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Health Coverage Portability

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

U.S. Department of Labor
Employee Benefits Security Administration

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Contents

Introduction

This booklet explains some of your rights and protections under Federal law when dealing with health coverage offered by your employer. It provides information that can be useful when you or your spouse ...

- Start a new job or change jobs;
- Lose or change health coverage;
- Marry;
- Give birth to or adopt a baby.

Health Coverage Portability addresses the portability requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its interpretive regulations. While the booklet does not cover all the specifics of this law, it does provide an informal explanation of legislation, statutes, and interpretations based on the most recent regulations. It is intended to provide general guidance through frequently asked questions; it should not be considered legal advice. If you would like further information, the list of resources at the end of the booklet should be useful.

If you have additional questions not addressed in this publication, contact the Employee Benefits Security Administation (EBSA) regional office nearest you. For a list of offices, visit the agency's Web site at www.dol.gov/ebsa or call 1-866-444-EBSA (3272).

If you are an employee in a health plan that provides benefits through an insurance policy issued by an insurance company or a health maintenance organization (HMO), you may also contact your state insurance department. Visit the National Association of Insurance Commissioner's Web site at www.naic.org for a list of state insurance department contacts. As discussed later in this publication, a state law applicable to insurance companies and HMOs can bolster some of the Federal rules under HIPAA if the state law is more protective of individuals.

The Health Insurance Portability and Accountability Act of 1996

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

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

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

Preexisting Conditions to Which Exclusion Periods May Be Applied

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

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

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

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

This six-month "look-back" period may be shortened under state law if your coverage is insured through an insurance company or offered through an HMO. Check with your State Insurance Commissioner's Office to see whether a shorter look-back period applies to you.

▶ I recently changed jobs. Seven months ago I received my last treatment for carpal tunnel syndrome. I have not received any medical advice, diagnosis, care or treatment for this condition since that time. Can my employer impose a preexisting condition exclusion period for this illness?

No. Your employer may only impose a preexisting condition exclusion period with respect to any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 months prior to your enrollment date.

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

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

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

▶ I changed employment recently. How do I know if I am subject to any preexisting condition exclusion period?

Many plans do not exclude coverage for preexisting conditions. A plan must tell you if it has a preexisting condition exclusion period (and can only exclude coverage for a preexisting condition after you have been notified). The plan must also notify you of your right to show that you have prior creditable coverage to reduce the preexisting condition exclusion period.

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

You are required to be notified of this determination if, after considering all evidence of creditable coverage, the plan will still impose a preexisting condition exclusion period with respect to any preexisting condition you may have. The notice must also tell you the basis of the determination, including the source and substance of any information on which the plan relied and any appeal procedure that is available to you.

The plan may modify its initial determination if it later determines that you do not have the creditable coverage you claimed. In this circumstance, the plan must notify you of its

reconsideration and, until a final determination is made, the plan must act in accordance with its initial determination for purposes of covering medical services.

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

HIPAA does not prohibit a plan or issuer from establishing a waiting period. For group health plans, a waiting period is the period that must pass before an employee or a dependent is eligible to enroll under the terms of the plan. Some plans have waiting periods and preexisting condition exclusion periods. However, if a plan has a waiting period and a preexisting condition exclusion period, the preexisting condition exclusion period begins when the waiting period begins.

Maximum Preexisting Condition Exclusion Period

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

➤ I changed employment and my new group health plan imposes a preexisting condition exclusion period. How does my new plan determine the length of my preexisting condition exclusion period?

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

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

A plan generally receives information about an individual's creditable coverage from a certificate furnished by a prior plan or issuer (*e.g.*, an insurance company or HMO). A certificate of creditable coverage must be provided automatically to you by the plan or issuer when you lose coverage under the plan or become entitled to elect COBRA continuation coverage and when your COBRA continuation coverage ceases. You also have a right to receive a certificate when you request one from your previous plan or insurance company within 24 months of when your coverage ceases. If you do not have a certificate, you may present other evidence of creditable coverage.

Crediting Prior Health Coverage To Reduce A Preexisting Condition Exclusion Period

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

➤ What is "creditable coverage"?

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

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

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

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

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

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

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

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

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

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

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

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

If your new employer's plan requests information from your former plan regarding any of the five categories of benefits under the alternative method, your former plan must provide the information regarding coverage under the categories of benefits.

➤ Can I receive credit for previous COBRA continuation coverage?

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

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

- I began employment with my current employer 45 days after my previous group health plan coverage terminated. I had coverage under my previous employer's plan for 24 continuous months prior to the termination. I had no other coverage before my enrollment date in my new plan. Will I be subject to the 12-month preexisting condition exclusion period imposed by my new employer?

