Hot Topics for Tennessee cities and towns

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Health Insurance Portability and Accountability Act of 1996:
You Must Comply, One Way or Another

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Introduction and Overview

Some of you may already be familiar with the new federal law, "Health Insurance Portability and Accountability Act of 1996" (HIPAA). But for those who are not, the act amended the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 to provide, among other things, improved portability and continuity of health insurance coverage.

The act is designed to protect workers from losing their health insurance coverage in cases where they want to change jobs, lose their jobs, or want to become self-employed. It does so by placing new restrictions on pre-existing condition exclusions, coverage termination, or limitations based on health status.

The act is applicable to group health plans (including government and church plans), that cover two or more employees. HIPAA coverage applies to any health insurance coverage offered in connection with a group health plan, including limited-scope dental and vision benefits, long-term care benefits, medical supplement plans, and specific disease or illness policies.

In general, group health plans are plans sponsored by employers, employee organizations, or both. HIPAA improves the availability and portability of health coverage by:

- limiting exclusions for pre-existing medical conditions,
- providing credit for prior health coverage and notifying new group health plans of previous coverage,
- providing new enrollment rights to individuals who lose other health coverage or have a new dependent,
- prohibiting discrimination in enrollment and premiums based on health status,
- guaranteeing renewability of health insurance coverage, and
- preserving a state's traditional role in regulating health insurance.

Opt-Out Option

The act also establishes a provision allowing state and local governments with fully or partially self-funded programs to "opt out" of the requirement. However, there are still rules to follow if a city opts out. (*See "Opt-Out Notice" on Page 4.*) It also modifies the COBRA rules affecting individuals with disabilities, newborns, and newly adopted children by allowing them an additional 11 months of coverage. (Individuals must pay 150 percent of the premium during the extension.)

Excluded from the definition of group health insurance are:

> (1) coverage only for accidents, including accidental death and dismemberment; (2) disability income insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) coverage issued as a supplement to liability insurance; (5) workers' compensation or similar insurance; (6) automobile medical payment insurance; (7) credit-only insurance (i.e., mortgage insurance), and (8) coverage for on-site medical clinics.

Exemptions

Cities with fully or partially self-funded programs may elect to be exempt from the requirements of certain aspects of the law. The exemption remains in effect for a single plan year. Cities can elect to be exempt from the following requirements:

> (1) limitations on pre-existing condition exclusion periods, (2) special enrollment periods for individuals (and dependents) losing other coverage, (3) prohibitions on discriminating against individual participants and beneficiaries based on health status, (4) standards relating to benefits for mothers and newborns, and (5) parity in the application of certain limits to mental health benefits.

The election of exemption must be in writing. It must include an attached copy of the notice to participants of the exemption election. It must state the name of the plan and the name and address of the plan administrator. It must either state that the plan does not include premium-funded health insurance coverage, or it must identify which portion of the plan is not funded through insurance. Additionally, the election must be made in conformance with all the plan sponsor's rules, including any required public hearings. Also, the election document must certify that the person signing it, including, if applicable, a third-party plan administrator, is legally authorized to do so by the plan sponsor. Finally, the election document must be signed by the person legally authorized to do so by the plan sponsor.

Since most city plans are not subject to collective bargaining agreements, the election must be sent to the Health Care Financing Administration (HCFA) by the day preceding the beginning date of the plan year. HCFA may extend the deadline for good cause.

If the city fails to file a timely exemption election, the plan is subject to the requirements of the act for the entire plan year. If appropriately filed, the exemption may be extended through subsequent elections.

A city that makes the exemption election must notify the participants individually of the election and explain its consequences. This notice must be provided to each participant at the time of enrollment under the plan and to all participants on an annual basis.

The notice must include at least the following information:

> (1) a statement that, in general, federal law imposes requirements on group health plans concerning pre-existing conditions, special enrollment periods, discrimination, benefits for mothers and newborns, and parity for mental health benefits (which must be individually described in the notice); (2) a statement that federal law gives the plan sponsor the right to exempt the plan in whole or in part, and that the plan sponsor has elected to do so; (3) a statement identifying which parts of the plan are subject to the election, and each of the requirements from which the plan sponsor has elected to be exempt; (4) if the plan chooses to provide any of the protections voluntarily, or is required to under state law, a statement identifying which protections apply.

