

Compliance Corner: Overcoming Legal Compliance Hurdles in Disease Management and Wellness Programs

Part 3 of a 3-Part Series

*John R. Hickman, Esq.
Alston & Bird LLP*

A. COBRA

Under COBRA, an individual who might otherwise lose coverage under a group health plan can pay to continue that coverage for a limited time. Thus, under COBRA, an employer must give a “qualified beneficiary” who has had a qualifying event the opportunity to continue the health coverage that he or she was previously receiving before the qualifying event. Notice and disclosure obligations relating to the continuation coverage are imposed upon employers that sponsor COBRA-covered plans.

COBRA applies to group health plans. Generally, a plan is a group health plan if it provides medical care and is maintained by the employer. Medical care, defined under section 213(d) of the Internal Revenue Code, includes the diagnosis, cure, mitigation, treatment, or

Internet Tools Can Encourage Appropriate Healthcare Decisions

Managed Care Weekly Digest

Companies that are best at controlling healthcare costs are more likely than their poorer performing counterparts to offer multifaceted Internet tools that help employees model healthcare options, a study by Watson Wyatt and the National Business Group on Health has found.

A majority (58%) of the 585 companies surveyed provide Internet resources that allow employees to compare healthcare insurance options side by side, but companies that are best at controlling costs offer additional Web tools. They are 38% more likely to provide quality comparison tools and 36% more likely to provide tools to model the tax impact of healthcare decisions, such as signing up for a flexible spending account. In addition, while only a small number of companies offer Internet resources for provider pricing, those best at controlling costs are 108% more likely to do so.

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prevention of disease and any undertaking affecting any structure or function of the body and is not just merely beneficial to an individual's general health or well being. A group health plan can require a qualified beneficiary to pay an amount that does not exceed 102% of the "applicable premium" for the coverage. The "applicable premium" is the cost to the plan of providing coverage.

When a plan offers DM, wellness or health improvement programs, how does this fit into the COBRA picture? Is the DM or wellness program part of the health plan or a health plan in and of itself? Should qualified beneficiaries be afforded the opportunity to continue in the DM or wellness program; and if yes, at what cost? Is continuation of the primary medical plan necessary to receive on-going DM benefits? Should the individual receive any premium discounts or other incentives? It's easy to raise questions, but not so easy to answer them. Often, there may be no clear answers. Some plans extend benefits (and even the discounts) to COBRA qualified beneficiaries; others do not. When it comes to DM programs and COBRA, it's best to seek legal advice about whether or not COBRA requires that the program be extended to continuees.

Several considerations come into play when analyzing whether COBRA continuation

coverage must be extended in a particular DM program:

1. Consider what type of program it is – DM, wellness or health improvement program. This may have bearing on whether the program would be considered a medical plan under COBRA. For example, a program that simply promotes healthy living or offers referrals may not be considered to be medical care. On the other hand, a program that promotes healthy living, but also provides smoking cessation and weight loss classes, in addition to counseling services and screening services with follow up consultations with program physicians would likely be considered to be medical care.
2. Consider what type of incentive is offered – cash, flex credits, premium reduction or discount or improved benefit? It seems fairly clear that if the incentive involves cash or a premium discount or reduction, COBRA would apply differently, or maybe not at all. COBRA only attaches to "medical care."
3. Is the DM program part of the health plan, or a free-standing arrangement? Would it be considered a separate group health plan? Does the DM program offer medical coverage? Who delivers the DM program? Is it offered by an

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outside vendor? By the health issuer or employer health plan? Does it make a difference who provides the discount – the employer, the vendor, the insurer?

The key here turns on whether the DM program offers medical care or would be considered medical care. If the DM program provides health credits, discounts or cash incentives when a participant fills out a health risk assessment, some argue the DM program is related to the cost of coverage and is not a medical benefit at all. Others believe that if a “premium discount” is offered for DM participation, it likely means that COBRA continuees must be offered an opportunity to participate (i.e., with or without the discount based on DM participation) in the primary medical plan with the premium discount. This especially seems to be the case where the DM incentive is deposited into a health reimbursement account.

If the program is a “strict disease management program” that identifies individuals with risk factors once a claim is made, the services provided under the program (such as education, nurse contact to manage a chronic disease) seem to be clearly medical care provided through the employer. These services must be extended to COBRA continuees on the same basis as they are extended to active employees.

