Self-Compliance Tool for Part 7 of ERISA: HIPAA and Other Health Care-Related Provisions

INTRODUCTION

This checklist is useful for group health plans, plan sponsors, plan administrators, health insurance issuers, and other parties to determine whether a group health plan is in compliance with the provisions of Part 7 of ERISA.

The requirements described in this checklist generally apply to group health plans and group health insurance issuers. However, references in this checklist are generally limited to "group health plans" or "plans" for convenience.

Cumulative List of Checklist Questions for HIPAA and Other Health Care-Related Statutes Added to Part 7 of ERISA

I. Determining Compliance with the HIPAA Provisions in Part 7 of ERISA

If you answer "No" to any of the questions below, the group health plan is in violation of the HIPAA provisions in Part 7 of ERISA.

	YES	NO	N/A
SECTION A - Limits on Preexisting Condition Exclusions If the plan imposes a preexisting condition exclusion period, the plan must comply with this section. **Definition:** Generally, a preexisting condition exclusion is a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. *See ERISA* section *701(b)(1); 29 CFR 2590.701-3(a)(1).* **Tip:** Some preexisting condition exclusions are clearly designated as such in the plan documents. Others are not. Check for *hidden* preexisting condition exclusion provisions. A hidden preexisting condition exclusion is not designated as a preexisting condition exclusion, but restricts benefits based on when a condition arose in relation to the effective date of coverage. ◆ **Example:** A plan excludes coverage for cosmetic surgery unless the surgery is required by reason of an accidental injury occurring after the effective date of coverage. This plan provision operates as a preexisting condition exclusion			

	YES	NO	N/A
because only people who were injured while covered under the plan receive benefits for treatment. People who were injured while they had no coverage (or while they had prior coverage) do not receive benefits for treatment. Accordingly, this plan provision limits benefits relating to a condition because the condition was present before the effective date of coverage, and is considered a preexisting condition exclusion. A plan imposing a preexisting condition exclusion is required to comply with all the rules described in this **SECTION A**. Therefore, if the plan is not mindful that a provision operates as a preexisting condition exclusion, there could be multiple violations of this **SECTION A**. **Tip:** To comply with HIPAA, a plan imposing a *hidden* preexisting condition exclusion can rewrite its plan provision so that it is not a preexisting condition exclusion (i.e., benefits are not limited based on whether the condition arose before an individual's effective date of coverage) or the plan must limit the preexisting condition exclusion to comply with the rules of this **SECTION A.** If the plan does not impose a preexisting condition exclusion period, including a *hidden* preexisting condition exclusion period, check "N/A" and skip to **SECTION B**			☐
Question 1 – Six-month look-back period **Does the plan comply with the 6-month look-back rule?** ..... ◆ A preexisting condition exclusion may apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period ending on an individual's "enrollment date." *See ERISA section 701(a)(1); 29 CFR 2590.701-3(a)(2)(i).* **Definitions:** An individual's enrollment date is the earlier of - (1) the first day of coverage; or (2) the first day of any waiting period for coverage. (Waiting period means the period that must pass before an employee or dependent is eligible to enroll under the terms of the plan. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such enrollment date is not a waiting period.) Therefore, if the plan has a waiting period, the 6-month look-back period ends on the first day of the waiting period, not the first day of coverage. *See ERISA sections 701(b)(1) and (4); 29 CFR 2590.701-3(a)(3).* **Tip:** If the plan has a waiting period for coverage, ensure that the 6-month look-back period is measured from the first day of the waiting period, not the first day of coverage.	☐	☐	

	YES	NO	N/A
Question 2 – Twelve/eighteen-month look-forward period **Does the plan comply with HIPAA's 12-month (or 18-month) look-forward rule?** ..... ◆ The maximum preexisting condition exclusion period is 12 months (18 months for late enrollees), measured from an individual's enrollment date. *See ERISA section 701(a)(2); 29 CFR 2590.701-3(a)(2)(ii).* **Tip:** If the plan has a waiting period, the 12-month (or 18-month) look-forward period must begin on the first day of the waiting period, not the first day of coverage. Therefore, the preexisting condition exclusion period runs concurrently with the waiting period, rather than beginning after the waiting period ends.	☐	☐	
Question 3 – Offsetting the length of preexisting condition exclusions by creditable coverage **Does the plan offset the length of its preexisting condition exclusion by an individual's creditable coverage?** ..... ◆ The length of the plan's preexisting condition exclusion must be offset by the number of days of an individual's creditable coverage. However, days of coverage prior to a "significant break in coverage" are not required to be counted as creditable coverage. Under Federal law, a significant break in coverage is a period of 63 days or more without any health coverage. *See ERISA section 701(a)(3); 29 CFR 2590.701-3(a)(2)(iii).* **Definition:** Creditable coverage means coverage of an individual under any of the following: ◆ A group health plan (including COBRA coverage), ◆ Health insurance coverage, ◆ Medicare, ◆ Medicaid, ◆ TRICARE, ◆ The Indian Health Service, ◆ A State health risk benefit pool, ◆ The Federal Employee Health Benefit Program, ◆ A public health plan, ◆ Peace Corps Act health benefits, or ◆ The State Children's Health Insurance Program. *See ERISA section 701(c); 29 CFR 2590.701-4(a)(1).*	☐	☐	
Question 4 – Preexisting condition exclusion on genetic information **Does the plan comply with HIPAA by not imposing a preexisting condition exclusion with respect to genetic information?** ..... ◆ Genetic information alone cannot be treated as a preexisting condition in the absence of a diagnosis of a condition related to such information. *See ERISA section 701(a)(1) and (b)(1); 29 CFR 2590.701-3(b)(6).*	☐	☐	

