 1563(2)(f) of the Patient Protection and Affordable Care Act.

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In addition, COBRA requires a group health plan to provide certain notices to participants and beneficiaries about their rights to continued coverage, including the services of an on-site health center, and about early terminations of such rights, if applicable. HIPAA's portability provisions require a group health plan to provide: certificates of creditable coverage to participants and beneficiaries who lose coverage under the plan; general and individual-specific notices to participants and beneficiaries of any pre-existing condition exclusion period that may be applicable to their coverage; and notices of special enrollment rules to employees at or before the time they are initially offered an opportunity to enroll in the plan. If a group health plan offers a wellness program that requires individuals to meet a standard related to a health factor in order to obtain an award, the plan sponsor must disclose, in all materials that describe the terms of the program, the availability of an alternative standard (or possibility of waiver of the otherwise applicable standards). The Women's Health and Cancer Rights Act (WHCRA) requires an ERISA plan to provide notices describing benefits for mastectomy-related reconstructive surgery, prostheses and treatment of physical complications of mastectomy.[45]

Many of these notices can be combined with the plan's SPD, and as noted above, an on-site health center that is a part of an employer's overall group health plan is not required to provide these notices separately.

Coverage and Benefit Requirements Under COBRA and HIPAA

In addition to disclosure, notice and reporting requirements under ERISA, an on-site health center may be subject to certain federal coverage and benefit requirements.

COBRA. IRS regulations implementing COBRA's continuation of coverage requirements provide that the provision of health care at a facility that is located on the premises of an employer does not constitute a group health plan and therefore is not required to provide COBRA coverage if:

(1) the health care consists primarily of first aid provided during the employer's working hours to treat health conditions, illnesses or injuries that arise during working hours;
(2) the health care is available only to current employees; and
(3) employees are not charged for the use of the facility.[46]

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[45] U.S. Department of Labor, Employee Benefit Security Administration, *Reporting and Disclosure Guide for Employee Benefit Plans*, Revised October 2008.
[46] 26 C.F.R. § 54.4980B-2 Q-1, A-1(d)

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For on-site health centers that do not meet these conditions, COBRA continuation of coverage requirements apply. A typical reason for failing to meet these conditions is that the center offers a broader array of medical services than just first aid for conditions arising during working hours. Thus, such an employer has to offer employees the option of continued coverage under the company's group health plan, including the services of the on-site health center, for 18-36 months, depending on the "qualifying event" that triggers the right to COBRA continuation coverage (e.g., job loss, divorce, legal separation, or death of the covered employee). An employer may charge those electing COBRA up to 102% of the total premium for the coverage.[47] In addition, the following requirements would apply:

- COBRA must be offered to all qualified participants and beneficiaries (e.g., an employee's spouse and children) for all qualifying events.
- Open enrollment rights must be extended under all of the employer's plans each year. At open enrollment, those receiving coverage only through an on-site health center must be permitted to enroll in other coverage offered under the employer's plans, such as the major medical plan.
- COBRA coverage must include all medical services under the plan. These include medical services provided through a wellness program.

The obligation of an employer to provide former employees, their spouses and children access to an on-site health center may present particular challenges, particularly if the center is located in a building that restricts access to non-employees for security, safety, or other reasons. In addition, it should be noted that the right to elect COBRA extends to all employees eligible for on-site health center coverage (including those who may not have participated in the employer's major medical plan).[48]

To mitigate COBRA obligations related to on-site health centers, employers may wish to structure these centers so that they are not considered ERISA group health plans (i.e., they solely provide first aid and treat minor injuries or illnesses during the workday). If the goal is to offer more extensive health care services, however, then an employer can either combine the centers with the "regular" health plan (and charge the employee one amount that covers both) or establish two, separately-priced plans, which may encourage participants to choose major medical coverage only when electing COBRA continuation coverage.[49]

[47] A disabled individual under the definition of the Social Security Act who elects to extend his or her COBRA from 18 to 29 months may be charged 150% of the total cost of the plan for those additional months.
[48] Towers Watson, 2008.
[49] Towers Watson, 2008.

