Benefits Alert
Legal developments affecting employee benefits

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This alert is the first in a two-part series describing the compliance obligations for employee wellness programs. Part I of the series discusses the new wellness regulations recently released under the Affordable Care Act, which will go into effect in 2014. Part II will discuss compliance with other laws that govern employee wellness programs.

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Wellness programs after the Affordable Care Act (Part I)

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In our May 20, 2013, Benefits Alert, *What's new with the Affordable Care Act?*, we provided an overview of the proposed wellness program regulations under the Affordable Care Act ("ACA" or "health care reform"), and described the impact of wellness program financial incentives on the determination of whether a group health plan meets the ACA's "minimum value" and "affordability" requirements.

Recently, the Departments of Treasury, Labor, and Health and Human Services (the "Departments") finalized the ACA nondiscrimination rules for wellness programs offered in conjunction with group health plans. For employers, the final rules are a mixed bag. While the rules allow employers to increase the monetary incentives for healthy behavior, they also make it easier for participants to qualify for the incentives at the employer's expense, and in most cases, the monetary incentives count against the employer when determining whether its health coverage is "affordable" for employees.

Background

The Departments last issued final rules regarding nondiscrimination in wellness programs in 2006 under the Health Insurance Portability and Accountability Act (HIPAA). Those rules generally prohibit group health plans and insurers from discriminating against participants as to eligibility, benefits, or premiums based on a health factor. An exception to this general rule allows premium discounts, rebates, or modification of cost sharing (e.g., copayments, deductibles, or coinsurance) for participation in employer wellness programs.

The ACA amended and expanded the HIPAA nondiscrimination and wellness provisions. For the most part, the ACA statute itself adopted the existing HIPAA wellness regulations, and increased the maximum permitted financial incentives. The new regulations interpreting the statutory provisions, however, make many more changes. These final rules apply to all group health plans, regardless of

whether they are grandfathered or non-grandfathered, insured or self-insured, for plan years beginning on or after January 1, 2014.

In many ways, the final rules are similar to the proposed rules issued in November 2012. While the proposed rules also distinguished between "participatory wellness programs" and "health-contingent wellness programs," the final rules further divide health-contingent wellness programs into "activity-only" and "outcome-based" wellness programs, and impose differing compliance burdens on each. A summary of the final rules follows.

Types of wellness programs under the final rule

Participatory wellness programs

Participatory (or "participation-only") wellness programs are programs that either do not provide a reward, or do not include any conditions for obtaining a reward that are based on satisfying a standard related to a health factor. Examples of participatory wellness programs include gym membership reimbursements, diagnostic testing that rewards participation but does not base any part of the reward on the outcome, and rewards for attending no-cost health education seminars.

There is very little regulation of participatory wellness programs under the ACA, and participatory programs do not need to comply with the onerous requirements for health-contingent wellness programs that are described below.

The primary requirement for participatory wellness programs is that they must be available "to all similarly situated individuals regardless of health status." If factors other than health status limit a participant's ability to take part in a program, a participatory wellness program does not discriminate based on a health factor. For example, if a plan made a premium discount available for attendees of an educational seminar, but only healthy individuals could attend (e.g., if it excluded employees on disability), then the program would discriminate based on a health factor because only healthy individuals could reduce their premiums. However, if all similarly situated participants could attend, but someone could not attend because the seminar was held on a weekend when the individual was unavailable, then the program would not discriminate based on health factor.

The final rule has very little else to say about participatory wellness programs, so long as they do not adjust benefits or premiums based on a health factor. As noted in the regulations, however, compliance with the HIPAA/ACA wellness regulations does not ensure compliance with other federal or state laws such as the Americans with Disabilities Act ("ADA") or the Fair Labor Standards Act ("FLSA"), which may impose additional requirements on wellness programs. Thus, employers should consult with counsel to ensure that a participatory wellness program design complies with all applicable laws.

