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

INTRODUCTION

This checklist is a useful self-compliance tool 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 Subtitle B of Title I (Part 7) of the Employee Retirement Income Security Act of 1974 (ERISA). The Part 7 provisions were added to ERISA by four separate laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Mental Health Parity Act of 1996 (MHPA); the Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act); and the Women's Health and Cancer Rights Act of 1998 (WHCRA). ERISA is administered by the Employee Benefits Security Administration (EBSA).

All of the foregoing laws amended Part 7 of ERISA by adding new requirements for group health plans. With respect to most of these requirements, corresponding provisions are contained in Chapter 100 of Subtitle K of the Internal Revenue Code (Code) and Part A of Title XXVII of the Public Health Service Act (PHS Act).

Arrangements Subject to Part 7 of ERISA: In general, Part 7 of ERISA applies to group health plans and health insurance issuers in the group market.

- A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including partners in a partnership) or their dependents (defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.
- A health insurance issuer or issuer means an insurance company, insurance service, or insurance organization (including a health maintenance organization (HMO)) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance.
- Group market generally means the market for health insurance coverage offered in connection with a group health plan.
  - Even though issuers in the group market are subject to Part 7, the Department of Labor cannot enforce against them. However, participants may bring a cause of action against an issuer for violations of Part 7.
  - States can enforce against issuers for violations of these new health care laws. Therefore, questions concerning issuers or suspected violations by issuers should be referred to the applicable State insurance department.

Arrangements Not Subject to Part 7 of ERISA: Certain arrangements that are group health plans are not subject to Part 7. These arrangements are listed below.

- Very Small Group Health Plans are generally not subject to Part 7 (except very small group health plans are subject to section 711 of ERISA, the Newborns' Act provisions). A very small group health plan is a group health plan that has fewer than two participants who are current employees on the first day of the plan year.

- Group health plans are not subject to Part 7 of ERISA in their provision of "excepted benefits." There are several types of "excepted benefits."
  - Certain benefits are always treated as "excepted benefits" because they are **not considered health coverage**, such as accident-only or disability income insurance and workers' compensation insurance.
  - Other benefits are treated as "excepted benefits" if they are **offered separately or are not an integral part of the plan**, including limited-scope dental or vision benefits or long-term care benefits.
  - Moreover, other benefits are treated as "excepted benefits" if they are **offered separately and not coordinated** with benefits under another group health plan, including coverage for a specific disease, and hospital indemnity or other fixed indemnity insurance.
  - Finally, other benefits are treated as "excepted benefits" if they are **offered separately and supplemental** to Medicare, Armed Forces health care coverage, or group health plan coverage.
- Church Plans are not subject to Part 7 because they are not subject to Title I of ERISA. (However, they are generally subject to parallel provisions in the Code. Questions concerning these plans should be referred to the Internal Revenue Service (IRS).)
- Governmental Plans are not subject to Part 7 because they are not subject to Title I of ERISA. (However, nonfederal governmental plans may be subject to parallel provisions in the PHS Act. Questions concerning these plans should be referred to the Department of Health and Human Services (HHS).)

Preemption: Part 7 of ERISA contains new preemption and applicability rules for group health plans and health insurance issuers.

(1) Group Health Plans. In general, section 514 of ERISA continues to apply with respect to group health plans.

(2) Group Health Insurance Issuers.

- With respect to the requirements of section 701 of ERISA, State laws regarding issuers cannot "differ" from the requirements of ERISA section 701, except as listed below:
  - State law may shorten the 6-month "look-back" period prior to the enrollment date to determine what is a preexisting condition;
  - State law may shorten the 12-month (18-month for late enrollees) maximum preexisting condition exclusion period;
  - State law may lengthen the 63-day significant-break-in-coverage period;
  - State law may lengthen the 30-day special enrollment period for newborns, adopted children, and children placed for adoption to enroll in the plan without a preexisting condition exclusion period;
  - State law may expand the prohibitions on conditions and individuals to whom a preexisting condition exclusion period may not be applied beyond the exceptions for newborns, adopted children, and children placed for adoption enrolled within 30 days of birth, adoption and placement for adoption, and pregnancy;
  - State law may require additional special enrollment periods; and
  - State law may reduce the maximum HMO affiliation period to less than 2 months (3 months for late enrollees).
- With respect to all other HIPAA provisions and the MHPA provisions, State laws relating to health insurance issuers continue to apply, except to the extent that the State law "prevents the application of a requirement of" these HIPAA and MHPA provisions.
- With respect to the WHCRA provisions, State law protections may apply to certain health insurance coverage if the State law was in effect on October 21, 1998 (the date of enactment of WHCRA) and the State law requires at least the coverage of reconstructive breast surgery that is required by WHCRA.