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HIPAA Portability & Nondiscrimination. In addition to the privacy and security issues described in the next section, HIPAA provides for federal minimum "portability" and "nondiscrimination" requirements on group health plans and issuers of individual and group coverage. These provisions, which impose pre-existing condition, special enrollment, creditable coverage and nondiscrimination rules, are designed to make it easier for individuals to obtain or retain health coverage without experiencing coverage gaps due to pre-existing condition exclusions as they transition to and from employment-based health coverage. Although HIPAA's portability and nondiscrimination provisions apply mostly to insurance sold in the individual and small group insurance markets, self-insured ERISA group health plans are subject to certain requirements of the law. For example, such plans are prohibited from discriminating in eligibility or enrollment on the basis of health-status related factors, a requirement which also extends to insured group health plans.

Certain group health plans (including ERISA plans) that fall within HIPAA's definition of "excepted benefits" are exempt from HIPAA's portability and nondiscrimination requirements. "Excepted benefits" include "coverage for on-site medical clinics." To date, relevant federal agencies have not provided guidance on the definition of "on-site medical clinics." At minimum, this term should encompass on-site health centers for "treatment of minor injuries or illness or rendering first aid in case of accidents occurring during working hours," which are exempt from ERISA and COBRA requirements. However, the term "on-site medical clinics" suggests that HIPAA "excepted benefits" include clinics that provide more extensive services than just first aid or similar treatment. Thus, on-site health centers should be able to provide more than first aid and still be exempt from HIPAA's portability and nondiscrimination requirements, although the extent of services that on-site health centers can provide and still remain "excepted benefits" remains an open question. Guidance from agencies providing that on-site health centers will be considered "excepted benefits" as long as they are supplemental to major medical coverage would be helpful in clarifying the legal status of on-site health centers.

HIPAA's nondiscrimination requirements merit more extended discussions because of their particular application to employer wellness programs. In most cases, on-site health centers will not be subject to these rules directly. However, on-site health centers may provide services associated with employer wellness programs, which are subject to these rules. Generally, a group health plan cannot deny eligibility for benefits or charge more for coverage, including premiums, deductibles, or other cost sharing because of a health status-related factor.[50] The Department of Labor has issued regulations clarifying that wellness programs that do not require satisfying

[50] A health status-related factor includes health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability.

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a standard related to a health factor (e.g., reimbursing for a gym membership or waiving copayments for prenatal care) are permitted.[51] However, if a wellness program conditions an incentive, such as a discount, rebate, or other award[52] on meeting a standard related to a health factor (e.g., maintaining a cholesterol level below 200 or attaining a certain body mass index), additional nondiscrimination rules must be met. These requirements have now been codified as part of the ACA.[53] In brief, a wellness program that conditions a reward based on satisfying a standard related to a health factor must:

- Not offer an award that exceeds 20% of the cost of employee-only coverage under the plan (or 20% of the cost of employee-plus-dependent coverage if dependents are allowed to participate in the wellness program);
- Be "reasonably designed" to promote health or prevent disease;[54]
- Give eligible individuals the opportunity to qualify for the reward at least once each year;
- Offer a reasonable alternative standard for obtaining the reward to those who cannot meet the program standard for medical reasons;
- Make available the full reward to all similarly situated individuals; and
- Meet disclosure requirements, including providing notice to employees of availability of alternative standard.

HIPAA Privacy and Security Rules

As part of HIPAA, Congress included provisions to protect the privacy and security of personal health information. These protections were viewed as necessary given the rapid evolution of health information systems and the increased potential for unauthorized disclosures of individually identifiable health information, such as patient medical information. The privacy and security requirements were implemented by the Department of Health and Human Services (HHS) through rules published in 1999-2003. There is no exemption from these requirements for on-site health centers.

Congress also included in HIPAA a "transactions and code sets" provision requiring federal standards to improve the efficiency and effectiveness of the health care system by facilitating the electronic exchange of information with respect to certain transactions carried out by health plans, health care clearinghouses and health care

[51] *Federal Register*, Nondiscrimination and Wellness Programs in Health Coverage in the Group Market; Final Rules, December 13, 2006, www.dol.gov/ebsa/regs/fedreg/final/2006009557.pdf.

[52] Under HIPAA, the wellness incentive is limited to 20%; the ACA, however, permits the incentive to increase to 30%, beginning in 2014 although it appears that the implementing departments may permit an earlier effective date.