Not if you enroll when you are first eligible. The 45-day break in coverage does not count as a significant break in coverage under HIPAA. Under federal law, a significant break in coverage is a break in coverage of at least 63 consecutive days. Since you had over 12 months of creditable coverage from your previous group plan without a significant break, you would not be subject to the preexisting condition exclusion period imposed by your new employer's plan if you enroll when you are first eligible.

- I began employment with my current employer 100 days after my previous group health plan coverage terminated. I had been covered by my previous employer's plan for 36 continuous months prior to termination. I had no other coverage before my enrollment date in my current employer's plan. Will I be subject to the 12-month preexisting condition exclusion period imposed by my current employer's plan?

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

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

- How can I avoid a 63-day break in coverage?

There are several things you can do. If your last coverage was under a group health plan, you may be able to elect COBRA continuation coverage. "COBRA" is the name for a federal law that provides workers and their families the opportunity to purchase

group health coverage through their employer's health plan for a limited period of time (generally 18, 29 or 36 months) if they lose coverage due to specified events, including termination of employment, divorce or death. Workers in companies with 20 or more employees generally qualify for COBRA. Some states have laws similar to COBRA that apply to smaller companies.

You also may try to purchase an individual health insurance policy. (See page 28 under the heading *Switching from Group Coverage to an Individual Insurance Policy* for more information on individual health insurance policies.)

▶ What can I do if I don't have enough creditable coverage to offset a preexisting condition exclusion period?

During any preexisting condition exclusion period under a new plan you may be entitled to COBRA continuation coverage under your former plan. You also may try to purchase an individual health insurance policy. (See page 28 under the heading *Switching from Group Coverage to an Individual Insurance Policy* for more information on individual health insurance policies.)

Certificates of Creditable Coverage

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

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

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

- *may be provided through the use of the model certificate.*

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

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

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

You may also request a certificate, free of charge, until 24 months after the time your coverage ended. For example, you may request a certificate even before your coverage ends.

▶ I received a certificate from my former plan. What do I do now?

You should:

- ensure that the information is accurate. Contact the plan administrator of your former plan if any information is wrong.

- keep the certificate in case you need it. You will need the certificate if you leave your health plan and enroll in a subsequent plan that applies a preexisting condition exclusion period or if you purchase an individual insurance policy from an insurance company. But, if you lose your certificate and cannot obtain another, you can still show prior coverage using other evidence of prior health coverage (e.g. pay stubs, copies of premium payments or other evidence of health care coverage).

▶ What steps should I take if I am not provided a certificate by my plan or issuer?

If you do not receive a certificate by the time you should have received it or by the time you need it, your first step should be to contact the plan administrator of the plan responsible for providing the certificate and request one. If any part of your creditable coverage was through an insurance company, you can also contact the insurance company for a certificate that reflects that part of your creditable coverage as long as you make the request within 24 months of your coverage ceasing under the insurance policy. Group health plans and insurers that fail or refuse to provide such certificates are subject to penalties under HIPAA.

In any event, if you do not receive a certificate, you may demonstrate to your new plan that you have creditable coverage (as well as the time you were in any waiting periods) by producing documentation or other evidence of creditable coverage (such as pay stubs that reflect a deduction for health insurance, explanation of benefits forms (EOBs) or verification by a doctor or your former health care benefits provider that you had prior health insurance coverage). Accordingly, you should keep these records and documentation in case you need them.

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

Yes.

▶ Can plans contract with an issuer to provide the certificates for their employees?

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

▶ When must group health plans and issuers provide the certificates?

Plans and issuers must furnish the certificate automatically to:

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

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

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

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

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

Yes.

▶ Can my old plan simply call my new plan to relay information about my creditable coverage?

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

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

Yes. A plan or issuer must make reasonable efforts to collect the necessary information for dependents and issue the dependent a certificate of creditable coverage. If the

coverage information for a dependent is the same as for the employee, one certificate with both the employee and dependent information can be provided.

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

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

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

- For a certificate that is issued automatically, the certificate should reflect the most recent period of continuous coverage.

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

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

Special Enrollment

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

▶ What events trigger a special enrollment opportunity?

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

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

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

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

When an employee or a dependent of an employee loses other health coverage, a special enrollment opportunity may be triggered (only if the individual had other health insurance coverage when first eligible to enroll). The employee or dependent must request special enrollment within 30 days of the loss of coverage. In addition, the

resulting coverage must be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

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

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

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

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

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

Nondiscrimination Requirements

Individuals may not be denied eligibility or continued eligibility to enroll for benefits under the terms of the plan based on specified health factors. In addition, an individual may not be charged more for coverage than similarly situated individuals based on these specified health factors.

