HIPAA's Nondiscrimination Rules: Agencies See Green Light for Regulating Plan Design

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In their Spring 1997 Benefits Law Journal *article, the authors discussed the nondiscrimination rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). They considered how these rules may affect common elements of health plan design such as benefit caps and exclusions, waiting periods, and wellness programs. They concluded that Congress probably intended the HIPAA rules to have only very modest effects on plan design but that the statute and legislative history are full of ambiguities. Thus, the agencies responsible for regulations or a reviewing court could easily infer strict and far-reaching restrictions. In this follow-up article, the authors examine the nondiscrimination questions raised by the agencies in the April 1997 HIPAA regulations package, what those questions suggest about future rules, and the possible effects on plan design. The early warning signs lead the authors to think that their most pessimistic predictions were not too gloomy.*

HIPAA regulations were issued in early April 1997 by the Departments of Labor, Treasury, and Health and Human Services.[1] For the most part, the regulations do not advance the interpretation of the nondiscrimination rules but merely repeat the language of the statute. There is an obvious and sensible reason for this. Coverage certification and other HIPAA requirements that necessitate very specific actions by plan sponsors and administrators are effective starting this summer. The agencies apparently focused on getting out early guidance on these requirements, delaying consideration of the nondiscrimination rules.

The agencies' joint preamble to the regulations is a source of concern for employers. The preamble only raises issues and requests comments, promising more detailed regulations in the future. But the issues raised suggest that the Labor and Treasury Departments are

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now eyeing the HIPAA nondiscrimination rules as possible authority for significant regulation of health plans. Rules evidently under consideration would both constrain benefit design and regulate coverage across an employer's workforce.

The five specific issues on which the agencies have requested comment are as follows:

- The extent to which the statute prohibits discrimination against individuals in eligibility for particular benefits.
- The extent to which the statute may permit benefit limitations based on the source of an injury (e.g., motorcycling, skiing, and other high-risk behavior).
- The permissible standards for defining groups of "similarly situated individuals."
- Application of a possible prohibition on discrimination between groups of similarly situated individuals.
- The permissible standards for determining bona fide wellness programs.[2]

THE STATUTORY NONDISCRIMINATION RULES

HIPAA contains an eligibility nondiscrimination rule and a cost nondiscrimination rule.

Eligibility Rule

The basic statutory rule is that a health plan may not establish "rules for eligibility . . . to enroll under the terms of the plan" on the basis of specified "health status-related factors": health status, medical condition, claims experience, receipt of health care, medical history, genetic information; evidence of insurability (including conditions arising out of acts of domestic violence); and disability.[3]

These statutory terms are generally not fleshed out. But the Conference Committee Report clarifies that "evidence of insurability" includes "motorcycling, snow-mobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities."[4]

The statute provides three adjunct rules:

- The basic rule may not be read to require that a plan provide "particular benefits other than those provided" under its terms.
- The basic rule may not be read to prevent "limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals. . . ."

- A plan's waiting periods are among the eligibility provisions covered by the basic rule.

Cost Rule

The basic rule is that a health plan may not charge any individual a premium, as a condition of enrollment or continued enrollment in the plan, higher than the premium charged to "a similarly situated individual" enrolled in the plan on the basis of any health status-related factor of that individual (or a dependent of that individual).[5]

The statute then provides that the basic rule does not prohibit premium discounts or rebates, or the modification of otherwise applicable copayments or deductibles, in return for adherence to programs of health promotion and disease prevention. As an example, the Report of the Senate Labor and Human Resources Committee states that premium discounts may be offered to nonsmokers.[6]

EVIDENCE OF INSURABILITY

One point (and perhaps the only point) that is clear from the statutory HIPAA nondiscrimination rules is that a plan may not condition plan enrollment on an individual's ability to produce evidence of insurability.

