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HIPAA Compliance Update for Group Health Plans

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Major Requirements for Health Plans Under HIPAA

- Portability
- Privacy and Security Rules (a.k.a., Administrative Simplification)
- Nondiscrimination – Wellness Program Exceptions

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Special Enrollment Periods

- Health plans must provide special enrollment periods for individuals experiencing certain events:
  - The involuntary loss of other health coverage,
  - Gaining new dependents, and
  - Gaining eligibility for Medicaid or CHIP premium assistance or the termination of Medicaid or CHIP coverage.

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Privacy Requirements: Who Must Comply?

- Covered Entities
  - Health Plan
  - Health Care Provider
  - Health Care Clearinghouse
- Business Associates of a Covered Entity – directly liable for impermissible uses and disclosures of Protected Health Information.

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Privacy Requirements: Hybrid Entities:

- A hybrid entity means a single legal entity (for example, a government entity with an onsite health clinic):
  - That is a Covered Entity,
  - Whose business activities include both HIPAA covered and non-covered functions, and
  - That designates its components that are health care components and documents such designation.
- Health Plan = Separate covered entity from employer which may itself be a covered entity or hybrid entity.

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Separation Between Health Plan & Plan Sponsor

- Plan documents must include provisions to restrict uses and disclosures of Protected Health Information consistent with the requirements of HIPAA's Privacy Rule:
  - Plan generally must be amended to provide for separation between the plan and the plan sponsor
    - Exception if plan only discloses (i) summary health information for certain purposes or (ii) enrollment/disenrollment information
  - Requires certification from plan sponsor that plan documents have been amended
  - Establish permitted and required uses and disclosures

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Privacy Requirements: What information is protected?

- Protected Health Information (PHI) means individually identifiable health information held or transmitted by a Covered Entity, in any form or media, whether electronic, paper, or oral.

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Privacy Requirements: Disclosures of PHI

- A Covered Entity must obtain an individual's authorization for any use or disclosure of PHI not expressly allowed by the HIPAA Privacy Rule, including any uses for employment-related or non-health plan-related purposes.

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Privacy Requirements: Permissible Uses and Disclosures

- Treatment, payment, health care operations
- To Business Associates
- To the sponsor of a health plan
- To Secretary of HHS
- When required by law
- For public health activities
- Abuse, neglect, or domestic violence
- For health oversight activities
- For judicial and administrative proceedings
- For law enforcement purposes
- To coroners, medical examiners, and funeral homes
- To organ procurement organizations
- For research purposes
- To prevent a serious threat to health or safety
- For military and national security
- Workers' compensation
- Others involved in an individual's health care

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Privacy Requirements: Disclosures for Judicial and Administrative Proceedings

- Court Orders
- Subpoenas and discovery requests that are not accompanied by a court order
  - If request not accompanied by a court or administrative order, the Covered Entity must receive satisfactory assurances that reasonable efforts have been made to (a) notify the individual who is the subject of the PHI or (b) secure a qualified protective order

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Privacy Requirements: Disclosures to Law Enforcement

- As required by law or pursuant to legal process
- Limited information to identify & locate a suspect, fugitive, witness, or missing person
- About a suspected victim of a crime if the individual who is the subject of the PHI agrees or if disclosure is necessary for immediate law enforcement activity
- Regarding a death that may have resulted from criminal conduct
- To provide evidence of criminal conduct on the Covered Entity's premises
- Reporting crimes in emergencies

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Recent Changes to HIPAA's Privacy Rule

- Final HITECH regulations published on January 25, 2013.
- HIPAA documents need to be reviewed to ensure that they comply with the final regulations.
  - Need to review (1) Policies and Procedures; (2) Notice of Privacy Practices; (3) individual rights forms (e.g., access, amendment, confidential communications); (4) Business Associate Agreements; (5) training documents; and (6) the HIPAA provisions in any health plan documents
- Compliance deadline: Generally September 23, 2013
  - For Business Associate Agreements entered before 1/25/2013 that have not been changed since 3/ 25/2013, deadline is 9/23/2014 (or when agreement renewed or modified, if earlier

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Changes in the Final Privacy Regulations

- The standard for determining a "breach"
  - Exception to breach notification rules – new risk assessment process
- Individual requests for access – 30 days to comply even for off-site records
- New definition of "marketing"
- Notice of Privacy Practices – must include list of disclosures that require authorization

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Wellness Program Exceptions to Nondiscrimination Rules

- Overview of Existing Wellness Program Rules
  - Under HIPAA, group health plans are prohibited from discriminating in eligibility or premiums based on health factors.
  - Exception to HIPAA's nondiscrimination rule for wellness programs that meet certain requirements.

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Wellness Program Changes

- Final regulations implementing the Affordable Care Act's changes to wellness programs were published on June 3, 2013.
- Changes to existing wellness rules:
  - Increase in maximum permissible reward
  - How wellness programs are categorized
  - Expansion of reasonable alternative requirement

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Increase in Maximum Permissible Reward

- Existing law: Cannot exceed 20%
- Change made by the Affordable Care Act: Cannot exceed 30%, or 50% for wellness programs designed to prevent or reduce tobacco use

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How Wellness Programs are Categorized

Existing Regulations	Final Regulations
1. Participatory	1. Participatory
2. Health-Contingent	2. Activity-Only
	3. Outcome-Based

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Participatory Wellness Programs

- Employees are provided with a financial incentive to participate without requiring the employee to satisfy any health-related condition to receive the incentive.

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Activity-Only Wellness Programs

- Employees must perform an activity that some individuals may be unable to perform or complete based on health status, such as walking, diet, or exercise programs.
- Requirements for activity-only wellness program:
  - Eligible individuals have the opportunity to qualify for the reward at least annually;
  - The aggregate reward for all activity-only and outcome-based wellness programs combined does not exceed 30 percent of the total cost of coverage (employer + employee) under the health plan (50 percent for programs designed to prevent or reduce tobacco use);
  - The program is reasonably designed to promote health or prevent disease;
  - The reward is available to all similarly situated participants;
  - The plan makes available (and pays for) a reasonable alternative standard or program for individuals for whom it is unreasonably difficult due to a medical condition or medically inadvisable to meet the normal standard; and
  - The availability of an alternative standard or program is disclosed in any materials describing the terms of the program.

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Outcome-Based Wellness Programs

- An individual must attain and/or maintain a specific health outcome in order to obtain a reward, such as being a nonsmoker or maintaining a specific weight or body mass index ("BMI") score.
- Requirements for outcome-based wellness program:
  - Eligible individuals have the opportunity to qualify for the reward at least annually;
  - The aggregate reward for all activity-only and outcome-based wellness programs combined does not exceed 30 percent of the total cost of coverage (employer + employee) under the health plan (50 percent for programs designed to prevent or reduce tobacco use);
  - The program is reasonably designed to promote health or prevent disease, which for outcome-based wellness programs requires that a reasonable alternative standard or program to qualify for the reward be offered to any individual who does not meet the initial standard;
  - The reward is available to all similarly situated participants;
  - The plan makes available (and pays for) a reasonable alternative standard or program for any individual who does not meet the normal standard; and
  - The availability of an alternative standard or program is disclosed to any materials describing the terms of the program.

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Recommendations

1. Refrain from making a program mandatory to qualify for health coverage.
2. Avoid questions regarding family health history.
3. Weigh the costs and benefits of financial incentives.
4. Have the program reviewed for compliance.

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