

HIPAA NONDISCRIMINATION AND PORTABILITY UPDATE

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HIPAA: THE NEVER ENDING STORY

I. Overview

- A. Topics Covered. This outline will focus upon the employee health benefit plan implications of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and subsequent legislation. This outline will address only tax implications related to employee health benefit plans and other requirements that impact employee health benefit plans. It is not intended to be a full outline of the Medicare and Medicaid or Public Health Service Act changes or other changes contained in HIPAA or other subsequent legislation. Some of the sections added by HIPAA (§§ 704-707 are now §§ 734-737) were renumbered by the Newborns' and Mothers' Health Protection Act of 1996 (the "Newborns' Act"). Some of the sections added by HIPAA were renumbered by the Taxpayer Relief Act of 1997 ("TRA '97") which renumbered Code §§ 9804, 9805 and 9806 as 9831, 9832 and 9833, respectively renumbered and added to the Code new §§ 9811 and 9812. The sections renumbered are noted in the outline. TRA '97 amended the Code to add the provisions in the Newborns' Act and in the Mental Health Parity Act and renumbered Code §§ 9804, 9805 and 9806 as 9831, 9832 and 9833. TRA '97 then inserted new §§ 9811 and 9812 in the Code. The term "Temporary Regulations" is used herein to refer to the Temporary Regulations issued under the Internal Revenue Code and the Interim Regulations issued by the U.S. Department of Labor and the Health Care Financing Administration on April 1, 1997 related to HIPAA as such were corrected on June 10, 1997, at 62 Fed. Reg. 31689, 62 Fed. Reg. 31695, 62 Fed. Reg. 31669 and 62 Fed. Reg. 31695 (June 10, 1997).
- B. Caveats. In order to keep this outline to a manageable length, many sections and technical rules will be described in a summary fashion and others may be omitted entirely. No one should take any action based solely upon this outline.
- C. Background Regarding HIPAA and the Laws it Changes. HIPAA is lengthy and contains many provisions affecting health plans not only in the provisions of HIPAA amending the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Public Health Service Act ("PHSA"), and the Internal Revenue Code of 1986, as amended ("Code"), but also amending portions of the Social Security Act and PHSA that were not previously applicable to employee benefit plans providing health or medical benefits. HIPAA was signed into law or enacted on August 21, 1996.
- D. Request For Comments on HIPAA Temporary Regulations. The initial Temporary Interim Regulations were issued on April 1, 1997 and invited comments on numerous areas.
- E. Preliminary Explanations. The IRS issued its description of HIPAA's impact on health plans in Publication 535, "Business Expenses" at pages 22-24. The DOL has also developed its own description of HIPAA entitled "Recent Changes in Health Care Law." The DoL's pamphlet is available at <http://www.dol/dol/pwba/pubs/q&aguide.htm#mental> or by calling 800-998-7542. The DoL has established two telephone inquiry lines for HIPAA, one for sponsors at 202-219-4377 and one for participants at 202-219-8776. The DoL is currently auditing health plans for HIPAA. See the ABA materials for the initial data request and a checklist used in the

audits. HCFA has issued some guidance in question and answer format that are available at <http://www.hcfa.gov/regs>.

II. Application of HIPAA

- A. General Rules - Employers of Two or More Employees. The Code and ERISA amendments generally apply to **all group health plans with two or more current employees** at the beginning of the first plan year beginning on or after July 1, 1997, that are not governmental plans; however, certain church plans were excepted from the Code requirements by TRA '97. It is important to note that while the PHSA and ERISA provisions define a group health plan using the ERISA definition of a plan, the Code provisions do not adopt the same definition of a group health plan. Instead the Code amendments apply to most church plans and all non-governmental employer sponsored plans. The Code does not define what constitutes the "plan." ERISA and the PHSA rely on the definition of a plan in ERISA. The PHSA amendments apply to **all governmental plans** and to **all insurers** for the first plan/policy year beginning on or after July 1, 1997, and thus, to all insured plans for employers with two or more participants who are current employees at the beginning of the plan year and to some extent to individual insurance policies.¹ The application of the PHSA to insurers is used to apply new restrictions not only to group policies, but also to individual health insurance policy provisions, to the extent the state alternate mechanisms provides, and requiring guaranteed issue and guaranteed renewability so certain qualifying individuals and self-employed persons are able to obtain and maintain individual health insurance coverage (either through insurance or under a state alternate mechanism which can mean a state high risk health insurance pool) and benefit from the portability provisions when they join a group plan or leave group coverage.² HIPAA is to be administered in part by the Department of Treasury and the Internal Revenue Service, the Department of Labor and Pension and Welfare Benefits Administration, and the Department of Health and Human Services and the Health Care Financing Administration. These agencies agreed to establish a committee to coordinate to ensure that all interpretations, regulations and enforcement strategies are consistent and the agencies do not duplicate efforts.³ HIPAA's protection does not apply to dental-only or vision-only plans if they are provided under a separate plan, policy, certificate or contract and are not an integral part of the medical-surgical plan.⁴
- B. Certain Small Church Plans Exempted. TRA '97 also amended Code § 9802 to except church plans from the prohibition on using evidence of good health for groups of 10 or fewer employees or for self-employment persons or for any person enrolling after the first 90 days of initial eligibility under the plan provided such church plan included this provision on July 15, 1997 and at all times thereafter before the beginning of such year. Note this is only a partial exemption permitting the use of evidence of good health and not an exemption from the other portability, access certification or notice requirements.
- C. Multiemployer Plans and MEWAs Subject to Guaranteed Renewal. HIPAA imposes guaranteed renewability requirements on multiemployer plans and multiple employer welfare

¹ PHSA § 2721.

² ERISA § 701(b)(1), PHSA § 2701(b)(1) and Code § 9801(b)(1).

³ 64 F.R. 70163 (December 15, 1999).

⁴ "The Health Insurance Portability and Accountability Act of 1996: Guidance on Frequently Asked Questions," Sept. 30, 1996 CRS Report for Congress ("CRS Report") CRS-8; see also II.F. below.

arrangement plans⁵ and imposes similar requirements on group plans⁶ and on individual policies.⁷ A multiemployer plan or a multiple employer welfare arrangement cannot deny an employer whose employees are covered under the plan with either continued access to the plan or to continued access to different coverage under the terms of the plan except in the event of: (1) nonpayment of contributions, (2) fraud or other intentional misrepresentation of material facts by the employer, (3) noncompliance with material plan provisions, (4) because the plan is ceasing to offer any coverage in a particular geographic area, (5) a plan offering benefits through a network plan learns there are no longer individuals enrolled through the employer who live, reside or work in the service area of the network plan and this requirement is applied uniformly without regard to claims experience of the employers or any health status related factor related to individuals or their dependents, or (6) failure to meet the terms of the applicable collective bargaining agreement.⁸

D. PHSA Changes Address Governmental Plan and Insurance Issuers Obligations Regarding Accessibility of Health Coverage.

1. Small Group and Individual Insurance Market Reforms. The PHSA was amended⁹ to apply the health plan requirements to governmental plans and insurance issuers. The additions in PHSA §§ 2701 and 2702 parallel the provisions contained in ERISA. The PHSA also includes provisions applicable only to health insurance issuers.¹⁰ PHSA §§ 2721 through 2723 to provide for exclusions of certain plans and enforcement mechanisms. HIPAA also added PHSA § 2791 to define certain other plans that are subject to HIPAA as group health plans. HIPAA § 111 amends the PHSA¹¹ to address changes required in the individual insurance market so that health insurance coverage will be accessible and portable by forcing insurers to make coverage available to qualifying individuals on a guaranteed issue basis provided certain conditions are met and requiring insurers to issue individual coverage on a guaranteed renewable basis. However, HIPAA included a provision permitting states to enact alternative mechanisms to provide access to health care coverage. Forty-eight states have notified HCFA that they will enact a separate mechanism. Thus, the individual insurance and small and large group insurance provisions may rely on a state by state basis.
2. Small Group Market Special Rules. The PHSA was amended to impose small group health insurance reform on all small group policies issued in the U.S. regardless of whether a particular state has adopted a small group health insurance reform statute.¹² The small group rules apply to small employers that have at least two, but no more than 50 employees on a business day during the preceding calendar year and employ at least

⁵ ERISA § 703.

⁶ PHSA § 2712 and 45 C.F.R. § 146.152.

⁷ PHSA § 2742.

⁸ Blue Book p. 360.

⁹ HIPAA § 102.

¹⁰ PHSA §§ 2711 through 2713.

¹¹ PHSA §§ 2741 through 2744 and 2761 through 2763.

¹² PHSA § 2711.

two employees on the first day of the plan year. Whether an employee is full-time or part-time is irrelevant for determining the number of employees the employer has.¹³ HIPAA's small group rules will only apply to the extent a state has not enacted a small group provision as part of its alternative mechanism. The "employer" is determined utilizing the definition of employer contained in ' 414(b), (c), (m) and (o) of the Code. An insurer's small group rules cannot place requirements on participation that make it impossible for any particular small employer to qualify for coverage (e.g., requiring at least 10 employees to participate to have coverage).¹⁴

3. Guaranteed Issue.

- a. Small Group Market. Each health insurance issuer that offers health insurance coverage in the small group market in any state must accept every small employer that applies for coverage, and must accept for enrollment under such coverage every eligible individual who applies for enrollment and may not place any restrictions that are inconsistent on an employee being a participant or a beneficiary.¹⁵ The Health Care Financing Administration ("HCFA") has stated in a Program Memorandum that setting agent commissions for sales to HIPAA eligible individuals or small groups so low that agents are discouraged from marketing policies to or enrolling such individuals or groups is a practice inconsistent with HIPAA's guaranteed availability provisions.¹⁶ HCFA has also stated that unreasonably delaying the processing of applications submitted by HIPAA eligible individuals or small groups violates the guaranteed availability provisions of HIPAA.¹⁷ Note: HIPAA does not prevent insurers from refusing to accept groups of over 50 employees since these larger groups are not protected by the guaranteed issue provisions applicable to small groups of 2-50 employees.¹⁸ Any insurance obtained by an eligible individual through a group health plan maintained by a small employer should be treated as subject to the small group rules on guaranteed availability and guaranteed renewal and the other rights in PHSA §§ 2701 and 2702.¹⁹

If the insurance issuer offering health insurance in the small group market uses a network plan (a plan that has a specified group of providers and that has

¹³ Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 99-03, September 1999.

¹⁴ Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 00-05, November 2000.

¹⁵ PHSA § 2711 and 45 C.F.R. § 146.150(a). Individuals are eligible if they are eligible under the terms of the plan under the rules of the issuer that are uniformly applicable in the state to small employers in the small group market and they are eligible in accordance with all applicable state laws governing the issuer and the market (45 C.F.R. § 146.150(b)).

¹⁶ Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 98-01, March 1999.

¹⁷ *Id.*

¹⁸ CRS Report CRS-10.

¹⁹ Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 00-06, November 2000.

been limited to certain geographic areas), then the issuer may limit the employers that may apply for coverage under the network plan to those who have eligible employees that live or reside or work in the area the network plan covers, and may deny coverage to the employers if the issuer demonstrates to the applicable state authority that it does not have the capacity to deliver services adequately to the employees of any additional groups because of its preexisting obligations.²⁰ The small group insurers must apply this restriction with respect to the number of individuals it permits to be covered uniformly to all employers without regard to claims experience of the employers or their employees, or any health status factor of the employers or the employees.²¹

If an issuer denies coverage in any service area, the issuer may not offer coverage in the small group market in that area for a period of 180 days after the coverage is denied.²² The health insurance issuer may deny coverage based on its financial capacity in the small group market if they have demonstrated to the applicable state authority that it does not have financial reserves necessary to underwrite additional coverage and this limitation is applied uniformly. If an insurer uses its financial capacity as the basis for denying coverage, the issuer may not offer any coverage to group health plans in that small group market in the state for a period of 180 days after it has been denied coverage or until it has demonstrated that it has sufficient financial reserves to underwrite additional coverage, whichever is later.²³

The restrictions requiring guaranteed availability of coverage to small employers does not prevent a health insurance issuer from establishing minimum employer contribution rules or group participation rules.²⁴ The preamble to the Temporary Regulations specifically requested comments on whether the regulations should define "contribution rules" or "group participation rules." An issuer of small group coverage must generally offer to each small employer in the state each product that is approved for sale in the small group market that is actively marketed by the issuer. Issuers are not relieved from the guaranteed availability requirements simply because a state law requires or permits issuers to offer products to some, but not all, small employers in the small group market. A state law prevents the application of HIPAA and is preempted if the state law makes it impossible for a party to comply with HIPAA. Thus, a state law that is contrary to HIPAA is preempted.²⁵

²⁰ PHSA § 2711(c) and 45 C.F.R. § 146.150(c).

²¹ PHSA § 2711(c) and 45 C.F.R. § 146.150(c)(1)(ii).

²² PHSA § 2711(c) and (d) and 45 C.F.R. § 146.150(c)(2), (c)(3) and (d)(2).

²³ PHSA § 2711(d) and 45 C.F.R. § 146.150(d)(2).

²⁴ PHSA § 2711(e) and 45 C.F.R. § 146.150(e).

²⁵ Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 00-03, June 2000.

- b. Individual Policies. In states using the federal HIPAA rules, individual insurance issuers only must offer individual policies on a guaranteed issue basis if the individual has not had a more than 63 day break in coverage and the individual has exhausted their COBRA or other continuation coverage and has had at least 18 months of creditable coverage, the individual's most recent coverage was under a group health plan,²⁶ a governmental plan or a church plan, the individual is not eligible for coverage under a group health plan, Medicare, Medicaid or does not have any other health insurance coverage and the individual's most recent coverage was not terminated because of nonpayment of premiums or fraud.²⁷ The purposes of requiring individual insurance on a guaranteed issue basis was to permit individuals to transfer from group to individual coverage; thus, it is only available on a guaranteed issue basis to individuals who have exhausted their group based (COBRA) coverage in states that did not enact an alternative mechanism.²⁸ COBRA continuation coverage, conversion coverage and coverage issued to eligible individuals who lose group coverage under PHSA § 2741 or § 2744 are treated as individual coverage and are subject to the guaranteed renewability and all of the other requirements of HIPAA.²⁹ In some states insurers do not offer individual insurance on a guaranteed issue basis because the alternate mechanism enacted by the state uses a high risk pool rather than requiring the insurers to offer individual coverage on a guaranteed issue basis. The state flexibility in developing alternative mechanisms is described in the regulations.³⁰ The federal provisions will only apply if a state does not implement an acceptable alternative mechanism.³¹ The Temporary Regulations defined what constitutes the "exhaustion of COBRA." Under the Temporary Regulations, the "exhaustion of COBRA" means that an individual's COBRA continuation coverage ceases for any reason other than failure of the individual to pay premiums on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material

²⁶ The most recent coverage may include group health plan coverage that only covers one employee, group health plan coverage provided through individual policies, if the arrangement is an employee welfare plan under section 3(1) of ERISA, a group health plan for a self-employed person as long as at least one employee is covered by the group health plan, and a group health plan that covers partners in a partnership and their dependents even if the plan is not subject to ERISA. Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 00-02, June 2000.

²⁷ Interim 45 C.F.R. § 148.103; 62 Fed. Reg. 16996; Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 99-02, June 1999.

²⁸ Preamble, 62 Fed. Reg. 16986-16987; see also Department of Health and Human Services, Center for Medicare and Medicaid Services, Program Memorandum, Insurance Commissioners, Insurance Issues, Transmittal No. 01-02, August 2001.

²⁹ Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 01-01, March 2001.

³⁰ Interim 45 C.F.R. § 148.126.

³¹ PHSA § 2744 and Interim 45 C.F.R. § 148.102(b); 62 Fed. Reg. 16996; Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 99-02, June 1999.

fact in connection with the plan. An individual is considered as having exhausted COBRA if that coverage ends (1) due to failure of the employer or responsible entity to remit premiums on a timely basis, or when the individual no longer resides, lives, or works in a service area of an HMO or a similar program and there is no other COBRA coverage available to the individual.³² The individual must not be eligible under any employer plan, Medicare or Medicaid or have any other health insurance coverage. The individual's coverage must not have been terminated because of fraud or nonpayment of premiums; however, if an individual's most recent coverage was group health plan coverage that was terminated due to the plan sponsor's nonpayment of premiums or fraud, the individual still qualifies as an eligible individual.³³ This does not require comparable individual coverage to the COBRA coverage. Nor does the law place any limits on the amount an individual may be charged for an individual health insurance policy and an issuer may collect medical information to use it only for determining premiums.³⁴ The law does not affect any state laws that may limit premiums or premium increases. This law permits states to enforce the individual market changes either by (1) enforcing the Federal statute's provisions on insurers (if this is chosen states may choose to impose certain limits on the policies the insurers are required to offer), or (2) states may choose to implement an alternative mechanism to ensure individual access to health insurance and states choosing this alternative must notify HCFA and provide HCFA with enough documentation for HCFA to determine if the alternate mechanism will suffice.³⁵ If a state implements an alternative mechanism, the states rules govern the issuance of individual policies and the rules described above do not apply.³⁶ However, in order for a state alternative mechanism to be acceptable it must be reasonably designed to ensure that all federally eligible individuals have (1) guaranteed availability of health coverage without any preexisting condition exclusion and (2) a choice of health coverage consisting of comprehensive coverage or a standard coverage option available under the state's group or individual health insurance laws. The state alternative mechanism must have a way to determine whether an individual is a federally eligible individual.³⁷ If a state does not use an alternative mechanism, the insurer must offer either its two most popular policies, forms or representative samples of individual health

³² Temp. Treas. Reg. § 54.9801-2T, 29 C.F.R. § 2590.701-2 and 45 C.F.R. § 144.103.

³³ 45 C.F.R. § 148.103; 62 Fed. Reg. 16996; Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 99-02, June 1999.

³⁴ CRS Report CRS-11 and 12, PHSA § 2741; Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 99-02, June 1999.

³⁵ 62 Fed. Reg. 1768-1776, Department of Health and Human Services, January 13, 1997, Notification Procedures for States Implementing Alternative Mechanisms in the Individual Insurance Markets.

³⁶ Interim 45 C.F.R. § 148.120(b) and § 148.102(b).

³⁷ Department of Health and Human Services, Center for Medicare and Medicaid Services, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 01-02, August 2001.

insurance offered by the insurer in the state.³⁸ (Most popular policies are measured by premium volume in that state.) The two policy forms must include both a lower level coverage form and a higher level coverage form. An issuer in the individual market is not required to offer family coverage with any policy form.³⁹

4. Guaranteed Renewal.

- a. Small Group. Once a health insurance issuer has offered coverage in the group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor. The issuer may not non-renew or discontinue coverage except in the event of nonpayment of premiums, fraud of the plan sponsor, if the plan sponsor failed to comply with the participation or contribution requirements.⁴⁰ If the insurance issuer refuses to renew any coverage, it must cease offering any coverage in the market for a period of at least five years and comply with all notification requirements in advance of the discontinuance of coverage. Guidance was issued on the market exist and product withdrawal exceptions in 2002.⁴¹ If the health insurance issuer notes that the employer no longer has individuals that live in the service area that are serviced by a network plan, or if the insurance was available through association membership only, then the insurer may terminate offering the insurance if membership of the employer in the association terminates, or if the employer ceases to have employees in the service area of the network plan.⁴² If a small group grows to over 50 employees, counting all employees, the guaranteed renewal provisions continue to apply in the large group market and so will the Mental Health Parity Act requirements. Likewise, a large employer that decreases to below 50 employees will be covered by the small group guaranteed renewability provisions. However, if a small group shrinks to below two employees on the first day of the plan year, HIPAA does not protect this "group coverage" for one employee, but state law may provide protections. If an individual is not renewed because the "group" shrank to fewer than two, the employee may be an "eligible individual" under HIPAA to transition to individual market coverage.⁴³
- b. Individual Policies. Individual policies that are issued under the portability provisions of HIPAA will generally be governed by state laws if the state

³⁸ Interim 45 C.F.R. § 148.120(c).

³⁹ Interim 45 C.F.R. § 148.120(g).

⁴⁰ PHSA § 2712 and 45 C.F.R. § 146.152(b); Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 99-03, September 1999.

⁴¹ Department of Health and Human Services, Centers for Medicare and Medicaid Services, Program Memorandum, Insurance Commissioners, Insurance Issuers, Transmittal No. 02-01, March 2002.

⁴² PHSA §§ 2712(b) and (c) and 45 C.F.R. § 146.152(d).

⁴³ Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 99-03, September 1999.

enacts its own access mechanism by January 1, 1998 (if the state legislature meets within 12 months of August 21, 1996) or by July 1, 1998 (if the state's legislature does not meet within the 12 months following August 21, 1996).⁴⁴ If a state does not adopt its own group of individual coverage rules, the federal statute's individual requirements will apply. A state is presumed to be implementing an acceptable mechanism if the state notifies the Secretary of Health and Human Services by April 1, 1997 that it has enacted or that it intends to enact legislation to implement a state group to individual coverage mechanism.⁴⁵ To determine what posture any particular state is taking on its need to adopt legislation, contact that state's department of insurance regarding the state's group to individual health insurance portability mechanisms or reforms.⁴⁶ (Missouri is permitting HCFA to enforce the Federal Statute in Missouri.) A health insurance issuer who offers health insurance to individuals must renew or continue the coverage in force at the option of the individual unless the individual fails to pay premiums, performs an act of fraud under terms of coverage, moves outside the insurer's service area if the plan is a network plan or the issuer ceases offering any individual coverage in the area or the individual bought coverage through an association and terminated his membership.⁴⁷ Individual coverage may only be nonrenewed for: (1) nonpayment of premiums; (2) fraud; (3) termination of the insurer's offering individual insurance coverage in the market; (4) the individual moves outside the service area of a network plan; or (5) the individual's coverage was purchased through a bona fide association and the individual's membership in the association terminates (such as an individual who purchased student coverage who ceases to be a student).⁴⁸ The above exceptions must be applied uniformly without regard to the health status of the individual.

5. Consequences of Terminating Group Coverage. If the insurance issuer terminates coverage in a small or large group market, the coverage must be discontinued in accordance with any applicable state laws and HIPAA, and only if notice of discontinuance is provided to each plan at least 90 days prior to the date of discontinuance of coverage. The issuer must offer to each plan sponsor, whose coverage is being terminated, the option to purchase all other health insurance coverage currently being offered by the issuer to that market. The issuer must act uniformly in discontinuing coverage without regard to claims experience of the sponsors, or any health status related factor relating to any new participants or beneficiaries that may become eligible for the coverage. When an issuer leaves either a large or small group market, it must provide notice to all groups that it is leaving that market at least 180 days prior to its discontinuance of coverage. All health insurance coverage issued or delivered by that issuer for issuance in that state or in the market must be discontinued

⁴⁴ CRS Report CRS-12.

⁴⁵ CRS Report CRS-12.

⁴⁶ You may also review the state alternative mechanisms at www.georgetown.edu/research/ihcrp/hipaa/.

⁴⁷ PHSA § 2742 and Interim 45 C.F.R. § 148.120, 62 Fed. Reg. 16996 and Interim 45 C.F.R. § 148.122(b).

⁴⁸ Interim 45 C.F.R. § 148.122(c).

or non-renewed and the health insurance issuer may not reenter that market for five years following their discontinuance of the coverage.⁴⁹

6. Insurance Issuer's Disclosures. Any health insurance issuer must make certain disclosures as part of its solicitation and sales materials to small employers. The information must describe provisions of the coverage concerning the right of the issuer to change premium rates and other factors that may change premium rates, provisions of the coverage relating to renewability, preexisting condition exclusions, and the benefits and premiums available under all health insurance coverage for which the employer is qualified. This must be provided in a manner that is understood by the average small employer and must be sufficient to reasonably inform the small employers of their rights and obligations. The Temporary Regulations⁵⁰ delineate the disclosures that must be made to any small employer group to which a solicitation is made for the sale of health insurance.⁵¹ The items that must be disclosed include the rate or rating schedule that applies to the product, the minimum employer contribution and the group participation rules that apply to any product, if the plan is a network plan, a map or list of the counties served and any other information required by state laws. However, the issuer is not required to disclose any proprietary information or trade secrets. Comments were requested on whether the regulations should define "proprietary information" or "trade secrets."

- E. Application of PHSA and Special Non-Federal Governmental Plan One Year Opt-Out. The requirements under the PHSA with respect to health insurance issuers and their obligations regarding portability, preexisting condition exclusions, and prohibited discrimination based on health status apply with respect to group health plans that are non-federal governmental plans and health insurance coverage offered in connection with a group health plan including a health plan that is either a church plan or a governmental plan.⁵² Only small group insured plans and individual insurance contracts are covered by the guaranteed issue protections and all insured plans are covered by the guaranteed renewability protections in the PHSA.

A plan that is a non-federal governmental plan may elect to have certain portions of the PHSA that relate to the preexisting condition exclusion limitation (including reducing preexisting condition exclusions for prior creditable coverage),⁵³ special enrollment periods, prohibited health status based discrimination, standards for Mothers and Newborns, mental health parity and the Women's Health and Cancer Rights Act of 1998 requirements to not apply for a single plan year at a time; however, this election may be renewed for subsequent years;⁵⁴ however, the provisions applicable to group health insurance coverage would still apply to the plan, to the extent it is an insured plan.⁵⁵ The non-federal governmental plan cannot opt-out of the issuing notices and certificates of creditable coverage. This election for a non-federal governmental

⁴⁹ PHSA § 2712(c) and 45 C.F.R. § 146.152(c) through (f).

⁵⁰ 45 C.F.R. § 146.160.

⁵¹ PHSA § 2713 and 45 C.F.R. § 146.160.

⁵² ERISA §§ 702 and 704, PHSA § 2721, and Code § 9802.

⁵³ The Model HIPAA Exemption Election Document promulgated by HCFA is attached at page 99.

⁵⁴ PHSA § 2721(b)(2) and 45 C.F.R. § 146.180(a).

⁵⁵ PHSA § 2721(b)(2) and 45 C.F.R. § 146.180.

plan to opt out of parts of HIPAA must be in writing, include a copy of the notice to participants mandated,⁵⁶ must state the name of the plan and the name and address of the plan administrator and state that the plan does not include health insurance coverage or must identify the portion of the plan not funded through insurance. See attached Model Notice. The election must comply with any rules that apply to the plan sponsor including public hearings, and must certify that the person signing the election is authorized.⁵⁷ The election must be received by HCFA by the day immediately preceding the plan year to which it applies for non-collectively bargained plans. The election for a collectively bargained plan must be received no later than 30 days after the date the governmental entity and the union officials agree or if applicable, when the union membership ratifies the agreement. If a plan fails to file the election with HCFA as required,⁵⁸ the plan is subject to the provisions and the election is null and void.⁵⁹ This election is only available for one single specified plan year per election, or if the benefits are subject to a collective bargaining agreement for the term of the agreement. The election may be made repeatedly. If this election is made, the enrollees must be notified of the fact the election has been made and the consequences of the election, and the certificates of the creditable coverage must still be provided.⁶⁰ If a plan decides not to opt-out in part or in total in any year, special rules govern the transition which are explained in II.G.

- F. Excepted Benefit. HIPAA's requirements do not apply to benefits that are listed as excepted from the requirements of ERISA, the Code and the PHSA.⁶¹ (See also IV.E.2. and 3).
- G. Enforcement of PHSA Provisions. States have the authority to enforce HIPAA's requirements added through the PHSA against health insurance issuers that sell new or offer health insurance coverage renewals in the state. If the state fails to enforce the requirements, then the Secretary of Health and Human Services may enforce the provisions of the Health Insurance Portability and Accountability Act of 1996 in that state.⁶² Some states have elected to permit the Secretary of Health and Human Services to enforce the federal provisions of HIPAA in their state. The Temporary Regulations provide a mechanism whereby individuals seeking to enforce HIPAA's requirements first must exhaust State remedies prior to seeking HCFA's assistance in enforcing HIPAA. HCFA notifies the State of the alleged deficient enforcement and gives the State an opportunity to correct the deficiency for 45 days. If at the end of such 45-day period the State has not established that it is enforcing HIPAA, HCFA makes a preliminary determination, consults with appropriate State officials, notifies the State of the deficiency and gives the State a reasonable opportunity to show correction. If the State fails to correct, HCFA makes a final determination and notifies the State that HCFA is taking over enforcement of HIPAA at a set date, including notifying the State that it can demonstrate in the future that it has corrected the failure and has established an enforcement mechanism.⁶³

⁵⁶ 45 C.F.R. § 146.180(b), (f) and (g); see also attached HCFA Model Notice to Enrollees in a Self-Funded Non-Federal Governmental Group Health Plan.

