VEDDER PRICE

Employee Benefits Bulletin

A review and analysis of recent developments affecting employee benefits

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HIPAA REGULATIONS REQUIRE IMMEDIATE ACTION/DESIGN CHANGES FOR HEALTH PLANS

On April 1, 1997, the U.S. Department of Health and Human Services, the U.S. Department of Labor, and the Internal Revenue Service jointly issued a series of regulations that are primarily designed to implement provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These regulations focus on several areas of particular interest to employers who maintain health plans:

- The certificate of prior coverage requirement;
- The scope of permissible preexisting condition exclusions;
- Special enrollment dates;
- What constitutes discrimination on the basis of health status;
- Required content of health plan summary plan descriptions ("SPDs"); and
- Electronic mail distribution of SPDs.

Each of these subjects is discussed below. **Of these subjects, the most urgent is the certificate of prior coverage requirement, as employers must take action on or before June 1, 1997.**

THE CERTIFICATE OF PRIOR COVERAGE REQUIREMENT

HIPAA provides that if an individual loses coverage under a group health plan, he/she is entitled to receive a certificate describing the length of his/her prior coverage. This information can be used by the individual to reduce the impact of any preexisting condition exclusion or limitation under another group health plan.

Who Must Get the Certificate?

Any individual who loses coverage under any group health plan with two or more participants (even if the plan is not subject to COBRA) must be given the certificate. Some of these individuals may be easy to identify from a systems perspective; others may not.

A certificate must be issued automatically to the following individuals:

- "Qualified beneficiaries" who lose coverage as a result of a "qualifying event" under COBRA (*e.g.*, termination of employment, divorce, loss of dependent status, etc.);
- Individuals who lose coverage when COBRA coverage expires, either because the maximum period of coverage has expired or due to failure to pay premiums; and
- Other individuals who lose coverage. This group would appear to include individuals who are dropped from or waive existing coverage during a plan's open enrollment period.

A certificate must be issued in response to a request by any individual who lost coverage under a group health plan within the 24 months immediately prior to the date of the request. This is true regardless of whether an automatic certificate was previously issued to this individual at the time coverage was lost.

Who Must Provide the Certificate?

The regulations obligate *both* the employer (technically, the group health plan) and the insurer (including an HMO) to provide the certificate. However, if one party provides the certificate, the other party is deemed to have done so. Consequently, it is important for employers and health insurer(s) or HMO(s) to agree on who will provide these

required certificates.

What Must Be in the Certificate?

Each certificate of prior coverage must contain the following general information:

- The date of the certificate;
- The name of the group health plan;
- The name of the participant;
- Any other information necessary to identify the individual (*e.g.*, the individual's identification number under the group health plan);
- The name of any dependents to whom the certificate applies;
- The name, address and telephone number of the plan administrator or insurer responsible for providing the certificate; and
- The phone number to contact for further information (if that number is different from that of the plan administrator or insurer).

The exact amount of prior coverage information depends on the length of the individual's prior coverage:

18 months or more of coverage: If the individual has been covered for 18 months or more without a significant (*i.e.*, 63-day) break in coverage, the certificate need only state that fact. This is because 18 months is the maximum preexisting condition limitation or exclusion that could ever be applied by another plan.

Less than 18 months of coverage: If the individual has been covered for less than 18 months, the certificate must disclose the following information:

- The date any waiting or affiliation period (in the case of an HMO) began;
- The date coverage began; and

- The date coverage ended.

It should be noted that the certificate need *not* include any information relating to an indi-vidual's coverage prior to July 1, 1996.

A single certificate may provide information with respect to both a participant and his/her dependents if the information is identical for each person. If the information differs, a separate certificate may be issued for each individual or a single certificate may provide a detailed description of the different information.

The regulations contain a "model" certificate, a copy of which is reproduced on page 9 of this *Bulletin*. This certificate may be customized, but it must include the information contained in the model certificate.

When Must the Certificate Be Provided?

The time frame for providing a certificate depends on what event caused the individual to lose coverage:

- If the individual is a "qualified beneficiary" who is entitled to elect COBRA coverage, the certificate must be provided no later than when a notice must be provided for a qualifying event under COBRA.

