

## **FINAL HIPAA REGULATIONS EXPAND AND SHARPEN GROUP HEALTH PLAN PORTABILITY REQUIREMENTS**

January 11, 2005

On December 30, 2004, the Department of the Treasury, the Department of Labor and the Department of Health and Human Services jointly issued final regulations that modify and clarify previously published interim rules governing group health plan portability under the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA, enacted in 1996, facilitates group health plan portability principally by limiting the time period during which group health plans can impose preexisting condition exclusions. The final regulations apply for plan years beginning on or after July 1, 2005.

Among the more significant modifications and clarifications to the interim HIPAA portability rules are the following:

- Certificates of creditable coverage must include an educational statement that informs individuals about their rights under the HIPAA portability provisions. Sample language is set forth in the regulations.
- Group health plans must have written procedures for individuals to request and receive certificates of creditable coverage.
- Under HIPAA, a group health plan's ability to enforce a preexisting condition exclusion is limited by, among other things, the creditable coverage a new participant earned in a previous plan. According to the three agencies, some group health plans have provisions that operate as preexisting condition exclusions even though the plans may not treat them as such. The final regulations identify several examples:
  - ⌘ A plan provision that covers accidental injury only if the injury occurs while the individual is covered under the plan.
  - ⌘ A plan provision that counts benefits provided under a previous plan against the lifetime benefits limit of the current health plan.
  - ⌘ A plan provision that denies benefits for pregnancy until 12 months after an individual generally becomes eligible for benefits under the plan.
- These provisions must be limited in their application to prevent a prohibited preexisting condition exclusion.

- Individuals who are eligible for coverage under a group health plan, but who have not yet enrolled because they are covered under another plan, may have special enrollment rights in the following situations:
  - ⊗ If the individual loses eligibility in his or her original plan due to the application of lifetime benefits limits;
  - ⊗ If the individual loses eligibility for HMO coverage because he or she moves out of the HMO's service area;
  - ⊗ If a dependent loses eligibility because his or her dependent status ends (e.g., a child who "ages out" of his or her parent's plan);
  - ⊗ If an individual loses eligibility because his or her health coverage option under the plan is terminated; or
  - ⊗ If an individual loses eligibility because the plan no longer offers coverage to a class of similarly situated individuals, such as part-time employees.
- Participants may change coverage options through special enrollment when they add one or more dependents in connection with marriage, adoption or placement for adoption.
- Health Flexible Spending Accounts ("FSAs") are excepted from the HIPAA portability requirements as long as certain requirements are satisfied.
- Health Savings Accounts ("HSAs") are also excepted, but the High Deductible Health Plans that accompany HSAs are not.
- Limited scope dental and/or vision benefits and long-term care benefits may be excepted, even if the benefits are part of a plan that includes other covered health benefits, if participants have the right not to elect those benefits and must pay an additional premium or contribution to receive those benefits.
- Health coverage under foreign and U.S. government programs must be treated as creditable coverage.

If you would like further information about the final and proposed HIPAA portability regulations, please contact any of the following Morgan Lewis attorneys:

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