

# Employer's Guide to Wellness Programs



**January 21, 2011 | A Publication of Lockton Benefit Group**

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# Employer's Guide to Wellness Programs

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### **The Usual Warning:**

**Hey, this can be complicated stuff. The rules aren't all that clear in some contexts, and it seems like everybody is looking to sue anybody anymore. Although the author is a lawyer, he's not your lawyer (because the local courts say he can't be, and your lawyer would probably be annoyed if he purported to be your lawyer).**

**So read on, but when you're ready to jump on the wellness bandwagon, the author encourages you to consult your lawyer.**

*About 75 cents of every dollar spent on health care in this country is spent on treatment of a preventable disease.*

*Wellness programs implicate a variety of federal and state laws, depending on how the programs are structured and operated.*

## EMPLOYER'S GUIDE TO WELLNESS PROGRAMS

### THE PROBLEM

According to a variety of sources, including the American Medical Association and the Centers for Disease Control, approximately 75 cents of every dollar spent on healthcare in this country is spent on treatment of a *preventable disease*. That is, it's spent on treatment of disease that is rooted in behavioral or lifestyle choices.

That's a sobering statistic. Clearly we see where the blame lies. But it's also reason for hope. If we can convince our employees to make better choices regarding exercise and diet, the potential cost savings are huge. That's where wellness programs come in.

Wellness initiatives can implicate a variety of federal and state laws. The federal laws at the center of the wellness storm are the Health Insurance Portability and Accountability Act (HIPAA)—specifically, its nondiscrimination rules—and the Americans with Disabilities Act (ADA), *particularly* after its modification by the ADA Amendments Act of 2008.

This *Employer's Guide* explores the compliance landscape of wellness programs in considerable detail, and also adds some practical observations and anecdotal experience. We hope you find it helpful.

*There are two types of wellness programs, generally speaking: Those that seek to effectively intervene with respect to existing illnesses, and those that seek to prevent future illnesses by changing employees' lifestyles.*

*Disease management and employee assistance programs (EAPs) are examples of reactive wellness programs.*

*Although not necessarily primarily focused on behavioral change, disease management programs are effective components of an employer's wellness initiative.*

## **TYPES OF WELLNESS PROGRAMS—GENERALLY**

### **Reactive—Disease Management/Employee Assistance Programs**

#### ***Generally***

Most employers already have at least one wellness program (such as an employee assistance or disease management program), but might not view it as such. But disease management and employee assistance programs, if well and aggressively managed, are key weapons in the war to control healthcare and related costs.

Often the return on investment (“ROI”) is easier to quantify with a disease management program than a wellness program designed to change employee behavior because the intervention and its results are more immediate and tangible.

#### ***Dealing with Already Identified Conditions***

Disease management and employee assistance programs (EAPs) deal with treating existing conditions, but if intervention happens *early enough*, and *aggressively enough*, they can significantly reduce the dollars spent by the health plan to treat the condition.

***May an employer or plan penalize an employee, through higher deductibles and co-insurance or co-payments, or unilateral disenrollments, for not cooperating with or participating in disease management programs?*** Probably not, unless the employer runs the penalty through the gauntlet of the HIPAA wellness program rules, discussed in detail in this *Employer's Guide*. In this regard, carrots (incentives to participate or cooperate) are probably better than sticks.

#### ***Dealing with Latent or Potential Conditions Identified Through the Wellness Initiative***

Disease management programs are also a key component of a wellness initiative because they are called upon to treat latent conditions discovered in the course of a more typical, *proactive* wellness program such as a health risk assessment initiative.

For example, if an employer is able to convince 60 percent of employees to take a health risk assessment,

***Integration of—that is, cooperation and communication between—various healthcare-related programs is critical to success.***

***When most contemporary employers speak about a wellness program, they're alluding to proactive, lifestyle-changing programs. Employers that head down this "road to wellness" inevitably come to a "fork in the road." In one direction are wellness programs not subject to federal nondiscrimination rules under HIPAA. In the other direction are programs subject to the HIPAA scheme.***

***Non-HIPAA programs are those that don't trigger HIPAA's nondiscrimination rules. They offer rewards either unrelated to a health care plan, or that are triggered not by health status factors but by mere participation.***

and 15 percent of those employees are found to have untreated, undiagnosed high blood pressure, the disease management program can be employed to intervene and provide treatment that might well prevent strokes and similar catastrophic (and costly) conditions later.

Of course, it is imperative to *integrate* the various healthcare-related programs—that is, get the various vendors (wellness, EAP, disease management, disability management, workers' compensation) talking to and sharing information with each other (more on this later).

### **Proactive—Wellness (Prevention): The Fork in the Road**

When dealing with *proactive* wellness programs, that is, those focusing on behavior change and prevention, we inevitably come to the "Wellness Fork in the Road."

Down one prong of the fork are "non-HIPAA" programs, or those not subject to the HIPAA nondiscrimination rules.

Down the other fork are wellness programs that, due to the nature of the reward (or penalty) and the conditions under which the reward or penalty will be awarded or imposed, *are* subject to the HIPAA requirements (these are discussed in detail, later).

As we see below, the rules under which these different types of programs operate are vastly different.

### **Non-HIPAA Wellness Programs**

By "*non-HIPAA wellness programs*" we mean programs that do not trigger HIPAA's nondiscrimination rules. These are by far the most prevalent types of wellness programs because they're inexpensive (relatively speaking), intuitive and don't require the bells and whistles that HIPAA otherwise imposes.

***The test for HIPAA applicability.*** A wellness program avoids HIPAA applicability if it is available to similarly situated individuals<sup>1</sup> and:

<sup>1</sup>The term, "similarly situated individuals" is defined in DOL Reg. § 2590.702(d). Distinctions may generally be drawn between participants and beneficiaries, different classes of participants (upon lines justifiable on the basis of bona fide business or related

**"Health status factors" are risk factors, such as obesity, smoking addiction, hypertension, diabetes, adverse medical history, etc.**

- ***The reward is unrelated to a healthcare plan*** (e.g., the reward is not a premium discount or reduction in deductible or coinsurance; for example, the reward might be a gift certificate, or raffle tickets, or cash; nor is the reward made available only to health plan participants), ***or***
- ***The reward is related to the healthcare plan*** (e.g., it's a premium discount or deductible waiver, etc., or is available only to health plan participants), ***but is NOT contingent on satisfying a standard related to a "health status factor"*** (this will become clearer when we look at some examples later). Rather, the reward is either (i) based on something more benign (e.g., merely taking a health risk assessment, without regard to whether the result shows the individual is healthy or sick; obtaining prenatal care, etc.) or (ii) is not contingent upon any action by employee (e.g., the incentive is an exercise facility at work).<sup>2</sup>

"Health status factors" (we'll call them "health risk factors" for the balance of this outline) include health status, medical condition (physical or mental), claims experience, receipt of healthcare, medical history, genetic information, medical history, genetic information, disability, or evidence of insurability.<sup>3</sup>

***Examples.*** There are some examples of common non-HIPAA wellness programs below, on pages 6-10

***But watch out for wellness programs that look like non-HIPAA programs, but actually might be HIPAA programs (and thus subject to the HIPAA nondiscrimination rules) because they supply medical care.*** See page 33.

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criteria, e.g., hourly-salaried, full-time or part-time, locations, date of hire, length of service, different occupations, etc.), and presumably between participants and non-participants.

Note that the wellness program regulations were issued jointly by the DOL, IRS and HHS, but the text of each agency's regulations is essentially identical. References to the regulations in this outline will refer only to the DOL regulations.

<sup>2</sup>See DOL Reg. § 2590.702(f)(1).

<sup>3</sup>See generally DOL Reg. § 2590.702-2(a).

***HIPAA generally prohibits discrimination in the context of a health care plan, based on health status, but leaves room for wellness programs that meet certain rules.***

***"HIPAA wellness programs," in contrast, are programs subject to HIPAA's nondiscrimination rules because they both supply rewards (or impose penalties) related to a health plan, and the rewards or penalties are triggered by whether the employee meets certain health standards.***

***You can spot a HIPAA wellness program because the reward or penalty is health plan-related, and the program asks health-related questions....***

### ***HIPAA Wellness Programs***

HIPAA's nondiscrimination rules apply to health plans, and generally prohibit discrimination in eligibility, premiums, benefits, etc. based on an individual's health status, although there are specific exceptions for wellness programs that satisfy certain requirements.

So, for purposes of this *Employer's Guide*, a "**HIPAA wellness program**"—a program that is subject to HIPAA's nondiscrimination rules—is one where the reward (or penalty, if you want to look at it from the other side of the coin) is ***both (1) related to a healthcare plan (it's a premium discount or deductible waiver) and (2) contingent upon the employee satisfying a standard related to a health factor.*** These programs are subject to HIPAA because, obviously, they operate within a health care plan, and "discriminate" to some extent based on an individual's health status.

For example, premium discounts granted to people who don't smoke, who are not obese or hypertensive, or who have low cholesterol, are health plan-related rewards tied to having or attaining favorable health risk factors, and while not prohibited *per se*, they are subject to a more complicated regulatory scheme under HIPAA, and perhaps under state law as well.<sup>4</sup>

#### ***How do you spot a HIPAA wellness program?***

First, of course, the reward or penalty is *health plan related* (i.e., it operates within the context of the health plan). Second, whether someone actually triggers the reward or penalty depends on his or her answer to a question like this:

- "Do you smoke?"
- "Is your 'bad' cholesterol count above 200?"
- "Are you overweight?"
- "Do you have high blood pressure?"
- "Are you a diabetic?"
- "Have you incurred significant healthcare claims?"

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<sup>4</sup>See DOL Reg. § 2590.702-2(f), and (f)(2).

*Non-HIPAA wellness programs (programs not subject to HIPAA's nondiscrimination rules) can be cost-free or cost-neutral to an employer, although these are rarely effective in the long run.*

*If so, the plan is conditioning a health plan-related reward on the presence or absence of a health risk factor, and the HIPAA rules will apply.*

For purposes of this outline we use the term "HIPAA wellness programs" to mean these kinds of programs, even if the employer is not subject to the HIPAA rules (e.g., a governmental employer).

Prior to the 2010 federal health reform law, self-insured governmental employers could opt out of having to comply with HIPAA's nondiscrimination rule. The health reform law eliminated the opt-out election for these plans.

### **TYPICAL CONTEMPORARY WELLNESS PROGRAMS**

#### **Non-HIPAA Wellness Programs**

##### ***Examples - Cost Neutral Programs***

Cost neutral programs, or programs where *employees* bear all or a majority of the cost, are rare and might not be as effective, because of the absence of incentives. But some employers utilize this approach. Here's an example:

##### ***FSA Reimbursements***

The cost of almost all wellness and preventive care programs and treatments are reimbursable tax-free from health flexible spending accounts. For example, an FSA should be permitted to reimburse customized nutritional supplements to address a specific, diagnosed condition; health trainer fees, exercise equipment, and perhaps even health club dues if prescribed by a doctor to treat an existing sickness or disease (e.g., hypertension); health coaching to mitigate an existing sickness or disease; and medical expenses for diagnostic procedures, etc.).

