HIPAA Nondiscrimination: A Short Course
Although the Health Insurance Portability and Accountability Act (HIPAA) is most widely known for its privacy and security rules, HIPAA also prohibits group health plans (employer plans) and health insurers from discriminating with regard to eligibility and health status factors. When an employer considers its plan design options, HIPAA’s non-discrimination rules should be considered in conjunction with non-discrimination rules provided by the Internal Revenue Service (IRS) rules under Section 125 (rules for cafeteria plans) and Section 105 (rules for self-funded plans), the Genetic Information Nondisclosure Act (GINA), the Patient Protection and Affordable Care Act (ACA), and the Americans with Disabilities Act (ADA). In addition, fully insured plans should continue to monitor the regulations relating to the implementation of the Section 105 rules for fully insured plans.

Health Factors

Under HIPAA, health factors are:

- Health status
- Medical condition (physical and mental)
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability
- Disability
- Any other health status-related factor determined appropriate by the Secretary of the Department of Health and Human Services (HHS)

This means that employers cannot exclude individuals who participate in dangerous activities or have a history of high health claims, or hinge eligibility of enrollees on evidence of insurability or “passing” a physical exam. Employers cannot charge individuals different premiums based on the existence or absence of health factors. Underwriting factors can be used to establish group premiums for large groups (50+ or 100+, depending on state law), so long as the process complies with the ACA.

Health factors may not affect eligibility rules, which include rules relating to enrollment, effective dates, waiting periods, late/special enrollment, eligibility for benefit packages (including rules for individuals to change their selection among benefit packages), benefits (covered benefits, benefit restrictions, coinsurance, co-pays, and deductibles), and continued eligibility and terminating coverage.

Clauses limiting coverage to those who are “actively at work” at the time their waiting period ends are not permissible.

Plans cannot exclude coverage of injuries resulting from a medical condition or act of domestic violence. This means plans could exclude self-inflicted injuries such as those that result from bungee jumping or sky diving, but not self-inflicted injuries as the result of a suicide attempt.

Health Questionnaires and Physical Exams

Employers and health plan issuers may require health questionnaires (only in the large group market) prior to enrollment so long as the information in the questionnaire is not used to deny, restrict, or delay benefits, or to determine premiums. The questionnaire cannot seek genetic information.
Employers cannot condition eligibility for the plan on completing a physical examination, but they can request individuals to undergo an exam to determine appropriate group rates for large plans in certain situations. Employers that wish to request employees undergo a physical exam for factors outside of eligibility should consult with legal counsel to ensure compliance with all federal regulations.

Similarly Situated Individuals

HIPAA allows group health plans to impose restrictions in benefit plans if they apply to all similarly situated individuals. Any employer considering offering different plans or plan options to different groups of employees should consider complying with HIPAA’s non-discrimination rules as the first step in determining if its potential plan design is allowable.

Plans can, in conformance with other laws, provide different benefits for different groups of similarly situated employees if the differences are based on a bona fide employment-related classification that is consistent with the employer’s usual business practice. Bona fide employment classifications might be part-time and full-time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service, provided the distinction is consistent with the employer’s usual business practice.

Differences are permitted between employees and beneficiaries (such as employee or spouse).

More Favorable Treatment for Those with Adverse Conditions

Plans may provide coverage to adult dependents age 26 and over that are disabled, as HIPAA allows plans to treat individuals with adverse health conditions more favorably.

This does not mean employers can offer individuals with high claims experience or expensive medical conditions an individual plan that is richer than the group plan. That practice would violate HIPAA and other laws. This prohibition includes offering opt-out incentives only to high-claims employees. Multiple federal agencies have issued guidance stating that offering high-claims employees a choice between cash (or an individual policy) and the group health plan is discrimination based on health status, subject to various penalties.

Wellness Programs

Wellness programs that provide incentives or penalties for health factors such as cholesterol levels, tobacco use, weight, exercise, or similar factors violate HIPAA unless they are provided in conjunction with a bona fide wellness program. For example, employers that penalize employees for tobacco use without a bona fide wellness program would be in violation of HIPAA.

Wellness programs are divided into three categories: participatory, health-contingent activity-only, and health-contingent outcome-based. Participatory programs are not subject to HIPAA.

A participatory program is a wellness program in which none of the conditions for obtaining the wellness reward require the individual to satisfy a condition related to a health factor.

Said another way, a participatory program is one that either has no reward or penalty (such as a program that provides free flu shots to employees who want one) or that does not include any conditions for obtaining the reward that are based on or related to a health factor (such as attending a series of lunch-
and-learns that virtually anyone can do regardless of their health). Most educational programs that are offered either to all employees or to all plan participants will be considered participatory.

