

Compliance Corner: Long-Awaited Electronic Benefit Card Guidance Includes Many Surprises

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The IRS has issued its much anticipated follow up to its original electronic payment card guidance. Notice 2006-69 (the "Notice") clarifies the parameters established in its original 2003 guidance (Notice 2003-43). In addition, the Notice clarifies and expands the substantiation requirements generally (whether a debit card is used or not). Plan sponsors and administrators should undertake a careful review of their current systems now, as many common industry practices may be adversely affected by the Notice. What follows are our very preliminary observations with regard to this Notice.

In a nutshell, the Notice provides the following clarifications and expansions:

- **Co-pay match expanded to allow certain multiples of co-pays:** Transactions equal to multiples of a co-pay or combinations of

America's Health Insurance Plans Urges Lawmakers to Build on the Success of Health Savings Accounts

Managed Care Weekly Digest

Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP) outlined for Congress a series of common-sense policy recommendations to expand access to health savings accounts (HSAs).

Testifying before the House Committee on Ways and Means, Ignagni said that HSA-eligible, high-deductible health plans (HDHPs) have quickly become valued health coverage options for consumers and employers and urged Congress to take the lead in facilitating the next generation of HSAs.

"HSAs are helping a substantial number of previously uninsured consumers purchase coverage, accumulate savings for their future medical needs, and access preventive care services. HSAs also are enabling many small employers to offer health coverage to their employees for the first time," Ignagni said.

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co-pays for a particular benefit require no additional substantiation provided that the employer has certified the co-pay amounts for that covered individual.

- **Point of sale merchant based adjudication confirmed (provided certain recordkeeping requirements are satisfied) and allowed even for non-healthcare merchants.** Merchant-based adjudication by healthcare providers was specifically allowed under Notice 2003-43. The Notice confirms that no additional substantiation is required for transactions that are approved at the point of sale by merchants through an inventory information approval (e.g., SKU) system that matches items to a list of eligible expenses. However, strict recordkeeping requirements must be satisfied whereby the employer (or TPA) has access to claims-level detail (i.e. certain recordkeeping requirements must be satisfied so that the IRS has sufficient information to examine payments on audit). In an expansion from the 2003 guidance, cards may be used at merchants who do not have a medical merchant category code if the merchant utilizes the inventory information approval process addressed in the Notice.

- **Electronic card substantiation allowed for certain dependent care FSA expenses.** The Notice clarifies that debit cards may be used to pay for dependent care FSA expenses, but that funds can only be released for expenses that have already been incurred. Advance reimbursement/payment through the card is not permitted.
- **Clarification provided with regard to EOB rollover adjudication.** The Notice clarifies that direct substantiation from a third party requires no additional review from the administrator and no certification from the employee contemporaneous with the reimbursement (e.g. an EOB from the health insurance carrier or administrator).
- **Claims cannot be self-certified.** Self-certification of expenses is strictly prohibited (in other words, if the transaction does not fit within one of the auto adjudication categories identified in Notice 2003-43 and Notice 2006-69, third party substantiation is required).

The Notice provides significant expansions to the auto adjudication rules established by Notice 2003-43; however, the IRS clarified certain

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aspects of Notice 2003-43 that many plan sponsors and administrators may find disappointing. The following is a more detailed analysis of the guidance provided by the Notice and a roadmap for plan sponsors and administrators.

Reiteration of the Original Guidance

At the outset, the Notice reiterates the parameters established in Notice 2003-43. In particular, the Notice reiterates the following:

- The employee must provide certification at enrollment and each time he/she swipes the card that the card will only be used for medical expenses
- With the exception of the newly created merchant-based adjudication category (described below), the card may only be used at merchants with healthcare merchant category codes
- All transactions require additional substantiation and certification except in the case of transactions that fall into one of the following categories:
 - o Transactions at *healthcare providers* that match co-pays under the employer's health plan covering the specific employee-cardholder (i.e., co-pay match)
 - o Transactions that match a previously approved expense as to amount,

duration and provider (i.e., recurring expenses)

- o Verification is provided by a merchant or other third party at the time of the transaction (or shortly thereafter) that the expense is an eligible medical expense (i.e., real-time adjudication)

The Notice does not revise these rules but instead clarifies their application and (e.g., in the case of merchant-based adjudication at non healthcare providers) expands on them.

