Health Promotion Program Legal Updates

Webinar Q&A: March 15, 2017

The following questions were submitted during WELCOA's *Health Promotion Program Legal Updates* webinar session that aired on **March 15, 2017**. To help further educate yourself in legal compliance with your wellness program, please review this list of attendee inquiries and the responses provided by presenter and health law attorney, Barbara Zabawa.

Please note that the responses in this document do not constitute legal advice. You are advised to seek legal counsel to obtain more definitive information about the issues raised in this document.

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1. What are good and acceptable RAS for a health-contingent program? How many coaching sessions would be "reasonable?" How long of an online course is acceptable? Can one RAS (e.g., coaching) provide credit for multiple outcome measures, e.g., BMI and Blood pressure?

The ACA rules promulgated in June 2013 did not dictate what qualifies as an acceptable RAS; the rules leave room for flexibility to design an RAS that will work for each employee or employee population. Specifically, the guidance states "These final regulations continue to permit plans and issuers flexibility in designing reasonable alternative standards (including using reasonable alternative standards that are health-contingent) while also providing some clarification of what constitutes being 'reasonable' in the context of an alternative standard." See 78 FR at 33163 (June 3, 2013). The RAS must not be overly burdensome, however, or act as a subterfuge for discrimination.

2. What are a few examples of reasonable alternatives? Should we refer to the employee's doctor?

Again, the rules do not dictate which RAS to use. See response to Question #1. But, some examples have been education classes, a more reasonable outcomes-based goal, or seeing one's primary care physician. The rules require wellness programs to allow the employee and his or her doctor to recommend an RAS. Only activity based wellness programs can require an employee to seek their physician's verification if they cannot meet the initial standard; wellness programs may not require physician verification for outcomes-based programs.

3. Will the HR 1313 override the EEOC regulations?

Mostly, yes, according to my reading of the proposed bill. The anti-discrimination provisions would still apply.

4. Can you talk a little more about the impact/risk of allowing employer collection of family history and removing the protections of GINA?

Right now, GINA prohibits employers from asking employees family medical history questions unless those answers are provided without incentives and completely voluntary. HR 1313 seems to allow employers to ask employees family medical history questions and tie incentives to answering those questions.

5. If the HR 1313 bill is passed do you see this bill benefiting or hurting workplace wellness programs success?

Depends on who you ask. HR 1313 would probably make administration of workplace wellness programs easier for vendors and employers, but employees would probably dislike the invasion of privacy that might accompany the new law as employers would be able to find out individually identifiable health information of employees and their families.

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6. Should HR 1313 become law. How long would a program have to adjust their incentive limit? Immediately? At the end of the year?

That remains to be seen. There should be at least a few months, but Congress could delay the effective date for a few years, like they have proposed with a number of provisions of the American Health Care Act.

7. During the webinar, you stated that the incentive reward was based on the plan the employee was enrolled in. I want to clarify that the reward/incentive is in fact according to the employee only coverage and if it is employee + spousal coverage the incentive limit is just the percentage of the employee only coverage X2, Correct?

It depends on which law we are discussing. Under the ACA, the incentive is measured against the coverage the employee is enrolled in. Under the ADA and GINA, the incentive is measured against the total cost of self-only coverage, regardless of whether the employee is enrolled in that coverage.

8. Clarification for our wellness program: If our programs are participatory, but we do get an aggregate report for the population's aggregate outcomes for Blood pressure, and biometrics that include glucose, cholesterol, etc. with no identifying factors on an individual level—does this still indicate a participatory program since we do not use this aggregate information to determine medical insurance premiums, but only use this to design our wellness programs offered to better address identified health risks for our employee population? We do not ever see individual information for health status?

Yes, that is still a participatory program because no reward is tied to a health factor. This also assumes that your wellness program is tied to a group health plan. If it is not, then the ACA rules would not apply.

9. When you are talking about total maximum reward, I am assuming this is based on 30% of insurance premiums? So, if we did incentives outside of insurance, like gift cards, is this considered 30% of insurance maximum payment?

The 30% maximum incentive is measured against the cost of coverage, but it applies to any financial and in-kind incentives that may be offered under the wellness program.

10. How exactly do you calculate the 30% maximum? Is it for the entire premium or the percentage of premium that the employee pays out themselves or what portion the employer pay?

It is based on the total cost of coverage, which includes what the employee and employer pays in premium.

11. If the HR 1313 becomes a law, would HIPAA rules not still apply to ease the mind of Associates and would a reasonable follow up of information about the genetic information need to be given? (i.e. we collect genetics information and we give informationals for preventative options.).