Some employers purchase access to web-based tools under which employees complete an assessment, qualify for various types of coaching, but pay the cost themselves. ***Pre-tax payments simply provide a better incentive for the employee to incur the expense.***

There's no rule that says the employer must pay the cost of a wellness program. As the preceding

**Health risk questionnaires or assessments are the most common non-HIPAA wellness programs. They're "non-HIPAA" programs, even if they supply a reward related to a health plan, because the reward is available simply by participating; that is, the reward is not contingent on the employee proving that he or she is healthy.**

**Some employers require employees to take a health risk assessment as a condition of enrolling in the health plan. The EEOC has informally warned that this practice appears to violate the Americans with Disabilities Act.**

paragraphs make clear, an employer is not required to offer, much less pay for, a wellness program. For example, an employer might encourage its employees who smoke to participate in a voluntary, online education program offered by the American Cancer Society, and reward those who do.

But these programs—because they typically rely upon the employee's representation that he or she has completed the course, and require the employee to discipline himself or herself enough to persevere through the process—usually achieve modest results at best.

### **Examples - Employer-Paid or Subsidized Programs**

#### **Routine physical exams/health risk assessments**

These are far and away the most common non-HIPAA programs. These "HRAs" are critical to do, in order to establish a claim cost baseline, and because they're so useful in "knowing the enemy," that is, spotting potentially chronic diseases. They should be offered to all "similarly situated individuals."<sup>5</sup>

These are "non-HIPAA programs" because either they don't provide medical care *per se*, or they do but the reward is supplied simply for taking the exam or assessment, and not upon the basis of how sick or healthy the individual turns out to be.<sup>6</sup>

**May an employer condition enrollment in a healthcare plan upon the employee taking a health risk assessment?** We think one may argue that the answer is "yes," but there are arguments to the contrary, and the EEOC cautioned against this approach in informal comments made in May 2006, to the American Bar Association, and more recently in a published opinion letter dated March 6, 2009. The EEOC has expressed similar views in the past, in both internal and external EEOC documents and

<sup>5</sup>DOL Reg. § 2590.702-2(f)(1).

<sup>6</sup>The Internal Revenue Code defines "medical care" in part as the "diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body." Internal Revenue Code § 213(d)(1)(A), 26 U.S.C. § 213 (d)(1)(A). ERISA § 733 contains a virtually identical definition. A shallow questionnaire might not rise to the level of medical care; a more comprehensive health screen almost certainly does. Detailed questionnaires delving into family medical history might pose other problems, under the Genetic Information Nondiscrimination Act (GINA). See the discussion of GINA on page 38.

***The key to the permissibility of conditioning health plan enrollment on the taking of a health risk assessment is whether the assessment can be said to be "voluntary." The EEOC has its doubts.***

***Similarly, some employers condition enrollment upon an employee's receipt of certain preventive care. The EEOC would likely have concerns about this too.***

policy statements.<sup>7</sup>

The key is whether the assessment—which will frequently be a “medical examination” under the ADA (because it will delve deeply enough to solicit information about disabling conditions<sup>8</sup>), and generally prohibited unless job-related or voluntary<sup>9</sup>—can actually be considered “voluntary.” It will not be seen as “voluntary” if there is a penalty against employees who do not participate.<sup>10</sup> The EEOC has suggested that denying enrollment is a “penalty” sufficient to pose an ADA problem.<sup>11</sup>

On the other hand, nobody is forced to enroll in health coverage. Perhaps, then, submitting to the assessment could be considered voluntary. Clear and formalized guidance from the EEOC on this issue is needed.

The HIPAA rules—another comprehensive federal scheme—do not prohibit an employer from conditioning health coverage on the taking of a health risk assessment. But the EEOC's view is that HIPAA does not trump the ADA, and recently final HIPAA nondiscrimination regulations take pains to point out that compliance with HIPAA does not necessarily mean a program is compliant with other federal laws (like the ADA) or state laws.<sup>12</sup>

What *is* clear is that more than a few employers are taking this approach, although that trend might slow in light of the EEOC's comments.

***May an employer condition enrollment in a healthcare plan upon an employee's agreement to obtain certain preventive care, such as a physical examination paid for by the employer's healthcare plan?*** Again, we think the answer

<sup>7</sup>Joint Committee on Employee Benefits (JCEB) Qs & As to EEOC (2007), Q&A 1 and 2; see <http://www.abanet.org/jceb/2006/home.html>; see also EEOC Notice 915.02 (July 27, 2000), Q&A 22.

<sup>8</sup>This is particularly true in light of the ADA Amendments Act of 2008, which effectively broadens—to a significant extent—the sorts of conditions that will be considered protected disabilities under the ADA.

<sup>9</sup>See generally EEOC Notice 915.02 (July 27, 2000).

<sup>10</sup>Id. See Q&A 22.

<sup>11</sup>See footnote 7 re JCEB Qs & As.

<sup>12</sup>E.g., see DOL Reg. §2590.702-2(b)(2)(i)(B) (“Whether any plan provision or practice with respect to benefits complies with this paragraph...does not affect whether the provision or practice is permitted under any other provision of the Act, the Americans with Disabilities Act, or any other law, whether State or Federal.”).

*Here are some other examples non-HIPAA wellness programs...*

might be “yes,” but the EEOC would likely have concerns here too, for the same reasons as those outlined above.

The HIPAA nondiscrimination rules prohibit conditioning enrollment upon “receipt of healthcare,”<sup>13</sup> but we think this prohibition is designed to prohibit an employer from denying health coverage to someone because they have *received* healthcare, not because they *declined* to receive healthcare, such as an employer-paid routine physical.

The real issue exists under the ADA, and as noted above, the EEOC would likely have concerns.

### ***Waiver of deductibles and/or co-insurance on preventive prescription drugs***

Pitney-Bowes is often credited with championing this approach, but published reports suggest other employees have experienced similar success. The company waived the out-of-pocket costs for its health plan's most expensive preventive medications. Although there was a short-term increase in drug costs, longer-term results suggested meaningful cost savings to the plan, because members were obtaining and taking their recommended preventive medications, helping avoid larger claims down the road.<sup>14</sup>

### ***Smoking cessation*** (not result-based).<sup>15</sup>

### ***On-site workout facilities.***

### ***Adding healthier menu items.***

### ***Obesity/weight reduction/diet groups.***

Reportedly, 800 Microsoft employees lost 13 tons of weight. The program capped lifetime program benefits, and was offered only to those who were morbidly obese. Employees paid 20 percent of the

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<sup>13</sup>See DOL Reg. § 2590.702-2(a)(1)(iv).

<sup>14</sup>Under the HIPAA wellness program regulations, this benefit should be made available to “similarly situated individuals.” DOL Reg. § 2590.702(f)(1)(iii).

<sup>15</sup>A “non-results based” smoking cessation program is one where the program pays for or reimburses the cost of a program, without any requirement that the person actually quit smoking. But note that these types of programs might be healthcare plans themselves, and thus subject to the HIPAA nondiscrimination requirements. See page 29. Note also that the program should be offered to all “similarly situated individuals.” DOL Reg. § 2590.702(f)(1).

*Perhaps the most vexing issue facing employers who install a non-HIPAA wellness program is avoiding disability discrimination requirements. The most practical way to avoid that problem is to design the program so "everyone can play."*

cost.<sup>16</sup>

***Subsidized gym programs.***<sup>17</sup>

***Work time for exercise.***

***Flu shots, healthier vending machine choices, wellness websites.***

***Waiving co-payments and deductibles on certain care.***

Media reports describe one employer spent \$3.5 million one year on neonatal care, although few babies were born. Seven infants were in neonatal ICUs because the mothers did not have prenatal care. *It's cheaper to spend a few thousand dollars in deductible waivers and baby gifts (as incentives for prenatal care) than to pay for one day in a neonatal ICU.*

### ***Disability Discrimination Issues and the Non-HIPAA Program***

Let's say the employer is running a non-HIPAA wellness program, such as a "Walk Five Miles a Week at Lunch" program, and the reward is an extra day of paid vacation. Or the employer offers an on-site exercise program during the first 20 minutes of the workday, and participants have a chance to earn additional cash bonuses or additional vacation.

Sounds innocent enough. But the employer might have disabled employees who cannot participate in the program, and thus are frozen out of the opportunity to earn additional compensation or vacation. This could trigger problems under state and/or federal disability discrimination laws, *particularly under recent amendments to the ADA, reflected in the ADA Amendments Act of 2008 (ADAAA)*. One consequence of the ADAAA is that the threshold for establishing a protected disability is substantially lowered, making it possible for nearly *every* employee to be considered "disabled" in some way, shape or form.<sup>18</sup>

The best play is to ensure that the wellness program is as ***inclusive as possible***. If the employer is wedded to the idea of a wellness program in which some

<sup>16</sup>Note that these types of programs might be healthcare plans themselves, and thus subject to the HIPAA nondiscrimination requirements. See page 29.

<sup>17</sup>The program should be offered to all "similarly situated individuals." DOL Reg. § 2590.702(f)(1).

<sup>18</sup>The ADA Amendments Act's impact on wellness programs is explored in additional detail beginning on page 34.

***About half the states have laws that prohibit employers from discriminating against employees based on their use of a lawful product like tobacco.***

***HIPAA wellness programs, again, are those that supply health plan-related rewards or penalties, and the trigger for the reward or penalty is tied to whether the employee has one or more health risk factors.***

***Employers can discriminate against unhealthy employees with respect to things such as health insurance premiums...but the employer must jump through certain hoops.***

employees cannot participate due to a disability, the employer should offer these employee some other reasonable way to obtain the reward (e.g., attending a class on the virtues of cardio-vascular exercise, etc.), or simply give them the reward outright, to avoid discriminating against them.

### ***Smokers' Rights Laws***

About half the states have laws protecting employees from discrimination based on their lawful activities (such as smoking) away from the workplace. So before an employer installs a "Quit Smoking or You're Fired!" campaign, it should consult with its employment law counsel.

### **HIPAA Wellness Programs**

#### ***Examples***

Typical "HIPAA wellness programs"—that is, programs that condition a health plan-related reward upon achieving a standard related to a health risk factor, and thus are subject to HIPAA's nondiscrimination rules—include the following:

- Smoker vs. non-smoker rates.
- Premium discounts, deductible discounts or waivers, co-insurance discounts or waivers, etc., based on an enrollee's weight being within acceptable limits.
- Premium discounts, deductible discounts or waivers, co-insurance discounts or waivers, etc., based on low cholesterol levels.
- Premium discounts, deductible discounts or waivers, co-insurance discounts or waivers, etc., based on normal blood pressure readings.

