BENEFITS MEMORANDUM

INFORMATION ITEM
Priority: Normal
Response not required

DATE: November 15, 2005

TO: Benefits Managers, Benefits Representatives, Health Care Facilitators, HR/Benefits Team Leaders and Unit Heads

FROM: Christine Dobrushin, CEBS
Coordinator,
Health & Welfare Policy & Program Design

SUBJECT: Impact of New HIPPA Portability Regulations on UC Medical Plans and UC *Group Insurance Regulations* Administration

KEYWORDS: HIPAA impact; New HIPAA Portability Regulations

ATTACHMENTS: 4

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Pages to follow: (11) including attachments

November 15, 2005

TO: Benefits Managers, Benefits Representatives, Health Care Facilitators, HR/Benefits Team Leaders and Unit Heads

RE: **Impact of New HIPAA Portability Regulations on UC Medical Plans and UC *Group Insurance Regulations* Administration effective on & after January 1, 2006**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contained provisions affecting many of UC's eligibility requirements as of January 1, 1998. In April 1998, we issued a memo regarding the impact of the following changes to UC's medical plans and the *Group Insurance Regulations* (GIRs) based on the April 1997 interim rules:

- Elimination of the statement of health process
- Elimination of deferred effective dates for health reasons
- Provision of special enrollment periods

In addition, UC added a 90-day waiting period for late enrollees to replace the statement of health process.

The Departments of Labor, Treasury and Health and Human Services have now issued final regulations governing the portability requirements of HIPAA. These final regulations will apply to UC's medical plans on and after January 1, 2006. These final rules do not significantly modify the April 1997 interim rules, so this memo will not address all aspects of the final regulations. We will cover just the changes UC needs to make to our policies and procedures.

Special Enrollment Periods

UC's GIRs now allow special enrollments (an added Period of Initial Eligibility [PIE]outside of a normal PIE or Open Enrollment) to otherwise eligible individuals who:

- involuntarily lose coverage under another medical plan; or
- become an eligible family member of an employee through marriage, domestic partner registration with the State of California or declaration with the University, birth, adoption, or placement for adoption.

The new regulations expand the list of situations that would constitute a "loss of eligibility" for coverage and require the additional offering of a special enrollment opportunity when:

- an individual reaches a lifetime limit on all benefits under a plan;
- an individual has opted out of UC's coverage due to other medical coverage, and the other employer subsequently stops paying for the other coverage;
- an individual ceases to be eligible under another plan due to cessation of dependent status;
- another plan ceases to offer benefits for a class of employees; and
- an individual no longer resides, lives or works in the service area of an HMO.

The new regulations also clarify that an employee enrolling a newly eligible family member during a special enrollment opportunity may select a different medical plan for which the employee is otherwise eligible. This clarification changes UC's current practice of allowing the employee to cover the new family member only under the plan in which the employee is already enrolled. However, UC's current rule that both the employee and family members must be enrolled in the same UC medical plan will still apply.

> **Example:** An employee who is enrolled in Core, an HMO, a POS or PPO plan may request to transfer coverage for him/her and family members to another UC medical plan for which he/she is eligible:
>
> - within 31 days of acquiring a new eligible family member; or
> - within 31 days of an eligible family member losing other medical coverage.

In the above example, if the employee or eligible family member fails to request special enrollment during the 31 days when first eligible, they lose the special enrollment opportunity and must adhere to UC's standard rules. In other words, they must wait until the next Open Enrollment Period to change medical plans.

Likewise, an employee who has opted out of UC medical coverage due to other medical coverage but fails to request special enrollment during the 31 days following the loss of the other coverage, will lose the special enrollment opportunity.

They may enroll, however, at any time under the 90 consecutive calendar day delayed effective date policy.

An individual who qualifies for a special enrollment opportunity and enrolls during a coinciding Open Enrollment Period cannot be treated as a late enrollee. As you know, Special Enrollments are handled by paper form.

> **Example:** If a newly eligible family member with a special enrollment event is enrolled during UC's November Open Enrollment, coverage for that family member would begin the first day of the Special Enrollment Period and not on January 1 of the following year as a normal Open Enrollment change would become effective.

Please note that the following GIR added PIEs that limit re-enrollment to the plan in which the employee was enrolled prior to the employee's loss of coverage, may now allow the employee (and eligible family members) to switch plans if the employee requests re-enrollment within 31 days of:

- acquiring a newly eligible family member; or
- the employee or eligible family members lose other medical coverage

Affected PIEs would include:

1) Leave Without Pay
2) Furlough/Temporary Layoff
3) Rehire
4) Return after Period of Insufficient Earnings
5) Return after Period of Insufficient Time

The GIRs for these PIEs currently state that if a "Leave is Less than 120 days: Enrollment is limited to the specific plan in effect and family members listed (if still eligible) when the leave started."

With the new HIPAA guidelines, if the employee has a special enrollment event within 30 days prior to returning to work under one of these PIEs, the employee would have a special enrollment opportunity and may select any medical plan for which he/she is eligible.

> **Example:** An employee is on a leave without pay (LWOP) for 90 days. Two weeks before returning to work the employee gets married.