[53] See section 1201of the Patient Protection and Affordable Care Act.

[54] A program satisfies this standard if it has a reasonable chance of improving the health of or preventing disease in participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease.

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providers who transmit information electronically. Such transactions include: claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, and premium payment. To implement this provision, HIPAA directed HHS to adopt uniform national standards for transactions, unique identifiers for employers and providers, and code sets for diagnosis and procedures to be used in all transactions.

On-site health centers that engage in electronic transactions are generally subject to the HIPAA privacy and security rules and transactions and code sets standards, even if the center is operated for the employer by a third party. On-site health centers that are not group health plans nor part of an employer's group health plan nor those that process all billing and other HIPAA transactions in paper form are exempt. However, employees of these centers, such as physicians, nurses, or other providers, will remain subject to these requirements.

An on-site health center and its health care providers should be clearly defined within the employer arrangement. In addition, the center must comply with the HIPAA privacy and security rules, including maintaining proper documentation, designating a privacy and security official for the organization, establishing policies and procedures governing the use and disclosure of protected health information (PHI), including electronic protected health information, training all employees with respect to the policies and procedures regarding PHI, and implementing administrative, technical and physical safeguards to protect PHI. Without specific authorization, PHI cannot be shared with other employer benefit arrangements, such as worker's compensation, or other third parties.[55]

If a group health plan contracts with another entity to provide services on behalf of the group health plan that requires the disclosure of PHI, that entity is a "business associate" of the plan. In this case, the contract between the plan and the business associate must be in writing and contain numerous provisions intended to ensure that the business associate safeguards the plan's PHI.

An on-site health center maintaining PHI is also subject to the breach notification rule under the Health Information Technology for Economic and Clinical Health (HITECH) Act, which amended HIPAA. The breach notification rule generally requires a group health plan and its business associates to provide notification to affected individuals, HHS, and in some cases, the media, if a breach of unsecured PHI (generally, unencrypted PHI) occurs. A breach is considered to have occurred if there is an impermissible use or disclosure of PHI under the privacy rule that compromises the security or privacy of the PHI such that the use or disclosure poses a significant risk of financial, reputational, or other harm to the affected individual.

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[55] *Federal Register*, Standards for Privacy of Individually Identifiable Health Information; Final Rule, Vol. 67, No. 157, August 14, 2002, p. 53264-53265.

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Internal Revenue Code (Code)

The Code includes a number of provisions that are relevant to on-site health centers. Most important, perhaps, is that if an on-site health center is either part of an employer's overall health plan or qualifies as a stand-alone group health plan, then any employer-paid expenses for services provided by the health center generally are not taxable to employees. This includes employer-paid premiums and health care reimbursements from the employer's plan.[56] In addition, an employer is permitted to deduct the cost of an on-site health center as a business expense. On-site health centers sponsored by self-insured group health plans are also subject to the Code's non discrimination rules.[57] These rules prohibit employers from discriminating in favor of highly compensated individuals relative to rank-and-file employees with respect to eligibility to participate in, and benefits provided under, a group health plan. Similar rules now apply to insured plans as a result of a provision in the ACA, but the rules' application has been delayed by the IRS pending release of regulations.[58]

Health Savings Account (HSA)

Employers who offer on-site health centers need to be aware of the potential implications of such centers on employees' health savings accounts (HSAs). Under section 223 of the Code, an employer and/or an employee may make tax-free contributions up to a specified yearly amount to an employee's HSA that accompanies a qualified high deductible health plan (HDHP).[59] In 2011, for example, such employer and employee contributions may total $3,050 for an employee only and $6,150 for an employee and family.

One of the intended purposes of an HSA is to provide enrollees in HDHPs with tax-free contributions that they can withdraw to pay cost sharing for qualified services prior to satisfying the plan deductible. However, on-site health centers typically provide services to employees at no cost or at a reduced fee, thus reducing the likelihood that participants will incur the types of medical expenses that could otherwise be paid for out of an HSA. The question then arises whether the enrollee in the HDHP may still qualify for contributions to an HSA, whether the contributions are made by the employer or the employee or both.

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[56] As is true for the tax treatment of other employer-sponsored health benefits, certain services do not qualify as medical care (e.g., services that promote general well-being, cosmetic treatments and cash or cash equivalents) and thus are taxable to employees and subject to withholding.

