United Actuarial Services, Inc.
Actuaries and Consultants

2009-23

March 26, 2009

BENEFIT NEWS BRIEFS

New Law Adds Special Enrollment Events Under HIPAA

A recently enacted law, the *Children's Health Insurance Program (CHIP) Reauthorization Act of 2009,* amended the Internal Revenue Code, the *Employee Retirement Income Security Act of 1974, as amended (ERISA),* and the *Public Health Service Act* to add special enrollment periods to group health plans. Unlike the current 30-day special enrollment available under the *Health Insurance Portability and Accountability Act* (*HIPAA)* amendments to *ERISA, the new enrollment periods last for 60 days* and are **effective April 1, 2009**. (The current *ERISA* 30-day special enrollment periods are found under *ERISA Section* 701 and *ERISA* regulation 29 CFR Section 2590.701-6.)

The text of the new law is available *by "clicking here."* The new special enrollment provisions are found under Title III, Subtitle B, Section 311 of the law and begin at page 152, with the *ERISA* section beginning at page 157. The main *ERISA* section is also available by "*clicking here*." We say "main" because other parts of Section 311 amend *ERISA* to add penalties for non-compliance and notice requirements, among other things.

The new enrollment periods would appear to have little impact on multiemployer group health plans due to their nature, but *CHIP* is a law and group health plans must be aware of the change. There is also a notice requirement, but health plans are not required to send the notice until the *first plan year* that begins *after* the date on which the *government issues the initial model notices*.

Special Enrollment Periods

The new special enrollment periods are available to an employee or dependent who is *eligible*, but not enrolled, for coverage under the terms of the plan under one of the following circumstances:

Termination of Medicaid or CHIP Coverage

The employee or dependent is **covered** under a Medicaid plan or under a State child health plan and **coverage** of the employee or dependent under such a plan **is terminated** as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance

Prepared by Mike Ewing, J.D.
Director of Research
United Actuarial Services, Inc.
(317) 580-8659 • Fax (317) 580-8651
email: mewing@unitedactuarial.com

coverage) not later than **60 days** after the date of termination of such coverage,

OR

Eligibility For Employment Assistance Under Medicaid Or CHIP
The employee or dependent **becomes eligible for assistance**, with respect to coverage under the group health plan or health insurance coverage, under a Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than **60 days** after the date the employee or dependent is determined to be eligible for such assistance.

It would be very unusual for an employee eligible for coverage under a multiemployer group health plan to NOT be enrolled in the plan **and** to either: (1) be enrolled under a state Medicaid plan or have a dependent enrolled in a *CHIP* plan **or** (2) to be eligible and not enrolled and then become eligible for assistance for the cost of coverage under the group health plan or *CHIP* plan. Such a situation could theoretically occur during some waiting period before the employee earned eligibility under the multiemployer plan, although it seems unlikely.

Model Notices

Basically, each employer (or perhaps the plan in the case of multiemployer plans?) shall provide a written notice to each employee informing the employee of potential opportunities that are currently available in the State that the employee resides in for premium assistance under such plans for health coverage of the employee or the employee's dependents. Fortunately, the notice is not required to be distributed until the ***first plan year*** that begins ***after*** **the date on which the government issues the initial model notices** – the government has until February 4, 2010 to provide the notices to employers. If the initial model notices are not issued until then, the first notices would not be required to be distributed until the first plan year beginning on or after February 4, 2010. By then, guidance will probably be issued explaining these requirements in multiemployer plan context. Until then, we will use the statutory term of "employer"

Employers will be allowed to provide the model notice when: (1) furnishing materials notifying the employee of health plan eligibility, (2) concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan or (3) concurrent with the furnishing of the summary plan description.

Various government agencies are responsible to work together to produce the model notices which are to include information regarding how an employee may contact the State in which the employee resides for additional information regarding potential opportunities for such premium assistance, including how to apply for such assistance.

The new law allows the DOL to assess a civil penalty against any employer of up to $100 a day from the date of its failure to meet the new notice requirement. Each violation with respect to any single employee shall be treated as a separate violation.

Disclosure of Information to State Governments

In addition, in limited circumstances, such as the case of a participant or beneficiary of a group health plan who is also covered under a Medicaid State child health plan, the *plan administrator* of the group health plan may be required to disclose certain information to the State. Upon the State's request, this disclosure may include specific information about the benefits available under the group health plan to allow the State to make a determination concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan. In single employer plans the plan administrator is the employer; in multiemployer plans the plan administrator is the Board of Trustees – in both cases the day-to-day responsibilities of running the plan are usually delegated to a person hired to run the plan.

The government is to develop a form for this disclosure. The model coverage coordination disclosure form shall apply with respect to requests made by States beginning with the *first plan year* that begins after the *date such model coverage coordination disclosure form is first issued.*

Similar to the notice penalty, the DOL may also assess a civil penalty against any plan administrator of up to $100 a day from the date of the failure to timely provide any State with the information required to be disclosed. Each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

Closing Thoughts

It seems odd to require the special enrollment periods to be available beginning April 1, 2009 but the notice of such rights not required to be distributed until up to a year or more later. Plan administrators may wish to work with fund counsel to determine if their group health plan should be amended now for the special enrollment periods and/or if some sort of notice of this right is circulated. If the plan is amended, a summary of material modifications could be used to explain the new election periods. Summary plan descriptions will need to be modified when next updated. Plans should review their *HIPAA* Creditable Coverage notices to see if any references to special enrollment rights need to be updated; especially the Notice of Special Enrollment plans are required to give under *ERISA* regulation Section 2590.701–6.

* * *