

New HIPAA Portability Regulations

The Health Information Portability and Accountability Act (HIPAA) has been in place since 1997, giving credit to individuals maintaining health insurance coverage against the application of a pre-existing condition exclusion period when moving from one group health plan to another, from a group health plan to an individual policy, or from an individual policy to a group health plan. These rules, providing improved portability and continuity of health coverage, were interim regulations. These new “final” HIPAA portability rules clarify the existing law and were effective February 28, 2005 and apply to Plan years beginning on or after July 1, 2005.

What’s New?

Notices

There are no entirely new notices, but the new HIPAA portability regulations modify the requirements of the notices that BCBSNC sends today. The notices include: (1) general and specific notices of pre-existing conditions; (2) notice of special enrollment; and (3) HIPAA certificate of creditable coverage.

(1) General and Specific Notices of Pre-existing Conditions: A Plan/Insurer must satisfy the following notice requirements:

1. A general notice of the pre-existing condition exclusion (PCE) is provided as part of any written application materials for enrollment. Model language is provided by the regulations. The notice must specify the group-specific pre-existing condition exclusion period, the right to demonstrate creditable coverage and contact information for additional questions. The notice must be included as part of the enrollment materials, if provided.
2. A specific notice is provided upon enrollment to each member who has an applicable pre-existing waiting period exclusion. The Plan/Insurer is responsible for determining creditable coverage within a reasonable timeframe and notifying the member of any remaining pre-existing condition exclusion.

(2) Notice of Special Enrollment: HIPAA allows employees, dependents or COBRA beneficiaries in certain circumstances the same rights as regular enrollees, despite the fact that they did not enroll at their first opportunity. For example, a member may have the right to special enrollment upon the loss of other health coverage or upon the acquisition of a new dependent.

Regulations clarify that the Plan/Insurer must provide all employees (***those who enroll as well as those who decline enrollment***) with a notice of these special enrollment rights at or before the time the employee is initially offered the opportunity to enroll in the plan. The notice should also be included in the summary plan description (SPD). Model language is provided by the regulations.

(3) Certificate of Creditable Coverage: A certificate of creditable coverage identifies the presence of any prior coverage and the length of that coverage which could greatly reduce or eliminate the pre-existing condition waiting period for members. A model form is provided by the regulations. The new portability regulations implement some new guidelines for issuing a certificate of creditable coverage:

1. The Plan/Insurer cannot impose any time limit on the amount of time an individual has to present a certificate or other evidence of creditable coverage.
2. Generally, the certificate of creditable coverage must be provided in writing, but other mediums such as by phone are acceptable if the individual makes such a request.
3. An individual may request a HIPAA certificate while coverage is still in effect.
4. Dependents are entitled to receive individualized certificates; however, one notice may be provided as long as all individuals have the same address.
5. An educational statement must be included in each certificate of creditable coverage, informing consumers of their HIPAA rights which include the following:
 - Explanation of pre-existing conditions exclusions
 - Special enrollment rights
 - Prohibition against discrimination based on a health factor
 - Right to individual health coverage
 - State flexibility
 - Contact information for more detailed information

Prior Creditable Coverage

New and/or Revised Categories of Creditable Coverage:

1. **S-CHIP** – The State Children’s Health Insurance Program (S-CHIP) was added as an eleventh category of creditable coverage.
2. **Governmental Entities** – The definition of public health plan was expanded to include any health coverage provided by a governmental entity. This would include any coverage provided under a plan sponsored by a foreign government.

For example, coverage under a foreign socialized medicine plan such as in Canada or England would be considered creditable coverage.

In addition, the new HIPAA portability regulations provide additional guidelines for how health plans count creditable coverage with regard to the Trade Act and Individual Coverage.

- **Trade Act:** The Trade Act amended COBRA continuation provisions to provide individuals who qualify for trade adjustment assistance (TTA) a second opportunity to elect COBRA. This means that individuals who are eventually determined to qualify for TTA but did not elect COBRA after their original loss of health coverage will have a second chance to do so. For purposes of pre-existing condition provisions, the period beginning with the individual's loss of coverage and ending on the first day of the second election period is not counted when determining whether a significant break in coverage has occurred.
- **Individual Coverage:** A waiting period begins on the date a substantially completed application is submitted to the Plan/Insurer. The waiting period is a period of time, which is not included in the calculation of a significant break in coverage.

Special Enrollment

The "final" HIPAA regulations have expanded the special enrollment criteria for certain individuals who lose coverage under a group health plan. Special enrollment in a group health plan is available if the individual:

- (1) Was covered under the other plan at the time coverage was previously offered to them, and
- (2) The individual stated at the time that coverage under the other benefit plan was the reason for declining enrollment.

In addition to the above requirements, the loss of coverage must be due to:

- Exhaustion of the COBRA continuation period;
- Loss of eligibility for that coverage including divorce, loss of dependent status, death of the employee, termination of employment, or reduction in the number of hours of employment;
- Termination of the other plan's coverage by the insurer;
- A member no longer residing, living, or working in the service area of the plan (applies to individual coverage provided through an HMO or group coverage (HMO) if there is no other coverage under the Plan available to the individual).
- Termination of employer contributions toward the coverage;
- Lifetime benefit maximum has been met or exceeded; or
- Termination of benefits to the employee's class of individuals.

Other laws may also apply which can affect the application of a pre-existing condition exclusion, such as the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Definitions

The “final” HIPAA regulations use the following expanded definitions:

- **Dependent:** “Any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.” The new regulations clarify that for purposes of HIPAA, the terms of the group health plan determine which individuals are eligible for coverage.
- **Pre-existing Condition Exclusion:** “Any limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day.” The final HIPAA regulations replaced the term *first day of coverage* with *effective date of coverage under group health plan or health insurance coverage*.
- **Waiting Period (Blue Assurance only):** “Waiting period begins on the date the individual submits a substantially complete application for coverage and ends on either the date coverage begins, or the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.” The modification addresses situations where some individuals have been denied individual market policies or individuals declined coverage, because, for example, the policies had an excessive premium.
- **Public Health:** The definition was modified to include any health coverage provided by a governmental entity. The definition includes health coverage provided under a plan established or maintained by a foreign country or a political subdivision.