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HIPAA Portability Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains rules for group health plans and health insurance issuers regarding portability, nondiscrimination and administrative simplification. HIPAA initially went into effect for plan years beginning on or after July 1, 1997.

On Dec. 30, 2004, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (the Departments) jointly released both final and proposed regulations governing HIPAA's portability requirements. The final regulations became effective for plan years beginning on or after July 1, 2005. The proposed regulations have not been finalized and health plans currently are not required to comply with their provisions.

In addition, the health care reform law, the Affordable Care Act (ACA), impacts HIPAA's portability provisions. On Feb. 24, 2014, the Departments issued a final rule that addresses how the ACA's prohibition on pre-existing condition exclusions affects the requirement to provide HIPAA certificates. **The rule eliminates the requirement to provide HIPAA certificates, beginning Dec. 31, 2014.**

PLANS SUBJECT TO PORTABILITY RULES

HIPAA's portability rules apply to group health plans and issuers offering group health insurance coverage. In some cases, the rules may also apply to individual health insurance policies. Certain benefits are excepted from the portability requirements, such as coverage for accidents, disability, liability and workers' compensation and limited-scope benefits.

PRE-EXISTING CONDITION EXCLUSIONS

HIPAA allows plans and issuers to exclude pre-existing conditions from coverage, but places significant limitations on those exclusions. In general, a pre-existing condition exclusion (or PCE) is any exclusion based on information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

> Effective for plan years beginning on or after Sept. 23, 2010, the ACA prohibits pre-existing condition exclusions for enrollees who are under 19 years of age. Effective for plan years beginning on or after **Jan. 1, 2014**, group health plans and issuers are prohibited from imposing PCEs on any enrollees. These restrictions on PCEs apply to both grandfathered and non-grandfathered group health plans.
>
> Until the ACA's restrictions take effect for a plan, the HIPAA rules regarding PCEs will continue to apply.

Under HIPAA, a PCE may be imposed only if it relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received within the "look-back period." The look-back period is a period of no more than **six months** before the enrollment date.

In addition, PCEs may be imposed only for a maximum period of **12 months for regular and special enrollees** and **18 months for late enrollees** (the "look-forward period"). The final portability regulations contain a number of examples describing provisions that constitute PCEs and discussing compliance with the limits.

HIPAA also contains exceptions to the ability to impose PCEs. PCEs may not be imposed on the following:

- A child who is covered under any creditable coverage within 30 days after birth if there is no significant break in coverage;
- A child who is adopted or placed for adoption before turning 18 and who, within 30 days after the adoption or placement for adoption, is covered under any creditable coverage if there is no significant break in coverage;
- Benefits related to pregnancy; and
- Benefits for conditions based solely on genetic information.

PRE-EXISTING CONDITION EXCLUSIONS—NOTICE REQUIREMENTS

HIPAA requires that the plan or issuer provide a written **General Notice of Pre-Existing Condition Exclusion** before it can impose a PCE. In some cases, HIPAA also requires that a **Determination of Creditable Coverage Notice** be provided.

The General Notice of Pre-Existing Condition Exclusion

The General Notice of Pre-Existing Condition Exclusion must be provided as part of any written application materials distributed by the plan or issuer for enrollment. It must contain all of the following: a) a description of the plan's PCE, b) the individual's right to reduce any applicable waiting periods by providing evidence of creditable coverage, and c) the name of the person to contact (including phone number or address) for assistance. A model notice is included within the final regulations.

The Determination of Creditable Coverage Notice

The Determination of Creditable Coverage Notice must be provided by the earliest date that the plan or issuer, acting in a reasonable and prompt manner, can provide it. The notice need not include a list of conditions excluded. In the event the plan's PCE is completely offset by creditable coverage, HIPAA does not require that a Determination of Creditable Coverage Notice be provided.

CREDITABLE COVERAGE—DEFINITION

HIPAA requires that the plan or issuer reduce any PCE by the amount of creditable coverage the individual had prior to his or her enrollment in the plan. The following types of coverage constitute creditable coverage:

- A group health plan;
- Health insurance coverage;
- A state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- A state Children's Health Insurance Program;
- Medicare Part A or B;
- Medicaid (excluding the program for distribution of pediatric vaccines);
- Medical and dental care for members of the uniformed services and their dependents;
- A medical care program of the Indian Health Services or of a tribal organization;
- All public health plans; and
- A health benefit plan provided for by the Peace Corps Act.

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06/05, EM 9/14

Coverage need not be terminated in order to qualify as creditable coverage. Also, the plan or issuer may not impose any limit on the amount of time that an individual has to present a Certificate of Creditable Coverage to prove that he or she had prior creditable coverage.

Creditable coverage that an individual had before a **significant break in coverage** is not required to be counted. A significant break in coverage is a period of **63 consecutive days** during which the individual does not have creditable coverage. Waiting periods generally do not count as a break in coverage. For some individuals eligible for a second COBRA election period, coverage followed by a 63-day break in coverage must still be counted as creditable coverage under the Trade Act of 2002.

The proposed regulations contain provisions regarding situations that would toll a significant break in coverage, including leave under the Family and Medical Leave Act (FMLA) and failure to provide a Certificate of Creditable Coverage on or before the date that coverage ceases.

CERTIFICATES OF CREDITABLE COVERAGE

HIPAA requires plans and issuers to provide a **Certificate of Creditable Coverage** automatically to individuals in the event they lose coverage under the plan. Additional copies of the Certificate of Creditable Coverage must also be provided upon request for a period of 24 months following termination of coverage.

