HIPAA Portability

On December 30, 2004, the Employee Benefits Security Administration (EBSA), the Internal Revenue Service (IRS), and the Centers for Medicare and Medicaid Services (CMS) published final regulations governing health coverage portability and continuity of health insurance coverage under the Health Insurance Portability and Accountability Act (HIPAA). This regulation finalizes interim rules that were issued in April 1997. The final portability sections describe minimum requirements for group health plans regarding:

- Limitations on a preexisting condition exclusion period.
- Certificates and disclosure of previous coverage (HIPAA Certificate of Creditable Coverage).
- Rules relating to credible coverage.
- Special enrollment periods.

The final rule will become effective for group health plans and health insurers for plan years beginning on or after July 1, 2005. For calendar year plans, these new rules will be effective January 1, 2006. However, if a plan has a plan year that begins July 1 or later, then the rules will be effective for the beginning of the plan year in 2005.
In order to assist you in complying with the final regulations under HIPAA, we have attached the following (which are explained below):

- Updated Model Certificate of Group Health Plan Coverage
- Special Enrollment Model Language
- Model Language for the General Notice of Preexisting Condition Exclusion

Certificate of Group Health Plan Coverage

The final regulations contain many of the same standards that were in the interim rule regarding the content requirements for the model Certificate of Group Health Plan coverage that were issued in April 1997. However, the final rule now requires new information about HIPAA portability rights be included in the certificate. Therefore, once the final regulation is applicable for the Plan, use of the 1997 model certificate will no longer satisfy the content requirement. Plans will be deemed to satisfy the new content requirements if they use a new model certificate provided in the final regulations (which is attached to this memorandum).

In addition to what is currently required, the Plan must now:

- Use reasonable efforts to determine information needed to complete a certificate for a dependent. The transitional rule from 1997 allowed plans to just provide the name of the participant and the nature of coverage (i.e., family coverage); and
- Have written procedures for how individuals can request and receive a Certificate of Group Health Plan Coverage. The procedure must include all of the contact information needed to request the certificate (such as name and phone number or address).

As was the case under the interim rule, the Certificate of Group Health Plan Coverage must be issued automatically when an individual:

- loses or voluntarily drops coverage and is entitled to elect COBRA continuation coverage. The Certificate of Group Health Plan Coverage must be mailed no later than when the COBRA Election Notice is due.
- loses or voluntarily drops coverage and is not entitled to COBRA continuation of coverage. In this case, the Certificate of Group Health Plan Coverage must be mailed to the individual within a reasonable time after coverage has ended.
- loses coverage because COBRA ends. The Certificate of Group Health Plan Coverage must be mailed to the individual within a reasonable time after coverage has ended.

The Certificate of Group Health Plan Coverage must also be provided upon request and additional requests can be made before coverage ends, up to 24 months after coverage ends and even if the individual previously received one.

Special Enrollment Model Language

As with the interim rule, the final rule requires plans to provide a notice of special enrollment rights on or before the time an employee is offered the opportunity to enroll for coverage under the Plan. The regulations have provided model language that will satisfy new requirement (as attached). Additionally, where a plan requires a written statement when an individual declines coverage in order to allow loss of coverage special enrollment later on, the notice will need to describe this procedure.

General Notice of Preexisting Condition Exclusion Model Language

Similar to the interim rule, the final regulations require group health plans that impose preexisting exclusion limitations to provide a written general notice of preexisting condition exclusion to participants. The regulations have provided model language that will satisfy this requirement. This notice should be a part of the enrollment materials distributed to participants under the Plan at the time of enrollment. If the Plan does not give out enrollment materials then the notice should be provided at the earliest date following a request for enrollment. The notice must be provided within “a reasonable and prompt fashion.”

In addition, plans that impose preexisting limitation exclusions will need to provide individual notice that states the plan’s determination on the length of the individual’s credible coverage and

the length of time remaining on the exclusion period. The regulations do not provide model language but does contain specific content requirements.

While many plans did away with obvious preexisting condition exclusions when the interim rule was initially passed, the final regulation highlights types of provisions that may not previously have been identified as preexisting continuation exclusions (like providing coverage for services that result from an injury only if the injury occurred while the person was covered under the plan) but must be treated as such. Therefore, a plan should review certain types of provisions for these “hidden preexisting condition exclusions” and decide how to handle any that may be present in the Plan.

It would be prudent for the Plan to review its procedures with regard to HIPAA Portability in order to assure that it complies with the final HIPAA portability requirements.

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

1. Date of this certificate: _____

2. Name of group health plan: _____
   _____

3. Name of participant: _____

4. Identification number of participant: _____

5 Name of individuals to whom this certificate applies: _____
   _____

6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____
   _____

7. For further information, call: _____

8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip lines 9 and 10: ___

9. Date waiting period or affiliation period (if any) began: _____

10. Date coverage began: _____

11. Date coverage ended (or if coverage has not ended, enter "continuing"): _____

[Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.]

Statement of HIPAA Portability Rights

IMPORTANT — KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

➔ Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

➔ Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

➔ Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

Special Information for people on FMLA leave. If you are taking leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without health coverage while on FMLA leave will not count towards a 63-day break in coverage. In addition, if you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends.

➔ Therefore, when you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages - Health *E*laws, or http://www.cms.hhs.gov/hipaa1.

Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office at New Rochelle Federation of United School Employees (F.U.S.E.) Welfare Fund at 2 Hamilton Avenue, Suite 201, New Rochelle, NY 1080.

General Notice of Preexisting Condition Exclusion Model Language
(from final HIPAA portability regulation 12/30/04)

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior ``creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18- month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to [Individual] at [Address] or [Telephone Number].

Qualified Medical Child Support Order (QMCSO)

According to Federal law, you might be required to enroll your children in the Plan due to a Qualified Medical Child Support Order (QMSCO) or a National Medical support order (NMSO) – a support order of a court or state administrative agency that usually results from a divorce or legal separation. The Fund Office can provide more details about enrolling your children in such cases. A statement that describes procedures on these orders is available upon written request, free of charge, from the Plan Administrator.