Health contingent wellness programs

In contrast to participatory wellness programs, "health-contingent" wellness programs require an individual to satisfy a standard related to a health factor in order to obtain a reward (or in some cases, they require the participant to do more than a similarly situated individual to obtain the same reward

because of a health factor). A health-contingent wellness program may involve performing or completing an activity related to a health factor or attaining or maintaining a specific health outcome.

Health contingent wellness programs are further divided into two types: "activity-only" and "outcome-based" wellness programs.

- Under an *activity-only wellness program*, an individual must perform or complete an activity related to a health factor to obtain a reward. An activity-only wellness program does not require the participant to attain or maintain a specific health outcome. Examples include walking, diet, or exercise programs.
- In an *outcome-based wellness program*, an individual must attain or maintain a specific health outcome, like not smoking, or receiving certain results on a biometric screening, in order to obtain a reward. The programs often, but not always, have two parts: (1) a measurement, test, or screening as part of the initial standard; and (2) a program that targets individuals who do not meet the initial standard with wellness activities. Examples of outcome-based wellness programs include tests for specific medical conditions or risk factors (e.g, high cholesterol, high blood pressure, abnormal BMI, tobacco use, or high glucose), and provide a reward to employees who are within a normal or healthy range, but require individuals who are outside the normal or healthy range to take additional steps to obtain the reward. Such additional steps can include, but are not limited to, meeting with a health coach, taking a health or fitness course, participating in a tobacco-cessation program, adhering to a health improvement action plan, or complying with a health care provider's care plan. Although individuals who do not meet or maintain the specific health outcome may be offered an educational program or an activity as an alternative to achieve the same reward, and the alternative itself would be considered a "participatory" or "activity-only" wellness program, the overall program is still an "outcome-based wellness program." In other words, if a measurement, test, or screening is part of the initial standard for getting the reward, the program is an outcome-based wellness program.

While many of the requirements in the final rules are the same for both activity-only and outcome-based wellness programs, there are some key differences, discussed below.

Maximum reward increased for health-contingent wellness programs

Under the previous HIPAA wellness regulations, the maximum financial incentive plans could offer for participation in health-contingent wellness programs could not exceed 20% of the health plan's premiums. However, as permitted by the ACA, the new regulations increase the maximum reward to 50% of the premium for health-contingent wellness programs designed to prevent or reduce tobacco use, and 30% of the premium for all other health-contingent wellness programs.

For all health-contingent wellness programs, "rewards" include both "carrot-like" incentives (such as discounts or rebates on premiums, waivers of cost-sharing, providing additional benefits, and any financial or other incentive), as well as "stick-like" penalties (such as surcharges or other financial or nonfinancial disincentives).

Common requirements for both activity-only and outcome-based wellness programs

The intention of the regulations is that, regardless of whether the health-contingent wellness program is activity-based or outcome-based, every individual should have a fair opportunity to receive the full amount of any reward, irrespective of the individual's health status. Thus, all health-contingent wellness programs must comply with the following five standards:

1. **Frequency of opportunity to qualify**—Individuals must be given the opportunity to qualify for the reward at least once each year.

2. **Size of reward**—The total reward offered under all health-contingent wellness programs cannot exceed the applicable percentage (i.e., 50% for health-contingent wellness program designed to prevent or reduce tobacco use, and 30% for all other wellness programs) of the total cost of health coverage, including both employer and employee premium contributions for the benefit option in which the employee is enrolled. If dependents cannot participate in the wellness programs, then the reward cannot exceed the applicable percentage of the cost of single coverage. If dependents can participate in the wellness programs, then the reward cannot exceed the applicable percentage of the cost of coverage in which the employee and dependents are enrolled (such as employee + 1 or family coverage), and any premium variation should be apportioned among the family members eligible for the incentive. For example, where either the employee or the dependents fail to satisfy the tobacco standard, the 50% "reward" (a.k.a., penalty) should be applied on the approximate portion of the premium attributable to the family member who met or failed to meet the standard. While health insurers in the small group market must apply rating variation to family coverage based on the portion of the premium attributable each covered family member, other plans have flexibility to determine apportionment of the reward among family members, as long as the method they choose is reasonable.

