

## **HIPAA Guidelines for Eligible Individuals Waiver of Preexisting Condition Exclusion Period**

### **Overview**

Members who are 19 years old and older who enroll in individual coverage are subject to a waiting period for all pre-existing conditions. Eligible individuals as defined under HIPAA guidelines are eligible for waiver. The decision to waive the pre-existing waiting period is determined by Individual Business Underwriting.

Under HIPAA guidelines, a member is an eligible individual if all of the following criteria are met.

- The member must have at least 18 months of continuous coverage immediately before enrolling.
- There must be no gap in coverage greater than 62 days.
- The most recent coverage must have been through a group health plan. The definition of a group health plan is an employer plan with two or more contracts enrolled at the time the member was enrolled.
- If the member was eligible for COBRA at the time the member became ineligible under the prior group health plan, the member must have purchased and exhausted the COBRA benefits before enrolling.
- The member must not be eligible for other health care coverage including group, Medicare or Medicaid. If the member is eligible for group benefits, the member is not eligible for BCBSM individual coverage and is also not eligible for waiver.
- If the member is eligible for group conversion and chose not to purchase BCBSM conversion but enrolled in a product that is open as a conversion option, the member is not eligible for waiver. **NOTE: if the member purchased an individual product that is not offered as a conversion product, they may be considered for waiver under HIPAA guidelines.**
- They must not have been terminated from their prior health plan for reasons of fraud or nonpayment.
- The member must not have voluntarily terminated their prior coverage.

### **Prior BCBSM coverage**

Members previously enrolled in BCBSM coverage may be eligible for group conversion. Many BCBSM group members are eligible for group conversion. Members who were enrolled in any insured group with two or more employees enrolled on the group health plan, and self-funded (ASC) groups that fund the conversion subsidy are eligible to purchase conversion when they lose eligibility for their prior group health plan. If they apply for a product that is offered as group conversion, they must purchase group conversion. If they do not purchase the conversion version of that product, they are not eligible for waiver of their pre-existing condition waiting period. If they apply for a product that BCBSM does not offer as group conversion, they may request review as an eligible individual under HIPAA.

Members who were previously enrolled in self-funded groups that did not fund the conversion subsidy are not eligible for group conversion. If they meet the criteria for waiver under HIPAA their waiting period will be waived. Refer to the Group Conversion Exclusion list.

Association members and One Subscriber Groups (OSGs) are not eligible for conversion unless BCBSM terminates them as no longer eligible for group. They are not eligible for waiver of their pre-existing condition waiting period if they voluntarily terminated their prior coverage. Their prior coverage will not be applied to their new waiting period.

### **Waiver Review Requests**

When a member requests waiver, provide member the application for waiver. It must be completed, signed and returned to BCBSM by the member. The request may be faxed to 313 983 2286 or mailed directly to mail code 1124.

Inform member that a certificate of creditable coverage for at least 18 months must be provided. The following are considered creditable coverage:

- Group (employer sponsored) health insurance
- Medicare
- Medicaid
- Military or federal benefit plans
- Indian Health Services
- COBRA or state continuation benefits
- Short term insurance policies
- Prescription Drug Coverage

The coverage must be medical or prescription drug coverage. Limited benefits such as cancer policies, life insurance, dental, short term disability, etc. are not considered creditable coverage.

Note, while all of these may be considered creditable health insurance the most recent coverage must be group health insurance. Group health insurance is a group health plan with

two or more employees enrolled. Many carriers call individual coverage for sole proprietors or one subscriber groups group coverage; the member must show proof there are two or more enrollees at the time the member was enrolled.

## **COBRA**

- If the member was eligible for COBRA the member must purchase and exhaust the benefits. Note that a standard qualifying event is 18 months. If a member is disabled and qualifies, the benefit period is 29 months. If a dependent loses eligibility for specific reasons, the benefit period may be 36 months. The member must exhaust all benefits.
- Many states have a state continuation benefit program. Some examples are California and Texas. These provide continuation benefits in addition to COBRA or for members whose group does not qualify under federal COBRA guidelines. If a member's benefits were in one of these states, the member must exhaust these benefits.
- The member must provide proof that COBRA was exhausted. Federal guidelines (as well as the state of Michigan) require group health plans to notify members upon loss of eligibility for group of their rights for COBRA. They also must provide notice when COBRA benefits are exhausted. This document must be sent in with the CCC and questionnaire.
- Members who do not have a qualifying event are usually members who voluntarily terminated their group health plan. These are **not** eligible for waiver.
- Members whose employer has terminated their group health plan must provide the letter they received from the employer notifying them of closure of the group health plan and loss of eligibility.