	YES	NO	N/A
Question 5 – Preexisting condition exclusion on newborns **Does the plan comply with HIPAA by not imposing an impermissible preexisting condition exclusion on newborns?** ..... ◆ A plan generally may not impose a preexisting condition exclusion on a child who enrolls in creditable coverage within 30 days of birth. *See ERISA section 701(d)(1); 29 CFR 2590.701-3(b)(1).* **Tip:** Even if a child is not covered under the plan within 30 days of birth, the child still cannot be subject to a preexisting condition exclusion if he or she was enrolled in any creditable coverage within 30 days of birth and does not incur a subsequent 63-day break in coverage.	☐	☐	
Question 6 – Preexisting condition exclusion on children adopted or placed for adoption **Does the plan comply with HIPAA by not imposing an impermissible preexisting condition exclusion on adopted children or children placed for adoption?** ..... ◆ A plan generally may not impose a preexisting condition exclusion on a child who enrolls in creditable coverage within 30 days of adoption or placement for adoption. *See ERISA section 701(d)(2); 29 CFR 2590.701-3(b)(2).*	☐	☐	
Question 7 – Preexisting condition exclusion on pregnancy **Does the plan comply with HIPAA by not imposing a preexisting condition exclusion on pregnancy?** ..... ◆ A plan may not impose a preexisting condition exclusion relating to pregnancy. *See ERISA section 701(d)(3); 29 CFR 2590.701-3(b)(5).* **Tip:** A plan provision that denies benefits for pregnancy until 12 months after an individual generally becomes eligible for benefits under the plan is a preexisting condition exclusion and is prohibited. See 29 CFR 2590.701-3(a)(1)(ii) Example 5.	☐	☐	
Question 8 – General notices of preexisting condition exclusion **Does the plan provide adequate and timely general notices of preexisting condition exclusions?** ..... ◆ A group health plan 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. This includes the length of the plan's look-back period, the maximum preexisting condition exclusion period under the plan, and how the plan will reduce this maximum by creditable coverage.	☐	☐	

	YES	NO	N/A
❖ A description of the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods) through a certificate of creditable coverage or through other means. This must include: (1) a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary; and (2) a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary. ❖ A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion. *See 29 CFR 2590.701-3(c)(2).* ◆ The general notice is required to be provided as part of any written application materials distributed for enrollment. If a plan does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan, acting in a reasonable and prompt fashion, can provide the notice. *See 29 CFR 2590.701-3(c)(1).* **Tips:** Ensure that the general notice is both complete and timely. The plan can include its general notice of preexisting condition exclusion in the summary plan description (SPD) if the SPD is provided as part of the application materials. If not, this general notice must be provided separately to be timely. A model notice is provided in the Model Disclosures on page 77.			
<u>Question 9 – Determination of creditable coverage</u> **Does the plan comply with the requirements relating to determination of individuals' creditable coverage?** ..... ◆ If a plan receives creditable coverage information from an individual, the plan is required to make a determination regarding the amount of the individual's creditable coverage and the length of any preexisting condition exclusion that remains. This determination must be made within a reasonable time following the receipt of the creditable coverage information. Whether this determination is made within a reasonable time depends on all the relevant facts and circumstances, including whether the plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care. *See 29 CFR 2590.701-3(d)(1).* ◆ A plan may not impose any limit on the amount of time an individual has to present a certificate or other evidence of creditable coverage. *See 29 CFR 2590.701-3(d)(2).*	☐	☐	

	YES	NO	N/A
Question 10 -- Individual notices of preexisting condition exclusions **Does the plan provide adequate and timely individual notices of preexisting condition exclusion?** ..... ◆ After an individual has presented evidence of creditable coverage and after the plan has made a determination of creditable coverage *(See 29 CFR 2590.701-3(d)),* the plan must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. *See 29 CFR 2590.701-3(e).* ◆ **Exception:** A plan is not required to provide this notice if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage. *See 29 CFR 2590.701-3(e).* ◆ The notice must disclose: ❖ The determination of the length of any preexisting condition exclusion that applies to the individual (including the last day on which the preexisting condition exclusion applies); ❖ The basis for the determination, including the source and substance of any information on which the plan relied; ❖ An explanation of the individual's right to submit additional evidence of creditable coverage; and ❖ A description of any applicable appeal procedures established by the plan. *See 29 CFR 2590.701-3(e)(2).* ◆ The individual notice must be provided by the earliest date following a determination that the plan, acting in a reasonable and prompt fashion, can provide the notice. *See 29 CFR 2590.701-3(e)(1).* **Tips:** Ensure that individual notices are complete and timely as well. A model notice is provided in the Model Disclosures on page 79.	☐	☐	
Question 11 -- Reconsideration **If the plan determines that an individual does not have the creditable coverage claimed, and the plan wants to modify an initial determination of creditable coverage, does the plan comply with the rules relating to reconsideration?** ..... ◆ A plan may modify an initial determination of an individual's creditable coverage if the plan determines that the individual did not have the claimed creditable coverage, provided that: ❖ A notice of the new determination is provided to the individual; and ❖ Until the new notice is provided, the plan, for purposes of approving access to medical services, acts in a manner consistent with the initial determination of creditable coverage. *See 29 CFR 2590.701-3(f).*	☐	☐	