Clarification and Expansion of Auto-Adjudication Parameters

Expansion of Co-Pay Match Auto-Adjudication to Address Multiples of Co-Pays

The Notice expands the original co-pay match auto-adjudication category to allow auto-adjudication in two additional situations:

- **Single co-pay for a specific benefit.** If the transaction equals a *multiple* of a specific co-pay applicable to the employee under the employer's plan, then no additional substantiation is required; however, the transaction will fall outside of this

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auto-adjudication category if the transaction amount exceeds five times the applicable co-pay amount. For example, assume Plan A imposes a \$20 co-pay for each doctor visit. Bob is covered under Plan A. Bob uses his card to pay \$80 at the doctor's office for services provided to himself, his spouse and two children. No additional substantiation is required because the \$80 transaction occurred at a healthcare provider and is a multiple of Bob's applicable physician co-pay that does not exceed five times the applicable co-pay amount.

- **Different co-pays for a specific benefit.** If the transaction equals a multiple of a co-pay for a particular benefit or a combination of the co-pays for a particular benefit, then no additional substantiation is required; however, this transaction will fall outside of the auto-adjudication category if the transaction amount exceeds five times the maximum co-pay for a particular benefit. For example, assume Plan A imposes a \$5 co-pay for generic drugs and a \$15 co-pay for brand name drugs. Bob uses his card at the pharmacy to purchase three generic drugs and two brand name drugs for himself and his family (assume it is flu season) for a total of \$45. No additional substantiation is required because the

\$45 is a multiple of a combination of the co-pays for the particular benefit.

This is a significant expansion of the parameters established in Notice 2003-43 but plan sponsors and administrators should also consider the following clarifications:

- If the transaction amount exceeds the maximum transaction amount (i.e. 5 times the maximum co-pay for that type of benefit) or it is not a multiple of the co-pay or combination of co-pays for a benefit, *additional substantiation is required for the entire transaction.* Assume that Bob uses his card to purchase two brand name drugs (\$30) and other over-the-counter drugs/products totaling \$7.00. The \$37 transaction does not exceed the maximum transaction amount but it is not a multiple of the combination of Bob's prescription drug co-pays. Therefore, the plan sponsor or administrator must request substantiation for the entire \$37. Administrators should resist the temptation to ask for substantiation for only the \$7 over-the-counter drugs.
- The co-pay must match the employee's (or dependent's) specific co-pay under the employer's plan. It is not sufficient if the

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transaction amount matches a co-pay under any health plan option provided by the employer; it must equal a multiple of the specific co-pay applicable to the employee or dependent. In addition, it would appear that auto-adjudication is not permitted for a co-pay match under a dependent's employer's health plan.

- The administrator must receive certification from the employer regarding the co-pay applicable to participants in the plan. Self-certification is not sufficient.

Merchant-based Adjudication Based on Inventory Information Approval System

No additional substantiation is required if a merchant compares the item or items to a pre-determined list of covered expenses and restricts use of the card only to those items that fall on that list. Many plan sponsors and administrators are already using healthcare vendors to verify the transaction at the point of sale by comparing the item(s) to a pre-determined list; the Notice simply confirms that this approach is permissible, and opens the door for its use at non-healthcare merchants. However, as noted below, the employer (or its TPA) must have access to claims level detail.

The IRS made three clarifications regarding this process that many plan sponsors, administrators,

and merchants will find very interesting. First, unlike the real-time verification parameters established in Notice 2003-43, contemporaneous information need not be sent to the plan sponsor or administrator at the time of the transaction. However, the employer is responsible for ensuring that sufficient claims level detail of each transaction is maintained in accordance with Rev. Proc. 98-25 so that the plan sponsor can appropriately respond to examinations by the IRS regarding the process.