#### ***How They Operate, and Legal Constraints***

##### ***Legal Constraints***

As noted earlier, programs that condition the health plan-related reward upon the attainment of a standard related to health status factor (i.e., a risk factor) run smack into HIPAA's general prohibition against discriminating in premiums or benefits on the basis of

***There are five prerequisites to that kind of discrimination...***

***... First, the size of the reward (for healthy people) or penalty (for the unhealthy) can't exceed 20% of the total premium cost for the employee's coverage.***

***This 20% cap can sometimes pose a problem where the employer's incentive is the waiver of a high deductible.***

such risks.<sup>19</sup>

However, the HIPAA rules allow *some* discrimination, but only under the umbrella of “HIPAA-compliant wellness programs.”

The federal government issued final regulations (in December, 2006) describing how a “HIPAA-compliant wellness program” must operate. Generally, they must meet **five** requirements:

***(1) The size of the reward may not exceed 20 percent of the total cost of coverage for an employee or family.***

The size of the reward is capped at 20 percent of the total cost of coverage for an employee, if the employee is enrolled in single coverage. If he's enrolled in family coverage, *and* if the dependents are eligible for the wellness program, the reward is capped at 20 percent of the total cost of coverage of the family unit under the tier or option in which the family is enrolled.<sup>20</sup>

This 20 percent cap is rarely an issue, because typically it costs around \$500 per month to insure an employee, so the maximum incentive would be approximately \$100 per month, which is more than most employers are willing to provide anyway.

***Problem: Waiving a high deductible.*** We saw a program recently where the employer's reward under its “bona fide wellness program” was the waiver of a relatively high deductible under the group plan. The deductible for single coverage was \$1,500, more than 20 percent of the cost of single coverage. Employers should avoid rewards of that magnitude. Note, too, that if the plan is a “qualifying” high deductible health plan designed to allow employees to make contributions to a health savings account (HSA), waiver of the high deductible renders the employee ineligible to make HSA contributions.

***Other Issues: Unique Incentives and Penalties.*** Under the final regulations the reward

<sup>19</sup>See DOL Reg. § 2590.702-2(f)(2).

<sup>20</sup>DOL Reg. § 2590.702-2(f)(2)(i). Federal health reform bumps this to at least 30% beginning in 2014. See page 44.

*...Second, the program must be designed to promote good health...*

may take one or more of several forms. The typical reward is a premium or deductible discount, but the final regulations make clear the reward may also be the absence of a surcharge or the value of a benefit that would otherwise not be available under the plan.

The reward under some contemporary wellness programs is the opportunity to enroll in a more generous or flexible coverage option (for example, a PPO as opposed to an HMO). In any such case it appears the *value* of that reward may not exceed the 20 percent limit.

**(2) *The program must be reasonably designed to promote good health.***

This requirement is “intended to be an easy standard to satisfy,” according to the final regulations. If a program has a reasonable chance of improving the health of participants and is not overly burdensome, is not a subterfuge for discrimination and is not highly suspect in the method chosen to promote health or prevent disease, it satisfies this standard.<sup>21</sup>

Interestingly, there does not need to be scientific proof that the method actually promotes wellness.<sup>22</sup> The standard is intended to allow experimentation in diverse ways of promoting wellness. The regulations state, for example, a plan may provide rewards for participation in a course of aromatherapy.

So, the “reasonableness” requirement merely prohibits bizarre, extreme, or illegal requirements in a wellness program.<sup>23</sup>

The final regulations include a number of examples of wellness programs (we discuss these examples later). The preamble to the regulations states that these examples are “safe harbors” with respect to the “reasonableness” requirement.<sup>24</sup>

<sup>21</sup>See DOL Reg. § 2590.702-2(f)(2)(ii).

<sup>22</sup>71 Fed. Reg. 75014, 75018.

<sup>23</sup>Id.

<sup>24</sup>Id. at 75019.

*...Third, eligible individuals must have the opportunity to qualify at least once each year...*

*...Fourth (and this is the most difficult, counter-intuitive requirement), employers must essentially reward for the effort, not necessarily results...*

*...in other words, if a health status factor prevents the employee from achieving the desired goal, despite his best efforts, as a general rule the employer must reward for the effort (or design an individualized, alternative and reasonable goal for the employee; more on this later...)*

**(3) Individuals who are eligible for the program must have the opportunity to qualify for the reward under the program at least once each year.<sup>25</sup>**

This does not mean the employer must continue the program indefinitely; it just means that if the employer continues the program, it must allow employees who went through the smoking cessation program last year, for example, to go through it again *this* year.

Presumably an employer may avoid having to allow the same employee to work through the program again in a subsequent year *as long as the employer simply give the reward to the employee in the subsequent year.*

**(4) The reward must be available to all similarly situated individuals.<sup>26</sup>**

This requirement is more difficult—and counter-intuitive—than it sounds. It means several things:

*First*, if an individual faithfully participates in the program but is not able to attain the desired goal (i.e., is unable to quit smoking, is unable to reduce cholesterol) or for whom it is unreasonably difficult to attain the goal *due to a medical condition* (i.e., nicotine addiction, genetic factors, etc.), the individual must *nevertheless receive the reward* or be offered an alternative standard that is not unreasonably difficult (due to his medical condition) to satisfy.<sup>27</sup>

In short, the program must more or less **reward the effort**. Of course, if the individual never even tries to attain the goal, or simply loses heart or interest and quits the program, then the reward may be denied.

<sup>25</sup>DOL Reg. § 2590.702-2(f)(2)(iii).

<sup>26</sup>DOL Reg. § 2590.702-2(f)(2)(iv).

<sup>27</sup>DOL Reg. § 2590.702-2(f)(2)(iv)(A)(1).

*...however, the employer can require the employee to supply proof that the reason he failed to achieve the desired goal was due to a health status factor.*

*Some employees cannot achieve the desired goal due to a health condition. The employer must be willing to fashion an individualized, alternative goal the employee reasonably can attain.*

**Can the employer require proof that the individual's failure is due to a health risk factor?** For example, may the employer require a doctor's note as proof that the individual has a nicotine addiction? Yes. The final regulations make clear that the employer may impose such reasonable conditions or restrictions in this regard.<sup>28</sup>

Of course, if it is unreasonably difficult to obtain a certification that, for example, the employee has a genetic problem that restricts his or her ability to reduce cholesterol, then the employer will likely simply have to provide the reward based on a representation from the program vendor or physician (and perhaps the employee as well) that the employee faithfully participated in the program.

Some employers pay for the cost of the wellness program up front, but want the employee to repay the employer if the employee fails to obtain the desired goal. Here again we think it's advisable that anyone who faithfully completes the program should be excused from the repayment obligation, **even if he or she does not obtain the desired results**. If the employer wants to require the employee to obtain a note from a physician certifying that the employee's failure is attributable to a health status factor, that's fine as long as it's not unreasonably difficult for the employee to obtain that certification.

**Second**, some individuals won't even be able to try (or should not try) to achieve the goal because it is medically inadvisable to do so.

For example, a person who desires to participate in a weight-loss program that has an exercise component might be under doctor's orders not to engage in certain exercises due to a heart condition, or might have poor knee or hip joints, etc. As a result, the program must be willing to fashion reasonable **alternative standards** for these individuals (e.g., perhaps presenting a report

<sup>28</sup>DOL Reg. § 2590.702-2(f)(2)(iv)(B).

***The employer may rely upon the employee's doctor for help in crafting an alternative goal.***

to other program members about the virtues of exercise, etc.).<sup>29</sup>

***Must such alternative standards be developed in advance?*** No. Most employers will want (and in fact, will need) to wait to see who requests an alternative standard, and then fashion alternative standards tailored to the individual and his or her conditions that prevent the individual from attaining the general standard.

***Who crafts the alternative standards?*** The plan sponsor or wellness vendor may do so, of course, but the final regulations also make clear that the wellness program may also accept, as a reasonable alternative standard, the recommendation of the individual's physician.

***Must the employer actually offer a coaching-based wellness program in order to meet this fourth prong?*** Apparently not. There's no *express* requirement under the regulations that the employer actually make a coaching program available. However, it's a little difficult for an employer to meet this fourth prong without some kind of structure in place, like a coaching program, to accommodate people who cannot meet the desired standard or for whom it is medically inadvisable to even try.

We suppose, for example, an employer could say, "If you fail the blood pressure or cholesterol test, we invite you to exercise and eat right for six weeks and then come back, and we'll test you again...or bring a note from your doctor that says you can't reasonably exercise your way to lower blood pressure or lower cholesterol in six weeks, or a note saying it would be medically inadvisable for you to even try . . . we'll give you the discount when we get the note."

But what does the employer really hope to accomplish in this manner? The idea is to get the employee to start making better lifestyle choices. The employer will have much better success in this regard if it offers a coaching program.

<sup>29</sup>DOL Reg. § 2590.702-2(f)(2)(iv)(A)(2).

*Lastly, the employer must publicize its willingness to fashion individualized, alternative standards.*

*Employers should tread carefully when attempting to compel health plan enrollees to cooperate with disease managers.*

**(5) The wellness program materials must disclose the availability of an alternative standard for those who need it.<sup>30</sup>** The final regulations suggest the following language:

*"If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward."*

The regulations provide samples of slight variations on this theme, in the context of specific examples of HIPAA-compliant wellness programs.

### ***Issues Associated with Integrating Wellness with EAP and Disease Management Vendors; How Hard May the Employer Push?***

There is an interesting question here. ***May a plan impose a penalty upon a covered person for failing to cooperate with a disease management vendor?*** Take, for example, the case of an employee who is diagnosed with high blood pressure. The disease manager recommends the employee take blood pressure or other medication to control hypertension, but the employee fails to abide by the recommendation and suffers a stroke. May the plan be written so as to limit benefits for treatment of the stroke, or to disenroll the employee outright (or force him into a different, less generous coverage option) when the plan learns he's not taking his medicine?

This might be a bit dicey. The potential for such a penalty is only brought into play on account of a health status factor (high blood pressure), and thus one might argue the penalty is impermissibly discriminatory under the HIPAA nondiscrimination scheme and may only be imposed—if at all—to the extent the sponsor complies with the HIPAA bona

<sup>30</sup>DOL Reg. § 2590.702-2(f)(2)(v).

***The EEOC has suggested that attempts to do this might pose problems under the ADA.***

vide wellness program rules. They might also argue that the wellness program rules are intended to apply in the context of a program of “health promotion and disease *prevention*.”<sup>31</sup> and not in the context of a program of disease *mitigation*.

The EEOC has opined informally, in comments to the American Bar Association, that it has concerns under the Americans with Disabilities Act about any such attempt to penalize an employee for not cooperating with disease management.<sup>32</sup> The EEOC indicated that it’s irrelevant that the “penalty” would apply to the disabled and non-disabled alike, since the portion of the ADA prohibiting disability-related inquires and involuntary medical examinations (“involuntary” meaning a penalty applies if the individual does not cooperate) applies without regard to the disabled or nondisabled nature of the employee.

One might argue that under ERISA a plan sponsor has a *fiduciary duty* to take steps (to the extent otherwise permitted under the law) to mitigate expenses incurred by the plan by reducing benefits for those who could cooperate in reasonable treatment efforts, but decline to do so. Proponents might also say that the penalty does not implicate HIPAA’s nondiscrimination rules because the penalty is not imposed due to the employee’s failure to meet a standard related to a health factor, but rather due to a failure to cooperate with the disease manager.

