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**To: BeniComp Advantage Agents**

**From: Doug Short, President**

**Date: March 17, 2008**

**RE: BeniComp Advantage and HIPAA Non-Discrimination**

**CORPORATE HEADQUARTERS**

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The BeniComp Advantage program is truly unique in providing a solution that minimizes an employer's legal and financial risk. The deductible reimbursement included in BCA occurs through a separate fully insured supplemental insurance policy. By offering a policy through an independent third party, BeniComp also gives employers the luxury of knowing their full cost for the program up front as well as shelter from being involved in the measurement, reporting or appeal of employee biometric screening results. Additionally, the underlying policy issued by Assurity Life Insurance Company or Pan American Life Insurance Company meets all applicable state filing and compliance requirements required for fully insured supplemental plans.

The BeniComp program does not attempt to skirt HIPAA non-discrimination requirements for wellness plans that are designed to ensure fairness for all covered members without discriminating based on health status factors. Employers should be comforted by the fact that the BeniComp program also complies with the final wellness rules for plans effective on or after July 1, 2007 because:

- The rewards are available annually
- The rewards are available to all similarly situated individuals. Reasonable alternatives are made when achieving a goal is medically inadvisable or unreasonably difficult to achieve based on an individual's medical condition.
- It is designed to promote health and prevent disease
- An appeal process is in place for each reward category
- The rewards and appeal options are fully disclosed in plan materials
- The total value of rewards that are contingent upon the satisfaction of health standards do not exceed 20% of the total cost of annual coverage. An annual calculation is performed to determine what if any portion of the total rewards available from BeniComp will be made available for participation in the program. For example, if BeniComp is offering up to \$2000 in rewards but 20% of premium on the plan is \$1,400, every employee who participates will earn a minimum of \$600 simply for participating in the program. In this way, even employees who fail all measures will not be penalized by more than the 20% of premium amount allowed as a result of their failing the tests. Additionally, because covered spouses are required to either fully or partially participate in the program, 20% of family premium is calculated in family situations.

On December 7, 2007 The U.S. Department of Labor issued Field Assistance Bulletin No. 2007-04 regarding: *Supplemental Health Insurance Coverage As Excepted Benefits Under HIPAA and Related Legislation*. This bulletin appears to target supplemental plans that attempt to absolve themselves from the wellness rules. BeniComp does not. We recognize that although the actual ERISA provisions indicate that supplemental plans must be similar to Medicare or TRICARE supplemental programs, this bulletin indicates that in order to be "similar supplemental coverage" supplemental plans must be "similar to Medicare Supplemental Coverage" (which unlike Tricare supplements, do not differentiate benefits based on health factors). While we do not fully understand how or why the "similar to TRICARE" language was omitted in the Field Bulletin we do not believe this has adversely impacted the current BCA product because it is structured to comply with the final wellness rules, not to ignore them. As a result, employers have a turn-key, safe program that allows them to stay out of their employee's health issues and the administrative burdens associated with home-grown wellness plans.



# Federal Register

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Thursday,  
December 30, 2004

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## Part III

### Department of the Treasury

Internal Revenue Service  
26 CFR Parts 54 and 602

### Department of Labor

Employee Benefits Security  
Administration

29 CFR Part 2590

### Department of Health and Human Services

Centers for Medicare & Medicaid Services  
45 CFR Parts 144 and 146

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Final Regulations for Health Coverage  
Portability; Final Rule

Notice of Proposed Rulemaking for  
Health Coverage Portability and Request  
for Information on Benefit-Specific  
Waiting Periods Under HIPAA Titles I &  
IV; Proposed Rules

generally be restricted by the employer or HSA trustee. Under the statute and administrative guidance, any expense incurred after an HSA is established is eligible for reimbursement, without restriction by an employer contributing to the HSA or trustee of the HSA. Thus, as a practical matter, whether or not an expense relates to a preexisting condition cannot determine the reimbursement. As such HSAs by design cannot impose a preexisting condition exclusion. Similarly, due to comparability rules requiring uniform contributions to HSAs by employers, employers and trustees generally cannot use differing amounts of contributions to impose a preexisting condition exclusion.

