

Watch Your Step With Health Factor Nondiscrimination

By Rich Glass, J.D.

When people think about nondiscrimination rules and benefits, what often comes to mind are the many forms of nondiscrimination tests for plans under various sections of the Internal Revenue Code: Sections 79, 105, 125, 129 and 401, to name a few. Nondiscrimination, though, extends its reaches to another section of the Code, Section 9802, regarding health factor nondiscrimination under HIPAA. Final HIPAA nondiscrimination rules were issued almost four years ago and have been in effect in some form since February 2002, but they are easy to overlook amid the recent focus on the HITECH Act and health reform.

HIPAA's nondiscrimination rules prohibit discrimination in premiums, contributions, eligibility and wellness programs. They define the term "health factor" broadly to include health status, physical and mental conditions, claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disabilities.

And two years ago, the Genetic Information Nondiscrimination Act (GINA) added more bite to the nondiscrimination rules. GINA, whose own set of interim final rules was issued Oct. 7, 2009, defines "genetic information" broadly to include genetic testing, genetic services, fetal information during pregnancy and family medical history. (See Tab 500.)

Here are just six of the many traps that the health nondiscrimination rules of HIPAA and GINA present for the unwary health plan administrator that does not take them into consideration when designing a group health plan.

Health Questionnaires

Historically, health questionnaires have been used to help with underwriting and enforcement of pre-existing condition exclusions. Under the recent health care reform law, however, the latter purpose soon will

be prohibited, first for children under age 19 and eventually for all participants (see related story, p. 9). HIPAA still allows such questionnaires to be used, but you cannot seek genetic information, including family medical history.

Health risk assessments (HRAs) used in wellness programs must be scrubbed to make sure they are not asking impermissible questions, even if the intent is to help the individual become healthier. Information obtained in the questionnaire cannot be used to deny coverage to a participant or charge a higher individual premium.

List Billing of Different Premiums

Plans cannot differentiate between participants in terms of premiums, contributions or benefits. Here is an example of such a prohibited design, taken straight from the rules.

Example. An insurance carrier reviews an employer's claims experience in advance of renewal in order to set the premiums for the upcoming plan year. Some participants had significantly higher claims experience than others who are similarly situated. The carrier quotes these individuals a higher rate.

Under the rules, this is impermissible list billing. However, a plan can differentiate premiums based on a bona fide employment-based classification. For example, an employer can pay 50 percent of the premium for its employees and only 30 percent of the premium for spouses and dependents. It could also differentiate based on full-time/part-time status, date of hire, work location and whether benefits were collectively bargained.

Wellness Programs

More and more employers are implementing and improving wellness benefits. The rationale is straightforward: healthier



Rich Glass is Chief Compliance Officer for Infinisource, Inc. He is a licensed attorney and brings more than 17 years of legal expertise, specializing in benefits, human resources and related regulatory compliance. He has testified before the IRS and has provided comments on regulations issued by several governmental authorities. He is a member of Thompson Publishing Group's Health Plan Advisory Panel and contributing editor of Thompson's Flex Plan Handbook. He is a frequent speaker and author on various benefits, employment law and compliance issues.

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employees are more productive, consume less sick time and over the long run will tend to have lower claims experience. There is a certain truth with wellness programs: if you want high participation rates, you need to consider offering a financial incentive. Providing an incentive based on participation only is permissible. This could include health club memberships and payments for completing an HRA.

A more complicated solution is to use group health benefits, because of their pre-tax nature, to accomplish this. HIPAA's nondiscrimination rules permit wellness programs to do this, providing a five-step framework when the required standard is based on a health factor (see also ¶530):

- 1) *Size of the reward.* The reward can at most be 20 percent of the health plan premium. Most wellness programs apply to employees only, not dependents, so the limit would be 20 percent of the premium for employee-only coverage (both the employer and employee contributions). Starting Jan. 1, 2014, the health reform law increases this limit to 30 percent, and the agencies will have the discretion to increase it to 50 percent, if appropriate.
- 2) *Reasonable design.* The program must be reasonably designed to promote health or prevent disease. It does not need to be based on scientific research, but the program cannot be overly burdensome or simply a subterfuge for discriminating based on a health factor.
- 3) *Annual qualification.* Eligible individuals must have the opportunity to meet the standard at least once per year.
- 4) *Reasonable alternative standard.* The program must make available a reasonable alternative standard, or waive the standard altogether, for those people who find it unreasonably difficult due to a health factor. For example, if an individual cannot meet a cholesterol count standard due to a medical condition, a program could require participation in a doctor-approved diet and exercise regime to meet the standard another way. Another example is for smokers to participate in a smoking-cessation program in order to meet a tobacco-free standard.
- 5) *Communication of the reasonable alternative standard.* The program must disclose the availability

of the reasonable alternative standard or waiver. The disclosure need not go into specifics on what the reasonable alternative standard will be. In fact, the rules provide model language for this disclosure:

*If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us and **we will work with you** to develop another way to qualify for the reward.*

Dangerous Activities

Shaun White is a two-time Olympic gold medalist in snowboarding. Quite a few Americans share his passion for risk-taking activities, whether they involve winter sports or other pursuits like skydiving and all-terrain vehicle riding. It might be tempting to deny coverage to individuals who engage in these activities, but that would be a mistake. The final rules include in the “evidence of insurability” definition these high-risk activities. Thus, they are a health factor, and plans may not discriminate on that basis (at least in eligibility for coverage — see ¶511).

Extra Requirements for Eligibility

Under the rules, several traditional eligibility rules were prohibited because they had the effect of discriminating based on a health factor. Requiring an employee to be actively at work on the first day after the benefit waiting period is prohibited. So is requiring any amount of continuous service (without taking sick leave) during a waiting period. Likewise, consider a non-confinement clause stating that enrollment does not start until a person is not confined in a hospital. Such a provision is also prohibited.

Mid-Year Plan Changes

Suppose a plan has had some unusually high claims and decides, mid-year, to impose limitations and/or exclusions on some of the high-cost benefits. Even if this change applies across the board to all participants, it could be argued that it has the effect of discriminating against the few participants who had large claims. Recall that claims experience is considered to be a health factor. In this case, such an action would be prohibited. However, if the plan waited until the start of the next plan year, such a change would be permissible. 🏠