Employee Health & Benefits

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COMPLIANCE NEWSLETTER

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Navigating the Wellness Program Rules for 2019

What a difference a year can make. Dealing with the various and differing wellness program requirements under HIPAA, the ADA, and GINA remains challenging, but we finally had a regulatory framework to work with for all three laws in 2017 and 2018. That was apparently too easy as a federal court determined that the Equal Employment Opportunity Commission (EEOC) hadn't done enough to justify its ADA and GINA wellness incentive limit rules and ordered the EEOC to try again. After the EEOC indicated it would be unable to complete revising its rules before 2021, the court issued an order vacating the existing ADA and GINA wellness incentive rules as of January 1, 2019.

So now what?

This leaves employers with a few options to consider heading into 2019:

1. Leave existing wellness programs that comply with the current HIPAA, ADA, and GINA regulations alone without making any design changes;

2. Modify existing wellness programs by eliminating or reducing incentives for activities that are subject to the ADA and/or GINA; or

3. Determine whether to implement new wellness program activities with incentives that are subject to the ADA and/or GINA.

We recommend employers discuss their wellness program design with their legal counsel *before* choosing a course of action, but leaving an existing compliant wellness program alone seems to be a reasonable course of action for now for reasons we will discuss below. We also recommend employers carefully consider whether to implement new or additional programs that rely on the soon-to-be-vacated wellness incentive limits until further guidance is available.

Recap of the existing wellness incentive rules

The three sets of wellness rules have much in common, such as a general requirement that a wellness program be reasonably designed to improve health and/or prevent disease without being overly burdensome or a subterfuge for discrimination against participants. A key difference between them is when and how their wellness incentive rules apply.

- **HIPAA** – Only "activity-only" and "outcome-based" wellness programs are subject to HIPAA's incentive limits. An activity-only program requires participants to complete an activity related to their health status without actually requiring a specific health outcome. Examples include walking and healthy eating challenges. An outcome-based program requires participants to actually achieve or maintain a specific health outcome. Examples include requirements for participants to be tobacco free or achieve biometric targets.

  The cumulative amount of all incentives cannot exceed 30% of the total cost of coverage (employee + employer contribution) or 50% of the total cost of coverage provided the excess over 30% is used toward tobacco cessation incentives. A wellness program could utilize the entire 50% limit for tobacco incentives. If spouses and/or dependents may participate, the incentive may be based on the total cost of coverage for the enrolled tier such as employee + spouse instead of employee-only. A program must include reasonable alternatives to qualify for incentives if it is medically inadvisable or unreasonably difficult for a participant to participate in an activity-only program or if a participant fails to achieve a required outcome in an outcome-based program.

- **ADA** – Wellness programs are subject to the ADA's rules if the program includes questions that may relate to whether the participant has a disability, such as family medical history questions, or requires the participant to undergo a medical examination. Participation must be voluntary. Under the ADA's wellness regulations, participation is considered voluntary if the cumulative amount of all incentives does not exceed 30% of the total cost of employee-only coverage. There are no reasonable alternative requirements, but reasonable accommodations must be provided to enable participants with disabilities to participate. For example, an accommodation may be required to enable hearing and/or visually impaired participants to complete a health risk assessment. An employer cannot limit or deny access to health plan coverage based upon participation which prevents an employer from using participation as a gateway to a richer plan design.

- **GINA** – GINA prohibits the use of genetic information for health plan underwriting. In today's wellness program context, GINA primarily impacts health risk assessments as family medical history questions are considered genetic information. Participation must be voluntary and occur after enrollment. Under GINA's wellness regulations, a spouse's completion of a health risk assessment is considered voluntary if the incentive does not exceed 30% of the total cost of employee-only coverage. The GINA regulations do not address permitted incentives for employees to complete health risk assessments as these

are already covered by the ADA's rules. No incentives may be offered for dependent children to participate.

We'll provide an example of how the existing wellness incentive limits under HIPAA and the ADA work at the end of this article.

Because, because, because

The court in AARP v. EEOC held that the EEOC failed to sufficiently justify the use of a 30% incentive limit to satisfy the voluntary requirement under the ADA and GINA because it largely relied on the use of the 30% limit standard from HIPAA without sufficient explanation for why this should be considered "voluntary" or addressing the differences between the laws. However, the court *didn't* say that the EEOC's wellness incentive limits were inappropriate. Instead, it merely indicated that the EEOC hasn't provided enough guidance to justify the 30% limit yet. The court also didn't vacate any other provisions of the ADA and GINA wellness regulations, so the rest of the rules remain in effect. There hasn't been any indication from the EEOC that it intends to back down, so the EEOC's next attempt may simply rehash the 30% limit with additional support (i.e. the 30% standard is voluntary "because, because, because").