The Certificate of Creditable Coverage is intended to enable an individual to establish prior creditable coverage for purposes of reducing or eliminating any PCE imposed on the individual by a subsequent group health plan.

The final portability regulations slightly modified the plan's and issuer's obligations.

- The final regulations added an "educational statement" which must be included within the Certificate of Creditable Coverage. The model Certificate of Creditable Coverage was updated to include a sample educational statement.
- The final regulations clarified that the plan or issuer must have written procedures for individuals to request and receive Certificates of Creditable Coverage. The procedures must include contact information, such as name, phone number and address.
- For individuals who lose coverage and are eligible for state or federal COBRA, the Certificate of Creditable Coverage must be automatically provided no later than the date the individual would lose coverage in the absence of COBRA. Plans may meet this obligation by sending the Certificate of Creditable Coverage with the COBRA Qualifying Event Notice. If the individual is not eligible for COBRA, the plan must automatically send the Certificate of Creditable Coverage within a reasonable time.

The ACA's prohibition on pre-existing condition exclusions for plan years beginning on or after Jan. 1, 2014, makes HIPAA certificates unnecessary. A final rule under the ACA eliminates the requirement to provide HIPAA certificates, **beginning Dec. 31, 2014**. The Departments imposed this effective date because they recognize that participants still may need HIPAA certificates during 2014 to avoid pre-existing condition exclusions in non-calendar year plans.

SPECIAL ENROLLMENT RIGHTS

HIPAA requires that individuals who do not initially enroll in the health plan be provided with rights to enroll at a later date in three situations:

- A loss of eligibility for other coverage;
- Acquisition of a new spouse or dependent; and
- Eligibility for a premium assistance subsidy under Medicaid or a State Children's Health Insurance Program (SCHIP).

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06/05, EM 9/14

Except as otherwise noted below, the special enrollment period must be at least **30 days**, beginning on the date of the marriage, birth, adoption or placement for adoption and all benefit packages under the plan must be available for enrollment. The proposed portability regulations would establish procedures surrounding the special enrollment process and extend the enrollment period for individuals who do not timely receive a Notice of Creditable Coverage.

In addition, the ACA created one-time special enrollment opportunities for individuals who lost health plan coverage due to the application of a lifetime limit or and for adult children who became eligible for coverage under the ACA's age 26 mandate.

Loss of Coverage

Under HIPAA, eligible employees and their eligible dependents must be provided with special enrollment rights if they:

- Had other coverage at the time of enrollment;
- Waived coverage at the time of enrollment; and
- Subsequently lose the other coverage.

The final HIPAA regulations clarified that a loss of coverage under the following example would also provide an eligible employee and their eligible dependents with a special enrollment right.

> *Example*: Rob is hired on Jan. 1 to work for ABC Company. Rob and Amber, his wife, decline coverage under Rob's employer's plan at initial enrollment. At the time Rob declined coverage, neither Rob nor Amber had health insurance coverage. On July 1, Amber accepts a new job and elects coverage for both herself and Rob under her employer's plan. On Jan. 1, Rob declines coverage during his employer's open enrollment period. On Feb. 1, Amber loses her job and declines COBRA coverage. Rob and Amber are entitled to a special enrollment period under Rob's employer's plan.

The final portability regulations expanded the list of events that constitute a loss of eligibility for other coverage that provide an individual with a special enrollment right to include the following scenarios:

- *Moving Outside the HMO Service Area*. If an employee and/or his dependents are covered under an HMO plan and no longer reside, live or work in the service area and the HMO does not provide coverage for that reason, these individuals are entitled to a special enrollment period.
- *Lifetime Benefit Limits*. Where an individual has a claim denied due to the operation of a lifetime limit on all benefits, there is a loss of eligibility for coverage and the individual is entitled to a special enrollment period. (Effective for plan years beginning on or after Sept. 23, 2010, the ACA prohibits lifetime limits on essential health benefits.)

Acquisition of a New Spouse or Dependent

Under HIPAA, special enrollment rights must be provided to newly acquired spouses and dependents and also to current employees who have acquired a new spouse or dependent, even if the employees previously declined coverage.

However, only **the employee**, **spouse** and **newly acquired dependent** are eligible for special enrollment rights. Other dependents, such as a newborn child's siblings, are not entitled to special enrollment rights, although a plan could choose to provide them.

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06/05, EM 9/14

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Effective April 1, 2009, eligible employers and their dependents must also be given special enrollment rights if they lose coverage under a Medicaid plan or SCHIP or become eligible for a premium assistance subsidy under Medicaid or SCHIP. In these cases, eligible individuals must be given **60 days** after the loss of coverage or determination of eligibility for assistance to request coverage under the plan.

SPECIAL ENROLLMENT RIGHTS—NOTICE REQUIREMENTS

HIPAA requires that plans and health insurance coverage issuers provide all eligible employees with a description of their special enrollment rights. The final portability regulations clarify that this notice must be provided to all eligible employees (both those who enroll as well as those who decline). The **Special Enrollment Notice** must be provided at or before the time the employee is initially offered the opportunity to enroll in the plan. The regulations require that an "educational statement" be included within the Special Enrollment Notice and include model language.

ENFORCEMENT

HIPAA's portability requirements are jointly enforced by the DOL, HHS and the Internal Revenue Service (IRS). These entities may impose penalties for noncompliance, such as excise taxes or fines. Also, under **IRS Form 8928**, group health plans are required to report and pay excise taxes for certain violations of HIPAA's portability requirements. Although HIPAA does not provide a private right of action, plans or health insurance issuers may also be subject to lawsuits by participants and beneficiaries under ERISA's enforcement provisions.

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06/05, EM 9/14