



BENEFIT *Advisor*

In This Issue

In this third issue of the McGrawWentworth Benefit Advisor for 2005, we examine the recently issued final HIPAA portability regulations. These final regulations dictate the guidelines employers must follow if they want to include pre-existing condition limitations in their plan. The final regulations also provide guidance on issuing certificates of creditable coverage and offering special enrollment rights to individuals that initially waive coverage under the plan.

New proposed regulations were also released to address specific administrative challenges for portability compliance. We will review these proposed regulations as well.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGrawWentworth web site at www.mcgrawwentworth.com.

“New Final & Proposed HIPAA Portability Regulations”

At the end of 2004, the Department of Treasury, Department of Labor, and the Department of Health and Human Services jointly released new regulations on the portability requirements of HIPAA (the Health Insurance Portability and Accountability Act). Two separate sets of regulations were released:

- Final regulations that address the portability and pre-existing condition limits.
- Proposed regulations that address several issues, including how to apply HIPAA’s portability requirements to coverage gaps that occur during an approved FMLA leave.

The final regulations are effective on the first day of your first plan year on or after July 1, 2005. The final regulations slightly modified the complex 1996 interim portability rules. While the changes are slight, it is a good idea to become familiar with their intricate details. This *Advisor* discusses the final and proposed regulations and their potential impact on your organization.

Portability Regulations

The final rules clarify employees’ rights and plan sponsors’ obligations under

HIPAA’s portability and pre-existing condition limitation provisions. Employers must meet many requirements for pre-existing condition limitations and portability. This *Advisor* explains the following:



Requirements outlined in the final regulations:

- Pre-existing condition definitions and limitations
- Creditable coverage for portability
- Special enrollment rights

New proposed regulations that address:

- Tallying of 63-day break in coverage
- Tallying of a break in coverage for special enrollments
- Interaction with the FMLA

Pre-Existing Condition Definitions and Limitations

The initial regulations require group health plans to comply with several provisions if the plan includes any limitation for pre-existing conditions. A plan can be more generous than the

regulations require but not less generous. The regulations, generally defined a pre-existing condition exclusion as a provision that limits or excludes benefits for conditions present before the coverage effective date, whether or not any medical advice, care, diagnosis or treatment was recommended or received before the effective date. This broad definition is designed to encompass all internal plan provisions, not just the ones that are "explicitly" labeled pre-existing condition limitations.



A plan can address pre-existing conditions in a number of ways, but if any plan provision limits or excludes benefits for pre-existing conditions, the plan must satisfy these requirements:

- A plan can only have a six month or less look-back period. Sample wording might be "A pre-existing condition is a condition for which a covered individual sought diagnosis, received medical advice, treatment or care within the six-month period preceding the enrollment date."
- All time periods must be measured from the employee's enrollment date. This date is not necessarily the date an employee actually enrolls in

the plan, nor is it the date the employee is eligible for coverage. The enrollment date is the first day of coverage or, if the plan contains a waiting period (such as a new hire waiting period), it is the first day of the waiting period.

- The group health plan's definition of a pre-existing condition must not contain "prudent person" language. To have a pre-existing condition, an individual must have been treated or continued a treatment regime during the six-month look back period. Including the phrase "a condition for which a prudent person would have sought treatment" in a pre-existing condition definition would violate the regulations.

Health plans may not impose pre-existing condition limitations on:

- A newborn or legally adopted child added to the plan within 30 days.
- The pregnancy of a plan participant.
- A plan participant whose genetic testing shows a potential medical condition. For example, genetic tests may reveal a predisposition for breast cancer. If the covered

individual subsequently develops breast cancer, the disease cannot be considered a pre-existing condition if the genetic counseling was the only medical advice received during the look-back period.

The exclusionary period for a pre-existing condition can be no longer than 12 months (or 18 months for late enrollees) measured from the enrollment date. A late enrollee is anyone who enrolls in a health plan later than the earliest date possible under the plan and is not considered a special enrollee. Special enrollments are covered in a separate section of this bulletin.