***To be sure, the plan doesn’t care whether in the wake of the disease management process the person’s condition actually improves; the plan simply wants the person to try and will reward (or at least not penalize) the person if he or she simply makes the effort.***

Fair enough. But remember, compliance with ERISA and HIPAA does not necessarily equate to compliance with the ADA.<sup>33</sup> In addition, it might be hard to distinguish such a scheme from, say, a smoking cessation program where a penalty (e.g., higher premiums) is imposed for failure to participate in the

<sup>31</sup> ERISA Section 702.

<sup>32</sup>See footnote 7.

<sup>33</sup>See footnote 12.

***The DOL has begun to audit for compliance with HIPAA's nondiscrimination rules.***

smoking cessation program (i.e., for failure to cooperate with the smoking cessation “disease manager”). ***It seems clear that the latter scheme may only be implemented through the gateway of the bona fide wellness program rules.***

***Frankly, that's not such a horrible result.*** If we weave a disease management program with the HIPAA-compliant wellness program rules, it appears a plan could still impose a penalty for failure to cooperate with a disease manager—for failure to participate in the disease management or wellness program—***but the size of the penalty would have to be limited***, and the penalty could not be imposed if the individual's condition prevented him or her from cooperating with the disease manager (not a likely possibility).<sup>34</sup>

In any event, a sponsor will want to tread carefully here. It might be the better part of valor to offer *incentives* to entice participation rather than *penalties* for failure to cooperate. Again, federal authorities have cautioned against this punitive approach, albeit informally. See “The Usual Warning” at the beginning of this material.

### ***DOL Enforcement***

Until relatively recently, it appeared the Labor Department had little interest in reviewing and policing wellness programs for HIPAA compliance. But that appears to have changed.

We've noticed that the DOL's standard document request letter, issued to ERISA plan sponsors in advance of a DOL audit, now asks the sponsor to produce documentation related to the design and administration of its wellness programs.

### **Getting Around the HIPAA Problem?**

#### **Excepted Benefits**

The HIPAA nondiscrimination rules do not apply to *fully-insured* supplemental plans (plans that reimburse deductibles, co-payments, etc.).<sup>35</sup>

<sup>34</sup> The ADA Amendments Act of 2008 might change this result. See the discussion beginning on page 34.

<sup>35</sup> See ERISA §§ 732(c)(3), 733(c)(4); DOL Reg. § 2590.732(c)(5)(C).

*Some have tried ingenious ways to reward healthier employees with health plan-related incentives, without complying with the HIPAA rules.*

*The Labor Department and IRS have nixed some of the more aggressive methods involving supplemental coverage.*

Some employers have sought to exploit this exception in novel ways. For example, they might increase the deductible under the comprehensive medical plan to \$2,000, and then purchase fully insured supplemental coverage to provide benefits in the \$2,000 deductible corridor . . . but with a catch.

Taking care not to run afoul of disability discrimination laws (more difficult than it looks, after 2008; see footnote 36), the employer might say, “If you don’t smoke, your benefit under the supplemental plan is \$500. If your blood pressure is not too high, you get another \$500. If your weight is within appropriate limits, you get another \$500. And if your cholesterol level is within the normal range, you get another \$500.”

In effect, the healthy employees have *no deductible* under the comprehensive plan, and the unhealthy have up to a \$2,000 deductible.

The program seemed to pass muster, for a while: The conditions singled out under the supplemental plan did not appear to be protected disabilities.<sup>36</sup> And providing disparate benefits under the supplemental plan, on the basis of risk factors, seems to be acceptable under HIPAA because the supplemental plan is not subject to the rules.

Recently, a national health insurer introduced a product based on this concept. Employees are required to submit to a health examination in order to qualify for the supplemental benefit (this requirement poses issues under the ADA, as described earlier), and then the size of the benefit is determined by their health status. Employees who don’t qualify for the maximum benefit may attempt to “earn” additional benefits by participating in one or more appropriate wellness programs.

***Not so fast*** . . . but the Labor Department and the IRS have issued guidance calling these programs into question. The DOL fashioned a “safe harbor” for supplemental plans that meet four conditions. The

<sup>36</sup>At least not under federal law, where the Supreme Court had ruled that if an otherwise disabling condition may be controlled through medication, it might well not be a “disability” under the ADA. But the ADA Amendments Act of 2008 has eliminated this “mitigation” exception, effective January 1, 2009. State disability discrimination laws might be more expansive, but would be preempted to the extent they related to an ERISA-governed benefit plan.

***Cash payments might dodge HIPAA's nondiscrimination rules...or maybe not. But in any event an employer must still consider the impact of the Americans with Disabilities Act, as expanded by the ADA Amendments Act of 2008.***

program must:

- Be insured (as opposed to self-insured) and, if the comprehensive health plan is also insured, issued by an entity that does not provide the primary coverage under the plan;
- Be designed to fill gaps in primary coverage, such as deductibles and coinsurance, and not become supplemental or secondary only under a coordination of benefits provision;
- Not exceed, in total cost, 15 percent of the cost of the primary coverage ("cost" means "the cost of the plan," and is determined in the same manner that COBRA premiums are determined; if the primary coverage is insured, the "cost" of that coverage is the premium under the group contract); and
- *Not discriminate among individuals in eligibility, benefits or premiums based on any health factor of an individual or the individual's dependents.*<sup>37</sup>

In any event, the ADA Amendment Act of 2008 would likely have put the kabosh on these supplemental programs anyway, because the ADAAA makes diabetes, hypertension, etc. protected disabilities under the ADA, even though the conditions can be controlled by medication.

### **Cash Instead of Premium Discounts/Co-Payment Waivers?**

Other employers might seek to dodge the HIPAA nondiscrimination rules by paying cash bonuses instead of offering premium discounts or waivers of co-payments/co-insurance.

This *might* work; a lot of employers do it. But we've heard passionate arguments to the contrary. The opponents argue there's no functional difference between putting, say, an additional \$100 into an employee's pocket by reducing his health insurance premium, and putting an additional \$100 there by adding it to his paycheck.

<sup>37</sup>Field Advisory Bulletin 2007-4; IRS Notice 2008-23.

*Most employers who have headed down the road to wellness would say that incentives are critical to driving behavioral change.*

*How much is enough depends on the context. The easy answer is: Whatever it takes.*

Again, many employers are already taking this tack, but it's unclear just how the federal authorities will view the practice.

In addition, the ADA Amendments Act of 2008 might make the practice largely suspect. See the discussion beginning on page 38. See also the discussion of FLSA issues in the discussion of incentives, and "The Usual Warning" at the beginning of this material.

### **CARROTS AND STICKS—INCENTIVES AND PUNITIVE MEASURES**

#### **Carrots—The Role of Positive Incentives**

##### ***Generally***

Incentives are often necessary to change behavior. They must be large enough to make employees want to do something they would not otherwise do.

Nearly all of 150 top execs at large U.S. companies said recently, in a survey, that they believe the best option to reduce healthcare costs is financial incentives to encourage healthier behavior.

At least half of employers with wellness programs offer incentives, according to surveys.

Almost all employers with wellness programs say the biggest problem is inducing employees to participate. Meaningful financial incentives are designed to move employees off the dime.

This is why wellness education efforts, such as "lunch and learns," simply are rarely effective at changing employee behavior. Few things speak like money and trinkets.

Some vendors purport to achieve excellent return-on-investment results with no incentive, but their per-employee-per-month costs are higher because in lieu of an incentive the vendor places a representative on site, who daily or weekly is contacting, coaching, cajoling and encouraging employees in their wellness efforts.

##### ***How Much is Enough?***

Whatever it take to drive the result you want.

Obviously, the incentive must be large enough to get the participation for which the employer is hoping.

That will vary with the circumstances.

Conventional wisdom says that about **\$100** is necessary, for participation in a health risk assessment, for example, to get about 75 percent employee participation. Without the incentive, expect about 15 percent participation.

Cash helps with initial interest, but employers won't want to give cash payments just for showing up to a wellness coaching session. So after initial enrollment, employers must find ways to make the program fun: Movie tickets, raffles, team weight-loss or smoking cessation competitions, etc.

A large health insurer opined unofficially that about a \$100 premium reduction (per year) should yield about 50 percent participation or more in a health risk assessment initiative. It said it offered its own employees a discount of \$4 per pay period (\$104 per year) and had a 96 percent completion rate.

A major airline reportedly attracted 20 percent of its 52,000 employees to a health risk assessment simply by offering a raffle for free health benefits and 50 gift certificates of \$50 each (only 200 employees had taken the assessment the previous year, when there were no prizes).

Another major airline reported an "impressive" health risk questionnaire response, without incentives, when it put the questionnaire in open enrollment packets. The effort was as sneaky as it was ingenious; apparently, the belief (whether official or unofficial) was that employees would simply fill out the form, believing it was required.

Sound like a good idea? Assuming the questionnaire is not construed as a "medical exam" under the ADA (where involuntary exams are not permitted unless job-related) and complies with the Genetic Information Nondiscrimination Act (GINA; see page 38), the employer's guise might not pose significant risks. But the detail an employer will likely receive in the responses to the questionnaire will likely not be great, and the truthfulness of the responses might also be questionable if the employees believe the information will wind up in the employer's hands.

*Many employers overlook the tax implications of the incentives they supply...*

### ***The Law of Diminishing Returns***

There will likely be a point at which increasing the incentive does not yield appreciably better participation. This “vanishing point” will differ depending on many factors (nature of the program, nature of the reward, employee demographics, etc.). Conventional wisdom is that, for a health risk assessment initiative, the threshold is between \$50 and \$100.

### ***Repeated Incentives***

This topic is a corollary to the “law of diminishing returns.” An employer that, for example, pays \$100 to each employee who completes a health risk assessment is not likely to do it again the next year.

Instead, the employer might offer the assessments again (without the incentive, except for new employees), and take the cash it would have used to pay rewards and use it instead to further the aims of the wellness programs (perhaps use it to pay deductibles or co-insurance on certain preventive procedures, etc.).

But the extent to which the reward is offered on an ongoing basis will depend on the nature of the program, the size of the reward, and other factors.

### ***Taxes***

Cash incentives, and cash equivalents (like gift cards) are taxable. ***Don't forget to make this clear to employees, when you communicate the wellness program incentive.*** Employees have a tendency to become bummed out when they find that, after taxes, they only have \$65 of their promised \$100 incentive.

Non-cash incentives might be tax free if they can be considered “*de minimis*” ***fringe benefits***, under the federal Tax Code. Employers might wish to admonish employees to treat as taxable income any non-cash incentive with a value of more than a few dollars.

A typical gift card would, it seems to us, be taxable. Some employers pay cash to a vendor, who then supplies a gift card to employees. The vendor argues that it is not obligated to report the gift on a Form

*...particularly with respect to gift cards.*

1099-Misc to the recipient as long as the value does not exceed \$600. The employee, for his part, may or may not be aware that he should declare the gift card's value as taxable income (usually he's not even remotely aware).

