



Electronic Dispatch

Employee Benefits Law Information Memo

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FINAL RULES ISSUED GOVERNING HIPAA NONDISCRIMINATION AND WELLNESS PROGRAMS

Final rules under the Health Insurance Portability and Accountability Act (HIPAA) prohibiting discrimination based on health factors for group health plans and clarifying prior guidance for wellness programs were issued on December 13, 2006. These final rules are effective for plan years beginning on or after July 1, 2007.

HIPAA Nondiscrimination

A group health plan is generally not required to provide any particular benefit coverage to any group of similarly situated individuals. However, once provided, the benefits, and any restrictions on such benefits, must be uniformly available to all similarly situated individuals, and must not be based upon any health factor of participants or beneficiaries.

Health factors include:

- health status;
- medical condition (both mental and physical);
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability; or
- disability.

For example, a group health plan may limit or exclude benefits: (i) related to a specific condition; (ii) for certain types of treatments or drugs; or (iii) based on a determination that such benefits are experimental or not medically necessary. However, such limitations or exclusions must be applied uniformly to all similarly situated individuals, and not directed at specific individuals based upon health factors.

A group health plan may also impose annual or lifetime limitations on benefits and/or cost-sharing requirements (such as deductibles, copayments or coinsurance), provided such limitations or cost-sharing requirements are also applied uniformly to all similarly situated individuals, and are not directed at specific individuals based upon health factors.

The final rules caution that compliance with the HIPAA nondiscrimination rules does not ensure compliance with any other provisions of the Employee Retirement Income Security Act (ERISA), or any other state or federal law, including the Americans with Disabilities Act (ADA).

Source-of-Injury Exclusions

Group health plans often deny coverage for the treatment of an injury that arose from a specified cause or activity. Such exclusions are commonly referred to as "source-of-injury" exclusions. While source-of-injury exclusions are generally allowed, a group health plan may not deny coverage for the treatment of an injury if the injury results from a medical condition or an act of domestic violence.



For example, coverage for treatment of an injury may be denied in instances where the injury resulted from bungee jumping (or some other dangerous activity), but not in situations where the injury resulted from an attempted suicide due to depression. The final rules clarify that in instances of injury due to a medical condition, the medical condition does not have to be diagnosed prior to the injury.

Nonconfinement Clauses

Nonconfinement clauses that deny benefits due to an individual's confinement to a hospital or other health care institution at the time coverage would otherwise have become effective are prohibited. In situations where state law requires a prior issuer to continue coverage during a period of confinement, there was confusion as to whether a nonconfinement clause relieved a prior issuer from extending coverage during periods of nonconfinement. The final rules clarify that:

- state law cannot change a succeeding issuer's obligation to provide coverage;
- a prior issuer may also have an obligation to continue coverage; and
- in situations where both a prior and succeeding issuer have obligations to provide benefits during a period of confinement, coordination-of-benefit laws designed to prevent more than 100 percent reimbursement continue to apply.

In the event state law requires continued coverage by a prior issuer only if the hospitalization is not covered by the successor issuer, the prohibition on nonconfinement clauses may eliminate a prior issuer's obligation to continue coverage.

Wellness Programs

Wellness programs that provide incentives for health promotion and disease prevention generally do not violate HIPAA nondiscrimination rules.

The final rules identify certain types of wellness programs that would not have to satisfy any additional requirements to comply with the HIPAA nondiscrimination rules:

- a program that reimburses all or part of the cost of a fitness center membership;
- a diagnostic testing program that provides a reward for participation, without basing the reward on testing results;
- a program that encourages preventive care by waiving the copayment or deductible requirement (for example, prenatal care or well-baby visits);
- a program that reimburses employees for the cost of smoking cessation programs regardless of whether the employee actually quits smoking; and
- a program that rewards employees for attending monthly health education seminars.

In the event a wellness program rewards a person for meeting a standard related to a health factor, such program must satisfy five additional requirements:

- 1. The total reward for all wellness programs must not exceed 20 percent of the cost of employee-only coverage under the plan.** If dependents are allowed to participate, the total cost must not exceed 20 percent of the coverage for which the employee and dependents are enrolled.
- 2. The program must be reasonably designed to prevent disease or promote good health.** The "reasonably designed" standard will be satisfied if the program (a) has a reasonable chance of improving the health of participants, (b) is not overly burdensome, (c) is not an attempt to conceal discrimination based on a health factor, and (d) is not highly suspect in the method used to promote health or prevent disease.

3. The program must give eligible individuals the opportunity to qualify for the reward at least annually.

4. The reward must be available to all similarly situated individuals. A program must make a reasonable alternative standard (or waive the applicable standard) for individuals for whom it is unreasonably difficult (or medically inadvisable) to satisfy the standard due to a medical condition.

5. All documents and materials describing the program must disclose that a reasonable alternative standard (or waiver of the standard) is available for any individual for whom it is unreasonably difficult or medically inadvisable due to a medical condition to satisfy the program's standard.

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