**NONDISCRIMINATION PROVISIONS**
**OF THE HEALTH INSURANCE PORTABILITY AND**
**ACCOUNTABILITY ACT OF 1996**

1) **Interim Final Rules for Nondiscrimination in Health Coverage in the Group Market**
2) **Notice of Proposed Rulemaking for Bona Fide Wellness Programs**

## Background

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted on August 21, 1996. HIPAA amended the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code of 1986 (Code), with parallel provisions prohibiting group health plans and group health insurance issuers from discriminating against individuals based on health factors. These provisions are codified in 2702 of the PHS Act.

- Interim final rules implementing the HIPAA provisions were first made available to the public on April 1, 1997 (published in the **Federal Register** on April 8, 1997, 62 FR 16894) (April 1997 interim rules). In the preamble to the April 1997 interim rules, the Departments solicited comments on some more specific and complex issues arising under the nondiscrimination provisions. On December 29, 1997, the Departments published a clarification on the April 1997 interim rules as they relate to individuals who were denied coverage before the effective date of HIPAA on the basis of any health factor (62 FR 67689).

- These interim final rules interpret the HIPAA nondiscrimination provisions. The proposed rule implements and clarifies the term "bona fide wellness program" as it relates to the regulations implementing the nondiscrimination provisions. These rules apply to group health plans and to health insurance issuers of health insurance coverage offered in connection with a group health plan (the "group market").

- The Departments of Health and Human Services (HHS), Labor, and the Treasury published interim final rules on the HIPAA nondiscrimination provisions and notice of proposed rulemaking for bona fide wellness in the **Federal Register** on January 8, 2001. These rules and the statutory provisions of the HIPAA nondiscrimination provisions are described below.

## General Rules for the Interim Final Rules

- The HIPAA nondiscrimination provisions generally prohibit a plan or issuer from establishing rules for eligibility and continued eligibility to enroll under the terms of the plan based on any of the eight health factors listed in the statute.

- The HIPAA nondiscrimination provisions generally prohibit a plan or issuer from charging an individual a different premium or contribution than a similarly situated individual based on any of the eight health factors listed in the statute.

- The eight health factors are health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

- The interim regulations clarify that evidence of insurability includes participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities. In addition, the interim regulations incorporate the statutory clarification that evidence of insurability includes conditions arising out of domestic violence.

- The interim regulations clarify that rules for eligibility include, but are not limited to, rules relating to enrollment, the effective date of coverage, waiting (or affiliation) periods, late and special enrollment, eligibility for benefit packages (including rules for individuals to change their selection among benefit packages), benefits, continued eligibility, and terminating coverage of any individual under the plan.

- The interim regulations also clarify what is meant by the term similarly situated individuals and that the rules for eligibility apply in tandem with the rules describing similarly situated individuals. The interim regulations provide generally that participants may be treated as two or more groups of similarly situated individuals if the distinction between or among the groups is based on a bona fide employment-based classification consistent with the employer's usual business practice. These interim regulations also permit plans and issuers, in certain circumstances, to treat beneficiaries as different groups of similarly situated individuals.

- The interim regulations explain the application of these provisions to benefits. The interim regulations clarify that they do not require a plan or issuer to provide coverage for any particular benefit to any group of similarly situated individuals. However, benefits provided under a plan or group health insurance coverage must be uniformly available to all similarly situated individuals. Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances).

  For example, a plan or issuer may limit or exclude benefits in relation to a specific disease, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

- The interim regulations also contain a specific rule regarding source-of-injury restrictions. While a person cannot be excluded from a plan for engaging in certain recreational activities, benefits for a particular injury can, in some cases, be excluded based on the source of the injury. The interim regulations, however, clarify that if a group health plan or group health insurance coverage generally provides benefits for a type of injury, the plan or issuer may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

- The interim regulations also clarify the acceptability of provisions used by plans and issuers often called "nonconfinement" and "actively-at-work" provisions. Group health plans and health insurance issuers use these clauses to refuse to provide benefits to an individual who is confined to a hospital or who is not actively-at-work on the day coverage otherwise would become effective. The interim regulations generally prohibit plans and issuers from imposing such clauses. However, the interim regulations provide limited exceptions to the general prohibition against the "actively-at-work" clause. For example, under one exception, a plan or issuer may require an individual to begin work before coverage may become effective.

