HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions of Federal law governing health coverage portability, health information privacy, administrative simplification, medical savings accounts, and long-term care insurance. The responsibility of the Department of Labor and the subject of this segment of the booklet are the law's portability and nondiscrimination requirements.

HIPAA's provisions affect group health plan coverage in the following ways:

- *Provide certain individuals special enrollment rights in group health coverage when specific events occur, e.g., birth of a child (regardless of any open season);*

- *Prohibit discrimination in group health plan eligibility, benefits, and premiums based on specific health factors; and*

- *While HIPAA previously provided for limits with respect to preexisting condition exclusions, new protections under the Affordable Care Act now prohibit preexisting condition exclusions for plan years beginning on or after January 1, 2014.*[2]

[2]For plan years beginning on or after January 1, 2014, plans are no longer required to issue the general notice of preexisting condition exclusion and individual notice of period of preexisting condition exclusion. Plans are also no longer required to issue certificates of creditable coverage after December 31, 2014. These amendments were made because plans are prohibited from imposing preexisting condition exclusions for plan years beginning on or after January 1, 2014.

Special Enrollment

Group health plans are required to provide special enrollment periods during which individuals who previously declined health coverage for themselves and their dependents may be allowed to enroll (regardless of any open enrollment period). In addition to HIPAA special enrollment rights, the Children's Health Insurance Program Reauthorization Act (CHIPRA) added additional special enrollment rights under ERISA. Rights related to CHIPRA special enrollment are discussed in this section.

Special enrollment rights can occur when:

- *An individual loses eligibility for coverage under a group health plan or other health insurance coverage (such as an employee and his/her dependents' loss of coverage under the spouse's plan) or when an employer terminates contributions toward health coverage;*

- *An individual becomes a new dependent through marriage, birth, adoption, or being placed for adoption; and*

- *An individual loses coverage under a State Children's Health Insurance Program (CHIP) or Medicaid, or becomes eligible to receive premium assistance under those programs for group health plan coverage.*

Employees must receive a description of special enrollment rights on or before the date they are first offered the opportunity to enroll in the group health plan (see model notice on page 138).

In addition, employers that maintain a group health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide a notice (referred to as the Employer CHIP Notice) to all employees to inform them of possible opportunities in the state in which they reside (for information on a model Employer CHIP notice, see page 20).

Some individuals losing coverage under an employment-based group health plan may want to consider enrolling for coverage in the Marketplace. For more information on the Marketplace, visit HealthCare.gov.

Can the special enrollment notice be provided in the Summary Plan Description (SPD)?

Yes, if the SPD is provided to the employee at or before the time the employee is initially offered the opportunity to enroll in the plan. If the SPD is provided at a later time, the special enrollment notice should be provided separately (for example, as part of the application for coverage).

How can the employer notice regarding premium assistance under Medicaid or CHIP (the Employer CHIP Notice) be provided?

Employers that maintain a group health plan are required to provide the Employer CHIP Notice if they provide medical care in a State that operates a Medicaid or CHIP premium assistance program. This notice may be provided with the SPD, enrollment packets or open season materials as long as these materials are provided no later than the date explained below, are provided to all employees, and are provided in accordance with the Department of Labor's disclosure rules. The notice must be provided annually.

A model Employer CHIP Notice is available at dol.gov/ebsa/chipmodelnotice.doc. The model notice includes State contact information for States that provide Medicaid or CHIP premium assistance programs. This contact information will be updated periodically, therefore, be sure to check the EBSA Website for the most recent version.

Upon loss of eligibility for health coverage or termination of employer contributions for health coverage, what are a plan's obligations to offer special enrollment?

When an employee or dependent loses eligibility for coverage under any group health plan or health insurance coverage, or if employer contributions toward group health plan coverage cease, a special enrollment opportunity may be triggered. The employee or dependent must have had health coverage when the group health plan benefit package was previously declined. If the other coverage was COBRA continuation coverage, special enrollment need not be made available until the COBRA coverage is exhausted.

For example, if an employee's spouse declined coverage when previously offered due to coverage under her own employer's plan, she and the employee must be offered a special enrollment opportunity when her coverage ceases under that plan or her employer terminates contributions to that plan.