3. **Reasonable design**—All health-contingent wellness programs must be reasonably designed to promote health or prevent disease. A wellness 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.

The determination of whether a wellness program is reasonably designed is based on the facts and circumstances. While programs are not required to be accredited or based on particular evidence-based clinical standards, practices like those found in the CDC's *Guide to Community Preventive Services* increase the likelihood that a wellness program is reasonably designed and the Departments recommend the use of these practices. A plan can also establish more favorable rules for individuals with adverse health factors than individuals without adverse health factors.

4. **Uniform availability and reasonable alternative standards**

Establishing a reasonable alternative

Health-contingent wellness programs are required to make the reward available to all "similarly-situated individuals." As described below, this requires that the wellness program make available a reasonable alternative standard to individuals who fail to satisfy the requirements for a reward under certain circumstances. A plan also has the option to waive the standard for an individual and provide the reward without satisfying an alternative.

Plans are not required to establish a reasonable alternative standard in advance of an individual's accommodation request, as long as a reasonable alternative standard is provided (or the condition is waived) upon request. Plans can determine a reasonable alternative standard for an entire class, or provide a reasonable alternative standard on an individual-by-individual basis depending on the facts and circumstances. The ACA's federal external review procedures are triggered when a plan does not provide a reasonable alternative standard upon request.

Is the alternative standard reasonable?

The facts and circumstances are taken into account when determining if a plan has provided a reasonable alternative standard. The factors considered include, but are not limited to:

- If the reasonable alternative standard is a completion of an education program, the plan must make the program available or assist the employee in finding a program. The plan *cannot require the individual to find a program unassisted* and *may not require an individual to pay the cost* of the program.
- The time commitment must be *reasonable*. For example, requiring an individual to attend a one-hour class every night would be unreasonable.
- If the reasonable alternative standard is a diet program, *the plan must pay any membership or participation fee*, but does not have to pay for food.

- If the individual's personal physician states that a plan standard (including the recommendation of the plan's medical professional, if any) is not medically appropriate for the individual, *the plan must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician*. Plans can impose their standard cost sharing under the plan for medical items and services furnished based on a physician's recommendations.

Plan may require different reasonable alternative standards

The regulations permit employers to require different reasonable alternative standards in subsequent years. For example, for tobacco cessation, a reasonable alternative standard in year one might be an educational seminar, and after attending the seminar, the participant would be entitled to the award (regardless of whether he successfully stopped using tobacco products). However, if the participant continues to use tobacco products, then the plan could require the participant to complete a different reasonable alternative standard in year two, such as complying with the recommendations of his personal physician or using a new nicotine replacement therapy. Completion of those recommendations or therapy would qualify him for the reward, regardless of whether he quits. In short, plans cannot cease to provide a reasonable alternative standard simply because a person did not satisfy the initial standard, and plans must continue to offer a reasonable alternative standard year after year, which might be the same or different than the alternative offered in the initial year. If the reasonable alternative standard is itself an activity-only or outcome-based wellness program, then it must also comply with the requirements for an activity-only or outcome-based wellness program, as applicable.

Retroactive payment of reward required upon satisfaction of reasonable alternative standard

A health-contingent wellness program's full reward must be available to all similarly situated individuals who satisfy a reasonable alternative standard. Recognizing that a participant may take some time to request, establish, and satisfy a reasonable alternative standard, the final rules provide that the same full reward must be provided to that individual as is provided to an individual who meets the initial standard. For example, if a calendar year plan offers a premium discount, and an individual satisfies the reasonable alternative standard on April 1, then the plan must provide premium discounts attributable to January, February, and March. Plans have discretion to determine the method of providing the portion of the reward related to the period before the individual satisfied the alternative (e.g., whether to provide for immediate retroactive payment, or prospective pro-rata payment for the remainder of the year), so long as the method is reasonable and the participant receives the full reward. If an individual does not satisfy the reasonable alternative standard until the end of the year, the plan may provide a retroactive payment of the reward for that year within a reasonable time after the end of the year, but cannot

provide pro-rata payments over the year after the year to which the reward corresponds.

