

HIPAA, the Health Insurance Portability and Accountability Act of 1996, extends new rights to millions of employees and their families who have preexisting medical conditions. The protection takes the form of limitations on exclusions for preexisting conditions as well as protection from discrimination in employment on the basis of individual medical conditions. HIPAA also takes steps to guarantee the availability of health coverage to certain employees leaving a group health plan.

Preexisting Conditions

As you may know, many group health plans limited or denied coverage as to medical conditions that were present prior to an individual's enrollment in the plan. Any symptom that had been treated, diagnosed or discussed with a doctor prior to enrollment would not be covered under the plan for a designated period. HIPAA does away with preexisting coverage limitations for stated conditions and for individuals who qualify for such protection by having sufficient continuous coverage under a previous group health plan. The specific rules are as follows:

1. Preexisting conditions are limited to those for which medical treatment, advice or diagnosis was sought during the 6 month period ending on an employee's enrollment date in the new plan. Enrollment date for this purpose is the first date of coverage, or if there is a waiting period, the first day of the waiting period, typically the date of hire. This means that a condition for which an employee received no medical advice or treatment during the 6 months prior to his enrollment date can never under any circumstances be a preexisting condition. An even shorter look back period may apply under state law. So, the first thing HIPAA does is that it confines the definition of preexisting condition.

2. Certain preexisting conditions cannot be excluded from coverage regardless of when treatment or initial consultation takes place prior to enrollment.

Preexisting condition exclusions can never be applied to pregnancy. Similarly, genetic information that has not required medical treatment can never be a preexisting condition. There are also classes of individuals to whom preexisting condition limitations cannot be applied. These classes include newborn children, newly adopted children under age 18, children under 18 placed for adoption so long as such children are covered within 30 days of their birth, adoption or placement for adoption.

3. HIPAA establishes a maximum period of 12 months during which a coverage exclusion for a preexisting condition can apply under a group health plan. This period can be extended to 18 months for late enrollees, but otherwise any exclusion of coverage for preexisting conditions is prohibited after 12 months from an employee's enrollment date. A late enrollee for this purpose is an individual who enrolls in the plan after the earliest date on which coverage is available under the plan.

4. HIPAA requires that all creditable coverage under a prior group health plan be set off against the 12 month (or 18 month) maximum exclusion period unless a newly covered employee has incurred a break in coverage of 63 days or more. So, if an employee has 18 months of creditable coverage under a prior health plan following any break in coverage of 63 days or more, the employee will not be subject to any exclusions for preexisting conditions even if he is a late enrollee. Similarly, an employee with at least 12 months of creditable coverage under a prior health plan who does not incur a 63 day break in coverage will not be subject to any exclusions for preexisting conditions if he enrolls in the new plan at his first opportunity to do so.

\$ **Creditable coverage** for this purpose means prior group health coverage including COBRA continuation coverage, HMO coverage, coverage under an individual health insurance policy and Medicaid or Medicare coverage.

Employment during any waiting period when an employee has no coverage is not included in creditable coverage. Creditable coverage does not include coverage consisting of only **excepted benefits** such as dental or vision coverage.

5. In order to document an individual's creditable coverage, HIPAA imposes on group health plans and health insurance companies an obligation to furnish certificates of coverage to document an individual's prior creditable coverage. A certificate of coverage:

\$ must be provided automatically when an individual loses coverage under the plan or becomes entitled to elect COBRA continuation coverage and when an individual's COBRA continuation coverage ends. This means an employee who elects COBRA coverage must automatically be given two certificates of coverage, one at the beginning of COBRA coverage and one at the end of COBRA coverage.

\$ A certificate of coverage also must be provided, upon employee request, before the employee loses coverage or within 24 months of actually losing coverage.

\$ The certificate of coverage is a standard form and should be easy for most plan administrators to complete except for those employees who have interrupted service. Remember, creditable service only counts from after a

63 day break in service, so if you have an employee who works for 2 years

and then leaves for, say, 3 months without electing COBRA coverage, and then returns for 6 months during which he has group health coverage, the employee's creditable coverage is 6 months, the period following his 63 day break in coverage.

\$ A certificate of creditable coverage need not reflect more than 18 months of creditable coverage because that's the maximum period that is relevant for HIPAA purposes.

