



Preexisting Condition Exclusions

HIPAA places strict limitations on a plan's ability to impose a preexisting condition exclusion. Specifically, HIPAA:

- *Provides that any exclusion for a preexisting condition 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 (This is known as the "6-month look-back" rule.)*
- *Limits the maximum period a preexisting condition exclusion can be applied to an individual to 12 months (or 18 months for late enrollees). The period begins on the individual's enrollment date in the plan (This is known as the "look-forward" rule).*
- *Reduces the 12- or 18-month maximum exclusion period by the number of days of an individual's prior "creditable coverage." (Most health coverage is "creditable coverage," as described in more detail on page 3.)*
- *Provides that certain people and conditions can never be subject to a preexisting condition exclusion.*
- *Requires that health plans give a general notice disclosing that the plan applies a preexisting condition exclusion and a separate individual notice that informs an employee or their dependent of the specific exclusion that applies to them.*

A model general notice and a model individual notice can be downloaded from the Waterstone website.

Following are frequently asked questions about the limits on preexisting condition exclusions:

What is a preexisting condition exclusion?

A preexisting condition exclusion is any limitation or exclusion of benefits for a health condition because it was present before coverage begins, regardless of whether any medical advice, diagnosis, care, or treatment was recommended or received before that day. Some preexisting condition exclusions are



designated in the plan documents. Others are not, but operate to exclude benefits because a condition arose before coverage began. For example, a dental exclusion that covers benefits in connection with accidental injury *if the injury occurred while the individual was covered under the plan*. The timing requirement in this example makes the exclusion a preexisting condition exclusion.

Can any prior health condition be subject to a preexisting condition exclusion?

No. Only those conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period prior to an individual's enrollment date (often referred to as the "6-month look-back period") can be subject to a preexisting condition exclusion. The "enrollment date" is considered the first day of coverage under the plan; or if there is a waiting period, it is the first day of the waiting period. Typically the enrollment date is an individual's date of hire.

Consequently, if an individual had a medical condition in the past, but has not received any medical advice, diagnosis, care, or treatment for the condition within the 6 months prior to his/her enrollment date in the plan, the condition is not a preexisting condition to which an exclusion can be applied.

Are there certain people or conditions that cannot be excluded from coverage under a preexisting condition exclusion?

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

My company's plan has a waiting period prior to enrollment. How does it impact our preexisting condition exclusion?

HIPAA does not prohibit a plan from having a waiting period before individuals become eligible for benefits. In fact, plans may have both a waiting period – the time that must pass before an employee or a dependent is eligible to enroll under the terms of the plan – *and* a preexisting condition exclusion.

If a plan has both a waiting period and a preexisting condition exclusion period, the maximum preexisting condition exclusion period begins when the waiting period begins. They must run concurrently.



What is creditable coverage?

Creditable coverage is most health coverage and includes coverage under a group health plan (COBRA continuation coverage is included in this category), an HMO, an individual health insurance policy, Medicaid, or Medicare. An individual's prior creditable coverage reduces the maximum preexisting condition exclusion period that a group health plan can apply to that individual.

Creditable coverage does not include coverage consisting solely of "excepted benefits," such as coverage solely for limited-scope dental or vision benefits. (Excepted benefits are described in more detail in the document Applying and enforcing HIPAA; State Flexibility available on our website.)

Days in a waiting period during which an individual has no other coverage are not considered creditable coverage, nor are these days taken into account when determining if there is a significant break in coverage. (A significant break in coverage generally occurs when an individual has no health coverage for 63 days or more.) Any health coverage an individual had before a significant break in coverage is not counted to reduce an exclusion period.

To illustrate: Suppose an individual had health coverage for 2 years followed by a break in coverage of 70 days and then resumed health coverage for 8 months. That individual would receive credit for 8 months of coverage but not for the 2 years of coverage prior to the break of 70 days, since it was more than 63 days.

How does the plan determine the length of an individual's 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: (1) the earliest date on which coverage can become effective under the terms of the plan, or (2) on a special enrollment date.

A plan must reduce this maximum period by the number of days of that individual's creditable coverage. However, a plan is not required to take into account any days of creditable coverage that precede a significant break in coverage.

A plan generally receives information about an individual's creditable coverage from a certificate furnished by a prior plan or health insurance issuer. However, individuals also may present other evidence of creditable coverage.



What is the first thing a plan must do before imposing a preexisting condition exclusion period?

A health plan must distribute a general notice of its preexisting condition exclusion that includes:

- A statement that the plan has a preexisting condition exclusion and the terms of the exclusion period. This includes the length of the plan's look-back period regarding preexisting conditions, the maximum exclusion period (the look-forward period) under the plan, and how the plan will reduce the maximum period by creditable coverage.
- A description of the individual's right to demonstrate prior creditable coverage and prior waiting periods through a certificate or other means. This includes a description of the right to request a certificate from a prior plan or issuer and a statement that the current plan will assist in obtaining a certificate from the prior plan or issuer, if necessary.
- The person to contact (including address and telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

This notice must be distributed as part of the application materials for health benefits coverage. If the plan does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan, acting in a reasonable and prompt fashion, can provide the notice.

A model general notice and a model individual notice can be downloaded from the Waterstone website.

What are the next steps after an individual demonstrates creditable coverage?

When an individual presents evidence of creditable coverage (such as a certificate of creditable coverage), the plan must determine how much creditable coverage that individual has and the length of any remaining exclusion period.

A plan may not impose any limit on the amount of time that an individual has to present evidence of creditable coverage.

