ASPEN PUBLISHERS VOL. 35, NO. 3 WINTER 2009

Employee Relations LAW JOURNAL

Employee Benefits

HIPAA's Special Enrollment Rights: Today's Rules

Anne E. Moran

One of the issues in the health care reform debate has been the ability of individuals to change coverage without penalties when their jobs or circumstances change. Most employers' health plans permit new enrollments in the employer's health plan when the individual employee first becomes eligible to enroll, as well as during an annual "open season." Group health plans subject to HIPAA must allow "special enrollments" that provide immediate access to the employer's health plan even outside of the open season enrollment period. This article discusses those special enrollment rules and recent changes to them.

Background—Enrollment Practices and the Need for Special Enrollments

Employer-provided health care arrangements generally allow entry upon the beginning of employment or, if there is a waiting period or other eligibility criteria, when those requirements are met. Often these plans also allow eligible individuals to sign up during an open enrollment season, which is usually annually. Open enrollment periods are not required by federal law, but are very common, and some state laws require them. Thus, an employee who chooses not to accept health care coverage when first offered—because the individual could not afford insurance, because he or she felt invincible, or because he or she had other coverage—generally must wait for open enrollment season if the individual wishes to sign up later. These limits provide administrative

Anne E. Moran is a partner at Steptoe & Johnson LLP in Washington, DC. She advises clients on executive compensation issues and on benefits issues arising under retirement, health, and other benefit plans. Over the course of her career, she has served as Tax Counsel for the Senate Finance Committee and on the ERISA Advisory Council for the Department of Labor. Ms. Moran may be reached at *amoran@steptoe.com.*

convenience for the employer, prevent adverse selection, and help the employer manage and predict costs.

However, enrollment restrictions can create burdens for an employee who unexpectedly needs health coverage and who must wait for the open enrollment season. Special enrollment relieves this problem. Special enrollment status is important not only because it allows immediate (generally prospective) access to an employer's health insurance, but because special enrollees are treated like initial enrollees for purposes of certain other HIPAA rights. For example, the special enrollee will be subject to the same (less restrictive) rules governing pre-existing conditions that are applied to initial enrollees.[1]

General Rules for Special Enrollment Periods

The Health Insurance Portability and Accountability Act of 1996 (HIPAA),[2] requires that in certain cases "special enrollees" must be allowed the opportunity to enroll in the employer's health plan outside of the plan's normal enrollment periods (which are generally upon initial eligibility and during open season). HIPAA's rules apply to group health plans, which are defined under the statute as any plan that provides health care and is maintained by an employer with two or more employees. The special enrollment rules apply only to "health insurance coverage," which would also exclude coverage such as accident or disability-only coverage, secondary coverage such as supplemental auto insurance coverage or liability coverage, and on-site medical clinics. Also, some types of benefits are not included for these purposes, such as "stand alone" vision or dental care if separate premiums are charged and if the employee has the right to opt out of such plan.[3] Certain health flexible spending accounts (FSAs) may not be subject to the HIPAA rules.

If an individual is eligible for special enrollment rights, that individual must be provided access to all options available under the health plan. As discussed below, the plan must provide a notice of HIPAA rights to all persons who are eligible to enroll in the plan. The HIPAA regulations provide a model notice for this purpose.

Most situations in which special enrollment is allowed involve circumstances that are new or changed since the last open enrollment. In addition, the Children's Health Insurance Portability Program Reauthorization Act of 2009[4] changed the law governing special enrollment rights by adding specified changes in eligibility for Medicaid or a state child health insurance plan (SCHIP) as an event which might allow special enrollment.

Situations in Which Special Enrollment Rights Apply

An employee is only eligible for special enrollment rights if he or she meets certain criteria. The individual (and his or her spouse or dependents, if applicable) must be eligible to participate in the employer's group

health plan; that is, the individual must meet waiting period or other plan requirements to participate. Special enrollment rights are permitted due to (1) the loss of other insurance covering the employee, his or her spouse or dependent; (2) the employee's marriage, or the birth or adoption of a dependent; or (3) certain changes in eligibility for Medicaid or SCHIP.