What about a DM program where the incentive is related to benefit coverage? An example of this type program is one that offers a higher level of benefit (e.g., smaller copays, coinsurance, or deductibles) for coverage of individuals who participate in the DM program. It would appear that this type of incentive must also be offered to COBRA continuees since it relates to the coverage under a medical plan. This coverage also, however has a value. While the continuee might be entitled to the better coverage under the DM program, they will have to pay 102% of any additional cost to get the benefit. Of course an actuarial analysis must be undertaken to justify whether there is indeed an additional cost (or whether the DM participation may in fact reduce claims costs). (See discussion of premium later in the article.)

If the program is of a “wellness” nature, the question of whether medical care is provided is less clear. A program that offers a health risk assessment and coaching services to promote a healthy lifestyle may not be considered medical care. A program that offers “targeted intervention” based on answers to the health risk assessment questions would more likely be construed as providing medical care. Much depends on what the “targeted intervention” entails. A program that offers smoking cessation or

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weight loss classes (rather than a referral to such classes) and provides screening and physician follow-up would likely be considered to offer medical care. It would seem appropriate in that instance to extend the program to continuees.

4. Is the DM program extended to a larger “footprint” than active medical coverage? For example, many employers make the DM program available to all employees – even if they do not participate in the medical plan. In this case, a DM program that is deemed to be medical care would create COBRA obligations (and a continuation right) for all employees eligible for the DM benefit – even if they are not in the employer’s primary medical plan. This could substantially increase the administrative burden and cost on the plan sponsor. On the other hand, if the DM program is structured as part of the employer’s group health plan, COBRA rights could be restricted to those in the medical plan, and continuation coverage obligations could be integrated into the active plan’s COBRA regime.

5. Ultimately, COBRA is not just about continuing medical care, but paying 102% of the actual cost of that medical care. Even if a DM program would be considered employer provided medical care, the COBRA premium for such care is 102% of the actual cost. An employer has wide discretion to determine

the number of group health plans it maintains. If the DM program is a separate plan, or priced separately, this determination is easy. In many cases, to accommodate COBRA, employers will be required to offer a COBRA rate with the DM program included in the health plan, and/or a rate with the DM program excluded.

Note that if the employer considers the DM program to be a separate medical plan, a COBRA notice obligation could also arise.

The issues presented here can be complex and intricate. In reality, probably few employers adequately consider the COBRA implications when it comes to their DM programs, particularly the ones that relate to healthy living or wellness program and those that offer cash incentives. As incentives for participation in these programs tie them tighter to medical benefits though, employers will have to carefully consider the COBRA implications. When COBRA applies, as a general rule, the plan sponsor must give COBRA continuees the same DM privileges as are extended to active employees. Employers will need their legal counsel to help them sort out all the issues.

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B. Taxability Concerns

As noted above, as an inducement for employees to complete a health risk assessment, many DM Programs provide financial incentives (the “carrot”) to employees for completing the health risk assessment. These financial incentives often take the form of gift certificates, cash, premium reductions or dollars in an HRA, FSA, or HSA. When the incentive is couched in terms of a health benefits, such as a premium reduction or a payment into a health FSA, HRA or HSA, the incentive may be excluded from taxation. When the incentive is couched in terms of a gift certificate, gift card or coupon or cash bonus, the incentive will be included in income and will be taxable. Often the infrastructure does not exist to properly address tax issues associated with DM financial incentives.

1. Premium Incentives

If an employer offers an incentive (or disincentive) related to a health premium, such as reduction in a health premium, a premium holiday, or a contribution to a health FSA, HRA or HSA (or a premium increase), the amount of that incentive will be excluded from the employee’s gross income pursuant to sections 105 and 106 of the Internal Revenue Code. Like other employer provided health benefits, an incentive of this nature will receive the same tax treatment.

The incentive will not be included in the employee’s gross income. Additionally, the incentive will be excluded from employment taxes (FICA and FUTA, generally) and will be a deductible business expense for the employer (under section 162 (a)).

