SUBCHAPTER MM. WELLNESS PROGRAMS

28 TAC §§21.4701 – 21.4708

INTRODUCTION. The Texas Department of Insurance adopts amendments to 28 TAC Chapter 21, Subchapter MM, §§21.4701 - 21.4707 and new §21.4708, concerning wellness programs. The amendments and new sections are adopted with no changes to the proposed text published in the April 17, 2015, issue of the *Texas Register* (40 TexReg 2168).

REASONED JUSTIFICATION. The amendments and new section reflect updates adopted in the federal regulations addressing wellness programs, which are located in the U.S. Code of Federal Regulations at 45 CFR Parts 146 and 147.

The amendments to §§21.4701 - 21.4707 and new §21.4708 are necessary because before this adoption the Texas regulations were more restrictive than necessary in regard to options and incentives carriers and employers may provide to insureds in wellness programs and were no longer aligned with the comparable federal regulations. The Texas regulations were also unclear regarding applicability to health maintenance organization coverage, and they were inconsistent with the federal regulations in how the types of wellness programs were addressed.

In 2007, following the adoption of federal statutes and regulations addressing wellness programs, the Texas Legislature adopted Insurance Code §1501.107, which authorizes a small or large employer health benefit plan issuer to offer a plan participant an incentive for participating in a plan's wellness program. In 2009, TDI adopted the wellness rules in 28 TAC Subchapter MM to meet minimum federal requirements to maintain the state's regulation of wellness programs. In 2010, Congress amended the federal statutes addressing wellness programs, and the U.S. Department of Health and Human Services issued conforming federal regulations in June 2013. Those federal

regulations became effective January 1, 2014. With the adoption of the federal regulations, Texas rules for wellness programs became inconsistent with the federal requirements.

The federal regulations are applicable to small and large employer coverage, individual and group coverage, and health maintenance organization coverage. However, before the amendments adopted in this order, the Texas rules only addressed small and large employer coverage. Amendments to §§21.4701, 21.4703, and 21.4704 are necessary to address all the types of coverage addressed by the federal regulations.

The federal regulations now permit rewards of up to 30 percent of the value of the premium for participation in wellness programs (and up to 50 percent for programs designed to prevent or reduce tobacco use), while prior to this adoption order, §21.4707(1) only permited a maximum reward of 20 percent of the value of the premium. Amendments to §21.4707 are necessary to allow health benefit plan issuers in Texas to offer the full reward permissible under the federal regulations.

Under the federal regulations, a participant must receive the full wellness reward even if it takes the participant an extended time to satisfy the carrier's alternative wellness standards. However, prior to this adoption order, §21.4707(4)(ii) allowed health benefit plan issuers to require a participant to meet alternative standards in the same amount of time as under the standard program. Amendments to §21.4707 are necessary to harmonize the section with the federal regulations.

The federal regulations have three categories of programs: those that are participatory only, those that require activity, and those that require health-related outcomes. The federal regulations also only permit participatory programs in the individual health insurance market. Before this adoption order, Texas rules lumped

activity and outcome programs together and permitted them in all markets. Amendments to §21.4707 and new §21.4708 are necessary to make the Texas rule consistent with the federal regulations.

Under the federal regulations, outcome-based wellness programs must automatically provide access to alternative wellness standards for a participant who does not meet the plan's primary standard, regardless of whether the participant has a medical condition making it unreasonably difficult or medically inadvisable to satisfy the regular standard. However, prior to this adoption order, §21.4707 permitted a carrier to require that a participant demonstrate that meeting the plan's regular standard is unreasonably difficult. Amendments to §21.4707 and new §21.4708 are necessary to make the Texas rules consistent with the federal regulations.

The federal regulations require, in some instances, that a plan must accommodate a participant's personal physician's recommendation for reasonable alternative standards and that this must be disclosed to the participant. Prior to this adoption order, §21.4707 did not require a carrier to heed a physician's recommendation. As amended, §21.4707 harmonizes the state and federal rules.

The federal rules permit carriers to require verification by a physician for activity-only programs but do not permit it for outcome programs. Prior to this adoption order, §21.4707 permitted verification requirements for all programs. Amendments to §21.4707 and new §21.4708 are necessary to make the Texas rules consistent with the federal regulations.

The federal regulations provide sample notice language that differed from the sample notice language in §21.4707 as the section existed prior to this adoption order. It was necessary to remove the sample notice language in §21.4707 to avoid the conflict between §21.4707 and the federal regulations.

Amendments to §21.4701 expand applicability of Subchapter MM to include individual and group accident and health insurance policies and health maintenance organization evidences of coverage by inserting references to these types of coverage. In addition, amendments to §21.4703 and §21.4704 insert references to individual and group accident and health insurance policies and health maintenance organization evidences of coverage. Amendments throughout the sections also make nonsubstantive changes to the rule text for consistency with current TDI rule drafting style.