[57] See section 105(h) of the IRC.

[58] Internal Revenue Service, Notice 2011-1. www.irs.gov/pub/irs-drop/n-11-01.pdf. Regulations implementing the ACA nondiscrimination requirements for insured plans may also affect how the IRS regards non discrimination for self-insured plans since a number of issues have remained unclear. See, for example, Buck Research, FYI For Your Information, *IRS Delays Application on Non-Discrimination Rules to Insured Group Health Plans*, Vol. 34, No. 1, January 5, 2011.

[59] A qualified high deductible health plan is one that meets federal requirements under section 223 of the IRC. Requirements include a minimum and maximum plan deductible, for example, which changes each year to account for inflation.

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In 2008, the IRS provided guidance to clarify this question, although the guidance still left uncertainty.[60] Under this guidance, an individual does not lose his or her eligibility for HSA contributions "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)." On-site clinics that provide free physicals and immunizations; allergy injections (or similar); a variety of aspirin and other nonprescription pain relievers; and treatment for injuries caused by accidents at the plant are not, in the view of the IRS, providing significant benefits in the nature of medical care. The IRS provides a contrasting case of a hospital that 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." The IRS further advises that "[b]ecause the hospital provides significant care in the nature of medical services, the hospital's employees are not eligible individuals under §223(c)(1)(A)," which means that they are not eligible to make HSA contributions or receive employer contributions to HSAs.[61]

Employers seeking to establish an on-site health center may still be uncertain whether their employees can participate in the center and remain eligible for HSA contributions if the range of the health center's services falls somewhere in between the two situations described in the IRS guidance. This uncertainty may discourage employers with current HDHP-HSA offerings from considering establishing an on-site health center (and vice versa).

Affordable Care Act (ACA)

The ACA builds on existing federal minimum requirements for health insurance coverage and group health plans, providing for additional rules relating to the availability, affordability and quality of coverage in the individual, small group and large group markets. Many of the ACA requirements apply to insurers and the health insurance that they sell to individuals and employers. The ACA also includes requirements that apply to self-insured ERISA group health plans.

To the extent that the coverage provided under an on-site health center is furnished through an employer's self-insured major medical plan, then that coverage will be subject to the ACA requirements that apply to self-insured group health plans. "Coverage for on-site medical clinics," however, is largely exempt from the ACA's

[60] Internal Revenue Service, Notice 2008-59. July 21, 2008, http://www.irs.gov/irb/2008-29_IRB/ar11.html.
[61] Internal Revenue Service, July 21, 2008.

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group health plan requirements. This is because such coverage is an "excepted benefit" under HIPAA and the ACA exempts such benefits from its group health plan requirements. As discussed below, however, certain ACA tax-related provisions apply both to employer major medical coverage and on-site health centers.

W-2 Reporting

Section 9002 of the ACA amends the Code to require that employers calculate and report the aggregate cost of all "applicable employer-sponsored coverage" provided to each employee annually on the employee's Form W-2.[62] This requirement becomes effective beginning with the 2012 tax year. The stated purpose for this requirement is "to provide useful and comparable consumer information to employees on the cost of their health care coverage."[63]

Forms W-2, generally, are furnished by employers to their employees in January of the following year (or, beginning in this case, in January 2013). For smaller employers, the reporting requirement will be optional at least through the 2012 tax year.[64]

"Applicable employer-sponsored coverage" is defined as coverage under any group health plan made available to any employee by the employer that is excluded from the employee's gross income under section 106 of the Code or would be so excludable if it were employer-provided coverage (within the meaning of section 106). Coverage is treated as applicable employer-sponsored coverage, meaning both the portion of the cost paid by the employer and the portion of the cost paid by the employee, regardless of whether the employee paid for that cost through pre-tax or after-tax contributions. "On-site medical clinics" are included in the definition of "applicable employer-sponsored coverage."[65]

More specifically, to comply with the new W-2 requirement, a covered employer will need to report the aggregate cost of all applicable coverage (i.e., not provide a specific breakdown of the different types of medical coverage). The aggregate cost should be computed under rules similar to the COBRA cost of coverage rules. For fully insured

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[62] See section 6051 of the Code.

