Contents

Introduction 1

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) 3

Basic Questions on HIPAA 4

Preexisting Conditions To Which Exclusion Periods May Be Applied 5

Maximum Preexisting Condition Exclusion Period 8

Crediting Prior Health Coverage to Reduce a Preexisting Condition Exclusion Period 9

Certificates of Creditable Coverage 12

Special Enrollment 16

Nondiscrimination Requirements 18

Enforcement and State Flexibility 26

The Newborns' and Mothers' Health Protection Act of 1996 (The Newborns' Act) 29

The Mental Health Parity Act of 1996 (MHPA) 33

The Women's Health and Cancer Rights Act of 1998 (WHCRA) 37

Appendices 43

Appendix A: *Model Language for HIPAA Disclosures* 45

Appendix B: *Sample Language for Newborns' Act Disclosure* 53

Appendix C: *Sample Language for WHCRA Disclosures* 57

Introduction

This booklet provides an overview of recent changes in Federal law that can affect the health benefits of millions of working Americans and their families. The questions and answers in this publication address the benefits and requirements of the following four pieces of legislation and the regulations that interpret them:

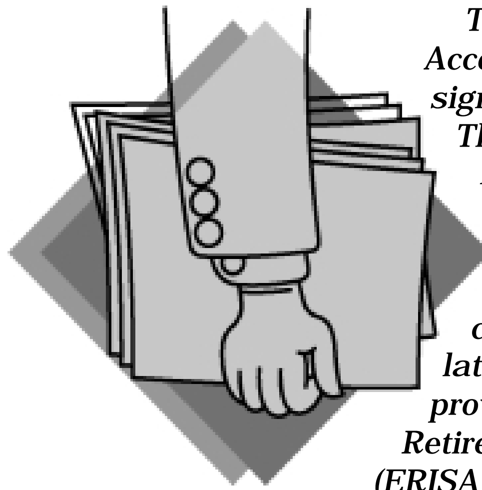
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act)
- The Mental Health Parity Act of 1996 (MHPA)
- The Women's Health and Cancer Rights Act of 1998 (WHCRA)

While this information does not cover all the specifics of these laws, it does offer employers who sponsor group health plans an understanding of their obligations. The information presented in this publication is designed to provide an informal explanation of legislation, statutes and interpretations based on the most recent regulations. It is intended to provide general guidance in areas of frequently asked questions and should not be considered legal advice.

If you have further questions that are not specifically addressed in this publication, please contact the Pension and Welfare Benefits Administration (PWBA) regional office nearest you. For a list of these offices, visit our Web site at **http://www.dol.gov/pwba**.

If you are an employer whose plan provides benefits through an insurance policy issued by an insurance company, you may also contact your State insurance commissioner's office. Visit the National Association of Insurance Commissioner's Web site at **http://www.naic.org** for the most updated contact information for NAIC offices. As discussed in this publication, some of the Federal rules under HIPAA, the Newborns' Act, MHPA and WHCRA can be changed by State law for insurance companies and health maintenance organizations (HMOs) if the State law is more protective of individuals.

The Health Insurance Portability and Accountability Act of 1996



The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. This law includes important protections for millions of working Americans and their families who have preexisting medical conditions or who might suffer discrimination in health coverage based on a factor that relates to the individual's health. HIPAA's provisions amend Title I of the Employee Retirement Income Security Act of 1974 (ERISA), as well as the Internal Revenue Code and the Public Health Service Act, and place requirements on employer-sponsored group health plans, insurance companies and HMOs. HIPAA includes provisions that:

- *limit exclusions for preexisting conditions;*
- *prohibit discrimination against employees and dependents based on their health status; and*
- *guarantee renewability and availability of health coverage to certain employees and individuals.*

The following information provides general guidance on frequently asked questions about HIPAA.

Basic Questions on HIPAA

Does HIPAA require employers to offer health coverage or require plans to provide specific benefits?

No. The provision of health coverage by an employer is voluntary. HIPAA does not require specific benefits, nor does it prohibit a plan from restricting the amount or nature of benefits for similarly situated individuals.

Am I required to provide new employees enrolling in my group health plan the same benefits they received under their prior group health plan?

No. When a person transfers from one plan to another, the benefits the person receives will be those provided under the new plan. Coverage under the new plan can be different than the coverage under the former plan.

I have a small business and I sponsor a group health plan. Do the HIPAA requirements described in this booklet apply to me?

These HIPAA requirements apply to group health plans with two or more participants who are current employees. However, your State may elect to regulate smaller groups.

Does HIPAA apply to self-insured group health plans?

Yes.

I am an employer who provides group health insurance coverage through an issuer. How does HIPAA affect policy renewal and termination?

At your option (as the plan sponsor), the issuer offering your group health insurance coverage must renew or continue in force your current coverage. However, the group health insurance coverage may not be renewed or may be discontinued because of nonpayment of premiums (including payments that are not timely), fraud, violation of participation or contribution rules, the issuer ceasing to offer that particular coverage or all health insurance coverage, or if all individuals move outside the service area, or if membership in a bona fide association ceases. For more information contact your State insurance commissioner's office.

Preexisting Conditions to Which Exclusion Periods May Be Applied

Traditionally, many employer-sponsored group health plans limited or denied coverage of conditions that were present prior to an individual's enrollment in that health plan. These types of exclusions are known as "preexisting condition exclusions" and HIPAA places strict limitations on such exclusions. For example, a preexisting condition exclusion must relate to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period prior to an individual's enrollment date in the plan. In addition, under HIPAA, certain people and conditions can never be subject to a preexisting condition exclusion.

How does HIPAA limit the preexisting conditions that can be excluded from coverage under a preexisting condition exclusion?

Under HIPAA, the only preexisting conditions that may be excluded under a preexisting condition exclusion are those for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on an individual's enrollment date. The "enrollment date" is the first day of coverage under the plan, or if there is a waiting period, the first day of the waiting period (typically, an individual's date of hire).

If an individual had a medical condition in the past, but has not received any medical advice, diagnosis, care or treatment for it within the 6 months prior to the enrollment date in the plan, the condition is not a "preexisting condition" to which an exclusion can be applied.

This 6-month "look-back" period may be shortened under State law if the coverage is insured through an insurance company or offered through an HMO. Check with the State insurance commissioner's office to see whether a shorter look-back period applies to individuals covered under your plan.

An individual who received treatment for carpal tunnel syndrome seven months ago recently joined my group health plan. The individual has not received medical advice, diagnosis, care or treatment for the condition since that time. May my plan impose a preexisting condition exclusion for this illness?

No. A group health plan may only impose a preexisting condition exclusion with respect to any condition for which medical advice, diagnosis, care or treatment was recommended or received within 6 months prior to the individual's enrollment date.

Are there other "preexisting conditions" that cannot be excluded from coverage?

