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Wellness Programs

Final Wellness Program Rules Bring Health Care Employers New Challenges and Opportunities to Promote Employee Wellness

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Health care providers, as employers, have been on the leading edge of encouraging healthier lifestyles and wellness among their employees, which enhances productivity and the image of the organization's services in its community. Due to the nature of the services they provide, hospitals and health care systems are in a unique and favorable position, as employers, to promote wellness initiatives among employees, and to reduce health plan costs. Some health providers also have leveraged successful employee wellness programs into new service lines by providing non-health care employers wellness program services. Wellness programs must be re-evaluated and updated in light of new regulatory guidance.

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New Regulations Effective in 2014

The Department of Health and Human Services, Department of Labor, and Department of the Treasury (collectively, the departments) recently released final regulations clarifying and amending standards for nondiscriminatory wellness programs to reflect changes to existing provisions made by the Patient Protection and Affordable Care Act of 2010.[1] The final regulations (2014 final rules) apply to all group health plans (including grandfathered plans) and group health insurance coverage for plan years beginning on or after Jan. 1, 2014. The 2014 final rules present new compliance challenges, as well as opportunities to emphasize healthy lifestyles and wellness.

HIPAA Prohibits Discrimination Based on a Health Factor

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) generally prohibits group health plans and group health insurance issuers from discriminating against individual participants and beneficiaries based on a health factor. Health factors include health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. However, wellness programs designed to promote health or prevent disease, including those that offer rewards to employees for participating, are excepted from the HIPAA nondiscrimination provisions if they meet certain conditions.

[1] *See* Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 29 C.F.R. Part 2590, available at http://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinalrule.pdf

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Highlights - Key Changes from the Existing HIPAA Nondiscrimination Wellness Program Requirements Include:

- Increase in maximum total reward to 30% of cost of coverage (additional 20%, for a total of 50%, for programs related to preventing or reducing tobacco use)
- Rules for health-contingent wellness programs differ depending on whether the program is activity-only or outcome-based
- Full reward must be provided even if it takes some time to satisfy a reasonable alternative standard
- Outcome-based programs must provide (automatically) access to alternative standards for participants not meeting the initial standard
- A plan must accommodate a participant's personal physician's recommendations in some instances
- A plan is not required to offer additional alternative standards if the alternative offered is a participatory alternative standard, but a plan must continue to offer additional alternatives if those alternatives are health-contingent
- Simplified model language for notice about the availability of reasonable alternative standards

Wellness Programs Exception

The 2014 final rules build upon rules issued by the Departments in 2006 related to the wellness program exception (2006 rules) and proposed rules issued by the departments in November 2012. The 2014 final rules maintain the two distinct categories of programs established under the 2006 rules: participatory wellness programs and health-contingent wellness programs. Significantly, the 2014 final rules divide health-contingent wellness programs into two types: activity-only programs and outcome-based programs.

Participatory Wellness Programs

Participatory wellness programs (previously called participation only programs under the 2006 rules) do not require an individual to satisfy a standard related to a health factor as a condition for obtaining a reward. For example, an employer may reimburse the membership cost of a fitness center, provide a reward to participate in diagnostic testing that is not outcome-based, or provide a deductible or copayment waiver to encourage preventive care, such as prenatal care or well-baby visits. Participatory programs are exempt from the HIPAA nondiscrimination provisions as long as participation in the program is made available to all similarly situated individuals, regardless of health status. There are no limits for financial incentives allowed for participatory programs. The 2014 final rules are consistent with the 2006 rules for participation only programs.

Takeaway: Keep in mind that different rules apply to whether a reward provided is taxable income to the participant. Even if the program is participatory (and therefore not subject to the five requirements for health-contingent programs described below), the reward offered may be taxable income under federal and/or state law. A common example is reimbursement of fitness center membership fees or the provision of gift cards.

Health-Contingent Wellness Programs

Health-contingent wellness programs (previously called standard-based programs under the 2006 rules) require individuals to satisfy a standard related to a health factor as a condition for obtaining a reward. Under the 2014 final rules, a ''reward'' includes both an incentive in the form of a reward (*e.g.*, premium discount, waiver of cost-sharing amount, an additional benefit or any financial or other incentive) and an incentive in the form of avoiding a penalty (*e.g.*, the absence of a premium surcharge or other financial or nonfinancial disincentive). Some popular rewards are reduced premiums, employer contributions to a health flexible spending account or health savings account, cash, and gift cards. In the 2014 final rules, health-contingent programs are further divided into activity-only programs and outcome-based programs:

- **Activity-only programs** require individuals to complete an activity related to a health factor to obtain the reward, but the activity need not result in a specific health outcome. For example, the employer may provide a reward for a walking, diet, or exercise program.
- **Outcome-based programs** require individuals to attain or maintain a specific health outcome in order to obtain the reward. For example, an employer could provide a reward for not smoking, for obtaining a certain result on a biometric screening, or for maintaining a certain body mass index (BMI).