	YES	NO	N/A
SECTION B - Compliance with the Certificate of Creditable Coverage Provisions Regardless of whether the plan imposes a preexisting condition exclusion, the plan is required to issue certificates of creditable coverage when coverage ceases and upon request. To be complete, under 29 CFR 2590.701-5(a)(3)(ii), each certificate must include: 1. Date issued; 2. Name of plan; 3. The individual's name and identification information (**Note: Dependent information can be included on the same certificate with the participant information or on a separate certificate. The plan is required to have used reasonable efforts to get dependent information. *See 29 CFR 2590.701-5(a)(5)(i));* 4. Plan administrator name, address, and telephone number; 5. Telephone number for further information (if different); 6. Individual's creditable coverage information: ❖ Either: (1) that the individual has at least 18 months of creditable coverage; or (2) the date any waiting period (or affiliation period) began and the date creditable coverage began. ❖ Also, either: (1) the date creditable coverage ended; or (2) that creditable coverage is continuing. ❖ Automatic certificates of creditable coverage should reflect the last period of continuous coverage. Requested certificates of creditable coverage should reflect periods of continuous coverage that an individual had in the 24 months prior to the date of the request (up to 18 months of creditable coverage). *See 29 CFR 2590.701-5(a)(3)(iii).* ❖ Requested certificates should reflect periods of continuous coverage that an individual had in the 24 months prior to the date of the request (up to 18 months of creditable coverage). *See 29 CFR 2590.701-5(a)(3)(iii).* 7. An educational statement regarding HIPAA, which explains: ❖ The restrictions on the ability of a plan or issuer to impose a preexisting condition exclusion (including an individual's ability to reduce a preexisting condition exclusion by creditable coverage); ❖ Special enrollment rights; ❖ The prohibitions against discrimination based on any health factor; ❖ The right to individual health coverage; ❖ The fact that State law may require issuers to provide additional protections to individuals in that State; and ❖ Where to get more information. **Tips:** Remember to include information about waiting periods and dependents. If a plan imposes a waiting period, the date the waiting period began is required to be reflected on the certificate. In addition, if the certificate applies to more than one person (such as a participant and dependents), the dependents' creditable coverage information is required to be reflected on the certificate (or the plan can issue a separate certificate to each dependent). (**Note: If a dependent's last known address is different from the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address.) A model notice is provided in the Model Disclosures on page 73.			

	YES	NO	N/A
** **Special Accountability Rule for Insured Plans:** ◆ Under a special accountability rule in ERISA section 701(e)(1)(C) and 29 CFR 2590.701-5(a)(1)(iii), a health insurance issuer, rather than the plan, may be responsible for providing certificates of creditable coverage by virtue of an agreement between the two that makes the issuer responsible. In this case, the issuer, but not the plan, violates the certificate requirements of section 701(e) if a certificate is not provided in compliance with these rules. (**Note: An agreement with a third-party administrator (TPA) that is not insuring benefits will not transfer responsibility from the plan.) ◆ Despite this special accountability rule, other responsibilities, such as a plan administrator's duty to monitor compliance with a contract, remain unaffected. Accordingly, this section of the checklist is organized differently to take into account this special accountability rule.			
Question 12 – Automatic certificates of creditable coverage upon loss of coverage **Does the plan provide complete and timely certificates of creditable coverage to individuals automatically upon loss of coverage?** ..... ◆ Plans are required to provide each participant and dependent covered under the plan an automatic certificate, free of charge, when coverage ceases. (If the plan is insured and there is an agreement with the issuer that the issuer is responsible for providing the certificates, check "N/A" and go to **Question 13.**) ◆ Under 29 CFR 2590.701-5(a)(2)(ii), plans and issuers must furnish an automatic certificate of creditable coverage: ❖ To an individual who is entitled to elect COBRA, at a time no later than when a notice is required to be provided for a qualifying event under COBRA (usually not more than 44 days); ❖ To an individual who loses coverage under the plan and who is not entitled to elect COBRA, within a reasonable time after coverage ceases; and ❖ To an individual who ceases COBRA, within a reasonable time after COBRA coverage ceases (or after the expiration of any grace period for nonpayment of premiums).	☐	☐	☐
Question 13 – Automatic certificate upon loss of coverage – *Issuer Responsibility* **If there is an agreement between the plan and the issuer stating that the issuer is responsible for providing certificates of creditable coverage, does the issuer provide complete and timely certificates?** ..... ◆ Even if the plan is not responsible for issuing certificates of creditable coverage, the plan should monitor issuer compliance with the certification provisions. ◆ If the plan is self-insured, or if there is no such agreement between the plan and the issuer, check "N/A" and skip to **Question 14.**	☐	☐	☐

	YES	NO	N/A
Question 14 – Certificates of creditable coverage upon request **Does the plan provide complete certificates of creditable coverage upon request?** ..... (If the plan is insured and the issuer is responsible for issuing certificates pursuant to an agreement, check "N/A" and go to **Question 15.**) ◆ Certificates of creditable coverage must be provided free of charge to individuals who request a certificate while covered under the plan and for up to 24 months after coverage ends. *See ERISA section 701(e)(1)(A); 29 CFR 2590.701-5(a)(2)(iii).* ◆ Requested certificates must be provided, at the earliest time that a plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate of creditable coverage. *See 29 CFR 2590.701-5(a)(2)(iii).*	☐	☐	☐
Question 15 – Certificates upon request – Issuer Responsibility **If the plan is insured and there is an agreement between the plan and the issuer stating that the issuer is responsible for providing certificates of creditable coverage, does the issuer provide complete certificates?** ..... ◆ Even if the plan is not responsible for issuing certificates of creditable coverage, the plan should monitor issuer compliance with the certification provisions. ◆ If the plan is self-insured, or if there is no such agreement between the plan and the issuer, check "N/A" and skip to **Question 16.**	☐	☐	☐
Question 16 – Written Procedure for Requesting Certificates **Does the plan have a written procedure for individuals to request and receive certificates of creditable coverage?** ..... ◆ The plan must have a written procedure for individuals to request and receive certificates of creditable coverage. The written procedure must include all contact information necessary to request a certificate (such as name and phone number or address). *See 29 CFR 2590.701-5(a)(4)(ii).*	☐	☐	☐
SECTION C – Compliance with the Special Enrollment Provisions Group health plans must allow individuals (who are otherwise eligible) to enroll upon certain specified events, regardless of any late enrollment provisions, if enrollment is requested within 30 days of the event. The plan must provide for special enrollment, as follows:			