⁵⁷ 45 C.F.R. § 146.180(b).

⁵⁸ 45 C.F.R. § 146.180(c).

⁵⁹ 45 C.F.R. § 146.180(1).

⁶⁰ PHSA § 2721(b) and 45 C.F.R. § 146.180(h).

⁶¹ PHSA §§ 2721(c) and (d) and 45 C.F.R. § 146.180.

⁶² PHSA § 2722(a)(2) and 45 C.F.R. § 146.184.

⁶³ 45 C.F.R. § 146.184(c).

Section 2722 applies a penalty of \$100 per day for each individual with respect to which there is a failure to comply with the requirements of HIPAA.⁶⁴ If the health insurance issuer fails to comply with the requirements, they are liable for the penalty. If the health plan is a non-federal governmental plan sponsored by two or more employers, then the plan is liable for the penalty. If it is a non-governmental plan that is not sponsored by two or more employers, then the employer is liable for the penalty. The exceptions contained in COBRA for failures to comply with the requirements that are not discovered by reasonable diligence are repeated for failures to comply with HIPAA's new health plan and insurance requirements in the PHSA. The penalty will not apply if failures are corrected within 30 days. The COBRA limitations in terms of the maximum penalties are not contained in the PHSA.⁶⁵ The penalties under the PHSA are paid to the Secretary of Health and Human Services.⁶⁶

H. Preemption and the PHSA. Section 2723 clarifies that this Act is not to be construed to supersede provisions of State law that establish or implement standards or requirements with respect to health insurance issuers except to the extent that the state requirements prevent the application of the federal requirements.⁶⁷ HIPAA also clarifies in new PHSA § 2723(a)(2) that ERISA continues to preempt State laws and that nothing in HIPAA is intended to affect or modify ERISA's preemption of state law. Section 2723(b) of HIPAA indicates that if a state imposes more stringent requirements than those imposed by HIPAA, the state provisions will survive. The Temporary Regulations specify the requirements contained in the Temporary Regulations that are superseded by State laws for **insured** coverage to include any provision that:

1. shortens the period of time from the "6-month period" for purposes of identifying a preexisting condition;
2. shortens the period of time from the "12 months" and "18 months" maximum periods for applying preexisting condition exclusions;
3. provides for a greater number of days than the "63 day period" used to determine a "break in coverage";
4. provides for a greater number of days than the "30-day period" during which individuals must enroll newborns, and newly adopted or placed for adoption children;
5. prohibits the imposition of any preexisting condition exclusion to (1) a newborn child, newly adopted child or child newly placed for adoption that was added to the coverage within 30 days of birth or placement for adoption, or (2) to any pregnancy;
6. requires special enrollments in more situations than those covered by HIPAA and the related Temporary Regulations; or

⁶⁴ 45 C.F.R. § 146.184(d) describes penalty imposition.

⁶⁵ *Cf.* § 4980D(b) of the Code and PHSA § 2722.

⁶⁶ PHSA § 2722(b).

⁶⁷ 45 C.F.R. § 146.143(a).

7. reduces the affiliation period below two months for initial newly eligible enrollees and three months for late enrollees.

- I. Individual Insurance Market Reforms and Preemption. HIPAA amends the individual market rules requiring guaranteed availability and guaranteed renewability, subject to the individual satisfying certain conditions, similar to the requirements imposed on small group insurers under the PHSA. The states have the authority to implement the changes and to enforce the changes and to enact its own alternative mechanism for implementing HIPAA. The individual market reforms are contained in § 111 of HIPAA and generally parallel those for the small group insurance provision with requirements for guaranteed issue, guaranteed renewal and noncancelability.⁶⁸ PHSA § 2762 reemphasizes that ERISA preemption is not to be modified by these new requirements. Individual insurance offered must be the insurer's two most popular policies, must be offered in a lower level and higher level policy and must offer eligible individuals every individual policy the insurer sells in the state.⁶⁹ (See II.D.3.b. regarding conditions that must be met for individual insurance to be issued on a guaranteed issued basis.)
- J. Association Health Plans. HIPAA did not expressly address association health plans; however, many associations sell individual or group health insurance coverage to their members and such insurance falls under the PHSA. Association is not defined by the Public Health Service Act or the regulations; however, the context of the statute makes clear the term is intended to cover any entity through which insurance is offered to a collection of employers and/or individuals, including, but not limited to, multiple employer welfare arrangements (MEWAs), purchasing alliances or purchasing cooperatives.⁷⁰

The requirements of HIPAA in the PHSA apply to association health plans that are self-insured as if it was an issuer and meets the definition of "issuer" in the PHSA. Thus the group market and individual market rules in HIPAA apply to a self-insured association plan because it meets the definition of issuer in the PHSA.⁷¹ The determination of whether the group or individual market rules apply to the association plan is not determined by state laws, but under federal laws and coverage that is provided to associations that is not related to employment is not group coverage.⁷² If the coverage is offered other than in connection with a group plan or is offered to an association member with fewer than two participants who are current employees, it is generally considered individual coverage.⁷³ Insurance coverage would be considered offered on a group basis either because a group health plan exists at the association level or because an employer member or employee organization member maintains a group health plan.⁷⁴ If the association has any members that are small employers for HIPAA purposes (employers with

⁶⁸ PHSA §§ 2741-2747 [§§ 2745-2747 renumbered as §§ 2761-2763 by the Newborns' Act].

⁶⁹ CRS Report CRS-12 and Interim 45 C.F.R. § 148.120(c).

⁷⁰ Department of Health and Human Services, Center for Medicare and Medicaid Services, Program Memorandum, Insurance Commissioners, Insurance Issuers, Transmittal No. 02-02, August 2002.

⁷¹ *Id.*

⁷² *Id.* and 45 C.F.R. § 144.102(c).

⁷³ Department of Health and Human Services, Center for Medicare and Medicaid Services, Program Memorandum, Insurance Commissioners, Insurance Issuers, Transmittal No. 02-02, August 2002.

⁷⁴ *Id.*

two to 50 employees), then the association, as issuer, is subject to the HIPAA rules applicable to small group coverage.⁷⁵

Association coverage that is not group coverage does not provide a basis for an individual to be Federally eligible under HIPAA (which status enables the individual who is federally qualified to obtain guaranteed issue individual coverage if available in that state or to access the state's alternative mechanism) even if the association coverage is treated as group coverage for state law purposes (unless the state enacted broader rights for portability).⁷⁶

If the association fails to pay premiums or committed fraud resulting in loss of the individual's access to group coverage through the association plan, the individual is not precluded from being a Federally eligible individual.⁷⁷

HIPAA's guaranteed renewability provisions apply to guarantee renewal to the plan sponsor, yet in association plans most state laws view the association and not the member employers as party to the insurance contract.⁷⁸ The application of HIPAA's guaranteed renewability provisions in the PHSA depends upon whether the group is at the association level or at the employer member level. If the rare instances where the group health plan exists at the association level, the association is the plan sponsor and must be given the right to guaranteed renewability. However, if the issuer makes the coverage available only through one or more associations, then the plan sponsor is deemed to include each employer that gets its coverage through the association and guaranteed renewability must be extended by the issuer to each employer.⁷⁹ Even if the association is the holder of the master policy, only the plan sponsor is entitled to the guaranteed renewability protections under HIPAA and the other protections under 45 C.F.R. § 146.152.⁸⁰ Since in most situations the group health plan sponsor is not the association, but the employer, the association's actions would not give the issuer the right to terminate or non-renew the coverage of any employer-member of the association.⁸¹ Thus, the issuer must renew coverage of each employer-member either through contracts with the association or with each member group.

If the association offers individual coverage, most state laws view the association and not the individual as the contractholder; thus the association would have the right to guaranteed renewability.⁸² However, if the coverage is only made available through one or more associations, then the individual market issuer must satisfy all requirements of 45 C.F.R. § 148.122(h) both with respect to the association and the individuals who obtain coverage through the association, including if the association fails to pay premiums or commits fraud, the

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ Department of Health and Human Services, Center for Medicare and Medicaid Services, Program Memorandum, Insurance Commissioners, Insurance Issuers, Transmittal No. 02-03, August 2002.

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

issuer may terminate the association's policy, but it must offer identical coverage to each individual member outside the association.⁸³

If an association has both employer and individual members, then the association's obligations with respect to guaranteed renewability of the group and individual members are as described above for individuals and groups.⁸⁴

A Bona Fide Association ("BFA") must be an association that has been formed and maintained in good faith for purposes other than obtaining insurance.⁸⁵ An association is not a BFA if it conditions membership on any health status related factor relating to an individual and whether membership is based on a health factor is determined based upon relevant facts and circumstances. In order to be a BFA, the association must make health insurance coverage available to all members regardless of health factors.⁸⁶ A BFA must not make health insurance coverage available to non-members and it must meet all state law requirements to be an association.⁸⁷ If an issuer is offering coverage in the small group market, it must offer all coverages available except coverages offered only to BFA members.⁸⁸ If a state uses an alternative mechanism rather than requiring guaranteed availability to Federally eligible individuals, then the exception for BFAs is irrelevant in that state. However, in states with guaranteed availability for individuals, then the issuer must offer all products offered in the individual market or the issuers two most popular policies, except the BFA-only coverage need not be offered to the Federally qualified individuals.⁸⁹

If coverage is sold exclusively through BFAs (with the BFA being in existence for at least five years and meeting the criteria described above), then the issuer must generally offer the plan sponsor the option to renew, except when the individual's or plan sponsor's membership voluntarily ceases in the BFA.⁹⁰

III. Health Insurance and Health Plan Accessibility

- A. Accessibility and Prohibitions on Health Status Based Discrimination. HIPAA attempts to increase access to health care coverage by removing employers' and insurers' ability (with respect to guaranteed issue provisions for individual policies, to the extent the applicable state alternative mechanism so provides, for qualifying individuals and group policies for 2-50 employees and guaranteed renewability for all group and individual insurance policies, subject to certain conditions) to deny or discriminate in making coverage available based upon an

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ Department of Health and Human Services, Center for Medicare and Medicaid Services, Program Memorandum, Insurance Commissioners, Insurance Issuers, Transmittal No. 02-04, September 2002.

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ Department of Health and Human Services, Center for Medicare and Medicaid Services, Program Memorandum, Insurance Commissioners, Insurance Issuers, Transmittal No. 02-05.

individual's health status. Insurers' ability to deny or non-renew coverage for qualifying individuals (to the extent provided in the state alternative mechanism for implementing HIPAA, to date 47 states have indicated they will implement an alternative mechanism) and for groups is eliminated unless one of the statutorily specified limited basis exists or the stringent notice and market withdrawal requirements are met. Thus, certain individual and group health insurance is made more accessible to all individuals regardless of their health status. While the accessibility is increased, there are no limits in HIPAA on what amounts can be charged for the health coverage. HIPAA does not require an employer to provide any health coverage to its employees, nor does it require an employer to pay for any health coverage, so the access provided by HIPAA is not access that any employer is required to purchase for its employees.⁹¹ If an employer does offer health benefits to an employee or his dependents, HIPAA's protections apply to the employee and the dependent in the same way.⁹²

1. Health Status Discrimination Prohibited - Access Only? Accessibility issues are addressed generally in ERISA § 702, PHSa § 2702 and Code § 9802.⁹³ These sections require group health plans and health insurance issuers offering group health insurance to not establish rules for eligibility or continued eligibility⁹⁴ for any individuals for enrollment that are based on any of the health status related factors enumerated below. Rules for eligibility include and are not limited to rules relating to enrollment, effective date of coverage, waiting or affiliation periods, late and special enrollment, eligibility for benefits packages (including rule relating to changing selection among benefit packages), and benefits includes covered benefits, benefit restrictions and cost sharing, copayment, coinsurance, continued eligibility and terminating coverage.⁹⁵
 - a. health status;
 - b. medical condition (mental or physical);
 - c. claims experience;
 - d. receipt of health care;
 - e. medical history;
 - f. genetic information;
 - g. evidence of insurability (including conditions arising out of acts of domestic violence);⁹⁶ or

⁹¹ CRS Report CRS-3.

⁹² CRS Report CRS-8.

⁹³ PHSa § 2741 for individual policies.

⁹⁴ 29 C.F.R. § 2590.702(b)(1)(i); Treas. Reg. § 54.9802-1(b)(1)(i); and 45 C.F.R. § 146.121(b)(1)(i) (2001) (effective May 8, 2001 (66 F.R. 14076)); Joint Committee on Taxation General Explanation (Blue Book) of Tax Legislation Enacted in 104th Congress (JCS-12-96), Issued 12-18-96 (the "Blue Book"), Blue Book p. 358.

⁹⁵ 29 C.F.R. § 2590.702(b)(1)(ii); Temp. Treas. Reg. § 54.9802-1T(b)(1)(ii); 45 C.F.R. § 146.121(b)(1)(ii) (2001) (effective for plan years beginning on or after July 1, 2001).

⁹⁶ 29 C.F.R. § 2590.702(a)(2)(i); Treas. Reg. § 54.9802(a)(2)(i); and 45 C.F.R. § 146.121(a)(2) (2001) (effective

- h. disability.⁹⁷ HCFA has interpreted state laws regarding succeeding carriers in the context of a disabled individual to be preempted if they do not protect the individual's ability to enroll in the succeeding carrier coverage. HCFA explained that HIPAA's prohibition on health status discrimination and its preexisting condition exclusion limitation preempts a state law if it prohibits a succeeding carrier from covering/enrolling an employee who is disabled or not actively at work.⁹⁸ The decision of whether to enroll at initial eligibility versus under a special enrollment or as a late enrollee by itself is not a health factor; thus benefit packages may vary for late enrollees.⁹⁹

Additional guidance on what does and does not constitute prohibited discrimination based upon a health status factor was also provided in the 2001 regulations. Requiring a late enrollee to either pass a physical exam or to satisfy evidence of insurability criteria to enroll is prohibited discrimination based upon a health status. Restricting late enrollees to only enroll in an HMO option while permitting other enrollees to select between HMO or PPO coverage is permissible because being a late enrollee is not a health status. A plan may not exclude individuals who engage in risky activities if they do not enroll at first eligibility. A plan may not exclude an individual based upon a history of high health claims.¹⁰⁰ An employer whose insurance contract for its group health plan is canceled due to late payment of premiums cannot allege a violation of HIPAA nondiscrimination provision under 29 U.S.C. § 1182 as an ERISA enforcement action because an employer does not have standing to sue for benefits under 29 U.S.C. § 1132.¹⁰¹

2. Evidence of Insurability Prohibited. The legislative history for HIPAA indicates that this evidence of insurability requirement is intended to ensure that individuals are not excluded from health care coverage due to their participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities, nor can they be required to pass a physical examination to enroll.¹⁰² Participating in motorcycling, snowmobiling, ATV riding and skiing qualify as evidence of insurability.¹⁰³ However, the preamble to the Temporary Regulations

May 8, 2000 (66 F.R. 14076)).

⁹⁷ Temp. Treas. Reg. § 54.9802-1T(a)(1), 29 C.F.R. § 2590.702(a)(1) and 45 C.F.R. § 146.121(a)(1).

⁹⁸ 29 C.F.R. § 2590.702(a)(1); Treas. Reg. § 54.9802-1(a)(1); and 45 C.F.R. § 146.121(a)(1) (2001) (effective May 8, 2001 (66 F.R. 14076)); Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 00-04, Aug. 2000.

⁹⁹ 29 C.F.R. § 2590.702(a)(3); Temp. Treas. Reg. § 54.9802-1T(a)(3); and 45 C.F.R. § 146.121(a)(3) (2001) (effective for the first plan year beginning on or after July 1, 2001).

¹⁰⁰ 29 C.F.R. § 2590.702(b)(1)(iii), Ex. 1-4; Temp. Treas. Reg. § 54.9802-1T(b)(1)(iii); and 45 C.F.R. § 146.121(b)(1)(iii) (2001) (effective for plan years beginning on or after July 1, 2001).

¹⁰¹ *Healthtek Solutions, Inc. v. Fortis Benefits Insurance Company*, 274 F. Supp.2d 767 (E.D. Va. 2003).

¹⁰² 29 C.F.R. § 2590.702(b)(1)(iii) Ex. 1; Treas. Reg. § 54.9802-1(b)(iii) Ex. 1; and 45 C.F.R. § 146.121(b)(iii) Ex. 1 (2001) (effective May 8, 2001 (66 F.R. 14076)); Blue Book p. 358.

¹⁰³ 29 C.F.R. § 2590.702(a)(2)(ii); Temp. Treas. Reg. § 54.9802-1T(a)(2)(ii); and 45 C.F.R. § 146.121(a)(2)(ii)

indicated that the regulators desire comments on whether source of injury exclusions should be permitted under HIPAA. The plan is not to be knowingly designed to exclude individuals and their dependents on the basis of health status.

3. Nonconfinement and Actively at Work Clauses. A participant, or any of the participant's dependents, cannot be denied enrollment or have their enrollment delayed based upon a nonconfinement or actively at work clause.¹⁰⁴ Actively at work clauses that require a person to be actively at work in order for coverage to become effective constitute prohibited health status based discrimination unless an absence from work due to any health factor is treated as being actively at work. Requirements for consecutive days of employment violate the health status based discrimination prohibition unless absences due to health status are treated as periods of consecutive employment. A requirement that you must be actively at work on the first day after 30 days of employment because of an absence on that day would delay coverage. However, a plan may require a participant to begin work before coverage becomes effective. A plan may require completion of a number of hours of service before coverage commences.¹⁰⁵
4. Disparate Impact and Other Laws. The legislative history indicates that if the generally applicable terms of a health plan have a disparate impact on individual enrollees, that is permitted.¹⁰⁶ For example, if a plan excludes all coverage for a specific condition or includes a lifetime cap on certain benefits or a lifetime cap on all benefits. However, group health plans must still consider the impact of the Americans with Disabilities Act on the health plan and any specific benefit limits or caps. These caps are permitted as long as they are not directed at a particular sick employee or dependent.¹⁰⁷
5. Limited Exception for Evidence of Insurability for Certain Church Plans. TRA '97 added an exception to the application of the prohibition on health status based discrimination which permits the use of "evidence of good health" to screen those eligible to obtain coverage under certain church plans (as defined in Code § 414(e)) with 10 or fewer employees (determined without regard to § 414(e)(3)(C) and any self-employed individual or for any individual who enrolls after the first 90 days of initial eligibility; however, this only applies if the plan included this restriction on July 15, 1997 and at all times thereafter before the beginning of the year in which the exception is being used.¹⁰⁸ Proposed Regulations further explained the church plan exemption in 2001. Self insured church plans that qualify for exemption may require evidence of

(2001) (effective for plan years beginning on or after July 1, 2001).

¹⁰⁴ 29 C.F.R. § 2590.702(e)(1); Temp. Treas. Reg. § 54.9802-1T(e)(1); and 45 C.F.R. § 146.121(e)(1) (2001) (effective for plan years beginning on or after July 1, 2001); Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 00-01, March 2000.

¹⁰⁵ 29 C.F.R. § 2590.702(e); Temp. Treas. Reg. § 54.9802-1T(e); and 45 C.F.R. § 146.121(e) (2001) (effective for plan years beginning on or after July 1, 2001).

¹⁰⁶ Blue Book pp. 358-359.

¹⁰⁷ Blue Book p. 359 and Congressional Record-House, July 31, 1996, p. H9519.

¹⁰⁸ Code § 9802(c).

good health for coverage. In order to qualify either (a) a church plan must have required evidence of good health on July 15, 1997 and at all times thereafter **and** either the plan is a plan for an employer of 10 or fewer employees required evidence of good health both of any employee of an employer of 10 or fewer employees and of any self-employed individual, **or** (b) the church plan must have required evidence of good health of any individual who enrolled after the first 90 days of initial eligibility under the plan **and** the plan does not require a longer or shorter period than 90 days.¹⁰⁹

6. Similarly Situated. HIPAA's mandates are intended to preclude plans from singling out similarly situated individuals based on health status or health status related factors for denial of benefits provided to other persons under the plan. "Similarly situated" is used to indicate that plans may provide different benefits to different groups of persons such as different geographical areas, part-time versus full-time or different collective bargaining units.¹¹⁰ Similarly situated individuals must not be grouped based upon a health status based distinction. Similarly situated individuals who are participants may be grouped based upon a bona fide employment based classification consistent with the employer's usual business practices provided those classifications are used for business reasons other than health care. Examples of classifications include, part-time versus full-time, geographic location, date of hire, length of service, current employee versus former employee, and collective bargaining unit membership. Beneficiaries may be treated differently than participants and groups of beneficiaries may be treated differently without violating the discrimination prohibition. For example, a spouse may be treated differently than a dependent child, dependent children may be grouped by age and/or full-time student status. A plan may not create or modify a coverage class if it is directed at an individual based on a health status factor unless the distinction provides the persons with the health status greater rights than required by law.¹¹¹
7. Premium Differentials. The Blue Book clarifies that the prohibition on discrimination based on health status is intended to preclude insurers from denying coverage to employees based on health status and related factors they traditionally have used.¹¹² The Blue Book further indicates that this provision is meant to prohibit insurers and employers from excluding employees from group coverage or from charging an employee a higher premium based on their health status or other factors that lead to higher costs, this is a practice known as list billing which is prohibited in the regulations for plan years beginning on or after July 1, 2001.¹¹³ The premium may not be different based on a health factor of an individual that varies from similarly situated individuals.¹¹⁴ The Blue Book advocates that this does not preclude anyone from

¹⁰⁹ Prop. Treas. Reg. § 54.9802-2 (2001).

¹¹⁰ 29 C.F.R. § 2590.702(b)(2)(i)(A); Treas. Reg. § 54.9802-1(b)(2)(i)(A); and 45 C.F.R. § 146.121(b)(2)(i)(A) (2001) (effective May 8, 2001 (66 F.R. 14076)); Blue Book p. 359.

¹¹¹ 29 C.F.R. § 2590.702(d); Temp. Treas. Reg. § 54.9802-1T(d); and 45 C.F.R. § 146.121(d) (2001) and 29 C.F.R. § 2590.702(g); Temp. Treas. Reg. § 54.9802-1T(g); and 45 C.F.R. § 146.121(g) (2001) (effective for plan years beginning on or after July 1, 2001).

¹¹² Blue Book p. 359.

¹¹³ 45 C.F.R. § 146.121(c)(2)(ii) (2001).

¹¹⁴ 29 C.F.R. § 2590.702(c)(1)(i); Treas. Reg. § 54.9802-1(c)(1)(i); and 45 C.F.R. § 146.121(c)(1)(i) (2001).

charging the entire group a higher premium, but only from singling out individuals for higher premiums or dropping their coverage.¹¹⁵ Increasing the premium for the entire group is permitted.¹¹⁶ A plan may establish a premium or contribution differential based upon an individual's compliance with a bona fide wellness program.¹¹⁷

- B. Wellness Programs. The Regulations clarify that health status based discrimination is prohibited with respect to (1) eligibility to enroll and (2) in premiums or contributions.¹¹⁸ Discounts, rebates, payments in kind and other premium differential mechanisms are used to determine if there is discrimination.¹¹⁹ However, the Temporary Regulations also state that the prohibited health status based discrimination does not (1) limit the amount an **employer** may be charged by an insurer for coverage **or** (2) prevent a group health plan or insurer from establishing premium discounts or rebates or modifying otherwise applicable co-payments or deductibles in return for adherence to a bona fide wellness program available to similarly situated individuals.¹²⁰ However, the health status based discrimination prohibition is not intended to restrict the amount that can be charged for coverage under the health plan or to prevent the group health plan or health insurance issuer from establishing premium discounts, rebates or otherwise modifying the applicable co-payments or deductibles in return for a participant's adherence to programs of health promotion and disease prevention.¹²¹

The regulations define a bona fide wellness program as a program of health promotion and disease prevention; however, receipt of benefits under the wellness program cannot be dependent upon achieving a certain health status.¹²² This means that health promotion programs and wellness programs that solely reward employees for certain healthy habits or lifestyles with reduced premiums or rebates, are not prohibited by HIPAA or by the Temporary Regulations provided the wellness program does not condition the benefit on attainment of a health status.¹²³

All wellness programs still must be reviewed under the Americans With Disabilities Act. The 2001 Proposed Treasury Regulations define a bona fide wellness program as a program that either (1) provides a reward that is not contingent on satisfying a standard related to a health factor, or (2) complies with the following four requirements:

¹¹⁵ Blue Book p. 359.

¹¹⁶ 29 C.F.R. § 2590.702(c)(2)(i); Treas. Reg. § 54.9802(c)(2)(i); and 45 C.F.R. § 146.121(c)(2)(i) (2001) (effective May 8, 2001 (66 F.R. 14076)).

¹¹⁷ 29 C.F.R. § 2590.702(c)(3); Treas. Reg. § 54.9802(c)(3); and 45 C.F.R. § 146.121(c)(3) (2001) (effective May 8, 2001 (66 F.R. 14076)).

¹¹⁸ Treas. Reg. § 54.9802-1(b)(1); 29 C.F.R. § 2590.702(b)(1); and 45 C.F.R. § 146.121(b)(1) (2001) (effective May 8, 2001 (66 F.R. 14076)).

¹¹⁹ 29 C.F.R. § 2590.702(c)(2)(ii); Temp. Treas. Reg. § 54.9802-1T(c)(2)(ii); and 45 C.F.R. § 146.121(c)(2)(ii) (2001) (effective for the first plan year beginning on or after July 1, 2001).

¹²⁰ Treas. Reg. § 54.9802-1T(b)(2)(ii); 29 C.F.R. § 2590.702(b)(2)(ii); and 45 C.F.R. § 146.121(b)(2)(ii) (2001) (effective May 8, 2001 (66 F.R. 14076)).

¹²¹ Congressional Record-House, July 31, 1996 p. H9519 and Blue Book p. 359 and Temp. Treas. Reg. § 54.9802-1T(a)(2), 29 C.F.R. § 2590.702(a)(2) and 45 C.F.R. § 146.121(a)(2).

¹²² Temp. Treas. Reg. § 54.9802-1T(b)(3), 29 C.F.R. § 2590.702(b)(3) and 45 C.F.R. § 146.121(b)(3) (2001).

¹²³ Temp. Treas. Reg. § 54.9802-1T(b)(3), 29 C.F.R. § 2590.702(b)(3) and 45 C.F.R. § 146.121(b)(3) (2001).