Generally, every taxpayer (including the employer) must maintain sufficient records and books to establish the amount of gross income, deductions, etc. required to be shown by a taxpayer on the tax return. Rev. Proc. 98-25 establishes rules for maintaining machine sensible records and information and clarifies that such data must be maintained as long as the information is material to administration of an IRS law (generally, the applicable statute of limitations on IRS assessments). Essentially, the records maintained as part of this inventory information approval system must be able to identify the following:

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- Name of individual
- Transaction amount
- Date expense incurred
- Nature of the expense

Plan sponsors and/or administrators must negotiate agreements with merchants for the merchant to maintain the information and make it accessible upon request or, alternatively, send the information at the time of the transaction to the employer, administrator (or other entity that can warehouse the data for the plan). Of course, where such information includes protected health information (PHI), HIPAA's requirements apply as well. The recordkeeping requirement associated with the inventory information approval approach applies for plan years beginning after December 31, 2006.

Second, this process opens up card use to merchants with non-healthcare merchant category codes (e.g. grocery stores and discount stores that sell medical items such as OTCs, but do not have a healthcare merchant category code) but only if this process is utilized. The Notice forecloses the possibility of using the card at non-healthcare provider merchants under other circumstances. This may require procedure changes for both administrators and merchants that have established other means of auto-substantiating medical expenses – e.g., such

as co-pay match or real-time adjudication at merchants without healthcare MCCs.

Third, merchant may permit split transactions. If the employee attempts to purchase \$20 of eligible expenses and \$40 of non-eligible expenses, the card may be used for the \$20 of eligible expenses; however, the merchant must ask for some other form of payment for the other \$40. The Notice confirms that the merchant need not reject the entire transaction. On the other hand, the Notice does not appear to prohibit merchants from rejecting the entire card transaction if both eligible and non-eligible items are purchased.

Electronic Card Substantiation for Dependent Care FSAs

The Notice clarifies that an electronic payment card may be used to pay dependent care FSA expenses, but only for expenses already incurred. The card may *not* be used to pay for day care expenses in advance of the services actually being rendered. However, the Notice does outline a procedure for reimbursing the participant with the card as services are rendered for advance payments made by the participant.

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The Notice indicates that employees required to pay a day care expense in advance may pay the expense out-of-pocket and submit the appropriate substantiation to the administrator. The substantiation that is initially provided must identify the provider, time period that the coverage will be provided, and the amount. The amount allocated to the card will be increased at the end of the time period identified in the substantiation (i.e. after the expense has been incurred) by an amount equal to lesser of the original expense or the account balance at that time. The employee may then use the card to pay the next day care installment without providing additional substantiation. The card amount will continue to be increased at the end of each previously identified time period by the lesser of the original expense amount and the account balance. Subsequent payments with the card of equal or lesser value to the same provider may be paid with the card without providing additional substantiation. The employee must immediately report to the administrator any changes in the amount, time period, or provider and provide additional substantiation as necessary.

Clarification and Expansion of Substantiation Requirements Generally

Direct Substantiation from Third Party

The Notice clarifies that no additional substantiation is required if the plan sponsor or administrator receives substantiation directly from a third party that verifies the date of the expense and the employee's responsibility for such expense. This opens the door for health FSAs and HRAs to automatically reimburse participants for health plan expenditures based on an EOB submitted directly to the health FSA or HRA administrator from the health plan insurance carrier or administrator. Essentially, it eliminates the requirement in this limited circumstance for the employee to provide contemporaneous certification that the expense has not been reimbursed from any other source and that the participant will seek reimbursement from another source.

Self-certification

The Notice confirms that self-certification of expenses is strictly prohibited. This further supports the proposition that only those card transactions that fit within the auto-adjudication

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parameters established in Notice 2003-43 and 2006-69 can be used to release funds prior to additional substantiation.

What Now?

Technically, the Notice is an expansion of the parameters established in Notice 2003-43 and the substantiation requirements set forth in Prop. Treas. Reg. 1.125-2 Q-7. Practically, many plan sponsors and administrators may find the Notice a disappointment for the following reasons:

- The record keeping requirements associated with the merchant-based inventory information approval approach will be considered by some to be burdensome.
- The Notice clarifies that cards may not be used at merchants that do not have a medical merchant category unless the inventory information approval approach is utilized.
- Co-pay matches at merchants that do not have a healthcare merchant category code are apparently not permitted.

Plan sponsors and administrators must take a serious look at their current electronic payment card adjudication procedures. Failure to comply with these rules can result in disqualification of the entire plan, which results in taxation of all reimbursements, even if the reimbursement was for an otherwise eligible expense. 