The eligibility for tax-free reimbursement from an HSA is also determined by statute; namely, the qualified medical expenses of the HSA owner and the HSA owner's dependents incurred after the HSA is established may be reimbursed on a tax-free basis by the HSA. Special enrollment rules for dependent children or spouses are not relevant because once an HSA is established they are eligible for tax-free reimbursements immediately. With respect to special enrollment upon loss of coverage, the rules for employer contributions generally require that all employees who are eligible for HSA contributions and participating in the employer's HDHP receive comparable HSA contributions. Thus, the combination of the comparability rules and the application of the special enrollment rules to the HDHP will generally ensure compliance with respect to employer HSA contributions because once an employee is enrolled in an employer-provided HDHP due to the special enrollment rules, the employer must make comparable contributions to the employee's HSA.

#### Indemnity Insurance

Under HIPAA, the April 1997 interim rules, and these final regulations, hospital indemnity and other fixed-dollar indemnity insurance are excepted benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; if there is no coordination of benefits between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and if the benefits are paid with respect to an event regardless of whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor. These regulations clarify that, for hospital indemnity or other fixed-dollar indemnity insurance to

qualify as excepted benefits, such insurance must pay a fixed dollar amount per day (or other period), regardless of the amount of expenses incurred. An example clarifies that if a policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum amount per day, the benefits are not excepted benefits. This is the result even if, in practice, the policy pays the maximum for every day of hospitalization.

#### Supplemental Insurance

Under HIPAA, the April 1997 interim rules, and these final regulations, Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act); coverage supplemental to TRICARE; and similar coverage that is supplemental to a group health plan are excepted benefits if they are provided under a separate policy, certificate, or contract of insurance. These regulations clarify that, for coverage supplemental to a group health plan to qualify as excepted benefits, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Coverage that becomes secondary or supplemental only under a coordination-of-benefits provision in the insurance contract or plan documents does not qualify as excepted supplemental benefits.

#### Treatment of Partnerships

Any plan, fund, or program that is established or maintained by a partnership and that provides medical care to present or former partners or their dependents, and that otherwise would not be an employee welfare benefit plan, is considered an employee welfare benefit plan that is a group health plan under Part 7 of ERISA and Title XXVII of the PHS Act.<sup>10</sup> As such, the partnership is considered the employer with respect to any partner. Participants in the plan include individuals who are partners of the partnership. Additionally, with respect to group health plans maintained by self-employed individuals (under which one or more employees are participants), the self-employed individual is considered a participant if this individual is or may become eligible to receive a benefit under the plan or if the individual's beneficiaries may be so eligible. These regulations clarify that, for purposes of Part 7 of ERISA and Title XXVII of PHS Act, a

<sup>10</sup>Such a plan, fund, or program is also considered a group health plan under section 5000(b)(1) and Chapter 100 of the Code.

partner must be a bona fide partner in order to be considered an employee, and the partnership is considered the employer of a partner only if the partner is a bona fide partner. These final regulations also clarify that whether an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

#### Counting the Average Number of Employees

A paragraph has been reserved in the final rules for determining the average number of employees employed by an employer for a year. For proposed rules on this topic, see the Departments' notice of proposed rulemaking, published elsewhere in this issue of the **Federal Register**.

#### C. Economic Impact and Paperwork Burden

*Summary—Department of Labor and Department of Health and Human Services*

HIPAA's group market portability provisions, which include limitations on the scope and application of preexisting condition exclusions, and special enrollment rights, provide a minimum standard of protection designed to increase access to health coverage. The Departments crafted these final regulations to secure these protections, consistent with the intent of Congress, and to do so in a manner that is economically efficient.