The exclusionary period must be offset by the participant's previous health coverage, providing there has not been a significant break in coverage. The next section addresses applying creditable coverage.

The final regulations include more details regarding pre-existing conditions:

- A plan cannot apply a pre-existing condition limitation unless the plan notifies participants in the writing of the pre-existing condition limitation. The notice requirement is not new, but the final regulations provided more detail addressing the required content and delivery requirements. The pre-existing condition notice must:
 - Describe the pre-existing condition limitation.
 - State the employee can provide evidence of creditable coverage to offset the limitation period.

NOTABLE THOUGHTS

TO READ WITHOUT REFLECTING IS LIKE EATING WITHOUT DIGESTING.

EDMUND BURKE

Continued on Page 3

- State the plan will help obtain a certificate of creditable coverage from any previous plan if necessary.
- Provide the name and address or telephone number of a contact person who can answer any questions.

The notice must be delivered in a “reasonable and prompt” fashion, preferably with enrollment information or application materials.

- Some limitations might not be expressly defined in a plan, but in practice operate as a pre-existing condition limitation. If a plan conditions payment on the fact a condition was present prior to enrolling in the plan, it may be considered a pre-existing condition limitation and subject to these requirements. Examples of these types of situations include:
 - A provision excluding coverage for prosthetic limbs, if the limb was lost before coverage was effective under the plan.
 - A plan that covers treatment for heart conditions and ailments but specifically excludes treatment for congenital heart disease.
- The new regulations clarify that an employee’s enrollment date does not change, even if



the health plan insurer or vendor changes. If the employer changes insurance carriers, the new carrier cannot institute a new pre-existing condition limitation based on the effective date of coverage. The new carrier must recognize the initial enrollment date for all individuals.

- If an employee chooses to change plan options at open enrollment, a new pre-existing condition limitation cannot be applied. However, if an individual has only met six months of a one-year limitation period under one plan and switches to a new option with a pre-existing condition limitation at open enrollment, the remaining six months of the limitation can be applied under the new plan election.

Creditable Coverage for Portability

A plan that includes any pre-existing condition limitation must offset the limitation period by any creditable coverage an individual has previously had, providing there has not been a “significant break” in the coverage.

The following types of coverage qualify as creditable coverage:

- Group health coverage (insured or self-funded).
- Individual health insurance coverage.
- Medicare and Medicaid.

- Government plans, including TriCare, Federal Employee Benefit Health program, Indian Health Service coverage.
- High risk pool coverage which many states sponsor.
- State-sponsored coverage for children (SCHIP).
- Public health plans, which include any plan a state, the US government, a foreign country or one of its subdivisions maintains. The inclusion of foreign government plans is new in the final regulations.

Coverage for excepted benefits is not considered creditable coverage. Generally, plans that offer only excepted benefits would not meet the definition of a group health plan. Excepted benefits include:

- Accidental death and dismemberment coverage.
- Disability income coverage.
- Liability coverage, including medical payments under an auto plan and any supplemental liability coverage.
- Workers’ compensation coverage.
- On-site medical care.
- Non-coordinated benefits including dread disease, fixed dollar hospital coverage, and so on.

Additional plans may be considered “excepted benefits” under certain conditions:

- Limited scope vision and dental benefits.
- Medical flexible spending accounts that meet certain requirements.

Limited scope vision and dental plans are considered excepted if the benefits are provided under a separate policy, certificate or contract or if benefits are not considered an integral part of the group health plan. The new regulations provide guidance that indicates limited scope means the primary benefits paid under the plan are limited to dental or vision expenses only. A plan can demonstrate these benefits are not an integral part of the health plan if:



- Participants can choose not to receive coverage under the dental or vision plan.
- Participants electing dental or vision coverage must pay a separate, additional premium.

Medical flexible spending accounts are generally considered excepted. However, a medical flexible spending account is not formally considered excepted if the benefit exceeds twice the participant's salary deduction for the plan year. In fact, even if this salary deduction requirement is not met, the FSA benefit can still be considered excepted if the benefit does not exceed \$500 plus the participant's salary deduction. This is a confusing concept. Employers who do not provide seed money to employees' FSAs will meet these requirements. If your plan is a credit-based flex plan, credits are considered participant salary deductions

if participants have a choice between taking flex credits as taxable income or diverting them to a medical flexible spending account.

