Employee Benefits Report

HOFFMAN
INSURANCE GROUP

14905 Southwest Fwy, Ste. 200
Sugar Land, TX 77478-5021 • ph 281-491-6565
fx 281-277-6565 • www.hoffmanig.com

Compliance | November 2014 | Volume 12 • Number 11

What You Need to Know About Wellness Programs

In August, the EEOC filed its first lawsuit against an employer regarding a wellness program. In October, it filed another. Here's what you need to know to avoid a similar situation.

The first lawsuit, *EEOC v. Orion Energy Systems*, alleges that Orion's wellness program violated Title I of the Americans with Disabilities Act (ADA). Orion instituted a wellness program that required medical examinations and made disability-related inquiries. When employee Wendy Schobert declined to participate in the program, Orion shifted responsibility for payment of the entire premium for her employee health benefits from Orion to Schobert. Shortly thereafter, Orion fired Schobert.

The second lawsuit, *EEOC v. Flambeau*, also claims an employer's wellness program violates the ADA. Flambeau's wellness program required employees to submit to biometric testing and a health risk assessment. If they did not, they faced cancellation of medical insurance, unspecified "disciplinary action," and a requirement to pay their full health insurance premium to stay covered, according to the EEOC.

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This Just In…

A majority of retirement plan participants surveyed by American United Life Insurance Co. said they would favor automatic annual increases to their defined contribution retirement plans. Although respondents recognize the importance of retirement saving, they cited paying off debt, day-to-day expenses, taking care of family and saving for colleges as competing financial priorities. Automatic annual contribution increases prevent plan participants from getting distracted by other concerns.

Many employers now automatically enroll employees in their defined contribution plans. Employees who do not want to participate must opt out. Since it's easier to do nothing, many employees will remain with the plan. Combining an escalation feature with automatic

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Learn from Others' Mistakes

Orion made a mistake in its wellness program by making medical and disability inquiries that were not job-related. Flambeau required employees to submit to medical testing that was not job-related. Requiring employees to participate to obtain company-provided health insurance made these wellness programs mandatory, according to the EEOC.

Title I of the ADA allows employers to conduct voluntary medical examinations and activities, including obtaining information from voluntary medical histories, as part of an employee wellness program. However, if the employer requires participation or penalizes employees who do not participate, the EEOC no longer considers the program voluntary.

Laws Affecting Wellness Plans

The ADA is only one law that could affect your wellness programs. Other laws could apply as well:

HIPAA: The Health Insurance Portability and Accountability Act (HIPAA) was one of the first to specifically address wellness programs. It prohibits group health insurance plans from discriminating based on a health factor. Group health plans cannot charge similarly situated individuals different premiums or contributions based on a health factor, such as body mass index. However, HIPAA allows an exception for "bona fide wellness plans." It permits premium discounts and rebates or reductions to copayments or deductibles in return for "adherence to programs of health promotion and disease prevention." HIPAA capped such rewards to 20 percent of the total group health plan premium.

GINA: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits genetic information discrimination in employment. Title II of GINA prohibits employers and other covered entities from requesting, requiring or purchasing genetic information. Six limited exceptions apply. One allows a covered entity to acquire genetic information about employees or their family members when it offers health or genetic services, including wellness programs, on a voluntary basis. The individual receiving the services must give prior written authorization. Participating employees and their genetic health providers may receive this genetic information, but employers can only receive it in aggregate form.

Final regulations implementing GINA make it clear that employers cannot offer financial incentives for individuals to provide genetic information as part of a wellness program.

Pregnancy Disability Act: This federal act prohibits sex discrimination on the basis of pregnancy. It requires employers to provide similar treatment to women affected by pregnancy, childbirth or related medical conditions as they would to other similarly situated employees. Employers' wellness programs cannot treat women differently on the basis of pregnancy, and employers cannot require pregnant women to participate in a wellness program.

Affordable Care Act: The Affordable Care Act recognized the importance of wellness programs. It increased the maximum incentive for participating in wellness programs to 30 percent of premiums if participants must achieve a health-related goal. It boosted incentives for programs aimed toward eliminating or preventing tobacco use to 50 percent.

enrollment can help ensure employees' savings keep pace with inflation and cost-of-living increases.

For more information on effective retirement plan design, please contact us.

Guidance for Employers

Rules governing wellness plans under the Affordable Care Act became effective on January 1, 2014. These rules apply to fully insured and self-insured plans. Under these rules, a wellness program:

- must be reasonably designed to promote health or prevent disease;
- must have a reasonable chance of improving the health of, or preventing disease in, participating individuals;
- cannot be overly burdensome;
- cannot be a subterfuge for discriminating based on a health factor; and
- must use a reasonable method to promote health or prevent disease.