But we think employers run a risk with the IRS in trying to avoid tax reporting issues associated with a direct exchange between the employer and employee, by endeavoring to inject a middleman into the picture. In fact, the IRS recently said as much.<sup>38</sup>

### ***FLSA Issues***

Must cash incentives be considered as part of an employee's "regular rate of pay" for purposes of determining his or her rate of overtime pay, under the Fair Labor Standards Act? Arguably not, but that answer probably changes if participation in the program that spawned the reward is compulsory.

### ***Types of Incentives***

As a general rule, incentives are limited only by imagination. The scope and variety are almost limitless, most tailored to what the employer believes will drive the largest participation and help the employer achieve its goals for the program. They may be tangible (cash, prizes, premium discounts, etc.) or intangible (recognition), but tangible are far and away the more prevalent and effective.

Note, however, that some incentives *are* limited by federal rules if the reward is contingent upon attaining a health risk factor, and possibly in some cases by state rules (such as "smokers' rights" laws).

<sup>38</sup> At a 2008 meeting between the American Bar Association and IRS representatives, the following fact pattern and questions were posed to the IRS:

An employer hires Provider A to run a wellness program for its employees. The wellness program is distinct from the employer's group health plans. Under the wellness program, if an employee completes a health risk assessment, Provider A sends the employee a \$50 gift card. In addition, if the employee schedules a physical exam with the employee's physician, during which the physician discusses the health risk assessment with the employee and then sends it back to Provider A with the physician's signature, the employee receives a \$100 gift card. The employer may contract with Provider A to have Provider A run additional wellness programs that offer gift cards as incentives to participate. If an employee completes both actions, are the gift cards taxable income? If so, does the employer or Provider A need to report the gift cards as taxable income?

The IRS opined that the value of the incentives is taxable income, reportable on the employee's W-2.

***Using FSA, HRA or HSA contributions as incentives raises issues worthy of an employer's attention.***

### ***Common Incentives Under Non-HIPAA Wellness Programs***

***Remember:*** Cash and cash equivalents, and other things of value that are taxable under the Tax Code will be subject to income taxes and (in the case of cash, payroll taxes) unless they are a “de minimis” fringe benefit (***but cash is never a de minimis fringe benefit***). Other incentives—for example, incentives provided under a health plan—should be nontaxable. Here's a list of common incentives:

- Cash.
- Cash contributions to flexible spending accounts, health reimbursement arrangements, or health savings accounts.<sup>39</sup>
- Reduced co-pay costs.
- Rebate of program costs.
- Free gym memberships (taxable; might be an argument that the value is nontaxable if the employee is under a doctor's orders to exercise as part of a treatment plan for an existing sickness, like obesity; but the IRS has been pretty clear that health club memberships are not “medical care” and cannot be provided on a tax favored basis by the employer.
- Cash equivalents (movie passes, etc.).
- Work time to exercise.
- Sizeable rewards based on points, accumulated through a variety of activities (points awarded for physical activity and health risk factors begin to encroach on HIPAA, however).

### ***Watch out for FSA, HRA or HSA contributions.***

Incentives may include employer contributions to health flexible spending accounts, health reimbursement arrangements (another “HRA” abbreviation), or health savings accounts. Generally, these contributions are nontaxable unless they are discriminatory. But the contributions pose other issues as well:

<sup>39</sup>These sorts of incentive require some planning to think through discrimination, COBRA and HIPAA portability consequences.

- **FSAs:** Employer contributions to FSAs can, under certain circumstances, trigger broader COBRA obligations than otherwise apply, HIPAA portability obligations (such as a duty to issue creditable coverage certificates) and federal health reform issues.<sup>40</sup> Although not likely unless the rewards are granted just to the highly paid, employer contributions might trigger taxation to certain highly paid beneficiaries of the reward, if the contributions are discriminatory in their favor.<sup>41</sup>
- **HRAs:** Employer contributions to health reimbursement arrangements are similarly subject to the same nondiscrimination rules that apply to FSAs.
- **HSAs:** Employer contributions to health savings accounts must be “comparable” for “comparable” employees, which in theory makes problematic the notion of “incentive” HSA contributions.<sup>42</sup> Happily, a nice exception applies to employer contributions run through the employer’s cafeteria plan.<sup>43</sup> How does the employer run its HSA contributions through its cafeteria plan? Accordingly to IRS regulations, by allowing employees to run their own HSA contributions through the cafeteria plan, on a pre-tax basis.<sup>44</sup>

***Unconventional:*** According to published reports a large chemical company installed a bonus program for its health staff, tied to performance goals established by the regional and national health staffers. The goal is to shave \$100 million in 10 years (current healthcare budget is \$750 million). Health staffers set goals such as getting 25 percent of smokers into smoking cessation programs, and 25 percent of those to quit smoking.

### **Common Incentives Under HIPAA Wellness Programs**

The most common incentive under a HIPAA (that is, health factor-based) wellness program is a premium

<sup>40</sup>See DOL Reg. § 2590.732(c)(3)(v); Treas. Reg. § 54.4980B-2 Q&A 8(c).

<sup>41</sup>See 26 U.S.C. § 105(h) and Treas. Reg. § 1.105-11.

<sup>42</sup>26 U.S.C. § 4980G; Treas. Reg. § 54.4980G-1.

<sup>43</sup>Treas. Reg. § 54.4980G-5.

<sup>44</sup>Id.

*Wellness programs collide with ERISA, COBRA, HIPAA and other federal laws at a chaotic intersection with malfunctioning traffic signals. The rules fit together poorly, and the federal government has been slow to supply meaningful guidance in many areas.*

*ERISA can apply to a wellness program if the program supplies a health care benefit. Many do.*

discount, or a reduction or waiver of co-payments and coinsurance amounts.

But regulations under HIPAA restrict the size of the incentive to no more than 20 percent of the cost of coverage (single employee coverage if only the employee is eligible for the wellness program, or family coverage if the family is enrolled in the plan *and* is eligible for participation in the wellness program).<sup>45</sup>

### ***Sticks***

“Sticks,” or penalties, under wellness initiatives are not as common because employers prefer the positive approach, rather than negative approach, to wellness. However, we have seen several types of “negative” or “stick” approaches.

### ***Examples***

Higher co-payments or co-insurance for not participating in a proffered disease management program (federal authorities have informally cautioned against this approach).

Some employers refuse to hire, and even fire, employees who engage in unhealthy behaviors, such as smoking. Note, however, that in some states it is against state law to discriminate against an employee, in the terms and conditions of employment, for using lawful products like tobacco.

## **OTHER “PURE” COMPLIANCE ISSUES**

### **Generally**

It would be swell if the intersection of wellness programs, ERISA, COBRA, and HIPAA privacy, security, and portability was obvious and well-defined. Sadly, it's anything but. These regulatory schemes do *not* fit together well. To the extent they fit at all, the fit is clumsy, uncomfortable and, most significantly, outright impractical.

### **ERISA Coverage**

#### ***ERISA Applicability to Wellness Programs***

To the extent the wellness program provides medical care—many contemporary wellness programs do,

<sup>45</sup>DOL Reg. § 2590.702-2(f)(2)(i).

*Few employers consider the ERISA implications of their wellness programs.*

*Sometimes, an employer thinks it has a wellness program that is not subject to ERISA, but it really is, by virtue of the benefit it offers. That can be a problem, because if the program is subject to ERISA, the program must not violate HIPAA's nondiscrimination rules.*

unless they are merely “lunch and learn” or health promotion education programs, or they merely make exercise facilities available, etc.—it will be subject to ERISA (to the extent the employer is subject to ERISA).<sup>46</sup>

In theory, this means the wellness program is either a stand-alone ERISA plan, requiring a plan document, SPD and potentially a Form 5500 filing, or it is considered part of the employer's medical plan or other preexisting welfare benefit plan. If the latter, ideally the program materials should describe it as such.

### ***Common Practice***

As a practical matter few employers even *consider* the ERISA implications of their wellness programs nor—to our knowledge—has the Labor Department been particularly aggressive in policing them for compliance with other than the HIPAA rules. But it might be prudent to consider whether, in designing and communicating a wellness program, it makes sense to treat it as part and parcel to an existing healthcare plan. Doing so requires the employer to directly wrestle with some HIPAA privacy/security and COBRA issues, but frankly the employer should consider those same issues even if it views its wellness program as wholly separate from its medical plan.

### ***The Law of Unintended Consequences***

Watch for “the law of unintended consequences.” Sometimes an employer will install a wellness program such as a smoking cessation program, that is conceived and viewed as wholly apart from the employer's healthcare plan. For example, the employer might say to its employees, “We'd like to help you quit smoking. We'll reimburse you for the cost of a smoking cessation program if you stay smoke-free for six months.”

Where the program provides a medical benefit (e.g., reimbursement for nicotine patches or gum, etc.), that fact arguably transforms the wellness program into a

<sup>46</sup>29 U.S.C. § 1002(1) (describing ERISA welfare benefit plans to include plans providing medical care), 29 U.S.C. § 1191b(a)(2) (defining “medical care”). The definition seems intended to substantially track with the Tax Code's definition; see 26 U.S.C. 213(d)(1) and regulations issued under that section. Medical care is defined to include care for “diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.”

***If a wellness program is subject to ERISA, that means it must comply with ERISA's reporting and disclosure rules, and perhaps COBRA, Medicare Part D, the HIPAA portability rules and HIPAA's privacy and security rules.***

medical plan. What then? Well, if the program/plan will reimburse the cost of the medication *only if the employee actually quits smoking*, the program/plan appears to violate the HIPAA nondiscrimination scheme outright.

What about a ***weight-loss wellness program*** where the employees are merely reimbursed the cost of participation in a Weight Watchers or similar program? Arguably there's no medical benefit involved; in most cases employees will be attempting to lose weight to improve their general health and well being, and their excessive weight is not so significant as to constitute a sickness or disease. The program would not appear to be a medical plan, so if the employer agrees to reimburse the cost only for those employees who attain a weight loss goal, it appears the HIPAA rules are not implicated.

But there might be issues under the ADA Amendments Act (see page 34 ) and state law to consider. At bottom, we think it's *always* prudent to be as inclusive as possible with wellness programs, even non-HIPAA programs, and reward employees for the effort as opposed to only for a specific result.

Note that the HIPAA nondiscrimination scheme contains an exception for an "independent, noncoordinated benefit offering coverage just for a specified disease or illness." However, the HIPAA regulations say this coverage must be provided under separate insurance contract in order to be "excepted," and most programs like those described in the preceding two paragraphs are self-insured (the employer reimburses the cost from its general assets).

### ***The Consequence of ERISA Coverage***

Where ERISA applies to a wellness program, ERISA's baggage follows. The program should have an SPD, potentially file a Form 5500, issue summary annual reports, summaries of material modifications, and summaries of material reductions in benefits, etc.<sup>47</sup> Where it is a self-insured program it's difficult to find an exception for it under the HIPAA portability and nondiscrimination rules, which means creditable

<sup>47</sup>See generally 29 U.S.C. §§ 1021-25.