The requirements of this exemption are considered to have been met if the notice is prominently printed in the summary plan document, or equivalent document, and each participant receives a copy of that document at the time of enrollment and annually thereafter.

Notwithstanding an election under this section, **a city's plan must provide for certification and disclosure of creditable coverage to participants and their dependents**. Failure to comply with this requirement invalidates an election made under this section.

Upon a finding by the HCFA that a city's plan has failed to comply with the requirements of the act and has failed to correct the noncompliance within 30 days, HCFA will notify the city that its election has been invalidated and that it is subject to the requirements of the entire act. A plan that fails to comply with the requirements is subject to federal enforcement by HCFA, including appropriate civil money penalties. The maximum daily penalty cannot exceed $100 for each day for each responsible entity for each individual to whom such a failure occurs.

For more information about the Health Insurance Portability and Accountability Act, contact Richard Stokes, MTAS municipal human resources consultant, at (615) 532-6827 or your municipal management consultant in the Knoxville, Johnson City, Nashville, Jackson, or Martin offices.

Sample Opt-Out Language

To: Health Care Financing Administration
Department of Health and Human Services
Insurance Reform Implementation Task Force
Attn.: David Holstein, Room SLL-17
7500 Security Building
Baltimore, MD 21244-1850

Pursuant to the Public Health Service Act and implementing Regulations Sec. 146.180, the **(name of plan)**, which is administered by **(name of plan administrator and administrator's address)**, is electing exemption from certain requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The **name of plan**, as a totally self-funded plan, [if plan is partly insured, identify that part that is self-funded] has elected to be exempt from the pre-existing condition exclusion provisions under HIPAA for the plan year beginning **(first day of the plan year)** and ending **(last date of the plan year)**.

This election is made in accordance with **(cite the state or local government authority and procedures for making such an election)** and is certified as noted below.

A copy is attached of the notice provided to plan participants as required under Sec. 146.180 informing them of the **(name of plan)** election to be exempt from certain HIPAA requirements.

By the authority of **(cite the public authority granting authority)**, the following named is authorized to make this election on behalf of the **(name of plan)**.

(Include authorized person's signature here.)

Sample Notice to Plan Participants

To: All participants in the **(name of governmental unit)** medical and dental benefit plan.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain obligations on group health plans for plan years beginning after June 30, 1997. These obligations apply to state and local government plans through amendments to the Public Health Service Act. Among the obligations are:

(1) limitations on pre-existing condition exclusion periods,
(2) special enrollment periods for individuals (and dependents) losing other coverage,
(3) prohibition against discrimination based on an individual's or other participant's health status,
(4) standards relating to benefits for mothers and newborns, and
(5) parity in the application of certain limits to mental health benefits.

The federal law also allows state and local government sponsors of self-funded plans to elect to opt out of any or all of the five requirements described above.

The **(name of plan)**, as the plan sponsor of the **(name of the governmental unit)**, has chosen to exercise this option, but only with regard to limitations on pre-existing condition exclusions (or name any other specific requirements the plan will not follow). Instead, the **(name of plan)** will apply the pre-existing condition exclusion terms and conditions described in this benefit plan material at (specify the section and page number containing pre-existing condition exclusion material).

However, the **(name of governmental unit)** plan will follow the federal standards relating to special enrollment, nondiscrimination rules, mother and newborn benefits, and mental parity.

For additional information concerning this notice, please contact (benefits, risk management, human resources, or the city recorder) at **(provide name and address here)**.

Model Certification Notice

Certification of Group Health Plan Coverage

Note: Separate certificates should be furnished if information is not identical for the participant and each dependent.

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 were recommended or received for the condition within the six-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 you 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. Names 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 Lines 3 and 5 has (have) 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: _____ (Check here if coverage is continuing as of the date of this certificate: _____)

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