Introduction

This booklet provides an overview of recent changes in federal law that can affect the health benefits of millions of working Americans and their families. The questions and answers in this publication address the benefits and requirements of the following four pieces of legislation and the regulations that interpret them:

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act)
- The Mental Health Parity Act of 1996 (MHPA)
- The Women's Health and Cancer Rights Act of 1998 (WHCRA)

While this information does not cover all the specifics of these laws, it does offer employers who sponsor group health plans an understanding of their obligations. It also provides employees and their families with information about their rights and protections under these laws.

If your questions are not addressed, please contact the Pension and Welfare Benefits Administration Regional Office nearest you or the PWBA Division of Technical Assistance and Inquiries in the Washington, D.C., office. For a list of these offices visit: **www.dol.gov/dol/pwba** or call 1-800-998-7542.

This publication contains numerous references to State Insurance Commissioners Offices. If you are an employee covered by an HMO or if the benefits under your health plan are provided through an insurance policy issued by an insurance company, you may also want to contact your state's Insurance Commissioner's Office. A list of these offices appears on the Web site of the National Association of Insurance Commissioners at **www.naic.org**. As discussed in this publication, some of the new federal rules under HIPAA, the Newborns' Act, MHPA, and WHCRA can be changed by state law for insurance companies and HMOs if the state law is more protective of individuals.

The information presented in this publication covers legislation and interpretations based on the most recent regulations. However, it does not represent the official position of the Department of Labor.

The Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. This law includes important new protections for millions of working Americans and their families who have preexisting medical conditions or who might suffer discrimination in health coverage based on a factor that relates to the individual's health. HIPAA's provisions amend Title I of the Employee Retirement Income Security Act of 1974 (ERISA), as well as the Internal Revenue Code and the Public Health Service Act, and place requirements on employer-sponsored group health plans, insurance companies and health maintenance organizations (HMOs). HIPAA includes provisions that:

- *limit exclusions for preexisting conditions;*
- *prohibit discrimination against employees and dependents based on their health status; and*
- *guarantee renewability and availability of health coverage to certain employees and individuals.*

The following information provides general guidance on frequently asked questions about HIPAA.

Preexisting Conditions to Which Exclusion Periods May Be Applied

Traditionally, many employer-sponsored group health plans limited or denied coverage of conditions that were present prior to an individual's enrollment in that health plan. These types of exclusions are known as "preexisting condition exclusions" and HIPAA places strict limitations on such exclusions. For example, a preexisting condition exclusion must relate to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period prior to an individual's enrollment date in the plan. In addition, under HIPAA, certain people and conditions can never be subject to a preexisting condition exclusion.

▶ How does HIPAA limit the preexisting conditions that can be excluded from coverage under a preexisting condition exclusion?

Under HIPAA, the only preexisting conditions that may be excluded under a preexisting condition exclusion are those for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on your enrollment date. Your "enrollment date" is your first day of coverage, or if there is a waiting period, the first day of your waiting period (typically, your date of hire).

If you had a medical condition in the past, but have not received any medical advice, diagnosis, care or treatment for it within the 6 months prior to your enrollment date in the plan, your old condition is not a "preexisting condition" to which an exclusion can be applied.

This six-month "look-back" period may be shortened under state law if your coverage is insured through an insurance company or offered through an HMO. Check with your State Insurance Commissioner's Office to see whether a shorter look-back period applies to you.

▶ I recently changed jobs. Seven months ago I received my last treatment for carpal tunnel syndrome. I have not received any medical advice, diagnosis, care or treatment for this condition since that time. Can my employer impose a preexisting condition exclusion period for this illness?

No. Your employer may only impose a preexisting condition exclusion period with respect to any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 months prior to your enrollment date.

▶ Are there other "preexisting conditions" that cannot be excluded from coverage?

Yes. Preexisting condition exclusions cannot be applied to pregnancy, regardless of whether the woman had previous coverage. In addition, a preexisting condition exclusion cannot be applied to a newborn, adopted child under age 18, or a child under 18 placed for adoption as long as the child became covered under the health plan within 30 days of birth, adoption or placement for adoption, and provided the child does not incur a subsequent 63-day or longer break in coverage. Finally, genetic information may not be treated as a preexisting condition in the absence of a diagnosis.

Again, if your coverage is insured through an insurance company or offered through an HMO, state law may provide additional protections. Check with your State Insurance Commissioner's Office to see whether additional State law protections regarding preexisting conditions apply to you.

▶ I changed employment recently. How do I know if I am subject to any preexisting condition exclusion period?

Many plans do not exclude coverage for preexisting conditions. A plan must tell you if it has a preexisting condition exclusion period (and can only exclude coverage for a preexisting condition after you have been notified). The plan must also notify you of your right to show that you have prior creditable coverage to reduce the preexisting condition exclusion period.

If the plan does apply a preexisting condition exclusion period, the plan must make a determination regarding your creditable coverage and the length of any preexisting condition exclusion period that applies to you. Generally, within a reasonable time after you provide a certificate or other information relating to creditable coverage, a plan is required to make this determination.

You are required to be notified of this determination if, after considering all evidence of creditable coverage, the plan will still impose a preexisting condition exclusion period with respect to any preexisting condition you may have. The notice must also tell you the basis of the determination, including the source and substance of any information on which the plan relied and any appeal procedure that is available to you.

The plan may modify its initial determination if it later determines that you do not have the creditable coverage you claimed. In this circumstance, the plan must notify you of its

reconsideration and, until a final determination is made, the plan must act in accordance with its initial determination for purposes of covering medical services.

➤ My employer has a "waiting period" for enrollment in the plan. How does this relate to the preexisting condition exclusion period?

HIPAA does not prohibit a plan or issuer from establishing a waiting period. For group health plans, a waiting period is the period that must pass before an employee or a dependent is eligible to enroll under the terms of the plan. Some plans have waiting periods and preexisting condition exclusion periods. However, if a plan has a waiting period and a preexisting condition exclusion period, the preexisting condition exclusion period begins when the waiting period begins.

Maximum Preexisting Condition Exclusion Period

Under HIPAA, the maximum preexisting condition exclusion period that can be applied to an individual is 12 months (18 months for late enrollees), beginning on the individual's enrollment date in the plan.

➤ I changed employment and my new group health plan imposes a preexisting condition exclusion period. How does my new plan determine the length of my preexisting condition exclusion period?