- If the individual is not a "qualified beneficiary" entitled to elect COBRA coverage, the certificate must be provided within a "reasonable time" after the coverage ceases.

- If the individual is covered under COBRA or alternative coverage (*e.g.*, retiree coverage), the certificate must be provided within a "reasonable time" after the coverage ceases or, if applicable, after the expiration of any grace period for the payment of COBRA premiums.

- If an individual who lost coverage within the past 24 months requests a certificate, it must be provided at the earliest time a plan administrator or insurer, acting in a reasonable and prompt manner, can provide the certificate.

How Must the Certificate Be Delivered?

The certificate should be sent by first class mail to the individual's last known address. If a dependent's last known address is different from that of the participant, a separate certificate must be sent to that dependent's address.

What Is the Effective Date of the Certification Requirement?

The certification requirement is effective June 1, 1997, but it applies to anyone who lost coverage on or after July 1, 1996. The level of immediate work imposed on plan sponsors relating to the certification requirement depends on when the individual lost coverage:

July 1, 1996 through September 30, 1996: If the individual lost coverage between July 1, 1996 and September 30, 1996, the employer or insurer is *not* required to provide any information to the individual on its own initiative. However, if the individual requests a certificate, it must be furnished.

October 1, 1996 through May 31, 1997: If the individual lost coverage between October 1, 1996 and May 31, 1997, the employer or insurer must provide a certificate to this individual regardless of whether the individual requests it. **This certificate (or the optional notice described below) must generally be provided on or before June 1, 1997.**

Optional Notice

The obligation to provide a certificate to individuals who lost coverage between October 1, 1996 and May 31, 1997 can be satisfied by providing those individuals with a notice informing them of their right to obtain a certificate of prior coverage. Employers and insurers will likely find it easier to send the notice to this group and generate certificates only for those individuals who affirmatively request them.

Individuals to whom the notice should be sent are:

- Individuals who had a COBRA qualifying event during this period (apparently *regardless* of whether they are still covered under the group health plan due to COBRA coverage);

- Individuals who otherwise lost coverage during this

period (*e.g.*, either waived existing coverage or were dropped from coverage during open enrollment); and

- Individuals whose COBRA coverage expired during this period.

As with the certificate, this notice generally must be sent to each individual's last known address on or before June 1, 1997. There are, however, later deadlines under limited circumstances. For example, if a participant has a qualifying event in late May 1997, and the deadline for providing the COBRA notice is in early June, then the deadline for providing this notice is that early June date.

Page 10 of this *Bulletin* contains a copy of the model notice that was included in the preamble to these HIPAA regulations. As with the model certification, employers and insurers are not required to use this model notice. However, any customized notice must include information substantially similar to the information included in the model notice.

THE SCOPE OF PERMISSIBLE PREEXISTING CONDITION EXCLUSIONS

Plans may continue to apply preexisting condition exclusions, but they will be constrained in doing so. In the first place, such an exclusion can only apply to a preexisting condition as defined under HIPAA, which is a condition (whether physical or mental, and regardless of its cause) for which medical advice, diagnosis, care, or treatment was *actually* recommended or *actually* received within the 6-month period ending on the individual's "enrollment date" (*i.e.*, the earlier of the first day of coverage or the first day of any waiting period). Next, such an exclusion cannot extend for more than 12 months (18 months for late enrollees) after a plan's enrollment date. Finally, the preexisting condition exclusion period must be reduced by the individual's days of creditable coverage as of the enrollment date.

What Is Creditable Coverage?

Creditable coverage is any type of health coverage under a group health plan, an individual policy, Medicare, or Medicaid. It does not, however, include coverage consisting solely of excepted benefits, which are defined

as coverage for accidents (*e.g.*, AD&D policies), disability, general liability insurance, supplemental liability insurance, workers' compensation, automobile medical payment insurance, credit only insurance (*e.g.*, mortgage insurance), and coverage for on-site medical clinics.

Counting Creditable Coverage

A plan can count creditable coverage using either the "standard" method of calculation or the "alternative" method of calculation.

Standard Method. Under the standard method, the plan counts credited service by counting all days on which the individual has one or more types of creditable coverage.