\$ Certificates of creditable coverage are also required for dependents of covered employees, and if the coverage information is the same as for the employee, it can be included on a single certificate with information for both the employee and the employee's dependent. However, an automatic certificate is not required until the plan or insurance company becomes aware through the exercise of reasonable diligence that a dependent has lost coverage. This may happen annually in connection with the collection of information during an open enrollment period.

Special Enrollment

The HIPAA certificate of coverage rules most directly affect administrators of group health plans. However, HIPAA also prescribes rules relating to special enrollment periods that extend health plan coverage to individuals who otherwise would have their coverage delayed. Just like the rules relating to preexisting conditions have expanded health coverage for millions of individuals, the HIPAA special enrollment rules have accelerated coverage for others. A special enrollment period under HIPAA is required when an employee with other health care coverage

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who has previously declined coverage loses that other coverage, or if a person becomes a new dependent of an employee through marriage, birth, adoption or placement for adoption. Such employees and their dependents do not have to wait for the plan's next open enrollment period but can seek immediate coverage.

- ! When an employee or dependent of an employee loses other health coverage, a special enrollment opportunity is required but only if the employee has previously declined coverage under the group health plan and the ~~other coverage~~ was in effect when group health coverage was previously declined.
- ! If the ~~other coverage~~ is COBRA continuation coverage under a prior plan, special enrollment applies only if the COBRA coverage is exhausted.
- ! Special enrollees are not late enrollees for purposes of the 18 month maximum period for excluding preexisting conditions from coverage.
- ! The employee or dependent must request special enrollment within 30 days of the loss of coverage. Resulting coverage must be made effective no later than the first day of the calendar month beginning after receipt of an enrollment request.
- ! Special enrollment also applies to new dependents resulting from marriage, birth, adoption or placement for adoption. Again, the individual must request coverage within 30 days of the marriage, birth, adoption or placement for adoption. In the case of marriage, coverage must be made available by the first day of the calendar month following the receipt of an

enrollment request. In the case of birth, adoption or placement for adoption, enrollment must be effective as of the date of such birth, adoption or placement for adoption.

Although plans are required to provide a description of special enrollment rights to employees before they are offered a right to enroll in group health coverage, the ball is in the employee's court when it comes to requesting special enrollment. As an administrator, you can take a passive position as to special enrollment because you don't need to do anything until an employee comes to you with a special enrollment request. However, you must make sure that your group health booklet does contain a proper notice of special enrollment rights.

HIPAA Nondiscrimination Requirements

The general nondiscrimination rule under HIPAA is that individuals cannot be denied eligibility - or continued eligibility - under a group health plan on the basis of specified health factors. Further, individuals may not be charged more for coverage than similarly situated individuals based on these specified health factors. These health factors include an employee health status, medical condition (physical or mental), claims experience, medical history, genetic makeup, disability or evidence of insurability. In short, all the factors that a health insurance underwriter might look at to evaluate a health insurance risk cannot be taken into account in making group health coverage available, and no extra premium contributions can be required of individual employees and covered dependents on the basis of such factors. An exception applies to wellness programs, which can offer premium discounts or rebates for participating in programs directed to influencing participant behavior.

HIPAA also imposes participant notification requirements relating to reductions in covered services and benefits as well as specific mandated federal coverage requirements.

Under pre-HIPAA law, participants would not have to be provided notice of plan changes until 210 days after the end of the plan year in which the change was adopted. This was the due date for a Summary of Material Modifications or a revised summary plan description explaining any material plan revisions. Under HIPAA, participants and beneficiaries must be advised of any material reduction in benefits or services within 60 days of the adoption of the change. A material reduction in covered services or benefits would include any charge that:

- ! eliminates benefits payable under the plan;
- ! reduces benefits payable under the plan;
- ! increases deductibles, co-payments or other amounts to be paid by a participant or beneficiary;
- ! reduces the service area covered by an HMO; or
- ! establishes new conditions or requirements for obtaining benefits such as preauthorization for in-patient surgery.
- ! The participant notification requirements also cover federally mandated benefits. Accordingly, participants must be specifically notified that federal law prohibits a limit of group health benefits for hospital stays to less than 48 hours for child birth, and 96 hours for cesarean sections.

So, plan administrators must make sure that any benefit cut backs - particularly those made during a plan year, are reflected in a revised summary plan description booklet or a separate summary of material modifications within 60 days of the adoption of the change.

Andrew S. Williams
Aronberg Goldgehn Davis & Garmisa
One IBM Plaza, Suite 3000
Chicago, Illinois 60611
312/755-3145
awilliams@agdglaw.com