The primary economic effects of HIPAA's portability provisions ensue directly from the statute. These regulations, by clarifying and securing HIPAA's statutory protections, will delineate and possibly expand HIPAA's effects at the margin.

#### Effects of the Statute

HIPAA's statutory group market portability provisions extend coverage to certain individuals and preexisting conditions not otherwise covered. This extension of coverage entails both benefits and costs. Individuals enjoying expanded coverage will realize benefits. In some instances these individuals will gain coverage for services they otherwise would have purchased out-of-pocket. In other instances the extension of coverage will induce individuals to consume more (or different) health care services, which in some cases may improve health outcomes. The dollar value of the extended coverage is estimated to be \$515 million annually. Potential additional benefits from improved health outcomes are difficult

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope*—(A) *Dental benefits.* Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits.* Limited scope vision benefits are benefits substantially all of which are for treatment of the eye.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care services, as defined in section 7702B(c)(1), or provided under a qualified long-term care insurance contract, as defined in section 7702B(b); or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements.* Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2)) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of

participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed \$500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (c)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, \$100/day) regardless of the amount of expenses incurred.

(ii) *Conditions.* Benefits are described in paragraph (c)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(iii) *Example.* The rules of this paragraph (c)(4) are illustrated by the following example:

*Example.* (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of \$100 a day.

(ii) *Conclusion.* In this *Example*, even though the benefits under the policy satisfy the conditions in paragraph (c)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of \$100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) Similar supplemental coverage provided to coverage under a group health plan. To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (c)(5) are illustrated by the following example:

*Example.* (i) *Facts.* An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example*, the coverage provided to retirees does not meet the definition of supplemental excepted benefits under this paragraph (c)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(d) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* (See 29 CFR 2590.732(d)(1) and 45 CFR 146.145(d)(1), under which a plan providing medical care, maintained by a partnership, and usually not treated as an employee welfare benefit plan under ERISA is treated as a group health plan for purposes of Part 7 of Subtitle B of Title I of ERISA and Title XXVII of the PHS Act.)

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.



# Federal Register

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Wednesday,  
December 13, 2006

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## Part III

### Department of the Treasury

Internal Revenue Service  
26 CFR Part 54

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### Department of Labor

Employee Benefits Security  
Administration  
29 CFR Part 2590

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### Department of Health and Human Services

Centers for Medicare & Medicaid Services  
45 CFR Part 146

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Nondiscrimination and Wellness  
Programs in Health Coverage in the  
Group Market; Final Rules

section clarifies that the wellness program does not violate this section if participation in the program is made available to all similarly situated individuals. If any of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, the wellness program does not violate this section if the requirements of paragraph (f)(2) of this section are met.

(1) *Wellness programs not subject to requirements.* If none of the conditions for obtaining a reward under a wellness program are based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness program does not violate this section, if participation in the program is made available to all similarly situated individuals. Thus, for example, the following programs need not satisfy the requirements of paragraph (f)(2) of this section, if participation in the program is made available to all similarly situated individuals:

(i) A program that reimburses all or part of the cost for memberships in a fitness center.

(ii) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

(iii) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits.

(iv) A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.

(v) A program that provides a reward to employees for attending a monthly health education seminar.

(2) *Wellness programs subject to requirements.* If any of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, the wellness program does not violate this section if the requirements of this paragraph (f)(2) are met.

(i) The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, must not exceed 20 percent of the cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses or spouses and dependent children) may participate in the wellness program, the reward must not

exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled. For purposes of this paragraph (f)(2), the cost of coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.

(ii) The program must be reasonably designed to promote health or prevent disease. A program satisfies this standard if it has a reasonable chance of improving the health of or preventing disease in participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease.

(iii) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

(iv) The reward under the program must be available to all similarly situated individuals.

