# More On HIPAA…
## *HIPAA's Nondiscrimination Rules*
### By: Dorothy M. Cociu, RHU, REBC

Just when we think it's really over, we discover it's only just begun. But with each new piece of legislation or introduction of new regulations, it all just seems a bit more than we can keep up with. And this is our business. Think about how it is for our clients out there, who depend on us to guide then through this maze of confusion…. So we do what we have to do. We roll up our sleeves and dive into it. And hope we come out on top of the surf that's pounding around us, and not buried underneath.

So what can we count on with HIPAA? Lots of new regulations….This last batch is related to the nondiscrimination rules. And just when I finish this article, the new Medical Records Privacy rules should be about at our fingertips. But, one thing at a time. Tomorrow is, after all, another day.

**Background and General Information**
The interim final rules and proposed regulations for the nondiscrimination regulations of HIPAA were released on January 8, 2001. The interim final regulations are applicable the first plan year on or after July 1, 2001, unless the provisions were covered in earlier rules, in which case they were effective May 8, 2001. The interim regulations allow for good faith compliance prior to 7/1/01.

Church plans and some governmental plans, if they meet specified requirements, may opt out of the nondiscrimination rules, and special transition rules apply.

In general, ***HIPAA prohibits health plans from discriminating on the basis of any of the following health factors***, as they relate to eligibility, premiums, or contributions:

- Health status
- Medical condition, physical or mental illnesses
- Genetic information
- Receipt of care
- Medical history
- Claims experience
- Evidence of insurability
- Disability

Evidence of insurability includes (i) conditions arising out of acts of domestic violence; and (ii) participation in hazardous activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, an other similar activity.[1]

The regulations include provisions relating to actively at work requirements, non-confinement clauses, benefit discrepancies between similarly situated individuals, benefit exclusions, waiting periods, and permissible wellness programs.

The interim regulations clarified that they do not require a plan or issuer to provide coverage for any particular benefit to any similarly situated individuals. Benefits must be uniformly available to all similarly situated individuals.

**Prohibited Discrimination in Rules for Eligibility**
A group health plan or issuer offering health coverage in a group plan may not establish any rule for eligibility, including continued eligibility, of any individual to enroll for benefits under the terms of the plan that discriminates based on any health factor that relates to that individual or dependent of that individual.

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[1] Nondiscrimination Interim Final DOL Reg. Section 2590.702

Rules for eligibility include, but are not limited to, rules relating to:

- Enrollment
- Effective date of coverage
- Waiting periods or affiliation periods
- Late enrollment or special enrollment
- Eligibility for benefit packages, including rules to change selections of plans or benefits
- Benefits, co-payments, coinsurance or deductibles
- Continued eligibility
- Terminating coverage, including disenrollment

Benefits must be uniformly available to all similarly situated individuals. Restrictions must also be made uniformly and may not be directed at individuals. A plan or health issuer may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants. [2]

**Interaction With Pre-existing Condition Exclusions and the Nondiscrimination Provisions**

The new regulations address the interaction between pre-existing conditions exclusions and the nondiscrimination rules. In general, you may allow for pre-existing conditions exclusions within the allowable terms of HIPAA. You may not, however, discriminate *within* pre-existing conditions exclusions based on health factors, such as imposing a pre-existing clause for the first time after a large claim is filed. The pre-existing limitation cannot be directed at individuals; the exclusion must be applicable to all similarly situated individuals. You may incorporate different treatment of late enrollees as long as such treatment complies with HIPAA's late enrollee rules and meets all nondiscrimination rule requirements.

Group health plans are restricted from applying a pre-existing condition exclusion by restricting circumstances under which the condition is considered pre-existing and by limiting the length of the exclusion period. A pre-existing condition is said to have satisfied HIPAA's nondiscrimination requirements if the exclusion applies uniformly to all individuals within the same group of similarly situated individuals and is not directed at individual participants based on health factors.

**Discrimination in Premiums or Contributions**

Differentiation of coverage or contribution rates appear to be permissible under HIPAA's nondiscrimination rules, as long as there is a bona fide reason for the difference. Differentiations between full-time and part time employment, coverage limits for exempt or non-exempt, or collectively bargained or non-union, appear to be acceptable. You cannot discriminate based on a health factor, however, or set up your benefit plans so that they have the effect of discriminating, unless there is a bona fide reason for the difference.

HIPAA *does not* limit the carrier's right to rate groups based on health status, as long as the premium rate is blended for all employees.[3] HIPAA prohibits quotes that break out the cost for specific individuals based on health status. List bills are prohibited.[4] Note that certain state laws may limit a carrier's flexibility in the setting of rates; these laws must still be followed when appropriate by carriers and HMO's.