The maximum length of a preexisting condition exclusion period is 12 months after the enrollment date (18 months in the case of a "late enrollee"). A late enrollee is an individual who enrolls in a plan other than on either the earliest date on which coverage can become effective under the terms of the plan or on a special enrollment date. This 12-month (or 18-month) period may be shortened under state law if your coverage is insured through an insurance company or offered through an HMO. Check with your State Insurance Commissioner's Office to see whether a shorter maximum exclusion period applies to you.

A plan must reduce an individual's preexisting condition exclusion period by the number of days of an individual's creditable coverage. However, a plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more ("significant break in coverage"). This 63-day break period may be extended under state law if your coverage is insured through an insurance company or offered through an HMO. Check with your State Insurance Commissioner's Office to see whether a longer break period applies to you.

A plan generally receives information about an individual's creditable coverage from a certificate furnished by a prior plan or issuer (*e.g.*, an insurance company or HMO). A certificate of creditable coverage must be provided automatically to you by the plan or issuer when you lose coverage under the plan or become entitled to elect COBRA continuation coverage and when your COBRA continuation coverage ceases. You also have a right to receive a certificate when you request one from your previous plan or insurance company within 24 months of when your coverage ceases. If you do not have a certificate, you may present other evidence of creditable coverage. (For more information on the Consolidated Omnibus Budget Reconciliation Act (COBRA) as it relates to HIPAA, see Apendix B.)

I am not changing jobs. How do the HIPAA preexisting condition exclusion

➤ provisions apply to me?

On the date your plan becomes subject to the HIPAA provisions, the plan may not exclude coverage for any preexisting condition for more than 12 months after your enrollment date (18 months for a late enrollee). This period may have already passed. If this period has not passed, your plan is required to use any creditable coverage without a significant break in coverage that you had accumulated prior to your enrollment date to reduce your remaining preexisting condition exclusion period.

Crediting Prior Health Coverage To Reduce A Preexisting Condition Exclusion Period

A preexisting condition exclusion period is not permitted to extend for more than 12 months (or 18 months for late enrollees) after an individual's enrollment date in the plan. The period of any preexisting condition exclusion that would apply under a group health plan generally is reduced by the number of days of creditable coverage.

➤ What is "creditable coverage"?

Most health coverage is creditable coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO, individual health insurance policy, Medicaid or Medicare.

Creditable coverage does not include coverage consisting solely of "excepted benefits," such as coverage solely for limited-scope dental or vision benefits.

Days in a waiting period during which you have no other coverage are not creditable coverage under the plan, nor are these days taken into account when determining a significant break in coverage (generally a break of 63 days or more). As mentioned earlier, this 63-day break period may be extended under state law if your coverage is insured through an insurance company or offered through an HMO. Check with your State Insurance Commissioner's Office to see whether a longer break period applies to you.

➤ How does "crediting" for prior coverage work under HIPAA?

Most plans use the "standard method" of crediting coverage.

Under the standard method, you receive credit for your previous coverage that occurred without a break in coverage of 63 days or more. Any coverage occurring prior to a break in coverage of 63 days or more is not credited against a preexisting condition exclusion period.

To illustrate, suppose an individual had coverage for 2 years followed by a break in coverage of 70 days and then resumed coverage for 8 months. That individual would only receive credit for 8 months of coverage; no credit would be given for the 2 years of coverage prior to the break in coverage of 70 days.

▶ Is there another way that a group health plan or issuer can "credit" coverage under HIPAA?

Yes. A plan or issuer may elect the "alternative method" for crediting coverage for all employees.

Under the alternative method of counting creditable coverage, the plan or issuer determines the amount of an individual's creditable coverage for any of the five specified categories of benefits. Those categories are mental health, substance abuse treatment, prescription drugs, dental care and vision care. The standard method (described above) is used to determine an individual's creditable coverage for benefits that are not within any of the five categories that a plan or issuer may use. (The plan or issuer may use some or all of these categories.)

When using the alternative method, the plan or issuer looks to see if an individual has coverage within a category of benefits (regardless of the specific level of benefits provided within that category).

For example, if an individual who is a regular enrollee (not a late enrollee) has 12 months of creditable coverage, but coverage for only 6 of those months provided benefits for dental care, a preexisting condition exclusion period may be imposed with respect to that individual's dental care benefits for up to 6 months (irrespective of the level of dental care benefits).

If your new employer's plan requests information from your former plan regarding any of the five categories of benefits under the alternative method, your former plan must provide the information regarding coverage under the categories of benefits. One way to provide this information is to use the Model for Categories of Benefits included in Appendix E of this pamphlet.

▶ Can I receive credit for previous COBRA continuation coverage?

Yes. Under HIPAA any period of time that you are receiving COBRA continuation coverage is counted as previous health coverage as long as the coverage occurred without a break in coverage of 63 days or more.

For example, if you were covered continuously for 5 months by a previous health plan and then received 7 months of COBRA continuation coverage, you would be entitled to receive credit for 12 months of coverage by your new group health plan.

➤ I began employment with my current employer 45 days after my previous group health plan coverage terminated. I had coverage under my previous employer's plan for 24 continuous months prior to the termination. I had no other coverage before my enrollment date in my new plan. Will I be subject to the 12-month preexisting condition exclusion period imposed by my new employer?

Not if you enroll when you are first eligible. The 45-day break in coverage does not count as a significant break in coverage under HIPAA. Under federal law, a significant break in coverage is a break in coverage of at least 63 consecutive days. Since you had over 12 months of creditable coverage from your previous group plan without a significant break, you would not be subject to the preexisting condition exclusion period imposed by your new employer's plan if you enroll when you are first eligible.

➤ I began employment with my current employer 100 days after my previous group health plan coverage terminated. I had been covered by my previous employer's plan for 36 continuous months prior to termination. I had no other coverage before my enrollment date in my current employer's plan. Will I be subject to the 12-month preexisting condition exclusion period imposed by my current employer's plan?

It depends. Your break in coverage of 100 days is a significant break in coverage under federal law, so under federal law you will not be able to count the 36 months of previous coverage as "creditable coverage."

