

HIPAA AND THE SLOW DEMISE OF “ACTIVELY AT WORK”

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For decades, insurers, health maintenance organizations and employer/plan sponsors have utilized “actively at work” provisions in insurance policies and plans to stave off adverse selection. Essentially, these provisions required that an employee be actively at work on the effective date of coverage. Otherwise, coverage did not become effective unless and until the employee returned to active employment. The purpose of these provisions was twofold: (1) ensure that an employer was not simply including participants who had no direct employment relationship, e.g. parents and grandparents, and (2) ensure that the financial responsibility for ill or injured employees not be foisted immediately onto the insurer, HMO or employer/plan sponsor.

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (“HIPAA”). HIPAA amended various federal laws with the intent that access and portability of health care coverages be extended to employers of all sizes. The majority of the federal HIPAA amendments occurred in connection with the Employee Retirement Income Security Act (“ERISA”) and the Public Health Services Act (“PHSA”).¹

HIPAA established a federal floor for accessibility and portability of health care coverages; however, HIPAA granted states the opportunity to adopt counterparts to HIPAA for health insurance issuers, provided the minimum federal requirements are satisfied.² Most states adopted their own statutory and regulatory counterparts to HIPAA.³

The federal version of HIPAA, and most state counterparts, included provisions limiting pre-existing conditions, requiring crediting of pre-existing conditions for prior coverage(s), identified exceptions to pre-existing conditions, defined special enrollment periods and prohibited discrimination based upon health status.⁴ The federal version of HIPAA also contained language mandating that regulations be adopted to facilitate implementation of the new standards for health care coverages. One HIPAA provision has caused insurers, HMOs and employer/plan sponsors significant interpretation difficulty. That provision relates to prohibiting discrimination based upon health status factors.

The non-discrimination provisions embodied within HIPAA prohibit discrimination in eligibility, benefits, premiums or other advantages of coverage on the basis of:

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

Notwithstanding the seeming simplicity of the preceding prohibitions, insurance carriers, HMOs and employer/plan sponsors continue to struggle with the notion of what constitutes “discrimination,” and as a corollary, what language may be included in plan documents.⁵

Consistent with HIPAA’s enabling provisions, the United States Department of Labor recently issued regulations designed to answer percolating inquiries about HIPAA interpretation. Those regulations are found at 29 U.S.C. 2590 et seq. The provisions which treat nondiscrimination are found at 29 U.S.C. § 2590.702 and are effective for plan years after July 1, 2001. The non-discrimination regulations specifically address the use of actively-at-work, confinement and continuous service clauses within employee benefit plans and policies.

Nonconfinement Provisions

The newly adopted HIPAA non-discrimination regulations (the “Regulations”) reiterate that group health plans and health insurance issuers may not discriminate against an individual on the basis of the above-detailed health status

factors.⁶ In that regard, the Regulations specifically discuss plan provisions that violate HIPAA. Several types of policy and plan provisions are discussed in the Regulations. One type of policy or plan provision relates to nonconfinement clauses.⁷ Nonconfinement clauses are those clauses contained in benefit plans and policies which state that an individual is not eligible for coverage if he or she is confined to a hospital or other health care institution on the effective date of coverage. The Regulations make it clear that such provisions violate HIPAA. Thus, notwithstanding confinement in a hospital or health care institution, an individual would nonetheless be eligible for coverage and coverage would need to become effective regardless of such confinement.⁸ To further demonstrate the prohibition, the Regulations contain the following example:

Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution does not become effective until the confinement ends.

The preceding example would violate HIPAA because the eligibility of the dependent is tied to whether he or she is confined to a hospital or other health care institution on the effective date of coverage. As noted previously, discrimination on the basis of medical conditions or receipt of health care is prohibited by HIPAA and its related Regulations.⁹

Continuous Service Provisions

The Regulations also contain prohibitions on the application of continuous service provisions in a method resulting in discrimination. Continuous service provisions typically require that an employee perform a period of continuous service in order to be eligible for coverage. For example, a plan may contain a provision that requires an employee to complete 90 days of continuous employment service for coverage under the plan to become effective. The Regulations prohibit the application of continuous service provisions to the extent such application would result in discrimination based upon a health factor.¹⁰ To demonstrate that point, the Regulations contain the following example:

Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service: that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

The preceding example violates HIPAA to the extent that the absence is caused by a health factor. Thus, continuous service clauses are not prohibited per se by the Regulations.¹¹ However, absence during the continuous service period that is based upon any health factor must not be counted as an absence under the continuous service clause. In other words, a plan or policy can still contain continuous service clauses, but an individual who is absent during such continuous service periods based upon a health factor must be treated as being actively-at-work.