Because the employee had a special enrollment event within 30 days before returning to work, the employee may enroll in any UC medical plan for which he/she is eligible, even though the LWOP was less than 120 days.

Note that if the above employee married within the first two weeks of leave, the employee would NOT have a special enrollment opportunity because the event happened more than 30 days before returning to work. The employee and eligible family members would be restricted to the medical plan in which the employee was enrolled before the LWOP began.

Additionally, if the employee is returning to a plan's service area from another HMO or EPO, this event should be treated as a loss of coverage because the individual no longer resides, lives or works in the service area of the HMO or EPO. The event would trigger a special enrollment opportunity and the employee may select any medical plan for which he/she is eligible.

> **Example:** An employee leaves California and relocates to Washington, D.C. The employee de-enrolls from Health Net and enrolls in the Kaiser Permanente Mid-Atlantic (KPMA) HMO plan. The employee then returns to California.

The employee cannot remain in KPMA because the employee has left the service area. This creates a special enrollment opportunity and the employee may select any medical plan for which he or she is eligible. The special enrollment opportunity applies even if the employee returns to the California service area within 120 days.
On the other hand, if the employee relocates to Washington, D.C. and transfers from Health Net to the Blue Cross PPO plan, upon the employee's return to California there is no special enrollment opportunity to enroll in any plan. The existing GIRs apply. The employee may transfer back into Health Net, the employee's original plan.

New HIPAA Notice

As a result of the clarifications of special enrollments discussed above, additional required language has been added to the original HIPAA notice that needs to be given to an employee on or before the employee is offered the opportunity to enroll in UC's medical plans. Attachment No. 1 contains a copy of the new notice that will appear in all UC publications containing information on enrollment for employees. Attachment No. 2 contains the notice applicable to retirees.

Certificates of Creditable Coverage

Currently certificates of creditable coverage are issued by our medical plans automatically upon coverage termination as well as upon an individual's request up to 24 months after coverage ceases. The new regulations require:

- an educational statement in the certificate that informs individuals of their HIPAA rights; and
- issuance of a certificate upon an individual's meeting a plan's lifetime limit on all benefits.

Attachment No.3 to this memo shows the new model certificate language containing the educational statement. All the medical plans are changing their standard certificates to reflect this language. You may also use the attached in the event a member asks UC to issue a certificate.

The procedures to request a Certificate of Creditable coverage must be in writing and all the plans will comply. In addition, UC includes the procedure in the *Your Group Insurance Plans* (YGIP) booklet and Open Enrollment materials.

Although the certificate must still be in writing, the regulations now permit the certificate information to be provided by other means such as by telephone when the issuer, the receiving plan and participant mutually agree.

A certificate of creditable coverage will now be issued when a member reaches the lifetime limit for ALL benefits under the plan. The following UC plans have such a lifetime limit:

- ***California Plans:*** Blue Cross PPO, High Option, Core CA, Definity Health-California (UCSB & UCSF only)

- ***New Mexico Plans:*** Options PPO Out-of-Area, Core NM

As mentioned above, the member reaching the lifetime limit may also request a Special Enrollment to switch the member and eligible family members into another UC medical plan for which they are eligible.

The final regulations also clarify that family members are entitled to individualized certificates of creditable coverage under the same circumstances as other individuals. However, one certificate may be provided with respect to the employee and family members, if the information is identical for all members. If the information is not identical (such as different lengths of individual coverage time), one certificate may still be provided if the form contains all the required information for each member.

If the employee needs an individualized certificate for a family member not living at the employee's address, the employee should request the certificate from the plan and advise the plan of the family member's different address.

If an employee or former employee requests UC issue a certificate to a family member, the new HIPAA guidelines mean that UC cannot send the certificate to the employee's address of record automatically. For each certificate request, the employee should confirm where they wish the certificate(s) to be sent.

The certificate of creditable coverage notice now contained in UC publications will be updated to alert employees/retirees to request a certificate for any family member not residing with the employee/retiree. See Attachment 4.

Pre-Existing Conditions Exclusions

UC's medical plans do not contain any exclusions for pre-existing conditions. The final regulations, however, identify certain situations that could be considered as "hidden" pre-existing conditions that the regulations will not allow. UC's plans have been reviewed and it has been determined that none of our plans contain such "hidden" situations.

Retirees

HIPAA Portability rules apply to employees, retirees and their family members. For example, this means that when a retiree suspends coverage and acquires a newly eligible family member, the retiree now has a 31-day Special Enrollment Opportunity to re-enroll in any UC medical plan for which the retiree is eligible. Please note, the HIPAA rules do not give a retiree an opportunity to re-enroll if the retiree is not otherwise eligible for medical coverage.

Applicability

UC's medical plans are the only Health & Welfare plans subject to these portability rules. The UC *Group Insurance Regulations* for employees and retirees and medical plan materials will be modified at a later date to bring the University into compliance with the final HIPAA portability regulations. However, we need to start administering these new rules on and after January 1, 2006.

The Federal Departments have also issued new proposed regulations, but we will not address those until they are final.