▶ Can I lose, or be charged more for, coverage if my health status changes?

Group health plans and issuers may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on "health status-related factors." These factors are your health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. For example, you cannot be excluded or dropped from coverage under your health plan just because you have a particular illness.

Also, plans and issuers may not require an individual to pay a premium or contribution that is greater than that for a similarly situated individual based on a health status-related factor.

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

No. A group health plan or group health insurance issuer may not require you to pass a physical examination for enrollment. Even if you are a late enrollee, you may not be required to pass a physical examination in order to be eligible for coverage.

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

No. The HIPAA nondiscrimination provisions do not automatically prohibit health care questionnaires. It depends on how the information that is obtained is used. In this case, the plan requires individuals to score a certain number of Health Points that are related

to prior or current medical conditions in order to enroll in the plan, which is impermissible discrimination in rules for eligibility based on a health factor.

▶ I am an avid skier. Can I be excluded from enrolling in my employer's health plan because I ski?

No. Participation in activities such as skiing is evidence of insurability, a health factor. Therefore, you may not be denied eligibility to enroll in your employer's plan because you ski.

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

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

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

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

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

Group health plans may exclude coverage for a specific disease, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or medically necessary, if the benefit restriction is applied uniformly to all similarly situated individuals and is not directed at any individual participants or beneficiaries based on a health factor. (Plan amendments applicable to all individuals in a group of similarly situated individuals and made effective no earlier than the first day of the next plan year after the amendment is adopted are not considered to be directed at individual participants and beneficiaries.)

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

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

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

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

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

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

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

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

➤ I have a history of high claims. Can I be charged more than similarly situated individuals based on my claims experience?

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

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

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

➤ Do the rules provide guidance on defining groups of similarly situated individuals?

Yes. The rules provide that distinctions among groups of similarly situated individuals may not be based on a health factor. Instead, if distinguishing among participants, plans and issuers must base distinctions on bona-fide employment based classifications consistent with the employer's usual business practice.

For example, part-time and full-time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service could be treated as distinct groups of similarly situated individuals, provided the distinction is consistent with the employer's usual business practice. In addition, a plan or issuer generally may treat participants and beneficiaries as two separate groups of similarly situated individuals. The plan may also distinguish between beneficiaries based,

for example, on their relationship to the participant (such as spouse or dependent child), or based on the age or student status of dependent children.

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

▶ My group health plan has a non-confinement provision which states that if an individual is confined to a hospital at the time enrollment eligibility begins, such eligibility is postponed until that individual is no longer confined. Is this permissible?

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

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

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

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

➤ My group health plan provides that dependents are generally eligible for coverage only until age 25. This age restriction does not, however, apply to disabled dependents who may continue health coverage past age 25. Is this plan provisions favoring disabled dependents permissible?

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

Disclosure Requirements

What kinds of information do group health plans have to give to participants and beneficiaries?

HIPAA and other recent laws made important changes in ERISA's disclosure requirements for group health plans. Under current Department of Labor interim disclosure rules, group health plans must improve their summary plan descriptions (SPDs) and summaries of material modifications (SMMs) (documents employers are required to provide to employees at certain key intervals) in four major ways to make sure they:

- notify participants and beneficiaries of "material reductions in covered services or benefits" (for example, reductions in benefits or increases in deductibles and co-payments) generally within 60 days of adoption of the change.

- disclose to participants and beneficiaries information about the role of issuers (*e.g.*, insurance companies and HMOs) with respect to their group health plan. In particular, the name and address of the issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer and the nature of any administrative services (*e.g.*, payment of claims) provided by the issuer.

- tell participants and beneficiaries which Department of Labor office they can contact for assistance or information on their rights under ERISA and HIPAA.

- tell participants and beneficiaries that federal law generally prohibits the plan and health insurance issuers from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections.

What is the definition of a "material reduction in covered services or benefits" that is subject to the new 60-day notice requirement?

Under the interim disclosure rules, a "material reduction in covered services or benefits" means any modification to a group health plan or change in the information required to be included in the summary plan description that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average

plan participant to be an important reduction in covered services or benefits under the group health plan.

The interim rules cite examples of "reductions in covered services or benefits" as generally including any plan modification or change that:

- eliminates benefits payable under the plan;
- reduces benefits payable under the plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations;
- increases deductibles, co-payments or other amounts to be paid by a participant or beneficiary;
- reduces the service area covered by a health maintenance organization; or
- establishes new conditions or requirements (*e.g.*, preauthorization requirements) to obtain services or benefits under the plan.