	YES	NO	N/A
Question 17 – Special enrollment upon loss of other coverage **Does the plan provide full special enrollment rights upon loss of other coverage?** ..... ◆ A plan must permit loss-of-coverage special enrollment upon: (1) loss of eligibility for group health plan coverage or health insurance coverage; and (2) termination of employer contributions toward group health plan coverage. *See ERISA section 701(f)(1); 29 CFR 2590.701-6(a)* . ◆ When a current employee loses eligibility for coverage, the plan must permit the employee and any dependents to special enroll. *See 29 CFR 2590.701-6(a)(2)(i).* ◆ When a dependent of a current employee loses eligibility for coverage, the plan must permit the dependent and the employee to special enroll. *See 29 CFR 2590.701-6(a)(2)(ii).* **Examples:** Examples of reasons for loss of eligibility include: legal separation, divorce, death of an employee, termination or reduction in the number of hours of employment - voluntary or involuntary (with or without electing COBRA), exhaustion of COBRA, reduction in hours, "aging out" under other parent's coverage, moving out of an HMO's service area, and meeting or exceeding a lifetime limit on all benefits. Loss of eligibility for coverage does not include loss due to the individual's failure to pay premiums or termination of coverage for cause - such as for fraud. *See 29 CFR 2590.701-6(a)(3)(i).* ◆ When employer contributions toward an employee's or dependent's coverage terminates, the plan must permit special enrollment, even if the employee or dependent did not lose eligibility for coverage. *See 29 CFR 2590.701-6(a)(3)(ii).* ◆ Plans must allow an employee a period of at least 30 days to request enrollment. *See 29 CFR 2590.701-6(a)(4)(i).* ◆ Coverage must become effective no later than the first day of the first month following a completed request for enrollment. *See 29 CFR 2590.701-6(a)(4)(ii).* **Tip**: Ensure that the plan permits special enrollment upon all of the loss of coverage events described above.	☐	☐	
Question 18 – Dependent special enrollment **Does the plan provide full special enrollment rights to individuals upon marriage, birth, adoption, and placement for adoption?** ..... ◆ Plans must generally permit current employees to enroll upon marriage and upon birth, adoption, or placement for adoption of a dependent child. *See ERISA section 701(f)(2); 29 CFR 2590.701-6(b)(2).* ◆ Plans must generally permit a participant's spouse **and** new dependents to enroll upon marriage, birth, adoption, and placement for adoption. *See ERISA section 701(f)(2); 29 CFR 2590.701-6(b)(2).*	☐	☐	

	YES	NO	N/A
◆ Plans must allow an individual a period of at least 30 days to request enrollment. *See 29 CFR 2590.701-6(b)(3)(i).* ◆ In the case of marriage, coverage must become effective no later than the first day of the month following a completed request for enrollment. *See 29 CFR 2590.701-6(b)(3)(iii)(A).* ◆ In the case of birth, adoption, or placement for adoption, coverage must become effective as of the date of the birth, adoption, or placement for adoption. *See 29 CFR 2590.701-6(b)(3)(iii)(B).* **Tips:** Remember to allow all eligible employees, spouses, and new dependents to enroll upon these events. Also, ensure that the effective date of coverage complies with HIPAA, keeping in mind that some effective dates of coverage are retroactive.			
Question 19 – Treatment of special enrollees **Does the plan treat special enrollees the same as individuals who enroll when first eligible, for purposes of eligibility for benefit packages, premiums, and imposing a preexisting condition exclusion?** ..... ◆ If an individual requests enrollment while the individual is entitled to special enrollment, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. *See 29 CFR 2590.701-6(d)(1).* ◆ Special enrollees must be offered the same benefit packages available to similarly situated individuals who enroll when first eligible. (Any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package.) In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied cannot exceed that applied to other similarly situated individuals who enroll when first eligible. *See 29 CFR 2590.701-6(d)(2).*	☐	☐	
Question 20 – Notice of special enrollment rights **Does the plan provide timely and adequate notices of special enrollment rights?** ..... ◆ On or before the time an employee is offered the opportunity to enroll in the plan, the plan must provide the employee with a description of special enrollment rights. **Tip:** Ensure that the special enrollment notice is provided at or before the time an employee is initially offered the opportunity to enroll in the plan. This may mean breaking it off from the SPD. The plan can include its special enrollment notice in the SPD if the SPD is provided at or before the initial enrollment opportunity (for example, as part of the application materials). If not, the special enrollment notice must be provided separately to be timely.	☐	☐	

	YES	NO	N/A
SECTION D – Compliance with the HIPAA Nondiscrimination Provisions Overview. HIPAA prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors. These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability. *See ERISA section 702; 29 CFR 2590.702.* Similarly Situated Individuals. It is important to recognize that the nondiscrimination rules prohibit discrimination within a group of similarly situated individuals. Under 29 CFR 2590.702(d), plans may treat distinct groups of similarly situated individuals differently, if the distinctions between or among the groups are not based on a health factor. 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. Whether an employment-based classification is bona fide is based on relevant facts and circumstances, such as whether the employer uses the classification for purposes independent of qualification for health coverage. Bona fide employment-based classifications might include: full-time versus part-time employee status; different geographic location; membership in a collective bargaining unit; date of hire or length of service; or differing occupations. In addition, plans may treat participants and beneficiaries as two separate groups of similarly situated individuals. Plans may also distinguish among beneficiaries. Distinctions among groups of beneficiaries may be based on bona fide employment-based classifications of the participant through whom the beneficiary is receiving coverage, relationship to the participant (such as spouse or dependent), marital status, age or student status of dependent children, or any other factor that is not a health factor. **Exception for benign discrimination:** The nondiscrimination rules do not prohibit a plan from establishing more favorable rules for eligibility or premium rates for individuals with an adverse health factor, such as a disability. *See 29 CFR 2590.702(g).* Check to see that the plan complies with HIPAA's nondiscrimination provisions as follows:			
Question 21 – Nondiscrimination in eligibility **Does the plan allow individuals eligibility and continued eligibility under the plan regardless of any adverse health factor?** ..... ◆ Examples of plan provisions that violate ERISA section 702(a) because they discriminate in eligibility based on a health factor include: ❖ Plan provisions that require "evidence of insurability," such as passing a physical exam, providing a certification of good health, or demonstrating good health through answers to a health care questionnaire in order to enroll. *See 29 CFR 2590.702(b)(1).*	☐	☐	