2. Cash Incentives

If the employer offers an incentive that takes the form of cash, such as a bonus or a gift certificate or card, the incentive will likely be taxable and should be included in the employee’s gross income as compensation. In some cases, it may be possible that an incentive offered in the form of an employee discount or meal, for example, could be excludable from the employee’s gross income because it is considered a fringe benefit under section 132. But these instances are rare. The more common situation, however, is where the employer offers a gift certificate, card, coupon (or outright cash) to the employee that participates in the DM program. These types of incentives will not qualify as nontaxable fringe benefits. The IRS treats gift certificates, card or coupons as cash equivalents. Cash to an employee is treated as compensation and is always taxable under section 61 of the Code. These incentive amounts will be subject to

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employment tax reporting and additional withholding obligations.

In addition, if the DM financial incentives are paid through a VEBA, the VEBA's tax-free status may be jeopardized, even though the incentive is tied to a permissible benefit (the health plan and DM Program). This is because VBAs must generally provide only certain permissible benefits (e.g., healthcare). VBAs may provide some level of other (e.g., impermissible) benefits, but the level of such impermissible benefits must be "de minimis" when compared to other benefits offered under the VEBA. There is no definition of "de minimis," in the Code or Treasury Regulations, but IRS rulings related to domestic partner benefits seem to use 3% as the threshold. While such incentives may be de minimis when considered separately, when combined with additional "non-health" benefits the incentive could raise exceed the 3% threshold. For example, if the VEBA presently pays benefits for domestic partners (also an impermissible benefit), the addition of the DM financial incentive might send the entire amount over the VEBA's "de minimis" limit.

3. Incentives Can Raise Nondiscrimination Red Flags

Although not intentional, DM incentives could cause nondiscrimination issues under sections

105(h) (self-insured medical plans) and/or 125 (cafeteria plans). Nondiscrimination issues could arise depending on the employees who choose to participate in the program and receive the incentive. Those that receive the incentive, depending on the nature of the incentive (e.g., cash vs. premium reduction), could also get a better benefit under the self-insured medical plan and/or cafeteria plan which could, in turn, affect nondiscrimination testing. Incentives could affect the benefits test under section 105(h) and the key employee concentration and the benefit and contributions tests under section 125.

As a result of these tax issues, plan sponsors should seek the advice of competent benefits counsel to weigh the pros and cons of the type of incentives to offer, and to decipher potential tax issues.

C. Compliance Concerns That May Arise When DM Programs are Integrated With HSAs or HRAs

In light of the tax and VEBA compliance issues associated taxable financial incentives, many employers seek to direct incentives toward tax-free health savings account (HSA) or health reimbursement arrangement (HRA) benefits. As discussed in this section, great care should be

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exercised to ensure that the applicable operating rules associated with HSA and HRA arrangements are not violated.

1. HSAs and the Comparability Requirement

As employers search for new ways to keep illness and health plan spending down and promote wellness programs, HSAs are often considered. An employer that sponsors an HSA is not required to make HSA contributions. However, if an employer makes HSA contributions, the employer is subject to a 35% excise tax on all of its HSA contributions made during the calendar year unless it “makes available comparable contributions to the [HSAs] of all comparable participating employees for each month during such calendar year.” Generally, if an employer makes contributions to HSAs, it must contribute the same amount or the same percentage of the deductible to all employees who are eligible individuals, and who have the same coverage category (self-only or family). The employer may, however, restrict its contributions to those eligible individuals covered under the employer’s HDHP provided that the employer makes no contributions to any employee not covered under the employer’s HDHP. Also, the test may be run separately for “part-time employees”, which is statutorily defined as those who customarily work fewer than 30 hours per week. We call this the “HSA comparability rule.”

Unfortunately, this inflexible “comparability” requirement does not fit well with the goal of rewarding DM Program participants with HSA-based financial incentives for DM participation. However, the HSA comparability rule does not apply when employer contributions (including matching contributions and bonuses for disease management and wellness programs) are “made through a Section 125 cafeteria plan”. IRS Notice 2004-50 includes the following discussion:

Q-49. If under the employer’s cafeteria plan, employees who are eligible individuals and who participate in health assessments, disease management programs or wellness programs receive an employer contribution to an HSA, unless the employee elects cash, are the contributions subject to the section 4980G comparability rules?

A-49. No. The comparability rules under section 4980G do not apply to employer contributions to an HSA through a cafeteria plan.

Employers struggle, however, with this concept of a DM-based HSA contribution being made “through a cafeteria plan.” Exactly when is a

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contribution considered to be made "through a cafeteria plan?" If the example above is read too literally, it would seem that a "cash" incentive must always be available for the DM incentive to be offered through the cafeteria plan.

