AN ALERT FROM SMITH LEONARD PLLC:

Smith Leonard Healthcare Update

Subject: CHANGED HIPAA RULES APPLICABLE TO GROUP HEALTH PLANS AFTER 2013 UNDER THE ACA

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CHANGED HIPAA RULES APPLICABLE TO GROUP HEALTH PLANS AFTER 2013 UNDER THE AFFORDABLE CARE ACT

SUMMARY

As a result of the Patient Protection and Affordable Care Act (Affordable Care Act) as it relates to requirements imposed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other related acts, there are changed requirements for your group health plan. These HIPAA requirements include HIPAA's "portability" rules that restrict a health plan's ability to exclude individuals based on pre-existing conditions, and "access" rules prohibiting plans from excluding individuals based on their health status. These rules have largely been eliminated by the Affordable Care Act, except for individual health plans that retain "grandfathered" status (that is, those plans in existence on September 23, 2010, that have not been modified or renewed). HIPAA's rules regarding privacy and security of "private health information" continue and remain unaltered by the Affordable Care Act.

PORTABILITY

The HIPAA portability rules, which no longer exist, were designed to make it easier for an employee to retain health coverage in the event of a job switch. Under the pre-Affordable Care Act rules, a group health plan might have imposed a "pre-existing condition exclusion" (defined below) on an individual only if: (1) the exclusion was for a mental or physical condition, regardless of cause, for which medical advice, diagnosis, care, or treatment had been recommended or received within the six-month period ending on the enrollment date, (2) the exclusion did not extend for more than 12 months, and (3) the exclusion period was 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 was extended to 18 months for an individual enrolling "late," i.e., at a time other than during the first period the individual was eligible to enroll or at a special enrollment period.

CERTIFICATES OF CREDITABLE COVERAGE

Under HIPAA rules, a health plan, whether it imposed a pre-existing condition exclusion, or not, was required to provide a certificate of creditable coverage to participants to document the duration of the participant's health coverage under that plan. The certificate is required to be issued when coverage was lost under a group health plan; when an individual was entitled to elect COBRA continuation coverage; and when COBRA coverage ended for the individual. The certificate must show the individual's most recent period of creditable health coverage and requires a reduction or elimination in the applicable pre-existing condition exclusion period that

the individual would be subject to based on the time the individual had "creditable coverage" under a prior plan—provided any lapse in "creditable coverage" was less than 63 days.

A "pre-existing 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.

ELIMINATION OF PRE-EXISTING CONDITION EXCLUSIONS

Since September 23, 2010, pre-existing condition exclusions in group health plans have been prohibited for plan enrollees under age 19. For plan years starting on or after Jan. 1, 2014, pre-existing condition exclusions are prohibited for all enrollees in group health plans. This includes group health plans that are grandfathered plans, and applies to collectively bargained plans and non-collectively-bargained plans, alike. However, grandfathered health plans for individual health coverage may retain a pre-existing condition exclusion for as long as the plan retains its grandfathered status.

Given the elimination of pre-existing condition exclusions for all group health plans for plan years beginning on or after January 1, 2014, the need to provide certificates of creditable coverage is expected to be eliminated by December 31, 2014. This expectation is based on proposed guidance issued by the federal government. The certificate must be provided through December 31, 2014, to take into account the possibility of lingering pre-existing condition limitation exclusions in non-calendar year plans.

WAITING PERIODS PERMISSIBLE

The Affordable Care Act, while not permitting pre-existing condition exclusions for plan years beginning on or after January 1, 2014, for group health plans, permits an employer that offers a group health plan to employees to require an eligibility waiting period (as defined, below) up to 90 days for group health coverage enrollment. The Affordable Care Act, thus, prohibits waiting periods in excess of 90 days for group health plan coverage starting with the first plan year beginning on or after January 1, 2014. The 90-day rule applies to all grandfathered and non-grandfathered group health plans and group health insurance issuers, including multiemployer health plans and health plans maintained under collective bargaining arrangements. Under proposed guidance, while a group health plan is permitted to have a waiting period up to 90 days, certain "large employers" (that is, employers of 50 or more "full-time" employees) may still be subject to the so-called "pay-or-play" employer shared responsibility rules under the Affordable Care Act. While penalties will apply for failure of these large employers to offer plans satisfying "minimum essential coverage" requirements or providing a sufficient employer subsidy for the coverage, these "pay-or-pay" employer penalties have been delayed until 2015.

A “waiting period” is defined as the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. An individual is considered “otherwise eligible to enroll” if he or she has met the group health plan's substantive eligibility conditions (e.g., being in an eligible job classification).

ACCESS

In addition to the above requirements regarding specific pre-existing 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 AND SUBSTANCE ABUSE BENEFITS

If a group health plan provides both (a) medical and surgical benefits, and (b) mental health benefits, the plan can't impose limits on mental health benefits that are not imposed on substantially all medical and surgical benefits. These so-called mental health parity rules also include substance abuse benefits, and rules regarding: (i) financial requirements and treatment limits; (ii) disclosure of information on medical necessity criteria and claim denials; and (iii) a plan's out-of-network provisions.