The new regulations add an additional qualifier for medical spending accounts to be considered "excepted". If an employer offers group health plan options and medical flexible spending accounts, the group health plan must have an annual open enrollment period that allows employees to make election changes or elect coverage if previously waived. If a group health plan does not have an open enrollment period, the FSA will not be considered "excepted".

Any coverage under excepted benefits is not considered creditable coverage under these HIPAA rules.

Employers can use either of the following methods to count creditable coverage days:

- Standard method
- Alternative method

Standard Method

If you use the standard method, do not consider the type of benefits your group health plan provides when you count covered days. Health plans must reduce the pre-existing condition limitation period

by the number of days the individual was covered before the enrollment date. If an individual has incurred a significant break in coverage, do not count any time covered under a plan before the break. A significant break in coverage is a period of 63 consecutive days in which an individual is not covered by a health plan.

Certain timeframes are not counted when determining whether a significant break in health plan coverage has occurred:

- Days spent in a health plan's waiting period or an HMO's affiliation period are not counted.
- If an individual is entitled to receive benefits under the Trade Act of 2002, do not count the days between the last day of group health plan coverage and the first day of the second COBRA election period.

Plans can be more generous than the rule allows. For example, if according to the standard method of calculating creditable coverage, an individual's pre-existing condition limitation should extend to May 18, the plan could allow the pre-existing condition limitation period to end on May 1 for administrative ease and still meet these requirements.

Alternative Method

If you use this method, you may apply a separate pre-existing condition limitation to each of the following benefit categories:

- Mental health
- Substance abuse treatment
- Prescription drugs
- Dental care
- Vision care

NOTABLE THOUGHTS

**CONTINUOUS EFFORT - NOT STRENGTH OR INTELLIGENCE
- IS THE KEY TO UNLOCKING OUR POTENTIAL**

BLACK ELK

Continued on Page 5

With the alternative method, you will need to request detailed information from the previous plan to independently calculate the amount of creditable coverage for each category. The previous plan may charge a reasonable fee for this information.

As a practical matter, most health plans do not offer the above benefit categories separately (except dental and vision). An organization would expect the period of coverage to be the same for mental health, substance abuse and prescription drugs. If dental and vision are considered excepted, they will not be counted as creditable coverage.

Whichever counting method you choose, you must uniformly apply it to all plan participants.

Once you receive a certificate of creditable coverage, you need to determine how much creditable coverage applies and how much of the exclusion period remains. If the creditable coverage eliminates the pre-existing condition limitation, you need not notify the participant. However, if the creditable coverage eliminates only part of the exclusionary period, you must promptly notify the individual in writing of how much time remains in the exclusionary period. The notice must include:

- How much longer the pre-existing exclusion period will be in effect. It must state the last day for which the pre-existing condition exclusion will apply.

- The information you relied on in making the determination.
- An explanation that the individual has the right to submit any additional evidence regarding potential creditable coverage.
- A description of any applicable appeal procedure.

Evidence of Creditable Coverage

These rules compel group health plans and group health insurance carriers to provide certificates of creditable coverage to individuals when their coverage ends. These certificates contain specific information regarding the plan coverage that was in effect. However, efforts do not need to be duplicated. An insurer can agree in writing to provide the certificate of creditable coverage, typically as part of the contract. If an insurer agrees to distribute the certificate, the insurer alone will be held responsible if an individual does not receive it.



The issuer or the health plan must provide these certificates automatically when any of the following events occur:

- A qualifying event that causes a COBRA qualified beneficiary to lose coverage under a group health plan.
- An individual not considered a COBRA qualified beneficiary loses coverage under the plan; for example, an employee who discontinues coverage during the annual open enrollment period.

- Temporary coverage under the Federal Employee Benefits Program ends.
- Coverage ends because the individual has exhausted the lifetime benefit amounts the plan offers. The individual loses coverage on the date he or she receives a notice the plan lifetime benefits have been exhausted.
- A qualified beneficiary exhausts coverage under COBRA.