(3) Special Applicability Rule. The Newborns' Act contains a special applicability rule. This applicability rule is explained on page 19 of this checklist.

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. 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. ◆ If the plan imposes a hidden preexisting condition exclusion, the plan may violate many or all of the provisions discussed in this section. For example, if the plan excludes coverage for cosmetic surgery unless it is required by reason of an accidental injury occurring after the effective date of coverage, there could be multiple violations 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 period requirement?** ..... ◆ 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)(1)(i).* **Note: 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.	☐	☐	

	YES	NO	N/A
Question 2 — 12/18-month look-forward period **Does the plan comply with HIPAA's 12-month (or 18-month) look-forward period requirement?** ..... ◆ 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)(1)(ii).* **Note: 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.	☐	☐	
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 an individual's creditable coverage. However, days of coverage prior to a "significant break in coverage" are not required to be taken into account. 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)(1)(iii) [using ERISA section 701(c) rules for crediting previous coverage].*	☐	☐	
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); 29 CFR 2590.701-3(a)(1)(i) [using ERISA section 701(b)(1) definition of a preexisting condition exclusion].*	☐	☐	
Question 5 — Preexisting condition exclusion on newborns **Does the plan comply with HIPAA by not imposing an impermissible preexisting condition exclusion on newborns?** ..... ◆ The 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).*	☐	☐	

	YES	NO	N/A
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?** ..... ◆ The 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?** ..... ◆ The plan may not impose a preexisting condition exclusion relating to pregnancy. *See ERISA section 701(d)(3); 29 CFR 2590.701-3(b)(4).*	☐	☐	
Question 8 — Adequate general notices of preexisting condition exclusions **Does the plan provide adequate general notices of preexisting condition exclusions?** ..... ◆ 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 (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. *See 29 CFR 2590.701-3(c).* Guidelines for the general notice of preexisting condition exclusion are available in EBSA's publication, ***Compliance Assistance Guide: Recent Changes in Health Care Law,*** which is located in the Compliance Assistance section of the agency's Web site at www.dol.gov/ebsa.	☐	☐	
Question 9 — Adequate individual notices of preexisting condition exclusions **Does the plan provide adequate individual notices of preexisting condition exclusions?** ..... ◆ A group health plan (or issuer) seeking to impose a preexisting condition exclusion with respect to an individual must, within a reasonable time following receipt of creditable coverage information, make a determination about the individual's period of creditable coverage.	☐	☐	

	YES	NO	N/A
◆ If the individual does not have enough creditable coverage to completely offset the preexisting condition exclusion period, the plan must then provide, in writing, to the individual— ❖ Its determination of the length of any preexisting condition exclusion that applies to the individual, including the source and substance of any information on which the plan or issuer relied; and ❖ A written explanation of any appeal procedures established by the plan or issuer. The plan must also allow the individual a reasonable opportunity to submit additional evidence of creditable coverage. *See 29 CFR 2590.701-5(d)(2).* ◆ Guidelines for the individual notice of preexisting condition exclusion are available in EBSA's publication, ***Compliance Assistance Guide: Recent Changes in Health Care Law,*** which is located in the Compliance Assistance section of the agency's Web site at www.dol.gov/ebsa.			
SECTION B — Compliance with the Certificate of Creditable Coverage Provisions A group health plan (or a group health insurance issuer, on the plan's behalf) must issue complete certificates of creditable coverage (free of charge) automatically to individuals whose coverage under the plan ends, and (free of charge) to individuals upon request. A model certificate that may be used to satisfy this notice requirement is available in EBSA's publication, ***Compliance Assistance Guide: Recent Changes in Health Care Law,*** which is located in the Compliance Assistance section of the agency's Web site at www.dol.gov/ebsa. Check to see that the plan issues complete certificates of creditable coverage within the required time frames. ** 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 plan cannot be held accountable for a violation of Part 7. (**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 under Part 7, 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.			

	YES	NO	N/A
<u>Question 10 — Automatic certificates of creditable coverage upon loss of coverage</u> **Does the plan provide complete certificates of creditable coverage to individuals automatically upon loss of coverage?** ..... ◆ Plans are required to provide each participant and dependent covered under the plan a 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 11.** ◆ 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 (**<u>Note</u>: 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 <u>reasonable efforts to get dependent information</u>. *<u>See</u> 29 CFR 2590.701-5(a)(5)(i));* 4. Plan administrator (or issuer) name, address, and telephone number; 5. Telephone number for further information (if different); and 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.	☐	☐	☐
<u>Question 11 — Automatic certificate upon loss of coverage — *Issuer Responsibility*</u> **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 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 12.**	☐	☐	☐

