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CHANGES IN GROUP HEALTH PLANS

INVOLVING REQUIRED NOTICE TO EMPLOYEES

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In the recent rash of laws passed by Congress and by President Clinton, the Health Insurance Portability and Accountability Act of 1996, (HIPAA), was adopted on August 21, 1996. Portability, as defined by Webster's Dictionary means "capable of being carried or moved about".

HIPAA was, thus, enacted to improve the movement of health insurance coverage between jobs and eliminate exclusions of individuals from coverage based on preexisting conditions or health status.

The HIPAA legislation has "bite" to it, in that group health plans, other than governmental and small employer plans that fail to comply with these restrictions are subject to a penalty of $100 per day with respect to individuals to whom the failure relates during the noncompliance period.

HIPAA imposes its requirements through changes in ERISA, the Internal Revenue Code, the Public Service Act and the Social Security Act. Interim regulations were issued on April 8, 1997, which include model notices and certificates that employers are required to use beginning June 1, 1997. Those model samples are included in this article.

HIPAA is designed to work in conjunction with COBRA to facilitate a complete health insurance portability system that allows employees to change jobs without the fear of losing coverage. These rules will also improve coverage access for individuals with health conditions that until now prevented them from getting coverage before.

The Act provides for the following:

- A limitation on preexisting condition exclusions that are currently found in many plans;
- A prohibition against discrimination in eligibility or premiums based solely on an individuals health status;
- Guaranteed renewability for employers participating in multiemployer plans; and,
- A penalty tax for failure to comply with the new plan.

These new rules do not apply to the following:

- Government plans;
- Plans covering fewer than 2 current employees at the beginning of the plan year;
- Accident insurance, disability insurance income, liability insurance and supplements (including workers' compensation), automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other coverage specified in future regulations in which medical care is secondary or incidental to other insurance benefits;

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- Limited dental or vision benefits, long-term care insurance, nursing home insurance, home health care insurance, or coverage for community based care, if these benefits are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan;

- Coverage for a specified disease or illness, or hospital indemnity or other fixed indemnity insurance if the following apply:

a. These benefits are provided under a separate policy, certificate, or contract of insurance;

b. no coordination exists between the provisions of such benefits and any exclusion under the plan, and;

c. benefits are paid for an event regardless of whether benefits are provided under any group health plan maintained by the same plan sponsor;

- Medicare supplemental coverage or other similar supplemental coverage, if provided under a separate policy, certificate, or contract of insurance.

Effective Date of Availability Rules

These particular rules will become effective for plan years beginning after June 30, 1997. This date is extended for plans maintained under one or more collective bargaining agreements ratified before the date of enactment until the first plan year after the expiration of the last such agreement (without regard to extensions approved after the date of enactment).

In addition, no enforcement action will begin before January 1, 1998 or the date that permanent regulations are issued, if later.

Coordination with COBRA

Due to the expanded access to new coverage under HIPAA, new rules allow termination of COBRA coverage if a qualified beneficiary becomes covered under another group health plan, so long as the coverage is not excluded by an allowable preexisting condition. HIPAA also allows change of coverage status under COBRA upon the birth or adoption of a child in the same way that such changes are allowed in a group health plan under the new law. HIPAA also states that 29 months of COBRA coverage applies to disabled qualified beneficiaries of the covered employee. The disability is not required to exist prior to coverage but may arise during the first 60 days of COBRA's coverage.

Effective Date of COBRA Coordination Rules

The effective date for this particular provision is January 1, 1997, regardless of whether the qualifying event occurred before, on, or after that date.

Limitation of Exclusion for Preexisting Conditions

There are several new limitations on exclusions for preexisting conditions under HIPAA.

First, a group health care plan may exclude coverage for preexisting conditions only for 12 months (18 months for late enrollees).

This period is further reduced by counting certain prior coverages of prior employers. The new rules provide that an employee is credited for prior coverage under a wide variety of health plans, including group health plans, individual policies, HMO's, Medicare and various governmental programs. However, coverage is not counted toward the exclusion period of the new plan if there has been an intervening break in coverage of 63 days or more.