(A) A reward is not available to all similarly situated individuals for a period unless the program allows—

(1) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(2) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

(B) A plan or issuer may seek verification, such as a statement from an individual's physician, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

(v)(A) The plan or issuer must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under paragraph (f)(2)(iv) of this section. However, if plan materials merely

mention that a program is available, without describing its terms, this disclosure is not required.

(B) The following language, or substantially similar language, can be used to satisfy the requirement of this paragraph (f)(2)(v): "If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward." In addition, other examples of language that would satisfy this requirement are set forth in Examples 3, 4, and 5 of paragraph (f)(3) of this section.

(3) *Examples.* The rules of paragraph (f)(2) of this section are illustrated by the following examples:

*Example 1.* (i) *Facts.* An employer sponsors a group health plan. The annual premium for employee-only coverage is \$3,600 (of which the employer pays \$2,700 per year and the employee pays \$900 per year). The annual premium for family coverage is \$9,000 (of which the employer pays \$4,500 per year and the employee pays \$4,500 per year). The plan offers a wellness program with an annual premium rebate of \$360. The program is available only to employees.

(ii) *Conclusion.* In this *Example 1*, the program satisfies the requirements of paragraph (f)(2)(i) of this section because the reward for the wellness program, \$360, does not exceed 20 percent of the total annual cost of employee-only coverage, \$720. ( $\$3,600 \cdot 20\% = \$720$ .) If any class of dependents is allowed to participate in the program and the employee is enrolled in family coverage, the plan could offer the employee a reward of up to 20 percent of the cost of family coverage, \$1,800. ( $\$9,000 \cdot 20\% = \$1,800$ .)

*Example 2.* (i) *Facts.* A group health plan gives an annual premium discount of 20 percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists solely of giving an annual cholesterol test to participants. Those participants who achieve a count under 200 receive the premium discount for the year.

(ii) *Conclusion.* In this *Example 2*, the program fails to satisfy the requirement of being available to all similarly situated individuals because some participants may be unable to achieve a cholesterol count of under 200 and the plan does not make available a reasonable alternative standard or waive the cholesterol standard. (In addition, plan materials describing the program are required to disclose the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) for obtaining the premium discount. Thus, the premium discount violates paragraph (c) of this section because it may require an individual to pay a higher premium based on a health factor of the individual than is required of a similarly situated individual under the plan.

<b>Premium Calculation</b>		
Base Plan Monthly Premium	\$450	(Use COBRA rate less 2%)
BCA Monthly Premium	\$50	(Use COBRA rate less 2%)
Total Monthly Premium	\$500	
Total Annual Premium	\$6,000	
20% of Premium	\$1,200	<i>This amount represents the maximum outcome-based penalty or reward allowed under HIPAA</i>
<b>Reward/Penalty Analysis</b>		
Value Per Credit	\$500	
Maximum Credits Available	\$2,000	<i>4 credits @ \$500 each</i>
Minimum Credits Available	\$800	<i>Maximum credits minus 20% of premium = Minimum Credits</i>
<b>Application of Credits</b>		
4 credits passed	\$2,000	This employee earned an amount that is equal to 20% of premium more than the minimum credit and is in compliance.
3 credits passed	\$1,500	This employee earned an amount that is equal to 11.6% of premium more than the minimum credit and is in compliance.
2 credits passed	\$1,000	This employee earned an amount that is equal to 3.3% of premium more than the minimum credit and is in compliance.
1 credit passed	\$500	Employee will be given an alternative way to earn \$300 in additional credit bringing the total of outcome based penalties to \$1200. Since they were not penalized >20% this is compliant.
0 credits passed	\$0	Employee will be given an alternative way to earn \$800 in additional credit bringing the total of outcome based penalties to \$1200. Since they were not penalized >20% this is compliant.
<i>Note: In all of the above scenarios employees will be given the opportunity to earn the FULL \$500 per category if attempting to achieve the stated goal is impossible or medically inadvisable.</i>		