▶ Can employers use e-mail systems to communicate these new disclosures to employees, and if so, do employees have a right to get a paper copy of the information from their plan?

Yes. The interim disclosure rules provide a "safe harbor" for using electronic media (*e.g.*, e-mail) to furnish group health plan SPDs, summaries of "material reductions in covered services or benefits" and other SMMs (summaries of plan modifications and SPD changes). To use the "safe harbor," among other requirements, employees must be able to effectively access at their worksite documents furnished in electronic form. Participants also continue to have a right to receive the disclosures in paper form on request and free of charge.

Although the interim rule is not the exclusive means by which electronic media can be used to lawfully communicate plan information, the HIPAA "safe harbor" is limited to group health plans. The Department of Labor is considering extending the rule to other plans, including pension plans, and to other plan disclosures, but is exploring whether special precautions are necessary to ensure the confidentiality of electronically transmitted individual account or benefit-related information.

Enforcement and State Flexibility

▶ Who enforces HIPAA?

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

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

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

▶ Can states modify HIPAA's portability requirements?

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

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

described in federal law (the "exceptions" under federal law are for certain newborns, adopted children, children placed for adoption, pregnancy, and genetic information in the absence of a diagnosis);

- require additional special enrollment periods; and

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

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

Switching From Group Coverage to an Individual Insurance Policy

What if I am unable to obtain group coverage?

You may be able to obtain coverage under an individual insurance policy issued by an insurance company or, in some states through a high-risk pool. HIPAA guarantees access to individual insurance to "eligible individuals." Eligible individuals:

- have had coverage for at least 18 months without a "significant break in coverage" (see section on crediting prior health coverage for the definition of a significant break in coverage) where the most recent period of coverage was under a group health plan;

- did not have their group coverage terminated because of fraud or nonpayment of premiums; and

- are ineligible for COBRA continuation coverage or if offered COBRA continuation coverage (or continuation coverage under a similar state program) have both elected and exhausted their continuation coverage.

The opportunity to buy an individual insurance policy is the same whether the individual is laid off, is fired or quits his or her job. For information on individual insurance policies or on state high-risk pools you should contact your State Insurance Commissioner's Office.

What if I cannot afford the premiums for an individual insurance policy?

HIPAA does not limit premium rates. However, many states limit insurance premiums and HIPAA does not preempt state laws regulating the cost of insurance. For information on how your state law may limit premium rates for individual insurance policies or for information on state high-risk pools you should contact your State Insurance Commissioner's Office.

➤ Is my individual insurance policy renewable? Can it be terminated?

At your option, individual health coverage must be renewed or continued in force. However, your individual health coverage may not be renewed or may be discontinued because you failed to pay premiums, committed fraud, terminated the policy, moved outside the service area, or ended membership in a bona fide association (if you terminated your membership in an association that is not a bona fide, your health insurance coverage cannot be terminated because your membership terminated). For information on whether an association is bona fide you should contact your State Insurance Commissioner's Office.

Additional Frequently Asked Questions on HIPAA

▶ If I change jobs am I guaranteed the same benefits that I have under my current plan?

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

▶ Will I be covered immediately under my new employer's plan?

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

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

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

▶ What if my new employer does not provide health coverage?

There is no requirement for any employer to offer health insurance coverage. If your new employer does not offer health insurance, you may be able to continue coverage under your previous employer's plan under COBRA continuation coverage.

▶ What if I cannot afford the premiums for group health coverage?

HIPAA does not limit premium rates, but it does prohibit plans and issuers from charging an individual more than similarly situated individuals in the same plan because of health status. Plans may offer premium discounts or rebates for participation in wellness programs. In addition, many states limit insurance premiums and HIPAA does not preempt state laws regulating the cost of insurance.

➤ Does HIPAA extend COBRA continuation coverage?

Generally no. However, HIPAA makes two changes to the length of the COBRA continuation coverage period.

Effective January 1, 1997, qualified beneficiaries who are determined to be disabled under the Social Security Act within the first 60 days of COBRA continuation coverage will be able to purchase an additional 11 months of coverage beyond the usual 18-month coverage period. This is a change from the previous law which required that a qualified beneficiary be determined to be disabled at the time of the qualifying event to receive 29 months of COBRA continuation coverage. This extension of coverage is also available to nondisabled family members who are entitled to COBRA continuation coverage.

COBRA rules are also modified and clarified to ensure that children who are born or adopted during the continuation coverage period are treated as "qualified beneficiaries."

➤ Does HIPAA apply to self-insured group health plans?

Yes.

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

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

If you have a question concerning whether coverage under your health FSA is creditable coverage and if you are entitled to a certificate of creditable coverage, contact your plan administrator or the Department of Labor office nearest you.