- (a) the reward for the wellness program combined with the reward for all other wellness programs must not exceed 10%, 15% or 20% of cost of employee only coverage under the plan. Employee only coverage is total of employer plus employee cost of employee only coverage, and the reward can be discount, premium rebate or contribution rebate or waiver of all or part of cost sharing program (deductibles, copayments or coinsurance) or absence of surcharge, **and**
- (b) the program must be reasonably designed to promote good health or prevent disease and it must give individuals the opportunity to qualify for the program at least once each year, **and**
- (c) reward must be available to all similarly situated individuals and this means it must allow a reasonable alternative standard to obtain the reward to any individual who for that period it is unreasonably difficult due to a medical condition to satisfy the otherwise required standard, **and** it must allow a reasonable alternative standard to obtain the reward to any individual for whom for that period it is medically inadvisable to attempt to satisfy the otherwise applicable standard for the reward, **and**
- (d) the plan must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard. The Proposed Regulation includes model language that can be used for the notice.¹²⁴

C. No Mandated Benefits. ERISA § 702 attempts to clarify that the prohibition on discrimination against individuals based on their health status is not to be construed as requiring a health plan or health insurance coverage to provide any particular benefits, or to prevent the plan from establishing limitations or restrictions on the amount, extent, or nature of benefits or coverage for similarly situated individuals. The regulations clarify that a group health plan is not required to provide coverage for any particular benefit to a group of similarly situated individuals. The benefit restrictions may be uniformly applied to all similarly situated individuals and must not be directed at any individual based on a health factor. A plan may impose limits, exclusions, annual and lifetime limits, copays, coinsurance and may vary cost sharing for an individual who participates in a bona fide wellness program. A plan amendment that is applicable to all similarly situated individuals in one or two groups of similarly situated individuals that is made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered directed at any individual.

An amendment made as the result of claims submitted by an individual that is targeted at the individual's illness violates HIPAA's prohibition on health status based discrimination. Limits may not be based on a health status such as a lower limit on treatment of congenital heart defects. A prescription drug program can limit covered prescriptions to those in a formulary list.¹²⁵

The prohibitions on discrimination apply to eligibility to enroll and the rules defining any applicable waiting period. The health status discrimination provision prohibits requiring any individual to pay a premium or a contribution that is greater than any premium or contribution

¹²⁴ Prop. Treas. Reg. § 54.9802-1(f); Prop. 25 C.F.R. § 2590.702(f); and Prop. 45 C.F.R. § 146.121(f) (2001).

¹²⁵ 29 C.F.R. § 2590.702(b)(2)(i); Temp. Treas. Reg. § 54.9802-1T(b)(2); and 45 C.F.R. § 146.121(b)(2) (2001).

required for a similarly situated individual who is enrolled in the plan on the basis of health status related factors related either to the individual or a dependent of the individual.

While HIPAA stated no mandated benefits, see XII. discussing the Newborns' Act and the Mental Health Parity Act of 1996 which were enacted on September 26, 1996, regarding benefit mandates and also see how IV.L. eliminating preexisting conditions for pregnancy interacts when a late enrollee described in IV.G. joins the plan in the 9th month of pregnancy resulting in mandated pregnancy coverage for the late enrollee if the employer is subject to the Pregnancy Discrimination Act.

- D. Source of Injury Exclusions. If a group health plan otherwise provides benefits for the treatment of a type of injury, it may not deny benefits otherwise provided for a type of injury because the injury resulted from either an act of domestic violence or a medical condition (either physical or mental). The regulations address self inflicted injury exclusions and states that if the injury is the result of depression, a recognized medical condition, a group health plan may not deny benefits. Similar coverage for an overdose that occurs as the result of an addiction may not be denied coverage because an addiction is recognized as a mental illness.¹²⁶
- E. Nondiscrimination Regulation Transition Rules. The timing of the transition rule provisions depends on whether or not there was good faith compliance with HIPAA.
1. Not Good Faith Compliance. For denials of coverage that were not in good faith compliance, a plan must offer enrollment by March 9, 2001, delayed to May 8, 2001.¹²⁷ The plan must give at least a 30 day enrollment period.
- a. A previous denial was not in good faith compliance if the previous denial of coverage was based on a health status factor.
 - b. Coverage is treated as denied if the individual did not apply for coverage because it was reasonable to believe application was futile due to a plan provision that discriminated based on a health status factor **or** the individual was not offered the opportunity to enroll and the failure to give the individual the application violated section 702 of ERISA or section 9802 of the Code or section 2702 of PHSA.
 - c. A denial was not in good faith if the plan denied coverage to a dependent because he was not able to engage in normal life activity and the plan never permitted the dependent to enroll after HIPAA became effective and the denial was not permitted under any guidance.
 - d. If the prior denial of coverage was not in good faith compliance, the plan must give an opportunity to enroll retroactively to the effective date of ERISA section 702 and Code section 9802, or if later, the date the individual met the eligibility requirements of the plan that did not discriminate on health status factor.

¹²⁶ 29 C.F.R. § 2590.702(b)(2)(iii); Temp. Treas. Reg. § 54.9802-1T(b)(2)(iii); and 45 C.F.R. § 146.121(b)(2)(iii) (2001) (effective for plan years beginning on or after July 1, 2001).

¹²⁷ 66 F.R. 14076 (2001).

- e. The plan must permit coverage to be effective when the plan received a request for enrollment with respect to this enrollment opportunity.
- f. The enrollment date for an enrollment under this transition rule is the date the plan was first covered by HIPAA, or, if later, the date the individual was first eligible to enroll regardless of when coverage was effective.
- g. The preexisting condition exclusion period is measured for non-good faith denials from the enrollment date.
- h. If the individual elects retroactive enrollment, the plan may provide benefits as if the individual had been enrolled and may require the individual to pay the premiums for coverage, but may charge no interest on premium.¹²⁸

2. Individuals Denied Coverage Based on Good Faith Interpretation of HIPAA's Nondiscrimination Rules.

- a. An individual previously denied enrollment based upon a good faith interpretation of HIPAA includes: prior to HIPAA the plan permitted persons to enroll when first eligible and on each anniversary of the plan year if the individual passed a physical exam, the employee did not enroll at initial eligibility and failed at subsequent enrollment opportunities to pass the physical exam requirement before HIPAA was in effect. The plan then eliminated late enrollment and no opportunity to enroll was provided after the plan became subject to HIPAA.
- b. Because the coverage was previously available to the employee without regard to any health factor and because the plan acted in good faith interpreting HIPAA, the plan must allow the individual to enroll at the next annual enrollment of the plan for the first plan year beginning on or after July 1, 2001.
- c. The plan may not treat a person enrolling under these transition rules as a late enrollee or as a special enrollee.
- d. The enrollment date for individuals enrolling under the transition rule is the effective date for HIPAA for the plan or if the individual otherwise first became eligible to enroll for coverage after HIPAA's effective date for the plan, on the date the individual was first eligible to enroll in the plan.
- e. The plan must give the affected individuals notice and an opportunity to enroll for at least 30 days before the first day of the first plan year beginning on or after July 1, 2001.¹²⁹

¹²⁸ 29 C.F.R. § 2590.702(i)(3)(i) and (ii); Temp. Treas. Reg. § 54.9802-1T(i)(3)(i) and (ii); and 45 C.F.R. § 146.121(i)(3)(i) and (ii) (2001).

¹²⁹ 29 C.F.R. § 2590.702(i)(3)(iii); Temp. Treas. Reg. § 54.9802-1T(i)(3)(iii); and 45 C.F.R. § 146.121(i)(3)(iii) (2001).

3. Special Transitional Rule for Self-Funded Non-Federal Governmental Plans Exempted Under 45 C.F.R. § 146.180.
 - a. If an individual was denied coverage because a non-Federal governmental plan elected to opt-out of HIPAA and then the plan sponsor later chooses to bring the plan into compliance with HIPAA's requirements under the plan, the plan must do the following:
 - i. The plan must notify the individual that the plan will be complying with HIPAA, specify the effective date of compliance, and inform the individual of any enrollment restrictions that may apply under the plan when the plan is in compliance with HIPAA (may send notice to all employees);
 - ii. The plan must give the individual the opportunity to enroll that continues at least 30 days;
 - iii. The plan must permit coverage to be effective as of the first day of plan coverage to which HIPAA applies or July 1, 2001; and
 - iv. The plan may not treat the individual as a late enrollee or special enrollee.
 - b. An individual is considered to have been denied coverage if the individual failed to apply for coverage because of the non-federal governmental plan's election to opt out of HIPAA and it was reasonable to believe that an application for coverage would have been denied due to a health factor.
 - c. A non-federal governmental plan may elect into only parts of HIPAA.¹³⁰
 - d. Applicability dates for non-collectively bargained plans and collectively bargained plans are found at 45 C.F.R. § 146.125.

IV. Portability and Coverage Issues Related to Preexisting Condition Limitations

Portability and increased access to coverage is achieved by limiting the duration of the preexisting condition limitations or exclusions that health plans and insurance policies may impose to no more than 12 months as a general rule for those enrolling when they are first eligible or under a special enrollment period. Any preexisting condition limitation or exclusion must be reduced by continuous creditable coverage that is maintained until a date within 63 days of the "enrollment date." Preexisting condition limitations are also eliminated in certain situations, such as pregnancy and the addition of a newborn child or newly-placed for adoption or newly-adopted child within 30 days of birth, adoption or placement for adoption. HIPAA also changes the restrictions that can be applied to persons who do not enroll in the plan at their initial eligibility by developing new types of enrollees, "special enrollees" and "late enrollees." Special enrollees arise as the result of loss of coverage or the addition of a dependent and those situations are defined in the Temporary Regulations. Those who qualify as special enrollees are only subject to the general 12-month preexisting condition limitation, subject to reduction for prior

¹³⁰ 45 C.F.R. § 146.121(i)(4).

creditable coverage. Late enrollees are subject to an 18-month preexisting condition limitation, subject to reduction for prior creditable coverage. Portability does not mean that you can take a specific health insurance coverage from one job to another, but that once you obtain health insurance, you can use evidence of that coverage to reduce or limit preexisting condition limitations that might otherwise apply in your subsequent health plan or insurance coverage, provided you do not incur a 63-day break in coverage.¹³¹

HIPAA addresses limitations on preexisting conditions contained in health benefit plans by first limiting what can be treated as a preexisting condition, second by limiting the duration of the preexisting conditions, and third by crediting individuals who previously had "creditable coverage" with credits against the period of the preexisting condition exclusion. Thus, HIPAA limits any period during which a person would not be covered for preexisting health problems. Imposing a preexisting condition exclusion in compliance with HIPAA's statutory requirements is not a violation of the health status based discrimination prohibition.¹³² Reducing a preexisting condition exclusion based on a period without a claim violates the health status based discrimination prohibition.¹³³

- A. Imposition of Preexisting Condition Exclusions or Limitations. In order for a group health plan to be able to impose a preexisting condition exclusion, the employer must notify the employee that they intend to impose a preexisting condition limitation including the terms of any preexisting condition exclusion in the plan, the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods), a description of the right of the individual to request a certificate from a prior plan or issuer, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer if necessary.¹³⁴

- B. Creditable Coverage Reduces Preexisting Condition Exclusions. Procedural steps were added by the Temporary Regulations to address the determination of creditable coverage (see notice requirements for imposing preexisting condition exclusions described in IV.A.). The Temporary Regulations define how creditable coverage will be determined by "days of coverage."¹³⁵ Days of coverage prior to a significant break in coverage (63 days without any creditable coverage) are not counted; however, waiting periods (regardless of whether or not they lead to actual coverage) and affiliation periods are not taken into account in determining a significant break in coverage.¹³⁶ Creditable coverage may either be counted on the standard method by days of coverage or under any other method that is at **least** as favorable to the individual as the days method (e.g., counting days, but terminating the preexisting condition exclusion on the first day of the month in which it expires rather than on the 8th day where it

¹³¹ CRS Report CRS-2.

¹³² 29 C.F.R. § 2590.702(b)(3); Temp. Treas. Reg. § 54.9802-1T(b)(3); and 45 C.F.R. § 146.121(b)(3) (2001) (effective for plan years beginning on or after July 1, 2001).

¹³³ 29 C.F.R. § 2590.702(b)(3), Ex. 2; Temp. Treas. Reg. § 54.9802-1T(b)(3), Ex. 3; and 45 C.F.R. § 146.121(b)(3), Ex. 2 (2001) (effective for plan years beginning on or after July 1, 2001).

¹³⁴ 29 C.F.R. § 2590.701-3(c), Temp. Treas. Reg. § 54.9801-3T(c) and 45 C.F.R. § 146.111(c).

¹³⁵ Temp. Treas. Reg. § 54.9801-4T(b)(2), 29 C.F.R. § 2590.701-4(b)(2) and 45 C.F.R. § 146.113(b)(2).

¹³⁶ Temp. Treas. Reg. § 54.9801-4T(b)(2), 29 C.F.R. § 2590.701-4(b)(2) and 45 C.F.R. § 146.113(b)(2).

would have been expired under the days method).¹³⁷ Coverage that has not yet terminated must be counted as creditable coverage to reduce a preexisting condition exclusion period.¹³⁸

1. Preexisting Condition Exclusion and Creditable Coverages - the Standard Method. The concept of creditable coverage is used under HIPAA to eliminate preexisting conditions in a subsequent plan by applying the prior creditable coverage as a credit against the preexisting condition exclusion. Creditable coverage is prior coverage that results in a participant receiving credits for that coverage in a subsequent health plan to reduce the subsequent health plan's preexisting condition limit exclusion, similar to the way college credits may transfer from one school to the next.¹³⁹ Coverage can be credited under one of two methods. The standard method credits prior coverage against the preexisting condition exclusion provision in the subsequent plan for any continuous creditable coverage that was maintained within 63 days of the enrollment date in the current plan. The crediting occurs based solely on the fact that the other creditable coverage, that is not excepted coverage (as described below in IV.E.3.), existed without considering what benefits were provided under the prior plan.¹⁴⁰ Coverage under a reimbursement account or arrangement such as a flexible spending account (as defined in Code § 106(c)(2)) does not constitute coverage within any category under the alternate method of crediting coverage according to the Temporary Regulations. However, the Temporary Regulations do not specifically exclude health flexible spending account coverage from the definition of creditable coverage under the description of the standard method of crediting coverage, thus, its treatment is uncertain.¹⁴¹ The standard method applies the reduction to the preexisting condition exclusion applicable to all benefits in the subsequent plan regardless of whether the same benefits were covered in the predecessor plan.

2. Alternate Method for Crediting Coverage. The health plan or health insurance issuer offering group health insurance coverage may elect to credit coverage based on the coverage of benefits within several classes or categories of benefits that are specified in regulations. The crediting based on classifications of coverage must be applied on a uniform basis for all participants and beneficiaries.¹⁴² The Conference Report in the Congressional Record-House on July 31, 1996, clarified that the review of classes and categories of benefits was not to consider the level of benefits provided.¹⁴³ The initial categories of benefits are defined in the Temporary Regulations as mental health, substance abuse treatment, prescription drugs, dental care or vision care.¹⁴⁴ Differences

¹³⁷ Temp. Treas. Reg. § 54.9804-4T(b)(2)(v), 29 C.F.R. § 2590.701-4(b)(2)(v) and 45 C.F.R. § 146.113(b)(2)(v).

¹³⁸ Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 99-01, June 1999.

¹³⁹ CRS Report CRS-2).

¹⁴⁰ ERISA § 701(c)(3), PHSA § 2701(c)(3) and Code § 9801(c) and Temp. Treas. Reg. § 54.9801-4T(b), 29 C.F.R. § 2590.701-4(b) and 45 C.F.R. § 146.113(b).

¹⁴¹ Temp. Treas. Reg. § 54.9801-4T(c)(6)(i), 29 C.F.R. § 2590.701-4(c)(6)(i) and 45 C.F.R. § 146.113(c)(7)(i).

¹⁴² ERISA §§ 701(b)(3)(A) and (B), PHSA § 2701(b)(3) and Code § 9801(c)(3) and Temp. Treas. Reg. § 54.9801-4T(c)(2), 29 C.F.R. § 2590.701-4(c)(2) and 45 C.F.R. § 146.113(c)(2).

¹⁴³ Congressional Record-House, July 31, 1996, p. H9517.

¹⁴⁴ Temp. Treas. Reg. § 54.9801-4T(c)(3), 29 C.F.R. § 2590.701-4(c)(3) and 45 C.F.R. § 146.113(c)(3).

in deductibles were suggested as a possible classification that could be considered as a different class of benefits provided the difference is not a minor difference such as \$250 versus \$200; however, the Temporary Regulations did not expand the categories to include differences in deductibles.¹⁴⁵ If a plan decides to use the alternate method for crediting coverage, the plan must state prominently in any disclosure statements that such a method will be used to determine qualifying coverage and the plan will be required to include a description of the effect of the plan's election to use such alternate method in the disclosure. Not only must the use of the alternative method of crediting coverage be disclosed to the employees, but it must also be set forth in the **plan**.¹⁴⁶ The notice and the plan must

- a. prominently state that the plan is using the alternative method of counting creditable coverage in any disclosure statements on the plan (e.g., the summary plan description);
- b. state prominently to each enrollee at the time of enrollment that the plan counts creditable coverage using the alternative method; and
- c. the disclosure must describe the effect of using the alternative method and the categories used by the plan.¹⁴⁷

Under the alternative method the plan first looks back 365 days for initially eligible enrollees or special enrollment enrollees and 546 days for late enrollees to determine what coverage existed during this period, the "determination period." The plan must count all days of coverage that occurred in the determination period, regardless of whether or not a significant break in coverage existed for any category of benefits during the determination period. The plan must then reduce the individual's preexisting condition exclusion period for that category by the number of days of coverage the individual had for that category of benefits during the determination period regardless of whether or not the coverage of the category of benefits was maintained throughout the determination period.¹⁴⁸

An insurer must notify each employer at the time of the offer or sale of the coverage of its use of this alternative election. A description of the certifications of creditable coverage and disclosures of prior coverage categories is described below in II.F.

- C. Preexisting Condition Defined. HIPAA defines what constitutes a "preexisting condition exclusion"¹⁴⁹ for a group health plan, is a condition, either physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within a six month period ending on the enrollment date.¹⁵⁰ The preexisting

¹⁴⁵ Congressional Record-House, July 31, 1996, p. H9517.

¹⁴⁶ Temp. Treas. Reg. § 54.9801-4T(c)(2), 29 C.F.R. § 2590.701-4(c)(2) and 45 C.F.R. § 146.113(c)(2).

¹⁴⁷ Temp. Treas. Reg. § 54.9801-4T(c)(4), 29 C.F.R. § 2590.701-4(c)(4) and 45 C.F.R. § 146.113(c)(4).

¹⁴⁸ Temp. Treas. Reg. § 54.9801-4T(c)(6), 29 C.F.R. § 2590.701-4(c)(6) and 45 C.F.R. § 146.113(c)(7).

¹⁴⁹ § 701(a)(2) of ERISA (PHSA § 2701(a) and Code § 9801(a).

¹⁵⁰ Temp. Treas. Reg. § 54.9801-3T(a)(1), 29 C.F.R. § 2590.701-3(a)(1) and 45 C.F.R. § 146.111(a)(1).

condition must have been present before the enrollment date; however, medical advice, diagnosis, care or treatment need not have been requested or received prior to the enrollment date in order for the condition to be treated as a preexisting condition. Genetic information cannot be treated as a preexisting condition. The Blue Book provides that, AA preexisting condition exclusion is a limitation or exclusion of benefits relating to a condition, whether physical or mental, based on the fact that the condition was present before the enrollment date, whether or not any medical advice, diagnosis care or treatment was recommended or received before that date.¹⁵¹ The examples in the Temporary Regulations distinguish between medical care received for a condition and merely a follow up visit that was recommended, but not received. Since the follow up visit did not occur and the treatment preceded the six-month look back period, the medical condition for which the follow up care was recommended in the six-month look back period was not sufficient to make the condition a preexisting condition. This implies that a follow up visit may not be considered medical advice, diagnosis care or treatment that was recommended or received. The examples also distinguish between care solely as the result of an injury and increased care required for the same injury as the result of a preexisting condition. These may be challenging distinctions for claims administrators to adjudicate when reviewing claims.¹⁵² The limitation of the preexisting condition exclusion and the guaranteed issue provisions of HIPAA result in coverage availability (at some cost) on the same terms almost universally either through an individual policy (provided certain conditions are met) or group plan. Any waiting period or affiliation period runs concurrently with any preexisting condition exclusion period.¹⁵³ The waiting period or affiliation period starts the counting of the preexisting condition exclusion period even though there may be no coverage during this period because the maximum length of the preexisting condition exclusion is measured from the enrollment date.¹⁵⁴ Since these provisions were contained in ERISA, PHSA and the Code, they will apply to all group health plans including governmental health plans and church plans. Plan sponsors must not only review the stated preexisting condition exclusion in the plan, but should also review the plan's general exclusions for any provisions tied to when an injury or illness arose that operate as preexisting condition exclusions.

- D. Preexisting Condition Limitation Period Reduced for Creditable Coverage. Any preexisting condition period that is imposed by a group health plan must be reduced by any period of creditable coverage that ends within 63 days of the enrollment date.¹⁵⁵ If the termination of creditable coverage and the enrollment date are separated by a period of 63 days or more during which the individual is not covered with any creditable coverage, then the individual may be subjected to the preexisting condition exclusion without receiving any credit for prior coverage. Any waiting period for coverage or an affiliation period for an HMO is not counted in determining whether there was a break in coverage under the 63-day rule.¹⁵⁶ The waiting period is any period that the plan requires to pass while an individual is employed before the individual

¹⁵¹ Blue Book p. 357.

¹⁵² Temp. Treas. Reg. § 54.9801-3T(a)(i)(C), examples 1 and 4, 29 C.F.R. § 2590.701-3(a)(1)(i)(C), examples 1 and 4, and 45 C.F.R. § 146.111(a)(1)(C), examples 1 and 4.

¹⁵³ Blue Book p. 358.

¹⁵⁴ Temp. Treas. Reg. § 54.9801-3T(a)(1)(ii), 29 C.F.R. § 2590.701-3(a)(1)(ii) and 45 C.F.R. § 146.111(a)(1)(ii).

¹⁵⁵ ERISA § 701(c)(2), PHSA § 2701(c)(2) and Code § 9801(c)(2) and Temp. Treas. Reg. § 54.9801-3T(a)(1)(iii), 29 C.F.R. § 2590.701-3(a)(1)(iii) and 45 C.F.R. § 146.111(a)(1)(iii).

¹⁵⁶ ERISA § 701(c)(2), PHSA § 2701(c)(2) and Code § 9801(c)(2).

can become covered under the health plan at initial eligibility.¹⁵⁷ Waiting periods generally follow achieving an eligible status according to informal discussions with individuals in the U.S. Department of Labor; however, this point is not clearly stated in the Temporary Regulations, nor do the Temporary Regulations address individuals who move in and out of an eligible status when the plan's eligibility determination and waiting period run concurrently.

An affiliation period is a period used by health maintenance organization in place of a waiting period for any health coverage that is offered by the health maintenance organization. The affiliation period may only be used if there is no preexisting condition exclusion imposed for coverage by the organization, the affiliation period is uniformly applied without regard to health status related factors and the affiliation period does not exceed two months, or three months for a late enrollee. Any affiliation period must run concurrently with any waiting period imposed by the plan.¹⁵⁸ The plan must notify the individual in writing of (1) its determination of the preexisting condition exclusion period that applies to the individual, (2) the basis for that determination, (3) the source and substance of any information on which the plan relied in making its determination, and (4) a written explanation of any appeal procedures established by the plan. The plan must also provide the individual with a reasonable opportunity to present additional evidence of creditable coverage.¹⁵⁹

E. What is or is not Creditable Coverage?

1. Creditable Coverage. The types of health care coverage that can be used as creditable coverage to credit against the preexisting condition limitation in a new plan includes coverage under:
 - a. a group health plan;
 - b. health insurance coverage;
 - c. either Part A or Part B under Medicare;
 - d. Title 19 of the Social Security Act coverage other than coverage consisting solely of benefits under § 1928;
 - e. coverage under Chapter 55 of Title X of the United States Code;
 - f. medical care program of the Indian Health Service or tribal organization;
 - g. a state health benefits risk pool;
 - h. a health plan offered under Chapter 89 of Title V of the United States Code (Federal Employees Health Benefit Program);

¹⁵⁷ ERISA § 701(b)(4), PHSA § 2701(b)(4) and Code § 9801(b)(4).

¹⁵⁸ ERISA § 701(g), PHSA § 2701(g) and Code § 9801(g) and Temp. Treas. Reg. § 54.9801-2T, 29 C.F.R. § 2590.701-2, and 45 C.F.R. § 144.103.

¹⁵⁹ Temp. Treas. Reg. § 54.9801-5T(d)(2), 29 C.F.R. § 2590.701-5(d)(2) and 45 C.F.R. § 146.115(d)(2).

- i. a public health plan as defined in the regulations; or
 - j. a health benefit plan under § 5(e) of the Peace Corps Act (22 U.S.C. § 2504(e)).¹⁶⁰
2. Not Creditable Coverage. Creditable coverage does not include coverage that is treated as an "excepted benefit." Excepted benefits¹⁶¹ are not subject to the requirements of HIPAA. Excepted benefits may not be used as creditable coverage. Excepted benefits include:
- a. coverage only for accidents or disability income or a combination thereof;
 - b. coverage issued as a supplement to liability insurance;
 - c. liability insurance including general liability insurance and automobile liability insurance;
 - d. workers' compensation or similar insurance;
 - e. automobile medical payment insurance;
 - f. credit only insurance;
 - g. coverage for on-site medical clinics; or
 - h. any other similar insurance coverage that may be specified in regulations under which the benefits for the medical care is secondary or incidental to other insurance benefits.

Creditable coverage for purposes of using the alternative method of crediting coverage under the categories of coverage does not include coverage under a health flexible spending account or medical reimbursement account described in Code § 106(c)(2), does not count as coverage under any of the categories.¹⁶²

3. Excepted Benefits - Not Creditable Coverage. There are certain other benefits that can be excepted and not treated as part of the creditable coverage and not subject to the requirements of HIPAA if offered separately. These benefits, if offered separately and if they are not an integral part of the plan, are not subject to the requirements of HIPAA and are not treated as creditable coverage. The Temporary Regulations break the excepted benefits into four categories, provided they first are offered separately and are not an integral part of the plan. The four categories are limited scope, long term care, non-coordinated benefits and supplemental benefits.

¹⁶⁰ ERISA § 701(c), PHSA § 2701(c) and Code § 9801(c) and Temp. Treas. Reg. § 54.9801-4T(a)(1), 29 C.F.R. § 2590.701-4(a)(1) and 45 C.F.R. § 146.113(a)(1).

¹⁶¹ ERISA § 706(c), PHSA § 2791(c) and Code § 9805(c) [renumbered as § 9832 by TRA '97].

¹⁶² Temp. Treas. Reg. § 54.9801-4T(c)(6)(i), 29 C.F.R. § 2590.701-4(c)(6)(i) and 45 C.F.R. § 146.113(c)(7)(i).

- a. Limited scope benefits -- Limited scope benefits are dental or vision benefits that are sold or offered under a separate policy or rider and that are limited in scope to a narrow range or type of benefits that are generally excluded from hospital/medical/ surgical benefit plans or packages.¹⁶³ Similar or limited benefits as may be specified in the regulations. The regulations specify that limited benefits must not be an integral part of the plan. This means the participant must be able to elect to receive or not to receive these benefits and if they elect to receive the benefits they must pay an additional premium. The regulations also require that these benefits must be of a limited scope under a separate policy or rider. The limited scope must be for a narrow range or type of benefits that are generally excluded from hospital/medical/surgical benefits packages, policies or plans.¹⁶⁴
- b. Other Excepted Benefits -- Benefits for long term care, nursing home care, home health care, community based care or a combination thereof are excepted benefits.
- c. Non-coordinated Benefits Coverage -- Other benefits that cannot be treated as creditable coverage and are not subject to HIPAA are the following if these coverages are offered as independent non-coordinated benefits:
 - i. coverage that is offered for only a specified disease or illness (such as cancer policies); or
 - ii. hospital indemnity or other fixed indemnity insurance (e.g., \$100 per day if you are hospitalized). These benefits (1) must be provided under a separate policy or contract, (2) must not coordinate with a group health plan's exclusion (or carve out) of benefits, and (3) must pay benefits regardless of whether other benefits are paid under any other group health plan.¹⁶⁵
- d. Supplemental Benefits Coverage. Medicare supplemental insurance is not subject to the requirements of HIPAA and will not be treated as creditable coverage if it is offered as a separate insurance policy. Medicare supplemental health insurance is defined in § 1882(g)(1) of the Social Security Act as any coverage that is supplemental to the coverage provided under Chapter 55 of Title X of the United States Code and other similar supplemental coverage provided to coverage under a group health plan. Coverage supplemental to CHAMPUS coverage and similar coverage that is supplemental to other group coverage would also be treated as excepted benefits.¹⁶⁶ In order for coverage

¹⁶³ Temp. Treas. Reg. § 54.9804-1T(b)(3)(iii), 29 C.F.R. § 2590.732(b)(3)(iii) and 45 C.F.R. § 146.145(b)(3)(iii).

