Provided by Clarke & Company Benefits, LLC

HIPAA Nondiscrimination Rules

The Health Insurance Portability and Accountability Act (HIPAA) prohibits group health plans and group health insurance issuers from discriminating against individuals with regard to eligibility, premiums or coverage based upon a health status-related factor.

In addition, the Affordable Care Act (ACA) made a number of important changes to the HIPAA nondiscrimination provisions. Many of these ACA changes became effective for plan years beginning on or after Jan. 1, 2014. However, some ACA changes, such as the prohibition on preexisting condition exclusions for enrollees under age 19, became effective in prior years.

While the HIPAA nondiscrimination rules are not new requirements for group health plans, employers should take the opportunity to regularly review their health plans to confirm they do not violate any of the provisions within the HIPAA nondiscrimination rules, as amended by the ACA.

LINKS AND RESOURCES

- The Department of Labor has a self-compliance tool that includes a checklist for compliance with HIPAA's nondiscrimination rules.
- Final regulations on HIPAA's nondiscrimination rules for wellness programs.
- Final regulations on HIPAA's nondiscrimination rules

HIGHLIGHTS

OVERVIEW

- Group health plans cannot discriminate based on health status-related factors regarding eligibility, premiums or contributions.
- The ACA made a number of important changes to HIPAA's nondiscrimination requirements.
- Special rules apply to genetic information (under GINA) and wellness programs.

PROHIBITED TYPES OF DESIGN

- Actively-at-work provisions for eligibility
- Non-confinement clauses regarding effective dates of coverage
- Source of injury restrictions for premiums or eligibility

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HEALTH STATUS-RELATED FACTORS

HIPAA identifies these as health status-related factors:

- Health status;
- Medical condition (both physical and mental illnesses);
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability; and
- Disability.

The ACA added the following broad, "catch all" category to the list of health status-related factors: any other health status-related factor determined appropriate by the Department of Health and Human Services (HHS).

SIMILARLY SITUATED INDIVIDUALS

The HIPAA nondiscrimination rules generally apply within a group of similarly situated individuals. As a general rule, employers that offer health insurance benefits to their employees may not treat individuals within a group of similarly situated individuals differently. However, certain individuals may be treated as distinct groups of similarly situated individuals for purposes of the HIPAA nondiscrimination rules.

For example, an employer may provide different health benefits for employees in different groups if the distinction between the groups is based upon a **bona fide employment-based classification**.

The following employment classifications may reflect bona fide business practices:

- ✓ Full-time versus part-time employees;
- ✓ Occupation;
- ✓ Date of hire;
- ✓ Geographic location;
- ✓ Membership in a collective bargaining unit;
- ✓ Length of service; and
- ✓ Current versus former employees.

DISCRIMINATION IN ELIGIBILITY

Employers and health insurance issuers may not discriminate with respect to eligibility between similarly situated employees based upon a health factor. Eligibility rules include those related to enrollment, the effective date of coverage and eligibility for benefit packages.

Employers may not require an employee to pass a physical examination in order to be eligible to enroll in the health plan, even if the individual is a late enrollee, or exclude individuals from coverage because they participate in dangerous activities or have a history of high health claims.

DISCRIMINATION IN PREMIUMS

Employers may not charge an individual within a group of similarly situated individuals a different rate for coverage based upon that individual's health factors. However, if an employer has a wellness program in place that complies with HIPAA's requirements governing wellness plans, an employer may establish premium contribution rates that vary based upon an individual's participation in the wellness program.

HIPAA does not prohibit a health insurance issuer from considering all relevant health factors of the applicants in order to establish aggregate rates for coverage provided under a group health plan. However, the issuer is required to blend the individual-by-individual rates into an overall group rate and provide a per participant rate to the employer. Employers may not charge an individual within a group of similarly situated individuals a different rate for coverage based upon that individual's health factors.

ACA Premium Rating Requirements

Effective for plan years beginning on or after Jan. 1, 2014, the ACA prohibits issuers of non-grandfathered plans from charging higher rates due to health status, gender or other factors in the small group market. Premiums may vary based only on age (no more than 3:1), geography, family size and tobacco use.

Also, the ACA generally requires issuers in the small group market to use the per-member rating methodology (also referred to as "list billing"). Under this methodology, the total premium charged by an issuer to a group health plan in the small group market is generally determined by adding up the premiums of each individual enrolled in the plan based on their age and tobacco use.

BENEFIT LIMITATIONS

A group health plan or issuer may include benefit limitations within their health plan so long as they apply uniformly to all similarly situated individuals under the health plan. For example, coverage may be denied for treatment that is not medically necessary. While limits or exclusions applicable to all similarly situated employees are permissible under the HIPAA nondiscrimination rules, employers and issuers must also determine whether the plan design violates laws such as the Americans with Disabilities Act (ADA) and the Pregnancy Discrimination Act.

In the event an employer or issuer implements a plan design change effective at the beginning of the plan year, it will not be considered to be directed at any one individual. However, a plan design change implemented in the middle of the plan year will be reviewed under a facts and circumstances test to determine if the changes were made in anticipation of a specific individual's claim for treatment—which violates the HIPAA nondiscrimination rules.