As mentioned earlier, however, the length of time that passes before a significant break in coverage is reached may be longer under state law that applies to HMOs and health insurance. If your current plan provides health insurance coverage through an insurance policy or an HMO (an "insured" plan), check with your State Insurance Commissioner's Office to find out if you are entitled to a longer break in coverage. If your current plan is an insured plan and State law requires that a break in coverage be 100 days (or longer), you would be able to count the 36 months as "creditable" coverage."

➤ How can I avoid a 63-day break in coverage?

There are several things you can do. If your last coverage was under a group health plan, you may be able to elect COBRA continuation coverage. "COBRA" is the name for a federal law that provides workers and their families the opportunity to purchase group health coverage through their employer's health plan for a limited period of time (generally 18, 29 or 36 months) if they lose coverage due to specified events, including

termination of employment, divorce or death. Workers in companies with 20 or more employees generally qualify for COBRA. Some states have laws similar to COBRA that apply to smaller companies. (For more information on COBRA as it relates to HIPAA, see Appendix B)

You also may try to purchase an individual health insurance policy. (See page 26 under the heading *Switching from Group Coverage to an Individual Insurance Policy* for more information on individual health insurance policies.)

➤ What can I do if I don't have enough creditable coverage to offset a preexisting condition exclusion period?

During any preexisting condition exclusion period under a new plan you may be entitled to COBRA continuation coverage under your former plan. You also may try to purchase an individual health insurance policy. (See page 26 under the heading *Switching from Group Coverage to an Individual Insurance Policy* for more information on individual health insurance policies.)

Certificates of Creditable Coverage

Group health plans and health insurance issuers are required to furnish a certificate of coverage to an individual to provide documentation of the individual's prior creditable coverage. A certificate of creditable coverage:

- *must be provided automatically by the plan or issuer when an individual either loses coverage under the plan or becomes entitled to elect COBRA continuation coverage and when an individual's COBRA continuation coverage ceases;*

- *must also be provided, if requested, before the individual loses coverage or within 24 months of losing coverage; and*

- *may be provided through the use of the model certificate included in Appendix C of this pamphlet.*

➤ How do newly hired employees prove that they had prior health coverage that should be credited?

Under HIPAA, an employee's former group health plan and any insurance company or HMO providing such coverage is required to provide the employee with a statement of prior health coverage, commonly referred to as a "certificate of creditable coverage."

This certificate must be provided automatically to you when you lose coverage under the plan or otherwise become entitled to elect COBRA continuation coverage as well as when COBRA continuation coverage ceases.

You may also request a certificate, free of charge, until 24 months after the time your coverage ended. For example, you may request a certificate even before your coverage ends.

➤ I received a certificate from my former plan. What do I do now?

You should:

- ensure that the information is accurate. Contact the plan administrator of your former plan if any information is wrong.

- keep the certificate in case you need it. You will need the certificate if you leave your health plan and enroll in a subsequent plan that applies a preexisting condition exclusion period or if you purchase an individual insurance policy from an insurance company. But, if you lose your certificate and cannot obtain another, you can still show prior coverage using other evidence of prior health coverage (e.g. pay stubs, copies of premium payments or other evidence of health care coverage).

➤ What steps should I take if I am not provided a certificate by my plan or issuer?

If you do not receive a certificate by the time you should have received it or by the time you need it, your first step should be to contact the plan administrator of the plan responsible for providing the certificate and request one. If any part of your creditable coverage was through an insurance company, you can also contact the insurance company for a certificate that reflects that part of your creditable coverage as long as you make the request within 24 months of your coverage ceasing under the insurance policy. Group health plans and insurers that fail or refuse to provide such certificates are subject to penalties under HIPAA.

In any event, if you do not receive a certificate, you may demonstrate to your new plan that you have creditable coverage (as well as the time you were in any waiting periods) by producing documentation or other evidence of creditable coverage (such as pay stubs that reflect a deduction for health insurance, explanation of benefits forms (EOBs) or verification by a doctor or your former health care benefits provider that you had prior health insurance coverage). Accordingly, you should keep these records and documentation in case you need them.

➤ Do plans that do not impose a preexisting condition exclusion period (and the issuers that provide coverage under these plans) have to provide certificates?

Yes.

➤ Can plans contract with an issuer to provide the certificates for their employees?

Yes. To avoid duplication of certificates, a plan may contract with the issuer to provide the certificate. Furthermore, if any entity (including a third-party administrator) provides a certificate to an individual, no other party is required to provide the certificate.

➤ When must group health plans and issuers provide the certificates?

Plans and issuers must furnish the certificate automatically to:

- an individual who is entitled to elect COBRA continuation coverage, at a time no later than when a notice is required to be provided for a qualifying event under COBRA;

- an individual who loses coverage under a group health plan and who is not entitled to elect COBRA continuation coverage, within a reasonable time after coverage ceases; and

- an individual who has elected COBRA continuation coverage, either within a reasonable time after the plan learns that COBRA continuation coverage ceased or, if applicable, within a reasonable time after the individual's grace period for the payment of COBRA premiums ends.

Plans and issuers must also generally provide a certificate to you if you request one, or someone requests one on your behalf (with your permission), at the earliest time that a plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate.

➤ Is there a model certificate that group health plans and issuers can use?

Yes. See the Model Certificate in Appendix C of this pamphlet.

➤ Can my old plan simply call my new plan to relay information about my creditable coverage?

Yes. If you, your new plan, and your old plan all agree, the information may be transferred by telephone. You are also entitled to request a written certificate for your records when your coverage information is provided by telephone.

➤ Are plans and issuers required to issue certificates of creditable coverage to dependents of covered employees?

Yes. A plan or issuer must make reasonable efforts to collect the necessary information for dependents and issue the dependent a certificate of creditable coverage. If the coverage information for a dependent is the same as for the employee, one certificate with both the employee and dependent information can be provided.

However, an automatic certificate for a dependent is not required to be issued until the plan or issuer knows (or, making reasonable efforts, should know) of the dependent's loss of coverage. This information can be collected annually, such as during an open enrollment period.

➤ What is the minimum period of time that should be covered by the certificate?

It depends on whether the certificate is issued automatically or upon request:

- For a certificate that is issued automatically, the certificate should reflect the most recent period of continuous coverage.

- For a certificate that is issued upon request, the certificate should reflect each period of continuous coverage ending within 24 months prior to the date of the request.

At no time must the certificate reflect more than 18 months of creditable coverage that is not interrupted by a break in coverage of 63 days or more.

