



Wellness Programs - Legal Background and Requirements

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Employers and other sponsors of group health plans looking for strategies to control increasing health insurance costs often consider implementing various programs or ideas to promote good health or wellness as a means of improving claims experience and reducing costs. These programs are often linked to the employer's group health plan, either offering incentives for participants with good behavior and/or imposing penalties for participants with bad behavior.



For example, often employers want to punish smokers by imposing a premium surcharge on them. Plan sponsors considering this type of linkage should understand that federal law (and in some cases, state law) may impose important limits on their ability to do so.

What Federal Laws Limit A Plan Sponsor's Ability to Offer Incentives or Impose Penalties to Encourage or Discourage Certain Behaviors?

Every plan or program established or maintained by an employer (or by an employee organization or both) for the purpose of providing medical, surgical, sickness or hospital care or benefits, whether through the purchase of insurance or on a self-insured basis is subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA is a federal statute that, among other things, establishes specific rules and requirements that apply to employer-sponsored group health plans.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), among other things, amended ERISA by prohibiting plans (and insurance companies) from treating individuals differently with respect to eligibility, benefits and premiums based on health factors. In other words, ERISA prohibits employers from excluding participants, limiting coverage or charging participants a higher rate based on a health factor. Simply put: an employer that imposes different rules on individuals based on a health factor violates federal law and can be subject to fines and penalties imposed by the federal government, and can be sued by participants against whom these requirements are imposed.

What Are Health Factors?

Under federal law, health factors include:

- a person's health status, medical condition (including both physical and mental illnesses),
- claims experience,
- receipt of health care,
- medical history,
- genetic information,
- evidence of insurability (including conditions arising out of acts of domestic violence and participation in

- activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and
- disability.

So, under federal law, an employer is prohibited from treating an employee with a health factor differently from employees without that health factor. Health factors include any type of disease or illness and conditions that are recognized by the federal government as constituting a health condition.

For example, under these non-discrimination rules, an employer cannot charge employees with diabetes a higher premium rate because of their diabetes. Also, for example, this means that an employer may not charge smokers a higher premium because they smoke. Employers can usually understand why it would be unfair to charge an employee with diabetes a higher premium, but do not understand why the same rules applies to smokers. The answer is simple: the federal government recognizes smoking (i.e., nicotine addiction) as a health factor, according to employees with this addiction the same level of protection as those with other health conditions, like diabetes.

Also, these rules—specifically the “evidence of insurability rules”—prohibit an employer from excluding a participant from a group health plan, and prohibit an employer from charging a higher premium, because that employee participates in a “risky activity.” For example, a plan cannot exclude those who sky-dive or bungee jump from participating in a plan.

Does This Mean That All Employees Must Receive the Same Benefits Under a Group Health Plan?

No. In general, ERISA does not establish coverage standards for employers sponsoring group health plans (aside from the nondiscrimination rules). The anti-discrimination rules set out above prohibit discriminating based on health facts between similarly situated individuals. Group health plans may treat distinct groups of similarly situated individuals differently, if the distinctions between the groups are not based on a health factor.

Employers distinguishing among groups of participants must base the distinctions on bona fide employment-based classifications consistent with the employer’s usual business practice. Whether an employment-based classification is bona fide is based on relevant facts and circumstances, such as whether the employer uses the classification for purposes independent of qualification for health coverage. Bona fide employment-based classifications might include: full-time versus part-time employee status; different geographic location; membership in a collective bargaining unit; date of hire or length of service; or differing occupations.

Plans may also distinguish among beneficiaries. Distinctions among groups of beneficiaries may be based on bona fide employment-based classifications of the participant through whom the beneficiary is receiving coverage, relationship to the participant (such as spouse or dependent), marital status, age or student status of dependent children, or any other factor that is not a health factor.

Does This Mean That Employees With Health Factors Cannot Be Treated Better?

No. The nondiscrimination rules do not prohibit a plan from establishing more favorable rules for eligibility or premium rates for individuals with an adverse health factor, such as a disability.

Do These Rules Mean That An Employer Cannot Establish a “Wellness Program” Under Which Incentives Are Offered to Employees Who Participate in Programs Designed to Improve Health?

No. The federal government has established special rules that permit employers to establish wellness programs, as long as certain rules are followed.

What are the Wellness Plan Rules?

Under federal law, an employer can provide incentives to employees who participate in a wellness plan. That is, under federal law a group health plan that requires a higher premium payment from an individual, based on a health factor of that individual or a dependent of that individual, than for a similarly situated individual, does not violate the discrimination requirements discussed above if the premium payment differential is based on whether an individual has complied with the requirements of a “wellness program.”

To meet the requirements for this exception, a wellness program must:

- limit the amount of the program’s rewards
- be designed to promote good health and prevent disease
- provide a reasonable alternative—a reward that’s available to all similarly situated individuals; and
- disclose the reasonable alternative standard.

Here is a closer look at these requirements:

Limit the Amount of the Program’s Rewards.

Under federal law, the “reward” may not exceed 20% of the cost of employee-only coverage under the plan. If any class of dependents (e.g., spouses or spouses and dependent children) may participate in the wellness program, the reward may equal as much as 20% of the cost of the coverage in which an employee and any dependents are enrolled. For this purpose, the 20% incentive can be based on the total amount of employer and employee contributions for the benefit package under which the employee (or the employee and any insured dependent) receives coverage. Under federal law, the “reward” may be in the form of a discount, a rebate of a premium or contribution, or a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), or the absence of a surcharge

Example: An employer sponsored group health plan’s individual (employee-only) annual premium coverage is \$3,600 (of which the employer pays \$2,700 per year and the employee pays \$900 per year). The annual premium for family coverage is \$9,000 (of which the employer pays \$4,500 per year and the employee pays \$4,500 per year). The plan offers a wellness program with an annual premium rebate of \$360. The program is available only to employees. The rebate meets the wellness plan rules because the reward it provides, \$360, is 10% of the individual-only coverage amount, and does not exceed the 20% of the total annual cost limit. If dependents are allowed to participate in the program and the employee is enrolled in family coverage, the plan could offer the employee a reward of up to 20% of the cost of family coverage, or up to \$1,800 [$\$9,000 \times 20\% = \$1,800$].