Each health-contingent program must meet five requirements to be exempt from HIPAA nondiscrimination provisions.

1. Frequency of Opportunity to Qualify

The program must give eligible individuals an opportunity to qualify for the reward at least once per year.

2. Size of Reward

The 2014 final rules increase the total reward that may be offered for all wellness programs under a plan from 20 percent to 30 percent of the total cost of employee-only coverage under the plan (including both employee and employer contributions). If dependents participate in the wellness programs, the total cost of coverage considered is the coverage in which the employee and dependent(s) are enrolled. Further, if the program is designed to prevent or reduce tobacco use, the maximum reward is 50 percent of the cost of coverage.

Takeaway: The maximum reward applies to all wellness programs in place under one plan. Therefore, if a plan offers both a tobacco-reduction program and an additional health-

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contingent program, the maximum reward for both programs may not exceed 50 percent of the cost of coverage. Within that 50 percent, the health-contingent program not related to tobacco use may not exceed 30 percent of the cost of coverage.

Example of Maximum Total Reward

Type of Coverage	Employer Pays	Employee Pays	Total Premium	Total Non-Tobacco Reward	Additional Tobacco Reward	Total Maximum Reward
Employee Only	$2,700	$900	$3,600	$1,080	$720	$1,800
Employee + Spouse	$4,500	$4,500	$9,000	$2,700	$1,800	$4,500

3. Reasonable Design

Health-contingent programs must be reasonably designed to promote health or prevent disease, whether activity-only or outcome-based. A program is reasonably designed if it:

- Has a reasonable chance of improving the health of, or preventing disease in, participating individuals;
- Is not overly burdensome;
- Is not a subterfuge for discrimination based on a health factor; and
- Is not highly suspect in the method chosen to promote health or prevent disease.

This determination is based on all relevant facts and circumstances.

Takeaway: Wellness programs are not required to be accredited or based on particular evidence-based clinical standards, but such practices are encouraged as a best practice by the departments because they may increase the likelihood of wellness program success.

- **Activity-only programs:** In order to be reasonably designed, activity-only wellness programs must take into account each factor set out above in light of all relevant facts and circumstances.
- **Outcome-based programs:** In addition to the facts and circumstances determination, in order to be reasonably designed, an outcome-based wellness program must provide a reasonable alternative standard to qualify for the reward for all individuals who do not meet the initial standard that is related to a health factor.

4. Reasonable Alternative Standard and Uniform Availability

Special Rules for Activity-only and Outcome-based programs

- **Activity-only programs:** The 2014 final rules related to reasonable alternative standards offered by activity-only programs essentially follow the 2006 rules, but now limit those rules to activity-only programs. Under these rules, a reward is not available to all similarly situated individuals unless the program allows a reasonable alternative standard (or waiver of the applicable standard) for any individual for whom it is either unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard or medically inadvisable to attempt to satisfy the otherwise applicable standard. It is permissible for a plan to require verification (such as a statement from the individual's personal physician) that the individual has such a medical condition, but only if it is reasonable under the circumstances. The 2014 final rules specify that it would be reasonable to require such verification if medical judgment is required to evaluate the validity of a request for a reasonable alternative standard.
- **Outcome-based programs:** The 2014 final rules related to reasonable alternative standards offered by outcome-based programs are significantly changed from the 2006 rules. If an individual does not meet a plan's target standards for outcome-based programs based on a measurement, test, or screening related to a health factor, the individual must be provided with a reasonable alternative standard, *regardless* of any medical condition or other health status, to ensure that outcome-based initial standards are not a subterfuge for discrimination or underwriting based on a health factor.

If a reasonable alternative standard is, itself, an outcome-based program, it also must satisfy the requirements of the 2014 final rules, including offering another reasonable alternative standard, which makes maintaining an outcome-based program more difficult due to the potential for a never-ending cycle of reasonable alternative standards. However, certain special rules apply to prevent such a never-ending cycle. First, the reasonable alternative standard cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual's circumstances. For example, if the initial standard is to achieve a BMI less than 30, the reasonable alternative standard cannot be to achieve a BMI less than 31 on that same date. A permissible reasonable alternative standard in this case would be to reduce the individual's BMI by a small amount or percentage over a realistic period of time, such as within a year. Second, an individual must be given the opportunity to comply with the recommendations of the individual's personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard de-

fined by the plan, but only if the physician joins in the request.

