ABC's HIPAA News!

Summer, 2007

Guidance Issued on HIPAA Nondiscrimination Rules and Wellness Programs; Final Rules Effective Plan Years on or After July 1, 2007

On December 13, 2006, The Departments of Treasury, Labor, and Health and Human Services issued their Final Rules for the Nondiscrimination and Wellness Programs in Health Coverage in the Group Market (71 Fed. Reg. 75014). Many of the provisions have not changed since ABC reported on these provisions in 2001. However, on June 27, two separate regulations were released to provide guidance on the nondiscrimination provisions under HIPAA, and FAQ's were released on June 27, 2007 and July 2, 2007.

History on the regulations:

The regulations were published in the Federal Register on January 8, 2001(interim final nondiscrimination rules and proposed bona fide wellness program rules 66 Fed Reg. 1378 – nondiscrimination, and 66 Fed. Reg. 1421 - wellness). The effective dates were the first plan year beginning on or after July 1, 2001. Public comments on the interim final and proposed rules were to be submitted by April 9, 2001.

On December 13, 2006, The Final Rules were published. The final rules generally restate the interim rules, but offer clarifications on source-of-injury exclusions, carryovers under health reimbursements arrangements (HRA's), state extension interactions with HIPAA's non-confinement rule, and the interactions of other laws, including the Americans with Disabilities Act (ADA). New requirements were also added for wellness programs, which are to be permissible under the HIPAA nondiscrimination rules. The effective date of the final rules is the first of the plan year beginning on or after July 1, 2007.

General Background:

HIPAA's nondiscrimination provisions *generally prohibit a group health plan or group health insurance issuer from denying an individual eligibility for benefits based on a health factor, and from charging an individual a higher premium than a similarly situated individual based on a health factor.* Health factors include health status, medical conditions (physical, and mental health), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. The term "evidence of insurability" includes conditions arising from acts of domestic violence, as well as participation in activities such as motorcycle riding, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities. *The nondiscrimination rules also generally prohibit plans from charging similarly situated individuals different contributions or imposing different deductible, co-payment or other cost sharing requirements based on a health factor.*

Newer Items/Clarifications:

Source of Injury Rules – Although ABC has previously discussed this in our HIPAA manual, new clarifications have been issued. Under HIPAA's nondiscrimination rules, a health plan may not exclude an individual from coverage simply because they engage in hazardous activities, such as snowmobiling, skiing, or bungee jumping. Participation in those activities relates to an individual's evidence of insurability, which is a protected health factor. However, HIPAA does NOT prevent a health plan from imposing limits on medial expenses that these individuals might sustain from participating in hazardous activities. A health plan *must allow* an individual who participates in dangerous activities to participate in the health plan for products and services that the plan offers in its normal benefit package, but the plan *can* be designed to NOT cover injuries (or impose limits) that result from an accident from such activities. We have reported this previously, but additional guidance is now available.

The final regulations retain the provisions in the 2001 interim rules and add a clarification. Some inquiries related to whether a suicide exclusion can apply if an individual had not been diagnosed with a medical condition such as depression before a suicide attempt. The final regulations clarify that *benefits may not be denied for injuries resulting from a medical condition even if the medical condition was not diagnosed before the injury.*

HRA's – The final regulations clarify that amounts carried forward under a health reimbursement account from one year to the next will not violate the nondiscrimination requirements simply because a healthy individual may be able to carry forward a larger dollar amount than a less healthy participant, who may have exhausted completely or most of his balance in his or her HRA to pay for needed medical expenses.

Delays in Coverage/Non-confinement Clauses and State Law Impacts- HIPAA prohibits health plans from delaying coverage for an employee who has started work because a medical condition prevents the employee from being actively-at-work on the date that coverage would otherwise have begun. HIPAA also prohibits health plans from delaying an individual's coverage because of that individual's hospitalization. Under some state laws, a prior issuer has the obligation to provide health benefits to an individual confined in a hospital beyond the nominal end of the policy only if the hospitalization is not covered by a succeeding issuer. Because HIPAA requires the succeeding issuer to provide benefits that would otherwise provide if not for the non-confinement clause, in such case State law would *not* require the prior issuer to provide benefits for a confinement beyond the nominal end of the policy. According to the Federal Register[1], there has been some dispute about how this potential ambiguity should be resolved. One interpretation is that the succeeding issuer can never impose a non-confinement clause, and if this has the effect under State law of not requiring the prior issuer to provide benefits beyond the nominal end of the policy, then the prior issuer is not obligated to provide the extended benefits. This interpretation, according to the Federal Register, is consistent with the text of the non-confinement rule and the main point of example 2 of the regulations, though it could be read to conflict with the last sentence in example 2 of the regulations.

Another interpretation proposed by some is that, consistent with the last sentence of example 2, the obligation of a prior issuer is never affected by the HIPAA prohibition against non-confinement clauses. There is discussion that this interpretation is contrary to the intent of the 2001 interim rules.