America's Health Insurance Plans Urges Lawmakers to Build on the Success of Health Savings Accounts

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“Now is the time for Congress to build on this track record by ensuring that HSAs can meet the needs of those with chronic conditions, leveling the playing field for those seeking coverage in the individual market, and rewriting the rules that prohibit Medicare beneficiaries and many veterans from even considering HSAs as an option,” said Ignagni.

Ignagni also described a recent AHIP member census which found that 3,168,000 people were covered by HSA-eligible HDHPs as of January 2006. The census found that 31% of those purchasing these plans in the individual market were previously uninsured, and that one third of policies purchased in the small group market were purchased by companies that previously did not offer coverage.

AHIP's Policy Recommendations to Create the Next Generation of HSAs:

Expanding Coverage for the Chronically Ill

- Allow employers to assist employees or their family members who suffer from chronic conditions by permitting increased contributions into the HSAs of individuals who are enrolled in disease management or care coordination programs

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- Allow HDHPs to cover certain prescription drugs used to treat chronic conditions without the patient first being required to satisfy the minimum annual deductible on the HDHP

Encouraging Families to Participate in HSAs

- Allow individuals to establish an HSA if their spouse has a Flexible Spending Arrangement (FSA)
- Allow HDHPs for family HSAs to include separate deductibles, also known as “embedded deductibles,” for individual family members below the overall family deductible

Promoting Tax Parity and a Level Playing Field for Individuals

- Enact an above-the-line tax deduction for all health insurance coverage, including HSA-compatible health plans, purchased in the individual market
- Enact tax credits to help low-income persons purchase HSA-compatible health plans and other types of health insurance
- Increase HSA contribution limits to allow consumers to contribute an amount equal to the out-of-pocket limits of their HDHP

Expanding Access to Early Retirees, Seniors and Veterans

- Allow early retirees (ages 55-64) to use HSA funds to purchase retiree health coverage
- Allow seniors to use HSA funds to purchase Medigap coverage to complement Medicare
- Allow veterans who use Veterans Administration (VA) healthcare facilities to contribute money to an HSA. Under current law, any veteran who has accessed the Veterans Administration medical system within the past three months is prohibited from putting money into an HSA. This restriction hurts veterans - especially returning service personnel who have service-related injuries

Giving Employers More Flexibility

- Allow employers to combine HSAs with FSAs or Health Reimbursement Arrangements (HRAs) to cover medical expenses below the HDHP's deductible
- Allow individuals with unspent funds in employer-based FSAs or HRAs to transfer these funds into their HSAs

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Easing Administrative Burdens

- Give employees the opportunity to make the full annual contribution when they enroll during the middle of a plan year, or permit the employer to charge a smaller deductible
- Announce the annual adjustment of deductible amounts, out-of-pocket expense limits, and contribution limits by June 1 each year to give employers sufficient time to determine their plan offerings for the new year
- Extend to April 15 of the second year the deadline to set up an HSA account once a consumer signs up for a HDHP to allow for payments to be made for health costs incurred during the previous year 🚫

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HIPAA Regulatory Alert: Compliance with HIPAA Privacy Regulation is Dropping

American Health Consultants

Survey says: Don't take compliance for granted

While the majority of health care facilities continue to essentially be in compliance with HIPAA privacy and security regulations, the number that consider themselves more than 85% compliant with the privacy regulation has dropped in the last year. That's one of the key findings in the American Health Information Management Association (AHIMA) 2006 survey — "The State of HIPAA Privacy and Security Compliance."

The percentage of respondents who said they believed their institution was more than 85% compliant dropped to 85% in 2006 from 91% in 2005. Likewise, the percent of respondents who believed they were less than 85% compliant increased from 9% in 2005 to 15% in 2006.

AHIMA analysts said that while this is not a significant change, it is enough to raise concern — especially given that 55% of respondents said that adequate resources are their most significant barrier to full privacy compliance. "Privacy officers particularly need support for education and training of new staff, while a lack of resources and competing priorities have led some hospital and health system staff to slack off regarding all aspects of the privacy rule," the survey report said.

