

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 in place wellness incentives 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 inadvisable for a participant to satisfy the program standards, the program must provide a reasonable alternative. These alternatives can be established

on an individual basis and can be established after the program begins, in an effort to include all employees and to allow for reasonable personal variances.

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 that describe 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 do not discriminate employees for any reason.



What's a 'reasonable' ADA accommodation? See new guide...

Federal law says companies with 15 or more workers have to provide "reasonable accommodations" to disabled workers, unless it would cause the company "undue hardship." Newly updated guidelines from the Equal Employment Opportunity Commission help explain those definitions and offer tips on how to comply.

The guide incorporates key Supreme Court decisions from 2002. Go to www.eeoc.gov/docs/accommodation.html. For an Americans with Disabilities Act primer, go to www.eeoc.gov/ada/adahandbook.html.

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COBRA Continuation Rules Apply To Health Reimbursement Arrangements

For years, employers have countered rising health care costs with increased employee cost sharing and a variety of managed care techniques. More recently, “consumer-directed” health care plan designs have been introduced as a way to address rising costs. Though consumer-directed plans come in many designs, a key element typically is a health reimbursement arrangement (HRA).



An HRA is an account set up by an employer to reimburse an employee for medical expenses incurred by the employee and his or her dependents. The employer determines the annual amount of the HRA and whether to make this amount available immediately, or on a graduated basis throughout the year. An HRA can be offered on a standalone basis or in conjunction with a medical plan. Because consumer-directed designs frequently include a catastrophic insurance product as an option, deductibles, copayments, and coinsurance amounts can be substantial, and these can be paid from the HRA.

Unlike a flexible spending account (FSA)-which is offered through a cafeteria plan and funded with employee pre-tax contributions-an HRA is funded entirely by the employer. Also unlike an FSA, HRA amounts unspent by the employee can carry over into subsequent coverage periods. HRA sponsors hope that the carryover feature will encourage employees to give the same careful consideration to health care expenditures as they would to other purchases for which they are using their “own” money. In other words, if the employee does not deplete the HRA funds in one plan year, leftover funds can accumulate and be available to the employee in subsequent years when the employee or dependents may have more significant health care expenses. (Note that HRA funds can be used only for health care expenses, and that unused amounts cannot be taken in cash.)

In 2002, the IRS formally approved HRAs and issued some guidance for their operation. In this guidance, the IRS specified that an HRA is considered a group health plan and is subject to COBRA continuation of coverage requirements.

Premiums for continuation coverage are determined in accordance with existing COBRA rules. In the case of an HRA, the annual COBRA premium would be the “cost” of the plan (or the amount of the annual employer contribution), plus the allowable 2% administrative cost. If an HRA has been “zeroed out” (i.e., prior to the COBRA qualifying event, an employee already had used up the HRA for medical expenses), that individual would have little reason to elect COBRA, since the amount of coverage being bought by continued participation would not exceed the required premium payments. (Note that the uniform coverage rule of health care FSAs does not apply to HRAs.) A qualified COBRA beneficiary would, however, have reason to elect continuation coverage in order to access unclaimed funds that have accumulated in the account.

IRS guidance states that the premium is the same for any similarly situated COBRA beneficiary, regardless of the amount that the individual has remaining in the plan at the time of the COBRA qualifying event. For example, if the annual amount that an employer credits to the HRA is \$1,200, and Employee A (who is single) has \$500 remaining in his account at the time of his COBRA qualifying event and Employee B (who also is single) has \$1,000 remaining at the time of her qualifying event, the COBRA premium would be the same for both individuals. Premiums can be different for those with single and family coverage.

IRS guidance also specifies that plan rules may allow for continued reimbursements after a COBRA qualifying event, regardless of whether continuation coverage is elected. For example, a plan may allow former employees who have terminated or retired to use up amounts remaining in the HRA until these amounts have been exhausted.

Because HRAs are a new form of health plan, unanswered questions about the specifics of plan operation will persist for some time. For example, the IRS guidance on HRAs did not answer how multiple COBRA beneficiaries share the HRA amount. However, as with any promising new benefit design, employers, benefits practitioners, and governing agencies will work out these questions over time.



Design And Communication Strategies Make Health Care FSAs Cost-Effective For Employers

While health care flexible spending accounts (FSAs) offer tax-saving benefits to employees, they also can provide tremendous advantages to employers that sponsor them. Salary-reduction contributions that employees make to an FSA are not subject to Social Security and Medicare (FICA) taxes. Thus, employers save their 7.65% FICA contribution on the dollars that employees contribute to an FSA. If FSA participation is high, FICA savings can be substantial. Even small amounts of savings are “true” savings, since a health care FSA can be a no-cost benefit for the employer to offer: Typically, an employer makes no contribution to the plan and can pass on any associated administrative costs to employees.

Health care FSAs offer employers strategic advantages, too. With seemingly ever-rising health care costs, implementation of a new health care FSA-or enhanced communication of an existing plan-can be used in tandem with health plan changes that require increased employee cost-sharing. Such communications can help employees see how FSAs can lessen the financial burden of higher premiums, co-payments, or deductibles. Offering a health care FSA also gives an employer a hiring advantage over competitors without one, a fact that will become more important as the economy improves and unemployment rates decrease.