¹⁶⁴ ERISA § 736(c)(2), PHSA § 2791(c)(2) and Code § 9832(c)(2) and Temp. Treas. Reg. § 54.9804-1T(b), 29 C.F.R. § 2590.732(b)(3) and 45 C.F.R. § 146.145(b)(3).

¹⁶⁵ ERISA § 736(c)(3), PHSA § 2791(c)(3) and Code § 9832(c)(3) and Temp. Treas. Reg. § 54.9804-1T(b)(4), 29 C.F.R. § 2590.732(b)(4) and 45 C.F.R. § 146.145(b)(4).

¹⁶⁶ ERISA § 736(c)(4), PHSA § 2791(c)(4) and Code § 9832(c)(4) and Temp. Treas. Reg. § 54.9804-1T(b)(5), 29 C.F.R. § 2590.732(b)(5) and 45 C.F.R. § 146.145(b)(4).

to qualify as similar supplemental coverage, the supplemental coverage cannot duplicate primary coverage and must be specifically designed to fill gaps in primary coverage coinsurance or deductibles. In order for coverage to satisfy this requirement, it must not be an integral part of a group health plan that only becomes secondary or supplemental when a coordination of benefits provision becomes operative, such a coverage is subject to HIPAA.¹⁶⁷

The IRS, DoL and HHS issued a clarification of the HIPAA regulations on December 29, 1997¹⁶⁸ which stated that a health care flexible spending account will not be creditable coverage and will be treated as an excepted benefit if all of the following three criteria are satisfied: (i) the maximum benefit payable under the health flexible spending account does not exceed twice the employee's salary reduction election under the health flexible spending account for the year (or, if greater, the amount of the employee's salary reduction election under the health flexible spending account for the year plus \$500.00), (ii) the employee has other health care coverage available under a group health plan of the employer for the year, and (iii) the other coverage is not limited to benefits that are excepted benefits. If a health flexible spending account is not treated as an excepted benefit then it is creditable coverage and it is a group health plan subject to the portability provisions of HIPAA. The clarification also included a statement that coverage that consists solely of coverage under such a health flexible spending account does not constitute creditable coverage and also stated in the next paragraph that entities subject to HIPAA may rely on this document in treating benefits under a health flexible spending account that are described in i, ii and iii above as excepted benefits.

- F. Enrollment Date. The enrollment date is defined under HIPAA as either the actual date of enrollment of the individual into the plan or into coverage, or if earlier, the first day of a waiting period set for the enrollment into the plan.¹⁶⁹ The enrollment date is significant in determining the duration of preexisting condition exclusions because it is the starting point for measuring the duration of the preexisting condition going forward and is the last day to the six month look back period for determining preexisting conditions. The preexisting condition exclusion period runs concurrently with any waiting period for enrollment in the plan. The enrollment date is significant also because it ends any period during which days of breaks in coverage are counted. The period of any preexisting condition period runs from the enrollment date resulting in the waiting period (a period without coverage under the plan) reducing the duration of the preexisting condition exclusion that is applied once coverage is effective.¹⁷⁰ A waiting period does not include any period before the late or special enrollment for a late enrollee or a special enrollee.¹⁷¹

¹⁶⁷ Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, Insurance Commissioners, Insurance Issuers, Insurance Standards Bulletin Series, Transmittal No. 99-01, June 1999.

¹⁶⁸ ERISA Technical Release No. 97-01 at 62 Fed. Reg. 67687 .

¹⁶⁹ ERISA § 701(b)(2), PHSA § 2701(b)(2) and Code § 9801(b)(2) and Temp. Treas. Reg. § 54.9801-3T(a)(2)(i) and (ii), 29 C.F.R. § 2590.701-3(a)(2)(i) and (ii), and 45 C.F.R. § 146.111(a)(2)(i) and (ii).

¹⁷⁰ Temp. Treas. Reg. § 54.9801-3T(a)(1)(ii), 29 C.F.R. § 2590.701-3(a)(1)(ii) and 45 C.F.R. § 146.111(a)(1)(ii).

¹⁷¹ Temp. Treas. Reg. § 54.9801-2T, 29 C.F.R. § 2590.701-2 and 45 C.F.R. § 144.103.

- G. Consequences of Late Enrollment. An individual who does not enroll in a group health plan at their original enrollment date or under a special enrollment period is treated as a late enrollee and the preexisting condition maximum period that applies to the late enrollee may extend to 18 months instead of 12 months.¹⁷² A late enrollee is a person who does not enroll when they are first eligible to enroll in the plan or during a special enrollment period; however, if a person previously was covered, terminated his/her employment and then returned to employment in an eligible status only the most recent period of employment is considered when determining if the individual is a late enrollee.¹⁷³ HIPAA and the Temporary Regulations do not specify when a late enrollee must be covered or that late enrollees must be permitted to enter a plan.
- H. Late Enrollees Who Are Not Late Enrollees. Group health plans that excluded individuals on the basis of health status related factors prior to the enactment of HIPAA received a clarification regarding how the health plan must treat these previously excluded individuals after the enactment of HIPAA that was issued by the Departments of Treasury, Labor and Health and Human Services on December 29, 1997.¹⁷⁴ The clarification states that if an employee or dependent were previously denied coverage before HIPAA's effective date based on a health status related factor or because the individual failed to apply for coverage previously because it was reasonably believed that an application for coverage would be futile due to a plan provision discriminating on the basis of a health status related factor, then if the individual enrolls when first eligible on or after the effective date of HIPAA, the individual cannot be treated as a late enrollee. The clarification further states, "These rules apply whether or not the plan offers late enrollment. These rules do not change the special enrollment rules that prohibit treating a special enrollee as a late enrollee." The clarification leaves us with a number of questions regarding these individuals such as, what is the enrollment date for such an individual, what is the waiting period, how do we determine the enrollment date for this person?
- I. Special Enrollment Periods. A special enrollment period will occur for an employee who is eligible, but did not enroll in the plan if 1. or 2. are satisfied. The special enrollment periods statutory language requires careful review when determining how these special enrollment periods might apply to retiree health plans.

There are two types of special enrollment periods under HIPAA. Special enrollment periods can either be dependent special enrollments or special enrollments that occur as the result of an individual's loss of coverage, provided certain requirements are satisfied in each case.

1. Special enrollment of an individual as a result of the loss of coverage.
 - a. Who is eligible to enroll as the result of loss of coverage?
 - i. An employee can enroll under a special enrollment if the employee is eligible and had not enrolled for coverage under the terms of the plan when it was originally offered or previously offered to the employee, and the employee previously declined the coverage as a result of

¹⁷² ERISA § 701(a)(2), PHSA § 2701(a)(2) and Code § 9801(a)(2).

¹⁷³ ERISA § 701(b)(3), PHSA § 2701(b)(3) and Code § 9801(b)(3) and Temp. Treas. Reg. § 54.9801-3T(a)(2)(iii), 29 C.F.R. § 2590.701-3(a)(2)(ii) and 45 C.F.R. § 146.111(a)(2)(iii).

¹⁷⁴ ERISA Technical Release 97-02, 62 Fed. Reg. 67689.

having coverage under another group health plan or health insurance coverage.

- ii. A dependent can be enrolled under a special enrollment as the result of loss of coverage if the dependent is the dependent of an employee who is participating in the plan and the dependent was eligible but had not enrolled for coverage when enrollment was previously offered because the dependent was covered under another group health plan or had other health insurance.
- iii. Both an employee and a dependent can be enrolled under a special enrollment as the result of loss of coverage if the employee and dependent previously were eligible, but had not enrolled for coverage under the terms of the plan when the coverage was previously offered to the employee or the dependent, and that coverage was declined because the employee or the dependent was covered under another group health plan coverage or other health insurance coverage. This means that there only needed to have been coverage declined previously for either the employee or the dependent in order for both the employee and the dependent to take advantage of the special enrollment provisions.

b. Conditions that must be met for special enrollment as the result of loss of coverage.

- i. When the employee previously declined coverage because other coverage existed, the employee declined in writing, the plan required a written declination of coverage and the employee was given the model notice of enrollment rights and consequences. The plan must include a provision requiring a written declination of coverage due to other coverage if it is going to enforce such requirement.
- ii. The model notice of enrollment rights read as follows:

If you are declining coverage or 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 the result of a 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.

c. When the individual declined the coverage they had other coverage and that coverage was either COBRA coverage or other coverage and either the COBRA had been exhausted (the maximum period was met) or the coverage has terminated because of loss of eligibility or the employer has ceased contributing toward the coverage.

- d. The loss of eligibility for coverage would include loss of coverage as the result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing items. Loss of eligibility does not include loss due to failure of the individual or participant to pay premiums on a timely basis or termination for cause such as making fraudulent claims or intentional misrepresentations of facts in connection with the plan. Exhaustion of COBRA is defined in II.D.3.b.
 - e. Duration of special enrollment period for loss of coverage. In order for an employee to request enrollment for the employee and/or the employee's dependents under a special enrollment period for loss of coverage, the employee must notify the employer no later than thirty (30) days after the other coverage is exhausted. The plan may also impose the same requirements on individuals under special enrollments that they would apply to other employees who otherwise are eligible under the plan who immediately request enrollment or coverage, such as the requirement that they make the request in writing.
 - f. Effective date of enrollment. Enrollment under a special enrollment period as the result of loss of coverage is effective no later than the first day of the calendar month beginning after the date that the completed request for enrollment is received.¹⁷⁵
2. Dependent special enrollment periods for certain dependent beneficiaries. This provision permits certain dependents of a participant to take advantage of a special enrollment period under certain circumstances, if they request enrollment on a timely basis.
- a. Who is eligible to enroll under a dependent special enrollment period?
 - i. An employee can be enrolled under a dependent special enrollment period if the employee is eligible but is not enrolled in the plan, and the employee would be a participant but for the fact the employee had previously elected not to enroll in the plan during a previous enrollment period, and another individual becomes a dependent of the employee by marriage, birth, adoption or placement for adoption. Thus, an employee who is eligible but not enrolled can enroll in the plan if they become married, have a child either through birth, adoption, or placement for adoption.
 - ii. A spouse of a participant can be enrolled in a dependent special enrollment period if either the individual becomes a spouse of the participant (i.e., the individual marries the participant); or the individual is already a spouse of the participant and a child becomes the dependent of the participant through birth, adoption or placement

¹⁷⁵ ERISA § 701(f), PHS § 2701(f) and Code § 9801(f) and Temp. Treas. Reg. § 54.9801-6T(a), 29 C.F.R. § 2590.701-6(a), and 45 C.F.R. § 146.117(a).

for adoption. It is important to note that the spouse can only be added in this situation if the employee is already a participant in the plan (however see iii. below).

- iii. Dependent special enrollment for an eligible unenrolled employee and the spouse of the employee. If an employee is eligible, but did not enroll in the plan, and an individual who is dependent on the employee is eligible but unenrolled, and either the individual married the employee, or if the individual was married to the employee and they have a child that becomes a dependent of the employee through birth, adoption or placement for adoption, and the employee could have been a participant but for the prior election not to enroll in the plan, then the employee and the spouse can be enrolled under the dependent special enrollment program if the change in status is either because of marriage to the employee or because of the addition of a child through birth, adoption or placement for adoption.
 - iv. A dependent of a participant may be enrolled through a special enrollment period. If the individual is dependent on the participant and becomes a dependent as the result of marriage, birth, adoption or placement for adoption, that dependent may be added to the health plan as a dependent of a participant. This does require that the employee first be a participant before the dependent can be added to the plan. This does not permit dependents to be added separately if the employee is not a participant.
 - v. Both an employee who is eligible but not enrolled and a new dependent can be enrolled under the dependent special enrollment program. If the employee was not enrolled but was eligible for the plan and another individual is a dependent of the employee and the employee would have been a participant but for a previous election not to enroll during a prior enrollment period and the dependent is added to become a dependent of the employee as the result of marriage, birth, or adoption or placement for adoption, then the employee and the new dependent can both be enrolled.
- b. When must the dependent special enrollment period begin? The special enrollment period is a period of not less than thirty (30) days beginning on the date of marriage, birth, adoption or placement for adoption during which the individual may enroll themselves or the dependents. The special dependent enrollment period cannot begin before the date the plan would make dependent coverage generally available.
 - c. Effective date of enrollment. If the dependent special enrollment period was triggered as the result of marriage, the enrollment effective date for coverage cannot be later than the first day of a calendar month beginning after the date the enrollment materials were received by the plan.

If the dependent special enrollment period arises as the result of the birth of a dependent, the effective date of enrollment is the date of such birth. This means that an individual who is added as an employee or as a spouse as the result of the birth of a dependent would be covered back to the date of birth and not at the time of the normal special enrollment period as the result of loss of coverage.

In the event that a dependent's adoption or placement for adoption is the event triggering the dependent special enrollment period, then the coverage must be effective on the date of such adoption or placement for adoption.¹⁷⁶

3. Plan sponsors offering the health plan through a cafeteria plan under Code § 125 initially needed to use caution when changing the individual's coverage and election under the cafeteria plan. HIPAA and the regulations did not alter the requirements for changing elections under cafeteria plans to incorporate HIPAA's special enrollment period concepts. A change in health plan enrollment under a special enrollment period would not have necessarily equated with a change in family status under the cafeteria plan; thus some special enrollments may have resulted in a portion of the premium being paid with after-tax dollars. The Treasury Department initially addressed the discrepancy between the special enrollment periods and the changes in family status permitted under the proposed cafeteria plan regulations.¹⁷⁷

- J. A Preexisting Condition Exclusion Will Not Apply in Certain Situations for Newborns. The preexisting condition exclusion under any health plan or any group health insurance contract issued by a health insurance issuer does not apply to an individual, if as of the last day of the 30-day period beginning with their date of birth the individual is covered under creditable coverage. This exception does not apply after the end of the first 63-day period during which the individual newborn was not covered under any creditable coverage at any time. If a 63 day break in coverage occurs, this will result in the newborn being subject to preexisting condition limitations.¹⁷⁸ The Temporary Regulations clarify the scope of the legislative prohibition on any group health plan imposing a preexisting condition exclusion on a newborn that was added within 30 days of birth to cover not only the plan in which the infant is initially enrolled, but also any subsequent plan in which the individual is enrolled without incurring a break in coverage.¹⁷⁹ Thus, a newborn infant covered under **any** creditable coverage within 30 days of birth will not be subject to a preexisting condition exclusion in that plan or in any future plan as long as the individual does not incur a significant break in coverage. The Temporary Regulations include an example demonstrating this transfer of the no-preexisting condition exclusion to subsequent plans covering the newborn. This will require plan administrators to make special inquiries regarding dependent children (with 18 months of coverage or less) of new employees since the timing of enrollment for newborns is not specifically addressed on certificates of creditable coverage.

¹⁷⁶ ERISA § 701(f)(2), PHSA § 2701(f)(2) and Code § 9801(f)(2) and Temp. Treas. Reg. § 54.9801-6T(b), 29 C.F.R. § 2590.701-6(b) and 45 C.F.R. § 146.117(b).

¹⁷⁷ Prop. Treas. Reg. § 1.125-2Q/A6(c) by issuing new Temporary Regulations on November 7, 1997 which were originally scheduled to be effective for plan years beginning after December 31, 1998. 62 Fed. Reg. 60165 and 60196.

¹⁷⁸ ERISA § 701(d), PHSA § 2701(d) and Code § 9801(d).

¹⁷⁹ Temp. Treas. Reg. § 54.9801-3T(b)(1), 29 C.F.R. § 2590.701-3(b)(1) and 45 C.F.R. § 146.111(b)(1).

- K. Preexisting Condition and Adoptees. Preexisting condition limitations and exclusions will not apply to children adopted or placed for adoption before reaching the age of 18 years, if as of the last day of the 30-day period beginning on the date they were either adopted or placed for adoption, they were covered by creditable coverage. This is determined without considering any coverage that existed prior to the date of adoption or placement for adoption. If an individual is covered by creditable coverage at the time they are adopted or placed for adoption or within 30 days of such dates, and they lose coverage for 63 days, then the preexisting condition exclusion may apply to such individual.¹⁸⁰ While the statutory provisions addressing preexisting condition exclusions for Adoptees and individuals placed for adoption mirror the statutory provisions for newborns, the Temporary Regulations' provision on preexisting conditions for newborns refers to "any creditable coverage" while the regulations for Adoptees and children placed for adoption refer to "creditable coverage" and the provisions for Adoptees does not include the example demonstrating the carryover of the prohibition on imposing preexisting condition exclusions in the subsequent coverage. Since the statutory provisions mirror each other and the Omnibus Budget Reconciliation Act of 1993 mandates comparable treatment of Adoptees and children placed for adoption in health plan enrollment, one might presume that the regulatory provisions should also reflect the same restrictions; hence, the children placed for adoption and Adoptees should also be able to carry their prohibition on the imposition of preexisting condition exclusions forward to subsequent health plans provided they do not incur a significant break in coverage. However, this is not clear given the different treatment of the Adoptees and individuals placed for adoption in the Temporary Regulations.¹⁸¹
- L. Preexisting Condition and Pregnancy. If an individual is pregnant, then the group health plan or health insurance plan offering coverage may not impose any preexisting condition exclusion relating to the pregnancy as a preexisting condition. This provision applies even if there is a break in coverage of 63 days.¹⁸² Nothing precludes this provision from applying to late enrollees; however, there is no mandate on the effective date of coverage for the late enrollee. There is also no mandate that plans permit late enrollees to enroll.
- M. Waiting Periods/Affiliation Periods.
1. Waiting Periods -- Waiting periods are the periods that must pass before an individual is eligible to be covered under a group plan or policy.¹⁸³ **Any** waiting period, regardless of whether or not it leads to coverage, is not counted as breaks in coverage.¹⁸⁴ Waiting periods are not treated as breaks in coverage. However, employers do not issue certificates of creditable coverage to individuals identifying waiting periods when no coverage is ever obtained; thus an employer's only alternative is to rely on employee's ability to prove that he/she was in a waiting period. This may prove a difficult area to

¹⁸⁰ ERISA § 701(d), PHSA § 2701(d) and Code § 9801(d).

¹⁸¹ Cf. ERISA § 701(d)(1) and (2), PHSA § 2701(d)(1) and (2) and Code § 9801(d)(1) and (2) with Temp. Treas. Reg. § 54.9801-3T(b)(1) and (2), 29 C.F.R. § 2590.701-3(b)(1) and (2) and 45 C.F.R. § 146.111(b)(1) and (2).

¹⁸² ERISA § 701(d), PHSA § 2701(d) and Code § 9801(d) and Temp. Treas. Reg. § 54.9801-3T(b)(4), 29 C.F.R. § 2590.701-3(b)(4) and 45 C.F.R. § 146.111(b)(4).

¹⁸³ ERISA § 701(b)(4), PHSA § 2701(b)(4) and Code § 9801(b)(4).

¹⁸⁴ Temp. Treas. Reg. § 54.9801-4T(b)(2)(iv) Example 6, 29 C.F.R. § 2590.701-4(b)(2)(iv) Example 6, and 45 C.F.R. § 146.113(b)(2)(iv) Example 6.

administer since not all employers provide all employees with written statements or handbooks defining waiting periods. The maximum length of waiting periods is not specified in the statute.¹⁸⁵ However, any waiting periods must be applied uniformly to all persons without regard to the health status of the potential plan participant.¹⁸⁶

2. Affiliation Periods -- An affiliation period is the period under a health maintenance organization program that must expire before the coverage becomes effective.¹⁸⁷ An affiliation period must be intended to apply to all new enrollees and beneficiaries. During the affiliation period the HMO cannot be required to provide health care services and it cannot collect any premiums. Any affiliation period commences on the enrollment date. An HMO can use alternative methods to address adverse selection, if approved by state regulators.¹⁸⁸ An affiliation period can only be imposed by a group health plan offering an HMO option for that HMO option if no preexisting condition limit is imposed by the HMO, no premium is charged to a participant or beneficiary for the affiliation period, the affiliation period is applied uniformly without regard to health status, the affiliation period does not exceed two (2) months (or three (3) months for a late enrollee, the affiliation period begins on the enrollment date, and the affiliation period must run concurrently with any waiting period that applies under the plan.¹⁸⁹ There was no corresponding provision in the Temporary Treasury Regulations; thus, this provision would not apply to self-funded church plans that are only subject to the provisions of HIPAA included in the Code.

V. Effective Dates

- A. Alternate June 1, 1997 Notice in Lieu of Certain Certificate of Creditable Coverage Requirements. The new notification requirements related to the certificates of creditable coverage are generally effective for "events" (termination of coverage [at a COBRA qualifying event or otherwise] or termination of COBRA) that occur on and after October 1, 1996. The notice requirements that apply to events occurring on and after October 1, 1996 and prior to June 1, 1997, may be satisfied by either sending those persons a certificate of creditable coverage by June 1, 1997 or by sending those persons the model notice titled, "Important Notice of Your Right to Documentation of Health Coverage" (see Supplements). The reference to this notice in the Temporary Regulations referenced "events."¹⁹⁰
- B. Automatically Issued Creditable Coverage Certificates. Certificates of creditable coverage issued as the result of "events" occurring on and after June 1, 1997, must be completed and issued by employers/plans or insurers regardless of when the Portability and Accessibility provisions of HIPAA apply to the employer/plan. The certificates that must be issued by the employer, in the event of a termination of coverage that is also a COBRA qualifying event must be issued no later than the time the COBRA notice and election forms for the qualifying event

¹⁸⁵ ERISA § 701(c)(2)(B), PHSA § 2701(c)(2)(B), and Code § 9801(c)(2)(B).

¹⁸⁶ CRS Report CRS-7.

¹⁸⁷ ERISA § 701(g)(2), PHSA § 2701(g)(2), and Code § 9801(g)(2).

¹⁸⁸ Blue Book p. 358.

¹⁸⁹ 29 C.F.R. § 2570.701-7(b) and 45 C.F.R. § 146.119(b).

¹⁹⁰ Temp. Treas. Reg. § 54.9801-5T(a)(2)(ii).

must be sent.¹⁹¹ Certificates of creditable coverage that must be issued for events that are not COBRA qualifying events must be issued for events occurring on and after June 1, 1997, within a reasonable time period after the coverage ceases, and if the coverage was COBRA coverage within a reasonable time period after coverage ceases or after any grace period for payment ceases.¹⁹² The PHS A regulation states the timing as "by the earliest date that the issuer acting in a reasonable and prompt fashion can provide the certificate" for individual coverage certificates.¹⁹³

- C. Preexisting Condition Limitation Transition Rule. For individuals enrolled in plans and for whom the plan's preexisting condition exclusion applies at the time that the plan first becomes subject to HIPAA, the preexisting condition limit period cannot extend beyond the maximum permitted under HIPAA and it may be reduced by any creditable coverage the individual had before the enrollment date. This means that an individual described above who enrolled at initial eligibility and who has either 12 months of coverage under the plan or a total of 12 months coverage when the coverage under the plan and creditable coverage are combined would immediately have the preexisting condition exclusion period reduced to zero remaining when the plan became subject to HIPAA. Plans must review all individuals who may be subject to the preexisting condition limitations or exclusions as the result of their recent enrollment (within the last 12 months for initial enrollments and 18 months for late enrollees, or the plan's specified lesser period if the plan provides a lesser period of preexisting condition exclusion) at the time the plan first becomes subject to HIPAA, contact the individuals regarding any prior creditable coverage each may have and appropriately adjust the duration of the preexisting condition limit or exclusion.¹⁹⁴ While the Temporary Regulations provide a transition rule for application of the new preexisting condition exclusions, there is no similar transition rule for plans that permitted enrollment only at initial eligibility with proof of good health with respect to the prohibition on health status based discrimination and the previous exclusion of individuals based on health status factors. This omission may only be temporary since more regulations are expected to be issued.
- D. Portability, Accessibility and Prohibitions on Health Status Discrimination. HIPAA's provisions regarding preexisting condition exclusions and the limitation thereof, prohibitions on health status discrimination, guaranteed access and renewability, creditable coverage, waiting and affiliation periods are effective for plan years (the specified plan year, the deductible or limit year, the policy year or if none of the above apply, the calendar year) beginning on or after July 1, 1997, for all plans other than collectively bargained plans. Where the plan document did not specify the plan year and the summary plan description did specify the plan year, the plan year designated in the summary plan description governs to determine HIPAA's effective date for the plan and not any other communication.¹⁹⁵ Collectively bargained plans that have a collective bargaining agreement between employee representatives and one or more employers

¹⁹¹ Temp. Treas. Reg. § 54.9806-1T and § 54.9801-5T(a)(2)(ii)(A) and 29 C.F.R. § 2590.736(b).

¹⁹² Temp. Treas. Reg. § 54.9806-1T and § 54.9801-5T(a)(2)(ii)(B) and (C), 29 C.F.R. § 2590.736(b) and § 2590.701-5(a)(2)(ii)(B) and (C), and 45 C.F.R. § 146.25 and § 146.115(a)(2)(ii)(B) and (C).

¹⁹³ Interim 45 C.F.R. § 148.124(b)(1)(ii).

¹⁹⁴ Temp. Treas. Reg. § 54.9806-1T(a)(3), 29 C.F.R. § 2590.706-1(a)(3) and 45 C.F.R. 146.125(a)(3) - Note the PHS A regulations in this section begin to refer to "credible" coverage. It appears this is a typographical error and should probably read "creditable" coverage).

¹⁹⁵ *Stang v. Clifton Gunderson Health Care Plan*, 1999 U.S. Dist. LEXIS 16467 (W.D. Wis. 1999).

that was ratified before August 21, 1996 are not subject to HIPAA for plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without considering any extension to the agreement that were agreed to after August 21, 1996). Any plan amendments that are made to the plan solely to conform to HIPAA are not treated as a termination of the collective bargaining agreement.¹⁹⁶

- E. Limitation on Enforcement Actions. No enforcement action will be taken against a health plan or insurer with respect to a violation before January 1, 1998 if the plan or issuer sought in good faith to comply with the requirements.¹⁹⁷
- F. Non-Federal Governmental Plan Opt-Out. Governmental plans that are not maintained by the Federal government, provided that the plan is not insured, or if insured only to the extent it is not insured, may elect to be exempted from any or all of the requirements listed in II.A.5. above, provided the applicable notice requirements are satisfied.¹⁹⁸ The election for collectively bargained plans must be received by HCFA no later than 30 days after:
1. the date of the agreement between the governmental entity and union officials; or
 2. if applicable the ratification of the agreement.

The election for non-union plans must be received by HCFA by the day preceding the first day of the plan year.¹⁹⁹ If a non-federal governmental plan does not make the special election out of portions of HIPAA, HIPAA applies as otherwise described in this II.C. The non-federal governmental plan election out does not release such plan from the certificate of creditable coverage requirements.

VI. Application of Preemption

New ERISA §§ 701 through 703 and 734 through 737 apply to any group health plan subject to ERISA for any plan year if on the first day of such plan year that plan has two or more participants who are current employees.²⁰⁰ A group health plan includes a group health plan, fund or program which would not be an employee welfare benefit program because it is established or maintained by a partnership to provide medical care to present or former partners directly or through insurance reimbursement or otherwise. A participant in a group health plan will also include the partners in such partnership or a self-employed individual who maintains a group health plan covering one or more employees that are participants.²⁰¹

A group health plan is defined as a plan (including a self insured plan) of, or contributed to by, an employer (including a self-employed person) or an employee organization to provide health care directly

¹⁹⁶ Temp. Treas. Reg. § 54.9806-1T(a), 29 C.F.R. § 2590.736(a) and 45 C.F.R. § 146.125(a).