"The issue of budget also appears to impact the level of privacy training and monitoring that a

privacy officer or staff are capable of providing," the report continues. Finally, privacy officers report sensing a loss of support from senior management, both in ensuring that facility staff are aware of the need for privacy, as well as ensuring sufficient budget for education."

Dan Rode, AHIMA's vice president for policy and government relations, tells *HIPAA Regulatory Alert* it is becoming obvious that if organizations don't keep at it and reinforce behaviors necessary for compliance with the privacy regulation, it starts to lose meaning and bad habits from the past, such as leaving files open on a desk or talking about patients in an elevator, start to occur again.

"I think some things are going to happen" to bring more resources to bear on the issue, Rode says. "There have been a number of high profile incidents recently, like the loss of VA data and a Government Accountability Office report that there are serious security deficiencies in computer systems at the Department of Health and Human Services [HHS]," he says.

"These revelations are leading to discussions on how to keep records more secure. Privacy officers

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are trying to use these incidents to leverage their administration for more resources and support to do the job right."

Security compliance continues to increase

With the HIPAA security regulation, 25% of surveyed facilities indicated compliance at the top level, with another 50% saying they are close to full compliance. That represented an increase over 2005, when 17% of all respondents described themselves as "completely compliant" and 43% said they were 85% to 95% compliant.

"It appears that the security regulations were much easier to achieve than the privacy rule," AHIMA analysts said.

Three years after implementation of the HIPAA privacy rule, the AHIMA survey reached these conclusions:

1. HIPAA implementation has been a challenge for organizations, and it appears that for the majority the challenge has been met. However, the need for privacy, confidentiality, and security remain, especially as organizations tighten staffing and budgets. A slight drop in the number of facilities reporting themselves to be fully or mostly compliant with HIPAA should serve as a warning to the industry that compliance should not be taken for granted.

2. If the support for privacy and security and the need for ongoing training are not maintained (and in a few areas increased), all the work that has been put into HIPAA compliance efforts over the last few years may be undone over time.

3. The need for support of privacy and security must also reach beyond facilities. The federal government's approach to HIPAA enforcement has been to educate rather than to fine or prosecute offenders. While we applaud this approach, a concerted effort to educate and remind the healthcare industry and others of the need to maintain and continually improve privacy efforts is equally needed.

4. The healthcare industry has much to learn from HIPAA as it moves toward electronic health records and a nationwide health information network. There is considerable disagreement on whether electronic health records will improve privacy or security and there are many concerns on how information networks will protect data. Consumers will be watching the healthcare industry to see how well it complies with HIPAA rules before they put their trust in a national health information exchange. Communicating with consumers, answering their questions, and addressing their concerns may be key to advancing health information exchange activities.

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Privacy officers and health information management professionals will be important partners in this process. AHIMA believes that the time is right for an open dialogue about the value of privacy at both the national and organizational levels.

Rode says, most providers are growing accustomed to the various provisions of the privacy rule, but there still are reports of difficulties with specified requirements. Many respondents would like to see changes in the accounting for disclosure provision of the privacy rule. Most commonly, he says, respondents have received at most a few requests for an accounting.

He says that for many respondents the provision is not only burdensome but also significantly inefficient. The problem could easily be addressed while ensuring that individuals would have an accounting for all releases not covered by authorization or law. A major impediment, he says, is that most organizations still are paper-based and it's hard to deal with a complete accounting in a paper environment.

According to Rode, healthcare organizations and the general public remain in a HIPAA transition period, even three years after implementation, and the transition will continue until there has been a major adoption of electronic health records. He says that many of the issues that are problems

today can be resolved easily when there is a critical mass using electronic records. "But we're still moving slowly," he concluded.

Still no privacy fines

The mainstream media has picked up on the fact that enforcement of the HIPAA privacy regulation has not included any civil fines and only two criminal prosecutions. The *Washington Post* catalogued 19,420 grievances filed in the three years since protection for private medical information took hold, with more than 14,000 of the cases closed by the government, "either ruling that there was no violation or allowing health plans, hospitals, doctors' offices, or other entities simply to promise to fix whatever they had done wrong, escaping any penalty."

The *Post* reported the most common allegations have been that personal medical details were wrongly revealed, information was poorly protected, more details were disclosed than necessary, proper authorization was not obtained, or patients were frustrated getting their own records.

