

Benefit Insights

A Look at HIPAA: Can Health Plans Offer Rewards or Discounts for Employee Participation in Wellness Programs?

A closer look at the Health Insurance Portability and Accountability Act of 1996 (HIPAA) shows that its nondiscrimination provisions do not prevent health plans or insurers from putting wellness incentives in place that encourage participants to take part in health promotion and disease prevention programs. However, HIPAA's provisions do prohibit plans from imposing a penalty for unhealthy activities.

According to HIPAA, wellness programs offered to employees must be reasonably designed to promote good health and disease prevention. For instance, a program that offers reduced premiums to participants who achieve a cholesterol count below 200 is perfectly acceptable.

To qualify for such a program, participants must have the opportunity to be eligible for the program's reward at least once a year. However, a plan that bases a reward on health factors present when the participant first enrolls is not considered an effort to promote health or prevent disease and, therefore, is not permitted under HIPAA provisions.

Furthermore, HIPAA provisions state that employee rewards for participation in such wellness programs must offer a limited reward or discount. The reward may be a premium discount, a rebate of premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, co-pays or coinsurance), or the absence of a surcharge. The reward may not exceed a specified percentage of the cost of employee-only coverage under the health plan (based on the total amount of employer and employee contributions).

The reward must be consistent, and the same must be offered to all employees, according to HIPAA provisions. Therefore, if it is medically unadvisable for a participant to satisfy the program standards, the program must provide a reasonable alternative. In an effort to include all employees and to allow for reasonable personal variances, these alternatives can be established on an individual basis and can be established after the program begins.

This HIPAA provision is best demonstrated with programs

that offer incentives to nonsmokers. Because nicotine addiction is a medical condition, it may be unreasonable to expect a smoker to satisfy an initial program standard of not smoking. When this happens, an alternative must be offered. HIPAA also requires that all materials distributed describing the wellness programs and applicable incentives must also outline reasonable alternatives for the program.

For employers and Human Resource managers, HIPAA clearly outlines its provisions for employee wellness programs and rewards for participation. It is the responsibility of the employer to take it from there, and to ensure wellness programs meet HIPAA's outlined criteria, and that they do not discriminate against employees for any reason.



Welcome to Our Newsletter!

We can illustrate how your benefits, costs, deductibles, copays, and other benefits components compare with those of peer group employers. Please contact our benefits department to obtain a benefits benchmarking report for your zip/sic.

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Wellness by the Numbers: New Studies on the Cost Savings Associated with Prevention

Employers often do not pay a great deal of attention to wellness benefits when renegotiating health plan contracts or searching for a new plan provider. Most discussions are centered on premiums, exclusions or prescription benefit co-pay design, usually in search of cost savings or ways to minimize cost increases. Now that new results are available on the effectiveness of wellness benefits, it is time to look more closely at the value prevention can bring to your health plan offerings.

Prevention Lowers Health Care Costs

A review of news releases in 2000 through 2003 provides many eye-opening examples about the benefits of prevention.

- In 2002, annual medical claims for exercisers were \$200-\$724 less per employee than non-exercisers at Principal Financial Group in Iowa.^[1]
- GlaxoSmithKline reported significant savings for its corporate health-promotion program called the “Contract for Health and Wellness.” Participating employees signed a written agreement to improve health behaviors in five areas: tobacco use, nutrition, activity, stress management/depression, and preventive health practices. The study compared the company’s health care costs for 1996, the year before the program was implemented, through 2000. The analysis included information on more than 6,000 continuously employed workers. Health costs dropped by more than \$500,000 in the first year of the program, with total savings of about \$5.5 million over five years. Much of the savings came from reductions in dis-



ability benefits.^[2]

- Steel Case has also issued data on its prevention programs that included smoking, exercise, and overweight management of the company’s high-risk personnel (20% of all employees). As a result of prevention efforts, average medical claims were cut in half, lowering medical insurance costs by an average of \$618 per person per year. Cost savings continue as these employees have now moved to the low risk category.^[3]

The results are compelling enough to suggest that employers must move prevention benefits onto the table when exploring health care cost reduction.

Prevention Benefits

Look for the following types of prevention benefits in your health plan offerings.

- Smoking cessation programs
- Nicotine replacement programs
- Smoking cessation products
- Nutrition screening and counseling
- Physical activity screening and counseling
- Gym membership
- Yoga, massage and other alternative or complementary medicine options

If these benefits are not currently included, explore costs and request studies on their effectiveness. Once appropriate benefits have been added to the plan, advertise those value-added services to members. Member participation is the only way to turn potential cost savings into actual cost savings.

Finally, request that your insurer develop tracking mechanisms to measure the success of the prevention programming. If the experiences of companies like Steel Case and GlaxoSmithKline are at all predictive, the results should be very satisfying.

[1] Wellness Council of Central Iowa

[2] “Quantifiable Impact of the Contract for Health and Wellness: Health Behaviors, Health Care Costs, Disability, and Workers’ Compensation” by Gregg M. Stave, MD, JD, MPH; Lamont Muchmore, MBA; and Harold Gardner, MD *Journal of Occupational and Environmental Medicine* February 2003, Vol. 45, No. 2, pg. 109

[3] Basic Prevention-Related Benefits, NC Prevention Partners, <http://www.ncpreventionpartners.org/basic/eguide.htm>



Health Plan Cost Analysis Using Benchmarked Data

If your company is considered a large group or your health plan is self-funded, chances are you receive reports on a regular basis concerning how your plan's members utilize the health plan's services. Here are some pointers for interpreting and using the information as well as national comparison data.