2. HRAs and DM Incentives

Many consumer-driven healthcare arrangements include a health reimbursement arrangement (HRA) under which unused funds carry forward into subsequent years. Often plan sponsors seek to include the DM financial incentive as part of the HRA – i.e., participating in the wellness or DM program results in an increased HRA contribution. As discussed below, this plan design may create compliance issues under the current HRA rules.

Currently, employer contributions to an HRA may NOT be attributable in whole or part to pre-tax salary reductions made under a cafeteria plan. In addition, an HRA may not be funded with benefit credits that could otherwise be received as cashable compensation. This does not mean that the HRA cannot be offered in conjunction with a major medical plan (e.g., an HDHP) that is funded in part with employee pre-tax contributions. However, the "no direct/indirect" funding requirement must be satisfied in order for the HRA to be offered with a medical plan that is offered under the

cafeteria plan – i.e., employee salary reductions (or employer cashable credits) cannot fund the HRA either directly or indirectly.

No direct funding of HRA: The first condition is satisfied if employee pre-tax salary reduction amounts do not directly fund the HRA. Direct funding does not occur if (i) the salary reduction agreement indicates that salary reductions are used solely for the non-HRA portion of the major medical plan, and (ii) the employee pre-tax salary reductions for the major medical plan are less than the applicable COBRA premium for such coverage. For example, if the applicable COBRA premium for single major medical coverage is \$1,800 per year, the annual salary reduction election for such coverage must be less than \$1,800. The applicable COBRA premium is generally the cost to the plan to provide such coverage. The 2% administrative charge permitted by COBRA is in addition to the applicable premium. The salary reduction must be less than the applicable premium for such coverage without consideration of the 2% administrative charge.

No indirect funding of HRA: A substantially less clear condition is that the HRA cannot interact with a cafeteria plan in such a way that it is

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indirectly funded with pre-tax salary reductions. IRS HRA guidance indicates that where an employee who participates in an HRA has a choice among two or more medical plan options to be used in conjunction with the HRA (or a choice among various maximum reimbursement amounts), and there is a correlation between the maximum reimbursement amount under the HRA and the salary reduction election for a specified medical plan, then the salary reduction is attributed to the HRA, even if the salary reduction is less than the applicable COBRA premium. For example, an employer may not permit an employee to choose a higher salary reduction amount for a particular level of specific medical plan coverage in order to receive a higher HRA amount.

In the example provided by the IRS HRA guidance, the employer offers family medical coverage worth \$4,500. The employee may choose to contribute on a pre-tax salary reduction basis either \$2,500 or \$3,500 for such coverage. If the employee elects the \$2,500 salary reduction option, the employee receives a \$1,000 credit to his or her HRA. If the employee elects the \$3,500 salary reduction option, he or she will receive a much higher HRA credit of \$2,000.

The example set forth in the guidance (and discussed above) indicates that an employee

cannot have a choice between a higher salary reduction amount and a higher HRA. Thus, it may be permissible to offer multiple medical plan options in conjunction with the HRA provided that HRA reimbursement amounts increase as salary reduction amounts decrease. For example, assume an employer offers two medical plan options in conjunction with an HRA. Option 1 offers major medical with a \$3,000 deductible. The applicable premium for such coverage for the year is \$2,000. The required salary reduction amount is \$500 and the HRA amount is \$2,000. Alternatively, employees can choose Option 2, which offers a major medical plan with a \$4,000 deductible and an applicable premium of \$1,500. The salary reduction amount for Option 2 is \$300 and the HRA is \$3,000. This would appear to be permissible because the employee is not electing a higher salary reduction amount for a higher HRA (it is quite the opposite).

The IRS HRA guidance identifies two other situations where the salary reduction is attributable to the HRA, even though the salary reduction amount is less than the applicable COBRA premium. One, an HRA is deemed to be indirectly funded with pre-tax salary reductions if the employee may choose to apply the HRA amount toward the employee's share of medical

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plan coverage in lieu of the pre-tax salary reduction. Two, an HRA is deemed to be indirectly funded with pre-tax salary reductions if the amount credited to the HRA is related to an amount forfeited under a Health FSA.

