EMPLOYEE BENEFITS

FINAL REGULATIONS ISSUED ON NONDISCRIMINATORY WELLNESS PROGRAMS – NEW RULES FOR OUTCOME-BASED PROGRAMS

by Jordan Schreier

On May 29, 2013, the Departments of Labor, Treasury and Health and Human Services released final regulations on nondiscriminatory wellness programs in group health plan coverage. The regulations largely follow the proposed regulations that were issued in November 2012, with a few important exceptions. Many employers are in the process of designing their 2014 wellness programs, so prompt attention to the final regulations is important.

The following are highlights of the final regulations.

General Provisions

- Prior to PPACA, HIPAA's nondiscrimination rules generally prohibited health insurers and group health plans from discriminating on the basis of health status as to eligibility, benefits or premiums. However, this prohibition did not apply to health-contingent premium or cost-sharing discounts, surcharges, or other incentives offered or imposed through a wellness program that met specific requirements. The final regulations replace the existing HIPAA nondiscrimination regulations related to wellness programs and are effective for group health plans and health insurance issuers for plan years beginning on or after January 1, 2014. The final regulations apply to health insurance issuers and group health plans, regardless of whether they are large or small, fully insured or self-insured or grandfathered or non-grandfathered.

- The regulations do not affect the applicability of other laws such as the ADA, GINA, Title VII and ERISA's fiduciary provisions, or any state law, which may impose further limitations on wellness programs (though it is possible ERISA preemption could apply to such state laws – this can only be determined on a case by case basis). The wellness regulations are intended only to address programs that could violate the PPACA prohibition against discrimination based on health status in the absence of the wellness program exception. The key is whether or not a program offers a "reward." A reward can be a premium discount or rebate, a waiver of all or part of cost sharing, an additional benefit, or some other financial or nonfinancial incentive. A reward also includes the avoidance of a premium surcharge.

- The regulations confirm the increase in the permissible wellness incentive from 20% of the cost of the employee only coverage permitted by HIPAA to 30% of the cost of the employee only coverage (and up to 50% for programs that seek to reduce tobacco usage).

- The final regulations (like the prior HIPAA regulations) divide wellness programs into participatory and health-contingent categories. Participatory programs either do not offer rewards or do not make rewards contingent on the individual meeting a health-factor-related standard. For example, paying for a gym membership or smoking cessation program or offering a reward for undergoing a diagnostic test or attending an educational seminar is participatory as long as there is no penalty or reward associated with the outcome of the program or test. The only condition on participatory programs is that they have to be made available to all similarly situated employees regardless of health status. A health-contingent program is one which requires an individual to satisfy a standard related to a health factor to obtain a reward.

Health-Contingent Wellness Programs

- The final regulations, unlike the proposed regulations, divide health-contingent wellness programs into two categories, **activity-only programs** and **outcome-based programs**.

  - Activity-only programs offer rewards to an individual who performs or completes an activity — such as running, walking, diet, or exercise — which some individuals may not be able to participate in because of a health factor, such as asthma, pregnancy, or recent surgery. To be an activity-only program, the program may not require the individual to achieve or maintain a specific health outcome.

  - Outcome-based programs offer a reward to an individual to achieve or maintain a specific health outcome, such as not smoking or attaining a biometric screening result. A program is outcome-based if it requires a participant to submit to a test, screening, or measurement even if those who do not achieve the required outcome may still receive the reward by some alternative means, including by completing a participatory wellness program (such as education). The key factor is whether those who achieve the required health outcome receive a reward for doing so. If they do, the program is outcome-based.

- Health-contingent programs, both activity-based and outcome-based, must satisfy five requirements, the fourth of which is a meaningful change from the prior HIPAA rules.

  - One, every individual eligible for the program must be given an opportunity to qualify for the reward once a year.

  - Two, as noted above, the total reward offered for a health-contingent program cannot exceed 30% of the total cost of coverage of an employee under the plan, taking into account both the employer and employee contribution to the cost (and not just the employee's premium or contribution). If dependents, such as a spouse or children, can participate in the program, the percentage is applied to the total cost of coverage for the family or individual and spouse. If one family member does not meet program requirements but others do, the plan or insurer has flexibility to determine

what share of the cost of coverage should be attributed to that family member. Plans and insurers can offer a total reward of up to 50% for participation in tobacco cessation programs.

- Three, health-contingent wellness programs must be reasonably designed. This means that they must have a reasonable chance of improving health or preventing disease, not be overly burdensome or be a subterfuge for health status discrimination, and not be highly suspect in the method chosen to promote health or prevent disease. The rules do not require programs to be evidence-based or accredited. Plans and insurers may establish more favorable rules for persons with adverse health factors.