Amendments to §21.4707 revise the section heading to address “activity-only wellness programs.” An amendment to the section places the existing text of the section into subsection (b) and adds new subsection (a) in front of the existing text to clarify that a health-contingent wellness program that requires an individual to perform or complete an activity related to a health factor in order to obtain a reward, but that does not require the individual to attain or maintain a specific health outcome, is an activity-only wellness program. Amendments to §21.4707 also revise the existing text of the section to address activity-only wellness programs to track the related provision in the federal regulations. Amendments revise text addressing the size of reward, increasing the maximum value from 20 to 30 percent, and allowing a reward of up to 50 percent for programs designed to prevent or reduce tobacco use. The amendments also revise the text of provisions in the section addressing reasonable design, frequency of opportunity to qualify, uniform availability and reasonable alternative standards, and notice of availability of reasonable alternative standards. Finally, an amendment deletes from the text the specific language that could be used to satisfy the notice requirement.

New §21.4708 addresses outcome-based wellness programs and tracks federal requirements for this type of wellness program. Subsection (a) of the section clarifies

that "a health-contingent wellness program that requires an individual to attain or maintain a specific health outcome in order to obtain a reward is an outcome-based wellness program." Subsection (b) lists the requirements for an outcome-based wellness program, addressing size of reward, reasonable design, frequency of opportunity to qualify, uniform availability and reasonable alternative standards, and notice of availability of reasonable alternative standard.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI received no comments in response to the proposed text published in the April 17, 2015, issue of the *Texas Register* (40 TexReg 2168).

STATUTORY AUTHORITY. The amended sections are adopted under Insurance Code §§843.151, 1201.106, 1201.013, 1501.002, 1501.010, 1501.107, and 36.001.

Section 843.151 authorizes the commissioner to adopt reasonable rules as necessary to implement Insurance Code Chapter 843, and it includes authority for the commissioner to adopt rules necessary to meet the requirements of federal law and regulations.

Section 1201.006 authorizes the commissioner to adopt reasonable rules as necessary to implement the purposes and provisions of Chapter 1201, relating to the regulation of accident and health insurance.

Section 1201.013 provides that an insurer issuing an accident and health insurance policy may establish premium discounts, rebates, or a reduction in otherwise applicable copayments, coinsurance, or deductibles, or any combination of these incentives, for an insured who participates in programs promoting disease prevention, wellness, and health, and that a discount, rebate, or reduction established under this section does not violate Insurance Code §541.056(a).

Section 1501.010 defines “health benefit plan” to include evidence of coverage issued by a health maintenance organization that provides benefits for health care services.

Section 1501.010 authorizes the commissioner to adopt rules as necessary to implement Chapter 1501 to meet the minimum requirements of federal law.

Section 1501.107 provides that a small or large employer health benefit plan issuer may establish premium discounts, rebates, or a reduction in otherwise applicable copayments, coinsurance, or deductibles, or any combination of these incentives, in return for participation in programs promoting disease prevention, wellness, and health. A discount, rebate, or reduction established under this section does not violate Insurance Code §541.056(a).

Section 36.001 authorizes the commissioner to adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of Texas.

TEXT.

Subchapter MM. Wellness Programs

§21.4701. Applicability and Scope. This subchapter applies to any small employer health benefit plan issuer, any large employer health benefit plan issuer, any insurer issuing an individual or group accident and health insurance policy, or any health maintenance organization evidence of coverage, with respect to a policy or plan that establishes premium discounts, rebates, or reductions in otherwise applicable

copayments, coinsurance, or deductibles, or any combination of these incentives, in return for participation in programs designed to promote disease prevention, wellness, and health.

§21.4702. Definitions. The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Health status-related factor--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.

(2) Wellness Program--Any program designed to promote disease prevention, wellness, and health.

§21.4703. Wellness Programs Exception.

(a) Notwithstanding the provisions of Insurance Code Chapter 1501, §541.056(a) and §544.052, and the provisions of Chapter 26, Subchapter A of this title, an individual or group health benefit plan issuer, an accident and health insurance issuer, or a health maintenance organization may vary the amount of premium or contribution it requires similarly situated individuals to pay, or vary benefits, or both, including cost-sharing mechanisms such as a deductible, copayment, or coinsurance, based on whether an individual has met the standards of a wellness program that satisfies the requirements of §§21.4706, 21.4707, or 21.4708 of this title.

(b) Notwithstanding the provisions of Insurance Code §541.056(a) and §544.052, an insurer issuing an accident and health insurance policy may vary the amount of premium or contribution it requires similarly situated individuals or individuals of the same class and of essentially the same hazard to pay, or vary benefits, or both, including cost-sharing mechanisms such as a deductible, copayment, or coinsurance, based on whether an individual has met the standards of a wellness program that satisfies the requirements of §§21.4706, 21.4707, or 21.4708 of this title.