Impact of HRA Rules on DM financial incentives: Health plan sponsors must be especially vigilant of the HRA indirect funding rules when designing their DM financial incentive arrangements. For example, an employer that creates a DM health incentive for all employees that participate in a specified disease management or wellness program may run afoul of the HRA indirect funding rule if the DM financial incentive is deposited in an HRA. Consider the following:

Wellco currently has two health plan options. A PPO option with an employee contribution rate of \$100 per month and a high deductible HRA option with an employee contribution of \$200 per month with \$100 per month accruing in an HRA. Wellco is considering a DM incentive whereby employees in either option can receive a \$10 per month HRA credit for completing a health risk assessment. Are there any issues under the HRA indirect funding rule?

Under the above arrangement, it appears that participants have a choice of the Wellco PPO option or HRA option – both of which have a related DM HRA. While the PPO option has a DM HRA, additional HRA contributions can be obtained by electing to salary reduce an additional \$100 per month and electing the HRA option (in lieu of the PPO). This could be considered to be a violation of the indirect funding rule. The amount of the HRA accrual for the DM incentive for the PPO option is less than the HRA accrual for the HRA option. Therefore, if the salary reduction amount for the health coverage under the HRA health coverage option is greater than the salary reduction amount for the health coverage offered with the PPO Plan, then there may be an indirect funding issue – i.e., the HRA accrual increases in tandem with the salary reduction.

Arguments can be made that the Wellco plan does not violate the indirect funding rule – e.g., indeed, the DM incentive is equally available regardless of salary reduction contribution amount. However, once this issue is identified, conservative employers may wish to evaluate a couple of alternatives to possibly eliminate the "indirect funding" issue. First, given the nominal amount of the DM HRA, perhaps it could be offered without a carryover – thus making it an

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FSA but not an HRA at all. This would facilitate offering the DM incentive without adversely affecting the indirect funding rule. Alternatively, depending on pricing and benefit offerings, if the HRA option has a lower salary reduction requirement than the PPO option, then an indirect funding issue should not arise.

Needless to say, great care should be taken in designing a DM incentive program to ensure that the direct/indirect funding rules are not violated.

Conclusion

We have examined the ADA, HIPAA nondiscrimination as well as privacy, COBRA, ADEA, and tax issues (HSA and HRA issues) related to DM programs. While DM programs continue to gain popularity and make their mark on the healthcare industry, employers should take care to take a measured approach looking at the whole picture, including the benefits compliance issues associated with such arrangements. 🚫

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Internet Tools Can Encourage Appropriate Healthcare Decisions

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"The Web can be a great help in effectively delivering healthcare information to employees and is especially important for companies making significant plan design changes," said Jeri Stepman, Watson Wyatt's national leader for health and welfare administration. "Companies adopting a consumerism approach to healthcare are finding that employees need more than financial incentives to become better healthcare consumers - they need information as well. Tools that allow employees to consider many facets of their healthcare can make a significant difference in the healthcare options employees choose."

Although many companies are providing Web resources that help employees model their healthcare options, most are not yet offering the information on provider quality and pricing that employees need to make more cost-effective choices.

"Providing information on the cost-effectiveness of providers is key to directing employees to lower-cost, higher-quality healthcare," Stepman said. "Employers can harness the Internet to help provide this data and encourage employees to use healthcare providers with the best treatment outcomes." 🚫

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GAO: Consumer-Directed Health Plan Enrollees Reach 6 Million

BestWire Services

Prompted by rising healthcare costs, enrollees in consumer-directed health plans nearly doubled in a year, increasing to between 5 million and 6 million in January, up from about 3 million in January 2005, the Government Accountability Office (GAO) said in a report.

GAO, Congress's nonpartisan investigatory body, was told to find out how widespread CDHPs are, how they are funded and used, and the factors that could strengthen or weaken their appeal.

In the report, GAO found that such plans – the most common of which are health savings accounts and health reimbursement arrangements, both of which allow for tax-free withdrawals for medical expenses – grew from about 1.6% of all U.S. private health insurance enrollees to 2.8% to 3.4% in only a year. That, the GAO said, means those plans, while still relatively few in number, are becoming a fast-growing segment of the private health insurance market.

Citing health insurance industry officials and experts, GAO said, "the primary factor responsible for the growth of CDHPs is the rising cost of healthcare coverage."

Officials interviewed for the report said the growth in enrollment was prompted by a "desire to lower premiums" and to earn a tax advantage. Employers are more likely to offer CDHPs, the GAO found, if those plans show that they can rein in costs, and employees are more likely to enroll in them if employers offer "more comprehensive CDHP benefits" as well as more education about the plans.


