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New Special Enrollment Rights And Related CHIPRA Issues

By Rich Glass, J.D.

As most benefits professionals know, employees typically have three chances to enroll in group health plan coverage: initial enrollment, annual open enrollment and special enrollment.

The last reason was expanded earlier this year by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, Pub. L. 111-3), which added two new special enrollment triggers, with longer time frames, to HIPAA's two existing ones.

Traditionally, the special enrollment rules apply in two situations:

- a loss of other health insurance or group health coverage; and
- the addition of a spouse (by marriage) or a dependent (by marriage, birth, adoption or placement for adoption). (See Tab 400 of the *Guide*.)

Previously, in the March 2009 newsletter, we looked at how the special enrollment rules interact with the cafeteria plan election change rules. The cafeteria plan rules *permit* plans to allow all eligible dependents to "tag along" with the individual who is the reason for the special enrollment event, even dependents whom HIPAA does not *require* the plan to let "tag along." The same holds true for the two new situations brought on by CHIPRA.

Not all losses of coverage are created equal. For example, if COBRA was the coverage lost, the reason must have been that it was exhausted (that is, the end of the maximum coverage period of 18, 29 or 36 months). Another employer ceasing its contributions to the other coverage will justify special enrollment, but merely an increase in the cost of coverage will not.

Typical losses of coverage occur when a spouse dies or loses a job, or a divorce occurs. In addition, this coverage must have been in effect when the employer's plan was originally

made available during initial enrollment or annual open enrollment.

Not all family additions are created equal, either. For example, HIPAA does not require a plan to recognize domestic partnerships and same-sex marriages for special enrollment purposes, although some plans do. The rules for adding a dependent do allow a formerly non-covered employee to enroll both himself or herself and the new dependent(s).

With these two reasons, the ones HIPAA originally recognized, group health plans must allow participants at least 30 days after the loss of eligibility to request special enrollment. Under the existing HIPAA rules, plans must provide a notice of special enrollment rights to all eligible employees at or before the time of initial enrollment, even if the employee does not actually enroll in the plan. The final HIPAA portability rules issued in 2004 provided sample language for this notice (see ¶440).

Effect of CHIPRA

Until April 1, these special enrollment rules had been in place for many years, but as of that date, CHIPRA caused the landscape to shift. The primary purpose behind CHIPRA was to reauthorize the Children's Health Insurance Program (CHIP) and make it available for more children. Buried in this 280-page law are some additional protections that affect special enrollment in group health plans.

The first reason for special enrollment added by CHIPRA is when a person's Medicaid or CHIP coverage terminates as a result of loss of eligibility for that coverage. The second new reason involves the CHIP subsidy that is now available to some Americans. Under this program, CHIP will pay for a portion or all of employer-provided coverage.

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This program has existed for a while under Medicaid. When either of these subsidies becomes available, a special enrollment right now exists.

There is a catch to these two new reasons. The time frame for requesting special enrollment is 60 days from the event (either loss of coverage or start of subsidy eligibility), not 30 days. CHIPRA did not change the 30-day time frames for the other two special enrollment reasons, loss of other coverage and addition of a dependent.

Effective Dates

When does coverage become effective when one exercises a special enrollment right? It depends on the reason. The general rule is that no effective dates are retroactive, but like most rules, this one has exceptions. For birth, adoption or placement for adoption, a group health plan must make coverage effective as of the event date as long as the request was made within 30 days.

However, for all other special enrollment reasons — including, apparently, the two new reasons under CHIPRA, which was silent on this issue — the effective date is no later than the first of the next month after the month in which the request was made.

In essence, what CHIPRA did for group health plan administration is create two additional doors through

which employees and their dependents can enter into health coverage. They also have twice as long to get through those doors, thanks to CHIPRA.

Upcoming Notice Requirements

CHIPRA also directs the U.S. Department of Health and Human Services to develop model notices and disclosure forms to fulfill the following requirements. Plan sponsors failing to comply with these new notice and disclosure requirements, once the model notices are issued, could face penalties of up to \$100 per day (see ¶440).

Employee Notice. Informs employees of potential opportunities for premium subsidies in the states where they reside to help pay for health coverage for employees and/or their dependents, including contact information for that particular state.

This notice must be provided concurrently with materials furnished at initial enrollment, open enrollment or along with the SPD.

State Disclosure Form. Discloses information about plan benefits “in sufficient specificity” when a plan participant or beneficiary is covered under Medicaid or CHIP to allow states to determine the cost-effectiveness of providing premium subsidies to help pay for health coverage for employees and/or their dependents.

This notice must be provided upon request by a state, but no sooner than the first plan year starting after the date the model form is issued (for calendar-year plans, probably Jan. 1, 2011). ⬆

CHIPRA Compliance Steps

When CHIPRA was passed in February, it should have set in motion several wheels for plan administrators. To the extent that a plan has not completed the following action steps, it should:

- Update the notice of special enrollment rights notice to include the two new reasons and differing time frames.
- Update the plan’s special enrollment procedures to ensure that those who qualify are offered the opportunity to elect.
- Update the plan documents, including the summary plan description (SPD), and communicate this change to participants, perhaps via a summary of material modifications or reissuance of the SPD.
- Wait and see that will be issued for two additional required notices that could be required as soon as Feb. 4, 2010. ⬆

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guidance itself and the broader breach notification rules that ARRA directed the agency to issue by August. (The comment period expired May 21.)

Although the methods specified in this notice will not actually be “required,” using them will create what HHS called “the functional equivalent of a safe harbor” from the breach notification requirement if the PHI is improperly used or disclosed.

For More Information

The full text of ABC’s comments is available on the organization’s Web site at http://www.americanbenefitscouncil.com/documents/hit_comments052109.pdf. ⬆