

# Benefit Insights

## Rewards-Based Wellness Programs Require Scrutiny Under DOL Guidance

Wellness programs are increasing in popularity as employers hope that healthier lifestyles and behaviors on the part of employees will translate to higher productivity, reduced absenteeism and lower health care costs. These programs can be as simple as stocking healthy food in company vending machines or as elaborate as constructing onsite fitness facilities. An initiative that some employers are trying is rewarding employees for demonstrating healthy behaviors, such as not using tobacco products, or meeting established health status measures regarding weight, cholesterol/blood pressure/blood sugar levels, etc.

Recent guidance issued by the Department of Labor (DOL) requires employers to take a close look at how such reward programs are structured, to make sure that they don't run afoul of restrictions in the Health Insurance Portability and Accountability Act (HIPAA) concerning rewards or penalties based on health status.

Prior HIPAA guidance established a number of requirements that wellness programs must follow in order not to discriminate based on health status. For example, any reward provided must not exceed 20% of the cost of plan coverage, and the plan must offer people who, for medical reasons cannot meet the established health standards, a reasonable alternative for attaining the reward.

"Excepted benefits" are exempt from HIPAA rules—and thus from these requirements for wellness programs. One category of excepted benefits is "supplemental" health insurance coverage. A design that has emerged for health status rewards-based wellness programs relies on the supplemental coverage exception to avoid having to follow HIPAA's requirements for wellness programs. Basically, in such designs, the wellness reward is part of a separate supplemental policy. The primary group health plan might, for example, have a high copayment



or deductible, while the wellness component, which is part of the supplemental plan, offers employees meeting health status standards credits or dollars to offset the primary plan's high copayment or deductible. Because the supplemental excepted coverage issues the reward, it arguably is not subject to HIPAA requirements for wellness programs, which means that the reward could, for example, exceed 20% of the cost of plan coverage, and that the program need not offer an alternative to those who cannot meet the health standards.

The recent DOL guidance, which was issued in Field Assistance Bulletin 2007-04, was issued "to prevent issuers from avoiding compliance with [HIPAA] by issuing multiple insurance contracts in connection with a plan." The bulletin establishes an enforcement safe harbor under which supplemental health insurance will be considered an excepted benefit. Supplemental coverage that does not meet the safe harbor requirements "may be subject to enforcement action."

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## **Inventory Information Approval System Now Required for FSA Debit Card Use At Non-Health Care Merchants**

Debit card technology has simplified the use of health care flexible spending accounts (FSAs). By accessing the stored value on a debit card when making a health care purchase, an FSA participant avoids having to pay for the expense out-of-pocket and then go through a claims submission process in order to be reimbursed. Debit cards also are used in other types of self-insured medical reimbursement plans, such as health reimbursement arrangements (HRAs).

Internal Revenue Service rules require substantiation of expenses for which a FSA participant seeks reimbursement. For transactions conducted with a debit card, IRS rules and notices define how the basic substantiation requirements can be met without the employee having to submit documentation after the fact. When the health care expense is incurred at a provider or merchant that does not have a health care-related merchant category code—such as a grocery store, discount store or online pharmacy—the IRS now requires that such merchants have in place an inventory information approval system (IIAS) in order for the debit card transaction to be processed.

Most major grocery store chains, discount stores and warehouse clubs now have in-store pharmacies to offer shoppers the convenience of filling prescriptions while doing their regular shopping. Plus, over-the-counter medications and health care supplies—pain relievers, cold remedies, first-aid supplies, contact lens solutions and the like—can be paid for with FSA money. Thus, when filling a prescription or picking up an over-the-counter medication, a shopper at these types of merchants frequently will make purchases that cannot be paid for from the FSA. An IIAS system is intended to ensure that, in such situations, the debit card is used to pay for only those items that qualify as Tax Code Sec. 213 medical expenses.

How does an IIAS work? Basically, such a system collects inventory control information about the items purchased (SKUs) and compares these SKUs against a list of qualified medical expenses. At the time of the transaction, the system approves only the amount of the qualified medical expense for payment with the FSA card, and requires the card user to pay for any remaining portion of the purchase in some other way. If an employee purchases over-the-counter medications at a grocery store, along with a few food items, and uses an FSA debit card, the IIAS validates the over-the-counter medications as qualified medical expenses, eligible to be paid from the FSA. This information is then electronically transmitted to the debit card vendor, and the employee need not submit



any further substantiation on the expense (though it's a good idea for the employee to keep these receipts).

If a non-health care merchant does not participate in the IIAS system, an employee's attempt to use a debit card to pay for a purchase would be rejected by the debit card vendor. The employee would have to pay for the items out-of-pocket and go through the FSA's substantiation/claims submission process to receive reimbursement.

The IIAS requirement became effective beginning in 2008 for merchants such as grocery stores, discount stores, warehouse clubs and convenience stores, and for mail-order and online pharmacies. It will become effective in 2009 for stores that have a "Drug Stores and Pharmacies" merchant code, but which also sell a significant number of items that would not qualify as Sec. 213 medical expenses. Drug stores and pharmacies for which 90% of the gross receipts in the prior taxable year were for items that would qualify as Sec. 213 medical expenses—including over-the-counter products that so qualify—need not have an IIAS system in place in order to process debit card FSA transactions.

