Nondiscrimination Rules

HIPAA prohibits group health plans and health insurers from discriminating with regard to eligibility (which includes benefits), premiums, or contributions based on any health status-related factor.

1. What Is a Health Status-Related Factor?

The following items are considered health status-related factors:

- health status;
- medical condition;
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability (EOI), which includes participation in dangerous activities such as motorcycling, horseback riding, and skiing;
- disability; and
- any other health status-related factor determined appropriate by the Secretary of HHS.

2. Prohibited Discrimination in Eligibility, Premiums, and Contributions

HIPAA's nondiscrimination rules prohibit employers and insurers from establishing eligibility rules that discriminate based on a health factor. For example, the following are prohibited:

- applying an actively-at-work or continuous service provision to exclude from coverage a person who is absent due to a health status-related factor;
- excluding an otherwise-eligible dependent under a hospital nonconfinement or normal life activity provision;
- making eligibility for late enrollees or for a particular coverage option (e.g., an HMO) contingent on evidence of insurability;
- excluding individuals from coverage because they participate in dangerous activities;
- excluding individuals from coverage due to a history of high health claims; or
- charging individuals different premiums or imposing different costs based on the existence or absence of a health status-related factor.

Example. An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, individuals who do not enroll in the first 30 days cannot enroll

later unless they pass a physical examination. This plan discriminates on the basis of one or more health status-related factors, which violates HIPAA.

A plan may not require an individual to pay more in premiums or contributions for coverage than a similarly situated individual if the difference is based on a health factor. Although individuals may not be singled out to pay higher premiums based on a health factor, HIPAA does not prohibit insurers from applying underwriting principles to establish group insurance premiums. (However, health care reform restricts underwriting factors that can be considered in the small-group insurance market.)

3. Nondiscrimination Rules for Benefits

Although differences in eligibility and premiums or contributions cannot be based on health status-related factors, HIPAA allows group health plans to impose benefit restrictions that apply to all similarly situated individuals. For example, a plan may require participants to satisfy a deductible, co-payment, co-insurance, and other cost-sharing requirements. A plan may also limit or exclude benefits for specific conditions or diseases, for certain types of treatments or drugs, or based on a determination that the benefits are experimental or not medically necessary. However, any limits or exclusions may not be directed at individual participants based on health status-related factors.

In addition, a plan may provide different benefits for different groups of similarly situated employees, as follows: (a) differences are permitted based on bona fide employment-related classifications consistent with the employer's usual business practice (such as full-time or part-time status); (b) differences are permitted between employees and beneficiaries (spouses and dependent children); and (c) differences are permitted between different groups of similarly situated beneficiaries, if the distinction is based on a factor permitted by the regulations (such as relationship to the employee or marital status). However, these restrictions may not be directed at specific participants.

In addition, effective for plan years beginning on or after September 23, 2010, health care reform generally prohibits differences (for example, based on age, student status, or tax-dependent status) in eligibility, premiums, and coverage with respect to children up to age 26; if a plan offers dependent coverage for any children, it must make such coverage available to all children up to age 26.

Plans may also exclude or limit coverage for injuries that result from particular activities ("source-of-injury" exclusions). However, a plan cannot deny benefits otherwise provided for the treatment of an injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). For example, a plan exclusion for self-inflicted injuries could not be applied to someone who attempts suicide as a result of a medical condition (such as depression), but a plan exclusion for injuries resulting from bungee jumping would be permissible.

Caution Regarding Other Federal Laws. Compliance with HIPAA's nondiscrimination rules does not determine whether a particular plan provision complies with the Americans with Disabilities Act (ADA) or other federal or state laws.

4. Wellness Incentives

Although HIPAA's nondiscrimination rules generally prohibit employers and insurers from establishing premiums, contributions, or eligibility rules that discriminate based on a health factor, there is a limited

exception for wellness programs. Wellness programs must satisfy certain requirements to avoid violating the nondiscrimination rules. The requirements vary depending upon whether the wellness program is a participatory program (it simply rewards participation in the program regardless of whether the individual satisfies a standard related to a health factor) or a health-contingent program (it provides a reward that is contingent on satisfaction of a standard related to a health factor). For participatory programs, HIPAA generally requires only that the program be available to all similarly situated individuals.