	YES	NO	N/A
◆ Also, note that it may be permissible for plans to require individuals to complete physical exams or health care questionnaires for purposes other than for determining eligibility to enroll in the plan, such as for determining an appropriate blended, aggregate group rate for providing coverage to the plan as a whole. *See 29 CFR 2590.702(b)(1)(iii) Example 1.* **Tip:** Eliminate plan provisions that deny individuals eligibility or continued eligibility under the plan based on a health factor, even if such provisions apply only to late enrollees.			
Question 22 – Nondiscrimination in benefits **Does the plan uniformly provide benefits to participants and beneficiaries, without directing any benefit restrictions at individual participants and beneficiaries based on a health factor?** ..... ◆ A plan is not required to provide any benefits, but benefits provided must be uniformly available and any benefit restrictions must be applied uniformly to all similarly situated individuals and cannot be directed at any individual participants or beneficiaries based on a health factor. If benefit exclusions or limitations are applied only to certain individuals based on a health factor, this would violate ERISA section 702(a) and 29 CFR 2590.702(b)(2). ◆ Examples of plan provisions that would be permissible under ERISA section 702(a) include: ❖ A lifetime or annual limit on all benefits, ❖ A lifetime or annual limit on the treatment of a particular condition, ❖ Limits or exclusions for certain types of treatments or drugs, ❖ Limitations based on medical necessity or experimental treatment, and ❖ Cost-sharing, if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor. ◆ A plan amendment applicable to all similarly situated individuals and made effective no earlier than the first day of the next plan year is not considered directed at individual participants and beneficiaries. *See 29 CFR 2590.702(b)(2)(i)(C).*	☐	☐	
Question 23 – Source-of-injury restrictions **If the plan imposes a source-of-injury restriction, does it comply with the HIPAA nondiscrimination provisions?** ..... ◆ Plans may exclude benefits for the treatment of certain injuries based on the source of that injury, except that plans may not exclude benefits otherwise provided for treatment of an injury if the injury results from an act of domestic violence or a medical condition. *See 29 CFR 2590.702(b)(2)(iii)*. An example of a permissible source-of-injury exclusion would include: ❖ A plan provision that provides benefits for head injuries generally, but excludes benefits for head injuries sustained while participating in bungee	☐	☐	☐

	YES	NO	N/A
jumping, as long as the injuries do not result from a medical condition or domestic violence. ◆ An impermissible source-of-injury exclusion would include: ❖ A plan provision that generally provides coverage for medical and surgical benefits, including hospital stays that are medically necessary, but excludes benefits for self-inflicted injuries or attempted suicide. This is impermissible because the plan provision excludes benefits for treatment of injuries that may result from a medical condition (depression). ◆ If the plan does not impose a source-of-injury restriction, check "N/A" and skip to **Question 24.**			
<u>Question 24 -- Nondiscrimination in premiums or contributions</u> **Does the plan comply with HIPAA's nondiscrimination rules regarding individual premium or contribution rates?** ..... ◆ Under ERISA section 702(b) and 29 CFR 2590.702(c), plans may not require an individual to pay a premium or contribution that is greater than a premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health factor. For example, it would be impermissible for a plan to require certain full-time employees to pay a higher premium than other full-time employees based on their prior claims experience. ◆ Nonetheless, the nondiscrimination rules do not prohibit a plan from providing a reward based on adherence to a wellness program. *See ERISA section 702(b)(2)(B); 29 CFR 2590.702(b)(2)(ii) and (c)(3).* Final rules for wellness programs were published on December 13, 2006, at 71 FR 75014. These rules permit rewards that are not contingent on an individual meeting a standard related to a health factor. In addition, these rules permit rewards that are contingent on an individual meeting a standard related to a health factor if: ❖ The total reward for all the plan's wellness programs that require satisfaction of a standard related to a health factor is limited – generally, it must not exceed 20 percent of the cost of employee-only coverage under the plan. If dependents (such as spouses and/or dependent children) may participate in the wellness program, the reward must not exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled. ❖ The program must be reasonably designed to promote health and prevent disease. ❖ The program must give individuals eligible to participate the opportunity to qualify for the reward at least once per year. ❖ The reward must be available to all similarly situated individuals. The program must allow a reasonable alternative standard (or waiver of initial standard) for obtaining the reward to any individual for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the initial standard. ❖ The plan must disclose in all materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of a waiver of the initial standard). A model notice is provided in the Model Disclosures on page 81.	☐	☐	

	YES	NO	N/A
Question 25 – List billing **Is there compliance with the list billing provisions?** ..... ◆ Under 29 CFR 2590.702(c)(2)(ii), plans and issuers may not charge or quote an employer a different premium for an individual in a group of similarly situated individuals based on a health factor. This practice is commonly referred to as list billing. If an issuer is list billing an employer and the plan is passing the separate and different rates on to the individual participants and beneficiaries, both the plan and the issuer are violating the prohibition against discrimination in premium rates. This does not prevent plans and issuers from taking the health factors of each individual into account in establishing a blended/aggregate rate for providing coverage to the plan.	☐	☐	
Question 26 – Nonconfinement clauses **Is the plan free of any nonconfinement clauses?** ..... ◆ Typically, a nonconfinement clause will deny or delay eligibility for some or all benefits if an individual is confined to a hospital or other health care institution. Sometimes nonconfinement clauses also deny or delay eligibility if an individual cannot perform ordinary life activities. Often a nonconfinement clause is imposed only with respect to dependents, but they may also be imposed with respect to employees. 29 CFR 2590.702(e)(1) explains that these nonconfinement clauses violate ERISA sections 702(a) (if the clause delays or denies eligibility) and 702(b) (if the clause raises individual premiums). **Tip:** Delete all nonconfinement clauses.	☐	☐	
Question 27 – Actively-at-work clauses **Is the plan free of any impermissible actively-at-work clauses?** ..... ◆ Typically, actively-at-work provisions delay eligibility for benefits based on an individual being absent from work. 29 CFR 2590.702(e)(2) explains that actively-at-work provisions generally violate ERISA sections 702(a) (if the clause delays or denies eligibility) and 702(b) (if the clause raises individual premiums or contributions), unless absence from work due to a health factor is treated, for purposes of the plan, as if the individual is at work. Nonetheless, an exception provides that a plan may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan before eligibility commences. Further, plans may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in 29 CFR 2590.702(d). For example, a plan that treats full-time and part-time employees differently for other employment-based purposes, such as eligibility for other employee benefits, may distinguish in rules for eligibility under the plan between full-time and part-time employees. **Tip:** Carefully examine any actively-at-work provision to ensure consistency with HIPAA.	☐	☐	