### **Members whose claims reject due to a pre-existing condition**

If a member has claims that reject as pre-existing, and calls in, it is important to determine two different facts. First, determine if the claims are pre-existing. If the member believes the claims are not pre-existing request a claim review. Have the member complete the questionnaire for medical review.

If the member believes they are eligible individuals under HIPAA, initiate a review. Have the member complete the questionnaire and submit all documents necessary for review.



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## **Blue Cross and Blue Shield of Michigan Preexisting Condition Exclusion Rider Criteria for Waiver**

### **Read this First**

Your Blue Cross Blue Shield of Michigan individual coverage requires a 180-day pre-existing exclusion period during which coverage for pre-existing medical conditions is not available. A pre-existing condition is a condition or illness the individual has up to six months before becoming enrolled in a health plan, for which medical advice, diagnosis, care or treatment was recommended or received.

Under Federal and State of Michigan legislation, you may be eligible for waiver of the pre-existing condition waiting period if you meet the definition of an 'eligible individual' under HIPAA (Health Insurance Portability and Accountability Act) guidelines by meeting **ALL** of the following criteria.

- You must have 18 months of continuous coverage without any lapse in coverage greater than 62 days during the 18 months of coverage or lapse greater than 62 days between your most recent coverage and the day you applied for this coverage.
- Your most recent coverage must have been through an **employer-sponsored group health plan**. The State of Michigan defines a group health plan as a group with at least two subscribers. If there were not at least two subscribers enrolled at the time you terminated coverage, it is not considered a group health plan. An association with members individually enrolled is not considered a group health plan. Note the certificate may state 'group health plan', but there must be an employer sponsored plan with at least two contracts enrolled.
- If you were enrolled in a group health plan that was subject to COBRA (or some form of state continuation), you must have purchased and exhausted COBRA (or any state continuation benefits) before you meet the definition of 'eligible individual.' Under COBRA, the length of time for which COBRA coverage can be purchased is between 18 and 36 months, depending on your qualifying event.
- You must not have voluntarily terminated your health insurance. If you were enrolled in a group health plan, and you were still eligible for coverage in the group health plan, but chose not to purchase it or to continue it, you are not eligible for individual coverage with BCBSM. You are not eligible for waiver of your pre-existing condition limitation waiting period.
- You must not have been terminated for fraud.
- You must not have been terminated for nonpayment of your health insurance premium.

If you were eligible to enroll in a group conversion program after loss of coverage in a BCBSM group health plan, you may not be eligible for this waiver.

Based on the criteria above, BCBSM will review you for eligibility for waiver of your pre-existing waiting period. You will need to complete the attached questionnaire and provide all requested documentation.

**Please complete and sign the questionnaire. You will not be reviewed for waiver unless the questionnaire is complete and signed and all documentation requested has been submitted. You may keep this page for your information**

Send this application to:

Blue Cross Blue Shield of MI  
600 E Lafayette Blvd.  
Detroit, Mi. 48226  
Attn: Mail Code 1124

Fax: 313 983 2286  
Customer Service: 1-888-288-2738

### Application for Waiver of the Pre-Existing Waiting Period

Subscriber Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Contract Number: \_\_\_\_\_

1. **You must show proof of 18 months of continuous coverage without a gap in coverage greater than 62 days.**

Attach the Certificate(s) of Creditable Coverage (CCC) to show proof of 18 months of continuous coverage. This certificate should have been sent to you from your prior insurance carrier or the administrator of your group health plan. If you did not receive this document, you will need to contact your prior carrier to obtain this important document. **If you cannot provide the certificates to verify at least 18 months of creditable coverage with no gap of greater than 62 days, your request for removal of the pre-existing waiting period will be denied.**

Note: a CCC must be provided for **each** adult member (older than 18 years of age) on your contract requesting waiver of the pre-existing condition waiting period. BCBSM will review for waiver for each adult member who is enrolled on your contract.