The requirements for special enrollment that apply in each of these situations will be described below.

Special Enrollment Rights When an Individual Becomes Ineligible for Other Coverage

If certain conditions are met, special enrollment rights must be offered to an employee who declined coverage for himself or herself, a spouse, or a dependent under the employer's plan, because he or she or the other individuals were covered under another plan. This right can apply to coverage for the employee or coverage for the spouse or dependent.

Specific Requirements

In order to be entitled to special enrollment, the employee (or spouse or dependent) must have been eligible for coverage under the employer's plan and must have turned it down because he or she had other coverage. For example, the employee might have declined coverage because he or she was covered under the spouse's plan, or the employee might have taken employee-only coverage because the spouse or dependent was covered under another plan. The regulations make it clear that an employee who initially had no coverage when first eligible, but who later acquired other coverage and then turned down his or her employer's coverage (*e.g.*, at the next open season) would be eligible for special enrollment if he loses the other coverage.[5]

The employer has the option of requiring the employee to state in writing at the time coverage is declined that the employee (or covered spouse or dependent) has other coverage. In any event, even if the employer does not choose to require such a written statement, the special enrollment rights only apply if the employee can show that the employee, spouse, or dependent had other coverage and lost it.

This loss of coverage can be due to (1) termination of employment or death, divorce, legal separation, or loss of dependent status under the other plan; (2) the other employer's cessation of premium payments to, or termination of, its plan; and (3) effective April 1, 2009, loss of eligibility status under the plan (*e.g.*, a change from full-time to part-time employment in a company where part-time employees are not covered under the medical plan) or under Medicaid or SCHIP.

Individuals are also entitled to special enrollment rights if they have reached their lifetime limits under the other plan. Special enrollment rights will apply for loss of HMO coverage if the individual no longer

resides, lives, or works in the service area, but if the lost coverage is coverage in a group market, special enrollment status applies only if no other coverage is available to the individual.

Also, special enrollment rights are available if certain COBRA beneficiaries have lost coverage under another plan because their COBRA rights have been exhausted under that plan;[6] *i.e.*, they have completed the maximum period of COBRA coverage. An employee who terminates employment is not *required* to elect COBRA (for example, if the individual could become covered under the spouse's plan as a special enrollee). But if the individual does elect COBRA coverage, he or she cannot obtain special enrollee status by ceasing to pay premiums once coverage is elected. Rather, he must complete the entire COBRA period so that his COBRA coverage is "exhausted." However, "exhaustion of COBRA coverage" includes situations such as loss of coverage because the affected individual has moved out of the HMO or other required service areas as described above or because the employer has not paid any required premiums.[7]

Remember that these rules only apply if an employee or dependent loses coverage under a *group health plan*. For example, the employee does not need to be treated as a special enrollee if coverage is lost under an individual plan, the Federal Health Insurance program, a state health risk pool, or other arrangements that are not defined as group health plans.

Special enrollment rights are not available for termination of coverage for cause (*e.g.*, insurance fraud)[8] or for loss of coverage due to the employee's failure to pay premiums.

Election Timing Rules

Many administrative questions arise because of the requirement that the employee must notify the plan of the loss of coverage within 30 days of the loss of coverage—the minimum period required by law although a longer period may be permitted under the plan (if allowed by the insurer). This minimum 30-day period is extended to 60 days for loss of Medicaid or SCHIP coverage. In cases where eligibility for coverage is lost due to an individual's reaching a lifetime limit on amounts covered under another plan, the 30-day period begins to run from the date the individual receives notice of a claims denial due to lifetime limits.

There may be instances other than loss of coverage due to lifetime limits where the individual does not learn of his or her loss of coverage for a period of time longer than the 30-day period (for example, in cases where the employee is away from the office or the employer fails to notify all employees of a change in coverage promptly). Nonetheless, the current regulations are clear that for most purposes the 30-day period begins on the date of the loss of coverage. Another potential mishap with respect to notification involves an employee who waits until a full *month* after coverage is lost to inform the plan, and that monthly period spans 31 days.

Proposed (but not yet final) regulations under HIPAA would allow a longer period for the affected individual to inform the plan of the loss.