§21.4704. Purposes. The purposes of this subchapter are to provide for the circumstances under which, and the constraints within which, a group health benefit plan issuer, an accident and health insurance issuer, or health maintenance organization may:

(1) vary benefits, including cost-sharing mechanisms such as a deductible, copayment, or coinsurance, based on whether an individual has met the standards of a wellness program that satisfies the requirements of §§21.4706, 21.4707, or 21.4708 of this title; or

(2) vary the amount of premium or contribution it requires similarly situated individuals to pay based on whether an individual has met the standards of a wellness program that satisfies the requirements of §§21.4706, 21.4707, or 21.4708 of this title.

§21.4705. General Provisions Applicable to Wellness Programs.

(a) Wellness programs as set out in this subchapter are excepted from the general prohibitions against discrimination based on a health status-related factor for plan provisions that vary benefits, including cost-sharing mechanisms, or the premium or contribution for individuals eligible for plan coverage, in connection with participation in such a wellness program.

(b) A wellness program must be reasonably designed to promote disease prevention, wellness, and health. A program satisfies this standard if it:

(1) has a reasonable probability of improving the health of, or preventing disease in, participating individuals;

(2) is not overly burdensome;

(3) is not a subterfuge for otherwise prohibited discrimination based on a health status-related factor; and

(4) is not highly suspect in the method chosen to promote disease prevention, wellness, and health.

(c) A wellness program must comply, as applicable, with Insurance Code §1701.061 and provisions of rules codified in this title relating to Insurance Code §1701.061 and the administration of noninsurance benefits.

§21.4706. Wellness Programs with Participation as Sole Basis for Reward Eligibility.

(a) A wellness program that contains no condition for obtaining a reward premised on an individual satisfying a standard associated with a health factor does not

violate this subchapter so long as the status-related program is made available to all individuals eligible for coverage under the plan.

(b) Wellness programs meeting the description of this section would include the following program types:

(1) a program that reimburses all or part of the cost for membership in a fitness center;

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

(3) a program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan or individual policy for the costs of a particular preventive care item or items;

(4) a program that reimburses covered individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking; or

(5) a program that provides a reward to covered individuals for attending a monthly health education seminar.

§21.4707. Activity-only Wellness Programs.

(a) A health-contingent wellness program that requires an individual to perform or complete an activity related to a health factor in order to obtain a reward but does not require the individual to attain or maintain a specific health outcome is an activity-only wellness program.

(b) An activity-only wellness program does not violate this subchapter so long as the requirements of this section are met.

(1) Size of reward. The reward for the activity-only wellness program, coupled with the reward for other health-contingent wellness programs offered under the same plan, must not exceed in total value 30 percent of the cost of employee-only or member-only coverage under the plan; or 50 percent of the cost of employee-only or member-only coverage under the plan if the program includes a program designed to prevent or reduce tobacco use, except that no more than 20 percent of the reward may be attributable to the tobacco use program. However, if, in addition to employees or members, any class of dependents – such as spouses or spouses and dependent children – may participate in the activity-only wellness program, the reward must not exceed 30 percent of the cost of the coverage in which an employee or member, and any dependents, are enrolled; or 50 percent of the cost of the coverage in which an employee or member, and any dependents, are enrolled, to the extent that the additional 20 percent is in connection with a program designed to prevent or reduce tobacco use.

(A) For purposes of this section, the cost of coverage is determined based on the total amount of employer and employee contributions toward the cost of coverage, or member contributions toward the cost of coverage, for the benefit package under which the employee or member is, or the employee or member and any dependents are, receiving coverage.

(B) 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.

(2) Reasonable design. The activity-only wellness program must meet the criteria set out in §21.4705 of this title. This determination is based on all the relevant facts and circumstances.

(3) Frequency of opportunity to qualify. The activity-only wellness program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

(4) Uniform availability and reasonable alternative standards. The full reward under the activity-only wellness program must be available to all similarly situated individuals.

(A) A reward under this section is available to all similarly situated individuals for a period so long as the program allows, at a minimum:

(i) 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 or other health status-related factor to satisfy the otherwise applicable standard; and

(ii) 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) To the extent that a reasonable alternative standard under an activity-only wellness program is an activity-only wellness program, it must comply with the requirements of this subtitle in the same manner as if it were an initial program standard. To the extent that a reasonable alternative standard under an activity-only wellness program is an outcome-based wellness program, it must comply with the requirements of §21.4708 of this title.