2. **Was your most recent coverage through an employer-sponsored group health plan? If you have more than one CCC, please answer for your most recent coverage.**

- a. Please indicate if the coverage listed on your most current CCC was for any of the following:

- Medicaid, MiChild or other state or county health program for individuals
- HCTC (Health Care Tax Credit)
- Student Health Insurance
- Coverage as a self-employed individual with no employees enrolled
- Coverage you purchased directly from an insurer as an individual
- Coverage purchased as an association member
- Short Term Medical Policy

**If you checked any of the above, your most recent coverage was not a group health plan. Your pre-existing condition waiting period will not be waived.**

- b. If you were enrolled in a group health plan with two or more subscribers please provide the following information.

Name of Group Health Plan \_\_\_\_\_  
Employer providing Group Health Plan \_\_\_\_\_  
Address of Employer \_\_\_\_\_  
Benefits Contact Person at Employer \_\_\_\_\_  
Title of Contact Person \_\_\_\_\_  
Phone Number for Contact Person \_\_\_\_\_

**We may wish to contact your employer or prior insurance carrier. By signing this questionnaire you are authorizing Blue Cross Blue Shield of Michigan to speak to your employer or insurance carrier.**

- c. Please indicate the total number of employees (full and part time) working for the employer listed in section b above:
- There is only one employee
  - There are less than 20 employees
  - There are more than 20 employees
- d. Check the reason that best describes why you are no longer enrolled in group health coverage.
- I am no longer eligible for coverage.  
Provide reason no longer eligible \_\_\_\_\_  
Provide last day you were eligible \_\_\_\_\_
  - I completed COBRA  
Provide begin date for COBRA \_\_\_\_\_  
Provide end date for COBRA \_\_\_\_\_  
Provide COBRA qualifying event:  
 Changed employer  
 No longer meet definition of dependent  
 Divorce  
 Death of Subscriber  
 Disability  
 Terminated or laid off
  - Employer no longer offers health plan.
  - I could not afford the premium available to me.
  - I voluntarily terminated the coverage available to me.
  - Other, please explain \_\_\_\_\_

**3. If you were enrolled in a group health plan that is subject to COBRA guidelines, you must have purchased and exhausted COBRA. Please answer the following questions.**

Did your employer notify you of your rights under COBRA and offer you coverage?

- Yes, my employer notified me of my rights to COBRA. Please check the situation that applies to you.  
 I was not offered COBRA  
 I was offered COBRA, but I chose not to purchase it.  
 I was offered COBRA; I purchased it but I did not complete the COBRA benefits available to me.  
Provide the reasons why benefits were not completed. \_\_\_\_\_  
 I was offered COBRA; I purchased it and have exhausted all benefits available to me.
- No, my employer did not notify me of COBRA. Check the reason(s) that apply  
 There are less than 20 employees, full and part time  
 My employer is a church or religious organization  
 My employer no longer offers a group health plan  
 Other

**If you were not offered COBRA, please obtain from your employer or COBRA administrator a letter indicating why you were not eligible. Please attach it to this questionnaire along with all other documentation.**

**If you were offered COBRA but did not purchase it, you are not eligible for waiver of pre-existing conditions exclusion waiting period.**

**If you purchased COBRA, but did not exhaust all benefits available to you, you are not eligible for waiver of pre-existing conditions exclusion waiting period.**

**If you purchased and exhausted the COBRA benefits available to you, please attach the notice you received from your group health plan or the COBRA administrator. You would have received one notice prior to loss of coverage and a second after those benefits were exhausted.**

I authorize BCBSM to contact my prior insurance carrier, employer and COBRA administrator to obtain any necessary information in order to process my request for waiver of my pre-existing condition exclusion rider waiting period. I understand that BCBSM may collect personal and protected health information (PHI) about me in order to complete my application for coverage. BCBSM will use and disclose this information only in accordance with their Notice of Privacy Practices which is available on [bcbsm.com](http://bcbsm.com) or by calling 313-225-9000.

I understand all of the above information will be used to determine if the pre-existing exclusion period should be waived. I also understand, should the pre-existing condition period be waived, and it is determined at a later date that the information provided was false or misrepresented, that I may be responsible to reimburse BCBSM for any claims incorrectly paid based upon the false or misleading information.

If someone else has completed any part of this form on my behalf, I have reviewed the information and confirm that it is accurate.

**Name (please print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_