In one of the few substantive provisions under the nondiscrimination rule, the regulations affirm that even common evidence of insurability practices are forbidden by HIPAA. For example, many plans require that an individual who declines coverage when first eligible may not later enroll unless he or she passes a physical exam. The regulations clarify that a physical exam may not be required as a condition of plan enrollment at any time, even for late enrollees.[7]

CAPS AND EXCLUSIONS

Our best reading of congressional intent is that the nondiscrimination rules were not intended to prohibit benefit caps and exclusions. This conclusion is based, in part, on the rule adjunct to the basic eligibility rule that states that the basic rule does not require a plan to provide benefits "other than those provided" by the plan's terms. This adjunct rule supports the argument that the basic rule governs only access to a plan, and not the nature of benefits in that plan for individuals already participating in it. Moreover, the Conference Committee Report provides that the eligibility rule is not intended to prohibit caps, including, for example, caps on specific benefits or treatments, and lifetime caps on all benefits under the plan.[8]

But other provisions in the statute, and now the preamble to the regulations, confuse the issue.

The Statutory "Similarly Situated" Rule

The problem arises under the statute in a second adjunct rule, which provides that the basic eligibility rule prohibits "limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for *similarly situated individuals*. . . ."[9] Recall that the first adjunct rule states that no benefits "other than those provided" by the plan's terms are required. In the context of this first rule, the second rule arguably can be read as a limitation on the first: Benefits or coverage may be limited in amount, level, etc. *only* to the extent that the same limitations are applicable to all similarly situated individuals.

A fundamental problem of interpretation is that "similarly situated individuals" is not defined in the statute, and the legislative history is of no help in clearing up the ambiguity. One might conclude that the term means all individuals seeking similar treatment. For example, a cap on high-dose chemotherapy would be permitted if the cap is applied equally to all individuals seeking such chemotherapy. This reading is consistent with the legislative history's assurance that benefit caps are permitted.

But "similarly situated individuals" also might be read to denote, for example, all individuals who are equally sick or all those who have comparable health conditions. Under this reading, a limitation on the treatment provided to an individual would not be permitted if another individual with a similar health condition received the treatment without limitation.

"Similarly situated individuals" could even be read to mean all individuals whose medical conditions are equally costly, or for whom indicated treatments meet the same cost-benefit ratio. The EEOC has stated that a similar rule might apply under the Americans with Disabilities Act. A footnote in the EEOC Interim Guidance on the ADA and Health Insurance provides that limitations on treatment of a disability may not be permitted on the grounds that the treatment is worthless, if the plan covers comparably worthless treatments for any other condition.[10]

In short, the ambiguity of the "similarly situated" standard in the statute leaves open the possibility that benefit exclusions and caps may be restricted in some way—despite the legislative history's clear assurance that exclusions and caps are permitted.

"Similarly Situated" under the Preamble to the Regulations

The preamble adds to the uncertainty raised by an ambiguous statute. The agencies have clearly decided to sustain the ambiguity for now, while they fully consider its possible use. Of the five re-

quests for comments in the preamble, two explicitly relate to the meaning of "similarly situated individuals." (The preamble solicits comments on permitted standards for defining groups of similarly situated individuals, as well as application of the nondiscrimination rules between groups of similarly situated individuals.)

While never explicitly invoking this troublesome term, a third request for comments has even more far-reaching implications, especially for exclusions and caps. Specifically, the preamble solicits comments on the extent to which the statute permits benefit limitations based on the source of an injury. This shows that the agencies are considering banning the common plan practice of excluding or capping coverage for injuries incurred while engaged in high-risk behavior. Typical examples of this practice, noted in the preamble, are exclusions for coverage of injuries incurred while motorcycling or skiing.

Such a ban would seemingly contradict the Conference Committee Report's statement that benefit exclusions and caps are permitted by the statute. Motorcycling, skiing, and so forth are discussed in the Conference Committee Report, but only as examples of "evidence of insurability." In this context, they are among the HIPAA health status-related factors that cannot be used as a basis for a total denial of plan coverage. The Conference Committee Report discussion does not support a ban or coverage exclusions or caps related to motorcycling, skiing, or any other "source of an injury."

No Reference to Health Status-Related Factors?

Under the HIPAA nondiscrimination rule, a plan apparently may exclude coverage for all head injuries. If so, why couldn't a plan exclude coverage for all head injuries incurred while motorcycling?

The only difference between the two rules is that the latter is expressed by reference to an example of "evidence of insurability." This is one of the HIPAA health status-related factors that cannot be used to deny eligibility for plan coverage. The use of the factor here suggests that the agencies are contemplating taking criteria set forth by statute as part of an eligibility rule, and using them in a rule governing plan benefits. It thus would appear that behind the very limited rule discussed in the preamble—a possible ban on coverage limitations related to the source of an injury—lurks a more general rule: A class of "similarly situated individuals" and, therefore, any coverage exclusion or cap, is not permitted if defined by reference to any HIPAA health status-related factor also prohibited as a criterion for denying entrance to the plan.