(C) If reasonable under the circumstances, a plan or issuer may seek verification, such as a statement from an individual's personal physician, that the medical condition or other health status-related factor makes it unreasonably difficult for the individual to satisfy or attempt to satisfy the otherwise applicable standard of an activity-only wellness program. Plans and issuers may seek verification with respect to requests for a reasonable alternative standard for which it is reasonable to determine that medical judgment is required to evaluate the validity of the request.

(5) Notice of availability of reasonable alternative standard. The health benefit plan or policy, or health benefit plan or policy issuer, must disclose, in all plan materials describing the terms of an activity-only wellness program, the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard required under paragraph (4) of this subsection), including contact information for obtaining a reasonable alternative standard and a statement that recommendations from an individual's personal physician

will be accommodated. If plan materials merely mention that an alternative program is available, without describing its terms, this disclosure is not required.

§21.4708. Outcome-Based Wellness Programs.

(a) A health-contingent wellness program that requires an individual to attain or maintain a specific health outcome in order to obtain a reward is an outcome-based wellness program.

(b) An outcome-based wellness program does not violate this subchapter so long as the requirements of this section are met.

(1) Size of reward. The reward for the outcome-based wellness program, coupled with the reward for other health-contingent wellness programs with respect to the plan, must not exceed in total value 30 percent of the cost of employee-only or member-only coverage under the plan; or 50 percent of the cost of employee-only or member-only coverage under the plan, to the extent that the additional 20 percent is in connection with a program designed to prevent or reduce tobacco use. However, if, in addition to employees or members, any class of dependents – such as spouses or spouses and dependent children – may participate in the outcome-based wellness program, the reward must not exceed 30 percent of the cost of the coverage in which an employee or member and any dependents are enrolled; or 50 percent of the cost of the coverage in which an employee or member and any dependents are enrolled, to the extent that the additional 20 percent is in connection with a program designed to prevent or reduce tobacco use.

(A) For purposes of this section, the cost of coverage is determined based on the total amount of employer and employee contributions toward the cost of coverage, or member contributions toward the cost of coverage, for the benefit package under which the employee or member is, or the employee or member and any dependents are, receiving coverage.

(B) 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.

(2) Reasonable design. The outcome-based wellness program must be reasonably designed to promote health or prevent disease. An outcome-based wellness 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. This determination is based on all the relevant facts and circumstances. To ensure that an outcome-based wellness program is reasonably designed to improve health and does not act as a subterfuge for underwriting or reducing benefits based on a health factor, a reasonable alternative standard to qualify for the reward must be provided to any individual who does not meet the initial standard based on a measurement, test, or screening that is related to a health factor, as explained in paragraph (4) of this subsection.

(3) Frequency of opportunity to qualify. The outcome-based wellness program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

(4) Uniform availability and reasonable alternative standards. The full reward under the outcome-based wellness program must be available to all similarly situated individuals.

(A) Under this paragraph, a reward under an outcome-based wellness program is not available to all similarly situated individuals for a period unless the program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual who does not meet the initial standard based on the measurement, test, or screening, as described in this paragraph.

(B) To the extent that a reasonable alternative standard under an outcome-based wellness program is an activity-only wellness program, it must comply with the requirements of §21.4707 of this title in the same manner as if it were an initial program standard. To the extent that a reasonable alternative standard under an outcome-based wellness program is another outcome-based wellness program, it must comply with the requirements of this section, subject to the following requirements:

(i) The reasonable alternative standard cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual’s circumstances.

(ii) An individual must be given the opportunity to comply with the recommendations of the individual's personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the plan or issuer, but only if the physician joins in the request. The individual can make a request to involve a personal physician's recommendations at any time, and the personal physician can adjust the physician's recommendations at any time, consistent with medical appropriateness.

(C) It is not reasonable to seek verification under an outcome-based wellness program, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard as a condition of providing a reasonable alternative to the initial standard. However, if a plan or issuer provides an alternative standard to the otherwise applicable measurement, test, or screening that involves an activity that is related to a health factor, then the requirements of §21.4707 of this title for activity-only wellness programs apply to that component of the wellness program, and the plan or issuer may, if reasonable under the circumstances, seek verification that it is unreasonably difficult due to a medical condition for an individual to perform or complete the activity or it is medically inadvisable to attempt to perform or complete the activity.

(5) Notice of availability of reasonable alternative standard. The plan or issuer must disclose in all plan materials describing the terms of an outcome-based wellness program, and in any disclosure that an individual did not satisfy an initial

outcome-based standard, the availability of a reasonable alternative standard to qualify for the reward and, if applicable, the possibility of waiver of the otherwise applicable standard, including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on July 2, 2015.

Sara Waitt
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Texas Department of Insurance

The commissioner adopts amendments to §§21.4701 - 21.4707 and new §21.4708.

David C. Mattax
Commissioner of Insurance

COMMISSIONER'S ORDER NO. **4034**