Under the proposed regulations, the plan must be told before the earlier of (1) 30 days after the employee receives a certificate of creditable coverage (under HIPAA rules, a plan that ceases to cover an employer is required to provide such a certificate to the participant indicating the type and amount and length of prior coverage), or (2) if no certificate of creditable coverage is provided, 30 days after the close of the otherwise applicable period for providing a certificate (generally 44 days), for a total of 74 days.[9]

As discussed above, the employer can provide a longer notification period in its plan, but if the employer wants to do that, or if an employer wants to allow an administrative exception to the 30-day rule in the event of a demonstrated hardship due to a failure to be notified, that employer should check with its insurer or stop-loss carrier to make sure that those entities will cover the affected individuals under more generous terms. And under the principle of "no good deed goes unpunished," the employer also needs to ensure that any actions more generous than required will be acceptable for other legal purposes, such as the cafeteria plan rules, for example.

Eligible Individuals

Generally, the persons for whom special enrollment rights are available are those who lose coverage under the other plan. However, if an employee took a risk and did not elect coverage under his or her employer's plan because the spouse or dependents were covered under another plan (but he or she was not covered under either plan), if a special enrollment event occurs, the employee may elect coverage under the employer's plan for himself or herself and the affected spouse or dependents, even if the employee was not covered under the plan before. This is an exception to the general rule that the persons electing special enrollment must have been covered under another plan. Note, however, that although the employee can be added as a special enrollee even if the employee did not lose coverage, only the spouses or dependents *that lose coverage* can be added. For example, if an employee's spouse and her two children lose coverage under the spouse's plan, the employee, spouse, and those two children can be special enrollees in the employee's plan, but the employee could not add other dependents (children of a different former spouse) as special enrollees.

If the requirements for special enrollment are met, the affected individuals will be enrolled on the first day of the month following the date the plan receives the request for the special enrollment.

Special Enrollment Rights Upon Marriage, Birth, or Adoption

Assuming that the employee and dependents would be eligible for coverage under the employer's plan, special enrollment rights also

occur upon the employee's marriage. At that time, the employee can add either the spouse (if the employee is already covered) or himself or herself and the spouse (if the employee was not covered before). The employee can also add individuals who become dependents upon the employee's marriage. In addition, special enrollment rights apply upon the birth, adoption, or placement for adoption of the dependents.

The employee must notify the plan of the marriage, birth, adoption, or placement for adoption within 30 days of the occurrence of the event (or any longer period permitted by the plan). If the event allowing special enrollment is marriage, coverage begins on the first of the month after the plan is notified. If the event is birth, adoption, or placement for adoption, coverage will begin retroactively to when the birth, adoption, or placement occurs. Of course, this assumes that the plan does not impose a waiting period for dependents.

For these purposes, a dependent is defined as someone who is defined under the plan as a dependent. Therefore, this could include a domestic partner (if the plan defines dependents as including domestic partners). By contrast, under COBRA, only a "spouse" or "dependent child" obtains COBRA coverage under the statute.

Special Enrollment Rights When Employee Becomes Eligible for Payment of Insurance Coverage Under Medicaid or SCHIP Coverage

Effective April 1, 2009, new special enrollment rights were permitted for individuals who become eligible for Medicaid and SCHIP coverage.[10] This may seem counterintuitive, but the rationale for adding this right was that certain individuals who become eligible for Medicaid or SCHIP can receive funds to pay the premiums for employer-provided coverage, and those individuals might not otherwise have been able to afford coverage when they were first eligible for employer-provided health care. The employee who is eligible but not covered under the employer's plan may enroll himself or herself as well as the employee's spouse and dependents. The plan must allow a period of at least 60 days after the employee is determined to be eligible for Medicaid or SCHIP coverage. The statute does not state when an individual who elects coverage under the plan will become eligible; presumably it would be the first day of the month after the plan is informed that the eligible individual requested coverage.

Disclosure Requirements

Group health plans must provide notice of special enrollment rights,[11] at or before the time an employee is offered the opportunity to enroll in a group health plan. The notice must describe the special rights and provide the name, title, and contact information of the appropriate plan official. The regulations provide a model notice that can be used for this

purpose. However, the model does not reflect the changes made under the 2009 legislation described above.