- The interim regulations also clarify that it is permissible for plans and issuers to establish rules for eligibility favoring individuals based on an adverse health factor, such as disability. For instance, issuers may limit extended coverage for dependent children past a certain age to disabled children. Although disability is considered a health factor, the regulations clarify that such a rule would be acceptable.

- The interim regulations provide transitional rules for situations where coverage was denied to individuals based on one or more health factors, both where denial was based on a good faith interpretation of the statute or the Departments' published guidance (the April 1997 interim rules and the December 29, 1997 clarification) and where it was not. Where the denial was not based on a good faith interpretation, the interim regulations provide that the plan or issuer is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days. This opportunity must be presented not later than March 9, 2001. The rule differs for situations where coverage was denied to individuals based on a health factor but where the denial was based on a good faith interpretation of the statute or the Departments' prior published guidance. In those situations, these interim regulations require plans and issuers to give the individuals an opportunity to enroll that continues for at least 30 days and with coverage effective not later than July 1, 2001.

## Effective Dates for the Interim Final Rules

- The statutory group provisions of HIPAA and the Departments' April 1997 regulations, including the nondiscrimination provisions, generally applied to plans and issuers in the group market for plan years beginning after June 30, 1997. These

interim regulations provide more comprehensive guidance on the nondiscrimination provisions. Portions of this guidance that repeat the old regulations remain effective. Portions of the regulations that provide new guidance are generally effective on the first day of the first plan year beginning on or after July 1, 2001. The preamble to the interim regulations contains a chart, which describes the effective dates for the provisions.

**Notice of Proposed Rulemaking for Bona Fide Wellness Programs**

- The HIPAA nondiscrimination provisions generally prohibit a plan or issuer from establishing rules for eligibility based on a health factor and from charging similarly situated individuals a different premium or contribution based on a health factor. The interim final regulations provide further clarification regarding such rules including their application to benefits. Under the interim regulations, cost-sharing mechanisms such as deductibles, copayments, and coinsurance are considered restrictions on benefits.

- The HIPAA nondiscrimination provisions provide an exception to these general rules prohibiting discrimination based on a health factor. The nondiscrimination provisions do not prevent a plan or issuer from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. These programs are generally referred to as wellness programs. The April 1997 interim rules, the interim final rules discussed above and these proposed regulations refer to the wellness programs allowed under this exception as "bona fide wellness programs."

- The proposed rules clarify that the requirements for bona fide wellness programs apply only to a wellness program that provides a reward based on the ability of an individual to meet a standard that is related to a health factor. Therefore, without having to comply with the requirements for a bona fide wellness program, a wellness program could provide voluntary testing of enrollees for specific health problems and make recommendations to address health problems identified, if the program did not base any reward on the outcome of the health assessment.

- The proposed rules clarify that a wellness program must meet four requirements to be a bona fide wellness program.

    1) The total reward that may be given to an individual under the plan for all wellness programs must not exceed a specified percentage of the cost of employee-only coverage under the plan. The cost of employee-only coverage is determined on the total amount of employer and employee contributions for the benefit package under which the employee is receiving coverage. The proposed regulations specify three alternative percentages: 10, 15, and 20. The Departments request comments on the appropriate level for the percentage, which will be taken into account in determining the standard for the final regulations.

2) The program must be reasonably designed to promote good health or prevent disease. For this purpose, a program is not reasonably designed to promote good health or prevent disease unless the program gives individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

3) The reward under the program must be available to all similarly situated individuals. Thus, the program must allow a reasonable alternative standard to obtain the reward to any individual for whom, for that period, it is unreasonably difficult due to a medical condition or it is medically inadvisable to attempt to satisfy the otherwise applicable standard for the reward.

4) The plan or issuer must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard. However, plan materials are not required to describe the specific details of reasonable alternative standards. Moreover, disclosure of the availability of a reasonable alternative standard is not required if the plan materials merely mention the program and do not describe the general standard.

**Extension for Good Faith Compliance and Request for Comments for the Proposed Rule**

- The period for good faith compliance continues with respect to those provisions relating to bona fide wellness programs until further guidance is issued.

- Written comments on this notice of proposed rulemaking are invited and must be received by the Departments on or before April 9, 2001.