¹⁹⁷ Temp. Treas. Reg. § 54.9806-1T(c), 29 C.F.R. § 2590.736(c) and 45 C.F.R. § 146.125(c).

¹⁹⁸ 45 C.F.R. § 146.180 and § 144.103.

¹⁹⁹ 45 C.F.R. § 146.180(c)(1) and (2).

²⁰⁰ ERISA § 735(a).

²⁰¹ ERISA § 735(d) and PHS § 2721(e)(4).

or otherwise to employees, former employees of the employer, others associated with the employer in a business relationship, or their families.²⁰² While a "plan" can be defined in ERISA by a plan document and a Form 5500, what constitutes a "plan" for purposes of the Code is not as clear. The definition of what constitutes a "plan" for Code purposes will affect how the nondiscrimination rules are applied under the Code. Medical care includes amounts paid for the diagnosis, cure and mitigation, treatment, or prevention of disease affecting any structure or function of the body, amounts paid for transportation that is primarily or essentially to obtain medical care, amounts paid for insurance covering medical care.²⁰³

- A. ERISA Preemption and the Effect of HIPAA on ERISA Preemption. These additional requirements applied to group health plans by HIPAA do not effect ERISA's preemption provisions and there is no limitation of the enforcement provisions under § 502 of ERISA.²⁰⁴ The requirements applicable to group health plans will be enforced as they are enforced under current law except that the Secretary of Labor will not enforce provisions of Title I that are applicable to health insurance issuers.²⁰⁵ PHS § 2722 provides that states will enforce HIPAA's requirements on health insurance issuers. If a state fails to enforce HIPAA, the Secretary of Health and Human Services may enforce it on insurers.²⁰⁶

However nothing precludes an individual from asserting a private right of action under Part 5 of ERISA against any health insurance issuer. The enforcement of the requirements against a health insurance issuer generally will be limited to the civil remedies under the PHS amendments.²⁰⁷ The entity responsible for the violation is subject to the penalty under the regulations issued under the PHS and the responsible entity is determined under 45 C.F.R. § 146.184(d)(3).

- B. Preemption Issues. The exceptions to the preemption provided by § 514(a) of ERISA are expanded to address any state laws on group health insurance reforms that are described in ERISA § 734. Section 734 clarifies that ERISA is not to be construed to supersede any provision of state law that establishes, implements or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage, except to the extent that any state provision prevents the application of any portion of the provision enacted in Part 7 of ERISA.²⁰⁸ The preemption provision is clarified further by stating that nothing in § 701 through § 703 or § 734 through 737 is intended to affect or modify the provisions of § 514 of ERISA with respect to group health plans.²⁰⁹ However, § 734(b) provides that the provisions in ERISA §§ 701 through 703 and 734 through 737 relating to health insurance coverage offered by a health insurance issuer will supersede any state law

²⁰² Temp. Treas. Reg. § 54.9801-2T, Interim 29 C.F.R. § 2590.701-2 and 45 C.F.R. § 144.103.

²⁰³ ERISA § 736(a), PHS § 2791(a) and Code § 9832(d)(3) and Temp. Treas. Reg. § 54.9801-2T, 29 C.F.R. § 2590.701-2 and 45 C.F.R. § 144.103 and Code § 213(d).

²⁰⁴ PHS § 2723 and 29 C.F.R. § 2590.731(b) and 45 C.F.R. § 146.143(b).

²⁰⁵ 45 C.F.R. § 146.184 explains that the provisions of HIPAA related to the health insurance issuers' obligations will first be enforced by the States and second by HCFA.

²⁰⁶ 45 C.F.R. § 146.184 explains the procedures followed when a State fails to enforce HIPAA.

²⁰⁷ Conference Agreement recorded in the Congressional Record-House, July 31, 1996, p. H9520.

²⁰⁸ ERISA §§ 701 through 703 and 734 through 737.

²⁰⁹ ERISA § 734(a)(2).

provision that establishes, implements or continues in effect a standard or requirement applicable to the imposition of preexisting condition exclusions that is specifically governed by § 701 and that differs from the requirements of § 701.²¹⁰ However, there are exceptions. ERISA §§ 701 through 703 and §§ 734 through 737 will not supersede any provision in state law if the state law satisfies one of the following:

1. it substitutes a shorter period preexisting condition, limitation or exclusion than the 12 or 18-month period;
2. it substitutes a longer period than the 63-day period in which coverage may not exist and still requires the plan to credit prior coverage;
3. it provides for a longer enrollment period than the 30-day requirement for special enrollment periods;
4. it prohibits imposing any preexisting condition exclusion with respect to newborns, children adopted or placed for adoption before the age of 18 or for pregnant individuals, or expands those exceptions;
5. it requires additional special enrollment periods for reasons other than individuals who have lost coverage as a result of the expiration of COBRA, or the reduction in employer contributions, or loss of dependency status under another plan;
6. it reduces the maximum period permitted for an HMO to use as an affiliation period; or
7. it shortens the period of time from the "6 month" period for identifying preexisting conditions.²¹¹

While these provisions will affect what is subject to state law and what is subject to federal law, § 734(c) of ERISA clarifies that nothing in ERISA §§ 701 through 703 or §§ 734 through 737 shall be construed as requiring either a group health plan or group health insurance coverage to provide for specific benefits under the terms of the plan or coverage.²¹² However, this does not mean that other laws (such as state insurance laws mandating benefits) requiring certain benefits be provided or requiring that certain conditions be treated on a nondiscriminatory basis will not require the coverage of certain benefits.²¹³ Section 250 of HIPAA reiterates that the amendments made by HIPAA are not to affect the authority of the Secretary of Labor under ERISA § 506(b) with respect to any violations of HIPAA.

- C. Preservation of State Small Group Insurance Reform. State laws applicable to group health insurance issuers are preserved under PHSA § 2723, thus, each state's small group insurance reform provisions, to the extent they are more stringent than the requirements imposed by HIPAA, will survive and continue to apply to the group health insurance plans with respect to the state's small group insurance reform provisions.

²¹⁰ ERISA §§ 734-737.

²¹¹ 29 C.F.R. § 2590.731(c)(2) and 45 C.F.R. § 146.143(c).

²¹² 29 C.F.R. § 2590.731(b) and 45 C.F.R. § 146.143(b).

²¹³ 29 C.F.R. § 2590.731(a) and 45 C.F.R. § 146.143(a).

VII. Enforcement Provisions

HIPAA's access and portability provisions are enforced with a penalty of \$100 per day per violation. The \$100 per day per violation penalty was chosen because Congress believed the present COBRA sanctions were an effective mechanism for enforcement of the provisions of HIPAA on portability, limitations on exclusions of preexisting conditions and prohibitions on excluding individuals based on health status.²¹⁴ The minimum and maximum penalties vary by the type of employer. The party on whom the penalty is imposed may vary by the size of the employer, if the plan is insured.²¹⁵

- A. Enforcement of Health Plan Portability and Accessibility. Section 401 of HIPAA added §§ 9801 through 9803 and §§ 9831 through 9833 of the Code. Sections 9801 through 9803 of the Code mirror §§ 701 through 703 and 734 through 736 of ERISA also added by HIPAA. Section 402 of HIPAA amends and adds one of the enforcement provisions by which the new health insurance portability provisions can be enforced under § 4980D of the Code. Section 4980D of the Code applies to group health plans other than small employer (2-50 employees) insured plans. Small employers sponsoring insured plans are not subject to the tax imposed by the Code, but the insurer is subject to the similar penalty imposed under PHS § 2722. Section 4980D of the Code provides for a tax equal to \$100 for each day with respect to each individual for each act of noncompliance with respect to one of the requirements in Code §§ 9801 through 9833.²¹⁶ The penalty continues to accrue on a daily basis for the failure until the failure is corrected.²¹⁷ If a failure is discovered after the notice of an examination is sent to a taxpayer and the amount is not corrected before the date of the notice and it occurred or continued during the period under the exam, the minimum excise tax shall not be less than the lesser of \$2,500, or the amount of tax that would be imposed using the \$100 per day per individual per failure standards. If the violations are more than de minimis, the minimum amount of the excise tax shall be \$15,000 and not \$2,500.

The excise tax applies to a church plan under § 4980D of the Code; however, the minimum penalty provisions of § 4980D(b)(3) of the Code will not apply to church plans under § 414(e) of the Code. The PHS § 2722 provides for a similar penalty of \$100 per day, per individual, per violation with no maximum limit and no minimum penalty. The penalty in the PHS can be imposed on the health insurance issuer, the plan, if it is a non-federal governmental plan sponsored by two or more employers, or on an employer if it is a non-federal governmental plan with only one sponsor. The party responsible for the violation and the penalty is determined under 45 C.F.R. § 146.184(d).

- B. Waiver of Penalty. The tax under § 4980D of the Code and the civil penalty under PHS § 2722 will not apply where the failure is not discovered by a person exercising reasonable diligence to comply,²¹⁸ and not willful neglect and it is corrected within 30 days of discovery. The tax will not apply if the plan is a church plan that is not insured, the failure is corrected

²¹⁴ Blue Book p. 357.

²¹⁵ See 45 C.F.R. § 146.184(d).

²¹⁶ See Blue Book pp. 357 and 360.

²¹⁷ Blue Book p. 360.

²¹⁸ The failure "was unintentional" per Blue Book p. 360, see also 45 C.F.R. § 146.184(d)(7).

before the close of the correction period determined under the rules of § 414(e)(4)(C) of the Code for correcting violations in church plan status (270 days after the mailing by the Secretary of the Treasury of a notice of default with respect to the failure to comply with the group health plan requirements.²¹⁹ However, the civil penalty under PHSA § 2722 will apply if the church plan is insured and the violation was not corrected within 30 days of the violation's discovery and there is no extended grace period as the result of the church plan status for the insured plan's violation of the PHSA requirements.

The Secretary of the Treasury may waive all or part of the excise tax under § 4980D of the Code to the extent that the tax payment would be excessive relative to the failure involved.²²⁰

- C. Limitation on Penalty. If noncompliance was due to reasonable cause and not willful neglect, a single employer plan may incur the tax, but the tax shall not exceed the lesser of 10% of the aggregate amount the employer paid during the preceding taxable year for all group health plans or \$500,000, whichever is less. This maximum amount shall be calculated for the employer and if not, all persons who are treated as a single employer have the same taxable year, then the taxable years taken into account are determined under the principles of § 1561.²²¹
- D. Penalty Limit for Multiemployer Plans. If the violation occurs in a multiemployer health plan, then the tax imposed will be not greater than the lesser of 10% of the amount paid or incurred by the trust during the taxable year, to provide medical care directly or through insurance, reimbursement or otherwise, or \$500,000. The amount paid to provide medical care is calculated by treating all plans in the multiemployer plan as one plan.²²² If a multiemployer plan violates the requirements, the multiemployer plan is liable for the excise tax under § 4980D of the Code. If the employer is the party violating the requirements, then the employer will be subject to the tax, except in the case of a small employer in which case the insurer will be liable.²²³
- E. Small Insured Group Exception to Penalty on Employer. The tax will not apply to a small employer that has at least two employees and no more than 50 employees on the business days during the preceding calendar year (treating the employer as all employers aggregated under § 414(b), (c), (m) or (o) of the Code) if the violation is solely because of the health insurance coverage offered by the health insurance issuer.²²⁴ However, the insurer will still be subject to the civil penalty under PHSA § 2722(b). Predecessors are also covered by this provisions under §§ 4980D(d)(2)(B) and (C) and PHSA § 2791(e)(6). A "predecessor" is not defined in HIPAA or in the Temporary Regulations that were issued on April 1, 1997.
- F. MEWAs - Party Liable for Penalty. If there is a violation with respect to guaranteed renewability under a multiple employer welfare arrangement, the multiple employer welfare

²¹⁹ Blue Book p. 360, fn. 251, and Code § 4980D(c)(2)(B)(ii).

²²⁰ Blue Book p. 360.

²²¹ § 4980D(c)(3) of the Code.

²²² § 4980D(c)(3) of the Code.

²²³ See § 4980D(c) of the Code and PHSA § 2722 and 45 C.F.R. § 146.184(d).

²²⁴ § 4980D(d) of the Code and Blue Book p. 357.

arrangement will be responsible for the tax.²²⁵ A MEWA must now file a Form M-1 with the U.S. Department of Labor which inquires regarding the MEWA's compliance with HIPAA and the related health plan laws.

- G. Correction of Violation. The failure to comply with the requirements for a group health plan imposed by this Act will be treated as corrected only if the failure is retroactively undone to the extent possible and the person affected by the failure is placed in a financial position which is as good as such person would have been in if such failure had not occurred.²²⁶
- H. Enforcement through ERISA. ERISA § 502 was amended by HIPAA with some conforming amendments under § 502(a)(6) and §§ 502(c)(1) and (2). ERISA § 502(c)(1) was amended to clarify that each violation of the COBRA requirements for notification in § 606 or § 101(e) for a participant and beneficiary is subject to the \$100 per day penalty and shall be treated as a separate violation with respect to each separate participant and beneficiary.

ERISA § 502(c) is amended by adding new paragraph (5) that provides a \$1,000 per day penalty for a multiemployer welfare arrangement providing medical benefits that fails to report as required (but not more often than annually) on their compliance with the guaranteed issue and renewability.

Section 506 of ERISA is amended to provide that the Secretary of Labor may delegate to the states some of the Secretary's authority to enforce the requirements with respect to HIPAA on multiple employer welfare arrangements that are not group health plans. There was no evidence of any such delegation in the Interim Regulations issued by the Department of Labor on April 1, 1997.

- I. Initial Reprieve. According to the CRS Report at CRS-14, no enforcement action will be taken against a group health plan or health insurer with respect to a violation of HIPAA before January 1, 1998, or, if later, the date of issuance of the regulations if the employer or health insurance issuer in good faith sought to comply with HIPAA. The regulations were issued by April 1, 1997 and they clarified that no actions are permitted for any violation of HIPAA before January 1, 1998.²²⁷ The reprieve is over. The DoL is auditing health plans on HIPAA compliance.

VIII. New Notification and Certification Requirements

The Temporary Regulations including the Interim Regulations issued by the U.S. Department of Labor clarified a number of the notification requirements by providing guidance and/or model forms. The Temporary and Interim Regulations also added a number of notification requirements not specifically addressed in HIPAA, but which should facilitate the administration of the health plan's preexisting condition exclusion.

²²⁵ §§ 4980D(c) and (d) of the Code.

²²⁶ § 4980D(f)(3) of the Code.

²²⁷ Temp. Treas. Reg. § 54.9806-1T(c), 29 C.F.R. § 2590.736(c), and 45 C.F.R. § 146.125(c).

- A. Notice of Imposition of Preexisting Condition Exclusion. A group health plan or insurer may not impose a preexisting condition exclusion on a participant or dependent before they notify the participant in writing of:
1. the existence and terms of any preexisting condition exclusion under the plan;
 2. the rights of the individual to demonstrate creditable coverage (and any applicable waiting periods), including a description of the individual's right to request a certificate from a prior plan or insurer;
 3. a statement that the current plan or insurer will assist in obtaining a certificate from a prior plan or insurer.²²⁸

Since this notice must be provided before the preexisting condition exclusion is imposed, it must be provided after the individual is eligible but prior to the effective date for the coverage.

- B. Notice of Enrollment Rights. In order to be able to restrict the ability of employees and dependents to access a special enrollment period to those situations prescribed in HIPAA and in the Temporary and Interim Regulations, the plan must include the restrictions in the plan document and must provide the employee with the following model notice of enrollment rights:

Model Notice of Enrollment Rights

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 a 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.

This notice must be provided on or before the time an employee is offered the opportunity to enroll in the plan.²²⁹ This means that this notice must be provided either at enrollment (e.g., on the enrollment form) or prior to enrollment (e.g., as a separate item distributed to all eligible employees before enrollment). One court has found that when an employer's HR representative explains the group health plan's rules on enrollment, including when the enrollment form must be completed and returned within 31 days, the HR representative was acting as a fiduciary; however, the scope of what she should have disclosed depends on what she knew or should have known as a plan administrator.²³⁰

- C. Notice of Determination of Preexisting Condition Exclusion Period. For each new participant or dependent enrolled in a group health plan or insurance policy, the plan or insurer must notify the individual of its determination of the preexisting condition exclusion that it will impose on that

²²⁸ Temp. Treas. Reg. § 54.9801-3T(c), 29 C.F.R. § 2590.701-3(c) and 45 C.F.R. § 146.111(c).

²²⁹ Temp. Treas. Reg. § 54.9801-6T(c), 29 C.F.R. § 2590.701-6(c) and 45 C.F.R. § 146.117(c).

²³⁰ *Negley v. Breads of the World Medical Plan*, 2003 U.S. Dist. LEXIS 14431 (D. Col. 2003).

individual. These may vary within a family since not all members of any family may have the same amounts of creditable coverage under a plan (e.g., in the case of marriage). This written notice must include the following information:

1. the period the plan determined the preexisting condition exclusion applies to the individual;
 2. the basis for the plan's determination of the preexisting condition exclusion period;
 3. the source and substance of the information that the plan relied upon in its decision in 3.a.;
 4. a written explanation of any appeal procedures the plan established; and
 5. the plan must provide the individual with a reasonable opportunity to submit additional evidence of creditable coverage.²³¹
- D. Notice of Plan's Method of Crediting Coverage. If a plan elects to use the alternate method for crediting coverage based upon categories of coverage, then each participant must, at the time they enroll in the plan and in any other disclosure statements concerning the plan, receive a statement from the employer that includes a statement that prominently describes that the plan has made such election and includes a description of the effect of this election on individuals and identifies the categories used by the plan.²³²
- E. Certification of Creditable Coverage Upon Request. The requirements governing when certificates of creditable coverage must be provided immediately after HIPAA was passed was a bit ambiguous. The Temporary and Interim Regulations attempt to clarify and simplify some of these requirements by breaking the requirements down for "events" occurring (a) after June 30, 1996 and before October 1, 1996; (b) on or after October 1, 1996 and before June 1, 1997; and (c) on and after June 1, 1997.
1. Events Occurring After June 30, 1996 and Before October 1, 1996. If an individual on or after October 1, 1996 requests a certification of their creditable coverage in writing within 24 months of the termination of his/her coverage under the plan, the health plan or health insurance issuer must provide such certification to the individual covering any coverage occurring on or after June 30, 1996. The request must be written for **events** occurring after June 30, 1996 and before October 1, 1996, but the certificate is not required to be provided before June 1, 1997.²³³ An "event" is the loss of coverage at termination of employment or termination of COBRA but this is not clear in the statute. The CRS Report at fn. 6 indicates that for "events" occurring after June 30, 1996 and before October 1, 1996, individuals must request certifications in writing. The CRS

²³¹ Temp. Treas. Reg. § 54.9801-5T(d)(2), 29 C.F.R. § 2590.701-5(d)(2) and 45 C.F.R. § 146.115(d)(2).

²³² ERISA § 701(c), PHSA § 2701(c) and Code § 9801(c) and Temp. Treas. Reg. § 54.9801-4T(c)(3), 29 C.F.R. § 2590.701-4(c)(3) and 45 C.F.R. § 146.113(c)(3).

²³³ CRS Report CRS-5 and fn. 6.

Report at fn. 6 discusses that certifications generally apply to "events" occurring after June 30, 1996, but need not be provided until June 1, 1997.²³⁴

2. Events Occurring on or after October 1, 1996 and Prior to June 1, 1997. For events occurring during this time period, the employer is obligated to provide either a completed certificate of creditable coverage or the Model Notice of Rights to Request Certificate of Creditable Coverage by June 1, 1997. The employer may provide these prior to June 1, 1997 as the CRS Report alluded to at fn. 6. The footnote stated that, "in order to ease administration of this requirement plans and issuers may want to begin issuing certificates of creditable coverage for events before June 1, 1997." The corrected Temporary Regulations refer to events as defined in Temp. Treas. Reg. § 54.9801-5T(a)(2)(ii), 29 C.F.R. § 2590.701-5(a)(2)(ii) and 45 C.F.R. § 146.115(a)(2)(ii) which define events triggering the automatic issuance of certificates of creditable coverage. "Events" are the events of termination of coverage and of COBRA termination, this means that on June 1, 1997 employers should have issued certificates of creditable coverage to all persons who terminated coverage or had their COBRA coverage terminated from October 1, 1996 through May 31, 1997. Thus employers should have maintained lists of all persons whose coverage terminated on or after October 1, 1996 so that they could provide those individuals with certificates of creditable coverage (or the alternative notice) on or before June 1, 1997. Plans and issuers will not be subject to any penalty or enforcement action with respect to crediting or not crediting coverage during the "transition period" (apparently June 30, 1996 through June 1, 1997 (the transition period is not defined)) if the plan or issuer makes a good faith effort to comply.²³⁵ For any coverage period prior to June 30, 1996, the individual can present evidence of creditable coverage and the group health plan should not be subject to any penalty or enforcement action with respect to the issuers crediting or not crediting the coverage if they seek to comply in good faith with the requirements.²³⁶
3. Certificates of Creditable Coverage upon Written Request. Upon request certificates of creditable coverage must be provided by employers upon the written request of an individual after June 1, 1997 if the employee had an "event" of loss of coverage or loss of COBRA coverage within 24 months of the request. These certificates must be provided to the individual reasonably promptly. The CRS Report at CRS-5 indicates that an employee's request for a certificate of coverage must be made not later than 24 months after his/her coverage ends.²³⁷
4. Automatic Issuance of Creditable Coverage Notice at Coverage Termination Dates. Effective for "events" of loss of coverage or loss of COBRA coverage occurring on and after June 1, 1997,²³⁸ the health insurance issuer or group health plan will be required to

²³⁴ Temp. Treas. Reg. § 54.9806-1T(e)(1), 29 C.F.R. § 2590.736-1(e)(1) and 45 C.F.R. § 146.125(e)(1).

²³⁵ CRS Report CRS-5 and 6, fn. 6.

²³⁶ ERISA § 701(e) and Act § 101(g)(2)(B); Congressional Record-House, Conference Agreement July 31, 1996, p. H9531 and Temp. Treas. Reg. § 54.9806-1T(c)(3).

²³⁷ See also ERISA § 701(e)(1)(A)(iii) and Temp. Treas. Reg. § 54.9801-5T(a)(2)(iii), 29 C.F.R. § 2590.701-5(a)(2)(iii) and 45 C.F.R. § 146.115(a)(2)(iii).

²³⁸ ERISA § 701(e) and HIPAA § 101(g)(2)(B).

provide to an individual who ceases to be covered under the plan or ceases to be covered under COBRA continuation coverage, at the time such individual ceases to be covered, a certificate of creditable coverage.²³⁹ The certificate of creditable coverage that must be provided when coverage ceases at the occurrence of a COBRA qualifying event must be provided to the COBRA qualified beneficiary no later than at the time of the COBRA notice and election forms are provided. If a certificate of creditable coverage must be provided when coverage ceases at a time other than a COBRA qualifying event, the certificate of creditable coverage must be provided within a reasonable time period after coverage ceases.²⁴⁰ A certificate of creditable coverage must include a written certification of their period of creditable coverage under either COBRA or the plan and the waiting period imposed with respect to the individual for coverage under the plan.²⁴¹ A group health plan is deemed to have satisfied the requirement if the health insurance issuer offering the coverage provides the certification that is required.²⁴² The certificates of creditable coverage provided by the employer at termination of coverage or termination of COBRA coverage must include coverage on and after June 30, 1996. The participant must request a certificate in writing for events occurring on and after June 30, 1996 and before October 1, 1996.²⁴³ The certificate of creditable coverage may use the model form attached as a supplement to this outline or the plan may develop its own certificate form; however, the certificate must include the following information:

- a. the date the certificate is issued;
- b. the name of the group health plan that provided the coverage described in the certificate;
- c. the name of the participant and/or dependents to whom the certificate applies;
- d. any other information necessary for the plan certifying the coverage in the certificate to identify the individual such as identification numbers under the plan and the participant's name if the certificate is for a dependent;
- e. the name, address and telephone number of the plan administrator or party required to issue the certificate;
- f. the telephone number to call for further information; and
- g. a statement that the individual has at least 18 months or 546 days of creditable coverage disregarding any days before a 63-day break in coverage, or the date any waiting period (or affiliation period) began and the date creditable

²³⁹ Temp. Treas. Reg. § 54.9801-5T(a)(2)(ii), 29 C.F.R. § 2590.701-5(a)(2)(ii) and 45 C.F.R. § 146.115(a)(2)(ii).

²⁴⁰ Temp. Treas. Reg. § 54.9801-5T(a)(2), 29 C.F.R. § 2590.701-5(a)(2), and 45 C.F.R. § 146.115(a)(2).

²⁴¹ ERISA § 701(e)(1)(B).

²⁴² ERISA § 701(e) and HIPAA § 101(g)(2)(B).

²⁴³ HIPAA § 101(g)(2)(B); Congressional Record House-Conference Agreement H9518; CRS Report CRS 5-6 and fn. 6.

coverage began and ended, unless the certificate indicates the coverage is continuing as of the date of the certificate.²⁴⁴

Only the last period of continuous coverage must be included on the certificate. If the same information applies to all members of the family, then all may be covered by one certificate. If the information for members of family differs for some or all members, the certificates may be provided on one certificate if it provides all information for each individual and it separately states the information is not identical. Certificates are not required for excepted benefits (see IV.E.3. for a definition of excepted benefits).²⁴⁵

Certificates of creditable coverage should include the names of dependents. However, a group health plan or insurer that cannot provide the names of dependents or the related coverage information for a dependent may satisfy this requirement for certificates issued automatically by issuing the certificate with the participant's name and specifying the type of coverage the participant had for certificates of creditable coverage issued through June 30, 1998. For certificates of creditable coverage issued after June 30, 1998, the certificates must name the dependents covered by the certificate.

If an individual requests a certificate of creditable coverage, the plan or the insurer must make reasonable efforts to obtain and provide the name of the dependent(s) covered by the certificate if such information is requested to be provided. If a certificate does not include the dependent's name(s), the individual may demonstrate the dependent's coverage in a manner similar to the way a participant's creditable coverage is demonstrated.²⁴⁶

- F. Determination of Creditable Coverage. As a general rule, no period prior to July 1, 1996 shall be generally taken into account under ERISA for determining creditable coverage.²⁴⁷ However, individuals who need to establish creditable coverage for periods before July 1, 1996 may do so through a method outside of the employer certification of coverage by providing evidence of creditable coverage.

A plan must consider all information it obtains or that it is presented on behalf of an individual when it determines the creditable coverage for that individual. The plan must consider the relevant facts and circumstances and determine whether the individual has creditable coverage. A plan must treat an individual as having furnished a certificate of creditable coverage if the individual (a) attests to the period of creditable coverage, (b) presents relevant corroborating evidence of some creditable coverage on waiting periods during the period (such as explanations of benefits, plan correspondence, payroll stubs showing health coverage deductions, plan identification cards, records from medical providers indicating health coverage, third party statements verifying coverage, a certificate of coverage under a group policy and any other

²⁴⁴ Temp. Treas. Reg. § 54.9801-5T(a)(3)(ii), 29 C.F.R. § 2590.701-5(a)(3)(ii) and 45 C.F.R. § 146.115(a)(3)(ii).

²⁴⁵ Temp. Treas. Reg. § 54.9801-5T(a)(3)(iv)-(vi), 29 C.F.R. § 2590.701-5(a)(3)(iv)-(vi) and 45 C.F.R. § 146.115(a)(3)(iv)-(vi).

²⁴⁶ Prop. Treas. Reg. § 54.9801-5T(a)(5)(ii)-(iii), 29 C.F.R. § 2590.701-5(a)(5)(ii)-(iii) and 45 C.F.R. § 146.115(a)(5)(ii)-(iii).