- Four, the full reward under the program, whether activity or outcome-based, must be available to all similarly situated individuals. A program is not available to all similarly situated individuals unless the program provides a reasonable alternative standard (or waiver of an otherwise applicable standard) for achieving the reward. If it takes time to request, establish, and satisfy the reasonable alternative standard, the same full reward must still be offered as would have been offered had the individual attained the initial standard for the plan year. To satisfy this requirement, plans might have to provide a retroactive payment or pro rata payment over the rest of the year, but the reward cannot be delayed until the following year.

  For **activity-based programs**, the reasonable alternative must be made available for individuals for whom it is unreasonably difficult due to a medical condition to satisfy the standard or for whom it is medically inadvisable to attempt to do so. This is similar to the prior HIPAA rule. A plan may require verification of the difficulty or inadvisability, for example a statement from the individual's personal physician.

  For **outcome-based programs**, the reasonable alternative rules are more complex. For these programs, the reasonable alternative must be made available to all individuals who fail to comply or maintain compliance with the outcome measure, without requiring verification that the failure to meet the standard is based on a medical condition. This is because by definition, outcome-based programs are difficult for many individuals to achieve (e.g., it is difficult to stop smoking) so anyone who fails to meet the requirement must be offered an alternative. The Preamble to the final regulations makes it clear that the DOL wants every individual to be able to receive a reward, regardless of health status. The alternative standard may not be a requirement to meet a different level of the same standard unless the individual is given additional time to comply which takes into account the individual's circumstances. For example, a BMI standard cannot simply be replaced by a higher BMI standard that must be met immediately. A requirement to reduce BMI to a realistic amount over a realistic period of time (such as within a year) would be permissible. An individual must also be allowed to comply with the recommendation of an individual's personal physician as an alternative standard if the physician joins in the individual's request. This recommendation can later be adjusted by the physician if the individual's health condition requires adjustment. If the alternative proposed by the plan is an activity-based program (such as participation in a diet or exercise program for individuals who fail to meet a weight target), the plan or insurer can require verification if the individual claims that participation in the program is unreasonably difficult or medically inadvisable. However, a plan or issuer may not seek verification that an outcome-based program is unreasonably difficult or medically inadvisable for an individual to achieve.

  For both activity-based and outcome-based programs, a plan or insurer does not need to design a reasonable alternative before an individual requests an alternative, and can provide alternatives to a class of individuals or on an individual-by-individual basis. All facts and circumstances will be taken into account in determining if an alternative is reasonable, but:

  (a) If the alternative is an educational program, the plan or insurer must make it available or assist the employee in finding one and pay for it;

  (b) The time commitment for the alternative must be reasonable (e.g., requiring nightly attendance at a one-hour class would be unreasonable);

  (c) If the alternative is a diet program, the plan or insurer must pay any membership or participation fee, but not for the cost of the food;

  (d) If the individual's personal physician says that the plan standard is not medically appropriate (including the recommendations of the plan's medical professional, if any), the plan or insurer must provide a reasonable alternative that accommodates the personal physician's recommendations (and may charge standard cost sharing under the plan for medical items and services furnished under the physician's recommendation).

- Five, plans and insurers must disclose the availability of a reasonable alternative standard to qualify for the reward (or the possibility of a waiver of the standard) in all plan materials describing the health-contingent waiver program and in all communications disclosing to an individual that he or she did not satisfy an outcome-based standard. The disclosure must include contact information for obtaining an alternative and state that the recommendations of a personal physician will be accommodated. If plan materials only mention that a wellness program is available, the notice is not required. The regulations include sample notice language.

Next Steps

Employers should immediately review the structure of the wellness programs they intend to implement for 2014 and compare these structures to requirements of the final regulations. They should pay particular attention to the new requirements that apply to outcome-based wellness programs and consider what reasonable alternatives they will make available to individuals who do not satisfy the primary outcome-based standard.

As noted above, the final regulations do not address the implications of other laws on wellness programs. The EEOC is reviewing its position on whether wellness programs for which rewards are available are truly voluntary under the ADA, GINA, ADEA and Title VII but there is no indication on when it will respond. Dickinson Wright's employee benefits group recommends that employers review the various other laws that apply to wellness programs and not focus simply on the prior HIPAA regulations and these new final rules.

Dickinson Wright's employee benefits group is available to assist employers in the design and compliance of their wellness programs, their implications under non-PPACA laws and on any other issues related to health care reform.

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