"Our first approach to dealing with any complaint is to work for voluntary compliance," said Department of Health and Human Services Office

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of Civil Rights Director *Winston Wilkinson*. "So far, it's worked out pretty well."

Hospitals, insurance plans, and doctors may agree with Wilkinson's assessment, but it has been strongly criticized by privacy advocates and some healthcare industry analysts who say the Bush administration's decision not to enforce the regulation more aggressively has not safeguarded sensitive medical records and has made providers and insurers complacent about compliance.

"The law was put in place to give people some confidence that when they talk to their doctor or file a claim with their insurance company that information isn't going to be used against them," Health Privacy Project founding Director *Janlori Goldman* told the *Post*, "They have done almost nothing to enforce the law or make sure people are taking it seriously. I think we're dangerously close to having a law that is essentially meaningless."

The *Post* said the debate has intensified because of a government push for computerized medical records to improve healthcare efficiency and quality. Privacy advocates have expressed concern that large, centralized, electronic databases will be especially vulnerable to attack, making it even more important that safeguards be vigorously enforced.

Don't know if fines are needed

Wilkinson declined to discuss specific cases but said his staff have "been able to work out the problems... by going in and doing technical assistance and education to resolve the situation. We try to exhaust that before making a finding of a technical violation and moving to the enforcement stage. We've been able to do that." He said that with some 5,000 cases still open, there might be a need for some fines but "we don't know at this stage."

Those responsible for complying with the law generally praise the HHS approach to enforcement. "It has been an opportunity for hospitals to understand better what their requirements are and what they need to do to come into compliance," said the American Hospital Association's *Lawrence Hughes*. And American Academy of Family Physicians President *Larry Fields* said physicians "are more used to the government coming down with a heavy hand when it's unnecessary. I applaud HHS for taking this route."

But healthcare consultants say the lack of penalties has led to organizations becoming complacent about protecting patient records. They cite the latest AHIMA survey.

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Employers are Moving Away From Traditional Benefit Plans

Business Wire

Changes in the healthcare and insurance industry have been building for many years. Employers are seeking to control their benefit costs and are shifting more decisions as well as more of the cost to employees. Employers are moving towards defined contribution benefits and towards more voluntary employee-pay-all benefits (as opposed to employer-funded benefits).

In a recent survey of voluntary insurance carriers, the respondents were convinced that employers and employees are more interested today in products that cover the deductibles and out-of-pocket expenses associated with healthcare than they were in the past. Eighty-five percent of those surveyed agreed or strongly agreed, up from 65 percent in 2002.

"We're also seeing a migration from employer-paid benefits to voluntary benefits," remarks Gil Lowerre, president of Eastbridge. "Three-fourths of the carriers surveyed say they are seeing an increase in voluntary coverages that were previously fully or partially employer paid." Only 10 percent of those surveyed did not recognize this trend.

The survey also found that 77 percent of respondents believe that employers are likely to move towards a "defined contribution" approach to employee benefits. This was up from 68 percent in 2004. 📈

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"They are saying 'HHS really isn't doing anything so why should I worry?'" said Apgar & Associates consultant *Chris Apgar*.

Wilkinson said the limited size of his staff prevents them from doing more than to respond to complaints. "We've had challenges with our resources investigating complaints," he said. "We've been successful with voluntary compliance, so there has not been a need to go out and look."

The privacy advocates counter that other federal agencies, such as the Securities and Exchange Commission and Federal Trade Commission, take a different approach, looking for significant and high profile cases that will send a message to industry.

"The law came about because there was a real problem with people having their privacy violated," Goldman said. "They lost jobs, they were embarrassed, they were stigmatized. People are afraid. The law was put in place so people wouldn't have to choose between their privacy and getting a job or going to the doctor. That's still a huge problem." 📈

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Put a Premium on Privacy in Employee Health Protocol

American Health Consultants

Give info on need-to-know basis

One employee has a medical file detailing a back injury that occurred at work. Another is a diabetic and consults with the employee health staff but never had a work-related problem.

Their records raise different privacy issues, but for employee health professionals, one truism holds: Only give supervisors the information that they need to know.