If you have concerns or questions, please send them to the following listserv: GIRS-L@ucop.edu.

Sincerely,

Christine Dobrushin, CEBS
Coordinator
Health & Welfare Policy & Program Design

Attachments (4)

cc: Vice President Broome
Associate Vice President Boyette
Associate Vice President Hafner
Assistant Vice President Switkes
Vice Chancellor Relyea
Deputy to the AVP Ackerhalt
Executive Director Scott
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John Kessler, Deloitte Consulting
Tim Snyder, Blue Cross
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Todd Hesse, PacifiCare Behavioral Health, Inc.
Faith Arita, Health Net
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Scott Gregory, PacifiCare of CA
Kirsten Lobsinger, PacifiCare of CA
Sarah Williams-Foster, United Behavioral Health
Andrea Comporato, UnitedHealthcare
Patricia Kelly, UnitedHealthcare
Raymond Martin, UnitedHealthcare
Gladys Stone, Western Health Advantage

Attachment 1: HIPAA Notice for EMPLOYEES

HIPAA (Health Insurance Portability and Accountability Act of 1996)
Notification of Medical Program Eligibility

If you are declining enrollment for yourself or your eligible* family members because of other medical insurance or group medical plan coverage, you may be able to enroll yourself and your eligible* family members in a UC-sponsored medical plan if you or your eligible* family members lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage for you or your family members.) You must request enrollment within 31 days after your or your eligible* family members' other medical coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a newly eligible* family member as a result of marriage, domestic partner registration with the State of California or declaration with the University, birth, adoption, or placement for adoption, you may be eligible to enroll yourself and your eligible* family members. You must request enrollment within 31 days after the marriage, registration or declaration, birth, adoption, or placement for adoption.

If you do not enroll yourself and/or your eligible* family member(s) within the 31 days when first eligible, you may enroll at a later date. However, each member will need to complete a waiting period of 90 consecutive calendar days before medical coverage becomes effective, or you/they can enroll during the next Open Enrollment Period.

To request special enrollment or obtain more information, contact your local Benefits Office.

*Family members must meet all UC eligibility requirements for coverage as stated in the *Your Group Insurance Plans* booklet. Enrolled family members are subject, as a condition of coverage, to eligibility verification audit by the University and/or insurance carriers.

Note: If you are enrolled in a UC medical plan, you may be eligible to change medical plans on or after January 1, 2006 if:

- you acquire a newly eligible* family member; or
- your eligible* family member loses other coverage.

In either case, you must request enrollment within 31 days of the occurrence.

Attachment 2 -- HIPAA Notice for RETIREES

HIPAA (Health Insurance Portability and Accountability Act of 1996)
Notification of Medical Program Eligibility

If you* are declining enrollment for yourself or your eligible* family members because of other medical insurance or group medical plan coverage, you* may be able to enroll yourself and your eligible* family members in a UC-sponsored medical plan if you* or your eligible* family members lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage for you or your family members.) You* must request enrollment within 31 days after your or your eligible* family members' other medical coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you* have a newly eligible* family member as a result of marriage, domestic partner registration with the State of California or declaration with the University, birth, adoption, or placement for adoption, you* may be eligible to enroll yourself and your eligible* family members. You must request enrollment within 31 days after the marriage, registration or declaration, birth, adoption, or placement for adoption.

If you do not enroll your eligible* family member(s) within the 31 days when first eligible, you may enroll them at a later date. However, each member will need to complete a waiting period of 90 consecutive calendar days before medical coverage becomes effective, or you can enroll them during the next Open Enrollment Period.

To request special enrollment or obtain more information, contact the University of California's Customer Service Center (1-800-888-8267).

* You and your family members must meet all UC eligibility requirements for coverage as stated in the *Your Group Insurance Plans* booklet and the *University of California Retirement Handbook*. Enrolled family members are subject, as a condition of coverage, to eligibility verification audit by the University and/or insurance carriers.

Note: If you are enrolled in a UC medical plan, you may be eligible to change medical plans on or after January 1, 2006 if:

- you acquire a newly eligible* family member; or
- your eligible* family member loses other coverage.

In either case, you must request enrollment within 31 days of the occurrence.

Attachment 3

CERTIFICATE OF GROUP HEALH 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.

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.

Attachment 4

HIPAA Text for *Your Group Insurance Plans*

When you and/or your eligible family member end or change UC-sponsored medical coverage, you will receive a Certificate of Creditable Coverage from your former medical plan as required by the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Insurance carriers are required to issue the certificate to anyone who leaves their plan. A covered family member is entitled to an individual certificate.

This certificate provides evidence of your previous medical plan coverage. You do not need to present this certificate to UC when enrolling in a new plan. However, if you want to enroll in a non-UC group medical plan or buy a medical insurance policy, you may need to show this certificate to the new insurance carrier if the plan/policy would otherwise exclude coverage or impose a waiting period for certain pre-existing conditions. Contact your medical plan directly, if you do not receive a certificate. Additionally, enrolled family members who live at a different address from you should contact the plan directly to request a certificate be mailed directly to them at the different address.