The final rules define two major types of wellness programs: "participatory wellness programs" and "health-contingent wellness programs." Participatory wellness programs

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either do not provide a reward or do not require an individual to satisfy a health standard to obtain a reward. Examples include programs that reimburse employees for membership in a fitness center, a diagnostic testing program that does not base any part of the reward on outcomes, and a program that rewards employees for attending a no-cost health education seminar.

In contrast, health-contingent wellness programs require an individual to satisfy a standard related to a health factor to obtain a reward. Final regulations subdivide this category into: (1) activity-only wellness programs, and (2) outcome-based wellness programs, which require the achievement of some health-related standard, such as body mass index or cholesterol level.

Activity-only wellness programs must offer a "reasonable alternative standard" or waive the standard for individuals whose medical condition makes it unreasonably difficult or medically inadvisable to attempt to satisfy the standard. Because outcome-based programs condition receipt of a reward on meeting specific health standards, they must provide a "reasonable alternative standard" to all individuals who do not meet the initial standard, with or without a physician's note.

No employer should avoid implementing a wellness program for fear of a lawsuit. We can help you review your wellness programs to ensure they comply with applicable laws and achieve the desired results. Please contact us for more information.

Your Employees Want Education

Only one-third of working adults rated their employer's benefits education as excellent or very good in a recent survey. With open enrollments coming, how does your benefits education program measure up?

The survey, conducted by insurance company Unum, also found that benefits education correlates to employee satisfaction. Among the employees who rated their benefits education as very good or excellent, 79 percent rated their employer as very good or excellent. This compares to only 30 percent of employees who said the education they received was fair or poor.

"Offering employees effective benefits education can contribute to satisfaction with their employer," said Bill Dalicandro, vice president of Unum's Consumer Solutions Group. "Even if employees don't have a particularly good benefits package, those who say they received quality education about the benefits they are offered are far more likely to consider their employer a very good place to work."

Satisfaction Down

The Unum survey, conducted in December 2013, revealed a drop in satisfaction from 2012. Nearly three in 10 (27 percent) of respondents rated their benefits education as fair or poor.

In June 2014, benefits cost the average private industry employer $9.09 per hour worked. This is a sizable investment. Yet as the Unum poll proved, the cost of your benefits program matters less than your employees' understanding of it.

A more recent survey by Alegeus Technologies found a disconnect between how employers viewed their benefits communications and how employees viewed them. About half of employees surveyed said they were satisfied with their employer's benefits communications. But employers rated their communications at 9 to 19 percent higher.

Failing to pay attention to how your employ-

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ees perceive their benefits and your education efforts could affect your recruiting and retention. As the economy improves, more workers are looking for new jobs. More than 2.5 million people quit their jobs in July 2014, up from 2.3 million in July 2013, reported the U.S. Bureau of Labor Statistics. A survey by the Hay Group management consulting firm found that 38 percent of workers plan to change their job in the next five years—up from 30 percent just a few years ago.

Evaluating Your Benefits Communications

What do your employees know, versus what do they need to know? Surveying your employees can help you determine how effective your benefits communications are. A survey can help you gauge employees' understanding of their benefits.

Specific questions you might want to ask include:

- Do they know all the types of benefits available to them? (i.e., medical, life, disability and other types of insurance)
- Do they know how these benefits work?
- How do they rate the value they receive for their contributions?
- Do they know where to get information about their benefits? (For example, HR department, online portal, your insurance broker
- How do they rate the quality of information they receive?
- How do they rate the frequency of information they receive?
- How satisfied are they with the overall quality of their benefit program?
- How do they rate your organization's benefits versus other employers'?
- What would they do to improve the program?

Survey results can reveal the strengths and weaknesses of your benefit program and communications. After surveying, your next action steps are:

- Review survey results to define any problems/weaknesses.
- Set communication objectives. What do you want your communications to accomplish? Better understanding of benefit plans? Increase take-up rates of non-core benefits? Steer more employees to high-deductible health plan?
- Analyze and segment target audiences. Tailor messages to various audiences.
- Develop and pretest message concepts. What do you want to say?
- Remember the principles of effective communication. To change or spur action, use action verbs. Keep messages simple.
- Select communication channels. Where do you want to say it?
- Select, create and pretest messages and products. How do you want to say it?
- Evaluate your execution. How effectively did your communications meet their objectives?

As benefits professionals, we can help you evaluate your benefits package and how you communicate it to your employees. Please contact us for more information. ■

How the Affordable Care Act Affects Dental Plans

Although dental plans are "excepted health plans" exempt from Affordable Care Act (ACA) reforms, two provisions in the ACA could affect dental plans.

Coordinating dental coverage with the Affordable Care Act's requirements poses some challenges for plan designers and sponsors.