5. **Notice of reasonable alternative standard**—Plans must disclose the availability of a reasonable alternative standard for the reward (and, if applicable, the possibility of a waiver) in all plan materials describing the terms of the health-contingent wellness program. The disclosure must include contact information for requesting the alternative standard and a statement that a personal physician's recommendations will be accommodated. For outcome-based wellness programs, this notice must also be included in any notice to an individual that he did not satisfy the initial outcome-based standard. The regulations include sample language that plans can use for the disclosure.

   Disclosure of the reasonable alternative standard is not required to appear in plan materials that merely mention that a wellness program is available, but do not describe its terms. For example, a summary of benefits and coverage ("SBC") that notes that cost sharing may vary based on participation in a wellness program, without describing the program, will not trigger the disclosure. However, a notice that references a premium differential based on tobacco use, or based on the results of a biometric screening, must include this disclosure.

Additional requirements solely for activity-only wellness programs

In some cases, participants may not be able to participate in or complete (or may have difficulty participating in or completing) the program's activity because of a health factor. For example, an individual might not be able to participate in a walking program due to recent surgery, pregnancy, or severe asthma. Therefore, activity-only wellness programs must make a reasonable alternative standard (or waiver) available to individuals for whom, for that period, it is either unreasonably difficult due to a medical condition to meet the otherwise applicable standard, or for whom it is medically inadvisable to attempt to satisfy the otherwise applicable standard. When it is reasonable to determine that medical judgment is required to evaluate the validity of a request for a reasonable alternative, plans can ask for verification, including a statement from the individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard in an activity-only wellness program. No verification can be requested, however, where the validity of the request is apparent or it would otherwise be unreasonable (e.g., a plan could not require medical verification that an employee wearing a cast on his leg cannot participate in a walking program).

Additional requirements solely for outcome-based wellness programs

A participant who does not meet an outcome-based wellness plan target (e.g., numbers in an "acceptable range" for BMI, cholesterol level, glucose level) 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. The reasonable alternative standard can be another participatory, activity-only, or

outcome-based wellness program, so long as the reasonable alternative standard itself complies with the rules for participatory, activity-based, or outcome-based wellness programs, as applicable.

However, when another outcome-based wellness program is offered as a reasonable alternative, special rules apply. First, if the reasonable alternative standard is also an outcome-based wellness program, the reasonable alternative standard cannot be a requirement to meet a different level of the same standard without additional time to comply that considers the individual's circumstances. For example, if the initial standard is a BMI of less than 30, the participant cannot be required to have a BMI less than 31 on the same day. However, a reasonable alternative standard might be to reduce the individual's BMI by a small amount or percentage over a realistic period, such as a year.

Second, an individual must be given the opportunity to comply with the recommendations of his personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard of the plan, but only if the physician joins the request. The participant may request to involve a personal physician's recommendations at any time and the personal physician can adjust the recommendations at any time, consistent with medical appropriateness, as determined by the physician.

Third, an outcome-based wellness program generally cannot request physician verification that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard as a condition of providing a reasonable alternative to the initial standard. However, if a plan provides an activity-only wellness program as an alternative to the otherwise applicable standard of the outcome-based wellness program, then the plan may, if reasonable under the circumstances, seek verification for the activity-only component that it is unreasonably difficult or medically inadvisable due to a medical condition for the participant to perform or complete the activity. For example, if an outcome-based wellness program provides a diet and exercise program to participants who do not meet the targeted weight (i.e., offers an activity-only program as a reasonable alternative), the plan can seek verification that a second reasonable alternative standard is needed for individuals for whom it would be unreasonably difficult due to a medical condition to comply, or medically inadvisable to comply, with the diet and exercise program, due to a medical condition.