The problem with such a rule is that its natural stopping point is unclear.

Preexisting Condition Restrictions

Detailed rules in HIPAA specifically dealing with preexisting conditions limit the extent to which plans can restrict coverage based on such conditions but certainly do not ban restrictions entirely. But, if exclusions (or caps) based on a health status-related factor generally are banned, then why shouldn't a preexisting condition restriction be banned, since such a restriction is based on medical history, a health status-related factor? Instead of reading HIPAA's preexisting condition rules as proscriptive, should they be read as "loosening" an otherwise sweeping nondiscrimination rule?

Both Congress and the agencies have realized that a relationship exists between the "similarly situated" clause of the nondiscrimination rules and the preexisting condition rules but have left that relationship ambiguous. The nondiscrimination rules in the statute and regulations apply "to the extent consistent with" the preexisting condition rules.[11] It is unclear whether HIPAA does not regulate plan design except to the extent of its preexisting condition restrictions or whether, instead, HIPAA's general nondiscrimination rule forbids all preexisting condition restrictions except those specifically permitted by HIPAA's other rules.

Caps

A rule that prohibits defining classes of similarly situated individuals by reference to health status-related factors raises doubts about the legislative history regarding benefit caps. For example, a $1 million lifetime cap limits coverage for individuals on the basis of their prior claims history—a health status-related factor. Such a cap is permitted by the Conference Committee Report. But is legislative history overruled by a contrary statutory rule?

The answer is unclear. The statute permits a limitation on benefits if the "amount" of benefits is equal within a class of "similarly situated individuals." So caps—at least for each specific benefit—seem to be specifically permitted by the statute. But can a plan limit benefits on the basis of prior claims experience other than by benefit "amount"? Can it limit, for example, the number of covered psychiatric outpatient visits? Can it cap the amount of lifetime benefits under the plan, in addition to the amount of any single benefit?

From Plan Eligibility Rule to Benefit-by-Benefit Rule

The agencies charged with writing the HIPAA regulations have

taken a rule that governs eligibility for admission to a plan and apparently interpreted it so that it may also govern how benefits are provided to individuals covered by the plan. The apparent leap from plan eligibility rule to benefits coverage rule is actually a two-step process. The statutory basis is the adjunct rule that states that limitations are not prohibited with respect to the amount, level, extent, or nature of benefits for "similarly situated individuals." A short step makes this an affirmative rule: The amount, level, etc. of benefits may not be restricted within any class of similarly situated individuals. Under the second step, a class of similarly situated individuals may not be defined by reference to any health status-related factor that cannot be used to deny enrollment in a plan.

This apparent leap would appear to be the basis for any rule prohibiting benefit limitations based on the source of the injury. This leap also helps explain another issue on which the agencies have sought comment: the extent to which the statute prohibits discrimination against individuals in eligibility for particular benefits. The preamble illuminates this request slightly by stating that the agencies are considering interpreting the eligibility nondiscrimination rule to prohibit a plan from "providing lower benefits to individuals based on health-status-related factors."[12] Although the intent of this statement is not entirely clear, it appears to be an additional warning shot that the agencies intend to apply the HIPAA nondiscrimination rules on a benefit-by-benefit basis, rather than merely on a plan eligibility basis.

Presumably, from the agencies' point of view, an obvious virtue of a benefit-by-benefit approach is that it removes a certain amount of pressure to define "plan" under the rules. For example, Employer A may choose to offer uniform benefits to all employees but under two plan documents (one for hourly employees, one for salaried employees) or in the form of VEBA-funded benefits for one group and unfunded benefits for another group. Employer B may choose to offer different kinds of benefits to different employees or groups of employees but under a single plan document. Under a benefit-by-benefit approach, distinctions of this type would not matter in applying the eligibility and cost nondiscrimination rules. But, as we have seen, from the employer's point of view, the approach also opens the door to significant regulation and control of plan benefits design.

DEFINING A GROUP OF SIMILARLY SITUATED INDIVIDUALS: BACK DOOR REQUIRED COVERAGE RULE?