If an individual presents evidence of creditable coverage but does not have enough to offset the plan's entire preexisting condition exclusion period, then the plan must provide an individual notice of the preexisting condition exclusion period that will apply to that individual. The notice must include:



- The plan's determination (including the last day on which the exclusion for a preexisting condition applies);
- The basis for the determination (including the source and substance of any information on which the plan relied);
- An explanation of the individual's right to submit additional evidence of creditable coverage; and
- Any applicable appeals procedures.

Can a plan change the determination in light of additional evidence?

The plan may modify its initial determination if it later determines that an individual does not have the creditable coverage previously claimed. In this circumstance, the plan must notify the individual of its new determination. Until this notice of the new determination is provided, the plan must approve access to medical services according to its initial determination.

Evidence of Creditable Coverage

Group health plans are required to furnish a certificate of creditable coverage to an individual to document the individual's prior creditable coverage under the plan. This certificate can be used as evidence of creditable coverage for the individual's new group health plan to reduce the length of a preexisting condition exclusion period that might apply. The certificate must be provided free of charge and is given:

- Automatically (a) when an individual loses coverage under the plan or becomes entitled to elect COBRA continuation coverage, and (b) when an individual's COBRA continuation coverage ceases; and
- If requested, before that individual loses coverage or within 24 months of losing coverage.

(For more information on COBRA, see the U.S. Department of Labor's publication, *An Employer's Guide to Group Health Continuation Coverage under COBRA* at www.dol.gov/ebsa.)

Group health plans, in determining whether an exclusion period applies to a new employee or his/her dependents, must permit that employee (or dependents) to show prior health coverage, either by a certificate of creditable coverage, or in the absence of a certificate, by producing other evidence of creditable coverage. This evidence can include pay stubs showing a deduction



for health insurance, explanation of benefits forms (EOBs), or verification by a doctor or a former health care benefits provider that the employee or dependent had prior health insurance coverage.

Do plans that do not impose a preexisting condition exclusion period have to provide certificates?

Yes. Individuals previously covered under these plans may need to demonstrate this prior coverage, if they move to a new group health plan or individual health insurance coverage.

Are plans required to issue certificates of creditable coverage to dependents?

Yes. A plan must make reasonable efforts to collect the necessary information for dependents and issue a certificate of creditable coverage for the dependent. If the coverage information for a dependent is the same as for the employee, the plan may issue one certificate with both the employee and dependent information. If the information is not identical, it may still be provided on one certificate, if the certificate provides all the required information for each individual separately and includes a statement that the information is not identical.

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

When must group health plans provide certificates?

It depends on the event that triggers the certificate.

- For an individual who is entitled to elect COBRA continuation coverage, the automatic certificate must be provided no later than when an election notice is required to be provided for a qualifying event under COBRA (generally 44 days). For more information on the COBRA notice requirements, see *An Employer's Guide to Group Health Continuation Coverage Under COBRA* at www.dol.gov/ebsa.
- For an individual who loses coverage under a group health plan but is not entitled to elect COBRA continuation coverage, the automatic certificate must be provided within a reasonable time after coverage ceases.



- For an individual who loses COBRA continuation coverage, the automatic certificate should be provided within a reasonable time after COBRA continuation coverage ceases (or after the expiration of any grace period for the nonpayment of COBRA premiums).
- For an individual requesting a certificate, it should be provided at the earliest time that the plan, acting in a reasonable and prompt fashion, could provide it.

What information must be included on the certificate?

Certificates of creditable coverage currently must include:

- Date issued;
- Name of plan;
- Individual's name and ID;
- Plan administrator's name, address, and phone number;
- Phone number for further information;
- Individual's creditable coverage information; and
- An educational statement explaining HIPAA, including:
 - The preexisting condition exclusion rules;
 - Special enrollment rights;
 - The prohibitions against discrimination based on any health factor;
 - The right to individual health coverage;
 - The fact that State law may require issuers to provide additional protections to individuals in that State; and
 - Where to get more information.

A model general notice and a model individual notice can be downloaded from the Waterstone website.

Note: The Departments of Labor, the Treasury, and Health and Human Services issued proposed rules regarding the coordination of the HIPAA portability rules with the Family and Medical Leave Act (FMLA). The proposed rules include a revised educational statement for the HIPAA certificate with new model language to explain this coordination. Some plans may wish to avoid revising their certificates when the proposed rules become final, and therefore, use the model certificate under the proposed rules, which includes FMLA language. Check www.dol.gov/ebsa under "Laws & Regulations" periodically for the publication of the final rule.

**In reporting an individual's creditable coverage information, what is the minimum period of time that should be covered by the certificate?**

It will depend 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. A separate certificate may be provided for each period of coverage if there is more than one.

However, the certificate does not have to reflect more than 18 months of creditable coverage that is not interrupted by a break in coverage of 63 days or more. A certificate should also include either a statement that an individual has at least 18 months of creditable coverage or the date creditable coverage (and any waiting period for coverage) began. The certificate should also include the date coverage ended or state that coverage is continuing.

Can creditable coverage information be transferred by telephone?

Yes, if the individual involved, his/her new plan, and the old plan all agree, the information may be transferred by phone. Individuals are entitled to request a written certificate for their records when coverage information is provided by phone.

Can a plan contract with a health insurance issuer to provide certificates?

Yes, a plan and issuer can make an agreement that the issuer will be responsible for providing the certificates. While the issuer is liable for noncompliance with the certificate requirements, the plan administrator has the duty to monitor the issuer's compliance with the certificate requirements under the contract.

In addition, if any entity (including a third-party administrator) provides a certificate to an individual, no other party is required to do so.