For additional information regarding certificates see the *Timeline Relating to Effective Dates for Certifications* in Appendix G of this publication.

Special Enrollment

Group health plans and health insurance issuers are required to provide special enrollment periods during which individuals who previously declined coverage for themselves and their dependents may be allowed to enroll (without having to wait until the plan's next open enrollment period). A special enrollment period can occur if a person with other health coverage loses that coverage or if a person becomes a new dependent through marriage, birth, adoption or placement for adoption.

➤ What events trigger a special enrollment opportunity?

When the employee or dependent of an employee loses other health coverage, a special enrollment opportunity in the group health plan may be triggered. To have a special enrollment opportunity in this situation, the employee or dependent must have had other health coverage when coverage under the group health plan was previously declined. If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA continuation coverage is exhausted. If the other coverage was not COBRA continuation coverage, special enrollment can be requested when the individual loses eligibility for the other coverage.

In addition, a special enrollment opportunity may be triggered when a person becomes a new dependent through marriage, birth, adoption or placement for adoption.

For each triggering event, a special enrollee may not be treated as a late enrollee. Therefore, the maximum preexisting condition exclusion period that may be applied to a special enrollee is 12 months, and the 12 months are reduced by the special enrollee's prior creditable coverage. In addition, a newborn, adopted child or child placed for adoption cannot be subject to a preexisting condition exclusion period if the child is enrolled within 30 days of birth, adoption or placement for adoption and has no subsequent significant break in coverage.

➤ What are a plan's obligations with respect to special enrollment when an employee or a dependent of an employee loses other health coverage?

When an employee or a dependent of an employee loses other health coverage, a special enrollment opportunity may be triggered (only if the individual had other health insurance coverage when first eligible to enroll). The employee or dependent must request special enrollment within 30 days of the loss of coverage.

In addition, the resulting coverage must be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

➤ What are a plan's obligations with respect to special enrollment when an individual becomes a new dependent through marriage, birth, adoption, or placement for adoption?

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 may also have special enrollment rights after a marriage, birth, adoption or placement for adoption.

If a special enrollment opportunity is available, the individual must request special enrollment within 30 days of the marriage, birth, adoption or placement for adoption that triggered the special enrollment opportunity. In the case of marriage, enrollment is required to be effective not 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, enrollment is required to be effective not later than the date of such birth, adoption or placement for adoption.

➤ Are plans and issuers required to disclose individuals' special enrollment rights?

Yes. A description of special enrollment rights must be provided to employees on or before the time they are offered the opportunity to enroll in the group health plan. See Appendix D for a model description.

Nondiscrimination Requirements

Individuals may not be denied eligibility or continued eligibility to enroll for benefits under the terms of the plan based on specified health factors. In addition, an individual may not be charged more for coverage than similarly situated individuals based on these specified health factors.

➤ Can I lose, or be charged more for, coverage if my health status changes?

Group health plans and issuers may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on "health status-related factors." These factors are your health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. For example, you cannot be excluded or dropped from coverage under your health plan just because you have a particular illness.

Also, plans and issuers may not require an individual to pay a premium or contribution that is greater than that for a similarly situated individual based on a health status-related factor.

➤ My employer sponsors a group health plan that is available only to employees who pass a physical examination. Is this requirement that I pass a physical examination permissible?

No. This is a rule for eligibility to enroll in a plan that discriminates based on one or more "health-status related factors," and plans or group health insurance issuers may not establish rules for eligibility to enroll under the terms of the plan that discriminate based on one or more "health status-related factors."

➤ I was denied initial eligibility in my employer's plan, prior to the effective date of HIPAA, because I could not pass a physical examination. What are my rights after HIPAA becomes effective for my plan?

Individuals who, until the effective date of the HIPAA nondiscrimination provisions, were denied coverage under a group health plan because of a health status-related factor (or who failed to apply for coverage before the effective date of HIPAA because it was reasonable to believe that the application would have been futile due to a discriminatory plan provision) cannot be prevented from enrolling in the plan after HIPAA becomes effective.

Accordingly, if you were kept out of a health plan prior to HIPAA's effective date because of discrimination based on a "health status-related factor," you must be given an opportunity to enroll under the terms of the plan (even if the plan does not otherwise offer open enrollment seasons).

If you were kept out of a health plan due to a discriminatory plan provision and choose to enroll when first eligible after HIPAA's effective date, you cannot be treated as a late enrollee for purposes of applying a preexisting condition exclusion period. Therefore, the longest preexisting condition exclusion period that you may be subject to is 12 months from your enrollment date. Your enrollment date is the first day of the waiting period (*i.e.*, generally your first day of work, irrespective of whether it was before the effective date of HIPAA).

Disclosure Requirements

➤ What new kinds of information do group health plans have to give to participants and beneficiaries?

HIPAA and other recent laws made important changes in ERISA's disclosure requirements for group health plans. Under current Department of Labor interim disclosure rules, group health plans must improve their summary plan descriptions (SPDs) and summaries of material modifications (SMMs) (documents employers are required to provide to employees at certain key intervals) in four major ways to make sure they:

- notify participants and beneficiaries of "material reductions in covered services or benefits" (for example, reductions in benefits or increases in deductibles and co-payments) generally within 60 days of adoption of the change. This compares to current requirements under which plan changes can be disclosed as late as 210 days after the end of the plan year in which a change was adopted.

- disclose to participants and beneficiaries information about the role of issuers (*e.g.*, insurance companies and HMOs) with respect to their group health plan. In particular, the name and address of the issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer and the nature of any administrative services (*e.g.*, payment of claims) provided by the issuer.

- tell participants and beneficiaries which Department of Labor office they can contact for assistance or information on their rights under ERISA and HIPAA.

- tell participants and beneficiaries that federal law generally prohibits the plan and health insurance issuers from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections. Sample language is provided in Appendix F.

➤ What is the definition of a "material reduction in covered services or benefits" that is subject to the new 60-day notice requirement?

Under the interim disclosure rules, a "material reduction in covered services or benefits" means any modification to a group health plan or change in the information

required to be included in the summary plan description that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average plan participant to be an important reduction in covered services or benefits under the group health plan.