[63] U.S. Department of Treasury, Internal Revenue Service, *Interim Guidance on Informational Reporting to Employees of the Cost of their Group Health Insurance Coverage*, Notice 2011-28, March 29, 2011, http://www.irs.gov/pub/irs-drop/n-11-28.pdf.

[64] The IRS stated it delayed the requirement (originally beginning with the 2011 tax year) to give employers more time to update their payroll systems and procedures. It was also likely delayed because the IRS has not yet issued guidance regarding how the aggregate value of the coverage is to be calculated. U.S. Department of Treasury, Internal Revenue Service, *Interim Relief with Respect to Form W-2 Reporting of the Cost of Coverage of Group Health Insurance Under §6051(a)(14)*, Notice 2010-69, Fall 2010; Reporting is Voluntary for All Employers for 2011 and Small Employers for 2012, March 29, 2011.

[65] Applicable employer-sponsored coverage also includes medical plans, prescription drug plans, Medicare supplemental policies, employee assistance programs, and coverage under dental and vision plans, unless they are "stand-alone" plans.

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plans, the COBRA cost of coverage is generally the amount of premiums paid to the insurer. For self-insured plans, the COBRA cost of coverage is determined through one of two methods, the actuarial method or the past cost method.[66]

Under current guidance, an employer who has as yet not determined a value for its on-site health center for purposes of COBRA will have to determine reportable values for coverage under the center. Other issues, such as valuing the on-site health center for employees who are not covered under the employer's group health plan, will need to be resolved.[67] Until the IRS provides specific guidance on such situations, employers operating on-site health centers that are separate from their regular medical plans may find it difficult to come up with a valuation.

Patient-Centered Outcomes Research Trust Fund Fee (PCORTF)

Section 6301 of the ACA creates a Patient-Centered Outcomes Research Trust Fund (PCORTF) to finance comparative effectiveness research. The PCORTF will be funded in part by a fee payable by insurers and self-insured health plans. The fee, which applies to calendar plan years 2012 through 2018, is equal to $2 (or $1 for plan years ending before October 1, 2013) multiplied by the average number of lives covered under the policy or plan.[68]

Employers will not need to count employees participating in on-site health centers in their calculations of PCORTF fees, provided the centers are HIPAA "excepted benefits." However, as described above, there remains some uncertainty as to whether all on-site health centers are HIPAA excepted benefits.[69]

Excise Tax on High-Cost Plans

Section 9001of the ACA imposes an excise tax on health insurance issuers and plan administrators equal to 40% of the amount by which the aggregate value of employer-sponsored health benefits for an employee (including former employees, surviving

[66] IRS, *Interim Guidance on Informational Reporting to Employees of the Cost of their Group Health Insurance Coverage.* Notice 2011-28, March 29, 2011.

[67] This situation may arise, for example, in the case of an employer that builds its costs for its on-site clinic, including free services for employees who are not enrolled in the company's medical plan, into the premium that is paid by enrollees in the medical plan. Does the employer determine how much of the clinic costs should be allocated to employees who are not in the medical plan, regardless of whether such employees ever use the services of the on-site health center?

[68] Additional financing for the Trust Fund is provided through appropriations, beginning with $10 million for fiscal year 2010, rising to $150 million per year for FY 2012 through FY 2019.

[69] The Internal Revenue Service issued a Notice on June 8, 2011 (Notice 2011-35) seeking comments as it develops regulations and guidance on how the PCORTF fees should be determined and paid.

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spouses and other primary insured individuals) exceeds a threshold amount. This so-called "Cadillac plan tax" is scheduled to apply for taxable years after 2017. The threshold amount begins at $10,200 for self-only coverage and $27,500/other than self-only coverage, subject to an adjustment for unexpected increases in medical costs prior to 2018, and increased by an age and gender excess premium amount. After 2018, the threshold is indexed for general inflation.[70] Thresholds are increased by $1,650 for self-only coverage and $3,450 for other than self-only coverage for certain retirees and individuals in designated high-risk professions. Eligible retirees are those age 55 and older who are not Medicare eligible and are receiving employer-sponsored retiree coverage. Employees in high-risk professions are specifically defined in the statute.[71]

The excise tax will have to be paid by the plan administrator for self-insured group plans, health flexible spending accounts (FSAs), or health reimbursement accounts (HRAs). If an employer acts as plan administrator or makes contributions to an HSA or Archer MSA, the employer will be required to pay the tax. Parties that fail to comply will be subject to monetary penalties.