To avoid other interpretations, the final rules have replaced the final sentence of example 2 in the 2001 interim rules with three sentences. The new language clarifies that: *State law cannot change the succeeding issuer's obligation under HIPAA; a prior issuer may also have an obligation; and in a case in which a succeeding issuer has an obligation under HIPAA and a prior issuer has an obligation under State law to provide benefits for a confinement, any State laws designed to prevent more than 100% reimbursement, such as State coordination-of-benefits laws, continue to apply.* Thus, under HIPAA **a succeeding issuer cannot deny benefits to an individual on the basis of a non-confinement clause**.[2]

[1] Federal Register, Volume 71, No. 239, 75016
[2] Federal Register, Volume 71, No. 239, 75016

Actively-at-Work Rules and Employer Leave Policies - The final regulations make no changes to the 2001 interim rules relating to actively-at-work provisions. Actively-at-work clauses are generally prohibited, unless individuals who are absent from work due to any health factor are treated, for purposes of health coverage, as if they are actively at work. Nonetheless, a plan or issuer may distinguish between groups of similarly situated individuals, provided the distinction is not directed at individual participants or beneficiaries based on a health factor.

Relationship Between HIPAA and ADA- The relationship between HIPAA's nondiscrimination rules and the ADA has been unclear in the past. The final nondiscrimination rules expressly state that the HIPAA rules do not affect application of ADA requirements or the rules under other laws. This means that practices under HIPAA nondiscrimination rules may indeed, violate ADA requirements, particularly related to wellness programs. We anticipate additional clarifications here.

Wellness Programs- The HIPAA non-discrimination rules generally prohibit group health plans from *charging* similarly situated individuals different premiums or contributions or imposing different deductibles, co-payments or other cost sharing requirements based on a health factor. The final regulations also generally prohibit a plan or issuer from *requiring similarly situated individuals to satisfy* differing deductibles, co-payments or other cost-sharing requirements. However, the HIPAA nondiscrimination rules *do not prevent* a plan or issuer from establishing premium discounts or rebates or modifying otherwise applicable co-pays or deductibles in return for adherence to programs of health promotion and disease prevention; i.e, wellness programs.

In general, if none of the conditions for obtaining a reward under a wellness program are based on an individual satisfying a standard related to a health factor, or if no reward is offered, wellness programs comply with the HIPAA non-discrimination requirements, assuming the wellness program is available to all similarly situated individuals.

Wellness programs must meet five specific criteria:

- The reward for all wellness programs cannot exceed 20% of the total employee and employer cost of coverage under the plan. Rewards can vary in format, however, including discounts in employee contributions or reductions in deductibles or co-pays.
- The wellness program must be reasonably designed to promote good health or prevent disease.
- The program must give individuals the opportunity to qualify for the reward at least once per year, including when first eligible.
- Where rewards are conditioned on satisfaction of a standard related to a health factor, rewards must be available to all similarly situated individuals. The program must make a reasonable alternative approach for obtaining the reward available to individuals who, for medical reasons, find it unreasonably difficult or inadvisable to achieve the applicable standard.
- The program must disclose the availability of an alternative in all materials that describe the wellness program.

Examples of compliant wellness programs include:

- A program that reimburses all or part of the cost of membership(s) to a fitness center
- A diagnostic testing program that provides a reward for participation rather than outcomes
- A program that encourages preventative care by waiving co-pays or deductibles for the cost of wellness benefits, such as prenatal visits or well-baby visits
- A program that reimburses employees for the cost of smoking cessation programs without regard to whether the employee quits smoking
- A program that provides a reward to employees for attending a monthly health education seminar[3]

Only programs under which any of the conditions for obtaining a reward is based on an individual satisfying a standard related to a health factor must meet the five additional requirements above.

[3] Federal Register, Volume 71, No. 239, 75018

Limits on Rewards - The total reward that may be given to an individual under the plan for all wellness programs is limited. A reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of such cost-sharing mechanisms (such as deductibles, co-pays or coinsurance) the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.

Keep in mind that wellness programs that condition a reward on an individual satisfying a standard related to a health factor must meet five requirements in order to comply with the HIPAA non-discrimination provisions.

Prohibited Discrimination in Premiums or Contributions - In general, a group health plan may not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on any health factor that relates to the individual or a dependent of the individual.

Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate.

Nothing in the regulations restricts the aggregate amount that an employer may be charged for coverage under a group health plan. However, a group health plan may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. Rates may be blended, however, due to claims experience (and therefore not charging more for a high-cost participant). [4]

Exceptions to the HIPAA Non-discrimination Rules - HIPAA provides an exception for church plans that have met specified criteria since July 15, 1997. Church plans may require evidence of insurability if the plan either requires evidence of insurability from both employees (for employers with fewer than 10 employees) and self-employed participants (such as self-employed ministers); or requires evidence of insurability from any employee who enrolls more than 90 days after first becoming eligible to enroll (late entrants).

HIPAA also makes an exception for self-funded health plans maintained by state or local government entities. These entities may elect out of a number of HIPAA's portability rules as well as the non-discrimination rules, by meeting a set of strict election and notice requirements. The new regulations impose notice and enrollment requirements on government plans that become subject to HIPAA after opting out. However, *no opt-out election will exempt a government employer from the obligation to furnish a certificate of creditable coverage.*

The election for a self-funded governmental plan to opt out of the nondiscrimination rules can be found at section 2721(b)(2) of the PHS Act and 45 CFR 146.180.

Reference Sources: The Federal Register, December 13, 2006, Part III, Department of Treasury, IRS, 26 CFR Part 54, Department of Labor, EBSA, 29 CFR Part 2590, Department of Health and Human Services, CMS, 45 CFR Part 146, Nondiscrimination and Wellness Programs in Health Coverage in the Group Market; Final Rules

Disclaimer: The information contained herein should not be construed as legal advice of any kind. The author and Advanced Benefit Consulting suggests that you consult with your law firm as situations vary.

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[4] Federal Register, Volume 71, No. 239, 75032, 75033