Within 24 months of coverage ending, the plan must also send a certificate of creditable coverage upon request.

The certificate must include:

- The restrictions on applying a pre-existing condition limitation and using creditable coverage to offset the limitation.
- A description of special enrollment rights.
- A statement that a plan cannot discriminate because of a health factor.
- The rights to obtain individual coverage.
- Any state law that requires additional protections.
- The person to contact for more information.

The regulations include model certificate language. A copy of the model language is posted in a Word document on our website at <http://mcwent.com/hipaa.htm>.

A plan must deliver the certificate within the same timeframe as the notices COBRA requires. Therefore, a plan has 44 days to deliver the

certificate by first class mail. You may send the notice electronically if your system meets the DOL electronic delivery requirements.

In addition, if all family members reside at the same address, a single notice is sufficient. If the family members were covered for various lengths of time, the certificate must clearly indicate the different information and identify that the information varies among family members. If you know that a covered dependent resides elsewhere, you must make a good faith effort to deliver a separate notice to the dependent at the last known address.

The plan must establish a written procedure that an individual should follow to request certificates of creditable coverage. The procedure must identify the person the employee should contact to request a certificate. Although the rule does not establish how a plan should notify employees of this procedure, it makes sense to include it with the other information your plan disseminates regarding the HIPAA portability requirements.



Special Enrollment Rights

Plans must offer special enrollment rights to employees and dependents under these circumstances:

- **Loss of other coverage:** An employee and any eligible dependents are eligible for special enrollment in any benefit package (subject to plan eligibility requirements) if other coverage is lost. If eligible employees or dependents waive coverage un-

der your plan because they are covered under another group plan and then they lose that coverage, they have the right to special enroll in your health plan. The participant may lose previous coverage for a number of reasons:

- Leaving the company, legally separating or divorcing, no longer meeting the plan's eligibility requirements.
- Moving out of the HMO service area.
- Meeting the lifetime benefit maximum of the plan.
- Ending of the previous employer's contributions for coverage.
- Exhausting COBRA benefits.

To qualify for special enrollment, employees must have informed you in writing they were covered under another plan at the time they declined enrollment. If the plan requires this written notification, the employer must notify employees of this requirement.

In addition, a plan is not required to extend special enrollment rights if the loss of coverage is for cause; for example, if an individual loses coverage because of failure to pay required contributions or as result of making a fraudulent claim.

- **Dependents become eligible under the plan:** A dependent can become eligible for coverage under the plan in a number of ways:

- Birth or adoption of a child.
- Marriage or dependent child acquired through marriage.

The regulations allow the plan to define who is considered a dependent under the portability regulations.

An employee or dependent must notify the plan generally within 30 days of either the loss of other coverage or the family status change that permits dependents to special enroll in the plan. For most events, coverage can begin effective the date previous coverage was lost or the first of the month following the notification of the event. However, in the case of the birth or adoption of a child, coverage must be effective on the date of birth or adoption.

When employees are initially offered the opportunity to enroll in a group health plan, the plan must inform them of:

- Special enrollment rights, including:
 - If they decide to waive coverage because they already have other coverage, they may have special enrollment rights if they lose that alternative coverage.
 - If they decide to apply for special enrollment because they have lost their previous coverage, they must notify the employer within 30 days of losing that coverage.
 - If they acquire dependents through birth, adoption or marriage, the employees and any dependents have

Continued on Page 7

the right to elect coverage under the plan, providing they notify the plan within 30 days of the event.

- Contact information or a description of the process required to notify the plan of any events that would qualify an employee or dependent to special enroll in the plan.
- Any special steps employees must take to inform the plan that they have alternative coverage.

Special enrollees are entitled to the same benefit options available to similarly situated individuals that enrolled when first eligible.

Proposed Portability Regulations

Proposed regulations were released along with the final regulations. The proposed regulations covered the following issues:

- Tallying the days for the 63-day break in coverage.
- Tallying days for special enrollments.
- Interacting with the FMLA.
- Determining the number of plans.