Employees often feel uneasy about the confidentiality of information maintained by employee health, notes Marilyn Piek, RN, MSN, COHN-S, CCM, RMHC, director of employee/corporate health services at Palomar Pomerado Health, a hospital district in northern San Diego County.

"If we ever want to get to proactive wellness and safety, we have to create a comfort level of confidentiality," she says.

Piek has worked to build that trust by making it clear that her department shares information only on a need-to-know basis. For example, if an employee fills out a health risk appraisal as a part of the wellness program, only one employee health nurse reviews that information and communicates with the employee. Employee health is not a part of the human resources department and the health information is separate from human resources files.

In fact, the employee's medical file is kept in a locked room, and each worker's compensation claim, which has different privacy considerations, is kept in a separate file, says Piek.

"A manager can't walk into the employee health department and demand to see an employee's medical record," she says. "They can ask questions about things they feel they need to know. It's up to the department protocol what information can be released."

For Rosemary Bootes, RN, CNP, MSN, MBA, nurse practitioner at Alliance Employee Health at Health Alliance, a six-hospital system in Cincinnati, demeanor also is important. She is consistently neutral when addressing any health issue, from a minor first-aid treatment to a life-threatening condition such as HIV.

"I'm very guarded about disclosing information, whether it's completely innocuous or not," she says. "If I'm very cavalier about information, then the moment I'm not cavalier, you think it's something serious — and I've already given you information."

Supervisors simply receive information on whether the employee has any job restrictions,

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she says. "All they need to know is how it's going to affect this individual's ability to do the job."

Here are some specific privacy issues faced by employee health professionals:

HIPPA

Some employee health information is covered by HIPPA (Health Insurance Portability and Accountability Act) privacy provisions, which restrict access and require employee consent before it is shared. For example, personal health information obtained in a pre-placement exam but unrelated to work duties would be protected by HIPPA, Piek notes. Health information obtained in an employee health clinic to treat personal issues such as hypertension also would be protected. In general, employee health information should be treated with the same sense of confidentiality as that of other patients, says Piek. "We need to realize that the employer is not the owner of the medical information, the patient is."

Needlestick reporting

Incidents are reported on U.S. Occupational Safety and Health Administration (OSHA) logs without identifying the employee. Lab tests are treated with the same privacy

considerations as other patient records, and are released only to the employee health practitioner who is treating the patient. Because of sensitivity about possible HIV or other bloodborne pathogen exposure, some hospitals use codes instead of names and send the tests to an outside lab to further protect employee identity.

Workers' compensation claims

Workers' compensation claims are not covered by HIPAA regulations, and information on those work-related injuries and illnesses will be shared with the insurer and case manager. The workers' compensation insurer may request information on similar injuries — for example, to determine if an employee with a back injury had previous work-related or non-work-related back injuries. If the claim is for work stress, the workers' compensation investigator may delve deeper into the employee's personal health history, notes Piek.

"Many employees do not realize that information beyond their employee health file may be examined by the workers' comp claims adjuster," she says.

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Put a Premium on Privacy in Employee Health Protocol

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Accident investigation


At Palomar Pomerado Health, supervisors must conduct accident investigations, which include an interview with the injured employee. However, this discussion focuses on the incident and not the health effects. The supervisor also may discuss the accident with other employees to determine if there have been similar "near-misses" or to seek ideas about prevention. The employee's name and specifics about the injuries should not be discussed, however, says Piek.

Pre-placement exams

Seek only what you need to know to determine the ability of the newly hired employee to perform his or her job duties, advises Piek. At Palomar Pomerado Health, the medical history questionnaire asks, "Do you have any physical, medical, or mental conditions that would make you unable to perform the job duties for which you are applying?" and "Have you ever had any medical conditions that caused you to miss time from work?"

"We are hoping for honest disclosure during that process," she says. The health system also conducts physical exams to evaluate the employee's ability to perform job functions.

Electronic communication

Don't put personal medical information in an e-mail unless you use encryption, Piek advises. E-mail advisories may tell employees that they are due for a TB test or influenza immunization. They may be used to briefly alert a supervisor that an employee has been cleared for duty or has job restrictions. "We're very careful about what we put in an e-mail," she says. "None of the details of that clearance should be discussed." 

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