Yes. Preexisting condition exclusions cannot be applied to pregnancy, regardless of whether the woman had previous coverage. In addition, a preexisting condition exclusion cannot be applied to a newborn, adopted child under age 18, or a child under 18 placed for adoption as long as the child became covered under creditable coverage (as defined on page 9 of this booklet) within 30 days of birth, adoption or placement for adoption and provided the child does not incur a subsequent 63-day break in coverage. Finally, genetic information may not be treated as a preexisting condition in the absence of a diagnosis.

Again, if coverage is insured through an insurance company or offered through an HMO, State law may provide additional protections. Check with your State insurance commissioner's office to see whether additional State law protections regarding preexisting conditions apply.

A new employee recently enrolled in the group health plan that I sponsor. What notification must my group health plan provide to new employees regarding any preexisting condition exclusion periods that will be imposed?

A plan must tell new enrollees if it has a preexisting condition exclusion period (and can only exclude coverage for a preexisting condition after this notification has been given). The plan must also notify new enrollees of the right to demonstrate prior creditable coverage to reduce the preexisting condition exclusion period. (See Appendix A for guidelines relating to this general notice of preexisting condition exclusion.)

If the plan does apply a preexisting condition exclusion period, the plan must make a determination regarding an individual's creditable coverage and the length of any preexisting condition exclusion period that applies to that individual. Generally, within a reasonable time after an individual provides a certificate or other information relating to creditable coverage, a plan is required to make this determination.

An individual is required to be notified of this determination if, after considering all evidence of creditable coverage, the plan will still impose a preexisting condition exclusion period with respect to any preexisting condition an indi-

vidual might have. The notice must also tell the individual the basis of the determination, including the source and substance of any information on which the plan relied and any appeal procedure that is available to the individual. (See Appendix A for guidelines relating to this individual notice of a preexisting condition exclusion.)

The plan may modify its initial determination if it later determines that an individual does not have the creditable coverage previously claimed. In this circumstance, the plan must notify the individual of its reconsideration and, until a final determination is made, the plan must act in accordance with its initial determination for purposes of covering medical services.

My plan has a "waiting period" for enrollment. How does this relate to the preexisting condition exclusion period?

HIPAA does not prohibit a plan or issuer from establishing a waiting period before individuals become eligible for benefits. For group health plans, a waiting period is the period that must pass before an employee or a dependent is eligible to enroll under the terms of the plan. Some plans have waiting periods and preexisting condition exclusion periods. However, if a plan has a waiting period and a preexisting condition exclusion period, the maximum preexisting condition exclusion period begins when the waiting period begins. Also, time spent in a waiting period is not considered when determining a significant break in coverage.

How do HMO affiliation periods relate to the preexisting condition exclusion period?

HMOs may have an "affiliation period" during which an individual does not receive benefits and is not charged premiums. Affiliation periods run concurrently with any waiting period under a plan, may not last for more than 2 months (3 months for late enrollees) and are only allowed for HMOs that do not impose preexisting condition exclusion periods.

Maximum Preexisting Condition Exclusion Period

Under HIPAA, the maximum preexisting condition exclusion period that can be applied to an individual is 12 months (18 months for late enrollees), beginning on the individual's enrollment date in the plan.

How does a plan determine the length of an individual's preexisting condition exclusion period?

The maximum length of a preexisting condition exclusion period is 12 months after the enrollment date (18 months in the case of a "late enrollee"). A late enrollee is an individual who enrolls in a plan other than on either the earliest date on which coverage can become effective under the terms of the plan or on a special enrollment date. This 12-month (or 18-month) period may be shortened under State law if coverage is insured through an insurance company or offered through an HMO. Check with the State insurance commissioner's office to see whether a shorter maximum exclusion period applies.

A plan must reduce an individual's preexisting condition exclusion period by the number of days of an individual's creditable coverage. However, a plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more ("significant break in coverage"). This 63-day break period may be longer under State law if coverage is insured through an insurance company or offered through an HMO. Check with the State insurance commissioner's office to see whether a longer break period applies.

A plan generally receives information about an individual's creditable coverage from a certificate furnished by a prior plan or issuer (e.g., an insurance company or HMO). However, individuals may also present other evidence of creditable coverage.

Crediting Prior Health Coverage To Reduce A Preexisting Condition Exclusion Period

A preexisting condition exclusion period is not permitted to extend for more than 12 months (or 18 months for late enrollees) after an individual's enrollment date in the plan. The period of any preexisting condition exclusion that would apply under a group health plan generally is reduced by the number of days of creditable coverage.

What is "creditable coverage"?

Most health coverage is creditable coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO, individual health insurance policy, Medicaid or Medicare.

Creditable coverage does not include coverage consisting solely of "excepted benefits," such as coverage solely for limited-scope dental or vision benefits.

Days in a waiting period during which you have no other coverage are not creditable coverage under the plan, nor are these days taken into account when determining if there is a significant break in coverage (generally a break of 63 days or more). As mentioned earlier, this 63-day break period may be longer under State law if the coverage is insured through an insurance company or offered through an HMO. If the plan is insured, check with the State insurance commissioner's office to see whether a longer break period applies.

How does "crediting" for prior coverage work under HIPAA?

Most plans use the "standard method" of crediting coverage.

Under the standard method, an individual receives credit for previous coverage that occurred without a break in coverage of 63 days or more. Any coverage occurring prior to a break in coverage of 63 days or more is not credited against a preexisting condition exclusion period.

To illustrate, suppose an individual had coverage for 2 years followed by a break in coverage of 70 days and then resumed coverage for 8 months. That individual would only receive credit for 8 months of coverage; no credit would be given for the 2 years of coverage prior to the break in coverage of 70 days.

Is there another way that a group health plan or issuer can "credit" coverage under HIPAA?

Yes. A plan or issuer may elect the "alternative method" for crediting coverage for all employees.

Under the alternative method of counting creditable coverage, the plan or issuer determines the amount of an individual's creditable coverage for any of the five specified categories of benefits. Those categories are mental health, substance abuse treatment, prescription drugs, dental care and vision care. The standard method (described above) is used to determine an individual's creditable coverage for benefits that are not within any of the five categories that a plan or issuer may use. (The plan or issuer may use some or all of these categories.)

When using the alternative method, the plan or issuer looks to see if an individual has coverage within a category of benefits (regardless of the specific level of benefits provided within that category).

For example, if an individual who is a regular enrollee (not a late enrollee) has 12 months of creditable coverage, but coverage for only 6 of those months provided benefits for dental care, a preexisting condition exclusion period may be imposed with respect to that individual's dental care benefits for up to 6 months (irrespective of the level of dental care benefits).

If another group health plan requests information from your plan regarding any of the five categories of benefits under the alternative method, your plan must provide the information regarding coverage under the categories of benefits. One way to provide this information is to use the Model for Categories of Benefits included in Appendix A of this booklet.