Another example is if an employer offering two benefit package options, an HMO and an indemnity option, eliminates coverage under the indemnity option. Employees, spouses, and other dependents must be offered a special enrollment opportunity in the HMO option (and may also be eligible to special enroll in any other plan for which they are otherwise eligible, such as any plan offered by the spouse's employer).

What are examples of a loss of eligibility for coverage?

Some examples of events that cause an individual to lose eligibility for health coverage (there are other reasons as well):

- Divorce or legal separation;
- A dependent is no longer considered a dependent under the plan;
- Death of the employee covered by the plan;
- Termination of employment;
- Reduction in the number of hours of employment;
- The plan decides to no longer offer any benefits to a class of similarly situated individuals; or
- An individual in an HMO or other arrangement no longer resides, lives, or works in the service area.

If an employer terminates all contributions to a group health plan, but individuals have the option to continue coverage and pay 100 percent of the cost themselves, would these individuals still have a special enrollment right because the employer has terminated contributions?

Yes. If all employer contributions have ended, individuals covered under the plan would have a special enrollment right, regardless of their option to continue coverage under the plan by paying the full cost of coverage.

If a plan has to offer a special enrollment period upon loss of eligibility or termination of employer contributions, how long must the special enrollment period run?

The plan has to provide at least 30 days for the employee or dependent to request coverage after the loss of other coverage or termination of employer contributions.

If an individual does request coverage within the 30-day period, the plan must make the coverage effective no later than the first day of the first calendar month beginning after the date the plan receives the enrollment request.

Upon marriage, birth, adoption, or placement for adoption, what are a plan's obligations to offer special enrollment?

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

The plan has to provide at least 30 days for the employee or dependents to request coverage after the occurrence of one of these events.

If the event was a marriage, the coverage is required to be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan.

In the case of birth, adoption, or placement for adoption, coverage is required to be effective no later than the date of the event.

If an employee or dependent loses coverage under CHIP or Medicaid, or becomes eligible for State premium assistance under those programs, what are a plan's obligations to offer special enrollment?

A special enrollment opportunity is triggered if the employee or dependent who is otherwise eligible, but not enrolled in, a group health plan:

- loses eligibility for coverage under a State Medicaid or CHIP program, or
- becomes eligible for State premium assistance under a Medicaid or CHIP program.

The plan must provide at least 60 days for the employee or dependent to request coverage after the employee or dependent loses eligibility for coverage or becomes eligible for premium assistance.

Can States modify HIPAA's special enrollment requirement?

Yes, in certain circumstances. States may require additional special enrollment periods with respect to insured group health plans.

State laws related to health insurance issuers generally continue to apply except to the extent that such State law "prevents the application of" a requirement of Part 7 of ERISA. Therefore, if health coverage is offered through an HMO or an insurance policy, check with your State insurance department for more information on that State's insurance laws.

Nondiscrimination Requirements

Under HIPAA, individuals may not be denied eligibility or continued eligibility to enroll in a group health plan based on any health factors they may have. In addition, an individual may not be charged more for coverage than any similarly situated individual is being charged based on any health factor.

Note: *Compliance with HIPAA's nondiscrimination provisions does not in any way reflect compliance with any other provision of ERISA (including COBRA and ERISA's fiduciary provisions). Nor does it reflect compliance with other State or Federal laws (such as the Americans with Disabilities Act).*

What are the "health factors"?

They are:

- health status;
- medical condition, including both physical and mental illnesses;
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability; and
- disability.

The term "evidence of insurability" includes conditions arising from acts of domestic violence, as well as participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

Can a group health plan require an individual to pass a physical examination in order to be eligible to enroll in the plan?

No. A group health plan may not require an individual to pass a physical exam for enrollment, even if the individual is a late enrollee.

Can a plan require an individual to complete a health care questionnaire in order to enroll?

Yes, provided that the questionnaire does not ask for genetic information (including family medical history) and the health information is not used to deny, restrict, or delay eligibility or benefits, or to determine individual premiums.

Can plans exclude or limit benefits for certain conditions or treatments?

