Employee Benefits Report

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HIPAA: What Employers Need to Know

HIPAA, enacted in 1996, increased privacy protections and enhanced portability under group medical plans. This article discusses HIPAA's portability requirements.

The Health Insurance Portability and Accountability Act (HIPAA) restricts employers' and benefit plan administrators' ability to exclude coverage for a new employee or enrollee's pre-existing medical condition. To comply with HIPAA's portability provisions, employers must understand these key concepts creditable coverage, enrollment dates and the difference between regular enrollees and late enrollees.

Creditable Coverage

HIPAA limits any exclusions for pre-existing conditions to 12 months from date of hire or eligibility for enrollment in the health plan, or to 18 months in the event of a late enrollment. HIPAA regulations define pre-existing conditions as conditions "for which medical advice, care, diagnosis, or treatment was recommended or received within six months ending on the individual's enrollment date."

The major change HIPAA made was to give employees changing jobs credit for health coverage at their previous job for purposes of calculating exclusion periods for pre-existing conditions. Employers must use "creditable coverage" when calculating any pre-existing condition exclusion. Generally speaking, creditable coverage is coverage the employee carried without a significant break in time. The regulations define a "significant break" as one that lasts 63 or more days. Some states have laws allowing longer breaks in coverage, so check the laws in your state.

Employers must provide a certificate of creditable coverage when an employee leaves their employ. The certificate provides the new employer with the appropriate creditable coverage information to allow them to calculate any pre-existing condition exclusion periods. Coverage under COBRA plans also counts as creditable coverage, and plan administrators must to provide certificates for this coverage.

For example, if a new hire has a pre-existing condition and presents a certificate showing eight months of creditable coverage, the employer may only exclude coverage for that condition for four months. This assumes that the new hire is applying for and accepting coverage at

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This Just In

San Francisco's health access plan earns criticism from small businesses. In June, San Francisco mayor Gavin Newsom proposed a city-wide health access plan aimed at providing access to health care for the 82,000 San Franciscans who lack health insurance, but do not qualify for either Medicaid or Medicare. The $203 million program would be funded by employer contributions and re-routing the $104 million the city currently pays city hospitals and clinics toward the bills of the uninsured, business fees, and means-tested individual fees. Small businesses that cannot afford to offer health care are the plan's loudest critics. They claim the mandated contributions, up to $274 per employee per month, will force them out of business.

Group Long-Term Disability as a Benefit

By age 45, you have a 50 percent chance of having at least one disability that lasts 90 days or more. LTD can help employees survive such disabilities financially.

Baby boomers and Gen-Xers don't agree on much, but there is one thing they both like, according to a recent survey: long-term disability coverage (LTD). Aon Consulting polled employers to gauge demand for various voluntary benefits and found that 45 percent of boomers and 37 percent of Gen-Xers have purchased long-term disability benefits at work. These figures show LTD outpaced life insurance as the most popular voluntary benefit.

To employers, providing a benefit that employees understand the value of and want is a great recruiting and retention tool. In effect, the entire workforce is extending its hands to wear these golden handcuffs.

Voluntary or Employer-Paid LTD?

While employee-paid disability coverage has the advantage of providing tax-free benefits (if the product was purchased with after-tax dollars), employees who drop coverage when they leave will never see that benefit. Further, employers are better equipped to keep paying premiums while the employee is disabled than the employee is. Again, it is more likely the employee will actually receive benefits from an employer-paid policy.

Either type of policy will provide valuable benefits, but what about costs? LTD premiums have remained fairly stable over the last five years. According to the U.S. Group Disability Market Survey for 2005, premiums have grown at an average of 3.84 percent per year from 2001 to 2005, a figure just barely higher than inflation for the period.

Some employers have come up with innovative strategies to provide LTD plans at even lower costs. When one Michigan employer put out his health insurance for bids, one company bundled the LTD plan with the health coverage at no extra charge. Generally, employers with larger groups will be more successful with this sort of strategy than smaller groups. State insurance laws often dictate minimum sizes for groups and tie insurers' hands when it comes to offering innovative products.

Employers can survey employees and ask what benefits the employees would like to see, and then look for the best deal on those products. Coordinating benefits with recruiting and retention efforts can pay long-term dividends for both employers and employees.

Why Long-Term Disability Insurance?

A disability can affect anyone, at any time. By age 45, you have a 50 percent chance of having at least one disability that lasts 90 days or more. Since most people don't have the savings necessary to handle their regular expenses without a regular paycheck, a disability can have severe financial impacts.

In fact, the U.S. Census Bureau also found a link between having a disability and poverty. The poverty rate for people 25 to 64 with no disability was 8 percent, compared with 11 percent for those with a nonsevere disability and 26 percent for people with a severe disability.

For these reasons, LTD insurance makes good financial sense. The typical group long-term disability policy will begin paying between 40-66 percent of an individual's pretax salary, not including commissions and bonuses, when the disability lasts longer than the specified "elimination period." For most group policies, the elimination period is somewhere between 90 and 365 days.

