FAQs on HIPAA Portability and Nondiscrimination Requirements for Workers

U.S. Department of Labor
Employee Benefits Security Administration

What is the Health Insurance Portability and Accountability Act (HIPAA)?

HIPAA offers protections for workers and their families. The law provides additional opportunities to enroll in a group health plan if you lose other coverage or experience certain life events. HIPAA also prohibits discrimination against employees and their dependents based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information.

Taking Advantage of Special Enrollment Opportunities

What is Special Enrollment?

Special enrollment allows individuals who previously declined health coverage to enroll for coverage. Special enrollment rights arise regardless of a plan's open enrollment period.

There are two types of special enrollment – upon loss of eligibility for other coverage and upon certain life events. Under the first, employees and dependents who decline coverage due to other health coverage and then lose eligibility or lose employer contributions have special enrollment rights. For instance, an employee turns down health benefits for herself and her family because the family already has coverage through her spouse's plan. Coverage under the spouse's plan ceases. That employee then can request enrollment in her own company's plan for herself and her dependents.

Under the second, employees, spouses, and new dependents are permitted to special enroll because of marriage, birth, adoption, or placement for adoption.

For both types, the employee must request enrollment within 30 days of the loss of coverage or life event triggering the special enrollment.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

What are some examples of events that can trigger a loss of eligibility for coverage?

Loss of eligibility for coverage may occur when:

- Divorce or legal separation results in you losing coverage under your spouse's health insurance;
- A dependent is no longer considered a "covered" dependent under a parent's plan;
- Your spouse's death leaves you without coverage under his or her plan;
- Your spouse's employment ends, as does coverage under his employer's health plan;
- Your employer reduces your work hours to the point where you are no longer covered by the health plan;
- Your plan decides it will no longer offer coverage to a certain group of individuals (for example, those who work part time);
- You no longer live or work in the HMO's service area.

These should give you some idea of the types of situations that may entitle you to a special enrollment right.

How long do I have to request special enrollment?

It depends on what triggers your right to special enrollment. The employee or dependent must request enrollment within 30 days after losing eligibility for coverage or after a marriage, birth, adoption, or placement for adoption.

The employee or dependent must request enrollment within 60 days of the loss of coverage under a state CHIP or Medicaid program or the determination of eligibility for premium assistance under those programs.

After I request special enrollment, how long will I wait for coverage?

It depends on what triggers your right to special enrollment. Those taking advantage of special enrollment as a result of a birth, adoption, or placement for adoption begin coverage no later than the day of the event.

For special enrollment due to marriage or loss of eligibility for other coverage, your new coverage will begin on the first day of the first month after the plan receives the enrollment request. If the plan receives the request on January 3, for example, coverage would begin on February 1.

What coverage will I get when I take advantage of a special enrollment opportunity?

Special enrollees must be offered the same benefits that would be available if you are enrolling for the first time. Special enrollees cannot be required to pay more for the same coverage than other individuals who enrolled when first eligible for the plan.

Can my new group health plan deny me benefits because I have a preexisting condition?

While HIPAA previously provided limits on preexisting condition exclusions, new protections under the Affordable Care Act (ACA) prohibit group health plans from imposing any preexisting condition exclusion. Under this protection, a plan generally cannot limit or deny benefits relating to a health condition that was present before your enrollment date in the plan.

Where do I find out more about special enrollment in my plan?

A description of special enrollment rights should be included in the plan materials you received when initially offered the opportunity to enroll.

How will I know if I am eligible for assistance with group health plan premiums under CHIP or Medicaid?

You need to contact your state's CHIP or Medicaid program to see if your state will subsidize group health plan premiums and to determine if you are eligible for the subsidy under these programs. For information on the program in your state, call 1-877-KIDSNOW (543-7669) or visit **InsureKidsNow.gov** on the Web. If you are eligible for this premium assistance, you need to contact your plan administrator or employer to take advantage of the special enrollment opportunity and enroll in the group health plan.

HIPAA's Protections from Discrimination

What are HIPAA's protections from discrimination?

Under HIPAA, you and your family members cannot be denied eligibility or benefits based on certain "health factors" when enrolling in a health plan. In addition, you may not be charged more than similarly situated individuals based on any health factors. The questions and answers below define the health factors and offer some examples of what is and is not permitted under the law.

What are the health factors under HIPAA?

The health factors are:

- Health status;
- Medical conditions, including physical and mental illnesses;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability (see below); and
- Disability.