Can an individual receive credit for previous COBRA continuation coverage?

Yes. Under HIPAA any period of time that an individual is receiving COBRA continuation coverage is counted as previous health coverage as long as the coverage occurred without a break in coverage of 63 days or more.

For example, if an individual were covered continuously for 5 months by a previous health plan and then received 7 months of COBRA continuation coverage, the individual would be entitled to receive credit for 12 months of coverage.

An individual began employment with me 45 days after his previous health plan coverage terminated. The individual was covered under his previous employer's plan for 24

continuous months prior to the termination. The individual had no other coverage before his enrollment date in my plan. May I subject this individual to my plan's 12-month preexisting condition exclusion period?

Not if the individual enrolls when he is first eligible. The 45-day break in coverage does not count as a significant break in coverage under HIPAA. Under Federal law, a significant break in coverage is a break in coverage of at least 63 consecutive days. Since the individual had over 12 months of creditable coverage from a previous group plan without a significant break, the individual could not be subject to the preexisting condition exclusion period imposed by your plan if the individual enrolled when first eligible.

An individual began employment with me 100 days after her previous health plan coverage terminated. The individual had only been covered by her previous employer for 36 months prior to termination. The individual had no other coverage before her enrollment date in my plan. May I subject this individual to the 12-month preexisting condition exclusion period imposed by my plan?

It depends. A break in coverage of 100 days is a significant break in coverage under Federal law, so under Federal law the individual will not be able to count the 36 months of previous coverage as "creditable coverage."

As mentioned earlier, however, the length of time that passes before a significant break in coverage is reached may be longer under State law that applies to HMOs and health insurance issuers. If your plan provides health insurance coverage through an insurance policy or an HMO (an "insured" plan), check with your State insurance commissioner's office to find out if State law required a longer break in coverage. If your current plan is an insured plan and State law requires that a break in coverage be 100 days (or longer), the plan would be required to count the 36 months as "creditable coverage."

Certificates of Creditable Coverage

Group health plans and health insurance issuers are required to furnish a certificate of coverage to an individual to provide documentation of the individual's prior creditable coverage. A certificate of creditable coverage:

- *must be provided automatically by the plan or issuer when an individual either loses coverage under the plan or becomes entitled to elect COBRA continuation coverage and when an individual's COBRA continuation coverage ceases;*

- *must also be provided, if requested, before the individual loses coverage or within 24 months of losing coverage; and*

- *may be provided through the use of the model certificate included in Appendix A of this pamphlet.*

How do newly hired employees prove that they had prior health coverage that should be credited?

Under HIPAA, an employee's former group health plan and any insurance company or HMO providing such coverage is required to provide the employee and any dependents with a statement of prior health coverage, commonly referred to as a "certificate of creditable coverage."

This certificate must be provided automatically to the employee and any dependents when they lose coverage under the plan or otherwise become entitled to elect COBRA continuation coverage as well as when COBRA continuation coverage ceases.

An employee (or former employee) or any dependents may also request a certificate, free of charge, until 24 months after the time coverage ended. For example, they may request a certificate even before coverage ends.

If the employee or dependent does not have a certificate, the plan must permit the employee or dependent to show prior health coverage by producing documentation or other evidence of creditable coverage (such as pay stubs that reflect a deduction for health insurance, explanation of benefits forms (EOBs) or verification by a doctor or a former health care benefits provider that the employee or dependent had prior health insurance coverage).

Do plans that do not impose a preexisting condition exclusion period (and the issuers that provide coverage under these plans) have to provide certificates?

Yes.

Can a plan contract with an issuer to provide the certificates for their employees?

Yes. To avoid duplication of certificates, a plan may contract with the issuer to provide the certificate. Furthermore, if any entity (including a third-party administrator) provides a certificate to an individual, no other party is required to provide the certificate.

When must group health plans and issuers provide the certificates?

Plans and issuers must furnish a certificate automatically to:

- an individual who is entitled to elect COBRA continuation coverage, at a time no later than when a notice is required to be provided for a qualifying event under COBRA;

- an individual who loses coverage under a group health plan and who is not entitled to elect COBRA continuation coverage, within a reasonable time after coverage ceases; and

- an individual who has elected COBRA continuation coverage, either within a reasonable time after the plan learns that COBRA continuation coverage ceased or, if applicable, within a reasonable time after the individual's grace period for the payment of COBRA premiums ends.

Plans and issuers must also generally provide certificates to individuals upon request, or if someone requests one on an individual's behalf (with the individual's permission), at the earliest time that a plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate.

Is there a model certificate that group health plans and issuers can use?

Yes. See the Model Certificate in Appendix A of this booklet.

Can an individual's old plan simply call my plan to relay information about that individual's creditable coverage?

Yes. If the individual, your plan and the old plan all agree, the information may be transferred by telephone. Individuals are entitled to request a written certificate for their records when coverage information is provided by telephone.

Are plans and issuers required to issue certificates of creditable coverage to dependents?

Yes. A plan or issuer must make reasonable efforts to collect the necessary information for dependents and issue the dependent a certificate of creditable coverage. If the coverage information for a dependent is the same as for the employee, one certificate with both the employee and dependent information can be provided.

However, an automatic certificate for a dependent is not required to be issued until the plan or issuer knows (or, making reasonable efforts, should know) of the dependent's loss of coverage. This information can be collected annually, such as during an open enrollment period.

What is the minimum period of time that should be covered by the certificate?

It depends on whether the certificate is issued automatically or upon request:

- For a certificate that is issued automatically, the certificate should reflect the most recent period of continuous coverage.
- For a certificate that is issued upon request, the certificate should reflect each period of continuous coverage ending within 24 months prior to the date of the request.

At no time must the certificate reflect more than 18 months of creditable coverage that is not interrupted by a break in coverage of 63 days or more.

Are health flexible spending arrangements (FSAs) required to issue certificates?

If a health FSA is offered in conjunction with another group health plan and if the maximum benefit payable does not exceed a specified amount (two times the employee's salary reduction election under the health FSA for the year, or if greater, the amount of the employee's salary reduction election under the health FSA for the year, plus $500), in most cases the benefits under the health FSA will be excepted benefits and therefore not covered under HIPAA. Accordingly, the coverage under the FSA will not be creditable coverage, and the FSA is not required to issue certificates for the coverage.

Special Enrollment

Group health plans and group health insurance issuers are required to provide special enrollment periods during which individuals who previously declined coverage for themselves and their dependents may be allowed to enroll (without having to wait until the plan's next open enrollment period). A special enrollment period can occur if a person with other health coverage loses eligibility for that coverage or if a person becomes a new dependent through marriage, birth, adoption or placement for adoption.

What events trigger a special enrollment opportunity?

