Compliance Assistance for Group Health Plans

HIPAA and Other Recent Health Care Laws

The Pension and Welfare Benefits Administration administers the following health care laws that comprise Part 7 of the Employee Retirement Income Security Act (ERISA).

- ✓ The Health Insurance Portability and Accountability Act (HIPAA) places limitations on a group health plan's ability to impose pre-existing condition exclusions, provides special enrollment rights for certain individuals, and prohibits discrimination in group health plans based on health status.
- ✓ The Mental Health Parity Act (MHPA) provides for parity in the application of annual and lifetime dollar limits on mental health benefits with annual and lifetime dollar limits on medical/surgical benefits.
- ✓ The Newborns' and Mothers' Health Protection Act (Newborns' Act) requires group health plans that offer maternity hospital benefits for mothers and newborns to pay for at least a 48-hour hospital stay for the mother and newborn following childbirth (or, in the case of a cesarean section, a 96-hour hospital stay), unless the attending provider, in consultation with the mother, decides to discharge earlier.
- ✓ The Women's Health and Cancer Rights Act (WHCRA) provides protections for patients who elect breast reconstruction or certain other follow-up care in connection with a mastectomy.

Following are 15 key compliance considerations for group health plans. Under each is an example of a group health plan provision or practice that would not comply with the above laws and a tip on how to bring the plan into compliance. For more information on compliance with these laws, consult ***Compliance Assistance Guide: Recent Changes in Health Care Law.***

U.S. Department of Labor, Pension and Welfare Benefits Administration

1. Beware of "hidden" pre-existing condition exclusions in your plan.

Example: A group health plan covers treatment for injuries in connection with an accident only if the accident occurred while the individual was covered under the plan.

Tip: This plan provision operates as a pre-existing condition exclusion and should be removed or modified to comply with HIPAA's limitations on pre-existing condition exclusions.

- ❖ This plan provision operates as a pre-existing condition exclusion 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 other coverage) do not receive benefits for treatment. Accordingly, this plan provision limits benefits relating to a condition because the condition was present before an individual's enrollment date, and it is considered a pre-existing condition exclusion.

- ❖ To comply with HIPAA, the plan could:

  a. Delete its requirement that the accident must occur while the individual is covered under the plan; or

  b. Limit its pre-existing condition exclusion. Among other things, the only conditions that may be subject to a pre-existing condition exclusion are those for which medical advice, care, diagnosis, or treatment was recommended or received within the 6 months ending on an individual's "enrollment date" in the plan. (Under HIPAA, an individual's "enrollment date" is the first day of coverage or, if there is a waiting period, the first day of the waiting period.) In addition, the maximum pre-existing condition exclusion period is 12 months (or 18 months for late enrollees) after the individual's "enrollment date." The exclusion period must be offset by an individual's prior creditable coverage. Also, newborns and adopted children generally may not be subject to a pre-existing condition exclusion at all.

2. If the plan has a waiting period for coverage, ensure that any pre-existing condition exclusion period runs concurrently with the waiting period, rather than beginning after the waiting period ends.

Example: A group health plan imposes a 30-day waiting period from an individual's date of hire before coverage will become effective. Then, after an individual has satisfied this waiting period, the plan imposes a 12-month pre-existing condition exclusion from the individual's effective date of coverage (offset by creditable coverage).

Tip: The pre-existing condition exclusion period is required to begin on the first day of the waiting period.

- ❖ HIPAA requires that the maximum pre-existing condition exclusion period begin on an individual's "enrollment date." For plans that impose a waiting period, the enrollment date is generally the first day of the waiting period. (Under HIPAA, an individual's "enrollment date" is the first day of coverage or, if there is a waiting period, the first day of the waiting period.)

- ❖ In this example, the plan must begin counting the 12-month pre-existing condition exclusion period from the individual's enrollment date, which in this case is the first day of the waiting period.

3. **If the plan imposes a pre-existing condition exclusion, ensure that both the general notice of pre-existing condition exclusion and individual notice of pre-existing condition exclusion are provided.**

Example: A group health plan imposes a 12-month pre-existing condition exclusion. This exclusion is reflected in the plan document, which is provided to participants upon request.

Tip: The group health plan must provide general and individual notices of pre-existing condition exclusion.