HIPAA privacy and security rules apply to wellness programs that either: 1) delivered by a HIPAA covered entity provider acting as a provider when delivering the services; or 2) are tied to a group health plan. Many wellness programs, however, may fall outside HIPAA privacy and security requirements (although I think that is the case less often than many experts think). If HR 1313 becomes law, unless the program is a group health plan wellness program that is health contingent under the ACA rules, the reasonable follow up requirement would no longer exist.

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12. What will happen if the ACA is repealed and replaced with the American Health Care Act?

At this point, the full ramifications are hard to predict. However, the Congressional Budget Office came out with an analysis of the AHCA that sheds some light on what might happen. See **https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf**.

13. If a wellness program includes a premium discount and incentives, do you have to combine the discounted price and the incentive to determine the 30%.

Yes.

14. If you figure out your wellness program is noncompliant to ACA or EEOc regs, how long do you have to become compliant? I am framing this as now. For example, not passing one of the five factors.

Ideally before someone (such as a disgruntled employee) finds out and complains that you are not compliant.

15. If we do a biggest loser type program, can we offer an incentive to the team that loses the most weight? Would we have to offer a "reasonable alternative?" Would this change under HR 1313?

Yes, I recommend offering an RAS to the losing team per the ACA rules. 45 CFR § 146.121(f)(4)(iv).

16. If under GINA an employer is restricted from collecting any health information from dependents, what happens if an employee and dependent work for the same company that ties Health Risk Assessments to premium reductions? Is this a violation of GINA since they both happen to work for the same business and both opt to participate in the HRA to receive the reward?

I think the least risky approach is if the employer knows that family members work for the same company, the employer should not incentivize those "family member" employees to take the HRA. If they want to take the HRA, they can do that, but I would give them an alternative way to earn the reward (such as attending a class) so that they do not feel at all compelled to disclose their health information in the HRA. See 81 FR at 31147 (May 17, 2016) (stating that employers are not prohibited from offering health or genetic services (including participation in an employer-sponsored wellness program) to an employee's children on a voluntary basis and that they may do so but may not offer any inducement in exchange for information about the manifestation of any disease or disorder in the child).

17. Are Health Risk Assessments/Lifestyle Questionnaires permitted to ask questions about alcohol-use? I attended a seminar that stated alcoholism is a medical condition and therefore is not something that can be asked. Can you weigh-in on that?

Yes, I believe HRAs can ask about alcohol use. Questions about alcohol or substance use are medical exams under the ADA and generally, an employer may not conduct medical exams of employees unless it is job-related and consistent with business necessity. The ADA also provides an exception for conducting medical exams, such as HRAs, through a voluntary wellness program. As long as the employer followed the EEOC rules under the ADA about voluntary wellness programs, such as limiting incentives to 30% of the total cost of self-only coverage, providing notice and not using the information to discriminate against employees, the questions should be permissible.

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18. Under the proposed HR 1313, 30% would be universally applied to all types of programs?

Yes.

19. Where is the best place to find information regarding these rules/laws that is easy for us to understand?

Be on the lookout for my book, to be published by the American Bar Association (hopefully) in April this year, entitled Rule the Rules of Workplace Wellness Programs.

20. What's the rationale behind the government limiting any incentive?

I am not certain where the 30% maximum incentive came from, but subsequent laws seem to try to align with the 30% maximum to maintain consistency.

21. Can you define "Similarly Situated Individuals?"

It means a bona fide employment classification, such as part-time vs. full-time, salary vs. hourly, individuals in the same geographic location, group health plan enrollees vs. nonenrollees, etc.

22. When both spouse and employee are eligible for an incentive but only the spouse qualifies. Is it acceptable under ACA to deny spouse the incentive they earned because the employee did not earn their incentive?

Under the ACA I don't see an issue. The issue with tying an employee's reward to a spouse's completion of a wellness activity or meeting a goal arises under the ADA.

23. If a certain segment of the employee population does not have to pay a premium, do they have to be offered a similar incentive as those who pay a premium and can earn an incentive? For example, they are offered a gift card (instead of the premium discount) for completing the requirements to earn the incentive?

The ACA permits discrimination based on a bona fide employee classification, such as group health plan enrollees and nonenrollees.

24. This was brought up last week at a meeting. If an employee is on COBRA, we read that the law states they must still be offered the employee wellness program within the group health plan, is this accurate?

Yes, I would agree. The COBRA beneficiary could be charged a different premium (up to 102% of the total premium), but all other terms of the plans should be the same between COBRA and non-COBRA beneficiaires.

25. Do you have any handouts that show what the current ACA says is legal under the ADA, GINA, etc.?

Each law has its own set of requirements. I suggest obtaining my book, Rule the Rules of Workplace Wellness Programs, once it becomes available. I hope it serves to be a useful resource for the workplace wellness community.

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