To calculate the aggregate value of all employer-sponsored health coverage, employers and plan administrators will need to look at what is excludable from gross income under Code section 106. This generally includes health insurance and coverage under self-insured group health plans.[72] The statute provides that the value of coverage be calculated in the same manner as that used to determine COBRA premiums.[73]

It appears that on-site health centers must be included in the calculation of the aggregate value of employer-sponsored health benefits, thus making it more likely that a plan will exceed the threshold amount triggering the excise tax. Although the employer (or insurer) is responsible for paying the excise tax, most analyses, including

[70] Specifically, the health cost adjustment factor is equal to 100% plus the amount, if any, by which the per employee increase in the cost of coverage under the Blue Cross/Blue Shield (BC/BS) standard benefit option under the Federal Employees Health Benefits Plan (FEHBP) for the period 2010 to 2018 exceeds 55% (using the 2010 benefits package). For 2019, the thresholds, as established for 2018, are indexed annually to the CPI-U plus one percentage point, rounded to the nearest $50. For 2020 and beyond, the thresholds are indexed to the CPI-U rounded to the nearest $50. The age and gender adjustment is equal to the amount by which the premium cost of the FEHBP BC/BS standard option priced for the age and gender of the employer's employees exceeds, if at all, such coverage priced for the age and gender of the national workforce.

[71] High-risk professions include law enforcement, fire protection, out-of-hospital emergency medical care, longshore work, construction, mining, agriculture (excluding food processing), forestry and fishing. Retirees with at least 20 years employment in these professions are also eligible for the increased threshold.

[72] The following employer-sponsored coverage is not included: coverage for treatment of the mouth or eye provided under a separate policy, long-term care insurance, accident/disability coverage, worker's compensation insurance, general liability and automobile liability insurance, supplements to liability insurance, automobile medical insurance, credit-only insurance, and other similar medical care coverage that is secondary or incidental to other insurance. Specific disease or fixed hospital or other indemnity insurance is excepted unless any portion of the coverage is employer-provided.

[73] In the case of insured employer-sponsored coverage, the excise tax will be allocated among all insurers providing benefits to employees based on the ratio of the value of the benefits provided by the insurer to the total benefits provided by the employer to the employee.

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that of the Congressional Budget Office, say that the amounts would likely be passed along to employees through increased plan premiums. Most people could avoid the excise tax, however, by enrolling in plans with lower premiums. Alternatively, employers could lower plan premiums by managing benefits more tightly or covering fewer services.[74]

Although about 12% of covered individuals will be in employer plans subject to the excise tax in 2018,[75] more workers will likely be affected as additional plans become subject to the excise tax over time because the threshold amounts are likely to exceed the inflation adjuster, which is the consumer price index (CPI). Again, this will encourage many of those employers newly affected by the excise tax to scale back coverage. According to CMS' Office of the Actuary, "[t]his continuing cycle would have a moderate impact on the overall growth of expenditures for employer-sponsored insurance. The effect of the excise tax on reducing health care cost growth would depend on its ongoing application to an expanding share of employer plans and on an increasing scope of benefit reductions for affected plans. Since this provision is characterized as affecting high-cost employer plans, its broader and deeper impact could become an issue."[76]

As discussed in section II of this paper, on-site health centers are operated by employers in part to lower their overall employee benefit plan costs by encouraging health promotion and disease prevention. It thus seems counterproductive to require that the costs for on-site health center services be included in the aggregate employer costs for purposes of determining whether the plan should be subject to the ACA's high-cost plan excise tax. Moreover, the methodology for determining the tax may be problematic. Similar to the issues raised with respect to the W-2 reporting requirements under the ACA, employers will have to include the costs of any employees with access to an on-site health center in the calculation of the value of the health benefit plan even if such employees are not participating in the employer's medical plan.

[74] Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, November 30, 2009. (Note that this analysis predates final passage of the ACA.)

[75] Foster R. *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended*. Centers for Medicare & Medicaid Services, April 22, 2010. www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

[76] Foster R. April 22, 2010.