²⁴⁷ HIPAA § 101(g) and CRS Report CRS 5 and 6.

relevant documents evidencing periods of coverage), and (c) the individual cooperates with the plan's efforts to verify coverage. Cooperation includes giving written authorization to request a certificate and assistance in efforts to verify the validity of evidence coverage. A plan may consider an individual's refusal to cooperate, but may not consider an individual's inability to obtain a certificate to be evidence of the lack of creditable coverage.²⁴⁸

- G. Plan's Request for Coverage Description to Determine Creditable Coverage. If an individual enrolls in a plan that has elected the alternative method of crediting prior coverage by class or category, then if that plan or health insurance issuer requests, the entity that issued the certification of creditable coverage must promptly disclose to the requesting plan or issuer, information on the classes of coverage and categories of health benefits. The entity providing the additional information may charge the requesting plan or issuer the reasonable cost of disclosing such information.²⁴⁹
- H. Regulatory Guidance to Provide Additional Protections for Employee Portability of Health Coverage. The Secretary of Labor is directed to establish rules and regulations to prevent an entity that fails to provide the information on creditable coverage from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.²⁵⁰ This was addressed in 29 C.F.R. § 2590.701-5(a)(6), which addresses entities not subject to ERISA and how special certification rules exist for these entities and in 29 C.F.R. § 2590.701-5(c) which requires plans to permit individuals to demonstrate their periods of coverage if they do not have certificates of creditable coverage.
- I. New Quarterly SPD or Notice of Material Reduction in Health Benefits. ERISA § 104(b)(1) is modified by HIPAA § 101(c) requiring group health plans to provide an additional notification to the employees beyond the standard summary plan description in the event there is a modification or a change in the contents of the summary plan description that is a material reduction of benefits under the group health plan. If there is a modification or change in health plan benefits that is a material reduction, then a summary plan description or summary description of the modification or change should be furnished to the participants and beneficiaries no later than 60 days after the adoption of the modification or change. Alternatively, the plan sponsor may provide the summary plan descriptions at regular intervals of not more than 90 days. The interim regulation amends § 2520.104(b)-3(d) to require a notice of material reduction in health benefits for any modification to the plan or change in the SPD information that, independently or in conjunction with other contemporaneous modifications or changes would be considered by the average participant to be an important reduction in benefits or services. The preamble and regulations included as possible material reductions: change in formulas, methodologies or schedules that are the basis for determining benefits; increased deductibles or co-payments; reductions in the managed care network service area; or new conditions or requirements for obtaining services or benefits.²⁵¹ The revised summary plan description requirements are effective for all plan years beginning after June 30, 1997.

²⁴⁸ Temp. Treas. Reg. § 54.9801-5T(c), 29 C.F.R. § 2590.701-5(c) and 45 C.F.R. § 146.115(c).

²⁴⁹ ERISA § 701(e)(2), PHSA § 2701(e)(2) and Code § 9801(e)(2) and Temp. Treas. Reg. § 54.9801-5T(c)(3), 29 C.F.R. § 2590.701-5(c)(3) and 45 C.F.R. § 146.115(c)(3).

²⁵⁰ ERISA § 701(e)(3).

²⁵¹ Interim 29 C.F.R. § 2520.104b-3(d).

- J. Insured Plan Revised SPD Requirements. The summary plan description for any insured group health plan or group health plan in which the insurer is responsible for financing, administration or payment of claims for the plan, the summary plan description must not only include a statement on the type of administration, but also a description of whether the health insurance issuer is responsible for financing the plan, administration of the plan or payment of claims and if so, the name and address of the insurance issuer.²⁵² The new SPD requirements are effective for all plan years beginning after June 30, 1997. A summary plan description must also incorporate a statement of all the procedures to be followed in presenting claims for benefits under the plan, including the procedures a participant may follow at the Department of Labor to seek assistance or information regarding their rights under HIPAA and ERISA with respect to health benefits offered through a group health plan. Additional disclosures are also required by the 2001 amendment to the summary plan description rules.²⁵³ The claims procedures for group health plans and disability benefits were also dramatically changed by final regulations issued in 2000.²⁵⁴ Group health plan SPDs must also include a new reference to the address for contacting the DoL about rights under ERISA, "If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in your telephone directory, or the Division of Technical Assistance and Inquiries, PWBA, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210."²⁵⁵
- K. Multiemployer and MEWA Reporting Requirements. There may be additional reporting requirements imposed on multiple employer welfare arrangements providing health benefit plans. These may be imposed by the Secretary of Labor by regulation. These may be required to be made not more frequently than annually and in the form and in the manner determined by the Secretary of Labor.²⁵⁶
- L. Newborns' and Mothers' Health Protection Act Notice. The Interim DoL Regulations require SPDs for plan years beginning on or after January 1, 1998 to include a statement, if the plan provides maternity or newborn infant coverage. The statement must describe the participant's rights under the Newborns' Act and that Federal law prohibits a plan from restricting benefits for any inpatient hospital stay in connection with childbirth to less than 48 hours following a normal vaginal delivery or to less than 96 hours following a cesarean section delivery and prohibits a plan from requiring that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.²⁵⁷
- M. Electronic SPD. The Interim DoL Regulations add a provision permitting disclosing group health plan SPDs through electronic media provided certain conditions are met. Electronic SPDs are only available to group health plans under the interim regulations if:

²⁵² ERISA § 737(c) and Interim Reg. 29 C.F.R. § 2520.102-3(q).

²⁵³ 65 F.R. 70225 (2000) modifying 29 C.F.R. § 2520.102-3 and 5 (2000).

²⁵⁴ 65 F.R. 70245; 29 C.F.R. § 2560.503-1 (2000).

²⁵⁵ ERISA § 737(c)(2)(A), Interim Reg. 29 C.F.R. § 2520.102-3(l)(2).

²⁵⁶ ERISA § 737(g).

²⁵⁷ Interim Reg. 29 C.F.R. § 2520.102-3(u).

1. the plan administrator takes "appropriate and necessary measures to ensure that the system for furnishing documents results in actual receipt" (examples included return receipt e-mail and surveys confirming receipt);
2. the electronic SPDs must satisfy the SPD regulations' requirements for furnishing SPDs with respect to style, format and content;²⁵⁸
3. each participant is notified either electronically or in writing that the document is being furnished electronically, the document's significance, and the participant's right to request and receive free of charge a paper copy of each document; and
4. if a participant requests a written copy of the SPD or any document delivered electronically, the administrator must provide it at no charge.

Furnishing SPDs and other documents electronically only applies to participants who have the ability to effectively access the documents provided electronically at their worksite, and who have the ability at their worksite to convert the document from electronic media to paper free of charge. The electronic SPD interim regulation is effective on and after June 1, 1997.²⁵⁹

- N. Women's Health and Cancer Rights Act of 1998 Notice. An initial notice was required shortly after enactment and no later than in the next mailing date by the plan or issuer describing the rights enacted under the Women's Health and Cancer Rights Act of 1998 (the "Cancer Rights Act") and no later than January 1, 1999. Another notice must be included each year as part of the mailings to participants and beneficiaries at enrollment and it should also be included in the summary plan description in a prominent place.²⁶⁰

IX. Expansion of Medicare Fraud and Abuse Prohibitions to Health Plans

Additional guidance and regulations on Article IX may have been issued; however, such materials are beyond the scope of this outline.

- A. Health Plans Must Report "Final Adverse Actions".
1. Group Health Plans Must Report to Health Care Fraud and Abuse Data Collection Program. The requirements for fraud and abuse in the Social Security Act, includes a new requirement applicable to group health plans. Under this new provision health plans must report "final adverse actions" against health care providers, suppliers and practitioners. This provision is part of the Health Care Fraud and Abuse Data Collection Program. The Secretary of HHS is to establish this data collection program no later than January 1, 1997. The PHSA contained in Title 42 of the United States Code is amended by adding new § 1128E of the Social Security Act. Each health plan (as defined in § 1128C(c)), including any plan or program that provides health benefits whether directly, through insurance or otherwise and includes a policy of health insurance, contract or service benefit organization and a membership agreement with a

²⁵⁸ See 29 C.F.R. § 2520.102-2 through 2520.102-5.

²⁵⁹ Interim Reg. 29 C.F.R. § 2520.104b-1(c).

²⁶⁰ ERISA § 713.

health maintenance organization or a prepaid health plan, must report any "final adverse action" (not including settlements in which no findings of liability is made) taken against a health care provider, supplier or practitioner.

The health plan is required to report the name and tax identification number of the involved health care provider, supplier or practitioner who is the subject of the final adverse action. The health plan also must report the name, if known, of any health care entity with which the health provider, supplier or practitioner is affiliated or associated, the nature of the final adverse action and whether the action is on appeal and a description of the acts or omissions and injuries upon which the final adverse action was based and such other information as the Secretary determines by regulation.

The information reported is to be maintained confidential and the information is to be protected from disclosure once it is disclosed in a manner similar to the provisions under the Health Care Quality Improvement Act for peer review functions. The new reporting and data bank function is to operate in a manner similar to the National Practitioner Data bank that was implemented under the Health Care Quality Improvement Act of 1986 with limitations on the parties who can request information. Information will be reported to the Secretary of HHS. The Secretary of HHS may disclose information upon request to health care providers, suppliers, and licensed practitioners. The Secretary of HHS is to establish procedures to resolve any disputes regarding the accuracy of the information. The health plan is also required to correct any information that is reported regarding a final adverse action.

Access to this information will be provided to federal and state governmental agencies and health plans, but there will be a fee for such disclosure that approximates the cost of operating the database.

2. Final Adverse Action Defined. A final adverse action that must be reported includes:
 - a. any civil judgment against the health care provider, supplier or practitioner in federal or state court related to the delivery of health care items or service;
 - b. Federal and state criminal convictions related to delivery of the health care item or service; and
 - c. actions by federal or state agencies responsible for licensing and certification of health care providers, suppliers and health care practitioners including:
 - i. official actions such as revocations or suspension of a license, including the length of suspension, any reprimands, censure or probation;
 - ii. any other loss of license or the right to apply for a license of a provider, supplier or practitioner either by operation of law, voluntary surrender, nonrenewability or otherwise for any negative action or finding by a federal or state agency that is publicly available information; or

- iii. exclusions from participation in either the federal or state health care programs or any other adjudicated or decisions by the Secretary, that the Secretary establishes by regulation must be reported. A final adverse action for this purpose is not a malpractice action or any action related to such claim.

B. Coordination of Health Plan Reporting with Fraud and Abuse Enforcement. Section 201 of HIPAA requires that new reporting requirements under § 1128C be coordinated in a law enforcement program to reduce fraud and abuse with respect to federal and state health programs and health plans. The coordinated program will be conducted by the Department of Health and Human Services, the Attorney General and the Office of Inspector General. Interim Regulations on the Fraud and Abuse provisions and the statutory exceptions for shared risk arrangements were issued on November 19, 1999.²⁶¹ The Interim Regulations potentially apply to managed care arrangements because a common strategy of these organizations is to offer physicians, hospitals and other providers increased patient values in exchange for substantial fee discounts and these discounts could be the remuneration prohibited under the Fraud and Abuse provisions.

C. Certain Health Plan Incentives Do Not Violate Fraud and Abuse. HIPAA amends the Fraud and Abuse provisions in the Social Security Act effective for acts and omissions occurring on and after January 1, 1997. The amendment clarifies that certain incentives contained in health plans will not raise fraud and abuse issues. Differentials in co-insurance and deductibles are addressed under § 231 of HIPAA. The "remuneration to induce a referral" that is prohibited under the fraud and abuse statute is broadly defined; thus, any statutory exclusion provides some comfort. The statute amends § 1128A(i) of the Social Security Act by adding a safe harbor from fraud and abuse by defining that while remuneration generally includes waiver of co-insurance and deductible amounts and any part thereof or transfers of items or services for free or for other than fair market value; however, remuneration will not include waiver of co-insurance and deductible by a person if:

1. the waiver is not offered as part of any advertisement or solicitation;
2. the person does not routinely waive co-insurance and deductible amounts; and
3. the person (i) waives co-insurance and deductible amounts after determining in good faith that the individual is in financial need; (ii) fails to collect co-insurance or deductible amounts after making reasonable collection efforts; or (iii) provides for any permissible waiver specified in the fraud and abuse regulations under § 1128B(b)(3) or in any regulations.

This will impact physician office practices of routinely waiving their employees' co-payments and deductibles if the employee is treated at the employer's office.

D. Plan Design Based Incentives for Use of Certain Providers and Promoting Preventive Care Are Permitted. The statute specifically exempts differentials in co-insurance and deductible amounts that are part of a benefit plan design in which the differentials are disclosed in writing to all beneficiaries, third party payors and providers to whom the claims are presented, provided the

²⁶¹ 64 F.R. 63503 (1999).

differentials meet the standards that are to be defined in the regulations promulgated by the Secretary of HHS within 180 days after the enactment (or on or before February 17, 1997). An additional exemption is provided for any incentives given to individuals to promote the delivery of preventative care that are approved by the Secretary of HHS in regulations.

The amendments with respect to waivers of co-insurance and differentials in co-insurance and incentives for preventative care will apply to any acts or omissions occurring on or after January 1, 1997.

- E. Health Care Fraud and Abuse Includes Health Plans and Carries Significant Penalties. Section 242 of HIPAA also added new protection for health care plans by adding a provision in § 1347 defining health care fraud. Health care fraud is committed by a person who knowingly and willfully executes or attempts to execute a scheme or artifice to defraud any health care benefit program or to obtain by means of false or fraudulent pretenses, representations or promises any of the money or property owned by or under the custody or control of the health care benefit program in connection with the delivery or payment of health care benefits, items or services. This provision could be read to impose the penalty on a plan that tries to shift individuals out of its plan by falsifying certificates of creditable coverage to show 18 months of coverage resulting in any subsequent plan (provided there is no break in service) being unable to impose a preexisting condition exclusion and freeing the plan falsifying the record to terminate COBRA as the result of no preexisting condition being imposed by the subsequent plan.

A person who violates this provision may be fined under this title or imprisoned for not more than 10 years or both. If the violation results in a serious bodily injury (as defined in § 1365 of the Title), the person shall not be fined under the title or imprisoned not more than 20 years or both. If the violation results in death the person shall be fined under the title or imprisoned for any term of years or for life or both. A "health care benefit program" is to be defined in § 1347(b) of Title 18 of the U.S.C. However, no § 1347(b) can be located. Chapter 1 of Title 18 of the U.S.C. defines "health care benefit programs" in § 24(b) for purposes of Title 18 as "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit or item or service for which payment may be made under the plan or contract." The Conference Report indicates that a health care benefit program is any public or private plan affecting commerce under which any medical benefit, item or service is provided to any individual and includes the provision of such medical benefits items or services that are paid for by a plan.²⁶² This broad definition of health care benefit program will cover most employee benefit plans providing health benefits. Thus, health plans now can pursue persons who attempt to defraud the plan through reporting the potentially criminal actions. (Some services have reported that this is effective on and after January 1, 1997.)

- F. New Penalty for Theft from Benefit Plans. Section 243 adds additional protections for health plans by amending Title 18 of the United States Code by adding a new § 669 to Chapter 31. Section 243, like § 242 does not include a separate effective date; thus, it must be presumed that there is no delay in the operation of this provision. This section provides that anyone who knowingly and willfully embezzles, steals or otherwise without authority converts to their own use or the use of any other person other than the rightful owners or intentionally misapplies any monies, funds, securities, premiums, credits, property or other assets of the health care benefit

²⁶² Congressional Record- House, July 31, 1996, pp. H9537-H9538.

program shall be fined under this title or imprisoned for not more than 10 years or both. However, if the value of the property does not exceed \$100, the defendant may be fined and imprisoned for not more than one year or both. This applies to any health care benefit program as defined in § 1347(b) of the Title (some services have reported that this is effective on and after January 1, 1997). This provision could also be interpreted to apply to a person falsifying certificates of creditable coverage to shift the responsibility of a participant's health care costs to a new plan.

- G. Other Fraudulent Practices in Connection with Payment for Health Services. Further protection was added in § 244 of HIPAA by adding to Title 18 of the United States Code in Chapter 47, new § 1035 which penalizes anyone in a matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up any tricks, scheme or device of a material fact or makes any material false, fictitious or fraudulent statements or representations or uses any materially false writing or document knowing the same to contain any materially false, fictitious or fraudulent statement or entry in connection with delivery or payment of health care benefit items or services. This can result in a fine or imprisonment of up to five years, or both. This again applies to the health care benefit program defined under § 1347(b) of Chapter 47 of Title 18. This provides health plans with additional sanctions for false billing (some services have reported that this is effective January 1, 1997). This provision could also apply to an individual falsifying certificates of creditable coverage to shift the costs of a former employee's health care to a subsequent plan prematurely.

X. **Benefit Mandates Enacted After HIPAA**

- A. Newborns' and Mothers' Health Protection Act of 1996 (P.L. 104-204). These provisions were originally placed in ERISA and the PHS Act in September 1996. In August 1997, TRA '97 added these provisions to the Code.

1. Effective Date.
 - a. For insured health plans and individual health insurance policies, the law applies to the first contract year on or after January 1, 1998.
 - b. For employee health benefit plans that are either subject to the requirements of the Code or ERISA, or are governmental or insured plans, the law applies to the first plan year beginning on or after January 1, 1998.
 - c. Date of Enactment of original provision - September 26, 1996.
2. Application. After TRA '97 ERISA, the Code and the PHS Act were all amended to include the provisions originally in the Newborns' Act. By amending the Code, church plans that are self-insured are also subject to the Newborns' Act in addition to all ERISA plans, governmental plans and insured plans.
 - a. Application of the Newborns' Act of 1996 ("Newborns' Act"). The Newborns' Act's requirements apply to group health plans subject to ERISA, health

insurance issuers, group health insurance, governmental plans, church plans and individual insurance policies.²⁶³

- b. Exemptions from the Newborns' Act. The Newborns' Act does not apply to a group health plan or group health insurance coverage that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn.²⁶⁴ The Pregnancy Discrimination Act generally applies to employers with 15 or more employees (some states apply a lower threshold). The Pregnancy Discrimination Act requires that disabilities caused by or contributed to by pregnancy be treated for all job related purposes the same as disabilities caused by or contributed to by other medical conditions, under any health or disability insurance plan available in connection with employment.²⁶⁵ This nondiscrimination requirement does not extend to the pregnancy of dependents.²⁶⁶ This means that employers of 15 or more employees that sponsor group health plans will be required to cover the pregnancy of the employee or spouse, but the pregnancy of dependents need not be covered by a group health plan. However, if dependency pregnancy is covered by a group health plan, the Newborns' Act would apply to mandate a minimum length of stay.

3. New Requirements Imposed on Employee Health Benefit Plans and Health Plans - Mandated Coverage.

- a. Employer's Plan Requirements. If Plan provides maternity care (*i.e.*, is the employer subject to the Pregnancy Discrimination Act,²⁶⁷ the Federal law requires 15 or more employees, Indiana requires 6, and Texas requires 15 employees to apply the Pregnancy Discrimination Act), then the coverage must provide:
- i. A minimum of 48 hours inpatient stay following a normal vaginal delivery and a minimum 96 hours inpatient stay following a caesarean section delivery.
 - ii. If the health care provider decides to discharge the mother after consulting with the mother, the discharge may occur earlier than in paragraph 1.

²⁶³ The Newborns' Act amended the provisions in the Health Insurance Portability and Accountability Act of 1996 by renumbering new ERISA §§ 704 through 707 and 731 through 734 and new Public Health Service Act ("PHSA") §§ 2745 through 2747 as §§ 2761 through 2763 and was inserted in Code § 9811 by TRA '97. The Newborns' Act added new §§ 2704 and 2751 to the PHSA. The Newborns' Act added new ERISA § 711. The Newborns' Act was codified in part 2 of 42 U.S.C. §§ 300gg and is part of the provisions which non-federal governmental plans may elect out of its application by filing and distributing the required notice.

²⁶⁴ ERISA § 711(c)(2); PHSA § 2704(c)(2); Code § 9811(c)(2).

²⁶⁵ 29 C.F.R. § 1604.10.

²⁶⁶ 29 C.F.R. § 1604, Appendix Q/A 21.

²⁶⁷ 42 U.S.C. § 2000e(k).

The Newborns' Act does not require delivery in any particular setting. A provider may not be required to obtain authorization from the plan or insurer for a maternity stay of the length in section X.A.3.²⁶⁸

b. Prohibited Incentives. Employer's health benefit plans and insured health plans subject to the Newborns' Act may not:

- i. deny enrollment, renewal or continued coverage to a mother or a newborn who is a participant, beneficiary or policyholder because of compliance with the Newborns' Act;
- ii. provide monetary payments or rebates to encourage mothers to accept less than the Newborns' Act care requirement;
- iii. penalize or reduce or limit reimbursement of an attending health care provider who complies with the Newborns' Act;
- iv. provide incentives to health care providers to treat patients in a manner not in compliance with the Newborns' Act; or
- v. restrict benefits for any portion of a period within a hospital length of stay described in section X.A.3.a. that is less favorable than the benefits for any preceding portion of such stay.²⁶⁹

c. Notice Requirements.

- i. Employee health benefit plans subject to ERISA must provide a summary of material modifications or a revised summary plan description to each participant regarding the Newborns' Act's coverage requirements no later than 60 days after the first day of the first plan year in which the requirements apply.²⁷⁰ See X.A.1. above.
- ii. Health plan issuers (insurers, HMOs, and licensed MEWAs) and governmental plans must provide a summary of the changes to the coverage that result from the Newborns' Act within 60 days of the first day of the first policy year in which the Newborns' Act applies.²⁷¹
- iii. All health plans subject to ERISA must include in their summary plan descriptions for plan years beginning on or after January 1, 1998, a notice indicating that the group health plan 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 normal vaginal delivery or less than 96 hours following a

²⁶⁸ ERISA § 711(a)(1)(B), Code § 9811(a)(1)(B) and PHS § 2704(a)(1)(B) and 2751(a).

²⁶⁹ ERISA § 711(b), Code § 9811(b), PHS § 2704(b) and 2751(a).

²⁷⁰ ERISA § 711(d).

²⁷¹ PHS § 2704(d) and § 2751(b).

caesarean section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.²⁷² This notice must be provided no later than 60 days after the first day of the first plan year beginning on or after January 1, 1998.

- d. Enforcement. The Newborns' Act is to be enforced for employee health benefit plans under the Code and ERISA and for insured plans, insurance contracts and for governmental plans and insurers under the PHSA.
- e. Preemption. Preemption is not to be affected; however, the Newborns' Act's provisions regarding mandatory coverage of inpatient stays (but not follow up care, or definitions), prohibited incentives and notification requirements will not preempt state laws providing greater protections to patients or policyholders; requiring a length of stay that is more than 48 hours following a normal vaginal delivery or 96 hours following a caesarean section; that requires health plans (insured, HMOs, licensed MEWAs) to provide maternity and pediatric coverage in accordance with the guidelines established by the American Collegiate Obstetricians and Gynecologists, American Academy of Pediatrics, or other established professional medical associations, or that because the decision on the length of stay to the attending provider in consultation with the mother.²⁷³

B. Mental Health Parity Act of 1996 ("MHPA") (P.L. 104-204).

1. Effective Date.

- a. For group health plans subject to ERISA or the Code, plan years beginning on or after January 1, 1998.²⁷⁴
- b. For insurance contracts and governmental plans, contract years beginning on or after January 1, 1998.²⁷⁵
- c. Limited duration - the provisions are scheduled to expire September 30, 2001.²⁷⁶ The original Mental Health Parity Act expired on September 30, 2001 and was previously extended and was most recently extended to

²⁷² Interim 29 C.F.R. § 2520.102-3(u).

²⁷³ ERISA § 711(f), Code § 9811(f) (no Code § 9811(e) exists) and PHSA § 2704(f).

²⁷⁴ MHPA § 702(c) and TRA '97 § 1531(c).

²⁷⁵ MHPA § 703(b); however, since the MHPA was codified in part 2 of 42 U.S.C. §§ 300gg it is part of the provision which a non-federal governmental plan may elect out of annually by filing and distributing the required notification.

²⁷⁶ ERISA § 712(f), Code § 9812(f), PHSA § 2705(f), Temp. Treas. Reg. § 54.9812-1T(i), Interim DoL Reg. § 2590.712(i), and 42 C.F.R. § 146.136(i).

December 31, 2003, and again to December 31, 2004.²⁷⁷ The interim final regulations were extended to December 31, 2003.²⁷⁸

- d. Date of Enactment for MHPA - September 26, 1996 and for TRA '97 provision adding the MHPA to the Code - August 5, 1997.
- e. Temporary and Interim Regulations were issued on December 22, 1997 by the Department of Labor, Treasury and Health and Human Services on the Mental Health Parity Act provisions that are effective January 1, 1998; however, nonenforcement will apply if the employer sought in good faith to comply if the violation occurred before the earlier of the first day of the first plan year beginning on or after April 1, 1998, or January 1, 1999.²⁷⁹ No enforcement action shall be taken on violations based upon a different interpretation of the 1% exemption before April 1, 1998 provided the plan is amended to comply by March 31, 1998 and complies with the transition rule notification requirements.²⁸⁰ The Department of Labor announced a technical enactment extending its interim final rules to December 31, 2003.²⁸¹

- 2. Application of New Mental Health Benefit Requirements Imposed. The MHPA applies to "Group Health Plans" that provide mental health benefits that include annual or lifetime limits on benefits, and that are maintained by employers with more than 50 employees. Employer is defined under §§ 414(b), (c), (m) and (o) of the Code.²⁸²

Small group plans with at least two and 50 or less employees are not covered for mental health parity under the MHPA.²⁸³ Individual insurance policies are also not subject to this requirement. Regulations clarify that the small employer exemption applies if the employer on the average employed at least two and not more than 50 employees on business days during the preceding calendar year and employs at least two current employees at the beginning of the current year.²⁸⁴ If the employer was not in existence in the prior year, then the average number of employees the employer reasonably expects to employ on a business day during the current year is used. The employer for the small employer exemption considers all employers aggregated under § 414 (b), (c),

²⁷⁷ Mental Health Reauthorization Act of 2002, P.L. 107-313; and the Mental Health Parity Reauthorization Act of 2003, P.L. 108-197, Dec. 19, 2003.

²⁷⁸ 68 F.R. 38206 (June 27, 2003).

²⁷⁹ Temp. Treas. Reg. § 54.9812-1T(h)(2), Interim DoL Reg. § 2590.712(h)(2) and Interim 42 C.F.R. § 146.136(h)(2).

²⁸⁰ Temp. Treas. Reg. § 54.9812-1T(h)(3), Interim DoL Reg. § 2590.712(h)(2) and Interim 42 C.F.R. § 146.136(h)(2).

²⁸¹ 68 F.R. 18048 (April 14, 2003).

²⁸² ERISA § 712(c), Code § 9812(c) and PHS § 2705(c).

²⁸³ ERISA § 712(c), Code § 9812(c) and PHS § 2705(c).

²⁸⁴ Temp. Treas. Reg. § 54.9812-1T(e), and Interim 42 C.F.R. § 146.136(e) and DoL Reg. § 2590.712(e).

(m) and (o) of the Code and predecessor employers.²⁸⁵ Predecessor employers are not defined.

