

COMPLIANCE OVERVIEW

Provided by Clarke & Company Benefits, LLC

HIPAA Portability Rules

To help make health plan coverage more portable, the Health Insurance Portability and Accountability Act (HIPAA) includes rules for pre-existing condition exclusions, Certificates of Creditable Coverage (HIPAA Certificates) and special enrollment. The Affordable Care Act (ACA) made extensive changes to HIPAA's portability rules. Due to the ACA:

- ✓ Health plans are prohibited from imposing pre-existing condition exclusions on any enrollees, effective for plan years beginning on or after Jan. 1, 2014.
- ✓ Beginning Dec. 31, 2014, health plans are not required to issue HIPAA Certificates.

This Compliance Overview provides a summary of HIPAA's portability rules. Keep in mind that the rules regarding pre-existing condition exclusions and HIPAA Certificates are no longer applicable. These topics are included in this overview for historical purposes only. Group health plans are still required to comply with HIPAA's special enrollment rules.

LINKS AND RESOURCES

- Department of Labor's [Compliance Assistance Guide](#), which covers HIPAA's portability rules.
- [Final regulations](#) from 2004 regarding HIPAA portability
- Form 8928 and Instructions for Form 8928 are available on the IRS' [website](#).

HIGHLIGHTS

STATUS OF RULES

- Due to the ACA, pre-existing condition exclusions are prohibited and HIPAA Certificates are no longer needed.
- Health plans must still provide special enrollment rights under HIPAA.

SPECIAL ENROLLMENT RIGHTS

Group health plans must provide special enrollment rights in these situations:

- A loss of eligibility for other health coverage;
- Termination of eligibility for Medicaid or a state CHIP;
- The acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption; and
- Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP.



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PLANS SUBJECT TO PORTABILITY RULES

HIPAA's portability rules broadly apply to group health plans and health insurance issuers offering group health insurance coverage. However, certain categories of coverage—called “**excepted benefits**”—are not subject to HIPAA's portability rules. Excepted benefits include, for example, the following:

- Benefits that are generally not health coverage (such as automobile coverage, liability insurance, workers' compensation and accidental death and dismemberment coverage);
- Limited-scope dental or vision benefits; and
- Most health flexible spending accounts (FSAs).

HIPAA also includes an exemption for **very small group health plans**, including retiree-only plans. HIPAA's special enrollment rules do not apply to a plan that, on the first day of the plan year, has fewer than two participants who are current employees.

SPECIAL ENROLLMENT RIGHTS—STILL APPLICABLE

HIPAA requires group health plans to provide special enrollment opportunities outside of the plans' regular enrollment periods in certain situations.

Special enrollment must be available in these situations:

- A loss of eligibility for other health coverage;
- Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP);
- Gaining a spouse or dependent by marriage, birth, adoption or placement for adoption; and
- Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP.

A plan must allow an enrollment period of at least **30 days** after the special enrollment event and all benefit packages under the plan must be available for enrollment. The minimum enrollment period is **60 days** when the special enrollment event is the termination of Medicaid or CHIP eligibility or eligibility for a premium assistance subsidy.

Loss of Coverage

Under HIPAA, eligible employees and their eligible dependents have special enrollment rights if they had other coverage at the time of enrollment, waived coverage at the time of enrollment and subsequently

lost eligibility for the other coverage. A loss of eligibility that triggers special enrollment rights may include a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment or a reduction in the number of hours of employment.

Also, in the case of group coverage offered through an HMO, a loss of eligibility may occur when an individual no longer resides, lives or works in the service area (whether or not within the choice of the individual), and no other benefits package is available to the individual. A loss of eligibility for coverage may also include a situation where a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

Loss of eligibility does not include a loss resulting from the failure of the employee or dependent to pay premiums on a timely basis or a termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

Example: Rob is hired on Jan. 1 of Year One 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 of Year Two, 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.

Acquisition of a New Spouse or Dependent

Group health plans must offer a special enrollment opportunity to certain newly acquired spouses and dependents of participants and to current employees who acquire a new spouse or dependent. This special enrollment right only applies if the group health plan offers dependent coverage and the new dependent is acquired through marriage, birth, adoption or placement for adoption.

Only the employee, spouse and any newly acquired dependents receive special enrollment rights. Other dependents (for example, siblings of a newborn child) are not entitled to special enrollment rights upon the acquisition of a new dependent. Some plans go beyond what HIPAA requires and allow the employee's other children to be enrolled in addition the employee, spouse and newly acquired dependents. Before implementing a plan design that provides greater enrollment rights to participants and beneficiaries, employers should consult with their health insurance issuers or stop-loss carriers.

Medicaid/CHIP Plans

Eligible employees and their dependents must also be given special enrollment rights if they lose Medicaid or CHIP coverage or become eligible for a premium assistance subsidy through a Medicaid or

CHIP plan. 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.

Notice Requirements

HIPAA requires that plans and health insurance coverage issuers provide all eligible employees with a description of their special enrollment rights. 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.

PRE-EXISTING CONDITION EXCLUSIONS—NO LONGER ALLOWED DUE TO ACA REFORMS

HIPAA allowed plans and issuers to exclude pre-existing conditions from coverage, but placed 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 prohibited PCEs 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.

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

HIPAA also included exceptions to the ability to impose PCEs. PCEs could not be imposed on the following:

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

HIPAA required the plan or issuer to provide a written General Notice of Pre-Existing Condition Exclusion before imposing a PCE. In some cases, HIPAA also required that a Determination of Creditable Coverage Notice be provided.

In addition, HIPAA required 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.

CERTIFICATES OF CREDITABLE COVERAGE—NO LONGER REQUIRED DUE TO ACA REFORM

HIPAA required plans and issuers to provide a **Certificate of Creditable Coverage** (HIPAA Certificate) automatically to individuals in the event they lost coverage under the plan. Plans and issuers were also required to provide additional copies of the HIPAA Certificate upon request for a period of 24 months following termination of coverage.

The HIPAA Certificate was 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 ACA's prohibition on PCEs for plan years beginning on or after **Jan. 1, 2014**, made HIPAA Certificates unnecessary. A final rule under the ACA eliminated the requirement to provide HIPAA Certificates, beginning Dec. 31, 2014.

ENFORCEMENT

HIPAA's portability requirements are jointly enforced by the Departments of Labor, Health and Human Services and the Treasury. These agencies 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.