Under outcome-based programs, it is *not* reasonable to require verification that a health factor makes it unreasonably difficult or it is medically inadvisable for the individual to satisfy the otherwise applicable standard. However, if the reasonable alternative standard to an outcome-based program is an activity-only program, then the plan may seek such verification, if reasonable under the circumstances, with respect to the activity-only portion of the program.

Takeaway: Prior to the 2014 final rules, many plan sponsors began to make their wellness programs more stringent in the hopes of ensuring that individuals actually would become healthier. Such efforts still may be possible, but plan sponsors should structure such programs carefully to ensure consistency with the new restrictions on outcome-based programs. Hospitals and health care systems may be in a better position to create meaningful alternatives for their employees through the use of their own internal expertise, facilities, and existing programs.

Facts and Circumstances Determine Whether an Alternative Standard Is Reasonable

The determination of whether a plan has provided a reasonable alternative standard is based on the facts and circumstances. The 2014 final rules provide that the following factors, among others, should be taken into account in determining whether a plan has provided a reasonable alternative standard:

- If the reasonable alternative standard is completion of an educational program, the plan must make the educational program available or assist the employee in finding such a program, and may not require an individual to pay for the cost of the program.
- The time commitment required must be reasonable.
- If the reasonable alternative standard is a diet program, the plan is not required to pay for the cost of food but must pay any membership or participation fee.
- If an individual's personal physician states that any plan standard (including the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Plans may impose standard cost sharing for medical items and services furnished in accordance with the physician's recommendations.

Takeaway: If a plan offers more than one reasonable alternative standard, the 2014 final rules do not address the extent to which all alternatives made available must be paid for by the plan. For example, if an individual has high cholesterol and only can receive the reward by participating in a coaching program, is it enough that the plan provides a free video program even though in-person coaching is an additional charge? Similarly, it is unclear the extent to which supplies or materials related to the alternative must be paid for by the plan, other than in the specific examples listed. Additional guidance on these issues would be helpful.

Timing and Form Requirements for Reasonable Alternative Standards

Specific requirements for a reasonable alternative standard depend upon whether the alternative is a participatory or health-contingent wellness program. If the alternative is, itself, a participatory wellness program, no other alternative need be offered during that year. To the extent that a reasonable alternative standard is, itself, a health-contingent wellness program, it must satisfy the requirements in the 2014 final rules for either activity-only or outcome-based programs. For health-contingent alternatives, plans must continue to offer a reasonable alternative standard, whether it is the same or different, and cannot limit the number of times a reasonable alternative standard is offered. For example, if a plan offers a walking program as a reasonable alternative to a running program, the walking program is an activity-only program and therefore the plan also must provide a reasonable alternative for individuals for whom it is unreasonably difficult due to a medical condition to complete the walking program. If the reasonable alternative standard is, itself, an outcome-based program, it must adhere to special rules as previously described.

Takeaway: The departments noted that overcoming a tobacco addiction or meeting other health outcomes (e.g., weight loss) may require a cycle of failure and renewed effort.

Plans always may waive the otherwise applicable standard instead of providing a reasonable alternative standard. Additionally, plans do not need to establish a particular reasonable alternative standard in advance of an individual's specific request for one, as long as one is provided upon request. Reasonable alternative standards may be provided for a class of individuals or on an individual-by-individual basis.

Full Reward Must Be Provided to All Similarly Situated Individuals

The full reward under either an activity-only or an outcome-based program must be available to all similarly situated individuals. Individuals who qualify by satisfying a reasonable alternative standard must be provided the same, full reward that is provided to individuals who qualify by satisfying the otherwise applicable standard. This same, full reward must be provided even if an individual takes some time to request, establish, and satisfy a reasonable alternative standard. For example, if a calendar year plan offers a premium discount and an individual satisfies a reasonable alternative standard on April 1, the plan still must provide the premium discounts for January, February, and March.

Plans may determine how to provide the portion of the reward for the period before the alternative was satisfied (*e.g.*, a lump sum payment for the retroactive period or pro rata over the remainder of the year) as long as the method is reasonable and the individual receives the full reward. If the alternative standard is not satisfied until the end of the year, the plan may provide a retroactive payment for that year within a reasonable

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time after the end of the year, but may not provide pro rata payments over the following year.

Takeaway: Plan sponsors should be cautious about providing a Year 1 reward in Year 2, and should consider, in particular, the IRS rules relating to deferral of compensation. Additional guidance from the departments would be helpful.

5. Notice of Availability of Reasonable Alternative Standard

The plan must disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard) in all plan materials describing the terms of all health-contingent wellness programs (*e.g.*, summary plan descriptions and open enrollment materials). This disclosure must include contact information for obtaining the alternative. Additionally, in a change from the 2006 rules, the disclosure also must include a statement that recommendations of an individual's personal physician will be accommodated. For outcome-based wellness programs, a similar notice must be included in any communication that any individual did not satisfy an outcome-based standard. If plan materials only mention the existence of the program, without describing specific terms, disclosure is *not* required. The following sample language satisfies the requirement:

''Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and if you wish, your doctor) to find a wellness program with the same reward that is right for you in light of your health status.''

