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Subject: Benefit Exclusions that Cannot be Applied to Eligible Individuals Under HIPAA Individual Market Provisions

Markets: Individual Market Issuers, Risk Pools, and Other Entities that are Required to Offer Coverage to Eligible Individuals

I. Purpose

This bulletin applies to entities that are required to offer coverage to eligible individuals pursuant to sections 2741 and 2744 of the Public Health Service Act (PHS Act), as added by title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These entities include individual market health insurance issuers, state high risk pools, and other entities that are required under state law to offer coverage to HIPAA-eligible individuals, without preexisting condition exclusions. The bulletin clarifies that certain types of benefit exclusions meet the definition of a preexisting condition exclusion under title XXVII of the PHS Act, and are therefore impermissible, regardless of how the entities characterize the exclusions.

II. Background

The interim final regulation implementing the individual market provisions of title XXVII of the PHS Act provides that “eligible individuals,” as defined in 45 CFR 148.103, are entitled to purchase a choice of health care coverage, without any preexisting condition exclusion.ⁱ For purposes of that regulation, a preexisting condition exclusion is defined in 45 CFR 144.103 as:

...a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual’s health status before the individual’s first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

On December 30, 2004, the Centers for Medicare & Medicaid Services published a final regulation implementing the group market portability provisions of title XXVII.ⁱⁱ That regulation imposes limitations

on when group health plans and group health insurance issuers can apply preexisting condition exclusions, and on the length of such exclusions. The final group market regulation provides guidance to help determine when a given provision constitutes a preexisting condition exclusion. With regard to the federal fallback standards or state alternative mechanisms for covering eligible individuals, the individual market regulation's definition of preexisting condition exclusion is functionally identical to the definition used in the group market regulation. Therefore, we will apply the same guidance when determining whether an impermissible preexisting condition exclusion is being applied to eligible individuals seeking or having individual coverage under title XXVII.ⁱⁱⁱ A discussion of that guidance follows.

III. Exclusions that Constitute Preexisting Condition Exclusions Regardless of How They are Identified.

The preamble to the December 30, 2004 final group market regulation points out that, subsequent to the publication of the April 1997 interim final individual and group market regulations, several situations have repeatedly arisen in which a plan exclusion is not designated as a preexisting condition exclusion but nevertheless satisfies the definition of such an exclusion. These situations include plan provisions that:

- Provide coverage for accidental injury only if the injury occurred while covered under the plan.
- Count benefits received for a specific condition under prior health coverage, against a lifetime limit for that condition under the new coverage.
- Deny benefits for pregnancy until 12 months after an individual otherwise becomes eligible for benefits under the plan.
- Exclude benefits for a condition or conditions if it arises congenitally, while not excluding benefits for the condition if it arises otherwise.

(69 FR 78721, December 30, 2004)

More detailed examples of this type of provision can be found in the final group market portability regulations at 45 CFR 146.111 (69 FR 78783, December 30, 2004). To the extent an entity that is required to offer coverage to eligible individuals (as defined under 45 CFR 148.103) applies any of these provisions to such individuals, it is violating title XXVII.^{iv}

Where to get more information:

The interim final regulations cited in this bulletin are found in Parts 144, 146 and 148 of the Code of Federal Regulations (45 CFR 144, 146, 148). The final regulation cited in this bulletin is found in the Federal Register (69 FR 78720, December 30, 2004). Information about the PHS Act is also available on CMS' HIPAA health insurance reform Web site at <http://www.cms.hhs.gov/hipaa1>

If you have any questions regarding this bulletin, call the HIPAA Health Insurance Reform Help Line toll-free at 1-877-267-2323, extension 61565.

ⁱ Such coverage is provided either pursuant to federal fallback standards in 45 CFR 148.120, or through a state alternative mechanism that satisfies the standards in 45 CFR 148.128. In either case, the choices of coverage that must be provided cannot have a preexisting condition exclusion. To the extent an entity that is required to offer a choice of coverage to eligible individuals with no preexisting condition exclusion does so in such a way that satisfies 45 CFR 148.120 or 45 CFR 148.128, the entity can also offer such individuals additional choices that might include a preexisting condition exclusion, to the extent permitted under state law. Thus, in instances where this bulletin refers to the prohibition on applying a preexisting condition exclusion to eligible individuals, it refers only to the coverage offered to comply with 45 CFR 148.120 or 45 CFR 148.128

ⁱⁱ 69 FR 78720 (December 30, 2004).

ⁱⁱⁱ The final group market regulation defines a preexisting condition exclusion as “...a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual’s health status before the individual’s effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.” 69 FR 78783 (December 30, 2004), 45 CFR 146.111(a)(1)(i).

^{iv} On December 30, 2004, the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury jointly published a Request for Information on Benefit-Specific Waiting Periods Under HIPAA Titles I and IV (69 FR 88825). The primary purpose of that document was to ensure that the public could provide input into any criteria used to determine whether any given benefit-specific waiting period is a preexisting condition exclusion under HIPAA. The Departments requested this information to help decide whether to issue any guidance (in addition to the guidance in the final group market regulations referred to in this bulletin) on this question.