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UPDATE

HIPAA Portability Deadline Approaching

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While group health plans have focused on HIPAA's privacy requirements in recent years, HIPAA also has extensive provisions relating to portability of health care. Beginning January 1, 2006, calendar year group health plans must comply with the final portability regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Update summarizes the changes and clarifications made by the final regulations and provides a compliance checklist. It also summarizes the provisions of additional proposed regulations that were issued with the final portability regulations.

I. Final HIPAA Portability Regulations

- 1. Special Enrollment.** Group health plans (that are not excepted benefits) must allow certain individuals to enroll upon the occurrence of certain events, including acquisition of new dependents and loss of other coverage. The final regulations expand the scope of what constitutes a loss of other coverage to include:
 - Reaching a lifetime limit on all benefits.
 - Termination of employer contributions towards other coverage.
 - Moving out of an HMO service area if the other plan does not offer other coverage.
 - Ceasing to be a "dependent," as defined in the other plan.
 - Loss of coverage to a class of similarly situated individuals under the other plan (e.g., part-time employees).Additionally, individuals entitled to special enrollment must be allowed to enroll in all available benefit package options and to switch to another option if he or she has a spouse or dependent with special enrollment rights. For example, if an employee has individual coverage in her employer's HMO option instead of her employer's indemnity option, and her husband loses his individual coverage under his employer's plan and has special enrollment rights, both the wife and husband must be allowed to enroll in the indemnity option offered by the wife's employer.
 - Notice of Special Enrollment Rights must be provided at or before the time an employee is offered the opportunity to enroll. A model Notice from the final regulations is found in Exhibit A to this Update.
- 2. Creditable Coverage and Certificates of Creditable Coverage.** Group health plans (that are not excepted benefits) must provide certificates of creditable coverage automatically when an individual's coverage terminates, at the end of COBRA continuation coverage (if any), and at the request of the individual not later than 24 months after coverage terminates. Group health plans that impose a preexisting condition exclusion must reduce any exclusion period by the period of the individual's creditable coverage. The final regulations make the following changes related to creditable coverage and certificates of creditable coverage.
 - A HIPAA portability rights education statement must be included in the certificate of creditable coverage. The revised model certificate of creditable coverage, which includes the HIPAA portability rights education statement, is found in Exhibit B to this Update.
 - Additional categories of coverage are considered creditable coverage (e.g., coverage under the State Children's Health Insurance Program ("SCHIP"), any public health plan, and foreign government plan).

- An individual can present a certificate of creditable coverage at any time and the plan cannot impose a deadline.
- Plans must have written procedures for requesting a certificate of creditable coverage. These procedures could be included in the plan's summary plan description.

3. Preexisting Condition Exclusions. A group health plan contains a preexisting condition exclusion if it restricts benefits for a medical condition that was present before coverage was effective under the plan. The final regulations clarify several requirements.

- Additional examples of "hidden preexisting condition exclusions" are provided such as (i) enforcing a lifetime limit on coverage for treatment of a disease for those diagnosed with the disease before the effective date of coverage under the plan; (ii) covering accidental injury only if the injury occurred while covered under the plan; and (iii) denying pregnancy benefits until 12 months after an individual becomes eligible for benefits under the plan.
- A Preexisting Condition Exclusion Notice must be included in the written enrollment materials. Sample language for the Notice from the regulations is included as Exhibit C.
- A Notice of Determination of Length of Preexisting Condition Exclusion Period must be given to each individual whose creditable coverage does not completely offset the preexisting condition exclusion period. This notice must be customized for each individual. The regulators did not draft model language, but they did specify that this notice must contain the following information:
 - (i) the preexisting condition exclusion period and the last day on which it applies;
 - (ii) basis for the determination;
 - (iii) an explanation of the individual's right to submit additional evidence of creditable coverage; and
 - (iv) description of any right to appeal the determination.

II. Proposed HIPAA Portability Regulations

If the Proposed Regulations issued on December 30, 2004, become final, they would make the following clarifications and changes:

1. Special Enrollment

- A plan could require an individual to request special enrollment within the special enrollment period but could not require the individual to complete the process within the special enrollment period.
- If an employee drops coverage during an FMLA leave and does not return from the leave, the 30-day special enrollment period for other coverage would begin at the end of the FMLA leave.
- If the individual did not know he or she lost coverage, the 30-day period to request special enrollment would be tolled until the certificate of creditable coverage is provided, up to a maximum of 44 days.

2. Creditable Coverage and Certificates of Creditable Coverage

- Certificates of creditable coverage would have to explain how FMLA leave impacts creditable coverage.
- If the certificate of creditable coverage has not been provided, the 63-day break in coverage period would be tolled up to a maximum of 44 days.
- In determining whether there is a significant break in coverage that would result in certain coverage not being creditable coverage, a plan would not be permitted to take into account a break in coverage that occurs as a result of FMLA leave.

To assist you in complying with the final portability regulations, we have attached a portability compliance checklist to this Update. The regulations can be found at <http://www.dol.gov/ebsa/regs/fedreg/final/2004028112.pdf>. Regulations correcting the December 30, 2004 regulations were issued on April 25, 2005 and can be found at <http://www.dol.gov/ebsa/regs/fedreg/final/2005008154.pdf>.

HIPAA Portability Compliance Checklist

1. Special Enrollment

- Prepare a notice of HIPAA special enrollment rights and include with enrollment materials.
- Review and update plan documents and summary plan descriptions to include the additional loss of coverage events that trigger special enrollment rights and to explain the right to change options.

2. Certificate of Creditable Coverage

- Update the Certificate of Creditable Coverage to include new model portability education statement.
- Prepare written procedures for individuals to request and receive Certificates of Creditable Coverage. You may want to update the summary plan description to include this language.

3. Preexisting Condition Exclusions

- Review your group health plan documents to determine whether they contain any “hidden preexisting condition exclusions” and eliminate them unless you intend to comply with all the requirements that apply to preexisting condition exclusions.
- For plans with preexisting condition exclusions, prepare a notice of exclusions and include it with enrollment materials.
- For plans with preexisting condition exclusions, prepare a template Notice of Determination of Length of Preexisting Condition Exclusion that can be customized.

Exhibit A

Notice of Special Enrollment Rights (model language)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

Exhibit B**CERTIFICATE OF GROUP HEALTH PLAN COVERAGE**

1. Date of this certificate: _____
2. Name of group health plan: _____
3. Name of participant: _____
4. Identification number of participant:

5. Name of individuals to whom this certificate applies:

6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____
7. For further information call: _____
8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip lines 9 and 10: _____
9. Date waiting period or affiliation period (if any) began: _____
10. Date coverage began: _____
11. Date coverage ended (or if coverage has not ended, enter "continuing"): _____

[Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.]

Statement of HIPAA Portability Rights

IMPORTANT - KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

You have had coverage for at least 18 months without a break in coverage of 63 days or more;

- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: <http://www.dol.gov/ebsa>, the DOL's interactive web pages - Health Elaws, or <http://www.cms.hhs.gov/hipaa1>.

Exhibit C

Preexisting Condition Exclusion Notice (sample language)

Example. (i) Facts. A group health plan makes coverage effective on the first day of the first calendar month after hire and on each January 1 following an open season. The plan imposes a 12-month maximum preexisting condition exclusion (18 months for late enrollees) and uses a 6-month lookback period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Individual B at Address M or Telephone Number N.

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