***If the wellness program is part of the health care plan, but benefits more employees than those actually enrolled for major medical benefits, the employer should consider the implications of that when listing, on the health plan's Form 5500, the number of participants in the plan.***

coverage certificates might be required from the program and the program will need to be careful of discriminating on the basis of health status factors.

HIPAA's privacy and security schemes apply to ERISA plans unless they cover fewer than 50 participants, are self-funded and administered in-house. ERISA's COBRA provisions will apply (if the employer is large enough). The Medicare Part D rules might also apply where the wellness program provides prescription drug benefits, potentially triggering "creditable" or "non-creditable" disclosure obligations to Medicare-enrolled beneficiaries of the program, and to CMS.

Ugly stuff. For all these reasons most employers will want the wellness program—to the extent it provides medical care—to be considered part of the comprehensive health plan, allowing the program to bootstrap under the health plan's satisfaction of the myriad ERISA and related requirements. That has several immediate and practical consequences.

First, the wellness program will probably encompass more employees than are enrolled in the comprehensive health benefit portion of the plan, which will affect the "participant count" for Form 5500 purposes.

It also means some tinkering with the comprehensive health benefit portion's definition of "eligible employee" might be in order if the wellness program is offered more broadly than the comprehensive medical coverage.

The comprehensive plan's COBRA forms might require adjustment if the employer wishes to treat the comprehensive program and the wellness program as separate plans for COBRA purposes (see below). And where the wellness program is self-insured, its link to the comprehensive plan might trigger far broader HIPAA privacy and security obligations than the employer might currently have with the comprehensive program, if the comprehensive program is fully insured (there's more about this, too, below).

*COBRA can apply to a wellness program providing health care benefits or offered under a group health plan.*

*Few employers consider the COBRA implications of their wellness programs...but they should.*

*COBRA and wellness programs don't fit together particularly well. But in theory, a COBRA beneficiary should be offered the opportunity—at his or her own cost—to continue "coverage" under the wellness program. In most cases, however, we think the beneficiary need not be offered the same financial incentives supplied to active employees.*

## COBRA Coverage

### ***COBRA Applicability is Wider Than ERISA Applicability***

To the extent the wellness program provides medical care (again, many contemporary programs do), it is subject to COBRA (if the employer is subject to COBRA).<sup>48</sup> Most employers are subject to COBRA either because they're subject to ERISA, or they are public entities subject to the COBRA provisions in the Public Health Service Act. Churches who have not elected ERISA coverage may dodge COBRA applicability, but that is about it.<sup>49</sup>

Few if any employers view their wellness programs as subject to COBRA, and do not refer to the wellness program in COBRA materials, nor do they attempt to calculate the "COBRA cost" of the wellness program or give COBRA beneficiaries the opportunity to elect coverage under the wellness program.

### ***How Does COBRA Work in the Wellness Context?***

Like the issue of ERISA coverage of wellness programs, there has not been significant federal focus on the COBRA implications of wellness programs. How would COBRA work in the wellness context?

In theory, a COBRA beneficiary would have the right to pay for continuation "coverage" under the wellness program (whether it be health screenings, a smoking cessation program, etc.).

Would the beneficiary have a right to the incentives and rewards? The employer might want to make them available, but arguably would not have to do so, unless the employer included the cost of the incentives and rewards in the COBRA premium for the wellness program. For example, a premium discount reflects a reduction in the cost of the health plan, but COBRA beneficiaries may be required to pay the full cost of the coverage anyway.

Don't forget the forms. COBRA comes with an assortment of disclosure obligations tied to specific

<sup>48</sup>See Treas. Reg. § 54.4980B-2 Q&A 1, 4.

<sup>49</sup>See Treas. Reg. § 54.4980B-2 Q&A 4; 29 U.S.C. 1003(b)(2).

*The collision between wellness programs and the ADA gives rise to some of the most vexing and interesting issues of all.*

forms. Forms would have to be specially created and separately maintained for a wellness program that is treated as a separate plan for COBRA purposes.

### ***Picking the COBRA Plans***

There is wide latitude under the COBRA regulations for an employer to designate separate “plans” for COBRA purposes.<sup>50</sup> Many employers treat wellness programs as separate plans so as to avoid having to provide wellness benefits to COBRA beneficiaries who elect COBRA under the comprehensive medical plan. These individuals could, of course, elect COBRA under the wellness program too, but that is a rare event. Most prefer not to incur the additional cost.

### **ADA Issues**

#### ***Generally***

These are some of the more interesting—and vexing—issues in the wellness context. We have alluded to them in other sections of this outline, above.

#### ***ADA Issues***

Generally, an employer may not subject employees to “medical examinations” unless the examinations are relevant to the employee’s duties, or they are voluntary.<sup>51</sup> Many wellness programs, even health screenings, could rather easily be construed as “medical examinations” if they involve medical examinations or questions concerning disabilities.<sup>52</sup> Since they will rarely be relevant to an employee’s duties, they must then be “voluntary.” A program will not be “voluntary” if employees are penalized for not participating.<sup>53</sup>

We think almost all wellness programs would be (*and should be*) considered “voluntary.” But the greater the reward (participation in the health plan, for example),

<sup>50</sup>Treas. Reg. § 54.4980B-2 Q&A 6.

<sup>51</sup>See generally 42 U.S.C. §§ 12101-12117, 12201-12213, and EEOC Notice 915.02 (July 27, 2000).

<sup>52</sup>If a program simply promotes a healthier life style but does not ask any disability-related questions or require medical examinations (e.g., a smoking cessation program that is available to anyone who smokes and only asks participants to disclose how much they smoke), it is not subject to the ADA’s requirements concerning disability-related inquiries and medical examinations. EEOC Notice 915.02 footnote 78.

<sup>53</sup>EEOC Notice 915.02.

*Future guidance should let us know for sure...but initial analysis suggests the ADA Amendments Act might prohibit most HIPAA wellness programs.*

the more punitive it will appear to deny that reward to employees who do not desire to participate.

The EEOC has informally questioned the permissibility of conditioning health plan enrollment on submitting to a wellness initiative, such as health risk assessments.<sup>54</sup> For that matter, the EEOC has cautioned that even “positive” incentives under a wellness program (i.e., a cash reward for participating in a health risk assessment) might run afoul of the ADA if the incentives are sufficiently valuable; the argument is that the incentives are denied to those who do not submit to the medical inquiry, and the more valuable the incentive the more it appears that denying it is a “penalty.”<sup>55</sup>

### ***Issues Under the ADA Amendments Act of 2008***

The ADA, which applies to employers with 15 or more employees, prohibits discrimination in terms and conditions of employment against a person with a protected disability, a record of a disability, or perception of a disability. Employer-provided benefit programs, such as health insurance, are considered fringe benefits (i.e., terms and conditions of employment) and thus are subject to the law’s protections. Protected disabilities are those physical and mental impairments that substantially limit one or more “major life activities.”

Court decisions had made it harder for employees to prove a protected disability. Courts had narrowed the scope of “major life activities,” concluding that such activities were limited to those of central importance in most people’s daily lives. This interpretation, while perhaps reasonable, often excluded problems with thinking, concentrating, interacting with others, and internal bodily functions from the realm of protected disabilities.

In addition, judicial and administrative interpretations of the ADA had made it harder for employees with actual impairments to prove their conditions “substantially limited” one or more major life

<sup>54</sup>See footnote 7.

<sup>55</sup>EEOC Letter from Associate Legal Counsel (March 6, 2009); EEOC Letter from Assistant Legal Counsel, ADA Policy Division (March 31, 1998).

***The fact that a wellness program complies with HIPAA does not necessarily mean it complies with the ADA. Most HIPAA wellness programs arguably skirted the ADA only because the conditions they targeted—obesity, hypertension, diabetes, etc.—were not considered disabilities under the ADA, because the conditions could be mitigated through medication. The ADAAA changed all that.***

activities. The ADA does not define “substantially limits,” but the Supreme Court said the condition must “severely restrict” a major life activity. The Equal Employment Opportunity Commission (EEOC), which oversees the ADA, ruled that an impairment must “significantly restrict” major life activities.

And the Supreme Court also ruled that an individual whose impairment is otherwise clearly a disability nevertheless is not considered disabled if his condition can be mitigated with medication. For example, people with diabetes or hypertension generally came to be regarded as non-disabled because medication can mitigate those diseases.

Because of these interpretations, relatively few employees could qualify for protection under the ADA. In 2008 Congress passed the ADA Amendments Act (ADAAA) to restore what Congress saw as an erosion by the courts of the protections originally intended by the ADA.

The ADAAA:

- Significantly expands the concept of “major life activity” (remember that an “impairment” is protected under the ADA only if it substantially limits one or more “major life activities”). As a practical matter, the definition is now so broad that virtually everyone is disabled. For example, major life activities now include caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working.
- In addition, the ADAAA adds “major bodily functions” to the universe of major life activities. Thus, normal cell growth, and body systems such as the immune, digestive, bladder, bowel, neurological, brain, respiratory, circulatory, endocrine and reproductive systems are all “major life activities.” An impairment that substantially limits such a function is now a protected disability.
- Although an individual's condition must still “substantially limit” one or more of these major life

activities, the ADAAA does not supply a definition of “substantially limit,” but does reject the “severely restricts” and “significantly restricts” tests. In addition, the ADAAA says that “mitigating measures” can no longer be considered when determining whether someone is disabled. In other words, a diabetic is now considered to be disabled, even if insulin controls his diabetes. Same for a hypertensive employee, even though medication can easily control his high blood pressure.

- To underscore the expanded breadth of the ADA, the ADAAA says that henceforth the notion of “disability” is to be construed “in favor of broad coverage.” Further, an impairment that is episodic (epilepsy) or in remission (cancer) is a disability if it would substantially limit a major life activity when active.

Wellness programs that reward the non-obese, non-hypertensive or non-diabetic, for example, seem to pose issues under the ADA, as amended by the ADAAA, even though they can be structured to comply with HIPAA's nondiscrimination rules.<sup>56</sup> If the wellness program targets only those considered “disabled” (which is much more likely now, in the wake of the ADAAA) the question will be whether the program is a “subterfuge” to evade the purpose of the ADA. It would seem harder for wellness programs to overcome a “subterfuge” claim if they were installed after the ADAAA was enacted.

The same issues *might* exist for smoking cessation programs. Pre-ADAAA cases considered whether smoking or nicotine addiction is an ADA-protected disability. The cases generally conclude they are not, because these conditions can be mitigated with medication or other devices. But we know that the ADAAA eliminates the “mitigation” argument as a defense. So it's possible that even smokers are now entitled to protection, and that makes even contemporary smoking-cessation wellness programs suspect under the ADA.