When the employee or dependent of an employee loses eligibility for other health coverage, a special enrollment opportunity in the group health plan may be triggered. To have a special enrollment opportunity in this situation, the employee or dependent must have had other health coverage when coverage under the group health plan was previously declined. If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA continuation coverage is exhausted. If the other coverage was not COBRA continuation coverage, special enrollment can be requested when the individual loses eligibility for the other coverage.

In addition, a special enrollment opportunity may be triggered when a person becomes a new dependent through marriage, birth, adoption or placement for adoption.

For each triggering event, a special enrollee may not be treated as a late enrollee. In fact, the plan must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible. Therefore, the maximum preexisting condition exclusion period that may be applied to a special enrollee is 12 months, and the 12 months are reduced by the special enrollee's prior creditable coverage. In addition, a newborn, adopted child or child placed for adoption cannot be subject to a preexisting condition exclusion period if the child is enrolled within 30 days of birth, adoption or placement for adoption and has no subsequent significant break in coverage.

What are a plan's obligations with respect to special enrollment when an employee or a dependent of an employee loses other health coverage?

When an employee or a dependent of an employee loses eligibility for other health coverage, a special enrollment opportunity may be triggered (only if the individual had other health coverage when first eligible to enroll). The employee or dependent must request special enrollment within 30 days of the loss of eligibility for coverage. In addition, the resulting coverage must be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

What are a plan's obligations with respect to special enrollment when an individual becomes a new dependent through marriage, birth, adoption or placement for adoption?

Employees, as well as their spouses and dependents may have special enrollment rights after a marriage, birth, adoption or placement for adoption. In addition, new spouses and new dependents of retirees in a group health plan may also have special enrollment rights after a marriage, birth, adoption or placement for adoption.

If a special enrollment opportunity is available, the individual must request special enrollment within 30 days of the marriage, birth, adoption or placement for adoption that triggered the special enrollment opportunity. In the case of marriage, enrollment is required to be effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan. In the case of birth, adoption or placement for adoption, enrollment is required to be effective not later than the date of such birth, adoption or placement for adoption.

Are plans and issuers required to disclose individuals' special enrollment rights?

Yes. A description of special enrollment rights must be provided to employees on or before the time they are offered the opportunity to enroll in the group health plan. See Appendix A for a model description.

Nondiscrimination Requirements

Under the HIPAA nondiscrimination provisions, individuals may not be denied eligibility or continued eligibility to enroll for benefits under the terms of a group health plan based on any health factors. In addition, an individual may not be charged more for coverage than any similarly situated individual is being charged based on any health factor.

Initial interim final regulations were published in April of 1997, which addressed some frequently asked questions and solicited comments on other issues. Subsequently, in January of 2001, additional regulations were published. These regulations are discussed in detail below.

Note: Compliance with the HIPAA nondiscrimination provisions is not in any way determinative of compliance with any other provision of ERISA (including COBRA and ERISA's fiduciary provisions). Nor is it determinative of compliance with other State or Federal laws (such as the Americans with Disabilities Act).

I understand that my group health plan cannot deny individuals eligibility for benefits or charge individuals a higher premium or contribution based on a health factor. What are the health factors?

The health factors are health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

The term "evidence of insurability" includes conditions arising out of acts of domestic violence, as well as participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities.

Can a group health plan or group health insurance issuer require individuals to pass a physical examination in order to be eligible to enroll in the plan?

No. A group health plan or group health insurance issuer may not require an individual to pass a physical examination for enrollment, even if the individual is a late enrollee.

My group health plan requires individuals to complete a detailed health history questionnaire and subtracts "Health Points" for prior or current health conditions. In order to enroll in the plan, an individual must score 70 out of 100 total points. An individual scored only 50 points and was denied eligibility in the plan. Is this permissible?

No. The HIPAA nondiscrimination provisions do not automatically prohibit health care questionnaires. It depends on how the information that is obtained is used. In this case, the plan requires individuals to score a certain number of "Health Points" that are related to prior or current medical conditions in order to enroll in the plan, which is impermissible discrimination in rules for eligibility based on a health factor.

Can my group health plan exclude individuals from enrolling in my health plan because they ski?

No. Participation in activities such as skiing is evidence of insurability, a health factor. Therefore, the plan may not deny them eligibility to enroll based on this factor.

My group health plan excludes coverage for preexisting conditions, which existed prior to enrolling in the plan. Is this permissible?

HIPAA sets forth specific limitations on a plan's use of preexisting condition exclusions. If a plan complies with these limitations and applies the preexisting condition exclusion uniformly to all similarly situated individuals and does not direct the exclusion at individual participants and beneficiaries, the plan is considered to be in compliance with the nondiscrimination provisions. (For a question and answer discussing standards for defining similarly situated individuals, see page 22 of this booklet.)

For questions and answers that explain HIPAA's limits on preexisting condition exclusions, see pages 5-11 of this booklet.

My group health plan imposes a 12-month preexisting condition exclusion period but, after the first 6 months, the exclusion period is waived for individuals who have not had any claims since enrollment. Is this permissible?

No. A group health plan may impose a preexisting condition exclusion period, but the exclusion must be applied uniformly to all similarly situated individuals. Here, the plan's provisions do not apply uniformly because individuals who have medical claims for the first 6 months following enrollment are not treated the same as similarly situated individuals with no claims during that period. Therefore, the plan provision violates the HIPAA nondiscrimination provisions.

My group health plan excludes coverage for benefits for a certain health condition (without regard to whether it was preexisting in nature). Is my plan violating HIPAA's nondiscrimination provisions by imposing this exclusion?

Group health plans may exclude coverage for a specific disease, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or medically necessary, if the benefit restriction is applied uniformly to all similarly situated individuals and is not directed at any individual participants or beneficiaries based on a health factor. (Plan amendments applicable to all individuals in a group of similarly situated individuals and made 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.)

Therefore, as long as your plan's condition-specific benefit exclusion is applied uniformly to all similarly situated individuals, and is not directed at individual participants or beneficiaries based on a health factor, the benefit exclusion is permissible under the HIPAA nondiscrimination provisions.

My health plan has a $500,000 lifetime limit on all benefits covered under the plan. In addition, the plan has a $2,000 lifetime limit on all benefits provided for one particular health condition. Are these limits permissible?

A group health plan may apply lifetime limits generally or with respect to benefits for a specific disease or treatment, provided the limits are applied uniformly to all similarly situated individuals and are not directed at individual participants or beneficiaries based on a health factor.

Therefore, both the $500,000 overall lifetime limit and the $2,000 condition-specific lifetime limit are permissible if applied uniformly to all similarly situated individuals and not directed at any individual participants or beneficiaries based on a health factor.

Can my health plan or issuer deny benefits for an injury based on the source of that injury?

If the injury results from a medical condition or an act of domestic violence, the health plan or issuer may not deny benefits for the injury, if it is an injury the plan would otherwise cover.

For example, a plan may not exclude coverage for self-inflicted injuries (or injuries resulting from attempted suicide) with respect to an individual if the injuries are otherwise covered by the plan and if the individual's injuries are the result of a medical condition, such as depression.