3. Mental Health Benefit Limits.

a. Aggregate Lifetime Limits. If group health plan offered by insurer or plan sponsor provides medical and surgical benefits subject to a lifetime aggregate limit and the group health plan offers mental health benefits, then the plan must either:

- i. include payments for mental health benefits under the lifetime medical surgical aggregate limit, or
- ii. establish a separate lifetime limit for mental health benefits that is greater than or equal to the medical surgical lifetime benefit limit.²⁸⁶

If the group health plan does not cover mental health benefits, no benefits are required.

b. Annual Limit. If the group health plan offered by health insurance issuer (or plan sponsor) includes an annual limit on medical surgical benefits and provides a mental health benefit, then the plan must either:

- i. include benefits paid for mental health services under the medical surgical annual benefit limit; or
- ii. establish a separate mental health benefit annual limit that is greater than or equal to the annual limit on medical and surgical benefits.²⁸⁷

c. Does the Plan Have Benefit Limits? The Temporary and Interim Mental Health Parity Act Regulations clarify when a plan is considered to have limits on medical/surgical benefits. A plan is treated as having limits applicable to medical/surgical benefits if at least two-thirds of all medical/surgical benefits are either subject to aggregate lifetime or annual limits.²⁸⁸ The determination of whether two-thirds of all medical/surgical benefits are subject to an annual or aggregate limit is determined based upon the projection of all medical/surgical benefits to be provided under the plan for the next plan year in terms of dollars. Any reasonable method may be used to estimate whether the dollar amounts expected to be paid under the plan for the benefits subject to dollar limits will constitute two-thirds of the dollar amount of all plan payments for medical/surgical benefits. This means that you would look at the benefits subject to either annual limits or aggregate limits to determine the

²⁸⁵ Temp. Treas. Reg. § 54.9812-1T(e), Interim DoL Reg. § 2590.712(e) and Interim 42 C.F.R. § 146.136(e).

²⁸⁶ ERISA § 712(a)(1)(B), Code § 9812(a)(1)(B) and PHSa § 2705(a)(1)(B).

²⁸⁷ ERISA § 712(a)(2), Code § 9812(a)(2) and PHSa § 2705(a)(2).

²⁸⁸ Temp. Treas. Reg. § 54.9812-1T(b)(3), Interim DoL Reg. § 2590.712(b)(3) and Interim 42 C.F.R. § 146.136(b)(3).

projected amount that would be spent by the plan to pay for those benefits for the next plan year and compare that amount to the total cost of benefits expected to be paid by the plan for the next plan year for medical/surgical benefits and if that number is equal to two-thirds or greater then at least two-thirds of the benefits are subject to an annual limit or an aggregate limit.²⁸⁹

If a plan has a limit on at least two-thirds of all medical/surgical benefits that is either an aggregate lifetime limit or an annual limit, it must either apply the same aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits, or apply an aggregate lifetime limit or annual limit on mental health benefits that is not less than the aggregate lifetime or annual limits respectively on the medical/surgical benefits. The examples indicate that for instance that if the plan imposed a \$100,000 annual limit on medical/surgical in-patient benefits and a \$50,000 annual limit on out-patient medical/surgical benefits, then the mental health benefits would be in compliance by either imposing an annual \$150,000 limit on mental health benefits or imposing a \$100,000 annual limit on mental health in-patient benefits and an \$50,000 annual limit on out-patient mental health benefits. The regulations clarify that if a plan does not provide any out-of-network benefits for mental health benefits that is permissible as long as the plan offers parity in the dollar limits with those applied to the medical/surgical benefits.²⁹⁰

4. **Multiple Limits.** If a group health plan subject to the MHPA includes no or different aggregate lifetime limits on different categories of medical or surgical benefits, the Secretary of Labor will establish rules the plans must follow to compute the average aggregate lifetime limit that will be applied as the mental health benefit limit. The average aggregate limit is calculated taking into account the weighted average of the aggregate lifetime limits applicable to the categories.²⁹¹ The Temporary and Interim Regulations clarify that the calculation of the weighted average limit that applies to plans with multiple limits will only occur if a plan both (1) has aggregate lifetime or annual limits and (2) the limits are on more than one-third of all medical/surgical benefits, but the limits are also on less than two-thirds of all medical/surgical benefits. In the case that the plan has limits that exceed one-third of the medical/surgical benefits but are less than two-thirds of all projected medical/surgical benefits, then the plan must either impose no aggregate lifetime or annual limit as appropriate on mental health benefits, or impose an aggregate lifetime or annual limit on mental health benefits that is no less than the weighted average limit from the medical/surgical benefits calculated as described below.

²⁸⁹ Temp. Treas. Reg. § 54.9812-1T(b)(5), Interim DoL Reg. § 2590.712(b)(5) and Interim 42 C.F.R. § 146.136(b)(5).

²⁹⁰ Temp. Treas. Reg. § 54.9812-1T(b)(4) Exs. 2 and 3, Interim DoL Reg. § 2590.712(b)(4) Exs. 2 and 3, and Interim 42 C.F.R. § 146.136(b)(4) Exs. 2 and 3.

²⁹¹ ERISA §§ 712(a)(1)(C) or 712(a)(2)(C), Code §§ 9812(a)(1)(C) or 9812(a)(2)(C) and PHSA §§ 2705(a)(1)(C) or 2705(a)(2)(C).

The weighted average limit is calculated by using a weighted average of the aggregate lifetime or annual limits that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems such as in-patient and out-patient treatment or normal treatment of common low-cost conditions do not constitute categories for purposes of calculating the weighted averages. The regulation does not explain what does constitute a category for a limitation for purposes of the weighted average calculation. Benefits that are not within a category for purposes of this section that is subject to a separately designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that the plan may reasonably be expected to incur with respect to such benefits. The weighting of the medical benefits for each of the limits is then weighted in accordance with the expected amount to be paid by the plan for such category of medical benefits for the next year. The weighted average is then used to impose the aggregate lifetime or annual limit on mental health benefits that is no less than the average limit for the medical/surgical benefits.²⁹²

5. No Limits. If the group health plan subject to the MHPA includes no aggregate lifetime limits and no annual limits on medical and surgical benefits, then the plan can impose no corresponding (aggregate lifetime limit or annual limit) on mental health benefits.²⁹³ A plan is treated as a plan with no limits if under the Temporary and Interim Regulations if the plan has no limit or has limits on less than one-third of all medical and surgical benefits. If the plan does not have an aggregate lifetime or annual limit on any medical/surgical benefit or has aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits (calculated based on the projected cost for the next plan year), then the plan may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.²⁹⁴
6. Separate Benefit Packages. If a plan provides alternative benefit packages such as an indemnity package and managed care preferred provider organization package and an HMO package of benefits, then the regulations under the Mental Health Parity Act and the exemption provisions are to be applied separately for each benefit package. However, the mere fact that mental health benefits are administered separately under the plan does not mean that the mental health benefits are a separate benefit if the plan offers both medical/surgical and mental health benefits.²⁹⁵
7. Mental Health Benefits Defined. Mental health benefits do not include services for chemical dependency and/or substance abuse.²⁹⁶ This means that chemical dependency and substance abuse benefits cannot be counted toward a separate mental health benefit

²⁹² Temp. Treas. Reg. § 54.9812-1T(b)(5) and (6), Interim DoL Reg. § 2590.712(b)(5) and (6), and Interim 42 C.F.R. § 146.136(b)(5) and (6).

²⁹³ ERISA §§ 712(a)(1)(A) and 712(a)(2)(A), Code §§ 9812(a)(1)(A) and 9812(a)(2)(A) and PHSA §§ 2705(a)(1)(A) and 2705(a)(2)(A).

²⁹⁴ Temp. Treas. Reg. § 54.9812-1T(b)(2) and (5), Interim DoL Reg. § 2590.712(b)(2) and (5), and Interim 42 C.F.R. § 146.136(b)(2) and (5).

²⁹⁵ Temp. Treas. Reg. § 54.9812-1T(c) and (d), Interim DoL Reg. § 2590.712(c) and (d), and Interim 42 C.F.R. § 146.136(c) and (d).

²⁹⁶ ERISA § 712(e)(4), Code § 9812(e)(4) and PHSA § 2705(e)(4).

limit, but must be counted toward either the medical/surgical limit or counted toward a separate chemical dependency substance abuse benefit limit.²⁹⁷

8. Cost Containment. Plans are not prohibited from using certain cost containment methods. Plans may use cost-sharing, limits on the number of visits or days of coverage, or terms and conditions that relate to the amount, duration or scope of mental health benefits.²⁹⁸ Cost containment may affect the terms and conditions of the mental health benefits including cost sharing, limits on the number of visits or days of coverage, requirements related to medical necessity, requiring prior authorization or primary care physicians' referrals for treatment, relating to the amount, duration or scope of mental health benefits.²⁹⁹

9. Exemptions.

a. If the provisions of the MHPA result in a 1% or greater increase in the group health plan's (or insurance coverage's) cost, the group health plan (or insurance coverage) is exempt from the provisions of the MHPA. The Temporary and Interim Regulations clarify that the 1% exemption is determined based on a retrospective basis reviewing at least six months of claims. The 1% exemption can only be effective 30 days after the notification of both all participants and beneficiaries as well as the applicable governmental agency responsible for receiving the notification for the plan. The Temporary and Interim Regulations clarify that the 1% increased cost exemption is calculated separately for each benefit package and that in no event will this exemption be effective until 30 days after the notice requirements are satisfied with respect to the plan. Once the exemption is satisfied and the notification requirements completed, the exemption will continue in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.³⁰⁰

b. The 1% increase is calculated based on a base period that must begin on the first day in any plan year that the plan complies with the requirements of the Mental Health Parity Act and must extend for a period of at least six consecutive calendar months.³⁰¹ The ratio is calculated by dividing the expenses incurred in that base period ("IE") by the total expenses incurred during that base period ("IE") less the total of the claims that were incurred during the base period that would have been denied under the terms of the plan

²⁹⁷ Temp. Treas. Reg. § 54.9812-1T(a) and (b)(4) Ex. 4, Interim DoL Reg. § 2890.712(a) and (b)(4) Ex. 4, and Interim 42 C.F.R. § 146.136(a) and (b)(4) Ex. 4.

²⁹⁸ ERISA § 712(b), Code § 9812(b) and PHS A § 2705(b).

²⁹⁹ Temp. Treas. Reg. § 54.9812-1T(d)(3), Interim DoL Reg. § 2590.712(d)(3) and Interim C.F.R. § 146.136(d)(3).

³⁰⁰ Temp. Treas. Reg. § 54.9812-1T(f)(1), Interim DoL Reg. § 2590.712(f)(1), and Interim 42 C.F.R. § 146.136(f)(1).

³⁰¹ Temp. Treas. Reg. § 54.9812-1T(f)(2)(iv), Interim DoL Reg. § 2590.712(f)(2)(iv), and Interim 42 C.F.R. § 146.136(f)(2)(iv).

absent plan amendments required to comply with the Mental Health Parity Act ("CE") and also less the administrative costs related to the claims incurred as the result of compliance with the Mental Health Parity Act and other administrative costs that are attributable to complying with the requirements of the Mental Health Parity Act ("AE"). If the ratio of the incurred expense ("IE") is divided by the incurred expenses ("IE") minus (CE + AE) is greater than or equal to 1.01000, then the exemption applies (IE / (IE - (CE + AE))) \geq 1.01000).³⁰²

- c. If the plan is part of a rating pool, all plans in that rating pool are combined for purposes of calculating the base period and the incurred expenditures in the pool and whether or not participants in the pool have the 1% exemption. The individuals in the pool are all included regardless of whether the plans are in the pool for the entire base.³⁰³
- d. If the ratio calculated is more than a 1% increase in costs as the result of the increased claims and the administrative costs related to those claims, then the group health plan must notify participants and beneficiaries that the plan's decision to claim the 1% cost exemption by issuing a notice that includes the following:
 - i. A statement that the plan is exempt from the requirements of the Mental Health Parity Act and a description of the basis for the exemption;
 - ii. The name and telephone number of the individual to contact for further information;
 - iii. The plan name and plan number;
 - iv. The plan administrator's name, address and telephone number;
 - v. For single employer plans, the plan sponsor's name, address and telephone number and plan sponsor's employer identification number;
 - vi. The effective date of the exemption;
 - vii. The ability of the participants and beneficiaries to contact the plan administrator and to see how the plan benefits may be affected as the result of the plan's claim of the exemption and the availability upon request free of charge of the summary of information required to calculate this in the section.

³⁰² Temp. Treas. Reg. § 54.9812-1T(f)(2), Interim DoL Reg. § 2590.712(f)(2), and Interim 42 C.F.R. § 146.136(f)(2).

³⁰³ Temp. Treas. Reg. § 54.9812-1T(f)(2)(v), Interim DoL Reg. § 2590.712(f)(2)(v), and Interim 42 C.F.R. § 146.136(f)(2)(v).

- e. This notice must be provided to all participants and beneficiaries at their last known address by first-class mail. If the beneficiary's last known address is different from the participant's last known address, then a separate notice will be required for the beneficiary. A plan subject to ERISA may use the summary of material reductions and covered services or benefits to provide this notice. However, the exemption still will not be effective until 30 days after the notice has been sent.³⁰⁴ The notice is not effective for any plan until notification is made to the appropriate federal governmental agency. The notice may also be required to be made available for public inspection. The notice must be available for public inspection for plans that must report to both the Department of Labor and to the Department of Health and Human Services. Church plans are required to report to the Department of Treasury. Church plan notices will not be required to be made public. The notification requirement to the federal government agency is a condition precedent to claiming the exemption.³⁰⁵ A sample notice to participants and beneficiaries is attached to this outline as an exhibit.
- f. The MHPA does not apply to any plan that does not provide any mental health benefits, nor does it require a plan to provide any mental health benefits.³⁰⁶

10. Transition Period for Increased Cost Exemption. In the event a group health plan claimed an increased cost exemption based on assumptions inconsistent with the rules in the Temporary and Interim Regulations or using assumptions different than those contained in the regulations, the regulations included a transitional period relief. The transitional period relief applies to violations that occur before April 1, 1998 solely because the plan claimed the increased cost exemption based on assumptions inconsistent with the rules in the regulations. If the plan makes an amendment that complies with the Mental Health Parity Act requirement and is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirement, then no enforcement efforts will be made with respect to the violations prior to April 1, 1998. The plan must provide a notice to the applicable federal agency that it is using the transition period and must also provide the same notice to participants and beneficiaries indicating that it is using the transition period. The notice must indicate that the plan's decision to use the transition period by 30 days after the first day of the plan year beginning on or after January 1, 1998 but in no event later than March 31, 1998. The notice must be provided to the Department of Treasury for church plans, for plans subject to ERISA to the U.S. Department of Labor and to the Department of Health and Human Services for non-federal governmental plans and health insurance issuers. The notice must include the name of the plan and the plan number, the name, address and telephone number of the plan administrator. For single employer plans, the name, address and telephone number of the plan sponsor and the plan sponsor's employer identification number, the name and telephone number of the individual to contact for

³⁰⁴ Temp. Treas. Reg. § 54.9812-1T(f)(3), Interim DoL Reg. § 2590.712(f)(3), and Interim 42 C.F.R. § 146.136(f)(3).

³⁰⁵ For church plans see Temp. Treas. Reg. § 54.9812-1T(f)(3)(ii), for other group health plans see 29 C.F.R. § 2590.712(f)(3)(ii)(B) and see 42 C.F.R. § 146.136(f)(3)(ii)(A), (B) and (C) with respect to governmental plans.

³⁰⁶ ERISA § 712(a) and (b), Code § 9812(a) and (b) and PHSA § 2705(a) and (b).

further information, the signature of the plan administrator and the date of the signature. The notice must be provided at no charge to participants or their representatives within 15 days after receipt of a written or oral request for such notification and in no event before the notice has been sent to the applicable federal agency. A copy of the model transition period notice is attached in the exhibits to this outline.³⁰⁷

11. No Separate Enforcement Mechanism. The MHPA provisions are to be enforced with the same mechanism as is used for enforcing HIPAA through Code § 4980D, the PHSa and ERISA as described above in VII.

C. Women's Health and Cancer Rights Act of 1998.

1. Mastectomy Reconstruction Benefits Mandated. On October 21, 1998, the Women's Health and Cancer Rights Act of 1998 ("Cancer Rights Act") was enacted as part of P.L. 105-277. This added new section 713 to ERISA and section 2706 to the PHSa.³⁰⁸ The Cancer Rights Act requires a group health plan that provides benefits for mastectomy to also provide coverage for participants and beneficiaries receiving benefits in connection with a mastectomy for the following:
 - a. reconstruction of the breast on which the mastectomy was performed;
 - b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. prostheses and physical complications of all stages of mastectomy, including lymphedemas.

This treatment must be determined in consultation with the patient and the attending physician. The coverage may be subject to annual deductibles and co-insurance provisions as deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

2. Effective Date. The Cancer Rights Act is effective for group health plans and policies issued for plan years that begin on or after the date of enactment or October 21, 1998.³⁰⁹ A special rule exists for collective bargaining agreements. The group health plan is maintained pursuant to one or more collective bargaining agreements to employee representatives of one or more employers, than any plan amendments made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirements added by this section will not be treated as a

³⁰⁷ Temp. Treas. Reg. § 54.9812-1T(h)(3), Interim DoL Reg. § 2590.712(h)(3) and Interim 42 C.F.R. § 146.136(h)(3).

³⁰⁸ Since the Women's Health and Cancer Rights Act of 1998 was enacted as part of subpart 2 of 42 U.S.C. § 300gg, non-federal governmental plans may annually elect out of its application by filing and distributing the required notice.

³⁰⁹ ERISA § 713(c); PHSa § 2752(c)(1)(A).

termination of the collective bargaining agreement.³¹⁰ This will be effective for individual market on or after October 21, 1998.³¹¹

3. Discrimination Prohibition. Under ERISA, a group health plan and health insurance issuer offering insurance in connection with a group health plan is prohibited from denying any patient eligibility or continued eligibility to enroll for new coverage under the terms of the plan solely to avoid the requirements of the Cancer Rights Act and is also prohibited from penalizing or otherwise reducing or limiting reimbursement of an attending provider or to provide incentives (monetary or otherwise) to an attending provider to induce the provider to provide care to any individual participant or beneficiary in a manner that is inconsistent with the Cancer Rights Act.³¹² Group health plans may still negotiate with providers regarding the level and type of reimbursement for care that is provided in accordance with the Cancer Rights Act.
4. Preemption. The statute specifically indicated that the section should not be construed to preempt any state law that was in effect on October 21, 1998 that addressed health insurance coverage and required coverage of at least the same coverage of reconstructive breast surgery as required under the Cancer Rights Act. It also clarified that nothing was intended to modify the preemption provisions of section 514 with respect to group health plans as the result of the Cancer Rights Act.³¹³
5. Notice Requirements. The statute required notification of all participants in a group health plan following enactment and at enrollment and annually thereafter.
 - a. Initial Cancer Rights Act Notice. The initial Cancer Rights Act notice needed to describe each participant and beneficiary under the plan the coverage required by the Cancer Rights Act in accordance with the regulations. The notice must be written and prominently positioned in any literature or correspondence. The initial notice must be made by the next mailing date by the plan or issuer to a participant or beneficiary as part of all yearly informational package sent to the participant or beneficiary or no later than January 1, 1999, whichever is earlier.
 - b. Annual Enrollment Notice. The annual notice must occur each year as part of the mailings to each participant and beneficiary at enrollment and it should be included in the annual summary plan description in a prominent position. The exact content of the notice has not been described by regulation at this time.

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³¹⁰ ERISA § 713(c)(2); PHSA § 2752(c)(1)(B).

³¹¹ PHSA § 2752(c)(2).

³¹² ERISA § 713(c) which was also adopted in PHSA § 2706.

³¹³ ERISA § 713(e).

General Certificate of Creditable Coverage

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

*** IMPORTANT *** - This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: _____
2. Name of group health plan: _____
3. Name of participant: _____
4. Identification number of participant: _____
5. Name of any dependents to whom this certificate applies: _____

6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:

7. For further information, call: _____
8. If the individual(s) identified in line 3 and line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here _____ and skip lines 9 and 10.
9. Date waiting period or affiliation period (if any) began: _____
10. Date coverage began: _____
11. Date coverage ended: _____ (or check if coverage is continuing as of the date of this certificate: _____)

Note: Separate certificates will be furnished if information is not identical for the participant and each dependent.

[NOTE: The Model Certificate for individual health insurance differs slightly from the Model Certificate shown above.]

Certificate Information by Categories

INFORMATION ON CATEGORIES OF BENEFITS

1. Date of original certificate: _____
2. Name of group health plan providing the coverage: _____
3. Name of participant: _____
4. Identification number of participant: _____
5. Name of individual(s) to whom this information applies: _____

6. The following information applies to the coverage in the certificate that was provided to the individual(s) identified above:
 - a. MENTAL HEALTH: _____
 - b. SUBSTANCE ABUSE TREATMENT: _____
 - c. PRESCRIPTION DRUGS: _____
 - d. DENTAL CARE: _____
 - e. VISION CARE: _____

For each category above, (i) enter "N/A" if the individual had no coverage within the category, (ii) enter both the date that the individual's coverage began and the date that the individual's coverage within the category ended (or indicate if continuing), or (iii) enter "same" on the line if the beginning and ending dates for coverage within the category are the same as the beginning and ending dates for the coverage in the certificate.

MODEL NOTICE OF ENROLLMENT RIGHTS

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.

PWBA Office of Regulations and Interpretations

NOTICE OF CHANGES UNDER HIPAA TO COBRA

CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS

On August 21, 1996, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law (Pub. L. 104-191). HIPAA section 421 makes changes, described below, to three areas in the continuation coverage rules applicable to group health plans under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. These three areas relate to the disability extension, the definition of qualified beneficiary and the duration of COBRA continuation coverage. These changes are effective beginning Jan. 1, 1997, regardless of when the event occurs that entitles an individual to COBRA continuation coverage.

Section 421(e) of HIPAA requires group health plans that are subject to COBRA to notify, by November 1, 1996, individuals who have elected COBRA continuation coverage of these changes. The Department is issuing this release to apprise employers and plan administrators of the changes in the continuation coverage rules made by HIPAA and to inform them of their obligation under HIPAA to notify qualified beneficiaries of such changes. Such notification must be given to qualified beneficiaries by Nov. 1, 1996. The following is a discussion of the specific changes in the continuation coverage rules made by HIPAA.

Disability Extension. Under current law, if an individual is entitled to COBRA continuation coverage because of a termination of employment or reduction in hours of employment, the plan generally is only required to make COBRA continuation coverage available to that individual for 18 months. However, if the individual entitled to the COBRA continuation coverage is disabled (as determined under the Social Security Act) and satisfies the applicable notice requirements, the plan must provide COBRA continuation coverage for 29 months, rather than 18 months. Under current law, the individual must be disabled at the time of the termination of employment or reduction in hours of employment. HIPAA makes changes to the current law to provide that, beginning Jan. 1, 1997, the disability extension will also apply if the individual becomes disabled at any time during the first 60 days of COBRA continuation coverage. HIPAA also makes it clear that, if the individual entitled to the disability extension has nondisabled family members who are entitled to COBRA continuation coverage, those nondisabled family members are also entitled to the 29 month disability extension.

Definition of Qualified Beneficiary. Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain cases, the covered employee. Under current law, in order to be a qualified beneficiary an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (such as a termination of employment, or a divorce from or death of the covered employee). HIPAA changes this requirement so that a child who is born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage is also a qualified beneficiary.

Duration of COBRA Continuation Coverage. Under the COBRA rules there are situations in which a group health plan may stop making COBRA continuation coverage available earlier than usually permitted. One of those situations is where the qualified beneficiary obtains coverage under another group health plan. Under current law, if the other group health plan limits or excludes coverage for any preexisting condition of the qualified beneficiary, the plan providing the COBRA continuation coverage cannot stop making the COBRA continuation coverage available merely because of the coverage under the other group health plan. HIPAA limits the circumstances in which plans can apply exclusions for preexisting conditions. HIPAA makes a coordinating

change to the COBRA rules so that if a group health plan limits or excludes benefits for preexisting conditions but because of the new HIPAA rules those limits or exclusions would not apply to (or would be satisfied by) an individual receiving COBRA continuation coverage, then the plan providing the COBRA continuation coverage can stop making the COBRA continuation coverage available. The HIPAA rules limiting the applicability of exclusions for preexisting conditions become effective in plan years beginning on or after July 1, 1997 (or later for certain plans maintained pursuant to one or more collective bargaining agreements).

Effect of this Release. As noted above, the Department is issuing this release to advise employers and plan administrators of their obligation to notify, by Nov. 1, 1996, qualified beneficiaries of these statutory changes. The Department, as a matter of enforcement policy, will deem that supplying qualified beneficiaries with a written copy of the information described above (or with a copy of this release) constitutes compliance with the notice requirement in section 421(e) of HIPAA if this information is sent to each qualified beneficiary by first class mail at the last known address of the qualified beneficiary by Nov. 1, 1996.

[Federal Register: October 31, 1996 (Volume 61, Number 212)]
[Notices]
[Page 56239-56240]
From the Federal Register Online via GPO Access [wais.access.gpo.gov]
[DOCID:fr31oc96-66]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Requirements for Group Health Plans for Certain State and Local Government Employees -- COBRA Continuation Coverage

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: This notice contains information about the recently enacted amendments to Title XXII of the Public Health Service (PHS) Act. Title XXII requires that certain State and local government employers provide certain individuals and their family members the opportunity to continue health care coverage under a group health plan in certain instances where coverage under the plan would otherwise be terminated. Under the amendments, the group health plans maintained by these employers are required to provide to employees who have elected continuation coverage notice of the changes to the statute by November 1, 1996.

DATES: Section 421 of Public Law 104-191, "COBRA Clarifications," enacted amendments which will become effective on January 1, 1997, regardless of when the qualifying event (the event that leads to eligibility for COBRA continuation coverage) occurred.

See section 421(d), "Effective Date." Also, section 421(e), "Notification of Changes," requires that, no later than November 1, 1996, each group health plan covered under Title XXII of the PHS Act shall notify each qualified beneficiary who has elected continuation coverage of the amendments made by this section.

FOR FURTHER INFORMATION CONTACT: David Benor, Senior Attorney, Office of the General Counsel, Room 4A-53, 5600 Fishers Lane, Rockville, MD 20857. Telephone: (301) 443-2006.

[[**Page 56240**]]

SUPPLEMENTARY INFORMATION: On August 21, 1996, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law (Pub. L. 104-191). Section 421 of HIPAA makes changes, described below, to three areas in the continuation coverage rules applicable to group health plans under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. These three areas relate to the disability extension, the definition of qualified beneficiary and the duration of COBRA continuation coverage. These changes are effective beginning January 1, 1997, regardless of when the event occurs that entitles an individual to COBRA continuation coverage.

Section 421(e) of HIPAA requires group health plans that are subject to COBRA to notify, by November 1, 1996, individuals who have elected COBRA continuation coverage of these changes. The Department is issuing this notice to apprise State and local government employers and plan administrators of the changes in the continuation coverage rules made by HIPAA and to inform them of their obligation under HIPAA to notify qualified beneficiaries of such changes. Such notification must be given by November 1, 1996, to each qualified beneficiary who has elected continuation coverage. The following is a discussion of the specific changes in the continuation coverage rules made by HIPAA.

Disability Extension

Under current law, if an individual is entitled to COBRA continuation coverage because of a termination of employment or reduction in hours of employment, the plan generally is only required to make COBRA continuation coverage available to that individual for 18 months. However, if the individual entitled to the COBRA continuation coverage is disabled (as determined under the Social Security Act) and satisfies the applicable notice requirements, the plan must provide COBRA continuation coverage for 29 months, rather than 18 months. Under current law, the individual must be disabled at the time of the termination of employment or reduction in hours of employment. HIPAA makes changes to the current law to provide that, beginning January 1, 1997, the disability extension will also apply if the individual becomes disabled at any time during the first 60 days of COBRA continuation coverage. HIPAA also makes it clear that, if the individual entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the 29 month extended period of coverage.

Definition of Qualified Beneficiary

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain cases, the covered employee. Under current law, in order to be a qualified beneficiary an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (such as a termination of employment, or a divorce from or death of the covered employee). HIPAA changes this requirement so that a child who is born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage is also a qualified beneficiary.