The interim rules cite examples of "reductions in covered services or benefits" as generally including any plan modification or change that:

- eliminates benefits payable under the plan;
- reduces benefits payable under the plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations;
- increases deductibles, co-payments or other amounts to be paid by a participant or beneficiary;
- reduces the service area covered by a health maintenance organization; or
- establishes new conditions or requirements (*e.g.*, preauthorization requirements) to obtain services or benefits under the plan.

➤ Can employers use e-mail systems to communicate these new disclosures to employees, and if so, do employees have a right to get a paper copy of the information from their plan?

Yes. The interim disclosure rules provide a "safe harbor" for using electronic media (*e.g.*, e-mail) to furnish group health plan SPDs, summaries of "material reductions in covered services or benefits" and other SMMs (summaries of plan modifications and SPD changes). To use the "safe harbor," among other requirements, employees must be able to effectively access at their worksite documents furnished in electronic form. Participants also continue to have a right to receive the disclosures in paper form on request and free of charge.

Although the interim rule is not the exclusive means by which electronic media can be used to lawfully communicate plan information, the HIPAA "safe harbor" is limited to group health plans. The Department of Labor is considering extending the rule to other plans, including pension plans, and to other plan disclosures, but is exploring whether special precautions are necessary to ensure the confidentiality of electronically transmitted individual account or benefit-related information.

Enforcement and State Flexibility

➤ Who enforces HIPAA?

The Secretary of Labor enforces the health care portability requirements on group health plans under ERISA, including self-insured arrangements. In addition, participants and beneficiaries can file suit to enforce their rights under ERISA, as amended by HIPAA.

The Secretary of the Treasury enforces the health care portability requirements on group health plans, including self-insured arrangements. A taxpayer that fails to comply may be subject to an excise tax.

States also have enforcement responsibility for group and individual requirements imposed on health insurance issuers, including sanctions available under state law. If a state does not act in the areas of its responsibility, the Secretary of Health and Human Services may make a determination that the state has failed "to substantially enforce" the law, assert federal authority to enforce, and impose sanctions on insurers as specified in the statute, including civil money penalties.

➤ Can states modify HIPAA's portability requirements?

Yes, in certain circumstances. States may impose stricter obligations on health insurance issuers in the seven areas listed below. States may:

- shorten the 6-month "look-back" period prior to the enrollment date to determine what is a preexisting condition;
- shorten the 12- and 18-month maximum preexisting condition exclusion periods;
- increase the 63-day significant break in coverage period;
- increase the 30-day period for newborns, adopted children and children placed for adoption to enroll in the plan so that no preexisting condition exclusion period may be applied thereafter;
- further limit the circumstances in which a preexisting condition exclusion period may be applied beyond the "exceptions"

described in federal law (the "exceptions" under federal law are for certain newborns, adopted children, children placed for adoption, pregnancy, and genetic information in the absence of a diagnosis);

- require additional special enrollment periods; and

- reduce the maximum HMO affiliation period to less than 2 months (3 months for late enrollees).

In addition, states may sometimes impose other requirements with respect to insurance companies and HMOs. Therefore, if your health coverage is offered through an HMO or an insurance policy issued by an insurance company, you should check with your State Insurance Commissioner's Office to find out the rules in your state.

Implementation Timetable

When will the changes in HIPAA affect my health plan?

Group health plans must comply with all nondiscrimination, preexisting condition and crediting of prior health coverage requirements at the beginning of the first plan year starting after June 30, 1997. For example, if your employer's plan starts a new plan year on January 1, HIPAA's provisions generally apply beginning on January 1, 1998.

There is a special rule for group health plans maintained pursuant to collective bargaining agreements, ratified before August 21, 1996, that delays the effective date of HIPAA. HIPAA's provisions apply to these plans on the first day of the plan year beginning on or after either the date on which the last collective bargaining agreement ends or July 1, 1997, whichever comes later.

See table of *Effective Dates for HIPAA's Certification Provisions* in Appendix G.

Switching From Group Coverage to an Individual Insurance Policy

➤ What if I am unable to obtain group coverage?

You may be able to obtain coverage under an individual insurance policy issued by an insurance company or, in some states through a high-risk pool. HIPAA guarantees access to individual insurance to "eligible individuals." Eligible individuals:

- have had coverage for at least 18 months without a "significant break in coverage" (see section on crediting prior health coverage for the definition of a significant break in coverage) where the most recent period of coverage was under a group health plan;

- did not have their group coverage terminated because of fraud or nonpayment of premiums; and

- are ineligible for COBRA continuation coverage or if offered COBRA continuation coverage (or continuation coverage under a similar state program) have both elected and exhausted their continuation coverage.

The opportunity to buy an individual insurance policy is the same whether the individual is laid off, is fired or quits his or her job. For information on individual insurance policies or on state high-risk pools you should contact your State Insurance Commissioner's Office.

➤ What if I cannot afford the premiums for an individual insurance policy?

HIPAA does not limit premium rates. However, many states limit insurance premiums and HIPAA does not preempt state laws regulating the cost of insurance. For information on how your state law may limit premium rates for individual insurance policies or for information on state high-risk pools you should contact your State Insurance Commissioner's Office.

➤ Is my individual insurance policy renewable? Can it be terminated?

At your option, individual health coverage must be renewed or continued in force. However, your individual health coverage may not be renewed or may be discontinued because you failed to pay premiums, committed fraud, terminated the policy, moved outside the service area, or ended membership in a bona fide association (if you terminated your membership in an association that is not a bona fide, your health insurance coverage cannot be terminated because your membership terminated). For information on whether an association is bona fide you should contact your State Insurance Commissioner's Office.

Additional Frequently Asked Questions on HIPAA

▶ If I change jobs am I guaranteed the same benefits that I have under my current plan?

No. When a person transfers from one plan to another, the benefits the person receives will be those provided under the new plan. Coverage under the new plan can be different than the coverage under the former plan.

▶ Will I be covered immediately under my new employer's plan?

Not necessarily. Plans may set a waiting period before individuals become eligible for benefits. HMOs may have an "affiliation period" during which an individual does not receive benefits and is not charged premiums. Affiliation periods run concurrently with any waiting period under a plan and may not last for more than 2 months (3 months for late enrollees) and are only allowed for HMOs that do not impose preexisting condition exclusion periods.

▶ Does HIPAA require employers to offer health coverage or require plans to provide specific benefits?

No. The provision of health coverage by an employer is voluntary. HIPAA does not require specific benefits nor does it prohibit a plan from restricting the amount or nature of benefits for similarly situated individuals.