Conditions arising from acts of domestic violence as well as participation in activities like motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, and skiing are

considered "evidence of insurability." Therefore, a plan cannot use them to deny you enrollment or charge you more for coverage. (However, benefit exclusions known as "source of injury exclusions" could affect your benefits. These exclusions are discussed in more detail below.)

Can a group health plan require me to pass a physical examination before I am eligible to enroll?

No. You do not have to pass a physical exam to be eligible for enrollment. This is true for individuals who enroll when first eligible, as well as for late and special enrollees.

Can my plan require me to fill out a health care questionnaire in order to enroll?

Yes, as long as the questionnaire does not ask for genetic information (including family medical history) and the health information is not used to deny, restrict, or delay eligibility or benefits, or to determine individual premiums.

My group health plan required me to complete a detailed health history questionnaire and then subtracted "health points" for prior or current health conditions. To enroll in the plan, an employee had to score 70 out of 100 total points. I scored only 50 and was denied a chance to enroll. Can the plan do this?

No. In this case the plan used health information to exclude you from enrolling in the plan. This practice is discriminatory, and it is prohibited.

My group health plan booklet states that if a dependent is confined to a hospital or other medical facility at the time he is eligible to enroll in the plan, that person's eligibility is postponed until he is discharged. Is this permitted?

No. A group health plan may not delay an individual's eligibility, benefits, or effective date of coverage based on confinement to a hospital or medical facility at the time he becomes eligible. Additionally, a health plan may not increase that person's premium because he was in a hospital or medical facility.

My group health plan has a 90-day waiting period before allowing employees to enroll. If an individual is in the office on the 91st day, health coverage begins then. However, if an individual is not "actively at work" on that day, the plan states that coverage is delayed until the first day that person is actually at work. I missed work on the 91st day due to illness. Can I be excluded from coverage?

No. A group health plan generally may not deny benefits because someone is not "actively at work" on the day he would otherwise become eligible.

However, a plan may require employees to begin work before health plan coverage is effective. A plan may also require an individual to work full time (say, 250 hours per quarter or 30 hours per week) in order to be eligible for coverage.

Can my group health plan exclude or limit benefits for certain conditions or treatments?

Group health plans can exclude coverage for a specific disease or limit or exclude benefits for certain treatments or drugs, but only if the restriction applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor they may have. (Plan amendments that apply to all individuals in a group of similarly situated individuals and that are effective no earlier than the first day of the next plan year after the amendment is adopted are not considered to be directed at individual participants and beneficiaries.).

However, compliance with this rule under HIPAA does not affect whether the plan provision or practice is permitted under other laws including the ACA such as the requirement to offer essential health benefits in the individual and small group markets.

How do you determine "similarly situated individuals"?

HIPAA states that plans may distinguish among employees only on "bona fide employment-based classifications" consistent with the employer's usual business practice. For example, part time and full time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service can be treated as different groups of similarly situated individuals.

A plan may draw a distinction between employees and their dependents. Plans can also make distinctions between beneficiaries themselves if the distinction is not based on a health factor. For example, a plan can distinguish between spouses and dependent children, or between dependent children age 26 and older based on their age or student status.

I have a history of high claims. Can I be charged more than others in the plan based on my claims experience?

No. Group health plans cannot charge an individual more for coverage than a similarly situated individual based on any health factor.

However, be aware that HIPAA does allow an insurer to charge one group health plan (or employer) a higher rate than it does another. When an insurance company establishes its rates, it may underwrite all covered individuals in a specific plan based on their collective health status. The result can be that one employer health plan whose enrollees have more adverse health factors can be charged a higher premium than another for the same amount of coverage. Note that compliance with this rule under HIPAA does not affect whether the practice is permitted under the ACA including the rating requirements in the small group market.

Think of it this way: HIPAA's protections from discrimination apply within a group of similarly situated individuals, not across different groups of similarly situated individuals. For example, an employer distinguishes between full-time and part-time employees. It can charge part-time employees more for coverage, but all full-time employees must pay the same rate, regardless of health status.

Also, for insured plans, state law may govern rates for health coverage. More information is available at **NAIC.org**.

I am an avid skier. Can my employer's plan exclude me from enrollment because I ski?

No. Participation in activities such as skiing would be "evidence of insurability," which is a health factor. Therefore, it cannot be used to deny eligibility.

Can my health plan deny benefits for an injury based on how I got it?

It depends. A plan can deny benefits based on an injury's source, unless an injury is the result of a medical condition or an act of domestic violence.

