

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201



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Subject: Frequently Asked Questions on Health Insurance Market Reforms and Wellness Programs

Under Public Health Service Act (PHS Act) section 2705,¹ Employee Retirement Income Security Act (ERISA) section 702, and Internal Revenue Code (Code) section 9802 and their implementing regulations, group health plans and health insurance issuers in the group and individual market are generally prohibited from discriminating against participants, beneficiaries, and individuals in eligibility, benefits, or premiums based on a health factor.² An exception to this general prohibition allows premium discounts, rebates, or modification of otherwise applicable cost sharing (including copayments, coinsurance, or deductibles) in return for adherence to certain programs of health promotion and disease prevention, commonly referred to as wellness programs. The wellness program exception applies to group health coverage, but not individual market coverage.³

The Affordable Care Act added new rating reforms in section 2701 of the PHS Act and section 1312(c) of the Affordable Care Act. Section 2701 of the PHS Act restricts the variation in premium rates charged by a health insurance issuer for non-grandfathered health insurance coverage offered in the individual or small group market to certain specified factors. The factors are: family size, rating area, age, and tobacco use (within specified limits). Section 1312(c) of the Affordable Care Act generally requires an issuer to consider all enrollees in all health plans (except for grandfathered health plans) offered by such issuer to be members of a single risk pool for each of its individual and small group markets.⁴

¹ Section 1201 of the Affordable Care Act amended and moved the nondiscrimination and wellness provisions of the PHS Act from section 2702 to section 2705, and extended the nondiscrimination provisions to the individual market. The Affordable Care Act also added section 715(a)(1) to ERISA and section 9815(a)(1) to the Code to incorporate the provisions of part A of title XXVII of the PHS Act, including PHS Act section 2705, into ERISA and the Code and make them applicable to group health plans and group health insurance issuers.

² The statute and its implementing regulations set forth eight health status-related factors, which the 2006 regulations refer to as “health factors” for simplicity. Under the statute and the regulations, the eight health factors are health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. 71 FR 75014 (Dec. 13, 2006). In the Departments’ view, “[t]hese terms are largely overlapping and, in combination, include any factor related to an individual’s health.” 66 FR 1379 (Jan. 8, 2001).

³ Note, however, that “it is HHS’s belief that participatory wellness programs in the individual market do not violate the nondiscrimination provisions provided that such programs are consistent with State law and available to all similarly situated individuals enrolled in the individual health insurance coverage.” 78 FR 33167 (Jun. 3, 2013).

⁴ States have the option to merge the individual market and small group market risk pools (merged market) pursuant to section 1312(c)(3) of the Affordable Care Act.

The Affordable Care Act also added section 2702 of the PHS Act, which generally requires a health insurance issuer that offers non-grandfathered health insurance coverage in the group or individual market in a State to offer coverage to and accept every employer and individual in the State that applies for such coverage.

On February 27, 2013, the Department of Health and Human Services (HHS) published final regulations implementing the market reforms under sections 2701 and 2702 of the PHS Act and section 1312(c) of the Affordable Care Act.⁵ On June 3, 2013, the Departments of HHS, Labor, and the Treasury issued final regulations under PHS Act section 2705 and the related provisions of ERISA and the Code that address the requirements for wellness programs provided in connection with group health coverage.⁶ The following Frequently Asked Questions (FAQs) address several issues that have been raised since the publication of the market reform rules and the wellness program regulations. The responses are based on CMS's interpretation of how the market reform rules apply to wellness programs.

Q1: May an issuer limit its offering of a wellness program in connection with a particular health insurance product to only certain employer groups enrolling in that product, such as employers in certain industry classifications?

No. If an issuer offers a wellness program in connection with a particular product that is approved for sale in a market within a State, and the rewards under the program affect the health insurance coverage for that product, including the premiums, benefits, cost sharing, provider network or service area, then the offering of the wellness program would be considered a part of the plan design, and that plan design must generally be made available to every employer in the State and market that applies for such coverage, in accordance with the requirements of section 2702 of the PHS Act. The issuer cannot make a wellness program selectively available only to certain employers. For example, if an issuer's wellness program that offered a premium discount was only made available to employer groups who perform office work and not those who perform physical labor, that would not be permissible and the issuer would be in violation of the guaranteed availability requirements of section 2702 of the PHS Act.

This applies only to issuers offering health insurance coverage that is governed by the guaranteed availability provisions of section 2702 of the PHS Act, as added by the Affordable Care Act. It does not affect the ability of an employer to define the terms of the group health plan, including the employer's decision to offer wellness programs as part of the plan that are independent of those offered by the issuer. It also does not apply to excepted benefits under section 2791(c) of the PHS Act (e.g., employee assistance programs) or wellness programs with rewards that do not affect the coverage (e.g., gym memberships). Issuer marketing of wellness programs should be consistent with applicable nondiscrimination standards, including those set forth at 45 CFR 147.104(e).

⁵ See 78 FR 13406 (Feb. 27, 2013).

⁶ See 78 FR 33158 (Jun. 3, 2013). These regulations update earlier regulations implementing the nondiscrimination and wellness program provisions established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (the 2006 regulations). 71 FR 75014 (Dec. 13, 2006). The Affordable Care Act amended the statutory nondiscrimination and wellness provisions in large part to reflect the 2006 regulations regarding wellness programs.

Q2: Do the rating rules of section 2701 of the PHS Act prevent an issuer from offering premium discounts, rebates or other incentives for wellness programs other than those designed to prevent or reduce tobacco use?

No. Although providing a premium discount, rebate or other reward under a non-tobacco-related wellness program effectively varies the premium based on a factor not described in section 2701 of the PHS Act, the law specifically permits such rewards in connection with a wellness program meeting the standards of section 2705(j) of the PHS Act.

Q3: When establishing the index rate and plan-level adjustments under the single risk pool provision, may an issuer take into account the penalties or rewards expected to be provided under a wellness program (whether health-contingent or participatory)?

No. The penalties or rewards associated with participation in a wellness program (participatory or health-contingent) may be applied to individual participants' premiums or contributions (or otherwise accrue to individuals), but may not be used to establish an issuer's index rate for a market, or any permitted plan-level adjustments, under the single risk pool provision at 45 CFR 156.80. Any such penalties or rewards may be retained or paid out by the issuer or by the employer, as applicable, pursuant to the terms of the wellness program and in accordance with the wellness program regulations.

This guidance is applicable to health insurance issuers subject to the single risk pool requirement for rates effective on or after January 1, 2016. Issuers subject to the single risk pool requirement must establish rates consistent with this guidance and without regard to the rewards or penalties expected to be provided under a wellness program.