Essential Health Benefits: The ACA requires all health plans sold on the individual and small group markets, both inside and outside of the Health Insurance Marketplace, to cover "essential health benefits." This package of ten items and services must include pediatric oral care, or dental care for children. This means medical plans for small groups and individuals must include benefits for oral health risk assessments and screenings and treatment for dental cavities (caries) with no cost-sharing.

But wait…although the exchanges must offer pediatric dental coverage, not all medical plans sold on the exchanges offer this coverage. The exchanges must offer standalone dental plans. It's up to the individual consumers to buy this coverage if they need it.

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The situation differs for small group plans sold off the exchanges. They must offer pediatric dental benefits, unless the insurer is "reasonably assured that an individual has obtained such coverage through an Exchange-certified standalone dental plan…"

Annual Dollar Limits: A typical standalone group dental plan might limit a plan member's annual benefits to somewhere between $1,500 and $2,000 per year. The ACA changes that for individual and small group plans. Because pediatric dental benefits are considered one of the essential minimum benefits, a plan must cover them with no annual limits. This could increase the cost of covering children significantly.

Deductibles: If a medical plan includes dental benefits, how will the deductible apply? If your employees have coverage through a high-deductible health plan and the same deductible applies to dental benefits, high out-of-pocket costs could prevent many employees from using their dental benefits.

Medical Loss Ratios: The ACA's medical loss ratio provision, or MLR, generally requires insurance companies to spend at least 80 percent of the money they take in on premiums on healthcare and quality improvement activities instead of administrative, overhead and marketing costs. If an insurer's spending doesn't meet this ratio, it must make premium rebates to policyholders. Also known as the 80/20 rule, the MLR provision ensures consumers get good value for their premiums.

The medical loss ratio requirement does not apply to standalone dental plans. However, some states (including California) have considered legislation that would require MLR standards to apply to dental plans offered on their health insurance exchanges. This could pose problems because dental plans often have lower loss ratios than medical plans. This happens because dental plans have the same sorts of administrative expenses (enrollment costs, marketing costs and claims-handling costs) as medical plans, but dental services typically cost less than medical services.

Considerations for Employers

Because the ACA spells out what type of preventive benefits a plan must cover, pediatric dental benefits under an exchange or small group plan might be more expensive than coverage under a standalone plan. Although it's too early to tell exactly what effect the ACA will have on dental benefits, many fewer people have enrolled in dental coverage through the exchanges than expected.

The National Association of Dental Plans (NADP) estimates the cost of covering a child under a small group dental plan at about $21 per child per month without orthodontia benefits. Adding orthodontia benefits at 50 percent coinsurance (the insured pays half and the insurer pays half of covered charges) would increase plan costs by about $2.80 per month per child.

While the Affordable Care Act still has bugs to be worked out, it has made some difference in the availability of dental coverage. Many studies have shown the link between having dental insurance and obtaining regular dental care. To ensure your employees' health and well-being, we offer a variety of dental plan designs to meet your needs and budget. Please contact us to learn more.

The Importance of Dental Insurance

More than one-third of adults surveyed for the Surgeon General's study on oral health (2000) had not visited a dentist in the past 12 months. Laurence R. Weissbrot, FSA, MAAA, director of actuarial and underwriting at Northeast Delta Dental in Concord, N.H., says that "75 percent or more of the people who have dental coverage see their dentists on a regular basis. Fewer than 50 percent of people without dental coverage do so."

Unfortunately, oral health conditions can progress rapidly without treatment. Most adults show signs of periodontal or gingival (gum) diseases, with about 14 percent of those aged 45 to 54 having "severe" periodontal disease.

The Surgeon General's report points out that oral health is integral to general health. "You cannot be healthy without oral health…. Oral diseases are progressive and cumulative and become more complex over time. They can affect our ability to eat, the foods we choose, how we look, and the way we communicate. These diseases can affect economic productivity and compromise our ability to work at home, at school, or on the job."

Employees who drop their employer-based coverage will be able to buy standalone dental insurance on an individual basis on the Health Insurance Exchanges. However, Weissbrot points out that individuals buying coverage on the insurance exchanges will lack the double tax advantages employer-provided benefits enjoy: employers can deduct premiums as a business expense, and employees do not have to report their value as income.

Many employers, even some smaller employers, self-insure dental benefits. Even when they add the cost of using a third-party administrator to manage their plans, some employers may save money on dental benefits this way. Although standalone health reimbursement arrangements (HRAs) will not meet the ACA's "no annual limit" requirement, a dental HRA might fall under the "excepted health plan" exemption from ACA requirements.

Please contact us to discuss ways your organization can provide valuable dental benefits to your employees at reasonable cost. ■

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