However, a plan or issuer may exclude coverage for injuries that do not result from a medical condition or domestic violence, such as injuries sustained in high risk activities, for example, bungee jumping. (Nonetheless, as discussed earlier, the plan could not exclude an individual from enrollment for coverage because the individual participated in bungee jumping.)

Can individuals with histories of high claims be charged more than similarly situated individuals based on their claims experience?

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

Is it permissible for a health insurance issuer to charge a higher premium to one group health plan that covers individuals some of whom have adverse health factors than it charges another group health plan comprised of fewer individuals with adverse health factors?

Yes. HIPAA does not restrict a health insurance issuer from charging a higher rate to one group health plan (or employer) over another. An issuer may take health factors of individuals into account when establishing blended, aggregate rates for group health plans (or employers). This may result in one health plan (or employer) being charged a higher premium than another for the same coverage through the same issuer.

I am an employer. My health insurance issuer charges me a different premium for each individual within a group of similarly situated individuals based on each individual's health status. Is this permissible?

No. Issuers may not charge or quote an employer (or group health plan) separate rates, which vary for individuals based on health factors. This does not prevent issuers from taking the health factors of each individual into account in establishing a blended, aggregate rate for providing coverage to the employment-based group overall. The issuer may then charge the employer (or plan) a higher overall rate, or a higher, blended per-participant rate. This prohibition against "list-billing" based on health factors does not, however, restrict communications between issuers and employers (or plans) regarding rate calculations.

How are groups of similarly situated individuals determined?

Distinctions among groups of similarly situated individuals may not be based on a health factor. Instead, if distinguishing among groups of participants, plans and issuers must base distinctions 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 could be treated as distinct groups of similarly situated individuals, provided the distinction is consistent with the employer's usual business practice. In addition, a plan or issuer generally may treat participants and beneficiaries as two separate groups of similarly situated individuals. The plan may also distinguish between beneficiaries based, for example, on their relationship to the participant (such as spouse or dependent child), or based on the age or student status of dependent children.

Nonetheless, in any case, the creation or modification of a classification cannot be directed at individual participants or beneficiaries based on one or more of their health factors.

What guidance is provided with respect to wellness programs?

In January 2001, proposed regulations were issued with respect to bona fide wellness programs and comments were invited. Until further guidance is issued, the Federal government will not take any enforcement action against a plan or issuer that complies with a good faith interpretation of the statutory

provisions relating to wellness program provisions. Of course, compliance with the proposed regulations constitutes good faith compliance with the statutory wellness program provisions.

I am an employer that provides voluntary testing to group health plan enrollees to help detect early health problems. Under the program, no reward is given based on the outcome of the assessment. How do the bona fide wellness program provisions relate to my wellness program?

Under the proposed rules, the requirements for bona fide wellness programs apply only to a wellness program that provides a reward based on the ability of an individual to meet a standard that is related to a health factor, such as a reward conditioned on the outcome of a cholesterol test. Therefore, because your wellness program does not base any reward on the outcome of the testing, it is not subject to the requirements for bona fide wellness programs.

I am an employer that offers a premium differential between smokers and nonsmokers. That is, smokers pay more for coverage than nonsmokers. How do the bona fide wellness program provisions relate to my plan?

The plan is offering a reward based on an individual's ability to stop smoking. Medical evidence seems to suggest that smoking may be related to a health factor. (Under the Diagnostic and Statistical Manual of Mental Disorders, nicotine addiction is a medical condition, and a report of the Surgeon General stated that scientists in the field of drug addiction agree that nicotine, a substance common to all forms of tobacco, is a powerfully addictive drug.) Therefore, for the plan to maintain the premium differential and not be considered to discriminate based on a health factor, such a program would be required to meet the requirements for a bona fide wellness program.

Under the proposed rules, there are four requirements to be a bona fide wellness program:

- The total reward that may be given to an individual is limited. The proposed regulations invited comments on the appropriate level of the reward, suggesting that a limit of 10-20 percent of the total cost of employee-only coverage may be appropriate.

- The program must be reasonably designed to promote good health or prevent disease for individuals in the program.

- The reward must be available to all similarly situated individuals. More specifically, the program must allow any individual for whom it is unreasonably difficult due to a medical condition to meet the wellness program standard (or for whom it is medically inadvisable to attempt to meet the wellness program standard) an opportunity to satisfy a reasonable alternative standard.

- All plan materials describing the terms of the program must disclose the availability of a reasonable alternative standard.

Accordingly, under the proposed rules, the wellness program would be a bona fide wellness program if the premium differential is not more than 10-20 percent of the total cost of employee-only coverage; the program accommodates individuals for whom it is unreasonably difficult to quit using tobacco products due to addiction by providing a reasonable alternative standard (such as a discount in return for attending educational classes or for trying a nicotine patch); and plan materials that describe the premium differential describe the availability of a reasonable alternative standard to qualify for the lower premium.

My group health plan has a nonconfinement provision which states that if an individual is confined to a hospital at the time coverage would otherwise take effect, coverage will not begin until that individual is no longer confined. Is this permissible?

No. A group health plan may not restrict an individual's eligibility, benefits or the effective date of coverage based on the individual's confinement in a hospital or other health care facility. Additionally, a health plan may not set an individual's premium rate based on the individual's confinement.

My group health plan has a 90-day waiting period for enrollment. Under the terms of the plan, if an individual is actively at work on the 91st day, health coverage becomes effective on that day. If an individual is not actively at work on the 91st day, the effective date of coverage is delayed until the first day the individual is actively at work. An individual enrolled in my plan missed work on the 91st day due to illness. Can my plan exclude that individual from coverage under the plan's actively-at-work provision?

No. A group health plan or issuer generally may not refuse to provide benefits because an individual is not actively at work on the day the individual would otherwise become eligible for benefits. However, these actively-at-work clauses are permitted if the plan treats individuals who are absent from work due to a health factor (for example, individuals taking sick leave) as if they are actively at work for purposes of health coverage.

Nonetheless, a plan may require an individual to report for the first day of work before coverage may become effective. Additionally, plans may distinguish among groups of similarly situated individuals (for example, a plan may require an individual to work full time, such as 250 hours per quarter or 30 hours per week) in their eligibility provisions.

I am an employer.   Under the health plan I provide to my employees, dependents are generally eligible for coverage only until age 25. This age restriction does not, however, apply to disabled dependents who may continue health coverage past age 25. Is this plan provision favoring disabled dependents permissible?

Yes. It is permissible for a plan or issuer to treat an individual with an adverse health factor more favorably by offering extended coverage.

Enforcement and State Flexibility

Who enforces the HIPAA requirements described in this booklet?

The Secretary of Labor enforces these requirements on group health plans under ERISA, including self-insured arrangements. In addition, participants and beneficiaries can file suit to enforce their rights under ERISA, as amended by HIPAA.