Cost Per Member

With health insurance plans, your company is paying either 1) a premium based on individual or family contracts or 2) the actual costs of the care provided plus administrative fees. It is useful to look at the costs of each plan you offer in a consistent way as well as in comparison to benchmarks.

First, calculate the cost per member per month (PMPM). For example, in FY 2003, your company's total healthcare costs were \$3,000,000. There were 500 employees covered and a total of

1,400 members. To calculate PMPM:

1,400 members x 12 months = 16,800 member-months

\$3,000,000 divided by 16,800 = \$179 PMPM



Perform this calculation on each plan offered. Now you have a way to compare the relative cost of each plan. It's also useful to do this calculation based on employer + employee contribution to get a sense of overall healthcare costs.

Compare the PMPM results. Do they make sense? For example, is the highest cost plan the one with the most generous benefits? Or with the largest proportion of older members? If the results are not as expected, why not? What is driving costs higher or creating unexpected cost savings?

The second level of analysis, understanding unusual differences, is possible if your insurer provides you enough detailed information.

PMPM by Age or Gender

If your insurer provides many breakdowns of the data, you may be able to obtain the cost of care by age group or by gender. The analysis is essentially the same except that you calculate member-months only for the group in question, e.g., females, and use only the costs allocated to that group. Typical age groupings are:

- < 21
- 22-44 (male and female)
- 45-64
- 65 +

In an analysis by age, you should expect that the age groups that consume the most healthcare are children in the first one to two years of life and people over age 65. (The "< 18" data grouping masks early childhood costs.) Are there surprises? Can they be explained by known outliers, e.g., a 36 year old with a liver transplant, an older population with few children or a young population with high rates of depression, alcoholism, and pregnancy? If the deviations are explainable, can they be fixed, e.g., better availability of mental health for depression and alcoholism? If the variations are not explainable, request a detailed analysis from your insurer so that you can establish a plan of remedy.

Benchmarks

Finally, it is useful to compare your data to regional, national or industry data to get a sense of "average" in these categories. eHealth Insurance's analysis of 30,000 claims from its 2002 database, produced the following benchmarks.

Health Insurance Premiums for Single Policies by Age Bracket

Age	<18	18-24	25-34	35-44	45-64	65+	Total
Average monthly premium per single	\$ 104	\$ 123	\$ 134	\$ 163	\$ 241	NA	\$ 156
Average annual premium per single	\$1,258	\$1,480	\$1,609	\$1,962	\$2,890	NA	\$1,871
% of U.S. population by age	26%	10%	14%	15%	23%	12%	100%

These simple calculations can provide an excellent starting point for understanding your health plan costs and developing cost reduction strategies that are employee-supportive.

Employee Cost Sharing on the Rise

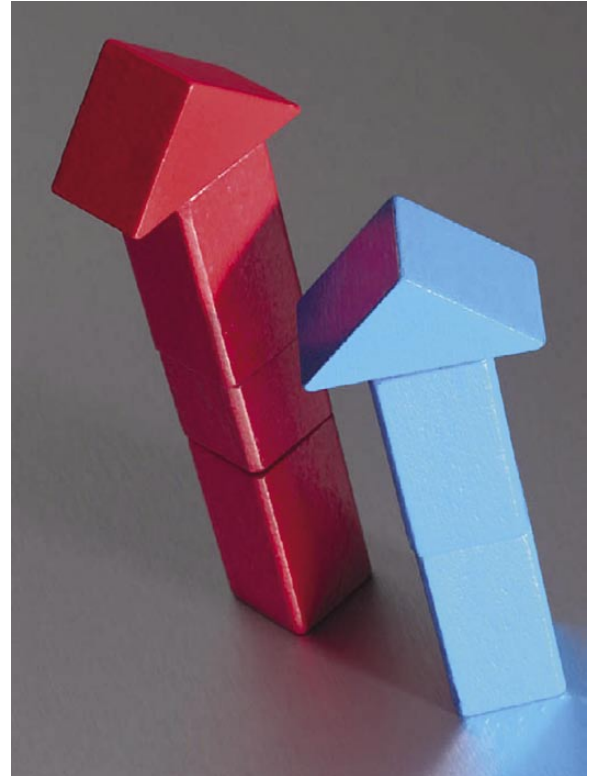
According to a study from Hewitt Associates, employers experienced a sixth straight year of double-digit health care premium increases in 2003, with average increases of 14 to 16 percent. For 2004, Hewitt is predicting slightly lower increases of 12 to 13 percent, which is perhaps an early indication that rates may be starting to level off.

On average, Hewitt forecasts that companies will receive 2004 cost increases of 13.5 percent for health maintenance organizations (HMOs), 12.5 percent for traditional indemnity plans, and 12.0 percent for preferred provider organizations (PPOs) and point-of-service (POS) plans.

As insurance costs continue to rise, employers are faced with having to pass these increases on to their employees. This trend has been evolving over the past several years. While new ways to distribute the increase in health care spending continue to be explored, Hewitt predicts that most employers will pass along at least 25 to 30 percent of this year's increase to their employees.

As in past years, pharmacy and hospital costs have caused the greatest spending increase, making them the main target of cost shifting. Although some companies are continuing to absorb most increases in health insurance costs, many also are raising co-payments and deductibles to keep increases to a minimum.

Cost sharing also occurs in the form of increased employee payroll deductions. Many employers find it more effective for employees to pay the increases out of their own pockets, encouraging them to become more cost-efficient decision-makers in their health care spending. Employees must become educated about the responsibilities and consequences of their choices, and what's right for them both medically and financially.



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