This notice requirement is an obligation of the plan and not the insurer. Providing such a notice in the summary plan description (SPD) is likely not sufficient because persons who decline coverage do not receive SPDs.

As a matter of prudence, these notifications should make it clear whether the plan (or insurance company) requires enrollment of a new dependent even if the employee has family coverage and an additional dependent would not cause a rise in premiums and the notice or enrollment forms should specify how the employee must provide notice. For example, in *Lindstrom v. W.J. Bauman Associates, Ltd.*,[12] an employee argued that she provided adequate notice of a newborn child within the required time period when she submitted a claims form listing that child as the recipient of health services. Although her argument was not successful, the case illustrates the importance of clear instructions.

If a plan requires that a written statement be provided if the employee declines coverage, then the plan must provide additional information stating (1) the effect of declining coverage; (2) the requirement of a written statement explaining that coverage was denied due to the existence of other coverage; and (3) the consequences of failure to provide a written statement.

The statute requires that each employer maintaining a group health plan in a state that provides medical assistance under a state Medicaid plan or SCHIP must provide each employee a written notice informing the employee of potential opportunities under the plans to receive assistance to pay an employer's plan's premiums.[13] Model notices will be provided by the Department of Health and Human Services.

Effect of Special Elections on Cafeteria Plans

Many health plans allow participants to pay for their health insurance coverage on a pre-tax basis. This requires compliance with the cafeteria plan rules for election changes. Under those rules, an employee cannot change coverage more than once a year. There are exceptions for changed circumstances, and under the cafeteria plan regulations, availability of special enrollment rights are one of those circumstances.[14] However, the IRS has limited the application of this exception, so these rules need to be reviewed carefully. For example, an illustration provided in the regulations states that when special enrollees become covered upon marriage, because no *retroactive* coverage is required under HIPAA, only a *prospective* cafeteria plan election is allowed.[15]

Conclusion

The special enrollment rules provide significant help to employees and families in situations that are often stressful. Employers who

sponsor medical plans must make sure that they not only follow the special enrollment rules required by law, but that they make it very clear to employees and plan participants what rules apply and how they are implemented.

Notes

1. Although not discussed in detail in this article, under HIPAA, the maximum period for exclusion for pre-existing conditions is 12 months for initial enrollees, and 18 months for late enrollees. Such waiting periods can be reduced by a showing of prior creditable coverage. *See* IRC § 9801(a). Parallel laws are found in ERISA and in the Public Health Service Act, but only Internal Revenue Code (Code) citations will be used for purposes of this article. The HIPAA regulations have been adopted by the three affected agencies: the Treasury Department, Labor Department, and Department of Health and Human Services. Only the Treasury regulations will be cited.

2. Pub. L. No. 101-191 (1996).

3. *See* IRC §§ 9801(c)(1) and 9832(c).

4. Pub. L. No. 111-3 (2009).

5. Treas. Reg. § 54.9801-6(a)(2)(iii) (Example 2).

6. Treas. Reg. § 54.9801-6(a)(3)(i)(B) and (C).

7. Treas. Reg. § 54.9801-6(a)(3)(iii).

8. Treas. Reg. § 54.9801-6(a)(3)(i).

9. *See* Prop. Treas. Reg. § 54.9801-6(a)(4) (Example (2)).

10. IRC § 9801(f)(3)(A).

11. Treas. Reg. § 54.9801-6(c).

12. Lindstrom v. W. J. Bauman Associates, Ltd., 2006 WL 278858 (W.D. Wisc. 2006).

13. IRC § 9801(f)(3)(B).

14. *See* Treas. Reg. § 1.125-4(b).

15. Treas. Reg. § 1.125-4(b)(2) (Example 2).

Reprinted from *Employee Relations Law Journal* Winter 2009, Volume 35, Number 3, pages 69-76, with permission from Aspen Publishers, Inc., Wolters Kluwer Law & Business, New York, NY, 1-800-638-8437, www.aspenpublishers.com