Examples in the regulations of participatory programs include reimbursement of a fitness center membership, a reward for participating in diagnostic testing programs like a cholesterol screen that does not base any part of the reward on the outcome of the test, a smoking cessation program where the wellness reward is provided whether or not the person quits smoking, and a wellness reward for attendance at a periodic health education seminar. As long as a participatory program is equally offered to all similar employees, the HIPAA/ACA requirements will not apply to the program. This means that there are no limits on the amount of incentives that can be offered and a reasonable alternative is not required unless the participatory program includes medical examinations or disability-related questions.

A health-contingent wellness program is a program that either requires the participant to satisfy a standard related to a health factor (such as maintaining a healthy weight, blood pressure, blood sugar, or cholesterol level) or requires the individual to do more than other similarly situated individuals in order to attain the reward because of the person’s health status. Health-contingent programs are divided into "activity-only" programs and "outcome-based" programs.

An activity-only program is a program that requires the individual to perform or complete an activity related to a health factor in order to obtain the wellness reward. However, the person simply needs to complete the activity and not achieve specific results to receive the reward.

An activity-only program includes things like a walking program, nutrition counseling, or a smoking cessation program, if the program does not have a target health measure. It also includes programs that require individuals with certain health factors – such as those who have unhealthy body mass indexes (BMIs), blood pressure levels, etc. – to participate in educational programs, even though they only need to attend the programs, because those individuals are required to do more to get the reward than those who have healthy levels.

An outcome-based program requires the individual to achieve or maintain a specified health outcome, such as reaching or maintaining a healthy weight or blood cholesterol level, or not using tobacco.

To be compliant with HIPAA, a health-contingent wellness program must meet all five requirements:

1. Be reasonably designed to promote health or prevent disease (the same rules apply to activity-only and outcome-based programs);
2. Give employees a chance to qualify for the incentive at least once a year (the same rules apply to activity-only and outcome-based programs);
3. Cap the reward or penalty at 50 percent of the total cost of coverage for avoiding tobacco and at 30 percent for all other types of wellness incentives (the same rules apply to activity-only and outcome-based programs);
4. Provide an alternative way to qualify for the incentive for those who have medical conditions (different rules apply to activity-only and outcome-based programs); and
5. Describe the availability of the alternative method for qualifying for the incentive in written program materials (the same rules apply to activity-only and outcome-based programs).
A program is considered reasonably designed to promote health or prevent disease if it:

- a) Has a reasonable chance of improving the health of, or preventing disease in, the participating individual;
- b) Is not overly burdensome;
- c) Is not a subterfuge for discriminating on the basis of a health factor; and
- d) Is not highly suspect in its methods.

This means, for example, that a plan cannot simply charge non-smokers less without also helping smokers to quit.

**Grandfathered Church Plans**

Self-funded church plans that meet a particular set of requirements continuously since July 15, 1997, will not be treated as violating HIPAA nondiscrimination requirements because they require evidence of good health for coverage of certain individuals. Employers that believe they are subject to this exemption should consult counsel when undergoing plan design changes to ensure they meet all requirements of the exemption.

**Lifetime and Annual Dollar Limits**

HIPAA's nondiscrimination rules allow annual or lifetime benefit limits under certain conditions, although this practice is severely limited by the ACA's prohibition of lifetime dollar limits and annual dollar limits on "essential health benefits." An employer who wishes to impose lifetime or annual dollar limits should consult with counsel to ensure it is not violating applicable regulations.

**Summary Plan Description Requirements**

Group health plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA) must distribute a summary plan description (SPD) to each participant and beneficiary covered under the plan. There are no specific requirements that the SPD disclose information that pertains to HIPAA’s nondiscrimination rules, but wellness programs that impact a beneficiary’s potential premium, contribution, or cost-sharing must be described in the SPD. The SPD should include the terms of the wellness program, reasonable alternative availability, contact information, and the fact that accommodations will be provided based on an individual participant’s personal physician’s recommendations. The regulations provide model language that can be edited to accommodate an employer’s wellness program.

**Penalties**

Violating HIPAA’s nondiscrimination requirements can trigger numerous potential penalties, including an excise tax penalty of $100 a day per affected plan participant. Employers and plan administrators are expected to self-report these compliance failures using IRS Form 8928.

Historically, enforcement of the filing requirement and collection of the excise tax has been light, but the IRS has indicated that it expects employers to report failures and pay fines as applicable.

The excise tax is imposed on the plan sponsor, which generally is the employer. In the case of a multiemployer plan, the plan sponsor may be the employee organization, board of trustees, or committee.

12/17/2015
Reviewed 11/8/2018