Since the IIAS requirement is new, your employees might be encountering situations where their debit card is being rejected for valid health care purchases from a merchant they've successfully used the card at previously. Thus, it could be helpful to let employees know why this is happening, or to check with your plan's debit card vendor to see whether it has any communications prepared on this issue.

## Facts Needed to Overcome Long-Term Care Misconceptions

Long-term care (LTC) insurance is a benefit that seems ripe for the needs of today's workforce. Yet, when employers offer employees the chance to purchase long-term care coverage through the workplace, the participation is usually low. (Typically, LTC insurance is offered as a voluntary benefit, for which an employee pays the entire premium.) A May 2000 study contracted by the U.S. Department of Health and Human Services (HHS) found that, while purchase rates varied considerably among the group of surveyed employers, 40% saw participation rates below 2%. A separate study published in May 2000 by the Employee Benefit Research Institute (EBRI) found employee participation rates for LTC insurance averaged less than 10%.

As with any voluntary benefit, there are advantages to purchasing LTC through the workplace: premiums are typically lower due to the power of group purchasing; underwriting may be less stringent; marketing comes to the employee, who does not have to take the time to seek out information; enrollment will be easy and payment convenient through payroll deduction. Given these advantages, why don't more employees opt to enroll when offered the chance?

A 2006 study from AARP indicates misconceptions among Americans about long-term care needs, costs and services, and this may be one factor contributing to the low number of individuals who decide to purchase LTC insurance coverage. According to this survey, "Americans age 45-plus know less about long-term care than they think they do." Some specifics from the survey indicate a sobering lack of knowledge about issues involving long-term care—

- Only 8% of respondents correctly estimated the monthly cost of a nursing home within 20% of the national average cost, and only 23% made a similarly correct estimate for the monthly cost of an assisted living facility.
- Close to a quarter didn't know the cost of an in-home visit from a skilled nurse or an aide.
- A majority (59%) thought Medicare pays for extended nursing home stays, and 52% thought Medicare covers assisted living costs.
- Almost 30% said that they have purchased LTC insurance, a figure considerably higher than industry estimates about the number of policies that have been sold.



Clearly, more work needs to be done to educate individuals about the issues involving long-term care. Employers that make LTC coverage available agree with this assessment. The HHS study cited above reveals that employers found educating employees about the LTC benefit to be very important, but also very challenging. When asked what they would have improved about their LTC offering, most named education and communication during the initial offering period.

Looking back at the employee misconceptions about LTC,



overcoming them indicates several key communications components:

- The cost of long-term care services. According to a 2007 study from Genworth Financial, the national average for a private room in a nursing home runs almost \$205/day or almost \$75,000/year; a stay in an assisted living facility costs more than \$2,700/month; and hourly rates charged by certified home health agencies average more than \$32.
- The funding sources for long-term care services. As noted above, many people think that, once they hit age 65, Medicare will pay for any long-term care needs that may arise. However, Medicare does not cover extended long-term care stays.
- The chances that long-term care services will be needed in one's lifetime. According to figures from the government, currently, about 9 million people over the age of 65 need assistance with their long-term care needs. By 2020, this figure will likely rise to 12 million. According to one government study, individuals who reach age 65 have a 40% chance of entering a nursing home, and about 10% of people who do enter a nursing home will stay there for five or more years.
- The advantages of purchasing coverage through a voluntary workplace-based offering.

The EBRI study cites surveys showing that communication is the most important determinant of participation in a long-term care program; one survey noted found that 38% of employers making LTC coverage available wished, in retrospect, that they had communicated the plan more effectively. Thus, when contemplating an LTC offering—or when looking at an existing program—do not underestimate the importance communication and education will play in the program's success.

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The safe harbor consists of four requirements:

1. The supplemental coverage must be issued by an entity that does not provide the primary group health coverage (entities in a controlled group of corporations or that are part of the same group of trades or businesses under common control are considered a single entity).
2. The supplemental coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles (but not for coverage that becomes secondary or supplemental as a result of a coordination of benefits provision).
3. The cost of the supplemental coverage cannot exceed 15% of the cost of the primary coverage (calculated in the same way as COBRA premiums are calculated).
4. The supplemental coverage cannot differentiate among individuals in eligibility, benefits or premiums based on the individual's (or any dependent's) health factors.

This last requirement essentially applies HIPAA's nondiscrimination rules.

Employers that currently offer rewards to employees for meeting health status-based standards should take a close look at these programs to make sure that

they comply with the HIPAA requirements for wellness initiatives, or that they fall within the new safe harbor. These programs may need to be modified, such as to offer an alternative to meeting the established health status standards or lowering the amount of the reward to no more than 20% of the cost of plan coverage.

Though the bulletin will directly impact wellness programs based on health status and rewards, it's important to remember that there are myriad other ways to improve wellness in the workplace. Walking clubs, healthy vending machine and cafeteria food, lunchtime nutrition speakers, voluntary health risk assessments, first-dollar coverage for preventive care, and countless other initiatives—both big and small—don't implicate these HIPAA restrictions and can bring about positive results for employee health, and for the company bottom line.



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