

## **IRS, DOL and HHS Release Final HIPAA Regulations**

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### **Introduction**

The Department of Labor's Employee Benefits Security Administration (EBSA), the Internal Revenue Service and the Department of Health and Human Services have published final regulations that provide guidance in complying with the nondiscrimination provisions of the Health Insurance Portability and Accountability Act ("HIPAA"). These final regulations were published in the Federal Register on December 13, 2006, and are effective on the first day of the plan year beginning on or after July 1, 2007. For calendar year plans, the new regulations generally apply beginning January 1, 2008.

No group health plan may discriminate under HIPAA against any individual or dependent as to eligibility for coverage, continued eligibility for coverage, or premiums based on:

- health status;
- medical condition, including physical and mental illness;
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability, including conditions arising out of domestic violence; or
- disability.

In January 2001, the IRS, EBSA, and HCFA issued an interim final rule on discrimination in health insurance. The rules updated a 1997 interim final rule implementing HIPAA.

Despite these nondiscrimination requirements, HIPAA also affirmatively recognizes that the nondiscrimination provisions were not meant to prevent a group health plan or an insurance policy issuer from establishing premium discounts or co-payments or deductibles in return for establishment of wellness programs of health promotion and disease prevention. These "wellness programs" are an exception to HIPAA's general nondiscrimination requirement.

The proposed regulations released in 2001 provided guidance for evaluating the permissibility of wellness programs under HIPAA's nondiscrimination requirements. Under this guidance, a separate standard applies depending upon whether the wellness program provides a reward that is contingent on a participant's satisfying a standard that is related to a health factor. If the program provides a reward based on a health factor, then satisfaction of the "bona fide wellness program" ("BFWP") requirements, constituted good faith compliance with the statutory requirements. There are four requirements that have to be met. If the program did not provide a reward based on a health factor, it is not required to comply with the requirements for a BFWP.

## **Final Regulations**

In general, the final regulations do not change the 2001 interim rules or the proposed rules on wellness programs. These regulations clarify how the source-of-injury rules apply to the timing of a diagnosis of a medical condition and add an example to illustrate how the benefits rules apply to the carryover feature of health reimbursement arrangements (“HRAs”). In addition, they clarify some ambiguities in the proposed regulations; make some changes in terminology and organization and provide a description of wellness programs not required to satisfy additional standards. The following is a summary of these important changes contained in the final regulations:

### **Changes:**

**Application to benefits:** There was some uncertainty in how HIPAA nondiscrimination rules would apply to HRAs with a carry forward feature. The final regulations include an example under which the carry forward of unused employer provided medical care reimbursement amounts to later years does not violate the HIPAA nondiscrimination requirements, even though the maximum reimbursement amount for a year varies among employees within the same group of similarly situated individuals based on prior claims experiences. The example concludes that because employees have participated in the plan for the same length of time and are eligible for the same total benefit over the length of time, the arrangement does not violate the HIPAA nondiscrimination requirements.

The final regulations also clarify that compliance with the nondiscrimination rules under HIPAA is not determinative of compliance with other provisions of ERISA, or any other State or Federal law, including the Americans with Disabilities Act.

The final regulations also indicate an employer may impose limits on benefits if they uniformly apply to all similarly situated individuals and must not be directed at individual participants based on any health factor for participants or beneficiaries. The wording of this restriction is the same as in interim regulations, but an example in the final regulations may indicate a change in the interpretation of this provision.

In one example, a group health plan imposed a \$2,000 lifetime limit for the treatment of temporomandibular joint syndrome and in another example a group health plan applies a \$2,000,000 life time limit on all benefits. But, the lifetime limit is reduced to \$10,000 for any participant or beneficiary under the plan that has a congenital heart defect. The final regulations indicates that the restriction in the first example does not violate the requirements because \$2,000 of benefits for the treatment of TMJ are available uniformly to all similarly situated individuals while they found the restriction in the second example to violate the requirements. They found a violation in the second example because benefits under the plan are not uniformly available to all similarly situated individuals and the plan’s lifetime limit on benefits does not apply uniformly to all similarly situated individuals. No other explanation was given of why the situation is in violation. Is it because the way the plan was designed or was it because of the disease picked to limit? Until we receive further clarification regarding this situation, please be very careful adding any limitations to benefits under health plans.