The HIPAA legislative history makes one stab at defining "similarly situated," which leads to additional troubling issues regarding

the use of this term. The Conference Committee Report states that, under the similarly situated rule, a plan "would be permitted to vary benefits available to different groups of employees."[13] The examples of "different groups" in the Report are part-time versus full-time, employees in different geographic locations, and employees in different collective bargaining locations. The purpose of these examples is unclear but, among other interpretations, they arguably may be read as the beginning of a list of exclusive ways in which benefits would be permitted to be varied among different groups in an employer's workforce.

In the preamble to the regulations, the agencies refer to the examples in the Conference Committee Report and then request comments "concerning the appropriate standards for determining 'similarly situated individuals,' including whether a plan is permitted to vary benefits according to an employee's occupation."[14] This suggests that the agencies are considering a rule that benefits may not be varied among employees in different occupations if the employees all work in the same geographic locale or are all full-time versus part-time, etc. To put it more strongly, the agencies are apparently considering ruling that no benefit variations are permitted among employees except between the groups listed in the legislative history (or possibly a longer list of groups set forth in regulations).

The natural boundaries of such a rule are unclear. It is not uncommon for employers to provide different benefit packages for different groups of employees—for example, different plans for hourly and salaried employees, outright exclusions of some employee categories (restaurant workers and cleaning staffs, for example), and special health plans for management or executive employees. All of these practices might be prohibited by the rule apparently under consideration. For example, the agencies might require that all full-time employees working in the same geographic locale would have to be covered by the same health plan benefit structure.

SIMILARITY OF COVERAGE ACROSS GROUPS

The agencies seem to view the HIPAA eligibility nondiscrimination rule as a potential employee coverage rule. But, even if it becomes a coverage rule, employers may think they have partial protection from the limitations built in by the legislative history. If nothing else, Congress apparently intended that health benefits are not required to be provided equally to both part-time and full-time employees, and to all employees in different geographic locales.

But the preamble raises an issue of how far employers can go, by asking for comments on application of the HIPAA nondiscrimination rules when looking at two or more groups:

> [I]s guidance needed on whether a plan covering employees in two different locations could have a longer waiting period for employees at one location because the health status of those employees results in higher health costs?[15]

Recall that, according to the Conference Committee Report, there should be no obstacle to imposing waiting periods that vary with geographic location. But the rule apparently under consideration by the agencies would override the Conference Committee Report where health status also was a factor—that is, even if otherwise permitted by the Conference Committee Report, coverage differences among groups would be prohibited if based on differences in overall health status between the groups.

Such an override would be a significant expansion of HIPAA. On its face, HIPAA forbids discrimination against *individuals* on the basis of their health status. The legislative history confirms that individuals are the focus. For example, the Conference Committee Report explicitly states that "disparate impact" of caps and exclusions is permitted as long as not directed at "individual sick employees."[16] But the rule that appears to be under consideration would extend the HIPAA principle to *groups* of employees.

The implications would be far-reaching. For example, although the legislative history would appear to bless the common practice of excluding part-time employees from health coverage altogether, the rule apparently under consideration might ban this practice, at least for many employers. If it can be shown that part-time employees have higher health costs than full-time employees and that the reason part-timers have been excluded is related to the higher costs, then the exclusion would be prohibited.

At the very least, the rule apparently under consideration would open up all coverage differences and exclusions to extensive litigation.

WELLNESS PROGRAMS

The regulations cast some light on the effect of HIPAA's cost nondiscrimination rules on employer-sponsored wellness programs. Recall that, under the cost rule, a plan may not require a higher premium or contribution on the basis of any health status-related factor,

including evidence of insurability. But a second rule then states that the premium discrimination rule may not be read to prohibit discounts or rebates for adherence to programs of health promotion and disease prevention ("bona fide wellness programs"). In our Spring 1997 article in this *Journal*, we discussed a number of apparent contradictions between these two rules.

The regulations clear up one puzzle. In an example of the "health promotion" rule, the regulations describe a hypothetical cholesterol-reduction program. Enrollees in the program who achieve a target blood cholesterol level after a certain time are given a premium discount.

The regulations treat this program as impermissible. The reason given is that individuals may be unable to attain a given cholesterol level because of health status-related factors. In other words, the premium discount discriminates on the basis of prohibited factors.