Second, employees with 12 months or coverage with one employer may move to a new employer with new coverage without becoming subject to the preexisting condition exclusion of the new employer.

Under the new rules, an exclusion is permissible only if it relates to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the six months before the enrollment in the new plan. Conditions that are not diagnosed or treated within the six month period may not be subject to any coverage exclusion.

In addition, genetic status is not an excludable condition unless diagnosis was rendered within the six-month period.

Newborns also may not be excluded if covered within 30 days of birth and adoptees (under the age of 18) may not be excluded if covered within 30 days of adoption. This preferred status may be forfeited, however, if there is a break in coverage of more than 63 days. Likewise, pregnancy may not be excluded and no break in coverage rule applies.

Employers may count coverage without regard to the specific benefits provided by the prior plan or they may elect to measure prior coverage by classes or categories of benefits that will be established by regulations.

Certification of Coverage - Employer Requirement

An individual's prior plan must supply a certification of coverage at the time coverage ceases or, upon request of the individual, at any time within the next two years (see model sample, provided herein). The certification must specify the period of credible coverage. Moreover, an employer that credits prior coverage by classes and categories of benefits must secure this information from the prior plan itself and pay a reasonable fee to the prior plan if requested.

Certificates are required by June 1, 1997, however, employers need not report events prior to July 1, 1996 and individuals will bear the burden of showing coverage prior to July 1, 1996 (if needed) under special procedures to be established by the IRS.

Employees are required to enroll in an employers group health plan at the first opportunity to take advantage of the 12 month preexisting condition exclusion period, otherwise, an 18 month period may apply. This rule does not hold true, however, if the employee declined coverage because he or she had other coverage under COBRA or another health plan (for himself or another family member) and the other coverage is lost because of the following circumstances:

- The other coverage was COBRA continuation coverage and the coverage was exhausted;

- The other coverage was terminated as a result of loss of eligibility for the coverage as a result of separation, divorce, death, termination of employment, or reduction in the number of hours worked; and

- The other coverage was lost because employer contributions were terminated.

In these circumstances, the employee must enroll within 30 days of the date the other coverage is lost.

Note that a special 30-day period also applies for enrollment of new dependants acquired by marriage, birth, adoption, or placement for adoption. No preexisting condition exclusion may apply to newborns or adoptees enrolled during this period but the 12 month exclusion could apply to a new spouse or child placed for adoption but not yet adopted.

ERISA Disclosure Changes

There are significant changes in the ERISA required disclosures in Summary Plan Descriptions. Effective for plan years beginning on or after July 1, 1997, disclosures are required in the summary plan descriptions indicating who administers the plan and its name and address. Furthermore, reference to DOL offices must be made available to participants so that they may contact them for information on rights under HIPAA.

In addition to the new required disclosures in summary plan descriptions, accelerated notices are required for certain health plan changes, stated as a summary describing "material changes" in covered services and benefits, in the following:

- Mother/newborn changes deemed material changes by statute, in effect January 1, 1998; and

- Change in preexisting condition requirements, required special enrollment dates, etc., probably material changes to.

In addition, adoption of changes from the usual SPD/SMM requirements must be provided within 60 days of adoption of the changes.

An alternative to these new ERISA disclosure changes would be to provide an updated summary plan description every 90 days.

A model sample of an ERISA disclosure notice is provided herein.

Penalties for Failure to Meet Rules on Portability Access and Renewability

As stated in the beginning of this article, employers will be subject to a stiff penalty tax for failure to meet the new rules on health care insurance portability and access to coverage. Multiemployer plans will be subject to the same penalty for failure to meet the new rules that guarantee renewability to participating employers.

Conclusion

An employer with a group plan should review the model sample certificates and begin implementing them with newly hired employees, as well as terminating employees.

In addition, a review of the group insurance plan is necessary to ensure that there are no illegal exclusions of health benefits to newly hired employees based on preexisting conditions and summary plan descriptions need to include the ERISA required disclosures.