Employee Benefits Law Action Memo

January 2005

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FINAL AND PROPOSED HIPAA PORTABILITY REGULATIONS ISSUED WHICH CLARIFY AND EXPAND PROTECTIONS UNDER GROUP HEALTH PLANS

On December 30, 2004, the United States Department of Treasury, Department of Labor and Department of Health and Human Services issued joint final and proposed regulations with respect to the portability rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The final regulations are effective for plan years beginning on or after July 1, 2005.

HIPAA was enacted to address several health coverage issues, including helping to make it easier for individuals to have access to health coverage. This was done, for example, by imposing certain limits on preexisting condition exclusions and by creating special enrollment rights.

Group health plans and insurers should review current plan documentation and administration to make sure such plans are operating in compliance with the clarifications and modifications set forth in the new final regulations. Additionally, notices regarding preexisting condition exclusions ("PCEs") and certificates of creditable coverage should be compared to sample and model language provided in the regulations, and modified where necessary and/or appropriate.

Final Regulations

The final regulations do not significantly modify the 1997 interim regulations. However, the final regulations contain provisions which are intended to increase protections for participants, while decreasing burdens on group health plans and group health insurers. Issues clarified by the final regulations include provisions on PCEs, creditable coverage, and special enrollment.

Preexisting Condition Exclusions

A group health plan or insurer will often limit a plan's liability for benefits due to an illness or injury that existed before an individual becomes covered under the plan. HIPAA was enacted to limit the scope and applicability of limitations and exclusions for preexisting conditions under most plans.

Clarifications made to the PCEs framework set forth in the 1997 interim regulations include, but are not limited to:

- modification of the definition of PCE to replace the term "first day of coverage" with "effective date of coverage" under a group health plan to determine when a PCE is present;
- retention of the six-month look-back rule, while allowing a plan or insurer to use a shorter period of time;
- a requirement that a plan or insurer must count all days of creditable coverage prior to an individual's enrollment date, even if that coverage is still in effect;
- a statement that the Uniformed Services Employment and Reemployment Rights Act can affect the application of a PCE to certain individuals who are reinstated in a group health plan following active military service;
- a requirement that a general notice of a PCE must be provided as part of any written application materials distributed by a plan or insurer for enrollment (or the earliest date the notice can be provided following a request for enrollment);

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- a description of what is required when disclosing the existence and terms of PCEs (including sample language to use in developing the general notice); and
- sample language to be used by a plan or insurer in developing the required notice of the length of a PCE that remains after an offset for prior creditable coverage.

Creditable Coverage

Creditable coverage is the coverage of an individual under one of ten existing categories of health insurance coverage, including a group health plan, Medicare, Medicaid, CHAMPUS, and/or a public health plan. Creditable coverage does not include coverage under excepted benefits such as limited-scope dental or vision plans. Group health plans and insurers are required to furnish a certificate of creditable coverage to an individual to verify prior creditable coverage.

The final regulations provide clarification with respect to creditable coverage, including:

- the addition of the State Children's Health Insurance Program as an eleventh category of creditable coverage;
- modification of the definition of "public health plan" to include any health coverage provided by a governmental entity and plans maintained by a foreign country or political subdivision;
- a requirement that plans and insurers must provide an educational statement of an individual's HIPAA rights when coverage under a plan is lost; and
- the provision of model certificates of creditable coverage and model language to be used for the educational statement.

Special Enrollment

HIPAA provides for certain situations in which a group health plan and any insurer offering group health coverage must provide special enrollment periods to certain individuals eligible for group health coverage who previously declined group health coverage and now wish to enroll themselves and/or their eligible dependents. In addition, the special enrollment rules extend to "new" dependents of a covered employee who become eligible for plan coverage after the regular enrollment date.

Modifications and clarifications to the special enrollment requirements that have been provided in the final regulations include the following:

- the initial opportunity for enrollment (generally the commencement of employment) is not the only time when an individual with other health coverage may decline coverage for purposes of satisfying the prerequisites to special enrollment upon loss of other coverage (the final regulations provide examples of other situations);
- expansion of the list of situations when an individual loses eligibility for other coverage; and
- a dependent is defined as an individual who, under the terms of the plan, is eligible for coverage because of a relationship with a plan participant.

Other Clarifications to the HIPAA Portability Requirements

Other clarifications to the HIPAA portability requirements include:

- "limited-scope dental benefits" are defined as benefits substantially all of which are for the treatment of the mouth, and "limited-scope vision benefits" are defined as benefits substantially all of which are for the treatment of the eye; and
- a health savings account ("HSA") is exempt from the HIPAA portability rules so long as the HSA is not subject to the Employee Retirement Income Security Act.

Proposed Regulations

In addition to issuing final HIPAA portability regulations, proposed regulations were issued which address the following:

- modification of the 63-day break in coverage rules to toll the period in cases in which a certificate of creditable coverage is not provided on or before the day coverage ceases (the period is tolled until a certificate is provided, but not beyond 44 days after the coverage ceases);
- modification of the educational statement to require a disclosure about the Family and Medical Leave Act ("FMLA"); and
- a plan or insurer must provide a certificate of creditable coverage when an individual leaves a plan while taking FMLA leave, and any period of time during which a person does not have coverage while under FMLA leave does not count against him or her with regard to HIPAA's protections.

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