The Secretary of the Treasury enforces these requirements on group health plans, including self-insured arrangements. A taxpayer that fails to comply may be subject to an excise tax.

States also have enforcement responsibility for group and individual requirements imposed on health insurance issuers, including sanctions available under State law. If a State does not act in the areas of its responsibility, the Secretary of Health and Human Services may make a determination that the State has failed "to substantially enforce" the law, assert Federal authority to enforce and impose sanctions on insurers as specified in the statute, including civil money penalties.

Can States modify HIPAA's portability requirements?

Yes, in certain circumstances. States may impose stricter obligations on health insurance issuers in the seven areas listed below. States may:

- shorten the 6-month "look-back" period prior to the enrollment date to determine what is a preexisting condition;
- shorten the 12- and 18-month maximum preexisting condition exclusion periods;
- increase the 63-day significant break in coverage period;
- increase the 30-day period for newborns, adopted children and children placed for adoption to enroll in the plan so that no preexisting condition exclusion period may be applied thereafter;
- further limit the circumstances in which a preexisting condition exclusion period may be applied beyond the "exceptions" described in Federal law (the "exceptions" under Federal law are for certain

newborns, adopted children, children placed for adoption, pregnancy and genetic information in the absence of a diagnosis);

- require additional special enrollment periods; and

- reduce the maximum HMO affiliation period to less than 2 months (3 months for late enrollees).

In addition, States may sometimes impose other requirements with respect to insurance companies and HMOs. Therefore, if your health coverage is offered through an HMO or an insurance policy issued by an insurance company, you should check with your State insurance commissioner's office to find out the rules in your State.

The Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act) was signed into law on September 26, 1996. The law includes important protections for mothers and their newborn children with regard to the length of the hospital stay following childbirth. The Newborns' Act is subject to concurrent jurisdiction by the Departments of Labor, the Treasury, and Health and Human Services.

The following information is intended to provide general guidance on frequently asked questions about the Newborns' Act.

How does the Newborns' Act affect health care benefits for pregnant women?

The Newborns' Act affects the amount of time a pregnant woman and her newborn child are covered for a hospital stay following childbirth. Group health plans, insurance companies and HMOs that are subject to the Newborns' Act may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider may decide, after consulting with the mother, to discharge the mother and her newborn child earlier. In any case, the attending provider cannot receive incentives or disincentives to discharge the mother and her child earlier than 48 hours (or 96 hours).

Who is the attending provider?

An attending provider is an individual licensed under State law who is directly responsible for providing maternity or pediatric care to a mother or newborn

child. Therefore, a plan, hospital, insurance company or HMO would not be an attending provider. However, a nurse midwife or a physician assistant may be an attending provider if licensed in the State to provide maternity or pediatric care in connection with childbirth.

Under the Newborns' Act, when does the 48-hour (or 96-hour) period start?

If a woman delivers in the hospital, the 48-hour period (or 96-hour period) starts at the time of delivery. So, for example, if a woman goes into labor and is admitted to the hospital at 10 p.m. on June 11, but gives birth by vaginal delivery at 6 a.m. on June 12, the 48-hour period begins at 6 a.m. on June 12.

However, if the woman delivers outside the hospital and is later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the admission. So, for example, if a woman gives birth at home by vaginal delivery, but begins bleeding excessively in connection with childbirth and is admitted to the hospital, the 48-hour period starts at the time of admission.

Under the Newborns' Act, may a group health plan, insurance company or HMO require an individual to get permission (sometimes called prior authorization or pre-certification based upon medical necessity) for a 48-hour or 96-hour hospital stay?

A plan, insurance company or HMO cannot deny a mother or her newborn child coverage for a 48-hour stay (or 96-hour stay) because the plan claims that the mother or her attending provider has failed to show that the 48-hour stay (or 96-hour stay) is medically necessary.

However, plans, insurance companies and HMOs generally can require an individual to notify the plan of the pregnancy in advance of an admission in order to use certain providers or facilities, or to reduce the individual's out-of-pocket costs.

Under the Newborns' Act, may group health plans, insurance companies or HMOs impose deductibles or other cost-sharing provisions for hospital stays in connection with childbirth?

Yes. But only if the deductible, coinsurance, or other cost-sharing for the later part of a 48-hour (or 96-hour) stay is not greater than that imposed for the earlier part of the stay. For example, with respect to a 48-hour stay, a group health plan is permitted to cover only 80 percent of the cost of the hospital stay. However, a

plan covering 80 percent of the cost of the first 24 hours could not reduce coverage to 50 percent for the second 24 hours.

Does the Newborns' Act require a plan to offer maternity benefits?

No. The Newborns' Act does not require plans, insurance companies or HMOs to provide coverage for hospital stays in connection with childbirth. However, other legal requirements may require this type of coverage, including Title VII of the Civil Rights Act of 1964. Questions regarding Title VII should be directed to the Equal Employment Opportunity Commission.

How does the Newborns' Act apply to different types of coverage?

If a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan.

"Self-insured" coverage is subject to the Newborns' Act. However, if coverage is "insured" by an insurance company or HMO and your State has a law regulating coverage for newborns and mothers that meets specific criteria, then an individual's rights depend on State law, rather than the Newborns' Act. If this is the case, the State law may differ slightly from the Newborns' Act requirements, so it is important to know which law applies to the coverage offered by your plan.

Based on a preliminary review of State laws as of September 1, 2001, 49 States, the District of Columbia and Guam appear have a law regulating coverage for newborns and mothers that would apply to coverage insured by an insurance company or HMO.

The following State and other jurisdictions do not appear to have a law regulating coverage for newborns and mothers that would apply to health coverage insured by an insurance company or HMO. Therefore, the federal Newborns' Act provisions appear to apply to health insurance coverage in the following State and other jurisdictions:

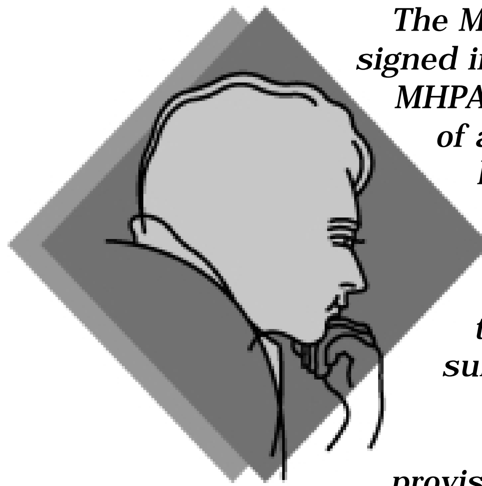
> Wisconsin, Puerto Rico, the Virgin Islands, American Samoa,
> Wake Island and the Northern Mariana Islands.

