

## **HIPAA Portability Final Regulations**

Additional final regulations (yes, still more) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) become applicable on the plan year starting on or after 7/1/05 (calendar year plans must be in compliance as of 1/1/06). Two action items employer's need to address are:

- 1) Replace the current HIPAA Special Enrollment Rights Notice with the attached revised version
- 2) Establish a procedure for current and/or previous employees to request a Certificate of Coverage (sample attached).

Continue reading below if you would like more detailed explanations of these final regulations.

### **Special Enrollment Rights**

Special enrollment rights for employees apply when they decline coverage because they have other health coverage and then lose eligibility for that other coverage (including elected and exhausted COBRA coverage). Special enrollment rights also apply to dependents acquired through marriage, birth, adoption or placement for adoption or when an employee's dependent loses other coverage. The final regulations define a dependent as someone who, according to the terms of the plan, is or may become eligible for coverage because of his or her relationship with the participant. The final rules make it especially important for employers to understand who qualifies as a dependent under their health plan's eligibility rules. For example if your plan offers coverage to domestic partners you may be obligated to extend special enrollment rights for a domestic partner who loses other coverage.

Additional clarifications have been made regarding special enrollment rights. The special enrollment right extends to all benefit packages available under the employer's plan. For example, the employee who is already enrolled in one benefit package (for example a PPO) may enroll with the newly acquired dependent in another benefit package the employer offers (for example the HMO option).

Keep in mind your plan is not subject to the new regulations until your plan renewal date after 7/1/05. We are currently working with our insurance carriers to confirm they agree with our interpretation of the new regulations to allow such changes at "special enrollment". As we have reported in the past, you must provide a notice of special enrollment rights to employees (those who enroll as well as those who are eligible but decline enrollment). The regulations slightly revised the model language for this notice. We encourage you to replace your prior version of this notice with the new one attached and if you have not already distributed to your benefit eligible employees you should do so now. In addition this notice should always be given to newly eligible employees prior to making their decision to enroll in the health plan or not. You may request a personalized electronic version of this notice by contacting Fredonna Smith at [fredonna.smith@conestoga.biz](mailto:fredonna.smith@conestoga.biz).

### **Certificate of Creditable Coverage**

The final regulations require that a plan must have written procedures in place for individuals to request and receive a Certificate of Creditable coverage. A sample of this procedure is attached. The final regulations have revised the model Certificate of Coverage. The regulations now require

that Certificates of Creditable coverage contain a new educational statement of HIPAA portability rights. Health plans must furnish a Certificate of Creditable coverage automatically (and upon request) when an individual loses coverage under the plan. If an insurer provides the Certificate (as do most insurers offering fully insured health plans) then the employer is deemed to have satisfied the HIPAA Certificate obligation. If you are a COBRA client of The Conestoga Group we also provide a Certificate of Coverage along with the COBRA Election Notice. Effective 7/1/05 we have begun using the new model notice.

### **Additional HIPAA Information to be Aware of**

#### **Preexisting Condition Exclusions and Waiting Periods**

If your health plan excludes coverage for preexisting conditions, it must adhere to HIPAA imposed restrictions on its Preexisting Condition Exclusions (PCEs). For fully insured plans most of the restrictions on PCEs involve plan design matters that fall within the insurers domain. If you offer a plan that imposes a PCE it is important to make sure the employee is aware of the PCE. This information must be part of the initial enrollment paperwork they complete for the carrier. Employees should also make sure they provide the insurer with certificates of prior coverage to help wipe out the exclusion period if possible. Usually Aetna and Independence Blue Cross (IBC) contracts do not contain PCEs. Check your plan document for details if you have a medical insurance carrier other than Aetna or IBC.

#### **Creditable Coverage**

The final regulations add that coverage under a State Children's Health Insurance Program (SCHIP) is now considered creditable coverage. This means health plans with PCEs must revise their procedures so they recognize as creditable coverage any health coverage under a SCHIP program. Final regulations also expand the definition of a public health plan to include health coverage provided under a plan established or maintained by a foreign country.

If you wish to review the complete document regarding the final HIPAA Portability regulations please go to <http://www.cms.hhs.gov/hipaa/hipaa1/content/04hipaafinal.pdf>.

*The Conestoga Group is an insurance, investment and employee benefits broker and consulting firm based in Frazer, PA. Conestoga specializes in providing financial products and services to small businesses and their owner/executives and other employees. Founder and President Brad Palmer is an Investment Advisory Representative of Commonwealth Financial Network-a registered investment advisor and member firm of the NASD/SIPC. Brad can be reached at 610-889-9500 extension 101 or at [brad.palmer@conestoga.biz](mailto:brad.palmer@conestoga.biz).*

#### **NOTICE**

These legislative descriptions are our interpretations of information provided to us by various legal and other resources as of July 28, 2005. It is possible the information was presented incorrectly or that we have misunderstood the presentation. The purpose of this communication is to provide you with basic summary information on the subject matter and assist you in determining whether or not you may need to seek further legal or other assistance. This communication should not be construed as legal, tax, investment, or other advice and does not take into consideration any specific factors that may be unique to the reader's situation.

