

EMPLOYEE BENEFITS

Alert

NEWS FOR EMPLOYEE HEALTH PLAN SPONSORS

FINAL HIPAA PORTABILITY REGULATIONS

January 6, 2006

Beginning January 1, 2006, calendar year group health plans must comply with the final regulations relating to the “portability” rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The final regulations may require amendments to group health plan documents and SPDs, and will change how group health plans are administered for compliance with the portability rules of HIPAA. This Alert summarizes the changes and clarifications made by the final regulations.

1. **Revised Model Certificate of Creditable Coverage.** Generally, group health plans must issue a Certificate of Creditable Coverage (“Certificate”) to an individual whose coverage under the group health plan has terminated or upon the request of the individual during coverage or not later than twenty-four (24) months after coverage has terminated. This Certificate is used to certify the individual’s period of coverage under the group health plan which then can be applied against a pre-existing condition exclusion period under a subsequent health plan. The required disclosures on this Certificate have been modified by the final regulations and now a lengthy HIPAA “educational statement” must be included. The model Certificate from the regulations is attached to this Alert. *Plan sponsors that contract with third party administrators to provide Certificates of Creditable Coverage should verify that their third party administrators are using the revised Certificate.*
2. **Written Procedures for Requesting Creditable Coverage Certificates.** Beginning in 2006, the new regulations require group health plans to establish a “written procedure” for individuals to request and receive Certificates of Creditable Coverage. These procedures should be included in the SPD.
3. **Designate Contact Person for Questions.** Group health plans that impose pre-existing condition exclusions must now include a Pre-existing Condition Exclusion Notice with their written enrollment materials. This Notice must describe the pre-existing condition exclusions and identify a contact person who can answer additional questions.

In addition, a new Notice of Determination of Length of Pre-existing Condition Exclusion Period must be given to each individual whose prior creditable coverage does not completely offset the pre-existing condition exclusion period.

EMPLOYEE BENEFITS

Alert

4. **Notice of Special Enrollment Rights.** A new Notice of Special Enrollment Rights must be included at the time an individual is offered the opportunity to enroll in a group health plan. This Notice should be included in the written enrollment material. This Notice explains the special enrollment periods for the following two classes of individuals who are eligible for coverage under a group health plan but not enrolled: (i) certain individuals losing other coverage, and (ii) new dependents due to marriage, birth, adoption or placement for adoption (and the spouse, if otherwise eligible for coverage). The model Notice from the final regulations is attached to this Alert.
5. **Special Enrollment Rights Expand.** The final regulations expand the scope of what constitutes a loss of coverage for the special enrollment rights to include:
 - Reaching a lifetime limit on all benefits.
 - Termination of employer contributions toward 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 (i.e., part-time employees).

As always, we are available to assist you in compliance with the HIPAA portability regulation, including the review and modification of plan documents and SPDs. If you would like any assistance or have any questions about this Alert, please let us know.

Bass, Berry & Sims Employee Benefits Attorneys

Memphis

David Thornton
901-543-5922
dthornton@bassberry.com

Michael Moore
901-543-5916
mtmoore@bassberry.com

Nashville

Fritz Richter
615-742-6256
frichter@bassberry.com

Richard Barry
615-742-6230
rbarry@bassberry.com

Curtis Fisher
615-742-7892
cfisher@bassberry.com

NASHVILLE *Downtown*
AmSouth Center
315 Deaderick St. · Ste. 2700
Nashville, TN 37238-3001
(615) 742-6200

KNOXVILLE
1700 Riverview Tower
900 S. Gay St.
Knoxville, TN 37902
(865) 521-6200

MEMPHIS
The Tower at Peabody Place
100 Peabody Place · Ste. 900
Memphis, TN 38103-3672
(901) 543-5900

NASHVILLE *Music Row*
29 Music Square East
Nashville, TN 37203-4322
(615) 255-6161

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

- | | |
|---|--|
| 1. Date of this certificate: _____ | 7. For further information, call: _____ |
| 2. Name of group health plan: _____
_____ | 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:
_____ |
| 3. Name of participant: _____ | 9. Date waiting period or affiliation period (if any) began: _____ |
| 4. Identification number of participant: _____ | 10. Date coverage began: _____ |
| 5. Name of individuals to whom this certificate applies: _____
_____ | 11. Date coverage ended (or if coverage has not ended, enter "continuing"): _____ |
| 6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____
_____ | |

[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 *E*laws, or <http://www.cms.hhs.gov/hipaa1>.

Description of Special Enrollment Rights

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 name, title, telephone number, and any additional contact information of the appropriate plan representative].

[If plan requires employees who decline coverage, for themselves or their dependents, to state in writing whether coverage is being declined due to other health coverage, then insert notice of this requirement and the fact that special enrollment rights will not be available to persons who do not provide the statement. Note: Plans requiring such written statements must contemporaneously give employees notice of the consequences of failing to provide the statement (i.e., that special enrollment rights will be lost)].