GAO also found the proportion of employers offering CDHPs to their workers quadrupled in

about a year, rising from about 1% in 2004 to 4% in 2005. Large employers were more likely than small ones to offer such plans, with larger companies more likely to offer HRAs and smaller companies more likely to offer HSAs.

Where employers offered multiple plans, employees were more likely to enroll in traditional health plans than in CDHPs, GAO said.

The GAO also found specific data about usage and contributions in the plans; data from three multistate insurance carriers, which GAO didn't name, showed that the most common employer HRA contribution in 2004 ranged from about \$500 to \$750 for an individual and from \$1,500 to \$2,000 for two or more people. Employers are required to contribute to the accounts associated with HRA-based health plans. GAO also found that usage within the HRA plans was high: nearly 75% of single HRA-based enrollees and more than 95% of family enrollees used some or all of their HRA funds in 2004.

Among HSA plans, about two-thirds of employers contributed to their workers' accounts, with an average 2005 employer contribution of \$553 for individuals and \$1,185 for families, GAO said.

GAO also said "employers would be more likely to offer a CDHP if the cost of healthcare coverage continues rising significantly or if CDHPs demonstrate the ability to reduce these costs." According to the report, premiums in the group health insurance market since 2000 have increased nearly five times faster than the overall rate of inflation and the rate of increase in workers' wages. 

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Bill Would Allow Health Insurers to Opt Out of HIPAA's Guaranteed-Issue Rule

BestWire Services

The chairman of the House Energy and Commerce Subcommittee on Commerce, Trade and Consumer Protection has introduced a bill that would allow insurers to opt out of a federal requirement that they provide small-group health coverage to any employer that seeks it.

Instead, the legislation would give insurers the option of offering employees high-deductible health plans associated with health savings accounts, so long as the insurers make those plans portable from job to job. The bill also would ensure that employees who seek individual coverage would be able to get it at no more than 1.5 times the standard rate.

Rep. Mike Rogers, R-Mich., announced the bill during a May 23 speech at the Heritage Foundation, in which he described the bill, called the HSA Accessibility and Portability Act, as "another tool for increasing free-market principles and consumerism in healthcare."

Currently, the 1996 Health Insurance Portability and Accountability Act requires insurers to accept any employer that applies for small-group health insurance coverage, regardless of employees' history or health status – the so-called "guaranteed issue" requirement. The Rogers bill, H.R. 5475, would allow insurers to opt out of that provision while adding language guaranteeing portability of HSA plans and individual coverage at the capped rate.

"With health savings accounts becoming more and more popular with employees in small businesses, and the accounts being portable from one job to another, we need to provide the same portability for the high deductible policies that give them backup for their HSAs in the event of major health problems," Rogers said in his speech, according to a transcript of his remarks.

According to Rogers' office, HIPAA's "guaranteed issue" requirement translates into 25% higher costs for small-group policies and reduced coverage, as carriers are exiting the small-group market and the number of small businesses that are able to offer health coverage is dropping as prices rise.

Under the terms of the bill, when small employers initially apply for insurance under the new option, the insurers would be allowed to reject a group, and any future employees would have to qualify for insurance separately. Once the group and its employees are insured under an HSA plan, however, employees would have to be given portability, meaning they would be able to maintain a policy from the same carrier providing the HSA group plan. When the individual policy first was offered, its rates couldn't be higher than 150% of the

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standard risk rate in the state where the policy initially was offered.

"Market competition has driven down the cost of many services and products, and the same free-market principles brought to bear on healthcare can give us the same result," Rogers said in a statement. "Actually, consumerism is already beginning to work in the American health sector. Studies show that HSAs and similar plans lower costs while increasing access to care."

Rogers spokeswoman Sylvia Warner said the bill is one of Rogers' legislative efforts to expand healthcare coverage. "Small businesses, when lumped together, are the largest employer in the country," Warner said, "(Rogers) wanted to see what he could do with an eye toward making it possible for small businesses to make healthcare available to their workers."

Another healthcare bill from Rogers, H.R. 3757, seeks to amend the Social Security Act to allow for "health opportunity accounts" under the Medicaid Program. Such accounts would be analogous to health savings accounts. Under the terms of that bill, filed last year, low-income Medicaid beneficiaries would have to meet a deductible before they could access their Medicaid benefits. 

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