	YES	NO	N/A
Question 12 — 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 13.** ◆ Certificates of creditable coverage must also be provided free of charge upon request to individuals 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 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).* ◆ The plan should also have a procedure for individuals to request and receive certificates of creditable coverage. *See 29 CFR 2590.701-5(a)(4)(ii).*	☐	☐	☐
Question 13 — 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 14.**	☐	☐	☐
Question 14 — Certificates within required time frames **If the plan issues certificates of creditable coverage, are they issued within the required time frames?** ..... ◆ 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.** ◆ 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 the plan learns that COBRA has ceased.	☐	☐	☐

	YES	NO	N/A
◆ Plans and issuers must also generally provide a certificate of creditable coverage upon request, 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 within required time frames — *Issuer Responsibility* **If the plan is insured and there is an agreement with the issuer stating that the issuer is responsible for providing certificates of creditable coverage, are those certificates being provided timely?** ..... ◆ 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 **SECTION C.**	☐	☐	☐
SECTION C — Compliance with the Special Enrollment Provisions Group health plans must allow individuals (who are otherwise eligible) to enroll upon certain specified events, if enrollment is requested within 30 days of the event. The plan must provide for special enrollment, as follows:			
Question 16 — Special enrollment upon loss of other coverage **Does the plan provide special enrollment upon loss of other coverage? (The plan must comply with *all* of the following.)** ..... ◆ Plans 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 coverage. *See ERISA section 701(f)(1); 29 CFR 2590.701-6(a).* ◆ Plans must permit eligible employees and dependents to special enroll because of a loss of eligibility (other than loss due to failure to pay premiums or termination of coverage for cause -- such as for fraud). ❖ Examples of reasons for loss of eligibility include: legal separation, divorce, death, termination of employment - voluntary or involuntary (with or without electing COBRA), exhaustion of COBRA, reduction in hours, "aging out" under other parent's coverage, or moving out of an HMO's service area. ◆ Plans must permit eligible employees and dependents to special enroll due to termination of employer contributions towards the other coverage whether or not they also lost the other coverage as a result. ◆ 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)(7).*	☐	☐	

	YES	NO	N/A
Question 17 — Dependent special enrollment **Does the plan provide special enrollment rights to individuals upon marriage, birth, adoption, and placement for adoption? (The plan must comply with *all* of the following.)** ..... ◆ Plans must permit employees, spouses, **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).* ◆ In the case of marriage, coverage must become effective not later than the first day of the month following a completed request for enrollment. *See 29 CFR 2590.701-6(b)(8)(i).* ◆ 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)(8)(ii) and (iii).*	☐	☐	
Question 18 — Notice of special enrollment rights **Does the plan provide 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 the plan's special enrollment rules. ◆ A model description of special enrollment rights is available at 29 CFR 2590.701-6(c) and in EBSA's publication, ***Compliance Assistance Guide: Recent Changes in Health Care Law,*** which is located in the Compliance Assistance section of the agency's Web site at www.dol.gov/ebsa.	☐	☐	
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			

	YES	NO	N/A
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. 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 19 — Nondiscrimination in rules for 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. (This is a violation, even if the plan provision is imposed only at late enrollment.) ◆ 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.	☐	☐	
Question 20 — Benefit restrictions **Does the plan uniformly provide benefits to participants and beneficiaries?** ..... ◆ 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).	☐	☐	

	YES	NO	N/A
◆ 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 21 — 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 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 benefits for medical/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 (such as depression). ◆ If the plan does not impose a source-of-injury restriction, check "N/A" and skip to **Question 22.**	☐	☐	☐
Question 22 — Nondiscrimination in premiums or contributions **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	☐	☐	

	YES	NO	N/A
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 bona fide wellness program. *See ERISA section 702(b)(2)(B); 29 CFR 2590.702(c)(3).* Proposed rules describing bona fide wellness programs were published on January 8, 2001 at 66 FR 1421. Essentially, these proposed rules permit rewards that are not contingent on an individual meeting a standard related to a health factor. In addition, these proposed rules permit rewards that are contingent on an individual meeting a standard related to a health factor if: ❖ The reward does not exceed a specified percentage of the total employee-only premium. (Comments were invited as to whether a 10%, 15%, or 20% limitation might be appropriate.) ❖ The program is reasonably designed to promote good health or prevent disease. (For this purpose, a program must allow individuals an opportunity to qualify for the reward at least once each year.) ❖ The reward is available to all similarly situated individuals. In particular, the program must allow a reasonable alternative standard for individuals for whom it is unreasonably difficult due to a medical condition to satisfy the original program standard or for whom it is medically inadvisable to attempt to satisfy the original program standard during that time period. ❖ The plan must also disclose the availability of a reasonable alternative standard in all plan materials describing the terms of the program.			
Question 23 — 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 24 — 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	☐	☐	