HIPAA *does not* exclude age rating. Issues may pertain to the Age Discrimination in Employment Act of 1967, however. The employer must show that the plan is bona fide, that the differential is made to observe the terms of the plan, and that the differential is actuarially based and not a subterfuge for discrimination. Hence, it must be based on valid and reasonable cost data.

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[2] Interim Final DOL Reg. Section 2590.702(b)(1)(iii)
[3] Interim Final DOL Reg. Section 2590.702(c)(2)(i)&(iii)
[4] Interim Final DOL Reg. Section 2590.702(c)(2)(ii)-(iii)

A group health plan or health plan issuer may not require an individual as a requirement of enrollment or continued enrollment under a group health plan to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual or dependent of that individual, based on any health factor that relates to that individual. Discounts, rebates, payments in kind or other premium differential mechanisms are taken into account. Bona fide wellness programs have certain special exceptions.

**Benefit Limitations**

The new regulations clarify that plans are not required to provide coverage for any particular illness, injury, or condition. The nondiscrimination provisions generally allow for plan design limits that affect participants, by permitting such limitations, but exclusions addressed at a specific participant are not allowed. It appears to be acceptable to make plan changes or limitations at the next plan renewal following a large claim, but not immediately after the claim is filed or known, as long as the limitation does not violate the Americans With Disabilities Act or other acts. (State law may specifically require insurers or HMO's to provide coverage for certain illnesses, for example).

In the case of similarly situated employees, benefits may be different for different groups of similarly situated employees as long as limitations are not directed at specific individuals. HIPAA uses "facts and circumstances" to determine appropriate measures regarding benefit limitations. A "safe harbor" for benefit limitations will be implemented in 2002. It appears that certain maximums will be allowable, such as a lifetime maximum, or a treatment maximum (such as speech therapy or hearing aids, TMJ, chiropractic or other maximums). Disease or injury caps placed on a specific injury or individual after a claim is filed, however, appears to violate the law. The regulations show how this can be complicated. You can decide not to cover TMJ, but not congenital heart disease, apparently because anyone can develop TMJ, but only those with a birth defect have congenital heart disease. (Keep in mind that state laws may mandate coverage for certain benefits, treatments, illnesses, etc., and theses laws would still apply to carriers and HMO's.)

All benefits must be the same for similarly situated employees and beneficiaries.

You can differentiate between groups of similarly situated individuals, so long as that differentiation is not based on health status. Distinctions must be bona fide, and not a subterfuge for separating out those individuals with health factors.

When deciding to carve out benefit programs for different groups of individuals, the employer should also consider the ADA and ADEA requirements. Other benefits may be at issue, such as a cafeteria plan or if the plan is self-funded, there may be discrimination testing issues which need to be considered.

HIPAA does not obligate an employer or carrier to cover all illnesses, diseases, or injuries. The regulations state "…a plan or issuer may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries…"[5]

When deciding not to cover a particular disease, illness or injury, the employer must be careful that the exclusion applies to all similarly situated individuals.

A plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at individual beneficiaries or participants.

[5] Preamble and Interim Final DOL Reg. Section 2590.702 (b) (2) (i) (B)

**Source of Injury Restrictions**
The regulations equate participation in certain dangerous activities, such as bungee jumping, sky-diving or horseback riding, and victims of domestic violence, to "evidence of insurability," which is deemed a health factor. In general, you cannot refuse to enroll someone or otherwise discriminate against them based on evidence of insurability. A plan can, however, exclude coverage for injuries received while someone is engaging in a hazardous activity, such as skiing or snowmobiling. The plan may also be designed to prohibit coverage for self-inflicted injuries (as long as they do not arise from a medical or mental illness, such as depression), or commission of a felony. The plan may not, however, refuse to cover injuries sustained as a result of an act of domestic violence or a physical or mental illness.

These source of injury restrictions should be discussed in detail with plan issuers, plan administrators and your legal counsel, as many of these provisions are complex and may also be affected by state law.

These new rules will have some potential for litigation or challenge, and I discussed some of these areas with John Hickman, LLP, of Alston & Bird in Atlanta, a partner in a top HIPAA compliance law firm. Potentially litigious issues include "Fairly common exclusions for dangerous activities, commission of a crime, drug and alcohol abuse and what have you [are potential problems]. The issue here is that if it can be established that the provision is conditioned on a health condition, and maybe it is a limitation or exclusion for driving under the influence, or use of illegal substances, or perhaps a suicide limitation or exclusion, then you will have a similar situation, where the participants in a lawsuit are able to demonstrate that the exclusion is *tied directly* to a health status condition, and therefore is impermissible under HIPAA, but the employer's plan contains language, which may have been perfectly legal language a couple of years ago, but language which under the new regulations is no longer allowed."

