

## **Group health plans subject to portability and access rules**

There are of requirements for your group health plan imposed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other related acts. The HIPAA requirements include "portability" rules restricting the plan's ability to exclude individuals based on preexisting conditions, and "access" rules prohibiting plans from excluding individuals based on their health status.

*Portability.* The portability rules are designed to make it easier for an employee to retain health coverage in the event of a job switch. Under the rules, a group health plan may impose a "preexisting condition exclusion" (defined below) on an individual only if: (1) the exclusion is for a mental or physical condition, regardless of cause, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date, (2) the exclusion does not extend for more than 12 months, and (3) the exclusion period is reduced by the length of coverage credited to the individual as of the enrollment date ("creditable coverage"). The 12-month exclusion period in (2) above is 18 months for an individual enrolling "late," i.e., other than during the first period the individual is eligible to enroll or a special enrollment period.

A "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that it was present before the date of enrollment, regardless of whether medical advice, treatment, etc., was recommended or received.

"Creditable coverage" means coverage under a group health plan, or other health insurance coverage or governmental benefit plan. In determining how long the individual had coverage, time preceding a 63-day break in coverage is not counted. A waiting period is not counted as part of a break in coverage.

Example: Donna seeks to enroll in her employer's group health plan when she is first eligible on May 1, 2007. She had received treatment for a heart condition in February of 2007. Donna previously had health coverage for five years but then lost her job and went 90 days with no coverage. She then obtained health insurance on January 1, 2007 (i.e., she has held it for four months as of the enrollment date).

Under the HIPAA rules, the plan can impose a preexisting condition exclusion relating to Donna's heart condition—i.e., it can limit or exclude benefits *relating to that condition*—because she received treatment for that condition within six months of the enrollment date. However, the exclusion can be imposed for only eight months: the 12-month maximum reduced by the four months of creditable coverage Donna had before the enrollment date. (Her five years of coverage did not qualify as "creditable" because she had a break in coverage lasting at least 63 days.)

Group health plans have certain record-keeping duties and are required to provide certification of creditable coverage.

*Access.* In addition to the above requirements regarding specific preexisting conditions, a group health plan is precluded from establishing rules for eligibility (including continued eligibility) based on any of the following factors: health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

A plan is also not permitted to charge higher premiums to particular individuals based on any of these factors.

*Benefits for mothers and newborns.* Group health plans are subject to requirements with respect to coverage of newborns and mothers, including a requirement that a group health plan can't restrict benefits for a hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section.

*Parity for mental health benefits.* Group health plans that provide both medical and surgical benefits and mental health benefits can't impose limits on mental health benefits that are not imposed on substantially all medical and surgical benefits. However, this requirement won't apply to benefits for services furnished after December 31, 2007.

*Penalties.* Employers are liable for the failure of a group health plan to meet the requirements described above, and can incur substantial penalties (in the form of an excise tax) for any failure about which they knew or should have known.

*Exceptions.* The rules outlined above do not apply to governmental plans or to plans that, as of the first day of the plan year, have fewer than two participants who are current employees.

Please bear in mind that the intent of this letter is to outline the requirements of the law for you in broad terms. Of course, there are many technical requirements and details involved.