**NOTICE OF HIPAA SPECIAL ENROLLMENT RIGHTS**

Our records show that you are eligible to participate in «Company»'s Group Health Plan, Federal law (called HIPAA) requires that we notify you of your and your dependent's right to enroll in the plan in the future under the plan's "Special Enrollment Provisions", as described below.

**Rule #1 - Loss of Coverage:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group 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 stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

**Rule #2 – Marriage, Birth or Adoption:** 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

***IMPORTANT WARNING***

*If you decline enrollment for yourself or your eligible dependent(s) and wish to retain your rights described in Rule #1 above, you must complete the Employee Declination Statement below. You are required to state that coverage under another group health plan or other health insurance coverage is the reason for declining enrollment, and you must identify that coverage. If you fail to complete the Employee Declination Statement, neither you nor your dependent(s) will be entitled to the special enrollment rights described in Rule #1 above, but you will still have the special enrollment rights described in Rule #2. Without the special enrollment rights described in Rule #1, you must wait until the plan's annual open enrollment period to enroll, except in cases of marriage, birth, adoption or placement for adoption.*

To request special enrollment or obtain more information about the plan's special enrollment provisions contact «Full\_Name» at «Company», «Business\_Address» or «Business\_Phone».

**Employee Confirmation of Receipt of HIPAA Special Enrollment Rights**

I acknowledge that I have read and understand the Notice of HIPAA Special Enrollment Rights. I understand my obligations should I experience an event in the future that falls under the Special Enrollment Provision. If I am declining coverage for myself and/or my eligible dependents I will also complete the required information on Section 2 below.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

**Employee Declination Statement**

I have read the "Notice of HIPAA Special Enrollment Rights", including the Important Warning section describing the requirements to decline coverage in writing if the reason I am declining coverage is because either my dependents or myself have other coverage. By signing this form, I hereby decline coverage under «Company»'s Group Health Plan for my dependents and/or myself. [If coverage is being declined for some, but not all, family members, please list here the individuals for whom coverage is being declined]:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The reason for declining coverage for my dependents and/or myself is that family members and/or myself for whom coverage is being declined have coverage under another group health plan or other health insurance coverage. [Please specify here the name(s) of the other coverage you have, and your subscriber number(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I also understand if I decline coverage for my dependents and/or myself and do not have other insurance coverage noted above I will not be entitled to the special enrollment rights described in Rule #1, but may still have the special enrollment rights described in Rule #2. Without the special enrollment rights described in Rule #1, I must wait until the plan's annual open enrollment period to enroll except in cases of marriage, birth, adoption or placement for adoption.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

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## Sample Procedures for Individuals to Request Certificates Of Creditable Coverage From «Company»'s Group Health Plan

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«Company»  
«Business\_Address»  
«Business\_Address\_City»  
«Business\_Phone»

A federal law called HIPAA requires that «Company»'s Group Health Plan provide a certificate of creditable coverage (HIPAA Certificate) to each individual who requests one so long as it is requested while the individual is covered under the Plan or within 24 months after the individual's coverage under the Plan ends. The request also can be made by someone else on behalf of an individual. For example, an individual who previously was covered under the Plan may authorize a new plan in which the individual enrolls to request a certificate of the individual's creditable coverage from the Plan. An individual is entitled to receive a Certificate upon request even if the Plan has previously issued a Certificate to that individual.

Requests for Certificates should be directed to, «Full\_Name», «Job\_Title», at «Business\_Address», «Business\_Address\_City» or «Business\_Phone». Telephone requests are accepted only if the Certificate is to be mailed to the address that the plan has on file for the individual to whom the request relates. Other requests must be made in writing.

All requests must include:

- The name of the individual for whom the Certificate is requested;
- The name of the participant that enrolled the individual in the plan; and
- A telephone number to reach the individual for whom the Certificate is requested, in the event of any difficulties.

Requests that are required to be made in writing must also include:

- The name of the person making the request and evidence of that person's authority to request and receive the Certificate on behalf of the individual;
- The address to which the Certificate should be mailed; and
- The requester's signature.

Upon receipt of required information, «Company» representative will contact the appropriate health insurance company that the individual is/was covered under to have a certificate of coverage prepared. Individuals may also contact the Customer Service department of the insurance company directly to request a certificate of coverage.