	YES	NO	N/A
SECTION E – Compliance with the HMO Affiliation Period Provisions If the plan provides benefits through an HMO and imposes an HMO affiliation period in lieu of a preexisting condition exclusion period, answer **Question 28.** If the plan does not provide benefits through an HMO, or if there is no HMO affiliation period, check "N/A" and go to **Section F.**			☐
Question 28 – HMO affiliation period provisions **Does the plan comply with the limits on HMO affiliation periods?** ..... ◆ An affiliation period is a period of time that must expire before health insurance coverage provided by an HMO becomes effective and during which the HMO is not required to provide benefits. ◆ A group health plan offering coverage through an HMO may impose an affiliation period only if: ❖ No preexisting condition exclusion is imposed; ❖ No premium is charged to a participant or beneficiary for the affiliation period; ❖ The affiliation period is applied uniformly without regard to any health factor; ❖ The affiliation period does not exceed 2 months (or 3 months for late enrollees); ❖ The affiliation period begins on an individual's "enrollment date"; and ❖ The affiliation period runs concurrently with any waiting period. *See ERISA section 701(g); 29 CFR 2590.701-7.*	☐	☐	
SECTION F – Compliance with the MEWA or Multiemployer Plan Guaranteed Renewability Provisions If the plan is a multiple employer welfare arrangement (MEWA) or a multiemployer plan, it is required to provide guaranteed renewability of coverage in accordance with ERISA section 703. If the plan is a MEWA or multiemployer plan, it must comply with **Question 29.** If the plan is not a MEWA or multiemployer plan, check "N/A" and go to **Part II** of this check list.			☐
Question 29 – Multiemployer plan and MEWA guaranteed renewability **If the plan is a multiemployer plan, or a MEWA, does the plan provide guaranteed renewability?** ..... ◆ Group health plans that are multiemployer plans or MEWAs may not deny an employer continued access to the same or different coverage, other than: ❖ For nonpayment of contributions; ❖ For fraud or other intentional misrepresentation by the employer; ❖ For noncompliance with material plan provisions; ❖ Because the plan is ceasing to offer coverage in a geographic area;	☐	☐	

	YES	NO	N/A
❖ In the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or any health-related factor in relation to such individuals or dependents; or ❖ For failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such agreement. *See ERISA section 703.* **Note: The Public Health Service (PHS) Act contains different guaranteed renewability requirements for issuers. For more information, see PHS Act section 2712.			

II. Determining Compliance with the MHPA Provisions in Part 7 of ERISA			
If you answer "No" to any of the questions below, the group health plan is in violation of the MHPA provisions in Part 7 of ERISA.			
	YES	**NO**	**N/A**
If the plan provides both mental health and medical and surgical benefits, the plan may be subject to MHPA. If this is the case, answer **Questions 30-34**. If the plan does not provide mental health benefits, check "N/A" here and skip to **Part III** of this checklist. Also, the plan may be exempt from MHPA under the small employer (50 employees or fewer) exception or the increased cost exception. (To be eligible for the increased cost exception, the plan must have filed a notice with EBSA and notified participants and beneficiaries.) If the plan is exempt, check "N/A" here and skip to **Part III** of this checklist			☐
Question 30 – Lifetime dollar limit **Does the plan comply with MHPA's rules for lifetime dollar limits on mental health benefits (excluding constructive dollar limits)?** ..... ◆ A plan may not impose a lifetime dollar limit on mental health benefits that is lower than the lifetime dollar limit imposed on medical and surgical benefits. *See ERISA section 712; 29 CFR 2590.712.* (Only limits on what the plan is willing to pay are taken into account. A plan may impose annual dollar out-of-pocket limits on participants and beneficiaries without implicating MHPA.) ** Note: Limits on out-of-network mental health benefits may be lower than limits on medical and surgical benefits if limits on in-network mental health benefits are unlimited, or in parity with medical and surgical limits. *See 29 CFR 2590.712(b)(4), Example 3.* But, limits on inpatient and outpatient mental health benefits must separately be in parity with limits on medical and surgical benefits. *See 29 CFR 2590.712(b)(4), Example 2.*	☐	☐	
Question 31 – Constructive lifetime dollar limit **If the plan imposes a "constructive lifetime dollar limit" on mental health benefits (see explanation and examples below), is the limit *greater than or equal* to that imposed on medical and surgical benefits?** ..... ◆ A lifetime visit limit that is coupled with a maximum dollar amount payable by the plan per visit is, in effect, a lifetime dollar limit. This is referred to as a constructive lifetime dollar limit. ◆ For example, a 100-visit lifetime limit on mental health benefits that is payable to a maximum of $40 per visit is a constructive lifetime dollar limit of $4,000 on mental health benefits. If this limit is less than the limit for medical and surgical benefits (or if there is no limit for medical and surgical benefits), the plan is not in compliance with MHPA. ◆ Again, remember only limits on what the plan is willing to pay are taken into account. **Tip:** The plan should eliminate any constructive dollar limit on mental health benefits that is lower than that for medical and surgical benefits. The plan can still impose visit limits under MHPA, provided they are not coupled with absolute dollar limitations, which would constitute a constructive dollar limit.	☐	☐	☐