Alternative Method. Under the alternative method, the plan determines the amount of an individual's creditable coverage for one or more of five identified categories of benefits. Those categories are:

- mental health;
- substance abuse treatment;
- prescription drugs;
- dental care; and
- vision care.

A plan may use the alternative method for any or all of the categories and may apply a different preexisting condition exclusion period with respect to each category. However, if a plan uses the alternative method, it must issue disclosure statements to participants indicating that this alternative method is being used, and this disclosure must be given to enrollees at the time of enrollment.

SPECIAL ENROLLMENT DATES

Most plans require employees and their dependents to enroll for coverage either when they first become eligible to enroll (*e.g.*, at the beginning of their employment or when they first become dependents) or at an annual open enrollment period. HIPAA has added a requirement that a

plan must permit employees and their dependents to enroll during "special enrollment periods" if they either (a) have previously declined coverage and then lose coverage under another plan, or (b) become or gain a dependent through marriage, birth, adoption or placement for adoption.

Loss of Coverage

In order to have a special enrollment right due to the loss of coverage, the affected individual must satisfy all the following requirements:

- The individual must otherwise be eligible for coverage under the terms of the plan;
- When the individual previously declined coverage, he/she must have been covered under another group health plan or must have had other health insurance coverage; and
- Special enrollment can only be requested within 30 days after losing eligibility for the other coverage or after cessation of employer contributions for the other coverage.

An individual does not have to elect COBRA continuation coverage or exercise similar continuation rights in order to preserve his/her right to make a special election. However, if COBRA is elected, the individual may not make a special election if coverage is lost due to the failure to pay premiums; the individual must exhaust his/her maximum COBRA period.

If an individual makes a special election, coverage under the plan must be effective no later than the first day of the month after an employee requests the enrollment for himself/herself or on behalf of a dependent.

New Dependent

As noted above, a special enrollment period also occurs if a person becomes or gains a new dependent by birth, marriage, adoption, or placement for adoption. The election to enroll must be made within 30 days following one of these events. The special enrollment rules permit the employee to enroll when he or she marries or has a new child. In addition, the spouse can be enrolled separately at the time of marriage or when a child is born,

adopted or placed for adoption. A child who becomes a dependent of a participant as a result of marriage, birth, adoption, or placement for adoption can be enrolled when the child becomes a dependent. Similarly, a child who becomes a dependent of an eligible employee as a result of marriage, birth, adoption, or placement for adoption can be enrolled if the employee enrolls at the same time.

Coverage with respect to a marriage is effective no later than the first day of the month after the date the request for enrollment is received, and coverage with respect to a birth, adoption, or placement for adoption is effective on the date of the birth, adoption, or placement for adoption.

If a person enrolls during a special enrollment period, the plan may not treat that individual as a late enrollee, and thus may not impose a preexisting condition exclusion period of longer than 12 months with respect to that person. This is true even if the special enrollment period coincides with the plan's annual open enrollment period, when the individual might otherwise be able to enroll as a late enrollee.

Finally, a plan must provide a description of the special enrollment rights to anyone who declines coverage. The HIPAA regulations contain a model description that reads as follows:

> If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, 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 dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

DISCRIMINATION BASED ON HEALTH STATUS

HIPAA contains broad prohibitions against discrimination in health coverage based on a "health status-related factor." The recently issued regulations provide some guidance as to what constitutes discrimination, but they mostly seek to elicit comments in this area.

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The rules prohibit discrimination in two areas: (1) the eligibility to enroll and (2) premiums and contributions. The rules define "eligibility to enroll" to encompass waiting or affiliation periods for enrollment and eligibility for late or special enrollment. A plan may not condition eligibility for enrollment of an individual or a dependent on: (i) health status; (ii) physical or mental condition, including any condition resulting from illness, injury (whether or not accidental), pregnancy, or congenital malformation; (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) disability; (vii) evidence of insurability (including conditions arising out of acts of domestic violence); and (viii) genetic information (including information about genes, gene products, and inherited characteristics, as well as information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes).