- ❖ A group health plan that contains a pre-existing condition exclusion must provide a written general notice of pre-existing condition exclusion to participants under the plan and cannot impose such an exclusion with respect to a participant or a dependent of the participant until such a notice is provided. The general notice of pre-existing condition exclusion must include:

  a. A description of the existence and terms of any pre-existing condition exclusion;

  b. A description of the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods);

  c. A description of the right of the individual to request a certificate from a prior plan or issuer, if necessary; and

  d. A statement that the current plan (or issuer) will assist in obtaining a certificate from any prior plan or issuer, if necessary.

- ❖ In addition, after an individual has presented evidence of creditable coverage and the plan has made a determination of creditable coverage, if the individual will still be subject to any pre-existing

condition exclusion, the plan must provide the individual a written notice of the length of pre-existing condition exclusion that remains after offsetting for prior creditable coverage. In the individual notice of pre-existing condition exclusion, a plan must disclose:

a. Its determination of any pre-existing condition exclusion period that applies to the individual (including the last day on which the pre-existing condition exclusion applies);

b. The basis for such determination, including the source and substance of any information on which the plan or issuer relied;

c. An explanation of the individual's right to submit additional evidence of creditable coverage; and

d. A description of any applicable appeal procedures established by the plan or issuer.

4. Ensure that certificates of creditable coverage are complete.

Example: A plan issues one certificate of creditable coverage for a participant and the participant's family. However, the certificate does not include information about dependents or waiting periods.

Tip: If a plan imposes a waiting period, the date the waiting period began is required to be reflected on the certificate. In addition, if a 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).

❖ 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.

5. Ensure that the plan's special enrollment provisions permit individuals to enroll when a "loss of eligibility" for other group health plan or health insurance coverage occurs and when employer contributions toward other coverage cease.

Example: A group health plan allows individuals to enroll through special enrollment for loss of other coverage only if the loss was due to an involuntary termination of employment.

Tip: The plan is required to permit individuals who declined health coverage under the plan because they had other group health plan or health insurance coverage to

enroll in the plan through special enrollment upon any "loss of eligibility" for the other coverage or if employer contributions toward the other coverage cease.

- ❖ Under HIPAA, individuals who are otherwise eligible, but had declined health coverage because they had other group health plan or health insurance coverage, must be permitted to enroll in the plan (regardless of any late enrollment provisions) upon "loss of eligibility" for the other coverage or if employer contributions toward the other coverage cease.

- ❖ Loss of eligibility includes loss of coverage due to legal separation, divorce, voluntary or involuntary termination of employment, reduction in hours, children's aging out of coverage, or moving out of an HMO service area. It does not include loss of coverage due to a failure of the individual to pay premiums on a timely basis or termination of coverage for cause.

- ❖ Under HIPAA, special enrollment rights are also triggered when employer contributions toward an individual's other coverage cease, regardless of whether the individual is still eligible for coverage under the other plan.

6. A plan's special enrollment provisions must also permit employees and dependents (who are otherwise eligible) to enroll upon marriage, birth, adoption, or placement for adoption.

Example: A group health plan allows employees who are already enrolled for coverage to add dependents upon marriage, birth, adoption, and placement for adoption. However, if an employee is not already enrolled, the plan does not permit any enrollment when these events occur.

Tip: HIPAA allows eligible employees and dependents to enroll upon marriage, birth, adoption, or placement for adoption.

- ❖ Group health plans are required to offer special enrollment to otherwise eligible employees, spouses, and any new dependents upon marriage, birth, adoption, or placement for adoption. Accordingly, an employee who is otherwise eligible, but not enrolled for coverage, can enroll (and can also enroll a spouse and any new dependents, if they are otherwise eligible under the plan) when any of these events occur.

- ❖ The plan should amend its special enrollment provisions to allow employees and dependents who are otherwise eligible to enroll upon these events.

7. For individuals who enroll through special enrollment, ensure that the effective date of coverage complies with HIPAA.

Example: After an individual enrolls through special enrollment, a group health plan makes coverage effective on the first day of the first calendar month following the date a completed request for enrollment is received.

Tip: HIPAA sets forth specific dates when coverage is required to be made effective for special enrollees. In this case, the plan is not making coverage effective early enough for some individuals.

- ❖ For special enrollment upon birth, adoption, or placement for adoption, group health plans are required to make coverage effective as of the date of the birth, adoption, or placement for adoption. For these events, this plan, in this example, is not making coverage effective early enough. Therefore, the plan should change the effective date of coverage provision to comply with HIPAA.

