

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XXV)

April 16, 2015

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at <http://www.dol.gov/ebsa/healthreform/> and <http://www.cms.gov/ccio/resources/fact-sheets-and-faqs/index.html>), these FAQs answer questions from stakeholders to help people understand the law and benefit from it, as intended.

Wellness Programs

Under Public Health Service Act (PHS Act) section 2705¹, Employee Retirement Income Security Act (ERISA) section 702, and Internal Revenue Code (the Code) section 9802 and the Departments' implementing regulations, group health plans and health insurance issuers in the group and individual market are generally prohibited from discriminating against participants, beneficiaries, and individuals in eligibility, benefits, or premiums based on a health factor.² An exception to this general prohibition allows premium discounts, rebates, or modification of otherwise applicable cost sharing (including copayments, deductibles, or coinsurance) in return for adherence to certain programs of health promotion and disease prevention, commonly referred to as wellness programs. The wellness program exception applies to group health coverage, but not individual market coverage.³

On June 3, 2013, the Departments issued final regulations⁴ under PHS Act section 2705 and the related provisions of ERISA and the Code that address the requirements for wellness programs provided in connection with group health coverage. Among other things, these regulations set the maximum permissible reward under a health-contingent wellness program that is part of a

¹ Section 1201 of the Affordable Care Act amended and moved the nondiscrimination and wellness provisions of the PHS Act from section 2702 to section 2705, and extended the nondiscrimination provisions to the individual market. The Affordable Care Act also added section 715(a)(1) to ERISA and section 9815(a)(1) to the Code to incorporate the provisions of part A of title XXVII of the PHS Act, including PHS Act section 2705, into ERISA and the Code and make them applicable to group health plans and group health insurance issuers.

² The statute and its implementing regulations set forth eight health status-related factors, which the 2006 regulations refer to as "health factors" for simplicity. Under the statute and the regulations, the eight health factors are 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 disability. 71 FR 75014 (Dec. 13, 2006). In the Departments' view, "[t]hese terms are largely overlapping and, in combination, include any factor related to an individual's health." 66 FR 1379 (Jan. 8, 2001).

³ Note, however, that "it is HHS's belief that participatory wellness programs in the individual market do not violate the nondiscrimination provisions provided that such programs are consistent with State law and available to all similarly situated individuals enrolled in the individual health insurance coverage." 78 FR 33167 (Jun. 3, 2013).

⁴ See 78 FR 33158 (Jun. 3, 2013). These regulations update earlier regulations implementing the nondiscrimination and wellness program provisions established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (the 2006 regulations). 71 FR 75014 (Dec. 13, 2006). The Affordable Care Act amended the statutory nondiscrimination and wellness provisions to in large part reflect the 2006 regulations regarding wellness programs.

group health plan (and any related health insurance coverage) at 30 percent of the cost of coverage (or 50 percent for wellness programs designed to prevent or reduce tobacco use).⁵ The wellness program regulations also address the reasonable design of health-contingent wellness programs and the reasonable alternatives that must be offered in order to avoid prohibited discrimination. In the preamble to the wellness program regulations, the Departments stated that they anticipated issuing future subregulatory guidance as necessary. The following FAQs address several issues that have been raised since the publication of the wellness program regulations.

Q1: What does it mean that a health-contingent wellness program must be “reasonably designed”?

Under section 2705 of the PHS Act and the wellness program regulations, a health-contingent wellness program must be reasonably designed to promote health or prevent disease. A program complies with this requirement if it (1) has a reasonable chance of improving the health of, or preventing disease in, participating individuals; (2) is not overly burdensome; (3) is not a subterfuge for discrimination based on a health factor; and (4) is not highly suspect in the method chosen to promote health or prevent disease.⁶

The determination of whether a health-contingent wellness program is reasonably designed is based on all the relevant facts and circumstances. The wellness program regulations are intended to allow experimentation in diverse and innovative ways for promoting wellness. While programs are not required to be accredited or based on particular evidence-based clinical standards, practices such as those found in the Guide to Community Preventive Services or the United States Preventive Services Task Force’s Guide to Clinical Preventive Services, may increase the likelihood of wellness program success and are encouraged.⁷

Wellness programs designed to dissuade or discourage enrollment in the plan or program by individuals who are sick or potentially have high claims experience will not be considered reasonably designed under the Departments’ wellness program regulations. A program that collects a substantial level of sensitive personal health information without assisting individuals to make behavioral changes such as stopping smoking, managing diabetes, or losing weight, may fail to meet the requirement that the wellness program must have a reasonable chance of improving the health of, or preventing disease in, participating individuals. Programs that require unreasonable time commitments or travel may be considered overly burdensome. Such programs will be scrutinized and may be subject to enforcement action by the Departments.

The wellness program regulations also state that, in order to be reasonably designed, an outcome-based wellness program must provide a reasonable alternative standard to qualify for the reward,

⁵ The cost of coverage is determined based on the total amount of employer and employee contributions towards the cost of coverage for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. 26 CFR 54.9802-1(f)(3)(ii) and (f)(4)(ii), 29 CFR 2590.702-1(f)(3)(ii) and (f)(4)(ii), and 45 CFR 146.121(f)(3)(ii) and (f)(4)(ii).

⁶ See PHS Act 2705(j)(3)(B). See also 26 CFR 54.9802-1(f)(3)(iii) and (f)(4)(iii), 29 CFR 2590.702(f)(3)(iii) and (f)(4)(iii), and 45 CFR 146.121(f)(3)(iii) and (f)(4)(iii).

⁷ See www.thecommunityguide.org/index.html and <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/>.

for all individuals who do not meet the initial standard that is related to a health factor. This approach is intended to ensure that outcome-based wellness programs are more than mere rewards in return for results in biometric screenings or responses to a health risk assessment, and are instead part of a larger wellness program designed to promote health and prevent disease, ensuring the program is not a subterfuge for discrimination or underwriting based on a health factor.

Q2: Is compliance with the Departments' wellness program regulations determinative of compliance with other laws?

No. The fact that a wellness program that complies with the Departments' wellness program regulations does not necessarily mean it complies with any other provision of the PHS Act, the Code, ERISA, (including the COBRA continuation provisions), or any other State or Federal law, such as the Americans with Disabilities Act or the privacy and security obligations of the Health Insurance Portability and Accountability Act of 1996, where applicable. Satisfying the rules for wellness programs also does not determine the tax treatment of rewards provided by the wellness program. The Federal tax treatment is governed by the Code. For example, reimbursement for fitness center fees is generally considered an expense for general good health. Thus payment of the fee by the employer is not excluded from income as the reimbursement of a medical expense and should generally be added to the employee wages reported on the Form W-2, Wage and Tax Statement. In addition, although the Departments' wellness program regulations generally do not impose new disclosure obligations on plans and issuers, compliance with the wellness program regulations is not determinative of compliance with any other disclosure laws, including those that require accurate disclosures and prohibit intentional misrepresentation.⁸

⁸ See 26 CFR 54.9802-1(h), 29 CFR 2590.702(h), and 45 CFR 146.121(h).