Be careful what you wish for

Was this a victory for the AARP and potential plaintiffs contemplating suing their employers in 2019 over wellness programs? We're not so sure.

Potential plaintiffs generally have to file a charge with the EEOC before filing a lawsuit under the ADA or GINA. The EEOC investigates the claim and issues a right to sue if it believes a wellness program violates either law. It seems unlikely the EEOC will find discrimination and issue a right to sue if a wellness program complies with the EEOC's existing final regulations as drafted, particularly if the EEOC intends to stick with its wellness incentive rules and provide greater justification for them later. Plaintiffs might anticipate this and choose to request a right to sue before the EEOC's investigation is completed. A lack of support from the EEOC isn't fatal to a plaintiff's claims of discrimination in court, but it certainly doesn't help.

It's also worth a mention that employer wellness programs were faring pretty well under the ADA in court before the final regulations were issued.[1] The court in AARP v. EEOC vacated the existing wellness incentive rules under the ADA and GINA and ordered the EEOC to try again, but it did not explicitly reject the incentive limits or find that they couldn't be justified. There's no basis to assume a wellness program that relies on those incentive limits will automatically lose in court.

[1] Remember, only the wellness incentive rules have been vacated. The EEOC specifically rejected the bona fide benefit plan safe harbor relied upon in Seff v. Broward County and EEOC v. Flambeau in the preamble to its final ADA regulations and attempted to strip this approach out, so this probably remains unavailable today.

In the meantime…

For these reasons, it seems reasonable for employers to stick with existing wellness programs that comply with the HIPAA, ADA, and GINA wellness rules as currently drafted until further guidance becomes available. That said, employers may consider tapping the brakes and not implementing any new or additional programs that rely on the soon-to-be vacated wellness incentive rules. There will be lawsuits and with the current uncertainty, employers may wish to avoid potential trouble they do not already have.

Example under the existing wellness incentive rules:

In the example below, assume the total cost of employee-only coverage is $5,000/year and only employees are eligible to participate in the wellness program.

Wellness Activity and Incentive	HIPAA	ADA
$250 incentive for completing a health risk assessment with health-related questions	N/A (participatory-only activity)	$250 counts toward incentive limit
$250 incentive for participating in biometric screening without regard to results	N/A (participatory-only activity)	$250 counts toward incentive limit
$1,200 annual surcharge for using tobacco based solely on employee attestation	$1,200 counts toward incentive limit*	N/A
Total permitted incentives	$1,500 (30% * $5,000) or up to $2,500 (50% * $5,000) if excess over $1,500 used for tobacco incentives	$1,500 (30% * $5,000)
Total incentives used	**$1,200 = compliant**	**$500 = compliant**

*HIPAA's reasonable alternative standard rules apply.

ABOUT THE AUTHOR

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Association Health Plans – Update

States challenge the DOL's Association Health Plan rules

In response to the Department of Labor's final rule on association health plans (the "final rule"), twelve states - New York, Massachusetts, California, Delaware, Kentucky, Maryland, New Jersey, Oregon, Pennsylvania, Virginia, Washington - and the District of Columbia (collectively, the "Plaintiff States") jointly filed suit.

In *The State of New York v. United States Department of Labor,* the Plaintiff States contend that the final rule's purpose and intended effect are simple: allowing small employers and individuals to shift from the small and individual markets – markets which have more robust core consumer protections and benefits – to the large group market which provides fewer protections and mandated benefits for the purposes of undermining the Affordable Care Act (ACA).

The Plaintiff States make several claims in their complaint.

- While the final rules enable association health plan (AHP) members to participate in the "large group market" for consumer protections and benefits, they are not considered "large employers" under the ACA's Employer Shared Responsibility mandate. This enables AHP members to offer less comprehensive coverage without paying a penalty that traditional ACA "applicable large employers" would face under the same circumstances.

- The Plaintiff States claim the final rule conflicts with Congressional intent, the ACA, and long-standing case law under the Employment Retirement Income Security Act (ERISA). The Plaintiff States claim that by expanding the definition of "employer" and "employee" to include self-employed individuals, those individuals and other consumers' health and financial security are at risk because they will be allowed to create large-market AHPs without the consumer protections of the small and individual markets. Additionally, the expanded definition of "employer" enables marketing of insurance plans by unlicensed, entrepreneurial "associations.