PREEXISTING CONDITION LIMITATIONS AND EXCLUSIONS

While HIPAA allowed the use of preexisting condition limitations and exclusions, it applied certain restrictions and required that the limitation or exclusion be applied uniformly to all similarly situated individuals. Effective for plan years beginning on or after Sept. 23, 2010, the ACA prohibited a plan or issuer from imposing preexisting condition exclusions for enrollees under age 19. Effective for plan years beginning on or after Jan. 1, 2014, preexisting condition exclusions for all enrollees are prohibited.

ACTIVELY-AT-WORK PROVISIONS

An employer or issuer may not delay enrollment in the health plan until an employee is actively at work, 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.

NON-CONFINEMENT CLAUSES

Non-confinement clauses are most often used to allocate responsibility for coverage of individuals that are confined to a hospital at the time an employer moves its coverage from one issuer to another. A plan or issuer may not deny coverage or delay an individual's effective date for coverage because the individual is confined to a hospital.

Final regulations under HIPAA address the interaction between HIPAA and state laws that require the prior carrier to continue to cover expenses incurred as a result of a confinement which began while the prior carrier insured the confined individual. The application of these state laws allows an issuer to delay coverage to an individual who is confined because state law requires the prior issuer to continue to pay claims related to that confined individual until the confinement ends. The final regulations make it clear that an issuer, regardless of state law, must make an individual's coverage effective even when that individual is confined to a hospital. The regulations indicate that the state laws be used as a coordination of benefits provision, but confirm that an individual's effective date under the new issuer's health plan cannot be delayed due to confinement.

SOURCE OF INJURY RESTRICTIONS

An employer may not charge an employee a higher premium or deny enrollment in the health plan based upon an employee's participation in a dangerous or hazardous activity (for example, skydiving or bungee jumping). However, the health plan may exclude coverage for treatment of injuries related to the participation in these activities.

A health plan may not exclude benefits because they are related to an act of domestic violence or a medical condition. For example, a health plan may not exclude coverage for treatment of self-inflicted injuries sustained in connection with an attempted suicide if the injuries were also caused by a medical condition such as depression. The final HIPAA 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.

MORE FAVORABLE TREATMENT OF INDIVIDUALS

Employers and issuers are not prohibited from establishing more favorable rules for eligibility for individuals with an adverse health factor, such as a disability, than for individuals without an adverse health factor. The following example demonstrates an acceptable and common plan provision that treats individuals with a health factor more favorably.

Example: An employer offers a health plan that provides benefits for eligible employees, their spouses and dependents. Dependents are eligible for coverage until they reach age 26. However, dependent children who are disabled are eligible for coverage beyond the age of 26.

HEALTH REIMBURSEMENT ARRANGEMENTS

Health reimbursement arrangements (HRAs) are tax-favored accounts intended to reimburse employees for medical expenses not otherwise covered by the health plan. Unused funds within an HRA may be carried over from year to year. The final regulations address whether HRAs with a carry-over feature violate the HIPAA nondiscrimination rules by including the following example.

Example: An employer sponsors a group health plan that is available to all current employees. Under the plan, the medical care expenses of each employee (and the employee's dependents) are reimbursed up to an annual maximum amount. The maximum reimbursement amount with respect to an employee for a year is $1500 multiplied by the number of years the employee has participated in the plan, reduced by the total reimbursements for prior years.

This example clarifies that even though unused employer-provided medical care reimbursement amounts carried forward from year to year varies among employees within the same group of similarly situated individuals based upon prior claims experience, the HRA does not violate the HIPAA nondiscrimination rules. Employees who have participated in the plan for the same length of time are eligible for the same total benefit over that length of time and the restriction on the maximum reimbursement amount is not directed at any individual participants or beneficiaries based on any health factor.

GENETIC INFORMATION

The Genetic Information Nondiscrimination Act of 2008 (GINA) included provisions related to genetic information that affect the HIPAA nondiscrimination rules. Genetic information is defined as information about genetic tests of an individual or the individual's family members, information about the manifestation of a family member's disease or disorder and an individual's request for or receipt of genetic services. Genetic information also includes information about the fetus of a pregnant individual or family member or embryo in the case of assisted reproductive technology.

Specifically, GINA prohibits a group health plan from:

- Adjusting premiums or contribution amounts based on genetic information;
- Requesting or requiring an individual or an individual's family member to undergo a genetic

test (this does not apply to health care providers);

- Requesting, requiring or purchasing genetic information prior to or in connection with enrollment in the plan; or
- Using genetic information for underwriting purposes.

However, group health plans may use the results of genetic tests for payment purposes as defined by the HIPAA Privacy Rules, as long as the minimum amount of information necessary is used. Also group health plans may request genetic information for research purposes if all applicable requirements are met.

WELLNESS PROGRAMS

The final HIPAA regulations provided guidance on when wellness programs comply with the HIPAA nondiscrimination rules. The ACA codified the HIPAA rules for nondiscriminatory wellness plans, while also increasing the maximum permissible reward that can be offered under health-contingent wellness programs. Effective in 2014, the wellness program incentive limit increased to **30 percent** of the premium (50 percent for wellness programs designed to prevent or reduce tobacco use).

On June 6, 2013, final regulations were issued on the ACA's nondiscrimination requirements for wellness plans. These rules became effective for plan years beginning on or after Jan. 1, 2014 and apply to both grandfathered and non-grandfathered plans. While the final regulations generally retain the HIPAA rules' nondiscrimination requirements for health-contingent wellness programs, there are some important differences that may require changes to the design and operation of wellness plans.