**Non-confinement Clauses**
Plans cannot restrict eligibility based on hospital confinement or inability to perform "normal life" activities. Simply stated, you cannot restrict eligibility or set rates based on a participant's confinement in a medical facility or on a participant not being able to perform "normal life activities" of someone of like age or circumstance.

One exception does exist pertaining to normal life activities, however. A plan or issuer may not establish a rule for eligibility or set any individual's ability to engage in normal life activities, except to the extent that is permitted to distinguish among employees based on the performance of services[6].

**Actively At Work Limitations**
Probably the most wide-reaching change in the marketplace may relate to the new actively at work limitations. Provisions which deny or exclude coverage because of a participant not actively at work must be removed from plans. In reality, the regulations allow you to keep the AAW provisions, as long as you treat them as if they are actively at work; therefore, there is no benefit to keeping the AAW provision.

In general, you cannot have conditions in which eligibility is based on AAW (or premiums or contributions), or for union or multiple employer plans, cannot use continuous service provisions. It is acceptable to have coverage which is not effective until the participant completes a certain number of days or hours at work, but you cannot have coverage effective only after a number of days of continuous service. You are allowed to have coverage effective after you've performed 90 days of services at work (keep in mind that this means greater than 90 days in total; there is approximately 67 working days in a 90 day period). A plan is allowed to have a 90 day waiting period (or any number of days) if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring the 90 days of continuous service.

The potential greatest liability or risk for employers is in connection with the actively at work limitation or exclusion, according to Mr. Hickman. "I imagine that there will be many employers out there who continue to have actively at work exclusions or limitations in their plans, and possibly some stop loss carriers or underwriters that will require that the plan be administered in accordance with its term. So even

[6] Nondiscrimination Interim Regulations, Section 2590.702 (e)(1)(i)

though HIPAA requires that someone be extended eligibility or coverage, that the individual in a lawsuit against the employer or against the plan would be entitled to be eligible for benefits under the plan, you may have a situation where there is no underlying stop loss coverage, because the stop loss carrier relies on the pre-HIPAA AAW exclusion or limitation in the plan that the employer can no longer enforce. In this area, updating the document, making sure that people are not excluded because of an actively at work provision, is key. If you want a similar but legally permissible provision, provide in the plan document [for an] hours of service, not an hours of continuous service, but a days of service or hours of service requirement, before coverage kicks in. I think that is the most important change to make."

**Wellness Programs**

Although HIPAA generally prohibits plans from having varying benefits based on health status, the nondiscrimination rules do allow for coverage variations to promote wellness under a bona fide wellness program. These rules, however, seem to have the greatest amount of "gray areas" of the new regulations. "Probably the most gray, or unworkable areas of the regulations is the proposed wellness regulations," said John Hickman. "The agencies admit as much in the preamble to the regulations... The individual accommodation rule is totally subjective, and from a plan administrator's standpoint, is very much unworkable."

Requirements for bona fide wellness programs apply only to wellness programs which provide a reward based on the ability to meet a standard that is related to a health factor, such as a reward conditioned on the outcome of a cholesterol or other test. Employers and plans can have a wellness program without complying with the requirements for a bona fide wellness program, however. Wellness programs that do not condition eligibility upon the ability to meet a health standard are permissible. Examples include:

- voluntary testing of enrollees for specific health conditions and make recommendations to address those health conditions, if the program does not base its reward on the outcome of the health assessment
- encouraging preventive care for participation in a pre-natal program through a waiver of the co-payment or deductible required for well-baby visits
- reimbursing employees for the costs of health club memberships
- reimbursing employees for the cost of smoking cessation programs, without regard to the outcome.

The exception to the rule prohibiting discrimination based on health factors pertains to a reward, such as a discount in premiums of waiving certain cost containment/cost sharing requirements, if such award is based on participation in a program of health promotion or disease prevention.