- The Plaintiff States claim the final rule is arbitrary, capricious, and exceeds the DOL's authority by disregarding the past fraud and abuse by AHPs that destabilized individual and small group markets. Both the timing and eventual outcome for this case are uncertain.

Other states' responses to the final rule vary. Some states are enacting legislation consistent with the final rule, while others are legislating for consumer protections similar to those in the small group and individual markets, requesting respective Insurance Commissioners to provide guidance, or looking to prohibit the final rule's expansion of AHPs altogether. All of this serves as food for thought for organizations considering forming AHPs under the final rules.

Our earlier article discussing the DOL's Association Health Plan rules is available here.

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Reminder: Medicare Part D Creditable Coverage Notice Deadline is October 14, 2018

Each year, employer group health plans including prescription drug coverage must provide a Medicare Part D creditable coverage notice to all Medicare eligible employees and dependents prior to October 15th. The purpose of this annual disclosure is to inform Medicare beneficiaries whether or not their employer's prescription drug coverage is comparable to Medicare's prescription drug coverage and help them decide whether to enroll in Medicare Part D. For 2019, the annual Medicare Part D enrollment period will begin on October 15, 2018 and end on December 7, 2018.

Take Action

Employers should review their prescription drug coverage to determine creditable coverage status and distribute the appropriate notice on or before October 14th. If a plan has multiple benefit options providing prescription drug coverage, the test must be applied separately for each benefit option. In order to assist employers with Medicare Part D requirements, the remainder of this alert provides additional background details including:

- Model disclosure notices
- Employers impacted by Medicare Part D
- An overview of who is considered a "Medicare eligible individual".
- Notice disclosure deadlines and delivery methods.

Model Disclosure Notices

The Centers for Medicaid and Medicare Services (CMS) provides guidance and sample creditable coverage disclosure notices on their website. Note that the templates are dated April 2011, and no changes have been made to the standard language since that time.

Employers Subject to Medicare Part D

An employer is subject to the Medicare Part D notification requirements if it offers prescription drug coverage to its active employees or retirees covering Medicare Part D eligible individuals (including dependents).

Medicare Part D Eligible Individuals

All Medicare Part D eligible individuals who are applying for, or are covered by, the employer's prescription drug benefits plan must receive the notice. A "Medicare Part D eligible individual" is a person who:

- Is entitled to benefits under Medicare Part A and/or is enrolled in Medicare Part B, as of the effective date of coverage under a Medicare Part D plan (active employees may have Medicare coverage); and
- Resides in a "service area" of a Medicare Part D plan. A "service area" is defined as a location that meets certain pharmacy access standards. Most individuals live in a service area.

"Medicare Part D eligible individuals" may include active employees, employees who are disabled or on COBRA, retired employees, and their covered spouses and dependents. An employer may not know the Medicare eligibility status for all of these individuals, and we recommend employers provide the notice to all covered individuals (Please see *Method of Delivery* below for delivery to covered families living at the same address).

Disclosure Deadlines

Disclosures must be made to Medicare Part D eligible individuals:

- Prior to the Medicare Part D Annual Election Period beginning on October 15th each year.
- Prior to an individual's initial enrollment period for Medicare Part D.
- Prior to the effective date of coverage for any Medicare-eligible individual that joins the employer's plan.
- Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable.
- Upon the request of the individual.

Method of Delivery

Plans may provide the creditable coverage notice with other member information materials (including new hire and open enrollment materials) or in a separate mailing. If the notice is combined with other information such as an enrollment brochure or guide, the notice must appear on the first page of the document and be in at least 14-point font in a separate box, or boldfaced or offset text, and refer to the appropriate page or section.

The notice may be hand-delivered or mailed. A single notice can be provided to a family living at the same address. Employers may also provide the notice electronically as long as they meet the Department of Labor's (DOL) electronic disclosure requirements or if the participants consent electronically. The DOL requires that:

- Electronic transmissions may be relied on only for participants who can access the documents in electronic format at their work sites.
- Appropriate measures must be taken to ensure actual receipt by participants.
- Participants must be notified in writing or electronically of their right to receive a paper copy of the notice free of charge.

In addition, if an employer provides the notice electronically, it must also notify participants that they are responsible for providing a copy of the disclosure to their Medicare eligible dependents covered by the group health plan.

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