**Wellness Programs and the Affordable Care Act**

Implementing and expanding employer wellness programs is a critical part of the American Health Care and is intended to not only improve the health of Americans, but also help control health care spending. Starting on January 1, 2014, the Affordable Care Act creates new incentives designed to promote employer wellness programs with the idea of creating and supporting a healthier workplace.

**What are the ten essential health benefits (EHBs) required by the 2010 federal health reform?**

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| The 2010 Patient Protection and Affordable Care Act requires the Secretary of HHS to define the EHBs through regulation. It also requires that at least some items and services within specific categories of benefits be included in the definition. The term “essential health benefits” means the benefits that non-grandfathered plans sold in the small group market on or outside of a state exchange must have, beginning in 2014. Grandfathered plans, self-insured group health plans, and health insurance coverage offered in the large group market are not required to offer essential health benefits. Minimum essential coverage is a separate concept and the phrase used to describe the coverage required to fulfill the individual and employer mandates. “Wellness services” is a component of one of the EHB categories.  The ten EHB categories are:  ·Ambulatory patient services;  ·Emergency services;  ·Hospitalization;  ·Maternity and newborn care;  ·Mental health and substance use disorder services, including behavioral health treatment  ·Prescription drugs;  ·Rehabilitative and habilitative services and devices;  ·Laboratory services;  ·Preventive and wellness services and chronic disease management; and  ·Pediatric services, including oral and vision care. |

**What are wellness programs?**

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| Some wellness programs are stand-alone programs and others are offered as part of or in conjunction with a group health plan. Wellness programs encourage good health and healthy lifestyles. Additionally, some may provide physical examinations, cholesterol screening, flu shots, nutrition counseling and education, and similar benefits. To the extent that a wellness program provides such medical benefits, it will likely be treated as a group health plan subject to the PHSA mandates in ERISA and the Internal Revenue Code for private employers or in the PHSA for state and local government employers.  The 2014 prohibition against discriminating based on a health status-related factor means, among other things, that plans and insurers may not charge individuals different premiums or impose different costs based on the presence or absence of a health status-related factor.  However, nondiscrimination provisions were not meant to prevent a group health plan or insurer from establishing premium discounts or reduced copayments or deductibles in return for “adherence to programs of health promotion and disease prevention.” Thus, certain programs of health promotion or disease prevention (referred to as “wellness programs”) are an exception to the general prohibition on discrimination based on a health status-related factor. |

**How are wellness programs that relate to group health plans regulated?**

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| A wellness program that relates to, or is a part of, a larger group health plan is subject to the Public Health Services Act (PHSA) coverage mandates, if the group health plan to which it is connected is subject to the mandates and is not an excepted benefit, such as a stand-alone vision or dental plan.  A wellness program is related to a group health plan if it is actually one of the benefits under the larger group health plan or if any of the incentives or rewards that it offers affect the benefits or contributions under the larger group plan. For example, an employer-sponsored wellness program that offers, as an incentive for undergoing certain testing, a discount on the amount that an employee must pay for major medical coverage is subject to the PHSA mandates.  The permissible reward under a health-contingent wellness program goes from 20 percent to 30 percent of the cost of individual coverage under the group health plan, and up to 50 percent for programs designed to prevent or reduce tobacco use. The codified rules are effective for plan years beginning on or after January 1, 2014.[[1]](http://pro.nuco.com/2014healthcarereformfacts/part-7/well-pro-rul/Pages/0229-00-ef1.aspx?k=wellness#_ftn1) The regulations apply the same standards to both grandfathered and nongrandfathered plans, except for grandfathered plans in the individual market.  Additional rules apply to certain wellness programs under HIPAA’s health status nondiscrimination rules. Employers offering wellness programs must also comply with the Americans with Disabilities Act (ADA). Wellness programs or discounts may violate the ADA if the discounts or other rewards are not available to individuals with disabilities. A wellness program could also violate the ADA provisions limiting an employer’s ability to make disability related inquiries and to require medical examinations during employment. |
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**How are stand-alone wellness programs treated?**

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| Stand-alone wellness programs are not subject to the PHSA mandates if they are not group health plans. A wellness plan is not a group health plan if it does not provide or pay for health or medical benefits. Examples of types of stand-alone wellness programs that are not group health plans include programs that pay for health or weight-loss club dues, award prizes to persons who walk a certain number of miles, or provide health information. Even when a wellness plan offers incentives, this does not make it a group health plan if the incentives are unrelated to the group health plan, such as a plan offering extra vacation days or bonuses to those who do not smoke or have a good cholesterol level, for example.  On the other hand, stand-alone wellness programs that provide or pay for medical benefits (such as a physical exam program) are group health plans and are subject to the PHSA mandates unless they qualify for an exception. |

**How is the cost for EAP’s, wellness programs and on-site medical clinics reported?**

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| The cost of EAPs (employee assistance programs), wellness programs, and on-site medical clinics is includible in the reported cost of coverage to the extent that the program is a group health plan. However, such coverage is not reportable if the employer does not charge a premium for that coverage for purposes of COBRA (or other federally required continuation coverage) or if the employer is not subject to COBRA |

**How do the percentage point plan-sponsor contribution rules relate to wellness programs?**

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| The agencies are studying this but caution that while premium discounts or additional benefits to reward healthy behaviors by participants or beneficiaries are acceptable, the use of penalties (such as cost-sharing surcharges) may trigger a violation of the not more than 5 percent reduction test and should be examined carefully. |

**What reporting is required by group health plans and insurers that is designed to improve the quality of care?**

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| Group health plans and health insurance companies must submit an annual report to HHS addressing plan or coverage benefits and provider reimbursement structures that may affect the quality of care in certain specified ways. The reporting requirements are to be developed in consultation with health care quality experts and representatives of care providers, care recipients, insurers, and employers. This requirement will be enforced by “appropriate penalties” developed by HHS. Grandfathered plans are not subject to these rules. |

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| The quality of care report will address whether plan or coverage benefits as well as provider reimbursement structures satisfy several criteria related to the cost and quality of health care.  These will include whether the plan or coverage:  ·improves health outcomes for treatment or services under the plan or coverage through such activities as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives (including the medical homes model);  ·implements activities to prevent hospital re-admissions using a comprehensive discharge program and post-discharge reinforcement;  ·improves patient safety and reduces medical errors through best clinical practices, evidence-based medicine, and health information technology; and  ·implements wellness and health promotion activities. |
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