	YES	NO	N/A
violate ERISA sections 702(a) (if the clause delays or denies eligibility) and 702(b) (if the clause raises individual premiums).			
Question 25 — 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.	☐	☐	
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 26.** 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 26 — 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.*	☐	☐	

	YES	NO	N/A
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 27. If the plan is not a MEWA or multiemployer plan, check "N/A" and go to **Part II** of this checklist.			☐
Question 27 — 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; ❖ 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 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/surgical benefits, the plan may be subject to MHPA. If this is the case, answer **Questions 28-32.** 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 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 28 — 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/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/surgical benefits if limits on in-network mental health benefits are unlimited, or in parity with medical/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/surgical benefits. *See 29 CFR 2590.712(b)(4), Example 2.*	☐	☐	
Question 29 — 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/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/surgical benefits (or if there is no limit for medical/surgical benefits), the plan is not in compliance with MHPA.	☐	☐	

	YES	NO	N/A
◆ Again, remember only limits on what the plan is willing to pay are taken into account.			
Question 30 — 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/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/surgical benefits if limits on in-network mental health benefits are unlimited, or in parity with medical/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/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 limit on participants and beneficiaries without implicating MHPA.	☐	☐	
Question 31 — 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/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. ◆ Again, remember only limits on what the plan is willing to pay are taken into account.	☐	☐	
Question 32 — 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.	☐	☐	☐

	YES	NO	N/A
◆ 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. Instead, benefits for substance abuse and chemical dependency can be counted against a medical/ 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 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 July 1, 2002, if the coverage is in Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, or Wyoming, 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** .... If the plan provides benefits for hospital stays in connection with childbirth, the plan is insured, and the coverage is in Wisconsin, Puerto Rico, the Virgin Islands, American Samoa, Wake Island, or the Northern Mariana Islands, it appears that the Federal Newborns' Act applies to the plan. If this is the case, answer **Questions 33-36.** *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 **Questions 33-36.**			☐ ☐
Question 33 — 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)*).	☐	☐	

	YES	NO	N/A
◆ Therefore, the plan cannot deny a mother or her newborn benefits for 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.			
Question 34 — Provider must not be required to obtain authorization from plan **Does the plan defer to the provider for a decision on hospital length of stay within the first 48/96-hour period?** ..... ◆ 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).*	☐	☐	
Question 35 — 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 co-payment 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 36 — 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. *See the Summary Plan Description (SPD) content regulations at 29 CFR 2520.102-3(u).* ◆ Model language for the Newborns' Act disclosure requirement is available in EBSA's publication, ***Compliance Assistance Guide: Recent Changes in Health Care Law,*** which is located in the Compliance Assistance section of the agency's Web site at www.dol.gov/ebsa.	☐	☐	

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 37-40.**			☐
<u>Question 37 — 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 lymphedemas, in a manner determined in consultation with the attending provider and the patient. *<u>See</u> ERISA section 713(a).* ◆ These required coverages can be subject to annual deductibles and coinsurance provisions if consistent with those established for other benefits under the plan or coverage.	☐	☐	
<u>Question 38 — Annual notice</u> **Does the plan provide annual notices as required by WHCRA?** ..... ◆ Plans must provide notices describing the benefits required under WHCRA upon enrollment in the plan and annually thereafter. *<u>See</u> ERISA section 713(a).* ◆ The annual notice must include— ❖ Information on the availability of benefits under the plan for the treatment of mastectomy-related services, including benefits for reconstructive surgery, surgery to achieve symmetry between the breasts, prostheses, and physical complications resulting from mastectomy (including lymphedemas); and ❖ Information (telephone number, Web address, etc.) on how to obtain a detailed description of the mastectomy-related benefits available under the plan.	☐	☐	

	YES	NO	N/A
◆ Model language for WHCRA's annual notice requirement is available in EBSA's publication, ***Compliance Assistance Guide: Recent Changes in Health Care Law,*** which is located in the Compliance Assistance section of the agency's Web site at www.dol.gov/ebsa.			
Question 39 — Enrollment notice **Does the plan provide enrollment notices as required by WHCRA?** ..... ◆ Plans must provide notices describing the benefits required under WHCRA upon enrollment in the plan and annually thereafter. *See ERISA section 713(a).* ◆ The enrollment notice must describe the benefits that WHCRA requires the group health plan to cover. Additionally, the enrollment notice must describe any deductibles and coinsurance limitations applicable to such coverage. (Under WHCRA, coverage of the required benefits may be subject only to deductibles and coinsurance limitations consistent with those established for other benefits under the plan or coverage.) ◆ Model language for WHCRA's enrollment notice requirement is available in EBSA's publication, ***Compliance Assistance Guide: Recent Changes in Health Care Law,*** which is located in the Compliance Assistance section of the agency's Web site at www.dol.gov/ebsa.	☐	☐	
Question 40 — Incentive provisions **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.	☐	☐	