HIPAA Wellness Rules

Preparing for new wellness program rules for 2014

The departments of Health and Human Services (HHS), the Treasury and Labor (DOL) issued final Health Insurance Portability and Accountability Act of 1996 (HIPAA) wellness regulations (78 Fed. Reg. 33158) this summer.

The new rules implement changes mandated by the Patient Protection and Affordable Care Act (PPACA), as well as other, rather sweeping, changes to wellness programs. The new rules apply to plan years that begin on or after January 1, 2014. Below, we respond to questions from employers on these new regulations.

Do these new rules apply to all wellness programs?

The new HIPAA wellness rules apply to an employer or plan that provides any type of incentive, reward or penalty to an individual, based on:

- Achieving a certain health status, such as a certain body mass index (BMI) level or being tobacco-free;
- Meeting a requirement that is imposed only on someone with a certain health condition, such as a coaching program that is required only for individuals with diabetes; or
- Engaging in an activity where there may be a health reason the individual could not participate, such as walking or running.

Requirements based on achieving a certain health outcome are called "outcome-based" programs. Requirements to take part in certain activities where a health reason may prevent engagement are called "activity-based."

The HIPAA wellness rules generally would not apply to activities that merely require participation—i.e., where no improvement in health is the goal. For example, providing a reward for simply taking a health screening, regardless of the results, or for attending a nutrition class where no diet change is required, likely would be considered "participatory" and not subject to the HIPAA rules.

If our program is subject to the HIPAA rules, what are the new requirements?

Similar to the prior HIPAA rules, the program must meet five requirements in order to satisfy the new HIPAA wellness rules:

1) Limit on reward. Where an activity is considered health-based, the plan is limited in the amount of the incentive it can offer. The limit is 30% of the cost of coverage—employer plus employee portion. For example, if the annual cost of coverage is $1,000, then the limit on the amount of incentives would be $300 per year. The 30% is based on the cost of single coverage if only employees are eligible for the wellness program. If dependents also are eligible, the 30% is based on the cost of the coverage in

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which the individual is enrolled—single or family. If a tobacco program is used, then this amount can increase to a total of 50% of the cost of coverage with respect to the tobacco piece—so, an extra 20% for tobacco programs. The limit is based on the incentives for all health-based wellness programs added together for a total of 30%, or up to 50% if including a tobacco program.

2) Annual qualification. HIPAA requires that the plan offer qualifications for health-based incentives on an annual basis, such as at annual enrollment.

3) Reasonable design. HIPAA requires that, overall, the program be reasonably designed to promote health and prevent disease.

4) Reasonable alternative. HIPAA requires that, where there is a health-based standard—either outcome-based or activity-based—the plan must provide an alternative for those who do not meet the initial standard. The type of alternative depends on the type of program. For incentives that are based on achieving a certain outcome—such as a reward for not smoking or having a favorable cholesterol level—the alternative must be provided to anyone who fails to meet the outcome, regardless of medical reason. For incentives that are based on an activity—such as walking or exercising—the alternative must be provided only to someone who can show that he medically cannot engage in the activity. The plan may require a doctor's note.

5) Disclosure of reasonable alternative. Plans must disclose in all plan materials descriptions of the wellness program and the availability of the reasonable alternative standard. The new rules require that this disclosure also include contact information and a statement that an individual's personal physician may be accommodated. The regulations provide sample language.

What type of alternative is required for those who do not meet the standard?

The new rules provide that whether an alternative is "reasonable" will be based on facts and circumstances, but they also provide the following guidelines:

• If the alternative is to complete an educational program, such as smoking cessation or coaching, the plan must make the program available or assist employees in finding a program. The plan cannot require an individual to find his own program unassisted. The plan also must pay for the cost of the program;

• If a time commitment is required, it must be reasonable. As an example, the regulations say that requiring nightly attendance at a one-hour class is unreasonable;

• If the alternative is a diet program, the plan must pay any membership fees but is not required to pay for food;

• If an individual's personal physician says the plan's alternative is not "medically appropriate" for that individual, the plan must provide an alternative that accommodates the physician's recommendations. However, the plan may impose cost sharing for medical items or services furnished as part of the physician's recommendations; and

• If the alternative is itself health-based—either outcome-based or activity-based—the plan must offer a second alternative, or more if necessary.

Are there special rules for outcome-based alternatives?

In addition to the guidelines above, if a plan sets an outcome-based alternative to an outcome-based initial standard, there are two additional special rules: The plan must give the individual additional time to try to meet the second outcome-based standard, or the plan must allow the individual to, instead, work with his personal physician to design his own alternative. The individual may make the request at any time, and the personal physician may adjust the recommendations at any time.

Do these rules apply to tobacco use? Can we require someone to stop smoking?

The new HIPAA rules expressly state that tobacco use is considered an outcome-based standard. That means that anyone who fails the tobacco-use test must be given an alternative, regardless of medical reason.

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These Q-and-A's first appeared on plansponsor.com in September. As health care law is evolving rapidly, there may have been further developments since the initial publication.