▶ What if my new employer does not provide health coverage?

There is no requirement for any employer to offer health insurance coverage. If your new employer does not offer health insurance, you may be able to continue coverage under your previous employer's plan under COBRA continuation coverage.

▶ What if I cannot afford the premiums for group health coverage?

HIPAA does not limit premium rates, but it does prohibit plans and issuers from charging an individual more than similarly situated individuals in the same plan because of health status. Plans may offer premium discounts or rebates for participation in wellness programs. In addition, many states limit insurance premiums and HIPAA does not preempt state laws regulating the cost of insurance. For special rules concerning the cost of COBRA coverage, see IRS Notice 98-12: *Deciding Whether to Elect COBRA Health Continuation Coverage After Enactment of HIPAA* in Appendix B.

▶ Does HIPAA extend COBRA continuation coverage?

Generally no. However, HIPAA makes two changes to the length of the COBRA continuation coverage period.

Effective January 1, 1997, qualified beneficiaries who are determined to be disabled under the Social Security Act within the first 60 days of COBRA continuation coverage will be able to purchase an additional 11 months of coverage beyond the usual 18-month coverage period. This is a change from the previous law which required that a qualified beneficiary be determined to be disabled at the time of the qualifying event to receive 29 months of COBRA continuation coverage. This extension of coverage is also available to nondisabled family members who are entitled to COBRA continuation coverage.

COBRA rules are also modified and clarified to ensure that children who are born or adopted during the continuation coverage period are treated as "qualified beneficiaries." Further information discussing these changes appears at the end of this publication. (See Appendices A and B).

▶ I am an employer who provides group health insurance coverage through an issuer. Is this policy renewable? Can it be terminated?

At your option (as the plan sponsor), the issuer offering your group health insurance coverage must renew or continue in force your current coverage. However, the group health insurance coverage may not be renewed or may be discontinued because of nonpayment of premiums (including payments that are not timely), fraud, violation of participation or contribution rules, the issuer ceasing to offer that particular coverage or all health insurance coverage, or individuals moving outside the service area, or if membership in a bona fide association ceases.

▶ I have a small business and I sponsor a group health plan. Does HIPAA apply to me?

The HIPAA health portability provisions apply to group health plans with two or more participants who are current employees. However, your state may elect to regulate smaller groups.

▶ Does HIPAA apply to self-insured group health plans?

Yes.

➤ Are health flexible spending arrangements (FSAs) required to issue certificates?

If a health FSA is offered in conjunction with another group health plan and if the maximum benefit payable does not exceed a specified amount (two times the employee's salary reduction election under the health FSA for the year, or if greater, the amount of the employee's salary reduction election under the health FSA for the year, plus $500), in most cases the benefits under the health FSA will be excepted benefits and therefore not covered under HIPAA. Accordingly, the coverage under the FSA will not be creditable coverage, and the FSA is not required to issue certificates for the coverage.

If you have a question concerning whether coverage under your health FSA is creditable coverage and if you are entitled to a certificate of creditable coverage, contact your plan administrator or the Department of Labor office nearest you.

The Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act) was signed into law on September 26, 1996. The law includes important new protections for mothers and their newborn children with regard to the length of the hospital stay following childbirth. The Newborns' Act is subject to concurrent jurisdiction by the Departments of Labor, the Treasury, and Health and Human Services.

Interim regulations issued by the Departments of Labor, the Treasury and Health and Human Services clarify the statutory requirements and provide information valuable to employers and employees in understanding their rights and obligations under the law.

The following information is intended to provide general guidance on frequently asked questions about the Newborns' Act.

▶ I am a pregnant woman. How does the Newborns' Act affect my health care benefits?

The Newborns' Act affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. Group health plans, insurance companies and health maintenance organizations (HMOs) that are subject to the Newborns' Act may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider may decide, after consulting with you, to discharge you or your newborn child earlier. In any case, the attending provider cannot receive incentives or disincentives to discharge you or your child earlier than 48 hours (or 96 hours).

▶ Who is the attending provider?

An attending provider is an individual licensed under state law who is directly responsible for providing maternity or pediatric care to a mother or newborn child. Therefore, a plan, hospital, insurance company or HMO would not be an attending provider. However, a nurse midwife or a physician assistant may be an attending provider if licensed in the state to provide maternity or pediatric care in connection with childbirth.

➤ Under the Newborns' Act, when does the 48-hour (or 96-hour) period start?

If you deliver in the hospital, the 48-hour period (or 96-hour period) starts at the time of delivery. So, for example, if a woman goes into labor and is admitted to the hospital at 10 p.m. on June 11, but gives birth by vaginal delivery at 6 a.m. on June 12, the 48-hour period begins at 6 a.m. on June 12.

However, if you deliver outside the hospital and you are later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the admission. So, for example, if a woman gives birth at home by vaginal delivery, but begins bleeding excessively in connection with childbirth and is admitted to the hospital, the 48-hour period starts at the time of admission.

➤ Under the Newborns' Act, may a group health plan, insurance company or HMO require me to get permission (sometimes called prior authorization or precertification based upon medical necessity) for a 48-hour or 96-hour hospital stay?

A plan, insurance company or HMO cannot deny you or your newborn child coverage for a 48-hour stay (or 96-hour stay) because the plan claims that you, or your attending provider, have failed to show that the 48-hour stay (or 96-hour stay) is medically necessary.

However, plans, insurance companies and HMOs generally can require you to notify the plan of the pregnancy in advance of an admission if you wish to use certain providers or facilities, or to reduce your out-of-pocket costs.

➤ Under the Newborns' Act, may group health plans, insurance companies or HMOs impose deductibles or other cost-sharing provisions for hospital stays in connection with childbirth?

Yes. But only if the deductible, coinsurance, or other cost-sharing for the later part of a 48-hour (or 96-hour) stay is not greater than that imposed for the earlier part of the stay. For example, with respect to a 48-hour stay, a group health plan is permitted to cover only 80 percent of the cost of the hospital stay. However, a plan covering 80 percent of the cost of the first 24 hours could not reduce coverage to 50 percent for the second 24 hours.

➤ Does the Newborns' Act require my plan to offer maternity benefits?