So, from an employer’s perspective, is there any downside in offering a health care FSA? The one financial risk employers face from FSAs is the impact of an IRS regulation known as the “uniform coverage” or “insurance risk” rule. The rule requires that the entire annual election amount (reduced by any reimbursements already made) be available to a health care FSA participant at all times during the plan year. For example, if an FSA participant elects to contribute \$600 to the plan, and contributions are made through monthly payroll deduction, in February the participant would have contributed \$100. The participant submits a substantiated claim for \$500. The claim is paid, and the participant quits. The plan is out \$400.



IRS regulations do not permit plans to operate in a way that eliminates or substantially reduces this risk, but there are ways to moderate it, making the plan more effective for employers. First, however, consider how real the risk is for your workplace. Because employees make FSA contributions through payroll deduction, only terminating employees potentially present this type of risk to a plan. How high is your employee turnover? Unless turnover is an issue for an employer, the insurance risk rule is unlikely to present a significant problem.

Also remember that employees face their own risk as FSA participants, that of forfeitures. Amounts employees have elected to contribute to the plan cannot carry over to a subsequent plan year. Even small amounts unclaimed by participants can add up to offset any losses the plan suffers from terminating participants who have been “over-reimbursed.” This (in addition to the FICA savings discussed above) is another reason why it is in the employer’s interest to keep plan participation as high as possible. Briefly, techniques that can enhance participation include maintaining frequent and effective communications that show employees the value of participation; offering easy tools for employees to enroll or obtain information about the plan; and facilitating employees’ claim filing (this could include use of stored-value debit-type cards for employees to use in making their FSA-related purchases or payments).



Beyond these, simple ways to lessen the chances that a plan will suffer a large hit from a terminating employee include setting a maximum amount that an employee can contribute to the health care FSA; limiting reimbursable expenses to exclude some types of big-dollar, elective expenses over which an employee can readily control the timing (such as multiple pairs of prescription eyewear); and requiring a longer period of service for eligibility, since the highest turnover typically occurs among newest employees (note that while the law sets a maximum three-year period of service for eligibility, most plans require far less).

More extreme techniques to control the risk of loss include accelerating the frequency of contributions or requiring full-year participation (and withholding the balance of contributions due for the remainder of the plan year from all terminating participants). Such techniques should be considered more aggressive and fully explored before implementing; they are not necessary for most employers and are considered by some to stretch the legal limits of FSA operation.

Remember that design constraints on the plan may run counter to encouraging employee participation and, for the vast majority of employers, a plan with healthy participation will work effectively, both for the plan sponsor and participants.

As The Work Force Ages, Voluntary Vision And Hearing Benefits Become Important Offering

If you felt a little older this morning as you made your commute to work, you're not alone. According to the Department of Labor's Bureau of Labor Statistics, the median age of today's work force is approaching 40 (39.3 years, up from 36.6 years in 1990). By 2010, 51.4% of U.S. workers will be older than 40, the BLS says, with those age 55 and older making up 17% of the work force. These increases reflect the aging of the 78 million baby boomers, those born between 1946 and 1964. The youngest baby boomers will turn 40 in 2004.

We all feel some of the impact of aging when our muscles ache or joints creak. Aging can have a subtler affect on the senses. The sometimes gradual degeneration of vision or hearing can profoundly impact an individual, both personally and in the workplace.

Normal changes in the aging eye include reduced acuity, decreased capacity to focus at short range, a need for more light, difficulty in adjusting to changes from dark to light, and reduced contrast sensitivity and depth perception. In the workplace, such problems, if uncorrected, can result in errors, "rework," and even accidents, all of which can come at a high cost to the employer.

According to the American Society on Aging, 15% of the overall population suffers from some type of hearing loss, with 60% of this group over the age of 55. Hearing loss can be even more insidious than vision degeneration, because it may go unnoticed or be ignored for a longer period of time. Employees with untreated hearing loss are more likely to misunderstand or entirely miss some of what is being said in group or one-on-one discussions. Oral instructions might be misunderstood and not followed, resulting in errors or accidents. Overall workplace communication can suffer.

Eye health is best protected by regular visits to an optometrist or ophthalmologist; an individual's regular physician is a good first source to screen for hearing problems, with referral to a specialist if appropriate. Most vision and hearing problems are readily correctable through appropriate eyewear or hearing aids. However, many employees may postpone seeking treatment for vision or hearing loss for financial reasons, and such delays can result in the kinds of workplace risks and costs discussed above.

Fortunately, employers can help workers affordably maintain the health of these important senses by offering vision and hearing coverages as voluntary benefits. Voluntary benefits are paid for in full by the employees who choose to buy them. However, employees save money because the benefits are usually offered with a group discount. They also enjoy the timesaving convenience of learning about the benefits and purchasing them through the workplace. (An employer also could choose to make a contribution to the coverage.)

There are a variety of voluntary vision care plans that can be made available to employees. Typically, vision care plans cover eye examinations and corrective lenses (eyeglasses or contacts). Plan enhancements could include coverage for laser or lasik surgery; safety eyewear for individuals in certain industries; and polycarbonate lenses for children and active adults.

How a vision benefit is provided will vary with the plan. Some plans offer discounted or reduced fee services and lenses through a list of exclusive providers or retail outlets; others use a preferred-provider approach and pay a larger or smaller benefit depending on the provider used; other pay according to a fee schedule.

Benefits under hearing care plans might include discounts on audiologists' fees, and coverage for hearing aids and related products and services (e.g., batteries and cleaning).

Voluntary vision and hearing benefits are a win-win offering: Both employers and employees are likely to benefit from improved vision and hearing health in the workplace.

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