The regulations specifically address the "proof of insurability" provisions contained in many plans for late enrollees. The eligibility discrimination rule would be violated by a health plan which is available to all employees who enroll within the first 30 days of employment but requires a physical examination for those who want to enroll after their initial 30 days. The physical examination requirement for late enrollees is prohibited discrimination.

The rules also prohibit discrimination in premiums and contributions. A health plan may not require an individual or a dependant of the individual to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual, if the greater amount is based on a health status-related factor. A plan may, however, establish premium discounts or premium rebates, or otherwise modify copayments or deductibles, in return for adherence to a bona fide wellness program of health promotion or disease prevention. For example, the regulations state that a plan may give discounts to a participant in exchange for following a regimen designed to lower cholesterol. The discount may not be contingent upon actually lowering cholesterol, however. Requiring an actual lowering of cholesterol would be prohibited discrimination based on a health status-related factor.

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The regulations invite comments on whether a premium reduction for nonsmokers (a relatively common plan provision) should be considered discrimination based on a health status-related factor.

REQUIRED CONTENT OF HEALTH PLAN SPDS

HIPAA amends the requirement for what must be included in an SPD of a group health plan to require a statement about whether a health insurance company is responsible for the financing or administration of the plan, so that participants and beneficiaries will know when a plan is self-funded. When a health insurance company is responsible for the financing or administration of a group health plan, the SPD must include the name and address of the insurance company, a statement about whether and to what extent benefits are guaranteed by the insurance company, and a statement about the nature of any administrative services provided by the insurance company. Thus, if a plan uses an insurance company as the third-party administrator for a self-funded plan, the limited role of the insurance company must be disclosed in the SPD.

SPDs must also include a reference to the DOL office through which participants and beneficiaries can seek assistance (which will be the nearest office of the Pension and Welfare Benefits Administration).

Another law enacted in 1996, the Newborns and Mothers Health Protection Act, prohibits group health plans and health insurance issuers from limiting hospital stays for mothers and newborn children to less than 48 hours following a normal (vaginal) delivery, or less than 96 hours following a cesarian section. These new requirements are deemed to be material modifications to the terms of health plans, and a summary of material modification ("SMM") must generally be provided to participants no later than 60 days into the 1998 plan year.

In addition, SPDs of group health plans must include a statement that federal law prohibits restricting benefits for hospital stays in connection with childbirth beyond the above lengths.

Material Reduction in Benefits

HIPAA also accelerates certain disclosure requirements

when a health plan has a material reduction in benefits. The general rule is that participants and beneficiaries must be furnished SMMs no more than 210 days after the end of the plan year in which the change is adopted.

However, in the case of any change which is a "material reduction in covered services or benefits provided under a group health plan," an SMM must be provided to participants and beneficiaries no more than 60 days after the adoption of the change, unless plan sponsors normally provide summaries of modifications or changes at regular intervals of not more than 90 days. The 60-day period does not apply when a system of communication (*e.g.,* a company or union newspaper) is in place which provides information concerning the plan to participants and beneficiaries at regular intervals of not more than 90 days. If a plan has participants or beneficiaries who do not receive such communications, these participants and beneficiaries must be provided with SMMs within 60 days.

A "material reduction in covered services or benefits" means any change that would be considered by the average plan participant to be an important reduction in covered services or benefits. Examples include such things as any modification or change that eliminates benefits payable under the plan, increases the deductibles or co-payments, or reduces the service area covered by a HMO.

DISCLOSURE OF SPD AND RELATED INFORMATION THROUGH ELECTRONIC MEDIA

On or after June 1, 1997, SPDs and SMMs for group health plans can be delivered via electronic media, which is to be considered "reasonably calculated to ensure receipt," provided the information delivered is equivalent in form and substance to what would have been furnished in paper form. Electronic delivery will be an acceptable method of delivery when it covers participants who can access electronic documents from their worksites and have the opportunity at their worksites to convert electronic documents into paper form, without charge. Nevertheless, the DOL feels that participants have a right to request and receive free paper copies of all disclosure documents.

If you have any questions about these new regulations, please call Phil Mowery (312/609-7642), Paul Russell (312/609-7740), or any other Vedder Price employee

benefits attorney with whom you work.

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