No. The Newborns' Act does not require plans, insurance companies or HMOs to provide coverage for hospital stays in connection with childbirth. However, other legal

requirements may require this type of coverage, including Title VII of the Civil Rights Act of 1964. Questions regarding Title VII should be directed to the Equal Employment Opportunity Commission.

▶ Does the Newborns' Act apply to my coverage?

It depends. If your plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether your coverage is "insured" by an insurance company or HMO or "self-insured" by the employment-based plan. (You should check your Summary Plan Description (SPD) or contact your plan administrator to find out if your coverage in connection with childbirth is "insured" or "self-insured.")

"Self-insured" coverage is subject to the Newborns' Act. However, if your coverage is "insured" by an insurance company or HMO and your state has a law regulating coverage for newborns and mothers that meets specific criteria, then your rights depend on state law, rather than the Newborns' Act. If this is the case, the state law may differ slightly from the Newborns' Act requirements, so it is important for you to know which law applies to your coverage in order to know what your rights are.

Based on a preliminary review of state laws as of July 1, 1998, the following states and other jurisdictions have a law regulating coverage for newborns and mothers that would apply to coverage insured by an insurance company or HMO:

> Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, the District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington and West Virginia.

Moreover, the following states appear to have a state law applicable to health insurance companies and HMOs that references the federal Newborns' Act provisions:

> Delaware, Idaho and Oregon.

Finally, the following states and other jurisdictions do not appear to have a law regulating coverage for newborns and mothers that would apply to health coverage

insured by an insurance company or HMO. Therefore, the federal Newborns' Act provisions appear to apply to health insurance coverage in the following states.

> Hawaii, Michigan, Mississippi, Nebraska, Utah, Vermont, Wisconsin, Wyoming, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, and the pertinent areas and installations of the Canal Zone.

If your coverage is insured by an insurance company or HMO, you should always contact your State Insurance Commissioner's Office for the most current information on State laws.

➤ If the Newborns' Act applies to my coverage, when do its requirements go into effect?

The Newborns' Act's requirements apply to group health plans for plan years beginning on or after January 1, 1998. To find out when your plan year begins, check your Summary Plan Description (SPD) or contact your plan administrator.

The Mental Health Parity Act of 1996

The Mental Health Parity Act (MHPA) was signed into law on September 26, 1996. MHPA provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. MHPA's provisions are subject to concurrent jurisdiction by the Departments of Labor, the Treasury, and Health and Human Services.

On December 22, 1997, the Departments of Labor, the Treasury, and Health and Human Service issued interim regulations that interpret MHPA. The regulations clarify the statutory requirements and provide information valuable to employers and employees in understanding their obligations and rights under the law.

The following information is intended to provide general guidance on frequently asked questions about MHPA.

▶ How does MHPA affect my benefits?

Under MHPA, group health plans, insurance companies and HMOs offering mental health benefits are no longer allowed to set annual or lifetime **dollar** limits on mental health benefits that are lower than any such dollar limits for medical and surgical benefits. A plan that does not impose an annual or lifetime dollar limit on medical and surgical benefits may not impose such a dollar limit on mental health benefits offered under the plan. MHPA's provisions, however, do not apply to benefits for substance abuse or chemical dependency.

▶ Does MHPA require all health plans to provide mental health benefits?

No. Health plans are not required to include mental health in their benefits package. The requirements under MHPA apply only to plans offering mental health benefits.

▶ May a plan impose other restrictions on mental health benefits?

Yes. Plans are still able to set the terms and conditions (such as cost-sharing and limits on the number of visits or days of coverage) for the amount, duration and scope of mental health benefits.

➤ Do all plans offering mental health benefits have to meet the parity requirements?

No. There are two exceptions to these new rules. First, the mental health parity requirements do not apply to small employers who have fewer than 51 employees. Second, any group health plan whose costs increase 1 percent or more due to the application of MHPA's requirements may claim an exemption from MHPA's requirements.

➤ How does a plan claim the 1 percent increased cost exemption under MHPA?

The increased cost exemption must be taken based on actual claims data, not on an increase in insurance premiums. The provisions of MHPA must be implemented for at least 6 months and the calculation of the 1 percent cost exemption must be based on at least 6 months of actual claims data with parity in place. In addition:

- Plans claiming the increased cost exemption must notify the appropriate government agency and plan participants and beneficiaries 30 days before the exemption becomes effective.

- A formula is provided for plans to calculate the increased cost of complying with parity.

- A summary of the aggregate data and the computation supporting the increased cost exemption must be made available to plan participants and beneficiaries free of charge upon written request.

- Once a plan qualifies for the 1 percent increased cost exemption, it does not have to comply with the parity requirements for the life of the MHPA provisions, which sunset on September 30, 2001.

➤ When do the MHPA requirements take effect? Are these changes permanent?

The MHPA requirements generally apply to group health plans for plan years beginning on or after January 1, 1998. Under MHPA, there is also a "sunset" provision providing that the law will cease to apply to benefits for services furnished on or after September 30, 2001.

The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (WHCRA) was signed into law on October 21, 1998. The law includes important new protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

The following information is intended to provide general guidance on frequently asked questions about WHCRA provisions that amend ERISA .

➤ I've been diagnosed with breast cancer and plan to have a mastectomy. How will WHCRA affect my benefits?

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

➤ Will WHCRA require all group health plans, insurance companies and HMOs to provide reconstructive surgery benefits?

All group health plans, and their insurance companies or HMOs, that provide coverage for medical and surgical benefits with respect to a mastectomy are subject to the requirements of WHCRA.

➤ Under WHCRA, may group health plans, insurance companies or HMOs impose deductibles or coinsurance requirements for reconstructive surgery in connection with a mastectomy?

Yes, but only if the deductibles and coinsurance are consistent with those established for other benefits under the plan or coverage.

➤ When do these requirements take effect?

The reconstructive surgery requirements apply to group health plans for plan years beginning on or after October 21, 1998. To find out when your plan year

begins, check your Summary Plan Description (SPD) or contact your plan administrator. These requirements also apply to individual health insurance policies offered, sold, issued, renewed, in effect, or operated on or after October 21, 1998. These requirements were placed in the PHS Act within the jurisdiction of the Department of Health and Human Services.

➤ My state requires the coverage for breast reconstruction that is required by WHCRA and also requires minimum hospital stays in connection with a mastectomy that are not required by WHCRA. If I have a mastectomy and breast reconstruction, am I also entitled to the minimum hospital stay?