- ❖ On the other hand, for special enrollment upon loss of eligibility for other coverage, upon loss of employer contributions toward other coverage, or upon marriage, coverage is required to be made effective no later than the first day of the first calendar month following the date a completed request for enrollment is received. Therefore, the plan's effective date of coverage provision is permissible with respect to these special enrollment events.

8. Ensure that the special enrollment notice is provided on or before enrollment in the plan.

Example: A plan's special enrollment notice is included in its summary plan description (SPD), which is sent 90 days after enrollment in the plan.

Tip: A plan must provide all employees with a notice of special enrollment at or before the time the employee is initially offered the opportunity to enroll in the plan.

- ❖ While the SPD is a permissible vehicle for delivering the special enrollment notice, the plan is also required to meet the timing rules for providing the special enrollment notice, even if this time frame is earlier than that for providing an SPD.

- ❖ The plan may continue to provide the notice in the SPD only if it is provided at or before the time of enrollment in the plan. Otherwise, the plan should provide a separate notice of special enrollment that meets the required time frame and continue to provide the SPD within 90 days of enrollment.

- ❖ The following model language may be used to satisfy the special enrollment notice requirement:

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

9. Eliminate plan provisions that deny individuals eligibility (including continued eligibility) under the plan based on a health factor, even if such provisions apply only to late enrollees.

Example: To be eligible for late enrollment, a group health plan requires employees and dependents to present evidence of insurability.

Tip: Plans cannot require individuals (even if they are late enrollees) to present evidence of insurability in order to enroll for coverage.

❖ A group health plan may not deny individuals enrollment in the plan (or delay the effective date of an individual's coverage) based on an individual's 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), or disability. Therefore, the plan must eliminate any evidence of insurability requirement. (Nonetheless, the plan is generally permitted to impose an 18-month pre-existing condition exclusion period on late enrollees, if it is offset by creditable coverage and complies with HIPAA's other limitations on pre-existing condition exclusion periods.)

10. Delete any nonconfinement clauses.

Example: A plan delays eligibility for benefits related to a condition for a dependent if the dependent is hospitalized on the day coverage otherwise becomes effective.

Tip: Under HIPAA's nondiscrimination provisions, a plan cannot make eligibility for benefits under the plan contingent upon any health factor. In this case, delaying eligibility for benefits to any individual due to confinement to a hospital would discriminate in eligibility based on one or more health factors. In addition, this plan provision is a pre-existing condition exclusion because it delays benefits for a condition because it was present before an individual's effective date of coverage. However, it does not comply with HIPAA's limits on pre-existing condition exclusions.

- ❖ The plan must delete the nonconfinement clause. However, the plan is permitted to include a coordination of benefits provision so that, for example, if a prior issuer is also responsible for benefits under a State extension-of-benefits law, benefits will be provided on a coordinated basis.

11. Eliminate annual or lifetime dollar limits (including constructive dollar limits) on mental health benefits if they are lower than the annual or lifetime dollar limits imposed on medical/surgical benefits.

Example: Outpatient benefits for mental health services under a group health plan consist of 50 doctor visits per year with a $50 maximum payment per visit. Outpatient benefits for medical/surgical services are unlimited.

Tip: While the plan does not impose an annual dollar limit on outpatient medical/surgical benefits, the 50 doctor visits per year limitation on mental health services, coupled with the absolute $50 maximum payment per visit, is a constructive annual dollar limit on outpatient mental health benefits of $2,500.

- ❖ Under MHPA, a plan may not impose annual or lifetime dollar limits on mental health benefits that are lower than those for medical/surgical benefits. Here, the plan is not in compliance with MHPA because, with respect to outpatient services, the plan imposes a $2,500 constructive annual dollar limit on mental health benefits and no annual limit on medical/surgical benefits.

- ❖ The plan should eliminate any constructive dollar limit on mental health benefits that is lower than that for medical/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.

12. Ensure that the plan does not require providers to obtain preauthorization from the plan in order for the plan to cover a 48-hour hospital stay in connection with childbirth (or a 96-hour hospital stay in the case of a cesarean section).

Example: For hospital stays, including those in connection with childbirth, a group health plan requires preauthorization from its utilization review telephone hotline, based on a determination of medical necessity.

