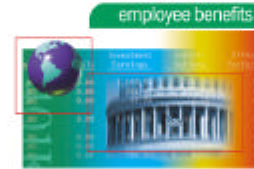
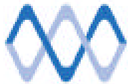
CLIENT ACTION BULLETIN





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HIPAA Nondiscrimination Requirements

SUMMARY

Interim final rules implementing the 1996 Health Insurance Portability and Accountability Act's (HIPAA) nondiscrimination requirements were issued by the Departments of Labor, Health and Human Services, and Treasury. The rules' provisions reiterating guidance under the prior proposed rules take effect on March 9, 2001, but new provisions apply to plan years beginning on or after July 1, 2001. The rules generally prohibit group health plans from using a health factor to discriminate against individuals in the nature or amount of benefits provided or in the premiums charged. They also allow plans to correct coverage denials that were based on health conditions. Separately, the agencies also proposed rules for "bona fide wellness programs."

DISCUSSION

Prohibited Discrimination – The new rules restate the prohibition against discriminating among individuals (including dependents) or groups regarding benefits, eligibility, waiting periods, enrollment requirements, or premiums based on any health factor. *Health Factor* includes: health status; medical condition (both physical and mental illnesses); claims experience; receipt of health care; medical history; genetic information; evidence of insurability (including conditions arising from domestic violence and participation in "risky" activities such as motorcycling, horseback riding, and skiing); or disability.

Permitted Disparate Treatment – The rules contain many examples of how plans may impose different conditions (e.g., coverage that differs in amount, eligibility, waiting periods, deductibles, or costs) upon groups of "similarly situated" employees if the groups are not defined by a health factor. Plans may group similarly situated employees by reference to any bona fide employment-based classification that is consistent with the employer's usual business practices (e.g., full or part-time; length of service; collective bargaining status; location; or salaried vs. hourly). Note, however, that while discrimination based on employment factors will not violate HIPAA, it might violate the tax code's nondiscrimination rules applicable to self-funded health plans.

Most importantly, a plan may not condition eligibility on individuals being actively at work unless it treats those who are not working due to sickness as being actively at work. Whether a plan may terminate coverage because a worker is on sick leave may well depend on whether it similarly terminates coverage for employees on non-medical leaves. In that case, the plan may treat the employees on sick leave the same as other employees on leave.

A plan may distinguish among groups of beneficiaries based on employment distinctions, relationship to employees, age, student status, or other non-health factors. Importantly, a plan may treat "late enrollees" – those who do not enroll when first eligible – as if they were a separate group; thus, higher deductibles or premiums or limits not applicable to other participants are allowed.

Although the rules offer broad flexibility in the design of plans and benefits as long as all similarly situated employees are treated the same, they also are

unclear in certain areas. In one example, the rules permit a separate limit for the treatment of teeth grinding (temporo mandibular joint syndrome or TMJ) but prohibit a lower lifetime limit for congenital heart defects. No explanation for this difference is given, but the rationale presumably is that anyone covered by the plan may suffer from TMJ but only some individuals have a congenital heart defect. This rule thus raises the possibility of providing lower limits for AIDs, but such a limit could violate other statutes. Exactly where the line is between limits that do and do not violate HIPAA is not clear and might have to await the outcome of litigation. In the case of insured plans, the HIPAA rules clearly allow states to impose stricter requirements.

Curing Prior Violations – HIPAA prohibits plans from conditioning eligibility on taking or passing a physical examination. The new regulations allow plans that improperly denied coverage under prior guidance to cure their violations. If a plan failed to give individuals a chance to enroll, it must give them a 30-day period to enroll, with the period starting before March 1, 2001. The plan must not treat them as late enrollees for any purpose, including imposing on them pre-existing condition limitations. The plan also must give them the option to have enrollment effective retroactively to HIPAA's effective date (generally, beginning with the 1997 plan year). Although the plan may charge the applicable employee premiums for that period, it must retroactively cover medical expenses.

Plans that failed to offer enrollment based on a good-faith interpretation of HIPAA may cure their noncompliance by giving individuals an opportunity to enroll by July 1, 2001. Enrollment need not be retroactive, except that any waiting period must be deemed satisfied by the passage of time from HIPAA's effective date to the effective date of enrollment. An example of such a situation is where a plan allowed enrollment at hire without a physical exam, but required an exam for late enrollment and then discontinued late enrollment prior to HIPAA's effective date.

Bona-fide Wellness Programs—The prohibition on discrimination in premiums, deductibles, and co-payments does not apply to bona fide wellness programs. Such programs may reward participants through decreased premiums or co-pays for attaining positive health conditions, but must provide an alternative mechanism for individuals who cannot meet the standard because of a medical condition.

ACTION

Group health plan sponsors and/or their insurers should modify any plan elements that violate the new rules. Particular care should be taken in defining different groups of participants, including "actively at work" requirements, so that the categories are not based on a health factor. Plans also should determine whether they had impermissibly excluded late enrollees and take steps to cure any violations. Because many of the requirements are imprecise, plans should consider obtaining assistance from health actuaries and medical professionals about different benefit limits for specific conditions or diseases. Plans also should be cognizant that any limits for the treatment of certain medical conditions will have to pass muster under the Americans with Disabilities Act and the nondiscrimination provisions of the equal employment laws.

Please contact your M&R consultant for additional information or assistance in this matter.

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