Therefore, a plan cannot exclude coverage for self-inflicted wounds, including those resulting from attempted suicide, if they are otherwise covered by the plan and result from a medical condition (such as depression).

However, a plan may exclude coverage for injuries that do not result from a medical condition or from domestic violence. For example, a plan generally can exclude coverage for injuries in connection with an activity like bungee jumping. While the bungee jumper may have to pay for treatment for those injuries, her plan cannot exclude her from coverage for the plan's other benefits.

My group health plan says that dependents are generally eligible for coverage only until they reach age 26. However, this age restriction does not apply to disabled dependents, who seem to be covered past age 26. Does HIPAA permit a policy favoring disabled dependents?

Yes. A plan can treat an individual with an adverse health factor (such as a disability) more favorably by offering extended coverage.

Are all family members, including a spouse, covered by HIPAA?

If your group health plan permits coverage of family members ("dependents"), and if they participate in the plan, then they will have the same HIPAA protections as employees.

Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) expands the HIPAA nondiscrimination provisions discussed above by generally prohibiting the use of genetic information to adjust group premiums or contributions, the collection of genetic information and requests for individuals to undergo genetic testing.

HIPAA and Wellness Programs

I've learned that my health plan will include a wellness program next year. What is a wellness program?

Wellness programs encourage employees to work out, stop smoking or generally adopt healthier lifestyles by offering some type of financial or other incentive. If a wellness program is part of a group health plan, it must comply with rules created by HIPAA and the ACA that prevent the employee from being impermissibly discriminated against based on a health factor.

There are two types of wellness programs - participatory and health-contingent. A participatory wellness program is one that offers a reward simply for participating in the program. For example, the program reimburses employees for all or part of the cost for membership in a fitness center. Participatory wellness programs are allowed under the nondiscrimination rules as long as they are available to all similarly situated individuals.

A health-contingent wellness program is one that rewards an employee for satisfying a standard related to a health factor. If the standard is an activity-only one, you need to perform or complete an activity, like walking or other exercise, to get the reward. If the standard is outcome-based, you must achieve a specific health outcome, like a certain result on a health screening, to get the reward. Health-contingent wellness programs must meet certain requirements.

I belong to a group health plan that rewards individuals who volunteer to be tested for early detection of health problems, such as high cholesterol. Can a plan do this?

Yes, as long as the program is available to all similarly situated individuals. If the health plan offers a reward based on participation in the program and not on test results, the program is considered a participatory wellness program and the plan does not have to comply with the additional requirements applicable to health-contingent wellness programs. For instance, a health plan can offer a premium discount for those who voluntarily test for cholesterol, as long as the discount is available to everyone who takes the test and not just those who get a certain result. If the discount was based on individuals having certain results, additional requirements discussed below would apply.

My plan's wellness program offers a lower deductible to those who participate in a specific walking program. How can I tell if this is permissible?

Because the reward (the lower deductible) is available to all who participate in a walking program, this is an activity-only health-contingent program. The program will be permissible if:

- Individuals have a chance to qualify for the reward at least once per year;
- The total reward for all of the plan's health-contingent wellness programs is not more than 30% of the cost of employee-only coverage in the plan. If dependents can participate, the reward cannot be more than 30% of the cost of the coverage in which an employee and dependents are enrolled. For wellness programs designed to prevent or

reduce tobacco use the allowable percentage is higher – the reward for those programs cannot be more than 50% of the cost of coverage;
- The walking program is reasonably designed to promote health or prevent disease;
- A reasonable alternative standard (or a waiver of the walking requirement) is offered to those for whom it is unreasonably difficult because of a medical condition, or medically inadvisable, to participate in the walking program; and
- The plan discloses the availability of a reasonable alternative standard (or the possibility of a waiver) in all materials describing the terms of the program.

I would like to participate in my plan's wellness program. Under the program, to get a discount on my premiums, my body mass index (BMI) must be 26 or lower. Is there any way for me to get the premium discount if my BMI is higher than 26?

Yes. The reward is provided to those who achieve a specific health outcome (BMI of 26 or lower), so this is an outcome-based health-contingent wellness program. If your BMI is above 26, the plan must provide you with a reasonable alternative standard to qualify for the reward. The reasonable alternative standard could be activity-based such as completion of an educational program, participation in a diet program, or following the recommendations of your personal physician; it could also be another outcome-based standard, such as a one-point reduction in your BMI over a set period of time. If it is unreasonably difficult because of a medical condition, or medically inadvisable, for you to complete the alternative, the plan must work with you to find a second alternative based on your physician's recommendations.