It depends. The federal WHCRA permits state law protections to apply to certain health coverage. State law protections apply if the state law is in effect on October 21, 1998 (date of enactment of WHCRA) and the state law requires at least the coverage for reconstructive breast surgery that is required by the federal WHCRA.

If state law meets these requirements, then it applies to coverage provided by an insurance company or HMO ("insured" coverage). If you obtained your coverage through your employer and your coverage is "insured," you would be entitled to the minimum hospital stay required by state law. If you obtained your coverage through your employer but your coverage is <u>not</u> provided by an insurance company or HMO (that is, your employer "self-insures" your coverage), then state law does not apply. In that case, only the federal WHCRA applies and it does not require minimum hospital stays. To find out if your group health coverage is "insured" or "self-insured," check your Summary Plan Description (SPD) or contact your plan administrator.

If you obtained your coverage under a private individual health insurance policy (not through your employer), check with your State Insurance Commissioner's Office to learn if state law applies.

Special Notice Requirements under WHCRA

WHCRA also requires that group health plans, insurance companies, and HMOs provide two notices regarding the coverage required by WHCRA. The following information is intended to provide general guidance on frequently asked questions about these notice requirements under the provisions of WHCRA that amend ERISA.

➤ Are all group health plans, and their insurance companies and HMOs, required to satisfy the notice requirements under WHCRA?

All group health plans, and their insurance companies or HMOs, that offer coverage for medical and surgical benefits with respect to a mastectomy are subject to the notice requirements under WHCRA.

➤ What are the notice requirements under WHCRA?

There are two separate notices required under WHCRA. The first notice is a one-time requirement under which group health plans, and their insurance companies or HMOs, must furnish a written description of the benefits that WHCRA requires. The second notice must also describe the benefits required under WHCRA, but it must be provided upon enrollment in the plan and it must be furnished annually thereafter.

➤ How must these notices be delivered to participants and beneficiaries?

These notices must be delivered in accordance with the Department of Labor's disclosure regulations applicable to furnishing summary plan descriptions. For example, the notices may be provided by first class mail or any other means of delivery prescribed in the regulation. It is the view of the Department that a separate notice would be required to be furnished to a group health plan beneficiary where the last known address of the beneficiary is different than the last known address of the covered participant.

➤ When must the initial one-time notice under WHCRA be furnished to participants and beneficiaries?

The one-time notice must be furnished as part of the next general mailing (made after October 21, 1998) by the group health plan and its insurance companies or HMOs, or in the yearly informational packet sent out regarding the plan; but in no event can the one-time notice be furnished later than January 1, 1999.

➤ Does a group health plan that already provided the coverage required by WHCRA have to send out the initial one-time notice?

A group health plan that, prior to the date of enactment of WHCRA (October 21, 1998), already provided the coverage required by WHCRA (and continues to provide such coverage) will have satisfied the initial one-time notice requirement if the information required to be provided in the initial notice was previously furnished to participants and beneficiaries in accordance with the Department's regulations on disclosure of information to participants and beneficiaries.

➤ What information must be included in WHCRA notices?

The notices must describe the benefits that WHCRA requires the group health plan, and its insurance companies or HMOs, to cover. The notice must indicate that, in the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The notice must also describe any deductibles and coinsurance limitations applicable to such coverage. Under WHCRA, coverage of breast reconstruction benefits may be subject only to deductibles and coinsurance limitations consistent with those established for other benefits under the plan or coverage.

➤ Must a group health plan, and its insurance companies or HMOs, furnish separate notices under WHCRA?

No. To avoid duplication of notices, a group health plan or its insurance companies or HMOs, can satisfy the notice requirements of WHCRA by contracting with another party that provides the required notice. For example, in the case of a group health plan funded through an insurance policy, the group health plan will satisfy the notice requirements with respect to a participant or beneficiary if the insurance company or HMO actually provides the notice that includes the information required by WHCRA.

Appendices

Appendix A

Technical Bulletin:
Notice of Changes under HIPAA to COBRA Continuation Coverage under Group Health Plans

TECHNICAL BULLETIN

U.S. Department of Labor
Pension and Welfare Benefits Administration
Washington, D.C. 20210

PENSION AND WELFARE BENEFITS PROGRAMS

ERISA TECHNICAL RELEASE No. 96-1

CONTACT: Division of Technical
Assistance and Inquiries
OFFICE: (202)219-8776
FOR RELEASE: Tuesday, Oct. 15, 1996

Notice of Changes under HIPAA to COBRA Continuation Coverage under Group Health Plans

On Aug. 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 Nov. 1, 1996, individuals who have elected COBRA continuation coverage of these changes. The Department is issuing this release to apprize 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, 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.

Appendix B

IRS Notice 98-12: Deciding whether to Elect COBRA Health Continuation Coverage after Enactment of HIPAA

IRS Notice 98-12

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

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 COBRA[1] 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, HIPAA[2], 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 in January 1998.[3]

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

www.irs.ustreas.gov

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

www.dol.gov/dol/pwba

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

www.hcfa.gov

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[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.

[3] 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.

➤ Which 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 percent) 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:

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 offers a booklet *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:

www.dol.gov/dol/pwba

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

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 cutoff 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 HMO 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, such as the Children's Health Insurance Program (CHIP). Eligibility for these programs varies by state and sometimes within a state. To find out more about the CHIP Program in your state, call 1-877-KIDSNOW. You can contact other state government officials to find out if you are eligible for additional programs.

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.

Appendix C

HIPAA Model Certificate

Model Certificate

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 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 beneficiary.

Appendix D

HIPAA Model Description of Special Enrollment Rights

Model Description of Special 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.

Appendix E

HIPAA Model For Categories of Benefits
(Alternative Method)

Model for Categories of Benefits (Alternative Method)

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, enter "N/A" if the individual had no coverage within the category or either (i) enter both the date that the individual's coverage within the category began and the date that the individual's coverage within the category ended (or indicate if continuing), or (ii) 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.

Appendix F

Sample Language for the Newborns' Act Disclosure Requirement

Sample Language for the Newborns' Act Disclosure Requirement

The following is the amended sample notice that group health plan may use to satisfy the Newborns' Act disclosure requirement:

> "Group health plans and health insurance issuers generally 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 vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)."