Client Alert

# Employer Action Required Before Start of Next Plan Year to Comply With Final and Proposed HIPAA Regulations

September 19, 2005

Employers will need to make changes to their health insurance plan materials and participant communications as of the start of their next plan year (January 1, 2006 for employers with calendar plan years), in order to comply with final regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The regulations, issued by the Departments of Treasury, Labor, and Health and Human Services on December 30, 2004, pertain to rules about pre-existing condition exclusions, certificates of creditable coverage and special enrollment rights, among other things. A set of proposed regulations providing more detail on those topics was also released by these agencies on the same day. This client alert provides a brief overview of the rules under the final and proposed regulations.

Executive Compensation and Benefits

## Background

HIPAA provides rules on the "portability" of health insurance coverage, including parameters relating to pre-existing condition exclusion periods (periods wherein a health insurance plan may deny a participant specific coverage due to a health condition that existed previous to the participant's enrollment in that plan), the creditable coverage assessment that is used to determine when a pre-existing condition exclusion may be applied, and the special circumstances wherein participant enrollment is allowed outside of ordinary enrollment periods. (Limited dental, vision and long-term care benefits that are provided under a separate policy are excepted from the HIPAA portability requirements.) The portability rules apply to all participants of an active employee group health plan, including former employees, retirees and dependents.

The final HIPAA portability regulations, effective as of July 1, 2005, replace the interim final regulations issued on April 1, 1997, and later clarified on December 29, 1997, but do not make significant changes. The final regulations clarify certain definitions and require new information to be included in participant notices and communications. Plans must comply with the final regulations as of their plan years beginning on or after July 1, 2005 (*i.e.*, plans with calendar plan years must comply as of January 1, 2006).

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The proposed regulations address topics such as gaps in creditable coverage, special enrollment procedures, and how the Family Medical Leave Act interacts with HIPAA.

### Pre-Existing Condition Exclusions – Notice Required

A pre-existing condition is evidenced by an individual's actual receipt of medical advice, diagnosis, care or treatment. A participant with a pre-existing condition may be excluded for coverage pertaining to that condition for up to, but no longer than, twelve months from enrollment, if he or she enrolls in the first open enrollment period in which he or she is eligible. If he or she is a late enrollee, the maximum permitted pre-existing condition exclusion period is eighteen months.

With respect to pre-existing condition exclusions, the final regulations provide that the maximum time period that a plan may "look back" to determine whether a pre-existing condition exists for purposes of imposing an exclusion is the six months prior to the *effective* date of coverage (a plan may use a shorter look back period, or may choose not to impose a pre-existing condition exclusion at all). Thus, when a group health plan switches health insurance providers, the subsequent health insurance provider may not deny benefits for a condition that occurred before coverage became effective under its successor policy, unless there was a significant break in coverage — a coverage gap of 63 days or more.

Policies that are not clearly identified as pre-existing condition exclusions, but have the same effect, are considered hidden pre-existing condition exclusions and must abide by the same restrictions. For example, a plan provision that limits accidental injury coverage to injuries occurring while the participant is covered under the plan; imposes a 12-month waiting period for pregnancy coverage after general benefits eligibility is granted; or counts benefits received under prior health coverage against a lifetime limit is an instance of a hidden pre-existing condition exclusion. A plan denying benefits for a congenital condition must also comply with the HIPAA rules on pre-existing condition exclusions. Employers will want to review their plans to ensure that any hidden pre-existing condition exclusions are in compliance.

A plan must provide a general notice of its pre-existing condition exclusion in order to impose such limitation. This notice must be included in any written enrollment materials provided by the plan; the final regulations contain sample language for this notice. In addition, the final regulations provide sample language for a required notice informing participants of the length of a pre-existing condition exclusion. (The exclusion period is reduced by the participant's creditable coverage from a previous plan or plans, as long as there are no coverage gaps of 63 days or more.) The final regulations, along with the model language can be found here: *http://www.dol.gov/ebsa/regs/fedreg/final/2004028112.htm*.

### Creditable Coverage – New Disclosure Required

Creditable coverage is used to offset the length of a pre-existing condition exclusion under a plan to which a participant has transferred, except if there has been a coverage gap of 63 days or more. Health coverage under various listed types of health insurance providers, including the State Children's Health Insurance Program, government health plans and health coverage under a plan

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established or maintained by a foreign country or political subdivision, counts as creditable coverage.

Plans are required to certify creditable coverage when coverage ends or upon a participant's request. The final regulations require that information on written procedures for requesting these certificates of creditable coverage must be provided to participants; employers may amend their summary plan descriptions to include this information. Also, an educational statement on HIPAA rights must be added to the certificate itself — two new model certificates containing the necessary language are provided by the final regulations (one for group health plans and one for Medicaid programs). Employers must begin using the updated model certificate of creditable coverage no later than the plan year beginning on or after July 1, 2005. The proposed regulations include an additional provision added to the model certificate explaining that the coverage gaps that occur when a participant takes leave under the Family and Medical Leave Act will not be considered in determining whether a significant break in coverage has occurred. The final regulations clarify that coverage gaps resulting when a participant elects COBRA coverage during a second election period are also not counted toward this purpose.

Additionally, the proposed regulations provide that the 63-day break in coverage rule is tolled for up to 44 days if a certificate of creditable coverage has not been provided on or before the day that coverage terminated. The proposed regulations also coordinate with HIPAA's special enrollment right (resulting from a mid-year loss in coverage) to provide for a delay of the start of the 30-day special enrollment period until the day after the certificate of creditable coverage is provided or the date 44 days after coverage ceases.

### Special Enrollment

The final regulations provide several circumstances in which individuals may enroll for coverage at times outside of the ordinary enrollment period, that are in addition to situations where there is a mid-year loss of other health coverage or when there is a new dependent via a mid-year birth, adoption or placement for adoption, or marriage. The regulations clarify that these special enrollment rights apply even if an individual has other coverage opportunities available, such as COBRA.

Individuals who lose coverage because: (i) they have reached the maximum lifetime limit for benefits under a plan; (ii) they no longer live or work within the health insurance coverage area and have no access to other coverage; or (iii) they have reached an age at which they no longer qualify as a dependent child under the plan are entitled to exercise these special enrollment rights, if the plan no longer offers benefits to similarly situated individuals.

To be eligible for special enrollment, the individual generally has to have declined coverage under the employer's plan because he or she depended on the other health coverage.

Additionally, all individuals eligible for participation must be provided with a notice of HIPAA special enrollment rights when they first become eligible to enroll. Model language is provided in the final regulations.

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## Required Employer Actions

Employers should review and revise their summary plan descriptions, enrollment materials, and other employee communications to reflect the new requirements for pre-existing condition exclusions, certificates of creditable coverage, and special enrollment rights. Employers should ensure that participants receive notice of the pre-existing condition exclusion and notice of special enrollment rights prior to enrollment in the plan. Summary plan descriptions should be revised to include procedures for participants to request certificates of creditable coverage, and the updated certificate of creditable coverage should be used no later than the plan year beginning on or after July 1, 2005.

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## Live Link

U.S. Department of Labor, Employee Benefits Security Administration Final Rule

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