In addition, as with an activity-only program, you must be given the chance to qualify for the reward at least once per year; the total reward for the plan's health-contingent wellness programs cannot be more than 30% (or 50% for tobacco-related programs) of the cost of employee-only coverage (or the cost of the coverage enrolled in if dependents can participate); and the plan must disclose the availability of a reasonable alternative standard (or the possibility of a waiver) in all materials describing the terms of the program. This notice must also be included in any disclosure that you did not satisfy the initial standard.

Can a plan charge a lower premium for nonsmokers than it does for smokers?

The plan is offering a reward based on an individual's ability to stop smoking so this is an outcome-based program. For this type of wellness program to be permissible:

- Individuals must have a chance to qualify for the nonsmoker's discount at least once a year;
- The difference in premiums between nonsmokers and smokers cannot be more than 50% of the cost of employee-only coverage (or 50% of the cost of coverage if dependents can participate);
- The program must be reasonably designed to promote health and prevent disease;
- There is a reasonable alternative standard to those who do not meet the otherwise applicable standard. For example, the reasonable alternative standard could include discounts in return for attending educational classes or for trying a nicotine patch; and
- Plan materials describing the premium discount (and any disclosure that an individual did not satisfy the standard) describe the availability of a reasonable alternative standard to qualify for the lower premium.

Coordination with Other Laws

Can states modify HIPAA's requirements?

State laws may complement HIPAA by allowing more protections than the Federal law. For example, states may increase the number of days parents have to enroll newborns, adopted children, and children placed for adoption or require additional circumstances that entitle you to special enrollment periods beyond those in the Federal law. However, these state laws only apply if your plan provides benefits through an insurance company or HMO (an insured plan). To determine if your plan offers insured coverage, consult your Summary Plan Description (SPD) or contact your plan administrator. You also can visit your state insurance commissioner's office or the National Association of Insurance Commissioners' Website (select your state) for more information.

How can I use HIPAA in conjunction with COBRA to extend my health coverage?

COBRA is a law that can help if you lose your job or if your hours are reduced to the point where the employer no longer provides you with health coverage. COBRA can provide a temporary extension of your health coverage – as long as you and your family members, if eligible, belonged to the previous employer's health plan and generally the employer had 20 or more employees. Usually, you pay the entire cost of coverage (both your share and the employer's, plus a 2 percent administrative fee). As long as the prior plan exists, COBRA coverage lasts up to 18 months for most people, although it can continue as long as 36 months in some cases.

If you enroll in COBRA, HIPAA provides you with the opportunity to request special enrollment in a different group health plan if you have a special enrollment event, such as marriage, the birth of a child, or if you exhaust your continuation coverage. To exhaust COBRA, you must receive the maximum period of continuation coverage available (usually 18 months for job loss) without early termination. If you choose to terminate your COBRA early, or fail to pay your COBRA premiums, you generally will not be entitled to special enroll in other group health coverage.

Do I have other special enrollment rights?

In addition to the special enrollment rights in a group health plan under HIPAA (described above), there are also special enrollment rights under the ACA for individual coverage including through the Health Insurance Marketplace. The Marketplace offers "one-stop shopping" to find and compare private health insurance and other options (such as Medicare and CHIP coverage). Losing your job-based coverage, marriage, birth, and adoption are a few of the special enrollment events that may allow you to purchase Marketplace or other coverage outside of the regular enrollment period.

To qualify for special enrollment, you must select a plan either within 60 days before losing your job-based coverage or within 60 days after losing your job-based coverage.

You can apply for Marketplace coverage online or get more information at **HealthCare.gov** or by calling 1-800-318-2596 (TTY users should call 1-855-889-4325). When you fill out a

Marketplace application, you also can find out if you and your family qualify for free or low-cost coverage from Medicaid and/or the Children's Health Insurance Program (CHIP).

Where can I get more information on my rights under HIPAA?

The Employee Benefits Security Administration offers more information on HIPAA and other laws mentioned above. Visit the Employee Benefits Security Administration's **Website** to view the following publications. To order copies or to request assistance from a benefits advisor, **contact EBSA** electronically or call toll free 1-866-444-3272.

- **Retirement and Health Care Coverage...Questions and Answers for Dislocated Workers**
- **An Employee's Guide to Health Benefits Under COBRA**
- **Top 10 Ways to Make Your Health Benefits Work for You**
- **Life Changes Require Health Choices...Know Your Benefit Options**