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On-Site Health Centers After Implementation of the Health Insurance Exchanges

The operation of state-based exchanges as a potentially attractive source of health insurance for individuals beginning in 2014 could lead some employees to obtain health insurance through an exchange instead of through their employer's group health plan. If one (or more) employee elects to obtain coverage from an exchange and qualifies for low-income subsidies that help pay for premiums and cost sharing, then the employer is subject to a federal penalty that is the lesser of $3,000 per full-time employee receiving a subsidy or $2,000 per full-time employee, minus the first 30 full-time employees.[77] Should that employee continue to use the services of the employer's on-site health center, then the employer would still have to account for the center's services for purposes of meeting the ACA's W-2 reporting requirement. However, it appears that the $3,000 penalty would not be included in the calculation of the aggregate cost of the health benefit plan for purposes of determining whether the plan triggered the high-cost plan excise tax.

Assuming a state opens its exchange to larger employers beginning in 2017, some larger firms may elect to eliminate their self-insured health plans and buy coverage for their employees from the state exchanges. Such an employer, nevertheless, could decide to operate an on-site health center to provide a range of medical services, perhaps for free or for a copayment. The question then becomes: can on-site health centers be combined with the insured health insurance products sold through an exchange?

Although federal regulations are unlikely to address such a scenario for some years to come, it would seem likely that the employer in this instance would still be required to calculate the per-employee value of the on-site medical care for purposes of the W-2 reporting requirement. Presumably, the on-site health center services would also have to be valued for purposes of compliance with the excise tax on high-cost health plans, although it seems likely that the value would fall far short of the threshold triggering the tax. Depending on the nature of the center services, the other federal requirements described above may or may not apply.

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[77] If a large employer does not offer "minimum essential coverage" to full-time employees and their dependents and at least one employee obtains a premium assistance tax credit in an exchange, a penalty of $2,000 per full-time employee will be imposed, with the first 30 employees not counted. If the employer offers minimum essential coverage and at least 1 employee obtains a premium assistance credit, a penalty of $3,000 per subsidized employee (capped at amount of penalty for not offering coverage) will be imposed. Employees are only eligible for premium credit if employer coverage is <60% actuarial value or employee contribution is at least 9.5% of income.

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V. State Laws and On-Site Health Centers

Some state laws have a bearing on the operation of on-site health centers. These may raise some concerns or at least require a sponsoring employer or its vendor to organize in certain ways, recruit specific types of health care professionals, and take other steps to demonstrate compliance. The ERISA exemption from state laws would not apply for any of these state law requirements even if the employers set them up as ERISA plans.

The most important state laws relate to licensure of health care facilities and providers, data privacy and access, disposal of biomedical waste, handling of laboratory specimens and storage, and dispensing of pharmaceuticals. Some states also have corporate practice of medicine laws that restrict or prohibit corporations from providing services through employed physicians. State laws also vary in terms of credentialing and oversight requirements for mid-level providers, such as nurse practitioners, which can affect the staffing of on-site health centers.[78]

Variations in state laws may present a challenge for employers with on-site health center locations across state lines. While different center sites can be tailored to different regulatory environments, employers may find it simpler to standardize across sites.[79] Because many employers engage vendors to operate their on-site health centers, such standardization is one of the services that can be facilitated by the vendor.

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[78] Center for Studying Health System Change, December 2010.

[79] One corporation, for example, was prohibited from extending clinic services to non-employees in Connecticut under the state's Department of Labor licensing regulations. Consequently, the company has carried employee-only eligibility over to clinic locations in other states. Center for Studying Health System Change, December 2010.

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VI. Policy Recommendations

The regulatory environment needs to adapt to the evolution of on-site health centers as employers continue to focus on lower spending growth, improved employee access to appropriate and high quality services, wellness initiatives, productivity, and the imperative to attract and retain the best possible workforce. Those developments are particularly important as the ACA is implemented with increasing attention to employee benefits, wellness, and the need to transform health care delivery to lower spending and ensure value, all of which align with the goals of the on-site health center model. Similarly, public policymakers need to recognize and encourage proven initiatives, such as on-site health centers, while ensuring appropriate protections for employees.