Takeaway: The new sample language is intended to be simpler to understand and to increase the likelihood that those who qualify for an alternative standard will contact their plan to request one.

How Rewards Impact Minimum Value and Affordability Under the Employer Mandate

Employers also are affected by proposed minimum value and affordability rules in connection with the shared responsibility rules beginning in 2015. Recent guidance addresses how to calculate for wellness incentives when performing affordability and minimum value testing. (*See* Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 26 C.F.R. Part 1, http://www.gpo.gov/fdsys/pkg/FR-2013-05-03/pdf/2013-10463.pdf.) To determine the affordability of employer-sponsored coverage, wellness program incentives should be broken into two groups: incentives related to tobacco use and all other (non-tobacco related) incentives. For incentives related to tobacco use, the employer should assume the wellness incentive is earned when calculating affordability. For example, if an employer charges a higher premium to tobacco users, the employer would calculate affordability using the premium charged to non-tobacco users. For all other incentives, the employer should assume the wellness incentive is not earned. Here, if an employer charges a lower premium for those who complete a wellness incentive program, the employer would calculate affordability based on the premium charged to those who do not complete the incentive program. Similar rules apply when determining whether employer sponsored coverage provides minimum value.

Other Compliance Issues

This is a good time for employers to consider their wellness programs in light of new standards under the 2014 final rules. Although health care providers are in a unique position to leverage internal resources to create viable wellness programs, they will also want to carefully consider employee relations and confidentiality in doing so, including compliance with the HIPAA privacy rules if the employer group health plan uses internal providers or departments to run it wellness initiatives. For example, some health care providers are using internal care managers to run their health plan disease management programs. Under such circumstances, a services agreement between the health plan and the internal provider or department, including a business associate agreement, may be required.

Additionally, employers are advised to consider compliance of their wellness programs with various other laws impacting wellness programs, including the Genetic Information Nondiscrimination Act of 2008, the Family and Medical Leave Act, the Americans with Disabilities Act of 1990, as amended, federal and state tax laws, ERISA's fiduciary provisions, HIPAA privacy rules, and continuation coverage rules under COBRA. Other federal and state laws also may impact wellness programs. For your reference on compliance matters affecting wellness programs, please refer to the following Legal Compliance Checklist for wellness programs.

Legal Compliance Checklist

Have you considered . . .

- Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1101 et seq. - Is it a group health plan?
- HIPAA Nondiscrimination Rules, 29 C.F.R. Part 2590.702 et seq. - Does it require achieving a particular health status?
- Genetic Information Nondiscrimination Act of 2008 (GINA), 29 U.S.C. § 1182 - Is there a request for, or use of, genetic information (including family medical history)?
- Americans with Disabilities Act (ADA), 42 U.S.C. § 12101 et seq. - Is there discrimination based on a disability (broadly defined, including obesity, nicotine addiction, and failure to meet biometric standards, such as cholesterol level)?
- Tax Treatment - Is there a financial incentive which is income subject to federal and/or state taxes?

- HIPAA Privacy Rules, 45 C.F.R. Part 160 et seq. - Does the program use or disclose protected health information from a health plan? Do all vendors providing services for the program have business associate agreements with the plan?
- Health Care Reform (the Patient Protection and Affordable Care Act (PPACA), 29 U.S.C. § § 218a - 218c) - Will the program be subject to new reporting obligations for wellness and health promotion activities? (no guidance yet)
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 29 U.S.C. § 1161 et seq. - Is it a group health plan subject to continuation coverage requirements?
- Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e et seq. - Does the program have a disparate impact on individuals because of race, color, religion, sex or national origin (e.g., because it is more difficult for members of a protected class to achieve a health standard)?
- Age Discrimination in Employment Act of 1967 (ADEA), 29 U.S.C. § 621 et seq. - Does the program have a disparate impact on older employees?
- National Labor Relations Act (NLRA), 29 U.S.C. § § 151 - 169 and collective bargaining agreements - Is the program a mandatory subject of bargaining? Do CBAs require renegotiation to permit the program?
- Laws Applicable to Raffles/Sweepstakes - Is there an incentive that is based on chance?
- Other Employment and State Laws - Have you thought about the impact of:

o Family and Medical Leave Act (FMLA), 29 U.S.C. § 2601 et seq. and state family and medical leave laws;

o Fair Labor Standards Act (FLSA), 29 U.S.C. § 201 et seq. and state wage/hour, wage payment laws;

o Lawful use/state privacy laws;

o State/local discrimination; and

o Workers' compensation?

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