Health-contingent programs are subject to more restrictive requirements. Health-contingent wellness programs must meet five specific conditions, which vary depending on whether the program is considered outcome-based (reward conditioned on attaining a particular health outcome, such as blood pressure or cholesterol readings below certain thresholds) or activity-only (reward conditioned on completing a particular activity, such as an exercise program). The conditions are—

- *Amount.* The reward must be no more than 30% of the cost of coverage (50% for standards related to tobacco use).
- *Purpose.* The program must be designed to promote health or prevent disease.
- *Frequency.* The program must give individuals an opportunity to qualify for the reward at least once a year.
- *Availability.* The reward must be available to all similarly situated individuals. Activity-only programs must provide reasonable alternative standards for individuals with medical conditions that make attainment of the stated standard unreasonably difficult or medically inadvisable, and they may seek verification from the individual's physician of the individual's medical condition. Outcome-based programs must provide a reasonable alternative standard regardless of whether the individual has a medical condition making attainment of the specified outcome unreasonably difficult or medically inadvisable. It is not reasonable for an outcome-based program to seek verification of the individual's medical condition from the individual's personal physician. Reasonable alternative standards are subject to additional requirements to ensure that they are reasonably attainable by all employees.
- *Disclosure.* The program must disclose in all materials describing the program that reasonable alternative standards or waivers are available. Sample language is provided in the regulations.

Other federal laws must be considered when designing a wellness program. For example, if a wellness incentive involves a medical examination (e.g., a cholesterol test) or a disability-related inquiry (e.g., a question about physical activity), then the incentive likely will have to comply with the Americans with Disabilities Act (ADA). The EEOC issued detailed regulations that are similar—but not identical—to the HIPAA regulations. After a court challenge, the EEOC moved the incentive provisions from its final wellness regulations, but that does not mean that all incentives necessarily violate the ADA. See Section XI.

Example: Body Mass Index (BMI). Plan A includes a lower employee contribution for employees whose BMI is 26 or lower. For any employee who does not meet the BMI target, the plan offers an alternative of walking 150 minutes per week, regardless of whether the employee has medical conditions making

attainment of the BMI target unreasonably difficult or medically inadvisable. Any employee for whom it is unreasonably difficult due to a medical condition to comply with this walking program (and any employee for whom it is medically inadvisable to attempt to comply with the walking program) during the year is given the same discount if the employee satisfies an alternative standard that is reasonable taking into consideration the employee's medical situation, is not unreasonably burdensome or impractical to comply with, and is otherwise reasonably designed based on all the relevant facts and circumstances. Plan A satisfies HIPAA's availability requirements for wellness programs.

5. Discrimination in Favor of Individuals With Adverse Health Conditions

HIPAA does not prohibit plans from providing more favorable terms (such as extended coverage or a premium waiver) to a participant or beneficiary with an adverse health condition. For example, a plan that generally covers dependent children only until age 26 could cover disabled dependent children beyond age 26.

6. The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prevents discrimination based on genetic information. GINA imposes restrictions on group health plans, group health insurance issuers, and insurance issuers in the individual market to prohibit—

- using genetic information to discriminate with respect to premium or contribution amounts;
- requesting or requiring that individuals or their family members undergo genetic testing (with limited exceptions);
- collecting (by requesting, requiring, or purchasing) genetic information for underwriting purposes and collecting genetic information with respect to any individual prior to enrollment or coverage under the health plan; or
- using genetic information to determine eligibility for coverage or to impose preexisting condition exclusions.

Genetic information includes any information about an individual's own genetic tests, the genetic tests of an individual's family members (including a spouse, even though an individual and his or her spouse generally do not share genetic material), and the manifestation of a disease or disorder in the individual's family members. For this purpose, a genetic test is any analysis of human DNA, RNA, chromosomes, proteins or metabolites that detects genotypes, mutations, or chromosomal changes—essentially, anything used to predict whether an individual has a predisposition to a disease, disorder, or pathological condition.

GINA's provisions became effective for group health plans in plan years beginning after May 21, 2009, and for health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after May 21, 2009.

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