Actively-at-Work Provisions

The Regulations also address actively-at-work provisions. In that regard, the Regulations do not prohibit actively-at-work provisions per se. Rather, the Regulations prohibit the application of actively-at-work provisions to instances where an individual is absent on the effective date of coverage due to a health factor. Actively-at-work provisions typically require that an employee be actively-at-work on the effective date of coverage. Historically, such provisions were used to ensure that an employer was covering only valid employees. Additionally, such provisions were used to limit the risk assumed by insurers, HMOs and employer/plan sponsors on the effective date of coverage. Based upon the non-discrimination provisions embodied within HIPAA, the United States Department of Labor specifically addressed actively-at-work provisions within the context of the Regulations. To demonstrate the prohibition, the Regulations contain the following example:

Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.

The preceding example would violate HIPAA if the absence was based upon a health factor. However, if absence from work due to any health factor is treated, for purposes of the plan or policy as being actively-at-work, then such provisions are allowable under the Regulations.¹² In other words, employees absent due to health factors on the effective date of coverage must be accorded protected status and treated as being actively-at-work.

First Day of Work Provisions

Notwithstanding the foregoing, the Regulations do allow for first day of work eligibility rules.¹³ In that regard, the Regulations specifically allow for eligibility rules that are tied to whether an employee begins employment with the employer sponsoring the plan. However, in order to be valid under the Regulations, first day of work eligibility rules must be applied regardless of the reason for the absence.¹⁴ The Regulations demonstrate this concept by the following example:

Under the eligibility provisions of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual H is scheduled to begin work on August 3, however, H is unable to begin work on that day because of illness. H begins working on August 4 and H's coverage is effective August 4.

The foregoing example does not violate HIPAA. The Regulations make it clear that an employer may still require an employee to report to work in order to become eligible for plan benefits. Thus, requiring an employee to begin work, regardless of whether a health factor contributed to the employee being unable to report to work, is still a permissible practice. However, the Regulations likewise state that all employees must be treated equally in that regard. Thus, if a plan seeks to enforce a first day of work provision, it must be applied equally to all employees, regardless of the reasons for failure to report to work.

It is clear that HIPAA has significantly modified the way in which health care is delivered in the United States. Insurers, HMOs and employer/plan sponsors are no longer free to include provisions of their choice in plan and policy documents if the application of such provisions violates HIPAA. The newly adopted Regulations specifically address the use of nonconfinement, continuous service and actively-at-work provisions. In that regard, nonconfinement clauses are essentially prohibited in plan and policy documents based upon the Regulations. Actively-at-work and continuous service clauses are allowed in plan and policy documents, but may not be applied to absences based upon health factors. The prohibition and limitation of such provisions is likely to have a significant impact on the risk transferred to insurers, HMOs and employer/plan sponsors. Given these constraints, mandating full disclosure during the initial underwriting process takes on increased significance. Otherwise, insurers, HMOs and employer/plan sponsors may lose the ability to effectively underwrite and appropriately charge for the transfer of risk.

Endnotes

1. See ERISA §§ 701 et seq. and PHSA § 2701 et seq.
2. See PHSA § 2723.
3. See A.R.S. §§ 20-2301 et seq.
4. HIPAA is made applicable to self-funded and government plans through ERISA and PHSA amendments. HIPAA is generally made applicable to insurers and HMOs through state HIPAA counterparts. Such insurers and HMOs are referred to as "health insurance issuers" in HIPAA.
5. See ERISA §§ 701 et seq.; PHSA §§ 2701 et seq.; see also A.R.S. § 20-2301 et seq.
6. See 29 C.F.R. 2590.702(a).
7. See 29 C.F.R. 2590.702(e).

8. The Regulations also address nonconfinement clauses as they are construed in connection with extension of benefits provisions. For example, a plan may not restrict eligibility or payment of claims if an individual is otherwise covered by extension of benefits from a prior plan. In that instance, the individual would be eligible for coverage under the “new” plan and the plans would simply coordinate their coverages pursuant to plan language and applicable state law. *See* HCFA Insurance Standards Bulletin 00-01.
9. *See* 29 C.F.R. 2590.702(e).
10. *See* 29 C.F.R. 2590.702(e)(2).
11. *Id.*
12. *Id.*
13. *See* 29 C.F.R. 2590.702(e)(2)(B).
14. *Id.*