If the coverage your plan offers is insured by an insurance company or HMO, you should always contact your State insurance commissioner's office for the most current information on State laws.

Do group health plans have to tell participants and beneficiaries about the Newborns' Act and any applicable State law protections?

A group health plan that provides maternity or newborn infant coverage must include in its summary plan description (SPD) a statement describing the Federal or State law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child. If the Federal Newborns' Act law applies in some areas in which the plan operates and State laws apply in others, the SPD must describe the Federal and State law requirements that apply in each area covered by the plan. Appendix B contains sample language that group health plans may use in their SPDs to describe the Federal Newborns' Act requirements. Plan's subject to State law requirements will need to prepare SPD statements describing any applicable State law.

The Mental Health Parity Act of 1996



The Mental Health Parity Act (MHPA) was signed into law on September 26, 1996. MHPA provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. MHPA's provisions are subject to concurrent jurisdiction by the Departments of Labor, the Treasury, and Health and Human Services.

Under MHPA, there is a "sunset" provision providing that the law will cease to apply to benefits for services furnished on or after September 30, 2001. This provision may be eliminated or changed by future legislation. For up-to-date information on the applicability of the Mental Health Parity Act contact the PWBA regional office nearest you (see p. 1 for Web address).

The following information is intended to provide general guidance on frequently asked questions about MHPA.

How does MHPA affect benefits?

Under MHPA, certain group health plans and group health insurance issuers offering mental health benefits are no longer allowed to set annual or lifetime <u>dollar</u> limits on mental health benefits that are lower than any such dollar limits for medical and surgical benefits. A plan that does not impose an annual or lifetime dollar limit on medical and surgical benefits may not impose such a dollar limit on mental health benefits offered under the plan. MHPA's provisions, however, do not apply to benefits for substance abuse or chemical dependency.

Does MHPA require all health plans to provide mental health benefits?

No. Health plans are not required to include mental health in their benefits package. The requirements under MHPA apply only to plans offering mental health benefits.

May a plan impose other restrictions on mental health benefits?

Yes. Plans are still able to set the terms and conditions (such as cost-sharing and limits on the number of visits or days of coverage) for the amount, duration and scope of mental health benefits.

Do all plans offering mental health benefits have to meet the parity requirements?

No. There are two exceptions to these new rules. First, the mental health parity requirements do not apply to small employers who have fewer than 51 employees. Second, any group health plan whose costs increase 1 percent or more due to the application of MHPA's requirements may claim an exemption from MHPA's requirements.

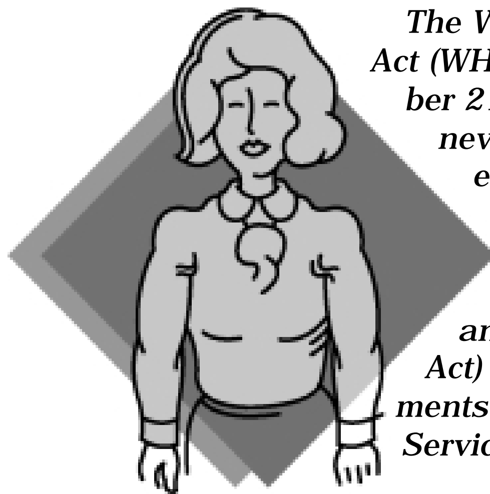
How does a plan claim the 1 percent increased cost exemption under MHPA?

The increased cost exemption must be taken based on actual claims data, not on an increase in insurance premiums. The provisions of MHPA must be implemented for at least 6 months and the calculation of the 1 percent cost exemption must be based on at least 6 months of actual claims data with parity in place. In addition:

- Plans claiming the increased cost exemption must notify the appropriate government agency and plan participants and beneficiaries 30 days before the exemption becomes effective.
- A formula is provided in the interim regulations for plans to calculate the increased cost of complying with parity.
- A summary of the aggregate data and the computation supporting the increased cost exemption must be made available to plan participants and beneficiaries free of charge upon written request.

- Once a plan qualifies for the 1 percent increased cost exemption, it does not have to comply with the parity requirements for the life of the MHPA provisions, which sunset on September 30, 2001.

The Women's Health and Cancer Rights Act of 1998



The Women's Health and Cancer Rights Act (WHCRA) was signed into law on October 21, 1998. The law includes important new protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

The following information is intended to provide general guidance on frequently asked questions about WHCRA provisions.

How will WHCRA affect the benefits of an individual who has been diagnosed with breast cancer and plans to have a mastectomy?

Under WHCRA, group health plans, insurance companies and HMOs offering mastectomy coverage must also provide coverage for certain services relating to the mastectomy in a manner determined in consultation with the attending physician and the patient. Required coverage includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

Does WHCRA apply to individuals who have not been diagnosed with cancer, but who must undergo a mastectomy due to other medical reasons?

Despite the title, nothing in the statute appears to limit entitlement to WHCRA benefits to cancer patients. If an individual is receiving benefits in connection with a mastectomy and the group health plan covers mastectomies, then the individual should be entitled to WHCRA benefits.

Does WHCRA require all group health plans, insurance companies and HMOs to provide reconstructive surgery benefits?

Generally, group health plans and insurance companies and HMOs providing coverage through group health plans that provide coverage for medical and surgical benefits with respect to a mastectomy are subject to the requirements of WHCRA.

Under WHCRA, may group health plans, insurance companies or HMOs impose deductibles or coinsurance requirements on the coverage specified in WHCRA?

Yes, but only if the deductibles and coinsurance are consistent with those established for other benefits under the plan or coverage.

Under WHCRA, is my plan required to cover reconstructive surgery (and the other benefits specified in WHCRA) when an individual underwent the mastectomy while covered under a previous employer's group health plan?

If your plan provides coverage for mastectomies and an individual is receiving benefits under the plan that are related to a mastectomy, then your plan generally will be required to cover reconstructive surgery, if the individual requests it. In addition, your plan generally is required to cover other benefits specified under WHCRA. It does not matter that your plan did not provide coverage for the mastectomy. However, a group health plan provision may limit benefits relating to a condition that was present before an individual's enrollment date in the current plan through a preexisting condition exclusion. HIPAA limits the circumstances under which a preexisting condition exclusion may be applied. For more information on HIPAA's limits on preexisting condition exclusions, see pages 5-11 of this booklet.

My group health plan provides coverage through an insurance company. I recently changed insurance companies. The new insurance company is refusing to cover reconstructive surgery for an individual who

underwent a mastectomy while covered under my plan through the previous insurance company. Does this violate WHCRA?

Yes, as long as the new insurance company provides coverage for mastectomies, the individual is receiving benefits under the plan related to the mastectomy, and the individual elects to have reconstruction surgery. If these conditions apply, the new insurance company is required to provide coverage for breast reconstruction as well as other required benefits under WHCRA. It does not matter that the new insurance company did not provide coverage for the mastectomy.

