

**BOARD OF PENSIONS
ADMINISTRATIVE RULES**

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| Section: 2 (Enrollment) | Subject: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT & PRE-EXISTING CONDITIONS |
| Rule Number: 201 | |
| Reference: Article XVIII, Section 18.1 Article XIII, Section 13.1 (j), 13.9(b)(19) | Resource: Benefits Original Date: 1/91 Revision Dates: 8/92, 6/95, 1/97, 4/97, 4/98, 4/00 |

BACKGROUND

In 1996 the United States Congress passed the Health Insurance Portability and Accountability Act (“HIPAA”). It guarantees the availability and renewability of health insurance for certain employees and individuals, and limits the use of pre-existing condition restrictions.

The Act is designed to ensure that people who are moving from one job to another or from employment to unemployment are not denied health insurance because they (or a member of their family) have a pre-existing condition. The Act also restricts the waiting time before a plan covers any pre-existing medical condition for participants and beneficiaries in group health plans.

The legislation became effective for group health plans on or after July 1, 1997.

LEGAL RESTRICTIONS ON PRE-EXISTING CONDITION PROVISION

HIPAA imposes certain limits on a group health plan’s imposition of pre-existing condition limitations. These provisions, which are applicable to church plans, are:

- The definition of a pre-existing condition cannot look back more than 6 months.
- A plan cannot limit coverage for pre-existing conditions for more than 12 months.
- A plan must reduce a member, spouse or eligible dependent’s pre-existing condition exclusion period by the number of days that the member, spouse or eligible dependent had continuous coverage for the condition prior to entering the plan. Continuous coverage means coverage without a break-in-coverage of more than 63 days.

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- A plan must provide members, spouses and dependents who are terminating medical coverage with a Certificate that states the dates of coverage under the plan. The new plan of the member, spouse or dependent must accept the Certificate as proof of previous coverage and reduce the pre-existing coverage period by the number of days the member, spouse or dependent had continuous coverage under the prior plan.
- Excludes pre-existing limitations for pregnancies, newborns, adoptions or placement of adoptions.

LOOK BACK PERIOD

The Plan defines a pre-existing condition **(1)** as any condition (physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, treatment, care or medication, was recommended or received within the six (6) month period ending on the enrollment date for Medical coverage. The six-month period is referred to as the “look back” period. A “look back” period is the period of time that an employer can look back to see if a Member or Eligible Family Member were treated for a medical (physical or mental) condition or illness.

To illustrate, if a Member enrolled for plan membership on March 15, Board staff can look back six months from the date of plan enrollment (March 15) to determine if the Member or Eligible Family Member were treated for a particular medical (physical or mental) condition or illness.

WAITING PERIODS

HIPAA limits the waiting period applied to pre-existing conditions to no longer than 12 months. **The Benefits Plan maximum limit on pre-existing conditions is 12 months beginning with the effective date of enrollment.**

Members will get credit for continuous coverage prior to plan enrollment. Continuous coverage means that a Member did not have a break in their previous coverage of 63 days or more. If a 63-day or more break in coverage occurs, the coverage prior to the break would not be credited against a possible exclusion period for a pre-existing condition. For example, if a Member had coverage for 18 months, followed by a break of 65 days, then reestablished medical coverage for 6 months, the Member or Eligible Family Member would only receive credit for 6 months towards any pre-existing condition.

1 Prior to April 1, 1997, a preexisting condition was defined as any condition (physical or mental), for which a Member or Eligible Family member received a diagnosis, medical advice, treatment, or medication, within the twelve (12) month period immediately preceding the date of eligibility for Medical coverage.

The length of the waiting period for coverage for pre-existing coverage must be reduced each day that a new employee was covered under creditable coverage before enrolling in the plan.

Coverages that count as creditable coverage are:

- Groups health plans
- Health insurance coverage (group, individual or otherwise)
- Part A & B of Medicare
- Medicaid
- Indian Health Insurance or a tribal organization
- State health benefits risk pool plans
- Public Health plans
- Federal Employees Health Benefits Program health plans
- Health plan of the Peace Corps Act.

CERTIFICATES OF COVERAGE

Certificates of Coverage are certificates that will show evidence of your prior health coverage. Employees who change jobs will use these Certificates to prove the length of time a previous employer has covered them.

HIPAA regulations require that the Board automatically send a certificate of coverage to any member, spouse or eligible dependent that terminates medical coverage on or after June 1, 1997.

PRE-EXISTING CONDITIONS

Liability under the medical provisions will be limited by the exclusion of all medical costs, other than outpatient prescription drugs, incurred for pre-existing conditions.

NATIONAL HEALTH CARE COVERAGE

National Health Care coverage will count as creditable coverage. The member will need to provide appropriate documentation confirming National Health Care if re-enrolling for coverage in the Medical Provisions of the Plan.