**Wellness Programs:** The final regulations no longer use the term “bona fide” in connection with wellness programs, add a description of wellness programs that do not have to satisfy additional requirements in order to comply with the nondiscrimination requirements, reorganize the four requirements from the proposed rules into five requirements, provide that the reward for a wellness program - coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factors - must not exceed 20% of the total cost of coverage under the plan and add examples and make other changes to more accurately describe how the requirements apply.

A paragraph has been added to the final regulation defining and illustrating programs that comply with the nondiscrimination requirements without having to satisfy any additional standards. Such programs are those under which none of the conditions for obtaining a reward on an individual satisfying a standard related to a health factor or under which no reward is offered. The final regulations include the following list to illustrate the wide range of programs that would not have to satisfy any additional standards to comply with nondiscrimination requirements:

- A program that reimburses all or part of the cost for memberships in a fitness center.
- A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
- A program that encourages preventive care through the waiver of the co-payment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits.
- A program that reimburses employees for the costs 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.

The proposed regulations had indicated that any reward offered under a wellness program had to be limited. It could not have exceeded a specified percentage of the cost of employee-only coverage under the plan. The final regulations provide that if, in addition to employees, any class of dependents (such as spouses or spouses and dependent children) may participate in the wellness programs, the limit on the reward is based on the cost of the coverage category in which the employee and any dependents are enrolled.

The proposed regulations also specified that any program must be reasonably designed to promote good health or prevent disease. A program did not meet this standard unless it gave individuals eligible for the program the opportunity to qualify for the reward at least once per year. Under the final regulations, this requirement has been divided into two requirements. This division is made to emphasize that a program that must satisfy the additional standards in order to comply with the nondiscrimination requirements must allow individuals to qualify for the reward at least once per year and must also be otherwise reasonably designed to promote health or prevent disease.

The “reasonably designed” requirement is satisfied if the program has a reasonable chance of improving the health of participants and it 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.

Under the proposed regulations, wellness programs providing a reward must also provide a reasonable alternative standard for obtaining the reward for certain individuals. This “alternative standard” must be available for individuals for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard, or for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard. The final regulations provide that a plan or an insurance company can waive the health-factor-related standard for all individuals for whom a reasonable alternative standard must be offered. The final regulations provide an example demonstrating that a reasonable alternative standard includes following the recommendations of an individual’s physician regarding the health factor at issue. If there is some question whether an individual can meet the standard, plans may seek verification, such as a statement from a physician, that a health factor makes it unreasonably difficult or medically inadvisable for an individual to meet a standard.

The last requirement for a wellness program that provides reward is that all plan materials describing the terms of the program must disclose the availability of a reasonable alternative standard. The final regulations provide two clarifications of this requirement. First, plan materials are not required to describe specific alternative standards. It is sufficient to disclose that some reasonable alternative standard will be available. Second, any plan materials that describe the general standard would also have to disclose the availability of a reasonable alternative standard. However, if the program is merely mentioned (and does not describe the general standard), disclosure of the availability of reasonable alternative standard is not required.

**Source-of Injury Exclusions:** There were some questions whether suicide exclusion can apply if an individual had not been diagnosed with a medical condition such as depression before the 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.

**Relationship of Prohibition of Nonconfinement Clauses to State Extension-of-Benefits Laws:** The final regulations clarify that state law cannot change the succeeding insurance issuer’s obligation under HIPAA; a prior insurance issuer may also have an obligation; and in a case in which a succeeding insurance issuer has an obligation under HIPAA and a prior insurance issuer has an obligation under State law to provide benefits for a confinement, any state laws designed to prevent more than 100 percent reimbursement, such as state coordination-of-benefits, continue to apply. Under HIPAA, a succeeding insurance issuer can not deny benefits to an individual on the basis of a nonconfinement clause. If this requirement under HIPAA has the effect under State law of removing a prior insurance issuer’s obligation to provide benefits, then the prior insurance issuer is not obligated to provide benefits for confinement. If under State Law this requirement under HIPAA has the effect of obligating both the prior insurance issuer and the succeeding insurance issuer to provide benefits, then any state coordination-of-benefits law that is used to determine the order of payment and to prevent more than 100 percent reimbursement continues to apply.