Are all group health plans, and their insurance companies and HMOs, required to satisfy the notice requirements under WHCRA?

All group health plans, and their insurance companies or HMOs, that offer coverage for medical and surgical benefits with respect to a mastectomy are subject to the notice requirements under WHCRA.

What are the notice requirements under WHCRA?

There are three separate notices required under WHCRA. The first notice is a one-time requirement under which group health plans, and their insurance companies or HMOs, must furnish a written description of the benefits that WHCRA requires. This notice generally was required to be furnished no later than January 1, 1998. The second notice must also describe the benefits required under WHCRA and it must be provided upon enrollment in the plan. The third notice is an annual notice requirement.

How must these notices be delivered to participants and beneficiaries?

These notices must be delivered in accordance with the Department of Labor's disclosure regulations applicable to furnishing summary plan descriptions. For example, the notices may be provided by first class mail or any other means of delivery prescribed in the regulation. It is the view of the Department that a separate notice would be required to be furnished to a group health plan beneficiary where the last known address of the beneficiary is different than the last known address of the covered participant.

I understand that my group health plan is required to provide individuals with notice of their rights under WHCRA upon enrollment in the plan. What information should I include in the enrollment notice?

This enrollment notice must describe the benefits that WHCRA requires the plan and its insurance companies or HMOs to cover. Also, the enrollment notice must state that for the covered worker or family member who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedemas.

The enrollment notice must also describe any deductibles and coinsurance limitations applicable to such coverage. Under WHCRA, coverage of breast reconstruction and other benefits specified in WHCRA may be subject only to deductibles and coinsurance limitations consistent with those established for other benefits under the plan or coverage. (See Appendix C for sample language for the WHCRA enrollment notice.)

What should my plan include in the annual notice?

The annual notice should describe the four categories of coverage required and should contain information on how to obtain a detailed description of the mastectomy-related benefits available under the plan. To satisfy this annual notice requirement, your plan may provide the same notice it provided to individuals upon enrollment in the plan if it contains the appropriate information as described above. (See Appendix C for sample language for the WHCRA annual notice.)

Must a group health plan, and its insurance companies or HMOs, furnish separate notices under WHCRA?

No. To avoid duplication of notices, a group health plan or its insurance companies or HMOs can satisfy the notice requirements of WHCRA by contracting

with another party that provides the required notice. For example, in the case of a group health plan funded through an insurance policy, the group health plan will satisfy the notice requirements with respect to a participant or beneficiary if the insurance company or HMO actually provides the notice that includes the information required by WHCRA.

My State requires health insurance issuers to cover the benefits required by WHCRA and also requires health insurance issuers to cover minimum hospital stays in connection with a mastectomy (which is not required by WHCRA). If an individual covered under my plan has a mastectomy and breast reconstruction are they also entitled to the minimum hospital stay?

The individual may be entitled to coverage for the minimum hospital stay under your State law. Many State laws provide more protections than WHCRA. Those additional protections apply to coverage provided by an insurance company or HMO (known as insured coverage). Thus if your group health plan provides coverage through an insurance company or HMO, the individual is entitled to the minimum hospital stay required by the State law. If your plan does not provide coverage through an insurance company or HMO, then the State law does not apply. In that case, only the Federal law, WHCRA, applies and it does not require minimum hospital stays.

If your plan provides "insured" coverage and you want to know if you have additional State law protections, check with your State insurance commissioner's office.

Some of my employees have questions regarding their rights under WHCRA? What information is available to them?

The Department of Labor recently published *Your Rights after a Mastectomy -- the Women's Health and Cancer Rights Act of 1998,* which provides answers to frequently asked questions about WHCRA. To obtain a copy of this booklet, call the PWBA toll-free Publication Hotline at 1-800-998-7542 or view it on the Web at **www.dol.gov/dol/pwba**.

Appendices

Appendix A: Model Language for HIPAA Disclosures

Appendix B: Model Language for Newborns' Act Disclosure

Appendix C: Model Language for WHCRA Disclosures

Appendix A

Model Language for HIPAA Disclosures

Model Certificate

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

* IMPORTANT - This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate:
2. Name of group health plan:
3. Name of participant:
4. Identification number of participant:
5. Name of any dependents to whom this certificate applies:
6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:
7. For further information, call:
8. If the individual(s) identified in line 3 and line 5 has at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here ____ and skip lines 9 and 10.
9. Date waiting period or affiliation period (if any) began:
10. Date coverage began:
11. Date coverage ended:________(or check if coverage is continuing as of the date of this certificate: _______).

*Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.

Model Description of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Guidelines for General Notice of Preexisting Condition Exclusion

A group health plan (or issuer) may not impose a preexisting condition exclusion with respect to a participant or dependent before notifying the participant, in writing, of —

- The existence and terms of any preexisting condition exclusion under the plan, and
- The rights of individuals to demonstrate creditable coverage (and any applicable waiting periods),
- Including a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and
- A statement that the current plan (or issuer) will assist in obtaining a certificate from any prior plan or issuer, if necessary.

Guidelines for Individual Notice of Preexisting Condition Exclusion

A group health plan (or issuer) seeking to impose a preexisting condition exclusion is required to disclose to the individual, in writing, —

- Its determination, including the source and substance of any information on which the plan or issuer relied,
- A written explanation of any appeal procedures established by the plan or issuer, and
- With a reasonable opportunity to submit additional evidence of creditable coverage.

Model for Categories of Benefits (Alternative Method)

INFORMATION ON CATEGORIES OF BENEFITS

1. Date of original certificate:

2. Name of group health plan providing the coverage:

3. Name of participant:

4. Identification number of participant:

5. Name of individual(s) to whom this information applies:

6. The following information applies to the coverage in the certificate that was provided to the individual(s) identified above:

a. MENTAL HEALTH:

b. SUBSTANCE ABUSE TREATMENT:

c. PRESCRIPTION DRUGS:

d. DENTAL CARE:

e. VISION CARE:

For each category above, enter "N/A" if the individual had no coverage within the category or either (i) enter both the date that the individual's coverage within the category began and the date that the individual's coverage within the category ended (or indicate if continuing), or (ii) enter "same" on the line if the beginning and ending dates for coverage within the category are the same as the beginning and ending dates for the coverage in the certificate.

Appendix B

Sample Language for the Newborns' Act Disclosure Requirement

Sample Language for the Newborns' Act Disclosure Requirement

The following is sample language that group health plan subject to the Newborns' Act may use in their SPDs to describe the Federal requirements relating to hospital lengths of stay in connection with childbirth:

"Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)."

Plan's subject to State law requirements will need to prepare SPD statements describing any applicable State law.

Appendix C

Sample Language for the WHCRA Disclosure Requirements

Sample Language for WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your Plan Administrator [insert phone number] for more information.

Sample Language for WHCRA Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits].

If you would like more information on WHCRA benefits, call your Plan Administrator [insert phone number].