Duration of COBRA Coverage

Under the COBRA rules there are situations in which a group health plan may stop making continuation coverage available earlier than usually permitted. One of those situations is where the qualified beneficiary obtains coverage under another group health plan. Under current law, if the other group health plan limits or excludes coverage for any preexisting condition of the qualified beneficiary, the plan providing the COBRA continuation coverage cannot stop making the COBRA continuation coverage available merely because of the coverage under the other group health plan. HIPAA makes a coordinating change to the COBRA rules so that if a group health plan limits or excludes benefits for preexisting conditions but because of the new HIPAA rules those limits or exclusions would not apply to (or would be satisfied by) an individual receiving COBRA continuation coverage, then the plan providing the COBRA continuation coverage can stop making the COBRA continuation coverage available. The HIPAA rules limiting the applicability of exclusions for preexisting conditions becomes effective in plan years beginning on or after July 1, 1997 (or later for certain plans maintained pursuant to one or more collective bargaining agreements).

Notice to Employees

As indicated above, group health plans maintained by State and local government employers subject to Title XXII of the PHS Act are required to notify their qualified beneficiaries who have elected continuation coverage of the amendments described above. This notice is required to be given by November 1, 1996. This Department believes that supplying qualified beneficiaries with the information set forth above (or with a copy of this notice) would constitute compliance with the notice requirement of section 421(e) of HIPAA if this information is sent to each qualified beneficiary who has elected continuation coverage by first class mail at the last known address of the qualified beneficiary by November 12, 1996.

This Department published a notice in the Federal Register on January 7, 1987, setting forth guidance on the Title XXII requirements. 52 FR 604-606. Included as an appendix to that notice was a model statement that covered employers (or the group health plans they maintain) could provide their employees about their continuation coverage rights. We also urge these employers to modify the general notice regarding continuation coverage rights to make it consistent with the HIPAA amendments. As provided in section 2206 of the PHS Act, the group health plan maintained by these employers must provide such notice to their employees at the time of commencement of coverage under the plan; in addition, the employer, the employee, and the plan administrator have certain other notice requirements related to specific qualifying events.

Dated: October 25, 1996.

Donna E. Shalala,
Secretary.

[FR Doc. 96-27964 Filed 10-29-96; 8:45 am]

BILLING CODE 4150-04-M

**NOTICE OF GROUP HEALTH PLAN'S EXEMPTION
FROM THE MENTAL HEALTH PARITY ACT**

*** DESCRIPTION OF THE ONE PERCENT INCREASED COST EXEMPTION - This notice is required to be provided to you under the requirements of the Mental Health Parity Act of 1996 (MHPA) because the group health plan identified in Line 1 below is claiming the one percent increased cost exemption from the requirements of MHPA. Under MHPA, a group health plan offering both medical/surgical and mental health benefits generally can no longer set annual or aggregate lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits. In addition, a plan that does not impose an annual or aggregate lifetime dollar limit on medical/surgical benefits generally may not impose such a limit on mental health benefits. However, a group health plan can claim an exemption from these requirements if the plan's costs increase one percent or more due to the application of MHPA's requirements.**

This notice is to inform you that the group health plan identified in Line 1 below is claiming the exemption from the requirements of MHPA. The exemption is effective as of the date identified in Line 4 below. Since benefits under your group health plan may change as of the date identified in Line 4 it is important that you contact your plan administrator or the plan representative identified in Line 5 below to see how your benefits may be affected as a result of your group health plan's election of this exemption from the requirements of MHPA.

Upon submission of this notice by you (or your representative) to the plan administrator or the person identified in Line 5 below, the plan will provide you or your representative, free of charge, a summary of the information upon which the plan's exemption is based.

1. Name of the group health plan and the plan number (PN): _____

2. Name, address, and telephone number of plan administrator responsible for providing this notice:

3. For single-employer plans, the name, address, telephone number (if different from Line 2), and employer identification number (EIN) of the employer sponsoring the group health plan:

4. Effective date of the exemption (at least 30 days after the notices are sent):

5. For further information, call: _____

**NOTICE OF GROUP HEALTH PLAN'S
USE OF TRANSITION PERIOD**

*** IMPORTANT - This notice is required to be provided if a group health plan uses the transition period under the requirements of the Mental Health Parity Act (MHPA). Under MHPA, a group health plan offering both medical/surgical and mental health benefits generally can no longer set annual or aggregate lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits. In addition, a plan that does not impose an annual or aggregate lifetime dollar limit on medical/surgical benefits generally may not impose such a limit on mental health benefits. However, a group health plan can claim an exemption from these requirements if the plan's costs increase one percent or more due to the application of MHPA's requirements. Under MHPA, a plan that claims the one percent increased cost exemption prior to the issuance of the MHPA interim regulations based on assumptions inconsistent with the MHPA interim regulations may delay compliance with the parity requirements of MHPA until a date no later than March 31, 1998.**

This notice is to inform you that the plan is utilizing the MHPA transition period and that the plan is delaying compliance with the parity requirements of MHPA until a time no later than March 31, 1998.

1. Name of the group health plan and the plan number (PN): _____

2. Name, address, and telephone number of plan administrator responsible for providing this notice:

3. For single-employer plans, the name, address, telephone number (if different from Line 2), and employer identification number (EIN) of the employer sponsoring the group health plan:

4. For further information, call: _____

5. Signature of plan administrator: _____

- Date: _____

Deciding Whether to Elect COBRA Health Care Continuation Coverage After Enactment of HIPAA

Notice 98-12

INTRODUCTION

A key decision that millions of Americans face each year is whether to elect "COBRA"¹ health care continuation coverage. The purpose of this notice is to help people decide whether to elect COBRA coverage. In order to make that decision, they need to know about two laws, COBRA and HIPAA.² This notice provides information -- in the form of questions and answers -- about some factors that employees and their families should take into account in deciding whether to elect COBRA continuation coverage.

An employer maintaining a group health plan is not required to provide this notice. The information in this notice may be used by employers and plan administrators who want to supplement the information they are required to give to covered employees and beneficiaries. The notice may be modified to provide information specific to a plan. The information in this notice is not a substitute for any of the notices required to be furnished under COBRA or for any other information required by law to be furnished to participants or beneficiaries in employer group health plans.

¹ COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985, the law that added the health care continuation coverage requirements.

² HIPAA is the Health Insurance Portability and Accountability Act of 1996.

SHOULD I ELECT COBRA HEALTH CARE CONTINUATION COVERAGE?

Questions and Answers

If you lose or leave your job, or if another event occurs that would cause you to lose coverage under an employer's group health plan, you may have the right to elect COBRA³ health care continuation coverage under the plan. In making this important decision, there are a number of considerations you should take into account, including:

- whether other group health coverage -- such as coverage under another employer's plan -- is available;
- whether any other available health coverage would exclude benefits for a medical condition that you or a family member has;
- when you will have the right to enroll in the other coverage;
- the cost, scope, and level of COBRA coverage compared with that of any other available group coverage or individual health coverage; and
- whether a guaranteed right to buy individual health coverage is important to you.

The following questions and answers are divided into three parts. Read Part I for background information about COBRA coverage and an important recent law, HIPAA⁴, that might affect your COBRA decision. Read Part II if group health coverage other than COBRA coverage is available to you. Read Part III if you do not have other group health coverage available. These questions and answers reflect the law as in effect January 1998.⁵

These questions and answers are available at the IRS Internet site at:

<http://www.irs.ustreas.gov>

These questions and answers are also available at the Department of Labor (DOL) Internet site at:

<http://www.dol.gov/dol/pwba>

and at the Health Care Financing Administration (HCFA) Internet site at:

<http://www.hcfa.gov>

³ COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985, the law that added the health care continuation coverage requirements.

⁴ HIPAA is the Health Insurance Portability and Accountability Act of 1996.

⁵ In most cases, HIPAA is effective by January 1998. However, a later effective date applies to certain employer group health plans and certain health coverage. The questions and answers below assume that HIPAA is in effect.

PART I: Overview of COBRA and HIPAA

COBRA

What rights to health care continuation coverage does COBRA provide?

If you are covered by an employer's group health plan, COBRA may give you the right to stay covered even if something happens, like losing your job, that would otherwise cause you to lose coverage. This continuation coverage under an employer's plan is called "COBRA coverage." COBRA coverage usually lasts only for a limited time, and you usually have to pay for it.

If you are covered by an employer's group health plan, and an event occurs that would otherwise cause you to lose that group health coverage, you need to understand whether COBRA applies to your specific situation and, if so, what your rights are under COBRA.

What employer plans are subject to COBRA?

COBRA applies to most employer group health plans but not to all of them. For example, it does not apply to plans of employers with fewer than 20 employees or to church plans. Many plans of small employers, though, are subject to State laws similar to COBRA. If you are covered under a plan of an employer with fewer than 20 employees, you can contact the department or commission of insurance in your State to find out if you have rights to continuation coverage under your State's insurance laws. (Federal employees, while not protected by COBRA, have similar continuation coverage rights under another federal law.)

What events result in COBRA rights and for how long is COBRA coverage available?

Even if COBRA applies to your group health plan, it gives rights only to certain people who would be losing health coverage for certain specific reasons. Some of the most common situations that give people COBRA rights are:

- ***Loss of job.*** If you are covered by your employer's group health plan and you lose or leave your job, COBRA generally gives you the right to stay in the employer's plan for up to 18 months. The same rights apply if you are the spouse or dependent child of an employee who loses his or her job. (The 18-month period can be increased to 29 months if someone in the family is disabled.)
- ***Reduced hours.*** If you are covered by your employer's group health plan and your hours are reduced, the employer's plan may provide that you lose coverage unless you elect COBRA. In this case, COBRA generally gives you the right to stay in the employer's plan for up to 18 months. The same rights apply if you are the spouse or dependent child of an employee whose hours are reduced. (The 18-month period can be increased to 29 months if someone in the family is disabled.)
- ***Death or divorce of spouse.*** You have the right to COBRA coverage if you are covered by a group health plan of your spouse's employer and you would lose coverage because your spouse dies or you and your spouse divorce or legally separate. In these cases, COBRA gives you the right to stay in the plan for up to 36 months.

- ***Death or divorce of parent.*** You have the right to COBRA coverage if you are a dependent child covered by a group health plan of your parent's employer and you would lose coverage because your parent dies or your parents divorce or legally separate. In these cases, COBRA gives you the right to stay in the plan for up to 36 months.
- ***Change of Status as Dependent.*** COBRA also gives you rights if you are a dependent child covered by a group health plan of your parent's employer and you would lose coverage because you reach an age or condition that causes you to no longer be covered as a dependent under the plan. In these cases, COBRA gives you the right to stay in the plan for up to 36 months.

If you become covered by another group health plan or by Medicare before your COBRA coverage would otherwise end, you usually lose the right to COBRA coverage. However, you do not lose the right to COBRA coverage if the new group health plan does not cover illnesses or conditions because you had them before you became covered under the plan.

What are the requirements for obtaining COBRA coverage?

If you want COBRA coverage, you can be required to elect it within 60 days after your coverage would otherwise end. If you elect COBRA coverage, the plan is required to continue the same coverage for you but can charge you for it.

- ***Cost of COBRA coverage.*** If you elect COBRA coverage, the plan can require you to pay for the entire cost of coverage, plus a small (2%) additional charge for administration. (If you are getting a longer period of coverage because of disability, you may have to pay more.) The cost of COBRA coverage will probably be more than what you were paying for coverage before. You can pay for COBRA coverage in monthly installments.

How can I get more information about COBRA?

COBRA has a number of special rules, and the information above covers only basic points. The plan administrator of your group health plan is required to give you information about your COBRA rights. You should read that information carefully. If you have any questions about your COBRA rights or would like additional information about COBRA and your group health plan, contact your plan administrator.

If you want to know more, the Department of Labor has a booklet called "Health Benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA)." You can request this booklet free of charge by calling 1-800-998-7542. The booklet is also available on the Internet at:

<http://www.dol.gov/dol/pwba>

HIPAA

What is HIPAA and why is it important in deciding whether to elect COBRA coverage?

HIPAA is a federal law that regulates employer group health plans and health insurance companies. HIPAA is important to your decision whether to elect COBRA coverage because HIPAA may affect when other coverage is available to you and the types of other coverage available to you, including the extent to which coverage can be restricted under a "preexisting condition exclusion."

What is a preexisting condition exclusion?

Some employer group health plans do not provide coverage for an illness or condition you had before you became covered under the plan. These illnesses or conditions are commonly called "preexisting conditions." A special limit on coverage for a preexisting condition is called a "preexisting condition exclusion."

How are preexisting condition exclusions limited by HIPAA?

HIPAA imposes the following limits on the situations in which employer group health plans may have preexisting condition exclusions and the length of time that such exclusions can apply:

- ***Treatment or advice received in 6 months before enrollment.*** An employer group health plan cannot exclude coverage for a preexisting condition you have unless medical advice, diagnosis, care, or treatment was received by you (or recommended to you) for the condition during a 6-month period. If there is a waiting period to get into the plan, the 6-month period is the 6 months before the start of the waiting period. If the plan has no waiting period, the 6-month period is the 6 months before you enter the plan.
- ***Preexisting condition exclusion cannot last for more than 12 (or 18) months.*** An employer group health plan cannot exclude coverage for a preexisting condition for more than 12 months after the start of the waiting period for coverage. If there is no waiting period, the plan cannot exclude coverage for a preexisting condition for more than 12 months after you enter the plan. However, if you do not enroll when you are first eligible and do not enroll when you have "special enrollment rights" (as described below), the plan can refuse to cover preexisting conditions for up to 18 months after you enter the plan.
- ***Previous coverage reduces length of exclusion.*** If you had other health coverage -- for example, under another group health plan (including COBRA coverage) or under an individual insurance policy, Medicare, or Medicaid -- your new plan's preexisting condition exclusion period generally must be reduced by the period of your other coverage. For example, if you were covered by your old employer's plan for 4 months and your new employer's plan has a 12-month preexisting condition exclusion, your new employer's plan cannot exclude coverage for you for any preexisting condition for more than 8 months. However, your new employer's plan does not have to count coverage before a 63-day break in coverage.
- ***63-day break in coverage.*** If there has been a break of 63 days or more during which you had no health coverage, then the plan can disregard your old coverage that preceded this break. Thus, if you had no coverage for at least 63 days just before you began working for your new employer, the new employer's plan can refuse to cover any preexisting conditions for up to 12 months (or 18 months, depending on when you enroll in the new plan). Time spent in any waiting period for coverage does not count toward the 63-day break.
- ***No preexisting condition exclusion permitted for pregnancy, or for newborn and adopted children.*** A plan cannot impose a preexisting condition exclusion relating to pregnancy. In addition, a plan cannot impose a preexisting condition exclusion on newborn children, adopted children, and children placed for adoption who are covered under a plan on the 30th day after their birth, adoption, or placement for adoption.
- ***State insurance laws.*** State insurance laws may further limit the extent to which insurance under an

employer's plan can exclude coverage for preexisting conditions.

How does HIPAA affect my ability to enroll in an employer's plan?

- ***Special enrollment rights.*** HIPAA gives you and your family a special opportunity to enroll in your employer's plan in two situations: (1) if you lose other coverage (including COBRA coverage) or (2) if you have a new spouse or dependent. In these two situations, you (or your spouse or dependent) can be enrolled in your employer's plan even if the plan normally would not allow enrollment at that time.
 - **Special enrollment because of loss of other coverage.** You (and your spouse and dependents) might have been eligible to enroll in your employer's plan at an earlier time but you decided not to because at that time you (or your family members) had other coverage (say, under the plan of your spouse's employer). In that case, if you (or your family members) later lose the other coverage, your employer's plan generally must allow you (and your family members) to enroll. The plan has to give you at least 30 days after that other coverage is lost to request enrollment, and must allow enrollment by the first day of the month after the plan receives your completed request.
 - This special enrollment right generally is available only if the coverage is lost because it is no longer available (and not lost because of failure to pay for it or for cause, such as making a fraudulent claim). You are not required to elect COBRA coverage in order to have a special enrollment right; however, if you do elect COBRA coverage, you must continue it for the entire period it is available to you in order to preserve this special enrollment right.
 - **Special enrollment because of a new spouse or dependent.** If you marry, then you, your spouse, and any new dependents you get as a result of the marriage have special rights to enroll. If a new child is born, you adopt a child, or a child is placed for adoption with you, then you, your spouse, and the new child also get special rights to enroll.
 - To be entitled to special enrollment on account of a new spouse or dependent, you must either be covered under the plan or be eligible to be covered under the plan. The plan has to give you at least 30 days after the marriage, birth, adoption, or placement for adoption to request enrollment.
 - If you get married, the plan must cover you, your spouse, and any new dependent by the first day of the month after the plan receives your completed request.
 - If you have a new child, the plan must cover you and your spouse and the child from the date of birth, adoption, or placement for adoption.
- ***The plan cannot exclude you (or make you pay more) based on health status.*** HIPAA prohibits employer group health plans from discriminating in their eligibility rules on the basis of your health.
 - For example, a plan cannot require you to pass a physical examination before you can enroll in the plan, or prevent you from enrolling because of your medical claims experience, medical history, genetic information, evidence of insurability, or disability.

In addition, a plan generally cannot require you to pay a higher contribution than similarly situated people covered under the plan due to your health or any of these other factors.

Which Employer Plans Are Subject to HIPAA?

HIPAA's limits on preexisting condition exclusions, special enrollment rights, and restrictions on discrimination based on health status apply to most but not all employer group health plans. For example, HIPAA generally does not apply to plans where fewer than 2 of the participants are current employees. In addition, special exceptions apply to certain plans maintained by State or local governments and certain plans maintained by church organizations. Further, the HIPAA rules generally do not apply to coverage for certain types of excepted benefits.

Where can I get more information about HIPAA?

HIPAA has a number of special rules, and the information above covers only basic points. If you want to know more about how HIPAA applies to group health plans, the Department of Labor has a booklet called "Questions and Answers: Recent Changes in Health Care Law." You may request this booklet free of charge by calling 1-800-998-7542. The booklet is also available on the Internet at:

<http://www.dol.gov/dol/pwba>

More information about HIPAA is also available at the Health Care Financing Administration (HCFA) Internet site at:

<http://www.hcfa.gov>

PART II: Should I Elect COBRA Coverage If I Have Other Group Health Coverage Available?

The questions and answers in this Part are designed to assist you if you have group health coverage available in addition to COBRA coverage. In deciding whether to elect COBRA coverage, an important factor is whether the other group health coverage has a preexisting condition exclusion that applies to you.

How do I know if an employer group health plan has a preexisting condition exclusion that applies to me?

You should first determine whether you received medical advice, diagnosis, care, or treatment (or they were recommended to you) for a medical condition during the 6-month period before the start of the plan's waiting period (or before you enter the plan, if there is no waiting period). For this purpose, only medical advice, diagnosis, care, or treatment from a physician or other licensed or authorized person counts.

- If not, the employer's group health plan cannot apply a preexisting condition exclusion to you.
- If so, contact the plan administrator to find out whether and for how long the plan excludes your condition. Then, determine whether and to what extent your prior health coverage will reduce any preexisting condition exclusion period.

- While you must be notified if the plan has a preexisting condition exclusion before the exclusion can be applied to you, the plan is not required to give you this notice before your coverage begins. You have to ask for the information if you need it earlier.

How do I know how long I will be subject to the plan's preexisting condition exclusion?

A plan with a preexisting condition exclusion should specify the maximum period that the exclusion can apply. That period is reduced by your prior health coverage, so you will need to determine how much prior health coverage you had. Remember that if there has been a break of 63 days or more during which you had no health coverage, then the plan may be able to disregard your old coverage. Time spent in any waiting period for coverage does not count toward the 63-day break.

- ***Proof of Previous Health Coverage.*** Your old plan must give you a certificate showing how much coverage you had under that plan. The plan must give you the certificate shortly after you become eligible for COBRA coverage, shortly after your coverage ends, and at any other time you request it while you are covered or up to 24 months after your coverage ends. If you become covered by a plan that has a preexisting condition exclusion, you may use the certificate to show your new plan how long you had coverage under your old plan.
 - If you do not have a certificate, you can prove your prior coverage by producing documentation or other evidence.
 - The new plan must notify you of any length of time that a preexisting condition exclusion may apply to you after counting your previous coverage.

What should I consider in deciding whether to elect COBRA coverage if I have other group health coverage available with a preexisting condition exclusion that applies to me?

If you have other group health coverage available, and that coverage has a preexisting condition exclusion that applies to you, your choices are to have (1) COBRA coverage instead of that other group coverage, (2) the other coverage instead of COBRA coverage (despite the preexisting condition exclusion), or (3) both COBRA coverage and the other coverage.

Your decision may depend on several factors, such as:

- how long your new coverage will be subject to the preexisting condition exclusion;
- how likely you are to need treatment for the preexisting condition before it is covered;
- the seriousness of your preexisting condition, how much the treatment would cost you in the absence of coverage, and the risks to you if treatment is delayed;
- the cost, level and scope of benefits of the COBRA coverage compared to the other coverage; and
- the HIPAA rules that require plans to offer special enrollment rights in certain cases and prohibit enrollment restrictions based on your health status (as discussed in Part I and below in this Part II).

What should I consider in deciding whether to elect COBRA coverage if I have other group health coverage available with no preexisting condition exclusion that applies to me?

If you have other group health coverage available that does not exclude coverage for a preexisting medical condition you have, your decision whether to elect COBRA coverage may be influenced by a variety of factors, including --

- ***COBRA cut-off due to other coverage.*** In general, if you get coverage from another employer's group health plan that is not subject to a preexisting condition exclusion, or from Medicare, your COBRA coverage can be cut off. This means that in most situations you would have to decline the other coverage if you decide you prefer the COBRA coverage. (Note that if you have been receiving disability payments from Social Security, you should not decline Medicare coverage without first consulting your Social Security office or the Medicare program.)
- ***Cost, scope, and level of coverage.*** Plans differ in their cost, and in the level and scope of benefits (such as particular medical services) they cover. You should take these differences into account in comparing the COBRA coverage with the other available coverage.
 - Employers often pay for a large portion of the cost of group health coverage for employees, while people on COBRA coverage typically have to pay for the entire cost of the coverage. This means it usually is cheaper to pay for the employee share of the cost of the other coverage than to pay for COBRA coverage. However, you might prefer more costly coverage if it provides more comprehensive benefits for treatment you may need.
- ***Waiting period before other coverage begins.*** If you (or your spouse or parent) get a new job that offers health coverage after some waiting period, you might want to elect to have COBRA coverage for that waiting period.
- ***Special enrollment rights.*** If you elect COBRA coverage instead of taking other available group health plan coverage, HIPAA generally gives you the right to enroll in the new plan within 30 days after the COBRA coverage ends, or within 30 days after you get married or have a new dependent child -- even if the plan would not otherwise allow you to enroll at that time.
 - But, once you have elected COBRA coverage, your special enrollment right for the loss of the coverage applies only if you keep the COBRA coverage for the entire period it is available to you. (Thus, this special enrollment right does not apply if the COBRA coverage ends because you stop paying for it.)
- ***HIPAA Limits on Enrollment Restrictions Based on Health Status.*** If you elect COBRA coverage instead of taking other group health plan coverage, but you later decide you want to enroll in the new plan, your new plan cannot exclude you (or charge you more) on the basis of your health.

PART III: Should I Elect COBRA Coverage If I Do Not Have Other Group Health Coverage Available?

The questions and answers in this Part are designed to assist you if you do not have other group health coverage available.

Why do I need health coverage?

You need health coverage to help pay for medical services for any health problems you might have after your current plan coverage ends.

Does HIPAA give me the right to buy individual health coverage?

If you meet certain requirements, HIPAA gives you the right to buy individual health coverage with no preexisting condition exclusion, without having to give evidence of good health. Depending on the State, the individual health coverage may be a policy issued by an insurance company, or coverage through a State high-risk pool or other governmental program. You must meet all of the following requirements to have this right:

- Your most recent period of health coverage must have been under an employer group health plan.
- If you were eligible for COBRA coverage (or coverage due to a similar State provision) under that plan, you must have elected and continued that coverage for the entire period it was available to you.
 - You would not have to continue COBRA coverage for the entire period to maintain these rights if the only COBRA coverage available was in an HMO and you ceased to reside, live, or work in the HMP service area.
- You must have at least 18 months of prior health coverage, disregarding coverage before a break of 63 days or more during which you had no health coverage.
- You must not have lost your most recent health coverage because you failed to pay the premiums or because you committed fraud.
- You must not now be eligible for coverage under any employer group health plan, Medicare, or Medicaid.
- You must not now have any other health insurance coverage.

For more information on your right to buy individual health coverage, contact your State's department or commission of insurance.

What should I consider in deciding whether to elect COBRA coverage?

- ***COBRA coverage compared to individual health coverage.*** In comparing COBRA coverage with any individual coverage you have available, consider differences in cost and in the level and scope of benefits (such as particular medical services) covered.
- ***COBRA coverage compared to no health coverage.*** You may want to elect COBRA coverage to make sure you are covered for any medical services you need. Many people consider the benefits from having the protection that COBRA coverage provides to be well worth the cost of COBRA coverage.
 - You might also want to elect COBRA coverage because, in the future, you could become

covered under an employer group health plan that has a preexisting condition exclusion. If you have a 63-day break in coverage, then your existing coverage may be disregarded. COBRA coverage can help you avoid having a 63-day break in coverage and also counts toward reducing any preexisting condition exclusion. See Part I for more information on these rules.

- ***COBRA coverage to protect your right to buy individual health coverage with no preexisting condition exclusion.*** As described above, if certain requirements are met, you and your family may have the right to buy individual health coverage with no preexisting condition exclusion, without having to give evidence of good health. These requirements include electing COBRA coverage as long as it is available to you. **THUS, FAILURE TO ELECT COBRA COVERAGE MAY CAUSE YOU TO LOSE YOUR GUARANTEED RIGHTS TO PURCHASE INDIVIDUAL HEALTH COVERAGE.**

Is there any State-sponsored coverage available to me?

Individuals in a family whose income is temporarily reduced (for example, due to loss of a job) may be eligible for low-cost or no-cost health insurance through public programs. Children are especially likely to be eligible for low-cost coverage. Eligibility for these programs varies by State and sometimes within a State. You can contact State government officials to find out if you are eligible.

CONCLUSION

There are many factors to consider in making the important decision whether to elect COBRA continuation coverage for you and each of the members of your family. The information above highlights factors that people in typical circumstances may want to take into account in deciding whether to elect COBRA coverage. You will need to consider your own family's circumstances in making your decision.

MODEL HIPAA EXEMPTION ELECTION DOCUMENT

(May be submitted on plan sponsor's or plan administrator's letterhead)

Name of Plan: _____

Plan Sponsor: _____

Address: _____

(Not applicable if election document is on letterhead showing the plan sponsor's address.)

EIN: _____ Plan Number (if applicable): _____

Plan Year/Period of Plan coverage: _____

(beginning date) through (ending date)

(may reflect multiple plan years governed by a collective bargaining agreement.)

Plan Administrator: _____

Address (if different from plan sponsor's): _____

(Name of plan, or portion of plan that is self-funded) is not provided through insurance. (Plan sponsor) elects under authority of section 2721(b)(2) of the Public Health Service (PHS) Act, and 45 C.F.R. 146.180 of Federal regulations, to exempt (name of plan or self-funded portion) from the following requirements of title XXVII of the PHS Act (list any or all of the following requirements):

1. Limitations on preexisting condition exclusion periods.
2. Special enrollment periods.
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status.
4. Standards relating to benefits for mothers and newborns.
5. Parity in the application of certain limits to mental health benefits.
6. Required coverage for reconstructive surgery following mastectomies.

This election has been made in conformity with all rules of the plan sponsor, including any public hearing, if required. I certify that the undersigned is authorized to submit this election on behalf of (name of plan). A copy of the notice to plan enrollees is enclosed. If HCFA has any questions regarding this election, please contact (name) at (phone number).

Signature: _____

Title: _____