Paul R. LePage
GOVERNOR

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

Eric A. Cioppa
SUPERINTENDENT

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Implementation of Wellness Programs in the Individual and Group Health Insurance Markets

Carriers and employers have been asking the Bureau about regulatory requirements and potential impediments to offering wellness programs – programs that provide incentives to promote health or prevent disease – in connection with group and individual health insurance products. The purpose of this Bulletin is to explain the standards applicable to wellness programs under state and federal law.

1. Federal Regulations Authorizing Employee Wellness Programs

In the small group and large group health insurance markets, federal law prohibits discrimination based on health factors while providing for the implementation of wellness programs through detailed "safe harbor" regulations at 45 CFR 146.121 adopted under the Health Insurance Portability and Accountability Act (HIPAA).[1]

The threshold question under 45 CFR 146.121 is whether the wellness program requires enrollees to satisfy a standard related to a health factor in order to obtain a reward. If not, the program does not violate HIPAA's nondiscrimination rules. Examples of programs that are permissible under this criterion include but are not limited to:

- A program that reimburses all or part of the cost for membership in a fitness center;
- A diagnostic testing program that provides a reward for participation rather than outcomes;
- A program that encourages preventive care by waiving the copayment or deductible for the costs of, for example, prenatal care or well-baby visits;
- A program that reimburses enrollees for the costs of smoking cessation programs without regard to whether the enrollee quits smoking; or
- A program that provides a reward to employees for attending a monthly health education seminar.

[1] The underlying statutory provision governing wellness programs, as amended and renumbered by the Affordable Care Act, is found at Subsection 2705(j) of the federal Public Health Service Act.

Further inquiry is required for wellness programs that base a reward on an individual satisfying a condition related to a health factor. Those programs do not violate HIPAA's discrimination rules if they meet all five of the following requirements:

- The total reward for all the plan's wellness programs that require satisfaction of a standard related to a health factor does not exceed 20% or the cost of the coverage (increasing to 30% in 2014, and up to 50% if permitted by HHS);
- The program must be reasonably designed to promote health and prevent disease;
- The program must give individuals eligible to participate the opportunity to qualify for the reward at least once per year;
- The reward must be available to all similarly situated individuals. The program must allow a reasonable alternative standard (or waiver of initial standard) for obtaining the reward to any individual for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the initial standard; and
- The plan must disclose the availability of a reasonable alternative standard (or the possibility of a waiver of the initial standard) in all materials describing the terms of the program.

2. State Laws Regulating the Health Insurance Market

Maine's guaranteed issue, community rating, and continuity requirements likewise prohibit discrimination based on health factors.[2] In the group market, the most significant difference between Maine law and HIPAA is Maine's community rating requirement for small group coverage, which prohibits premium discrimination in rating based on health status.[3] However, 24-A M.R.S.A. § 2808-B(2)(C) expressly permits variations in premium based on participation in wellness programs, to the extent permitted by federal law. The Bureau interprets this provision, which is the only express reference to wellness programs in Maine's health insurance laws, as reflecting a legislative intent that wellness programs satisfying the federal nondiscrimination standards are appropriate in the group insurance market. In Maine, the nondiscrimination standards applicable to group and individual policies are very similar and their treatment with respect to wellness programs should logically also be similar. Therefore, in reviewing and approving wellness programs in the small group, large group, and individual health insurance markets the Bureau will refer to and apply the federal "safe harbor" standards for wellness programs at 45 CFR 146.121 in assessing whether the wellness program complies with Maine guaranteed issue, community rating, and continuity requirements that prohibit discrimination based on health factors. In the individual market, 24-A M.R.S.A. § 2736-C(2) does not permit the use of participation in wellness programs as a rating factor, but other types of

[2] See generally 24-A M.R.S.A. §§ 2736-C (individual market standards), 2808-B (small group market standards), and 2848 through 2850-D (continuity of coverage).

[3] Similar requirements have been enacted at the federal level, but will not take effect until 2014.

financial incentives are not prohibited as long as they are otherwise in compliance with the federal safe harbor standards.

3. Unfair Discrimination Statutes

Carriers requested guidance as to whether the antidiscrimination provisions of the Maine Unfair Insurance Trade Practices Act could limit the types of incentives permitted for wellness programs in the individual market. The following provisions have been identified as potentially relevant:

- 24-A M.R.S.A. § 2159(2) provides in part: "No person may make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever." Wellness programs are based in substantial part on the premise that people who participate are not of essentially the same hazard as similarly situated nonparticipants. Therefore, such programs do not violate this provision when conducted in compliance with the nondiscrimination guidelines discussed earlier.

- 24-A M.R.S.A. § 2159-C(2) provides in part: "A carrier may not discriminate against an individual or eligible dependent on the basis of genetic information or the refusal to submit to a genetic test or make available the results of a genetic test or on the basis that the individual or eligible dependent received a genetic test or genetic counseling in the issuance, withholding, extension or renewal of any hospital confinement or other health insurance, as defined by the superintendent, by rule, or in the fixing of the rates, terms or conditions for insurance, or in the issuance or acceptance of any application for insurance." This statute does not appear to apply unless the program design distinguishes between different classes of individuals on the basis of either (a) genetic tests, or (b) family (as opposed to personal) history of inherited conditions. However, this statute is based on federal law and carriers are advised to review applicable federal guidance as well.

- 24-A M.R.S.A. § 2159-A provides in part: "No insurer authorized to transact business in this State may refuse to insure or continue to insure, limit the amount, extent or kind of coverage available to an individual or charge an individual a rate different from that normally charged for the same coverage solely because the insured or the applicant for insurance has a physical or mental handicap, as defined in Title 5, section 4553, subsection 7-A, other than blindness or partial blindness, unless the basis for that action is clearly demonstrated through sound actuarial evidence." The Bureau would anticipate that programs complying with federal wellness standards would likely comply with this statute as well. However, any complaint or other indication that a particular program discriminated on the basis of disability in an actuarially unsound manner would be reviewed on a case-by-case basis, and the Bureau would order that any noncomplying program be restructured in order to achieve compliance. Carriers are also advised to consider the Americans with Disabilities Act (ADA) and the Maine Human Rights Act when developing wellness

programs, and to contact the Maine Human Rights Commission regarding its requirements.

4. Rebating Statutes

Carriers have requested clarification as to whether wellness incentives outside the ordinary benefit and cost sharing provisions of the policy would violate Maine's rebating laws, 24-A M.R.S.A. §§ 2160 and 2163. Carriers are advised that rebating laws do not apply as long as the consideration, inducement, or other incentives are plainly described in the plan documents. As noted above, the federal wellness program regulations also require health insurers to disclose the terms of the wellness program and the availability of any alternatives. Also, Subsection 2160(2) provides that a provision may not be included within an insurance policy if its sole intent is to give the insured a benefit that is not associated with indemnification or loss. This provision does not prohibit wellness programs because they relate to indemnification or loss by seeking to reduce the incidence of benefit claims.

5. Privacy Issues

Wellness programs offered by employers or carriers, and insurance plans offered by carriers, should be conducted in manner that does not result in sharing of confidential information between the employer and the carriers without the enrollee's informed consent. Carriers are directed to implement appropriate safeguards to comply with HIPAA and with the privacy requirements of the Maine Insurance Code and Bureau of Insurance Rule 980.

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Eric A. Cioppa
Superintendent of Insurance

NOTE: This Bulletin is intended solely for informational purposes. It is not intended to set forth legal rights, duties, or privileges, nor is it intended to provide legal advice. Readers should consult applicable statutes and rules and contact the Bureau of Insurance if additional information is needed.