	YES	NO	N/A
Question 32 – Annual dollar limit **Does the plan comply with MHPA's rules for annual dollar limits on mental health benefits (excluding constructive dollar limits)?** ..... ◆ A plan may not impose an annual dollar limit on mental health benefits that is lower than the annual dollar limit imposed on medical and surgical benefits. *See ERISA section 712; 29 CFR 2590.712.* ** Note: Limits on out-of-network mental health benefits may be lower than limits on medical and surgical benefits if limits on in-network mental health benefits are unlimited, or in parity with medical and surgical limits. *See 29 CFR 2590.712(b)(4), Example 3.* But, limits on inpatient and outpatient mental health benefits must separately be in parity with limits on medical and surgical benefits. *See 29 CFR 2590.712(b)(4), Example 2.* ◆ Remember only limits on what the plan is willing to pay are taken into account. A plan may impose annual dollar out-of-pocket limits on participants *and* beneficiaries without implicating MHPA.	☐	☐	
Question 33 – Constructive annual dollar limit **If the plan imposes a "constructive annual dollar limit" on mental health benefits, is the limit greater than or equal to that imposed on medical and surgical benefits?** ..... ◆ An annual visit limit that is coupled with a maximum dollar amount payable by the plan per visit is, in effect, an annual dollar limit. This is referred to as a constructive annual dollar limit. ◆ If this limit is less than the limit for medical and surgical benefits (or if there is no limit for medical surgical benefits), the plan is not in compliance with MHPA. ◆ Again, remember only limits on what the plan is willing to pay are taken into account.	☐	☐	☐
Question 34 – Substance abuse dollars counting against mental health dollar limit **Does the plan *exclude* substance abuse or chemical dependency benefits from its definition of "mental health benefits?"** ..... If the plan does not impose any explicit or constructive annual or lifetime dollar limits on mental health benefits, check "N/A" and skip to **Part III** of this checklist. If the plan imposes any explicit or constructive annual or lifetime dollar limit on mental health benefits, the plan must not count benefits for substance abuse or chemical dependency against the mental health dollar limit. **Tip:** Benefits for substance abuse and chemical dependency can be counted against a medical and surgical cap, or a separate substance abuse or chemical dependency cap. *See 29 CFR 2590.712(b)(4), Example 4 [using ERISA section 712(e)(4) definition of mental health benefits].*	☐	☐	☐

III. Determining Compliance with the Newborns' Act Provisions in Part 7 of ERISA

If you answer "No" to any of the questions below, the group health plan is in violation of the Newborns' Act provisions in Part 7 of ERISA.

	YES	NO	N/A
Section A – Newborns' Act Substantive Provisions The substantive provisions of the Newborns' Act apply only to certain plans, as follows: If the plan does not provide benefits for hospital stays in connection with childbirth, check "N/A" and go to **Part IV** of this checklist. (Note: Under the Pregnancy Discrimination Act, most plans are required to cover maternity benefits.) ..... Special applicability rule for *insured coverage* that provides benefits for hospital stays in connection with childbirth: If the plan provides benefits for hospital stays in connection with childbirth, the plan is insured**,** and the coverage is in Wisconsin and several U.S. territories, it appears that the Federal Newborns' Act applies to the plan. If this is the case, answer the questions in **SECTION A and SECTION B**. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on State law. Based on a preliminary review of State laws as of January 1, 2005, if the coverage is in any other state or the District of Columbia, it appears that State law applies in lieu of the Federal Newborns' Act. If this is the case, check "N/A" and skip to **SECTION B** ..... *Self-insured* coverage that provides benefits for hospital stays in connection with childbirth: If the plan provides benefits for hospital stays in connection with childbirth and is *self-insured,* the Federal Newborns' Act applies. Answer the questions in **SECTION A and SECTION B.**			☐ ☐
Question 35 – General 48/96-hour stay rule **Does the plan comply with the general 48/96-hour rule?** ..... ◆ Plans generally may not restrict benefits for a hospital length of stay in connection with childbirth to less than 48 hours in the case of a vaginal delivery *(See ERISA section 711(a)(1)(A)(i)),* or less than 96 hours in the case of a cesarean section *(See ERISA section 711(a)(1)(A)(ii)).* ◆ Therefore, a plan cannot deny a mother or her newborn benefits within a 48/96-hour stay based on medical necessity. (A plan may require a mother to notify the plan of a pregnancy to obtain more favorable cost-sharing for the hospital stay. This second type of plan provision is permissible under the Newborns' Act if the cost-sharing is consistent throughout the 48/96-hour stay.) ◆ An attending provider may, however, decide, in consultation with the mother, to discharge the mother or newborn earlier.	☐	☐	