Designed to Promote Good Health and Prevent Disease.

A wellness program must be reasonably designed to promote good health and prevent disease. A program meets this requirement if it has a reasonable chance of improving the health of, or preventing disease in, participating individuals, and (a) is not overly burdensome, (b) is not a subterfuge for discriminating based on a health factor, and (c) is not highly suspect in the method chosen to promote health or prevent disease.

To this end, a program must offer its participants the opportunity to qualify for the available awards at least once per year.

Thus, a program might not be reasonably designed to promote good health or prevent disease if it imposed, as a condition to obtaining the reward, an overly burdensome time commitment.

In other words, the program cannot be a “one-off” that is designed to get a specific group of employees.

Provide a Reasonable Alternative—A Reward That’s Available to All Similarly Situated Individuals.

A program's reward must offer a reasonable alternative for obtaining the reward for that period for any individual for whom it is:

- unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard for the reward;
- **or**
- medically inadvisable to attempt to satisfy the otherwise applicable standard for that reward.

In other words, if an employer provides a 20% discount of its premium to non-smokers as well as those who go through a quit smoking program, and a participant who smokes presents a note from his or her doctor indicating that it is unreasonably difficult due to a medical condition for the participant to quit smoking or it is medically inadvisable for him or her to do so, the premium adjustment for non-smokers or those participating in a quit smoking program must be offered to this participant.

A plan may seek verification from an employee or their dependent that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the non-smoking or participation in a quit smoking program.

The employer could, however, at least require participation in the quit smoking program, and provide the discount for simply participating, without regard to whether the employee actually quits smoking.

Disclose the Reasonable Alternative Standard.

As indicated above, the employer can offer a "reasonable alternative" to satisfying the wellness requirement. Under federal law, this requirement must be clearly stated to all participants.

Example: In conjunction with an open enrollment period, a group health plan provides a form for participants to certify they do not use tobacco products or they will quit smoking through a smoking cessation program. Participants who do not provide the certification are assessed a surcharge (within the percentage-of-cost limit for wellness programs). However, all plan materials describing enrollment and the terms of the wellness program include a statement indicating that, if it is unreasonably difficult due to a medical condition for an individual to meet the program requirements (or if it is medically inadvisable for an individual to meet the program requirements), the program will make available a reasonable alternative standard to avoid the surcharge. If it is unreasonably difficult for an employee to stop smoking cigarettes due to an addiction to nicotine (a medical condition), that employee may participate in a smoking cessation program to avoid the surcharge. The employee avoids the surcharge for as long as the employee participates in the program, regardless of whether the employee stops smoking.

A wellness program that meets all of the requirements set forth above will not violate federal law. We note that certain states impose rules that may apply and that are not preempted by federal law. Certain states, for example, prohibit an employer from imposing any rule based on behavior that is not otherwise banned under state law. For example, in those states there may be a prohibition on imposing any type of rules on smokers because smoking is not illegal under state law.

These state laws are typically not preempted by federal law and may apply stricter standards than discussed above. Employers implementing wellness plans should always check with counsel to determine whether their proposed program is legal under state law.

Can Employers Establish Other Wellness-Type Initiatives Without Violating the ERISA Non-Discrimination Rules, Even if They Don't Meet the Wellness Rules?

Employers absolutely must follow the wellness rules set out above if it wants to charge higher premiums or offer discounts as a means to encourage healthier behavior. However, not all steps that an employer may take to reduce

health care costs will be covered by these rules. For example, employers may want to condition enrollment on the completion of a health risk assessment tool or establish well-baby or similar benefits. These programs are consistent with ERISA, as discussed above.

Specifically, the federal government has stated that employers can condition enrollment in a group health plan on the completion of a health risk assessment questionnaire, as long as the results of the questionnaire are not used to either increase premium cost, bar enrollment or decrease benefits.

In other words, if the sole purpose of a health risk assessment questionnaire is to provide employees with information about their own health risk factors—an important step in controlling risk factors—and not used by the employer to limit enrollment, decrease benefits or increase costs, then they can be used under ERISA.

However, employers should be advised that the United States Equal Employment Opportunity Commission (“EEOC”) has stated that requiring an employee to complete a health risk assessment tool is per se a violation of the Americans with Disabilities Act (“ADA”). Before using a health risk assessment tool, employers should consult with qualified counsel regarding the EEOC’s position with respect to the ADA.

In addition, certain state laws may apply and, as such, employers should consult with competent counsel before implementing these programs.

The federal government has stated that the following types of programs may be implemented if they are not based on an individual satisfying a standard related to health factor, and the program is made available to all similarly situated individuals). For example the following are permitted:

- A program that reimburses all or part of the cost for memberships in a fitness center.
- A diagnostic testing program that provides a reward for participation rather than outcomes.
- A program that encourages preventive care by waiving the copayment or deductible requirement for the costs of, for example, prenatal care or well-baby visits.
- A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.
- A program that provides a reward to employees for attending a monthly health education seminar.

Employers should note that some of the programs identified above are considered taxable benefits and will result in imputed income for employees. Before implementing any benefit program, employers should consult with competent ERISA counsel.

To summarize, employers may encourage health behavior by their employees. Before doing so, however, they should familiarize themselves with the applicable rules and ensure that their plan comply with applicable law.

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