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<sup>56</sup> The EEOC has said that a health plan does not receive a free pass under the ADA simply because it might be HIPAA-compliant. Perhaps employers can argue that a HIPAA-compliant program that, for example, allows for individualized standards or goals where necessary, and “rewards the effort” where a health condition prevents the employee from achieving the desired goal, is “reasonable accommodation” under the ADA, sufficient to allow the program to pass muster under the ADA.

*Verifying an employee's representations in the context of a wellness program might pose problems under the ADA.*

Wellness programs that are not health plans (because they don't supply medical care), or that supply employment-related rewards unrelated to a health plan (such as an extra day of vacation, prizes, etc.) will pose similar issues.

### ***Honor System; Limits and Remedies***

Some wellness programs (most commonly, HIPAA wellness programs) must rely upon the honor system (that is, the programs depend on employees certifying to various habits or exercise efforts, to trigger rewards or avoid penalties).

For example, a typical smoking cessation program will provide the reward to an employee ***upon the employee's attestation*** that he or she does not use tobacco products. But most employers who have implemented such programs agree that the honor system can take the employer's initiative only so far.

Outsourced vendors have the capacity to help verify an employees' ***progress*** via more objective means (blood tests, BMI tests, stress tests, etc.). Some employers have used breathalyzers to test for the presence of nicotine.

Again the ADA poses some issues. The ADA generally prohibits medical exams of employees, including blood tests and breathalyzers to test for alcohol, unless the test is related to job performance. The EEOC might well extrapolate that prohibition to tests for nicotine.

One possibility might be to get the employees who desire to participate in the wellness initiative to agree in writing that by participating they agree to submit to the test, to verify their earlier attestations that they do not smoke.

If the employee lies on the attestation, it seems relatively clear that the employer may discipline, even terminate, the employee for that fraud. In the smoking cessation context, please note that many states prohibit an employer from discriminating against an employee for smoking. But here, the disciplinary action would not be due to the smoking per se, but the misrepresentation.

*The Genetic Information Nondiscrimination Act of 2008 makes problematic the collection of family medical history in a health risk assessment.*

There is another twist to that latter point. We discuss later the HIPAA privacy and security implications of wellness program, and conclude that most programs are, indeed, subject to HIPAA privacy and, in many cases, HIPAA security. If a wellness vendor, subject to HIPAA, obtains protected health information (PHI) from the employee (e.g., perhaps the vendor obtains from an employee, on a health history form, that the employee smokes), and discloses the PHI to the employer because the vendor then knows the employee lied on his earlier nonsmoking attestation, can the employer use the information to fire the employee?

The HIPAA privacy rules say an employer may obtain some forms of PHI for plan administration functions, but can never take adverse personnel action against an employee based on that PHI. But surely an employee may not hide behind the HIPAA privacy shield to protect himself from the consequences of a fraud, right?

HHS, in informal comments to the American Bar Association, said that some employer action (such as suspending an employee from participation in the health plan, where an employee commits fraud against the plan) would not be prohibited under HIPAA.

Well, what to do? See “The Usual Warning” at the beginning of this outline.

The ability to verify progress might be an important factor in the employer's design and planning stage, and will also affect the wellness program's budget and availability (geographically) if an outsourced vendor will be utilized to oversee the program. At the end of the day the employer must decide how many resources it wants to spend—and how much employee goodwill it wants to put at risk—by policing the employees' personal habits.

### **Genetic Information Nondiscrimination Act**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in employment, and under health plans, on the basis of genetic information.

***GINA is designed to prohibit a health plan from using genetic information of an enrollee for purposes of underwriting on the plan as a whole.***

***Recent regulations under GINA prohibit a health plan from offering a reward for completing a health risk questionnaire or assessment that solicits family medical history. In addition, such a questionnaire or assessment cannot be conducted prior to or in connection with enrollment. An assessment or questionnaire that does not solicit family medical history avoids these restrictions.***

GINA includes two main sections: Title I, dealing with health plans, and Title II, dealing with employment discrimination on the basis of genetic information. Insofar as health plans are concerned, GINA applies for plan years beginning after May 21, 2009.

With respect to health plans, GINA is designed to pick up where HIPAA left off. HIPAA prohibits a group health plan from discriminating against an *individual* under the plan on the basis of the individual's genetic information. GINA, on the other hand, prohibits the use of genetic information for purposes of underwriting, with respect to *the plan as a whole*.

The IRS, in conjunction with the Department of Labor and the Department of Health and Human Services recently issued regulations under Title I of GINA. The regulations apply, as a practical matter, to plan years beginning on or after January 1, 2010.

Here's the gist of the regulations' effect on health risk assessments offered as part of or in connection with a health plan:

- Genetic information includes family medical history;
- It is impermissible for such a health risk assessment to solicit information about family medical history where there is either a reward offered for completion of the HRA, *or* where the HRA is conducted prior to or in connection with enrollment (including open enrollment).

Of course, if the assessment does not solicit family medical history or other genetic information, then it may be conducted prior to or in connection with enrollment, and a reward may also be supplied. An assessment that doesn't specifically ask for family medical history, but asks an open-ended question likely to elicit family medical history, should be accompanied by an admonition that the respondent should not include genetic information, to include family medical history.

*Title II of GINA allows employers to collect genetic information as part of a wellness program, as long as safeguards are observed. How this accommodation in Title II gels with the specific prohibitions in Title I is a bit tricky. The answer appears to depend on how closely related the health risk assessment is to a health plan.*

Title II of GINA restricts the deliberate acquisition of genetic information by employers, and strictly limits employers from disclosing genetic information. However, Title II includes a broad exception, allowing employers to collect genetic information where “health or genetic services are offered by the employer, including such services offered as part of a wellness program” (provided the employer satisfies other conditions). How does this broad exception gel with the broad prohibitions in Title I?

Additional guidance from the Equal Employment Opportunity Commission (EEOC), which has authority over Title II, will be welcome. Until then, it appears the analysis breaks down this way. If the wellness program is:

- A health plan (because it supplies medical benefits such as a doctor's care or prescription drugs), or
- Part of a health plan (many employers consider their wellness programs to be part of a health plan), or
- Offered in conjunction with a health plan (so that the reward for participation in the program is health plan-related, such as a premium discount or deductible waiver, etc.),

then the safe play is probably to treat the program as subject to Title I's prohibitions.

On the other hand, if the employer offers a wellness program that is not a health plan, part of a health plan or related to a health plan, then it appears the employer may be able to collect genetic information, provided the employer meets other specific requirements. For example:

- the employee must provide prior, knowing, voluntary, and written authorization for the employer's collection of genetic information;
- only the employee (or family member if the family member is receiving genetic services) and the licensed health care professional or board certified genetic counselor involved in providing such services may receive individually identifiable information concerning the results of such genetic services; and

*The HIPAA privacy and security rules also pose interesting issues with respect to wellness programs. In many cases the employer needs some information related to the program to supply incentives and, in some cases, ferret out misrepresentations by wellness program participants.*

- any individually identifiable genetic information provided in connection with the genetic services must be available only for purposes of such services and cannot be disclosed to the employer except in aggregate terms that do not disclose the identity of specific employees.

### **HIPAA Privacy and Security**

Wellness programs pose two main issues under the HIPAA privacy (and security) schemes.

First, is the wellness program subject to HIPAA privacy/security?

The HIPAA privacy and security rules provide that “health plans” are covered entities subject to the rules. They define “health plan” broadly enough to encompass wellness programs that actually provide a medical benefit.<sup>57</sup> At that point the scheme presents a host of subordinate questions, among them:

- Is the program insured or self-insured? The employer generally takes on the burden of HIPAA compliance with respect to a self-insured health plan, unless the plan is very small (fewer than 50 participants) and self-administered.
- If self-insured, are there fewer than 50 participants and does the employer self-administer the program (thus dodging the rules)?<sup>58</sup>
- If it does not dodge the rules that way, does or should the employer consider the program to be part of an existing health plan; the dilemma for a fully insured employer here is that incorporating a self-insured component (the wellness program; wellness programs are often self-insured) into the plan arguably subjects the *entire* plan to the full panoply of HIPAA privacy and security obligations that applies to self-insured plans. Thus, arguably the employer must have a privacy and security official in place, privacy and security policies, training protocols, privacy notices issued to employees, etc.

<sup>57</sup>See generally 45 C.F.R. 160.103.

<sup>58</sup>Id. (see definition of “group health plan”).

***HHS has said, at least informally, that in many cases a wellness vendor and health plan administrator may share PHI for health plan operations.***

Of course, if the employer treats the self-insured wellness program as a *separate* plan for HIPAA purposes, it is still self-insured, and the full panoply of HIPAA privacy and security obligations still attach, so perhaps it's a moot point.

- To what extent is the employer receiving PHI? For what purpose? Is it secured?
- Is the wellness program described in the appropriate "privacy notice"?

### ***Can the Wellness, Employee Assistance, and Disease Management Programs Share PHI?***

As noted above, it's critical that the wellness, employee assistance, and disease management programs ***work together*** to prevent and/or solve health-related issues. HIPAA privacy should permit the vendors to share information with each other for treatment purposes. All three programs are likely "covered entities" or at least "business associates" under the HIPAA scheme, and should be allowed to disclose PHI to each other, without authorization, for treatment purposes and for administering the wellness program.

If there are concerns in this regard the sponsor might consider designating the programs as members of the same "organized healthcare arrangement," which should further facilitate the sharing of PHI to allow each member to carry out its necessary healthcare operations.

HHS, in informal comments to the American Bar Association in May, 2006, was asked whether the third-party administrator (TPA) under a self-funded plan could share PHI with a wellness vendor. The assumed facts were that a business associate contract was in place between the plan and the TPA, the plan sponsor received PHI as part of plan administration activities, and the wellness program was a group health plan covered by the privacy rules.

HHS agreed that wellness programs often qualify as healthcare operations of a plan, and when they do (as in this example) a business associate (the TPA) acting on behalf of a plan may use PHI to identify and

*Wellness programs sometimes pose issues under state law, but ERISA might preempt state law if the wellness program is operating as or under a health care plan.*

contact individuals about the wellness program. Alternatively, the TPA could send the information to the plan sponsor and the sponsor could identify and contact the individuals, but only if the plan document had been amended to permit the disclosure of PHI to the plan sponsor for this purpose.

Disability plans are not “covered entities” under the HIPAA scheme, and it’s sometimes helpful to involve or integrate the disability program into the mix. Although “covered entities” may still disclose PHI without authorization for treatment purposes, *it might be worthwhile to have employees, perhaps as part of the health risk assessment, provide authorization to the various vendors in the wellness program mix, to share PHI for the purpose of treatment.*

### **State Law Issues**

State disability discrimination, smokers’ rights, and other laws might impact wellness programs. Of these, the smokers’ rights laws are the most interesting. About half of the states have laws essentially prohibiting employers from discriminating against employees in the terms and conditions of employment (including benefits) on account of the employees’ use of lawful products, like tobacco, away from the workplace.

So how do so many employers get away with smoking cessation programs that penalize smokers if they don’t participate in the program? Three reasons:

Many employers are located in the states that do not have “smokers’ rights laws.”