Group health plans may exclude coverage for a specific disease, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination that the benefits are experimental or medically unnecessary – but only if the benefit restriction applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor they may have. (Plan amendments that apply to all individuals in a group of similarly situated individuals and that are effective no earlier than the first day of the next plan year after the amendment is adopted are not considered to be directed at individual participants and beneficiaries.) Whether any plan provision or practice with respect to benefits complies with this rule under HIPAA does not affect whether the provision or practice is permitted under other laws including the Affordable Care Act. For example, the Affordable Care Act includes requirements related to coverage of certain preventive services.

Can a plan deny benefits otherwise provided for the treatment of an injury based on the source of that injury?

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

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

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

Can a plan charge individuals with histories of high claims more than similarly situated individuals based on their claims experience?

No. Group health plans cannot charge an individual more for coverage than other similarly situated individuals based on any health factor.

How are groups of similarly situated individuals determined?

Distinctions among groups of similarly situated participants in a health plan must be based on bona-fide employment-based classifications consistent with the

employer's usual business practice. Distinctions cannot be based on any of the health factors noted earlier.

For example, part-time and full-time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service can be treated as distinct groups of similarly situated individuals, with different eligibility provisions, different benefit restrictions, or different costs, provided the distinction is consistent with the employer's usual business practice.

In addition, a plan generally may treat participants and beneficiaries as two separate groups of similarly situated individuals. The plan also may distinguish between beneficiaries based on, for example, their relationship to the plan participant (such as spouse or dependent child) or based on the age or student status of dependent children.

In any case, a plan cannot create or modify a classification directed at individual participants or beneficiaries based on one or more of the health factors.

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

Yes. In fact, HIPAA does not restrict a health insurance issuer from charging a higher rate to one group health plan (or employer) over another. An issuer may take health factors of individuals into account when establishing blended, aggregate rates for group health plans (or employers). This may result in one health plan (or employer) being charged a higher premium than another for the same coverage through the same issuer. Whether any plan provision or practice with respect to benefits complies with this rule under HIPAA does not affect whether the provision or practice is permitted under the Affordable Care Act (including the requirements related to community rating administered by HHS).

Can a health insurance issuer charge an employer different premiums for each individual within a group of similarly situated individuals based on each individual's health status?

No. Issuers may not charge or quote an employer or group health plan separate rates that vary for individuals (commonly referred to as "list billing") based on any of the health factors.

HIPAA does not prevent issuers from taking the current health status of each individual into account when establishing a blended, aggregate rate for

providing coverage to the employment-based group overall. (However, the Affordable Care Act generally prohibits this practice with respect to small group insurance plans.) (Note: group health plans cannot adjust premium or contribution rates based on genetic information of one or more individuals in the group. For more information, refer to the section on GINA on page 33). Also, under the Affordable Care Act, the issuer may then charge the employer (or plan) a higher overall rate, or a higher blended per-participant rate.

While HIPAA prohibits list billing based on health factors, it does not restrict communications between issuers and employers (or plans) regarding the factors considered in the rate calculations.

Can a group health plan impose a nonconfinement clause (e.g., a clause stating that if an individual is confined to a hospital at the time coverage would otherwise take effect, coverage would not begin until that individual is no longer confined)?

No. A group health plan may not deny or delay an individual's eligibility, benefits, or the effective date of coverage because that individual is confined to a hospital or other health care facility. In addition, a health plan may not set an individual's premium rate based on that individual's confinement.

Can a group health plan impose an "actively-at-work" provision (e.g., a requirement that an employee be actively at work after a waiting period for enrollment in order to have health coverage become effective on that day)?

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

Plans may require individuals to report for the first day of work before coverage may become effective. In addition, plans may distinguish among groups of similarly situated individuals in their eligibility provisions. For example, a plan may require an individual to work full time, such as 250 hours per quarter or 30 hours per week, to be eligible for health plan coverage.

Is it permissible for a group health plan that generally provides coverage for dependents only until age 26 to continue health coverage past that age for disabled dependents?

Yes, a plan can treat an individual with an adverse health factor more favorably by offering extended coverage.