The government has requested comments on these proposed regulations.

Tallying a Significant Lapse in Coverage

Under the proposed rules, the period used to determine whether a significant break in coverage has occurred is tolled in cases where a certificate of creditable coverage is not provided on or before the date coverage ceases. The maximum timeframe for tolling this break period will not extend beyond 44 days following the day coverage ends.

The thought behind this proposed change is to be fair to individuals who may not be aware their coverage has ended. If they do not know their coverage has ended, it will be difficult for them to obtain other coverage without experiencing a significant break in coverage.

Tallying Special Enrollments

The current regulations require plans to provide special enrollment rights if certain events occur. Plans can require that requests to add coverage must be made within 30 days of the event.



The new proposed regulations eliminate abuse of the 30-day enrollment window. Some plans require specific application materials be completed within the 30 days, even if 30 days is not enough time to obtain the information requested. For example, some plans have requested a newborn's social security number be provided with the application materials. If the social security number is not provided within the 30-day special enrollment window, these plans are denying enrollment.

The newly proposed regulations require the written or oral request to special enroll to be made within the 30-day window. If the request is made, the plan can request the application materials be completed within a reasonable time. The regulations do not specify what would be considered a reasonable timeframe. If an employee cannot obtain required information within that time, the plan should allow an extension when the lack of information is beyond the employee's control.

The new rules also propose changes in effective coverage dates. If an employer requests certain information be submitted along with a request to special enroll, the plan can stipulate coverage will be effective on the first of the month after it receives substantially complete enrollment materials. However, if a newborn or adopted child is enrolled, the coverage must be retroactive to the date of birth or adoption.

Interacting with FMLA

The proposed regulations deal with several key administrative issues regarding the interaction of the portability requirements and the Family Medical Leave Act (FMLA). They include:

- If an individual is on an approved FMLA leave and discontinues coverage, any time not covered during the approved leave will not count in determining a significant break in creditable coverage.
- A group health plan or insurance issuer must automatically send a certificate of creditable coverage to an individual on an approved

FMLA leave if coverage is not continued.

- Individuals who do not return to work after an approved FMLA leave are entitled to special enrollment rights under any group health plan in which they may be eligible to enroll. The 30-day special enrollment window will be measured from the last day of the approved leave.
- The proposed regulations recommend that additional information be added to the certificate of creditable coverage to explain the interaction of HIPAA and the FMLA.

Determination of the Number of Plans

Finally, the proposed regulations attempt to clear up uncertainty when it comes to determining how many plans employers offer if they sponsor multiple medical plans. The proposed regulations recommend that all medical care benefits an employer or employee organization offers should generally be considered one group health plan for HIPAA portability purposes. Therefore, if an employee changes medical plan elections during the year, the plan would not have to issue a certificate of creditable coverage.

It does not mean that all employer health plans must be considered one plan for the purposes of this rule. An employer can establish more than one group health plan, if it sets up the required plan documents and the instruments governing the plans clearly outline the plans are considered separate. Employers cannot establish multiple plans for the sole purpose of evading compliance issues.

This language will allow employers flexibility in determining the best way to organize plan options from a portability administrative standpoint.

Action Plan

It is not hard to see why so many plans removed their pre-existing condition limitations when these requirements became effective in 1997. However, these final regulations are a great reminder of the complexities involved in managing the pre-existing condition limitation and portability requirements of HIPAA.

Although the final changes are minor, for the most part, now is a great time to evaluate whether your plan complies with the new portability rules.

If your plan maintains a pre-existing condition limitation:

1. Make sure the pre-existing condition definition and limitations meet the portability rule requirements.
2. Check to confirm you are providing a written notice of your pre-existing condition limitation with your application materials and that the notice contains all the information required.
3. Review your plan document to make sure you do not have plan provisions that are not expressly defined as pre-existing condition limitations, but operate as one. For



example, the plan covers the treatment of various heart conditions, but excludes coverage for congenital heart conditions.

