

## OBJECTIVE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides for improved portability and continuity of health insurance coverage for participants covered under any group or individual insurance policies.

## WHY OFFER IT?

Employers are required by federal law to comply with HIPAA's portability, special enrollment, and nondiscrimination requirements. Penalties and fines may be imposed for non-compliance.

## WHO OFFERS IT?

All employers with at least two health care enrollees must comply with HIPAA.

## WHAT ARE THE PROVISIONS OF THE LAW?

Following is an overview of HIPAA's portability, special enrollment, and nondiscrimination rules.

### PORTABILITY (PRE-EXISTING CONDITIONS)

#### PRE-EXISTING CONDITION DEFINED

Under HIPAA, the only permissible definition of a pre-existing condition is a condition (regardless of cause) for which medical advice, diagnosis, care or treatment was recommended or received within the six months prior to the enrollment date. In 2005, final regulations clarified that prescription drug utilization within the six months prior to enrollment date constitutes "medical care." For a condition to be pre-existing, treatment must have actually been recommended or received by a licensed professional. Plans cannot use a "prudent person" standard to consider a condition as pre-existing simply because the participant "should have" sought medical care.

The maximum pre-existing condition exclusion (PCE) period is 12 months (or 18 months for late enrollees) after the enrollment date. The maximum PCE period is reduced for each individual by the period of creditable coverage the individual has as of the enrollment date. The enrollment date is the day coverage begins or the first day of any applicable waiting period, whichever is earlier. For a participant who enrolls during a later open enrollment period (a "late enrollee") or pursuant to a special enrollment right (a "special enrollee"), the enrollment date is the date coverage actually begins.

#### PRE-EXISTING CONDITION LIMITATIONS

HIPAA limits application of PCEs in certain circumstances:

- Genetic information alone (without a diagnosis of a related condition) cannot be treated as a pre-existing condition.
- Pregnancy may not be treated as a pre-existing condition, regardless of whether the woman had previous health coverage.
- A plan's PCE clause may not apply to a newborn or child under age 19.

#### PRE-EXISTING CONDITION NOTICE REQUIREMENTS

The 2005 final regulations require insurers to provide notices pertaining to PCEs to participants:

- General Notice - If a plan imposes a PCE, the insurer (or plan sponsor for a self-funded plan) must provide a written general notice of PCEs to each participant. This notice informs individuals of any PCEs under their plan, and notifies them of the right to reduce the PCE through creditable coverage. PCEs cannot be imposed upon someone if they are not provided the general written notice. The notice should be distributed with other enrollment/application materials. A new [model general notice](#) has been provided by the DOL.
- If a plan imposes a PCE, the insurer (or plan sponsor for a self-funded plan) must send an [individual notice](#) to any person to whom a PCE will be applied. The notice informs the individual of several items, including the PCE period that applies and how the plan made this determination. The insurer or plan sponsor may need to make some changes to the individual notice under the new regulations, including stating the last day the PCE will apply and ensuring that the notice is promptly distributed.

#### CREDITABLE COVERAGE REDUCES PCE PERIOD

HIPAA requires a plan to reduce its pre-existing condition exclusion period by one day for every day of creditable coverage. Creditable coverage is coverage under another group health plan, group or individual health insurance policy, Medicare and certain other coverage.

Individuals with at least 12 months of creditable coverage (18 months for late enrollees) must be covered in full from the day they are eligible, and no PCE can apply. However, coverage under a prior plan does not count if, after that coverage ended, the individual had a 63-day break in coverage. A waiting period in the individual's new plan does not count towards this break-in-coverage period.

HIPAA requires group health plans to provide a HIPAA Certificate to employees when they are no longer covered under the group health plan and when COBRA coverage ends.

The 2005 final regulations did not change the content of the Certificate of Creditable Coverage; however, a new educational statement was added. A model [certificate](#) has been provided by the DOL.

#### SPECIAL ENROLLMENT RIGHTS

HIPAA requires a group health plan to provide special mid-year enrollment opportunities to certain employees and their dependents in two circumstances: loss of coverage and acquisition of a new dependent.

#### LOSS OF COVERAGE

- Late enrollees must be permitted to enroll in a group health plan if:
  - the employee or dependent was already covered under an alternative plan when the plan was previously offered; and
  - the employee stated in writing that the reason for declining coverage was an alternative source of coverage; and
  - the person applying for late enrollment has:
    - exhausted COBRA coverage or lost eligibility from the alternative coverage; and
    - requests coverage within 30 days of the loss of the alternative coverage.

- Termination of employer contributions (constitutes loss of coverage under new HIPAA rules, for plan years beginning on or after July 1, 2005).
- Covered individual exceeds lifetime limits on all benefits under plan (constitutes loss of coverage under new HIPAA rules, for plan years beginning on or after July 1, 2005).

#### ACQUISITION OF NEW DEPENDENT

The new HIPAA rules for plan years beginning on or after July 1, 2005 define a dependent as “any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to the participant.” A group health plan that provides dependent coverage must permit a special enrollment when an employee acquires a new spouse or dependent by marriage, adoption, placement for adoption, or birth. The special enrollment right applies to the employee, the employee’s spouse, and the newly acquired dependent. To obtain coverage under HIPAA’s special enrollment right, an employee must request enrollment within 30 days of the marriage, birth, adoption or placement.

#### NOTICE REQUIREMENTS

Plans must notify eligible individuals of their special enrollment rights on or before the time the individuals are given the opportunity to enroll in the plan.

#### NONDISCRIMINATION RULES

HIPAA prohibits group health plans and health insurers from discriminating with regard to eligibility, premiums or contributions based on any health status-related factor. The following items are considered health status-related factors:

- Health status
- Medical condition (physical or mental)
- Claims experience
- Receipt of healthcare
- Medical history
- Genetic information
- Evidence of insurability (EOI)
- Disability

This means that an employer or insurers cannot apply an underwriting or EOI requirement, even with regard to a late enrollee.

#### NEW REGULATIONS

The American Recovery and Reinvestment Act (“the Act”; also informally known as the “Stimulus Bill”) signed into law by President Obama on February 17, 2009 contained a section called the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”). The main purpose of the HITECH Act was to further promote electronic communication in the health care area.

The Act also requires business associates to comply directly with many of HIPAA's rules and subjects business associates to HIPAA's civil and criminal penalties. The Act increased the penalties for various HIPAA violations and dramatically expanded other remedial actions (such as increasing federal government audits; granting attorneys fees in some HIPAA lawsuits; and allowing a method for individuals to recover penalties under HIPAA). The changes are significant to all covered entities, which now indirectly includes employers as sponsors of Group Health Plans (ERISA plans).

## INFORMATIONAL LINK(S)

- [Centers for Medicare & Medicaid Service](#) (U.S. Department of Health & Human Services)
- [Department of Labor's Frequently Asked Questions](#) (U.S. Department of Labor)
- [ArlenGroup's HIPAA Privacy Rule Fact Sheet](#) (ArlenGroup)
- [HIPAA Portability & Accountability Final Regulations](#) (U.S. Department of Labor)
- [Health Information Technology for Economic and Clinical Health \(HITECH\) Act \(Congressional Research Service\)](#)



*This Fact Sheet is designed to provide a general overview of the benefit program, service, or regulatory act it describes. The information included in this document is not a substitute for legal or professional opinion relative to a plan sponsor's particular fact pattern. Your ArlenGroup consultant can answer more specific questions relative to its application for your organization.*