Tip: The plan's preauthorization requirement is too broad in that it applies to hospital stays that are the subject of the Newborns' Act.

- ❖ Under the Newborns' Act, the plan may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours (96 hours in the case of a cesarean section), unless the attending provider (in consultation with the mother) decides to discharge earlier.

- ❖ Plans may not require providers to obtain authorization from the plan for prescribing the stay. In addition, plans may not deny a stay within the 48-hour (or 96-hour) period because the plan's utilization reviewer does not think such a stay is medically necessary.

- ❖ The plan must eliminate this preauthorization requirement with respect to hospital stays in connection with childbirth for the first 48 hours (or 96 hours in the case of a cesarean section). The plan may impose such an authorization requirement for hospital stays beyond this period. In addition, the plan may impose a requirement on the mother to give notice of a pregnancy in order to obtain a certain level of cost-sharing or to use certain medical facilities. However, the type of preauthorization required by this plan (within the 48/96 hour period and based on medical necessity) must be eliminated.

13. Whether the plan is insured or self-insured, the plan must provide a notice relating to hospital length of stays in connection with childbirth.

Example: A group health plan provides benefits for a hospital length of stay in connection with childbirth for a mother or newborn. However, the plan's SPD does not provide any special notice relating to these benefits.

Tip: Group health plans that provide maternity or newborn infant coverage are required to make a disclosure with respect to a hospital length of stay in connection with childbirth. This is the case whether the Federal Newborns' Act provisions or State law provisions apply to the coverage.

- ❖ 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. If Federal law applies in some areas in which the plan operates and State law applies in other areas, the statement should describe the different areas and the Federal or State law requirements applicable in each.

- ❖ In the case of a group health plan where Federal law applies to some or all areas in which the plan operates, the following model language may be used to describe the requirements of Federal law:

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

14. If the plan provides benefits for mastectomies, ensure that the plan also provides coverage for all stages of reconstructive surgery and for physical complications in connection with a mastectomy (including coverage for lymphedemas).

Example: A group health plan provides benefits for mastectomies. However, the plan excludes benefits for reconstructive surgery after a mastectomy.

Tip: Plans that cover benefits for mastectomies cannot exclude benefits for reconstructive surgery or certain post-mastectomy services.

❖ Under WHCRA, the plan is required to provide (to an individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy) coverage for:

   a. All stages of reconstruction of the breast on which the mastectomy has been performed;

   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

   c. Prostheses; and

   d. Treatment of physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

❖ In addition, the plan is required to notify participants of WHCRA's coverage requirements upon enrollment and annually afterwards.

❖ For a more detailed explanation of WHCRA's disclosure requirements and for sample language that may be used, see ***Compliance Assistance Guide: Recent Changes in Health Care Law*** and ***Your Rights After a Mastectomy (WHCRA).***

15. The plan should provide a notice of rights under WHCRA upon enrollment and annually thereafter.

Example: A group health plan provides benefits required by WHCRA, but is unsure what notices must be provided.

Tip: The plan should provide an enrollment notice and an annual notice. These notices can be provided in the SPD if the plan distributes SPDs upon enrollment and annually. Otherwise, separate WHCRA notices should be provided once upon enrollment and once each year.

- ❖ The following is sample language that a plan may use to satisfy its enrollment notice requirement:

> If you have had or are going to have a mastectomy, you may be entitled to certain benefits, under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:
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> 1) All stages of reconstruction of the breast on which the mastectomy was performed;
> 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
> 3) Prostheses; and
> 4) Treatment of physical complications of the mastectomy, including lymphedemas.
>
> These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductible and coinsurance apply: [insert deductible and coinsurance applicable to these benefits].
>
> If you would like more information on WHCRA benefits, call your Plan Administrator at [insert phone number].

- ❖ For the annual notice, a plan may use the enrollment notice or may use a different notice. The following is sample language that a plan may use to satisfy its annual notice requirement:

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

Other related publications from the Pension and Welfare Benefits Administration:

— *Compliance Assistance Guide: Recent Changes in Health Care Law*
—*Your Rights after a Mastectomy (WHCRA)* (Also in Spanish)
— *Health Benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA)*
— *Top Ten Ways to Make Your Health Benefits Work for You* (also in Spanish)
—*Questions and Answers: Recent Changes in Health Care Law* (for employees)

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Revised October 2002