4. Determine how your plan handles the process of applying creditable coverage (in many cases, your health plan vendor will handle this process):

- How does your vendor request certificates of creditable coverage?
- Does your vendor send the individual a written notice disclosing the exclusion period? Does that notice include all the required elements? Is the notice delivered promptly?

5. If your vendor issues your plan's certificates of creditable coverage, request a copy of the certificate to ensure it contains all the required

elements, including the educational statement. Also, review your administrative agreements to make sure your administrator has contractually

outlined its responsibilities in assisting your plan with portability compliance.

6. Make sure your plan has a written procedure for requesting a certificate of creditable coverage and it notifies all plan participants of this procedure. Because the regulations do not specify a method for notifying your participants, you may choose to include this information in

your SPD or other plan documents.

- 7. Review your plan document to ensure special enrollment rights are explained accurately.
- 8. Determine whether your plan is sending a notice of special enrollment rights with the initial enrollment package. The notice needs to contain all the provisions outlined in this *Advisor*.
- 9. Find out whether employees waiving coverage are asked to indicate they have other coverage in effect. In order to qualify for special enrollment rights in the future, employees must indicate they have coverage elsewhere at the time they waive coverage, if your plan requires this information.

If your plan does not include a pre-existing condition limitation:

- 1. Review your plan document to make sure your plan doesn't include provisions that operate as pre-existing condition limitations. For example, the plan covers the treatment of various heart conditions, but does not cover congenital heart disease.
- 2. If your vendor issues your plan's certificates of creditable coverage, request a copy of the certificate to ensure it contains all the required elements, including the educational statement. Also,



review your administrative agreements to make sure they state the administrator's responsibilities in helping you comply with portability rules.

- 3. Make sure your plan has a written procedure for requesting a certificate of creditable coverage and it notifies all plan participants of this procedure. Because the regulations do not specify a method for notifying your participants, you may choose to include this information in your SPD or other plan documents.
- 4. Review your plan document to ensure it explains special enrollment rights accurately.
- 5. Determine whether your plan is sending a notice of special enrollment rights with the initial enrollment package. The notice needs to contain all the provisions outlined in this *Advisor*.

- 6. Find out whether employees waiving coverage are asked to indicate if they have other coverage in effect. In order to qualify for special enrollment rights in the future, employees must indicate they have coverage elsewhere at the time they waive coverage if your plan requires this information.

The final regulations are effective your first plan year on or after July 1, 2005.

The proposed regulations do not have an effective date; the government is soliciting comments on the practicality of adopting these proposed parameters.

Please call your Account Manager with any questions. **MW**

We Have Moved!

Effective February 14, our offices have moved to a new location. Our new address is:

3331 West Big Beaver Rd.
Suite 200
Troy, MI 48084

All phone numbers and fax lines have remained the same.

MCGRAW WENTWORTH TEAM

<p>PRINCIPALS</p> <p>ACCOUNT DIRECTORS</p> <p>DIRECTOR OF TECHNICAL SERVICES</p> <p>MANAGER, CLIENT SERVICES</p> <p>ASSISTANT MANAGER, CLIENT SERVICES</p> <p>SR. ACCOUNT MANAGERS</p> <p>ACCOUNT MANAGERS</p>	<p>SR. PLAN ANALYSTS</p> <p>PLAN ANALYSTS</p> <p>DIRECTOR OF ADMINISTRATION</p> <p>DIRECTOR OF INFORMATION TECHNOLOGY</p> <p>SYSTEMS SUPPORT SPECIALIST</p> <p>ADMINISTRATIVE SUPPORT</p> <p>MARKETING DEPARTMENT</p>
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Our technical bulletins are written and produced by McGraw Wentworth staff and are intended to inform our clients and friends on general information relating to employee benefit plans. They are not intended to provide either legal or tax advice. Before implementing any welfare or pension benefit program, employers are urged to consult with their benefits advisor and/or legal counsel for advice that is appropriate to their specific circumstances.

McGraw Wentworth
 3331 West Big Beaver Road, Suite 200
 Troy, MI 48084
 Telephone: 248-822-8000 Fax: 248-822-4131
www.mcgrawwentworth.com