Under the reasoning of the regulations, it would appear that undesirable levels of any physical trait may always be caused by a health status-related factor, rather than behavior. Thus, it should be concluded that any premium differentials based on measurable physical traits—for example, weight, blood pressure, body fat content—will not be permitted.

But, while clearing up one apparent contradiction, the regulations only deepen another. The Senate Labor and Human Resources Committee Report permits offering premium discounts for nonsmokers. At the same time, the statute apparently forbids charging higher premiums for smokers than nonsmokers. The conflict is readily apparent.

Some observers have concluded that the two rules may be reconciled by drafting every premium structure as a reward, rather than as a penalty. Under this approach, premium discounts are permitted, but premium penalties are not. The problem with the approach is that it lacks economic substance. If a plan charges a $100 premium for smokers and a $90 premium for nonsmokers, the effect on participants is the same whether the $10 differential is characterized as a premium discount or penalty.

The regulations and preamble show that the agencies have a concern about the penalty-versus-reward distinction. As indicated above, the regulations clearly provide that premium differentials for measurable physical traits are forbidden. The differentials cannot be salvaged by being cast as discounts rather than penalties.

In addition, the preamble requests comments on standards for determining what is a "bona fide wellness program," including

whether such a program may provide a discount for nonsmokers.[17] Thus, the agencies apparently are considering the possibility that premium discounts for nonsmokers are prohibited by the basic statutory cost nondiscrimination rule, even if permitted by the legislative history.

Of course, if prohibited for nonsmokers, whether premium discounts would be permitted for any "healthy" behavior is unclear. For example, and no less than smoking, refusal to adhere to a cholesterol-reducing diet arguably is part of an individual's evidence of insurability. Thus, premium discounts for good dietary habits should be permitted only to the same extent as premium discounts for nonsmokers.

This still leaves a puzzle. The rule permitting premium discounts for adherence to a program of health promotion and disease prevention is in the statute. Regulators are bound to interpret it to mean *something*. One possible interpretation might be that premium discounts are permitted only for behaviors with no measurable relationship to health or other indicia of insurability. A plan could give premium discounts for attendance at health workshops, for example, as long as there was no correlation between such attendance and any measurable health outcome.

CONCLUSION

Under the most defensible reading, the HIPAA nondiscrimination rules provide that individuals may not be barred—directly or indirectly, in the form of higher costs—from entrance to plans on the basis of health histories or other indicators of insurability. The rules do not regulate the provision of benefits under plans. And the rules are not intended to be employee health plan coverage rules.

But, according to the preamble of the recently issued HIPAA regulations, the Departments of Labor, Treasury, and Health and Human Services may view the rules differently. Issues raised in the preamble suggest that the agencies are at least considering the rules as the source of significant regulation of benefits design and employee coverage. Lack of clarity in the statute and its legislative history make strong arguments either for or against such regulations difficult at best.

NOTES

1. 26 CFR Part 54, TD 8716; 29 CFR Part 2590; 45 CFR Subtitle A, Parts 144 and 146, issued in 62 Fed. Reg. 16894 (Apr. 8, 1997).

2. 62 Fed. Reg. 16902.

3. ERISA §702(a); IRC §9802(a).

4. HR Rep. No. 736, 104th Cong., 2d Sess. 186 (1996) ("Conference Committee Report").

5. ERISA §702(b); IRC §9802(b).

6. S. Rep. No. 156, 104th Cong., 1st Sess. 20 (1995) ("Labor and Human Resources Report").

7. Treas. Reg. §54.9802-1T(a)(4); Labor Reg. §2590.702(a)(4).

8. Conference Committee Report at 187.

9. ERISA §702(a)(2)(B); IRC §9802(A)(2)(B).

10. EEOC Interim Policy Guidance on ADA and Health Insurance, June 8, 1993, reprinted at Americans with Disabilities Act Manual (BNA) Par. 70:1055, n. 17.

11. ERISA §702(a)(2); IRC §9802(a)(2); Labor Reg. §2590.702(a)(2); Treas. Reg. §54.9802-1T(a)(2).

12. 62 Fed. Reg. 16902.

13. Conference Committee Report at 187.

14. 62 Fed. Reg. 16903.

15. Id.

16. Conference Committee Report at 187. See also Labor and Human Resources Report at 13.

17. 62 Fed. Reg. 16903.

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