	YES	NO	N/A
Question 36 – Provider must not be required to obtain authorization from plan **Plans may not require providers to obtain authorization from the plan to prescribe a 48/96-hour stay. Does the plan comply with this rule?** ..... ◆ Plans may not require that a provider (such as a doctor) obtain authorization from the plan to prescribe a 48/96-hour stay. *See ERISA section 711(a)(1)(B); 29 CFR 2590.711(a)(4).* **Tips:** Watch for plan preauthorization requirements that are too broad. For example, a plan may have a provision requiring preauthorization for all hospital stays. Providers cannot be required to obtain preauthorization from the plan in order for the plan to cover a 48-hour (or 96-hour) stay in connection with childbirth. Therefore, in this example, the plan must add clarifying language to indicate that the general preauthorization requirement does not apply to 48/96-hour hospital stays in connection with childbirth. (Conversely, plans generally may require participants or beneficiaries to give notice of a pregnancy or hospital admission in connection with childbirth in order to obtain, for example, more favorable cost-sharing.) Nonetheless, the Newborns' Act does not prevent plans and issuers from requiring providers to obtain authorization for any portion of a hospital stay that exceeds 48 (or 96) hours.	☐	☐	
Question 37 – Incentives/penalties to mothers or providers **Does the plan comply with the Newborns' Act by avoiding impermissible incentives or penalties with respect to mothers or attending providers?** ..... ◆ Penalties to attending providers to discourage 48/96-hour stays violate ERISA section 711(b)(3) and 29 CFR 2590.711(b)(3)(i). ◆ Incentives to attending providers to encourage early discharges violate ERISA section 711(b)(4) and 29 CFR 2590.711(b)(3)(ii). ◆ Penalties imposed on mothers to discourage 48/96-hour stays violate ERISA section 711(b)(1) and 29 CFR 2590.711(b)(1)(i)(A). ◆ Incentives to mothers to encourage early discharges violate ERISA section 711(b)(2) and 29 CFR 2590.711(b)(1)(i)(B). ❖ An example of this would be if the plan waived the mother's copayment or deductible if mother or newborn leaves within 24 hours. ◆ Benefits and cost-sharing may not be less favorable for the latter portion of any 48/96-hour hospital stay. In this case less favorable benefits would violate ERISA section 711(b)(5) and 29 CFR 2590.711(b)(2) and less favorable cost-sharing would violate ERISA section 711(c)(3) and 29 CFR 2590.711(c)(3).	☐	☐	

	YES	NO	N/A
SECTION B – Disclosure Provisions Group health plans that provide benefits for hospital stays in connection with childbirth are required to make certain disclosures, as follows:			
Question 38 – Disclosure with respect to hospital lengths of stay in connection with childbirth **Does the plan comply with the notice provisions relating to hospital stays in connection with childbirth?** ..... ◆ Group health plans that provide benefits for hospital stays in connection with childbirth are required to make certain disclosures. Specifically, the group health plan's SPD must include a statement describing any requirements under Federal or State law applicable to the plan, and any health insurance coverage offered under the plan, relating to hospital length of stay in connection with childbirth for the mother or newborn child. *See the SPD content regulations at 29 CFR 2520.102-3(u).* **Tips:** Whether the plan is insured or self-insured, and whether the Federal Newborns' Act provisions or State law provisions apply to the coverage, the plan must provide a notice describing any requirements relating to hospital length of stays in connection with childbirth. A model notice is provided in the Model Disclosures on page 82.	☐	☐	

IV. Determining Compliance with the WHCRA Provisions in Part 7 of ERISA			
If you answer "No" to any of the questions below, the group health plan is in violation of the WHCRA provisions in Part 7 of ERISA.			
	YES	**NO**	**N/A**
WHCRA applies only to plans that offer benefits with respect to a mastectomy. If the plan does not offer these benefits, check "N/A" and you are finished with this checklist. ..... If the plan does offer benefits with respect to a mastectomy, answer **Questions 39-42.**			☐
<u>Question 39 – Four required coverages under WHCRA</u> **Does the plan provide the four coverages required by WHCRA?** ..... ◆ In the case of a participant or beneficiary who is receiving benefits in connection with a mastectomy, the plan shall provide coverage for the following benefits for individuals who elect them: ❖ All stages of reconstruction of the breast on which the mastectomy has been performed; ❖ Surgery and reconstruction of the other breast to produce a symmetrical appearance; ❖ Prostheses; and ❖ Treatment of physical complications of mastectomy, including lymphedema, in a manner determined in consultation with the attending provider and the patient. *See ERISA section 713(a).* ◆ These required coverages can be subject to annual deductibles and coinsurance provisions if consistent with those established for other medical and surgical benefits under the plan or coverage. **Tip:** Plans that cover benefits for mastectomies cannot categorically exclude benefits for reconstructive surgery or certain post-mastectomy services. In addition, time limits for seeking treatment may run afoul of the general requirement to provide the four required coverages.	☐	☐	
<u>Question 40 – Incentive provisions</u> **Does the plan comply with WHCRA by not providing impermissible incentives or penalties with respect to patients or attending providers?** ..... ◆ A plan may not deny a patient eligibility to enroll or renew coverage solely to avoid WHCRA's requirements under ERISA section 713(c)(1). ◆ In addition, under ERISA section 713(c)(2), a plan may not penalize or offer incentives to an attending provider to induce the provider to furnish care in a manner inconsistent with WHCRA.	☐	☐	

	YES	NO	N/A
Question 41 – Enrollment notice **Does the plan provide adequate and timely enrollment notices as required by WHCRA?** ..... ◆ Upon enrollment, a plan must provide a notice describing the benefits required under WHCRA. *See ERISA section 713(a).* ◆ The enrollment notice must describe the benefits that WHCRA requires the group health plan to cover, specifically: ❖ 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 ❖ Physical complications resulting from mastectomy (including lymphedema). ◆ The enrollment notice must describe any deductibles and coinsurance limitations applicable to such coverage. (Note: Under WHCRA, coverage of the required benefits may be subject only to deductibles and coinsurance limitations consistent with those established for other medical and surgical benefits under the plan or coverage.) **Tip:** A model notice is provided in the Model Disclosures on page 83.	☐	☐	
Question 42 – Annual notice **Does the plan provide adequate and timely annual notices as required by WHCRA?** ..... ◆ Plans must provide notices describing the benefits required under WHCRA once each year. *See ERISA section 713(a).* ◆ To satisfy this requirement, the plan may redistribute the WHCRA enrollment notice or the plan may use a simplified disclosure that: ❖ Provides notice of the availability of benefits under the plan for reconstructive surgery, surgery to achieve symmetry between the breasts, prostheses, and physical complications resulting from mastectomy (including lymphedema); and ❖ Contact information (e.g., telephone number) for obtaining a detailed description of WHCRA benefits available under the plan. **Tip**: The WHCRA annual notice can be provided in the SPD if the plan distributes SPDs annually. If not, the plan should break off the annual notice into a separate disclosure. A model notice is provided in the Model Disclosures on page 84.	☐	☐	