There are several priority areas for attention. The following section reviews the issues and presents recommendations for consideration.[80]

HIPAA Portability

Currently, HIPAA guidance has not clarified whether all “on-site medical clinics”— regardless of the extent of services provided — fall within the definition of “excepted benefits.” Such clarification would provide certainty for employers who provide on-site health centers with respect to HIPAA portability and other federal laws.

> **Recommendation: Clarify that on-site health centers will be considered “excepted benefits” under HIPAA as long as they are supplemental to major medical coverage.**

As an alternative, guidance could provide that on-site health centers will be considered “excepted benefits” if the costs of such centers do not exceed a certain percentage (e.g., 10%) of the costs of employer-sponsored health coverage.

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[80] Some of these approaches may require legislative changes, others changes in regulation or guidance.

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Internal Revenue Code

Three of the Internal Revenue Code (Code) issues identified in section IV of this paper merit attention.

- **HDHP/HSA:** The IRS has stated in guidance that an individual will be eligible for an HSA even if he or she has access to "free health care or health care at charges below fair market value from an employer's on-site clinic," provided "the clinic does not provide significant benefits in the nature of medical care (in addition to disregarded coverage or preventive care)." However, there remains uncertainty as to what amounts to "significant" medical care. *See pages 24-25.*
- **W-2 reporting:** The ACA's Form W-2 reporting requirement raises the issue of how an employer should calculate and allocate the cost of an on-site health center for Form W-2 purposes. Requiring W-2 reporting of the costs of on-site health centers may create difficulties in allocating these costs among employees who may or may not use an on-site health center, such as employees who are not covered under the employer's medical plan (typically because they get coverage through their spouses' plans) but may use the center for a limited number of services. *See pages 26-27.*
- **Excise tax on high-cost plans:** The application of the excise tax on high-cost plans, beginning in 2017, raises issues similar to those associated with Form W-2 reporting. *See pages 27-29.*

Recommendation: Establish a single, uniform standard for the application of Internal Revenue Code requirements to on-site health centers.

In applying the Code's requirements to on-site health centers, employers need a clear and consistent standard that encourages and reflects the benefits of on-site health centers. This standard could take different forms:

- The simplest and most efficient standard would make the treatment of on-site health centers under the Code consistent with that under HIPAA, provided the HIPAA definition of "excepted benefit" includes any on-site health center that is supplemental to major medical coverage. Under this standard, on-site health centers would be exempt from the Code's requirements, provided they satisfy this definition of "excepted benefit."
- As an alternative, the IRS could adopt the HDHP/HSA standard under which on-site health centers would be exempt from the Code's requirements, provided the benefits provided through an on-site health center merely supplement coverage under a major medical plan.

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COBRA Continuation Coverage

On-site health centers typically allow access to employees only, and often only those employees at a particular work site. This policy is applied for safety and security reasons, especially at manufacturing and warehouse facilities; and for practical reasons, such as if the facility is remote and is located far from where dependents live. On-site health centers are exempt from COBRA requirements if the care consists primarily of first aid provided free of charge to current employees only during working hours to treat conditions that arise during working hours. Only about one-fourth of centers allow access by dependents of current employees. A COBRA issue may arise as to whether a former worker who elects to continue his or her employer's coverage through COBRA must also be allowed to retain access (at the employee's expense) to the on-site health center even though the individual no longer works for that employer. Current regulations do permit employers to split their health coverage into two separately-priced plans for purposes of facilitating COBRA coverage for former employees that do not include the services of an on-site health center.

Recommendation: Establish an exemption to COBRA's continuation of coverage requirements for on-site health centers.

The simplest and most efficient form of exemption would make the treatment of on-site health centers under COBRA consistent with that under HIPAA, provided the HIPAA definition of "excepted benefit" includes any on-site health center that is supplemental to major medical coverage. Under this standard, on-site health centers would be exempt from COBRA's continuation of coverage requirements, provided they satisfy this definition of "excepted benefit."

Patient-Centered Outcomes Research Trust Fund Fee (PCORTF)

The PCORTF fee applies to employees covered under the employer's group health plan but does not apply to "excepted benefits." There is some uncertainty as to whether all on-site health centers are "excepted benefits" and therefore excluded for purposes of the PCORTF fee.

Recommendation: Clarify that all on-site health centers are excluded for purposes of the PCORTF fee.

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