Some employers in states that do have such laws simply do not know, or do not care (they are going to discriminate against smokers until someone tells them they cannot).

The wellness program runs in conjunction with an ERISA plan, or is considered an ERISA plan itself. ERISA probably preempts such state laws, to the extent they would “relate to” the employer’s ERISA plans. So, arguably the smokers’ rights laws—that might otherwise operate to frustrate an employer’s offering of a premium discount to non-smokers—are preempted by ERISA.

*Wellness program participation typically does not disqualify the participant from making HSA contributions.*

### **Health Savings Account Eligibility**

A person enrolled in qualifying high deductible health coverage, with a view to making HSA contributions, is not permitted to be enrolled in other, low-deductible coverage unless the other coverage is “permitted insurance,” such as dental, vision, long-term care, etc.<sup>59</sup>

There was some initial question about whether participation in a wellness program would be considered disqualifying coverage. The IRS has said, “no,” but only if the wellness program does not provide significant benefits.<sup>60</sup> Most do not, but a disease management program probably does.

As long as the disease management program is operating under the qualified high deductible plan (which is where it would normally exist), there would appear to be no problem.

### **WELLNESS PROGRAMS AND HEALTH REFORM**

The Patient Protection and Affordable Care Act of 2010, the massive federal health reform initiative, implicates wellness programs in several ways.

First, the law essentially codifies the HIPAA wellness program regulations. But with a twist. Beginning 2014, the federal law will bump the maximum health status-related incentive or penalty from 20% of the total cost of coverage, to 30%. It also authorizes the Department of Health and Human Services to increase the 30% to a whopping 50%, via any regulations HHS may decide to issue.<sup>61</sup>

Second, the law imposes a modest annual reporting obligation on employers and insurers who maintain various disease management, health care quality improvement processes, and wellness programs. A copy of the annual report must be made available to health plan enrollees during the open enrollment process.<sup>62</sup>

<sup>59</sup>See 26 U.S.C. 223(c)(1)(A).

<sup>60</sup> IRS Notice 2004-50 Q&A 10.

<sup>61</sup> Patient Protection and Accountable Care Act of 2010 (“PPACA”) § 1201 (adding Sec. 2705 to the Public Health Service Act).

<sup>62</sup> PPACA § 1001 (adding Sec. 2717 to the Public Health Service Act).

### PRACTICAL ISSUES

#### Rule Number 1: Know Thy Enemy

##### *Generally*

It is pointless to guess about wellness. A smoking cessation program, for example, will do little to impact the bottom line if smoking and its related illnesses are not material cost drivers under the healthcare plan.

##### *An Anecdote*

A client was approached by a local insurer, which offered to provide a four-pronged wellness program for the client during the next contract year. The program would target diabetes, heart disease, smoking, and obesity. The carrier offered to provide the program for \$75,000.

In digging into the client's demographics and claim data we discovered that in three of those four categories suggested by the carrier, the client was *below national benchmarks* in healthcare spending. The client had other problems—musculoskeletal injuries seemed unusually common—but the \$75,000 would **not** have been money well spent.

##### *Tools*

Getting after your healthcare cost drivers in an effective and systematic way requires access to *detailed* data about your company's medical and prescription drug claims, disability/absence information, and employee demographics. Only then can you design an adequately comprehensive and focused wellness initiative.

It is helpful to know additional information as well: Absenteeism rates, workers' compensation claim and trend information, workplace safety issues, and—maybe most importantly—whether persons receiving care under the healthcare plan are seeking and obtaining appropriate medications and other treatment, etc.

##### *Follow Up*

You cannot “set it and forget it” when it comes to wellness programs. It is critical that the sponsor re-evaluate from time to time whether the wellness program is, in fact, “engaging the enemy” and helping

the employer win the battle. If healthcare costs continue to rise, the sponsor must modify the battle plan.

### **Rule Number 2: Be Realistic, with Budget and Expectations**

With wellness, what an employer gets will almost always depend on how much it spends, how well it plans, and how well it sustains its communication effort. Return on investment (“ROI”) of a wellness program is not as precise as in a 401(k) plan . . . improved morale, enhanced productivity, decreased absenteeism all play a role in addition to tracking cost trends under a healthcare program.

But consider how much a health plan sponsor saves if it discovers just one impending catastrophic illness or disease in time to avoid it or to manage it cost-effectively. To prevent a single stroke is to save \$50,000 to \$75,000 in healthcare claim costs.

Conventional wisdom is to not expect a positive ROI for at least 18 months. Thereafter, a realistic ROI expectation may be three dollars saved for every dollar spent on a typical, plain vanilla wellness initiative. The ROI is often accelerated and greater when the employer spends more on enhanced (more comprehensive, hands-on, personal coaching, etc.) programs.

Many employers deal with the cost by rolling all or a part of it into the next year's employee contribution for health coverage. For example, an extra \$3 or \$5 per month in the employee's premium is often enough to pay the cost of the wellness program.

### **Rule Number 3: Communicate, Communicate, Communicate**

Without question, and *without exception*, the wellness initiatives that achieve the greatest success are the ones communicated on the most aggressive and sustained basis. ***Communication must start early, and continue often.***

Focus groups with employees, to determine what their health issues and fears are, can be a huge help in identifying the kind of wellness initiatives employees would utilize or participate in. Consider a “wellness committee” comprised of management and rank-and-

file representatives.

If there are bargaining units to consider, take the time to win over the bargaining unit representatives *first*. If convinced of the need for wellness, to help the employer hold down the cost of health insurance (or maintain a plan at all), bargaining unit reps will sometimes even *help sell* the program to their members.

***Communicating a wellness program effectively takes time, takes planning, takes effort, and corporate commitment to the long-term.***

#### **Rule Number 4: Attack on a Broad Front**

Many employers who are first dipping toes into the wellness waters move slowly, minimizing their investment by focusing on only one or two of their most costly problems. That is a start, but sometimes results are disappointing. That is because ***health issues are profoundly interconnected***, and individual behaviors are only part of the story. The key is to create a comprehensive “culture of health improvement.” This requires significant corporate commitment of both resources (time and money) and will, and also requires patience.

Many wellness vendors will say that an employer must consider its employee assistance program as a sort of wellness program, and ***integrate the EAP*** vendor's information with the disease management effort and the wellness vendor's efforts. Many large claim-driving conditions are spotted first by the EAP vendor. Additional intervention by the disease manager and wellness coach can pay huge dividends.<sup>63</sup> The same applies to ***disease management*** vendors, ***workers' compensation*** vendors, and even ***workplace safety*** programs, because wellness is so strongly interconnected to absenteeism rates, mental health, and workplace injuries.

Although most of these programs are not subject to HIPAA at the employer's end, the care providers might be subject to HIPAA as healthcare providers.

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<sup>63</sup>For example, an employee depressed about his weight and inability to lose weight might first contact the EAP for help with his melancholia. By bringing the wellness vendor into play at that time the employee can be coached on diet and exercise issues in addition to receiving mental health counseling. As the employee begins to lose weight, his mood improves, and so does his productivity.

To avoid HIPAA privacy and similar concerns from frustrating the free-flow of information between them, it might be helpful to get the employees to provide a HIPAA-compliant authorization as part of the health risk assessment, allowing these programs to share information with each other for purposes of treatment.

### **Rule Number 5: Management Leads the Way**

#### ***Selling Management on Wellness Program ROI Without a Pie Chart***

If the impetus for a wellness initiative comes from the bottom up (from HR/Benefits) rather than top down, management must be sold on the idea. This is challenging, because of the difficulty in showing concrete ROI. But anecdotal evidence from other employers, and rising premiums costs, help to bring management on board.

Most entrepreneurs have competitive personalities. Sometimes merely showing the boss what a competitor is doing, with respect to wellness, is enough to win a commitment to the program.

#### ***Management Commitment***

Leadership is about setting the example. Management must champion, and participate in (indeed, lead) the program. Management should not expect immediate results . . . this is a long-term commitment (but it often pays immediate dividends, although they are sometimes difficult to quantify).

### **Other Practical Issues**

#### **In-House or Outsourced Wellness Programs?**

Most employers out-source their wellness assessments and coaching. They might bring a contractor in-house to make him or her more accessible, but they take pains to make clear the arm's-length relationship between the employer and the wellness vendor. This does not mean that the employer is not significantly involved in the process, however. The employer remains significantly involved, particularly in the communication process. This outsourcing occurs for two reasons, both of them compelling:

First, *the vendor has a greater breadth of experience* in wellness program design, implementation and coaching. It understands what works well, and why. Many successful vendors have long practice with workers' compensation and workplace safety programs.

Second, employees are often less reluctant to share highly personal medical information about themselves and their families with a contractor that is independent of the employer. This pays a double dividend. *It enhances the employees' "trust factor"* in supplying candid answers to a health appraisal, for example.

In addition, it helps insulate an employer from later claims that the employer disciplined an employee due to health risk factors; the employer can legitimately claim that it was not privy to the details of the confidential medical information shared by the employee with the vendor.

Interestingly, this "trust factor" remains high even where the vendor works from the employer's premises, such as when it has an on-site office at the employer's location.

### **Incentives**

Incentives—and some of the legal issues they pose, particularly tax issues—are discussed in detail in earlier portions of this *Employer's Guide*.

### **Carrier-based or Independent?**

Many health insurers are leaping into the wellness arena in a sizeable way for three reasons:

There's money to be made.

They already have the key data regarding the employer's medical and prescription claim costs and trends.

By enhancing wellness among their insureds they can decrease claim payouts and improve their own bottom line.

### **Include Dependents?**

A fundamental question is the extent to which the employer will invite dependents to participate. Most commonly, employers confine their initial wellness

program efforts to employees. Depending on results, the employers will weigh the cost of expanding the programs to dependents.

Conventional wisdom is that including dependents, particularly in programs such as health risk assessments, is an appropriate and desirable move, at least ultimately. Juvenile diabetes, for example, has reached such absurd proportions that healthcare providers do not even call it that anymore. Certainly, early intervention by a disease manager can help save the employer's health plan a significant amount of money.

We note here that the final HIPAA regulations governing wellness programs provide that the value of the incentive (or penalty) under a health plan-related wellness program (where the incentive/penalty is a premium decrease/increase) may be larger where dependents are allowed to participate.

The more health risk-related the program and its reward (or penalty), however, the more resistance employers might meet from employees, who are often more willing to tolerate an employer's perceived "intrusion" into the employee's private life and behavior patterns, than they are to tolerate a similar intrusion into the lives of their dependents.

### **KISS (Keep it Secret, Stupid)**

Like the age-old mantra, "Keep it simple, stupid," we might adopt a new mantra in the wellness context: "Keep it secret, stupid!" Under the ADA, under the HIPAA Privacy and Security rules, under state privacy laws, and under simple common sense, it's critical that identifiable or individualized employee data acquired by an employer or its vendors, in the context of a wellness program, be maintained in *strict secrecy*. It is a rare case where it is a good idea for the employer to even get the information; usually far better to keep it in the hands of the outsourced wellness vendor to the extent practicable.

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