Permissible and impermissible reward amounts

The regulations provide a number of helpful examples to illustrate permissible and impermissible financial rewards under the final rules:

Example 1:

The annual premium for employee-only coverage under a group health plan is $6,000, of which the employer pays $4,500 and the employee pays $1,500. The plan offers a health-continent wellness program focused on exercise, blood sugar, weight, cholesterol, and blood pressure, with a reward of $600. Since the $6000 reward does not exceed 30% of the total annual cost of employee-only coverage, $1,800 (i.e., $6,000 x .3 = $1,800), the reward is acceptable.

Example 2:

The annual premium for employee-only coverage under a group health plan is $6,000, of which the employer pays $4,500 and the employee pays $1,500, but the wellness program is exclusively a tobacco prevention program. Employees who have used tobacco in the past 12 months are charged a $1,000 premium surcharge in addition to their contribution to coverage. In other words, a tobacco user's share of the employee-only premium is $2,500 rather than the $1,500 paid by a non-tobacco user. In this case, the reward is the avoidance of a $1,000 penalty, and the $1,000 reward does not exceed 50% of the total annual cost of employee-only coverage (i.e., $6,000 x .5 = $3,000). The reward complies with the wellness program reward limits.

Example 3:

The annual premium for employee-only coverage under a group health plan is $6,000, of which the employer pays $4,500 and the employee pays $1,500. The plan offers a health-continent wellness program focused on exercise, blood sugar, weight, cholesterol, and blood pressure, with a reward of $600. In addition, employees who have used tobacco in the past 12 months are charged a $2,000 premium surcharge in addition to their contribution to coverage. Since the total of all rewards (including absence of a surcharge for participating in the tobacco program) is $2,600 (i.e., $600 + $2,000 = $2,600), the reward does not exceed 50% of the total annual cost of employee-only coverage (i.e., $3,000). In addition, when tested separately, the $600 reward for a wellness program unrelated to tobacco use does not exceed 30% of the total annual cost of employee-only coverage ($1,800). Thus, the rewards comply with the wellness program reward limits.

Example 4:

An employer sponsors a group health plan, where the total annual premium for employee-only coverage (including both employer and employee contributions) is $5,000. The plan provides a $250 reward to employees who complete a health risk assessment, without regard to issues identified through the assessment (i.e., a participatory wellness program). In addition, the plan offers the "Healthy Heart" program, which is a health-contingent wellness program with a $1,500 reward. Although the $1,750 total reward (i.e., $250 + $1,500) exceeds 30% of the cost of employee-only coverage (i.e., $5,000 x .3 = $1,500), only the reward for the health-contingent wellness program (i.e., $1,500) is taken into account. In other words, the $250 for the participatory wellness program is irrelevant, and since the health-contingent wellness program offers a reward that does not exceed 30% of the total annual cost of employee-only coverage, the wellness program complies with the reward limits.

While these HIPAA/ACA final rules appear to offer some new flexibility, it is important to remember that other laws apply. For example, employers subject to the ACA's "play-or-pay" penalties may find that offering large wellness incentives can make their health plans "unaffordable" under the play-or-pay rules (see our May 20 Benefits Alert, *What's new with the Affordable Care Act?* for more information on how wellness program financial incentives are taken into account for purposes of the affordability analysis). Furthermore, compliance with the HIPAA/ACA wellness regulations does not ensure compliance with a number of additional laws that regulate employee wellness

programs, including the Americans with Disabilities Act (ADA), the Genetic Information Nondiscrimination Act (GINA), or the Consolidated Omnibus Budget Reconciliation Act (COBRA), among others. Stay tuned for *Wellness programs after the Affordable Care Act (Part II)*, which will review the other laws with which employee wellness programs must comply.

For more information on employee wellness program regulations, please contact a member of our Employee Benefits team or:

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