***Bona Fide Wellness Programs***

According to the proposed regulations, a wellness program must meet four requirements to be a bona fide wellness program (a wellness program that provides a "reward" based on the ability to meet a standard related to a health factor):

- The total reward that may be given to a plan participant for all wellness programs is limited. Rewards can be in the form of a discount, a rebate of a premium or contribution, or a waiver of all or part of a cost-sharing mechanism, such as a co-payment, deductible, coinsurance, or the absence of a surcharge. The reward must not exceed 20% of the cost of employee-only coverage under the plan (the cost of employee-only coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is receiving coverage);
- The program must be reasonably designed to promote good health or disease prevention. Participants must be allowed to re-qualify at least once per year;
- Be available to all similarly situated individuals, and you must make reasonable accommodations to allow for participation of those who may not meet the health standard;
- All plan materials describing the terms of the plan must disclose the ability of a reasonably alternative standard, i.e. a written notice of such accommodations.[7]

[7] Proposed Regulations on Bona Fide Wellness Programs, Preamble. 26 CFR Part 54, Reg 114084-00, RIN 1545-AY34; 29 CFR Part 2590, RIN 1210-AA77; 45 CFR Part 146, RIN 0938-AK19. Footnote relates to wellness items stated above this footnote.

The proposed regulations provide the following examples of permissible wellness programs:

- A bonus or discount for cholesterol levels below 200 as long as the program includes a provision allowing those medically unable to comply to discuss alternatives;
- A bonus or discount program for a specified body mass index as long as it allows for alternative qualification based on walking 20 minutes 3 days per week;
- A bonus for "tobacco free" employees that allows for alternative qualification based on enrollment in a smoking cessation program.

**Enforcement and Carrier Compliance**

Many Plan document changes should occur prior to January 1, 2002 for a calendar year plan for compliance with the nondiscrimination rules. You should seek the advice of your legal counsel for self-insured plan amendments and interpretations. Carriers should be compliant, but it has been my experience that carriers are often slow in getting the required plan changes implemented.

When asked what the carriers are doing to comply, Mr. Hickman discussed the status or fully insured and self-insured plans. Most larger self-insured plans, he felt, have already made many of the required changes with the other HIPAA changes in 1997/1998, while those remaining were waiting for the regulations. The state of compliance for small self-insured plans is pretty dismal. Self-insured plans generally have greater liability and are typically expected to comply more rapidly than a fully insured plan.

"Fully insured plans will also be required to come into compliance… The requirement applies both to the employer's plan and the health insurance issuer. In the context of the fully insured market, obviously there may be a situation where an employer is sued because they excluded someone, but to the extent that there is a HIPAA obligation, it should also be passed on to the insurance carrier. The employer, to the extent there is an insurance contract, ought to be able to thrust that liability, not the cost of the suit, but the liability for the actual claim, back on to the insurance carrier. I don't have as much of a fear or concern in the fully insured market, because for the most part, the carriers will be required to put those provisions in their plans."

I asked Mr. Hickman what he thought about the speed of compliance with the carrier market. "I think that the states and federal enforcement will take a while to catch up. There will be some carriers who continue to operate without the legally required changes, and it make take a little while. Looking back at the HIPAA portability provisions, and the pre-existing conditions provisions… Two or three years after the passage and effective date of HIPAA, [which was effective] in 1997, as late as 1999 or early 2000, we were still reviewing plans that had provisions that were not in compliance with pre-existing condition exclusion requirements. I think there will be a time-lag where some of the carriers and carriers' products are out of compliance."

When asked about the broker's role in all this, Mr. Hickman replied "I think as far as the brokers and agents are concerned, where they have fully insured clients, they might want to be a little more pro-active, to review the terms of their policies, and perhaps bring it up with their carrier representatives to ask how the carrier is addressing these [types of plan change issues]. The bigger carriers will likely have their uniform changes and updated certificates done prior to the effective date." The smaller, regional carriers, however, may take a bit longer.

The states, I've found, have been sometimes slow at addressing the federal issues and enforcing them. "It's a problem with our overlapping federal/state structure of government," replied Mr. Hickman, "in the sense that with the federal mandates, the states typically have enforcement jurisdiction over insurance products, but when it comes to federal mandates, the states look to HHS, and HHS, other than issuing a couple of bulletins here and there about improper carrier practices, on the enforcement front has not been real active."

The recent auditing by the Department of Labor may, however, speed up the process. Most DOL offices feel that they will add HIPAA's nondiscrimination rules to the list of audited items within one year of the effective date, or as early as this July.

So, I guess that leaves it up to us, to help our clients to figure out the myriad of new laws and regulations. So, roll up your sleeves and dig in. We have no time to get comfortable, just yet. ##

*Dorothy M. Cociu, RHU, REBC, is the current Legislative Chair for NAHU's Region 6, and is the Immediate Past President of the California Association of Health Underwriters. She is the author of The ABC's of HIPAA Compliance; An Employer's Simplified Guide to HIPAA Compliance. For information on this manual, call (888) 288-0164, or to speak with Dorothy, call (714) 870-8651, Ext. 3#.*

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