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A legal update from Dechert's Employee Benefits and Executive Compensation Group

Final HIPAA Nondiscrimination Requirements and Wellness Program Rules Issued

The Departments of Treasury, Labor, and Health and Human Services recently published final rules prohibiting discrimination based on a health factor and adopting wellness program requirements. These rules were issued under the Health Insurance Portability and Accountability Act (HIPAA). For the most part, the final rules adopt the interim nondiscrimination regulations and the proposed wellness program regulations published in 2001. Previously, the Departments had stated that they would not take enforcement action against a plan or employer that had sought, in good faith, to comply with the interim and proposed HIPAA rules. This nonenforcement policy ends on the effective date of the final rules, February 12, 2007.

General

HIPAA prohibits discrimination against a health plan participant or beneficiary with respect to eligibility, premiums, and contributions based on a person's "health factors." HIPAA defines "health factors" as an individual's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

Accordingly, plan rules regarding enrollment (including the effective date of coverage, late, and special enrollment), eligibility (including initial eligibility for benefits and benefit packages, continued eligibility, and termination of coverage), benefits (including benefit restrictions and annual or lifetime benefit limitations), and premiums and contributions (including cost-sharing, copayments, and deductibles) must not discriminate on the basis of individual health factors.

However, because HIPAA does not mandate any specific benefits, plans may limit or exclude benefits in relation to a specific disease or condition and may limit or exclude certain types of treatments (for example, experimental or non-medically-necessary treatments). Plans also may establish drug formularies or limitations. Plans should be wary of establishing any such limitation, however, if the effect is to single out and reduce benefits or coverage for certain identifiable participants or beneficiaries.

HIPAA's nondiscrimination rules apply to groups of "similarly-situated individuals." Accordingly, employers may group participants and beneficiaries separately and may establish subgroups thereof under bona fide employment-based classifications consistent with the employer's business practice. Permissible groupings of similarly-situated participants include, for example, full-time versus part-time employees, employees at different geographic locations, members of collective bargaining units, classifications based on date of hire or length of service, current versus former employees, and occupation-based classifications.

In addition, beneficiaries may be grouped separately based on the classification of the participant, the relationship to the participant (e.g., spouse versus child), marital status, and age or student status of dependent children.

Actively-At-Work and Nonconfinement Clauses

The regulations discuss the applicability of the nondiscrimination rules to plan terms conditioning benefits or plan eligibility on whether an individual is confined to a health care institution or actively-at-work. The rules prohibit plans from establishing eligibility rules or setting premiums or contribu-

tions based on whether an individual is confined to a health care institution, able to engage in normal life activities, or actively-at-work. Accordingly, for example, even if state law requires a plan to continue to provide coverage after the close of a policy period during an individual's hospitalization, HIPAA would not permit another plan to deny coverage to such individual (assuming he or she is otherwise eligible) based on such hospitalization. Instead, laws regarding coordination of benefits would apply to determine primary and secondary coverage, if necessary. The HIPAA regulations do permit, however, typical employment and service requirements such as first-day of work clauses.

Source-of-Injury Exclusions

Under the final rules, if a group health plan generally provides benefits for a type of injury, the plan may not deny benefits for such injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). So, for example, plan terms prohibiting coverage for self-inflicted injuries or injuries from attempted suicide may not be the basis to deny coverage if, due to depression, a participant suffers injuries from attempted suicide. The preamble clarifies that the rule applies regardless of whether such medical condition had been diagnosed prior to the injury. Plans are not prohibited, however, from limiting benefits for injuries resulting from dangerous activities like bungee jumping or sky diving.

Health Reimbursement Arrangements

Concerns arose under the interim regulations that health reimbursement arrangements may violate HIPAA based on participant claims experiences. For example, a plan may provide for a maximum annual reimbursement amount, but the actual amount reimbursed for any particular participant would depend on claims submitted. The final rules provide an example of such a scenario, and conclude that as long as the same total benefit (which may be a fixed amount or an amount determined according to participants' years of service) is available for similarly situated individuals, such arrangement would not violate HIPAA's nondiscrimination rules.

Wellness Programs

There are five requirements for wellness programs (listed below). The regulations also clarify that rewards to health plan participants that are not based on satisfying a standard related to a health factor are *not* subject to these requirements. For example, plans that reimburse for the cost of gym memberships, health education seminars, and other programs, but do not require participants to satisfy health standards are not subject to these rules.

Wellness programs that provide rewards based on achievement of a standard related to a health factor must satisfy the following five rules:

- The amount of the reward (for all wellness programs with respect to the plan) may not exceed 20% of the cost of employee-only coverage, or 20% of the cost of employee plus dependent coverage if dependents are eligible to participate in the wellness program. A reward for this purpose generally is in the form of a discount, rebate of premium or contribution, waiver of cost sharing mechanism, absence of surcharge or the value of a benefit that would otherwise not be provided under the plan.

- The program must be reasonably designed to promote health or prevent disease. The rule provides that if a program has a reasonable chance of improving the health of participants, 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, it satisfies this standard.

- The program must give eligible individuals the opportunity to qualify for the reward at least once per year.

- The reward must be available to all similarly-situated individuals. As part of this requirement, a reward program must make available a reasonable alternative standard for obtaining a reward for individuals for whom attempting to achieve the regular standard is unreasonably difficult due to a medical condition or is medically inadvisable. The rules permit plans to seek verification that achieving the regular standard is unreasonably difficult or medically inadvisable for any particular individual.

- All wellness program materials that describe the terms of the program must disclose the availability of a reasonable alternative standard for obtaining a reward, as described above. The regulations provide sample language for meeting this requirement.

Other Laws

Compliance with HIPAA's nondiscrimination rules does not affect whether health plan provisions or practices comply with the Internal Revenue Code, ERISA, the Americans with Disabilities Act, Title VII of the Civil Rights Act of 1964, the Family Medical Leave Act, other HIPAA provisions (including privacy and security regulations), and other state and federal laws. Accordingly, plans should be careful to consult with counsel prior to enacting provisions that may violate other laws.

Practice group contacts

If you have questions regarding the information in this legal update, please contact the Dechert attorney with whom you regularly work, or any of the attorneys listed. Visit us at www.dechert.com/employeebenefits.

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