LTD policies replace only a portion of lost income to give disabled individuals some incentive to return to gainful employment after a disability. And although they won't replace all income lost due to disability, LTD can mean the difference between maintaining a reasonable lifestyle and living in poverty after a disability.

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the first opportunity. This method of crediting coverage is known as the standard method.

Employers can also use an alternative method of calculating creditable coverage. Under the alternative method, employers calculate the employee's creditable coverage under five categories of coverage: mental health, substance abuse treatment, prescription drugs, dental and vision care. Employers can look at creditable coverage within each of these categories and establish exclusion periods for coverage based on the creditable coverage within each.

For example, an employee suffering from depression who only had six months of creditable mental health coverage could be excluded from coverage for depression for six months. Each of the other categories of coverage would be computed in the same way (assuming the employer offered those coverages). Employers would use the standard method to calculate creditable coverage for benefits outside these five categories.

Enrollment Dates

HIPAA regulations define the enrollment date as the first day of coverage or, if there is a waiting period, the first day of the waiting period. In other words, even though the employee is not covered during the waiting period, the time does not count as a break in creditable coverage when calculating any pre-existing condition exclusion period.

For most employees, the enrollment date will be the same as the first day of employment, even if the plan has a waiting period. Employers who deviate from this should have a sound legal reason for doing so.

Regular Enrollees/Late Enrollees/ Special Enrollees

Employees who enroll in a plan when they are first hired or are first eligible are considered regular enrollees. But employees who enroll at later times are considered late enrollees. The regulations allow employers to impose an 18-month pre-existing condition exclusion on late enrollees. The procedure for calculating the amount of creditable coverage is the same, with the exception that the employee must demonstrate 18 months of coverage to overcome a pre-existing condition exclusion instead of 12.

HIPAA also created a new class of enrollees known as "special enrollees." Special enrollees fall into two classifications. Special enrollees who become eligible for coverage because of the birth of a child, adoption or placement for adoption must be enrolled in the plan effective with their date of birth or adoption.

Special enrollee status can also be triggered by:

- ✔ an employer eliminating its contributions to health coverage
- ✔ marriage
- ✔ legal separation
- ✔ divorce
- ✔ cessation of dependent status
- ✔ death of an employee
- ✔ termination of employment
- ✔ reduction in the number of hours of employment
- ✔ an individual moving outside the coverage area of an HMO
- ✔ an individual incurring a claim that would exhaust the lifetime limits on a policy or
- ✔ a plan no longer offering benefits to a class of similarly situated individuals.

For example, Mary works for the ABC Widget Company, but has coverage under her husband John's policy on his job at XYZ Zipper. But XYZ drops its subsidy for John's policy, and suddenly ABC Widget's policy is cheaper for John and Mary. John and Mary may pick up ABC's coverage. This class of special enrollees may begin coverage on the first day of the calendar month following the completion of an application for coverage.

Prohibited Provisions

HIPAA also ended the practice of requiring enrollees to present evidence of insurability. Under HIPAA, group health plans may not deny individuals enrollment in the plan or delay the effective date of coverage based on the individual's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence) or disability.

In addition to HIPAA, several other federal laws limit provisions health plans may contain. The Mental Health Parity Act (MHPA) prohibits plans from including annual or lifetime dollar limits on mental health benefits if they are lower than similar limits on medical/surgical benefits. The MHPA also prohibits constructive limits such as limiting the number of annual mental health visits while allowing unlimited medical/surgical visits.

Also, the Newborns' and Mothers' Health Protection Act requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay for childbirth or a 96-hour stay for cesarean sections, and prohibits plans from requiring preauthorization to cover a stay of these periods. The attending health care provider may authorize earlier discharges. Plans may require authorizations for longer stays.

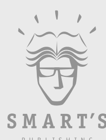
The Women's Health and Cancer Rights Act (WHCRA) provides protections for women electing breast reconstruction and other mastectomy follow-up care. Specifically, WHCRA requires plans to cover:

- ✔ All stages of breast reconstruction following mastectomy
- ✔ Surgery and reconstruction on the other breast to achieve symmetry
- ✔ Prostheses and physical complications of mastectomy, including lymphedemas as determined by the attending health care provider and the patient.

Plan administrators must notify plan participants of WHCRA's coverage requirements at the time of enrollment and annually thereafter.

Keeping to the Spirit and Letter

The U.S. Department of Labor's HIPAA guidance emphasizes complying with both the spirit and letter of the law. Plans with provisions that have the effect of illegally limiting coverage or imposing de facto pre-existing condition exclusions violate the law. Employers and plan administrators should evaluate their plans regularly to ensure they do not run afoul of HIPAA, the MHPA and WHCRA. Additionally, many states have coverage requirements that employers and plan administrators must be aware of. Factor these in when running your compliance checks. ■



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The Pension Benefit Guaranty Corporation's Inner Workings

How the PBGC protects defined benefit plan beneficiaries

The Pension Benefit Guaranty Corporation (PBGC) is the federal government agency created to monitor and, when necessary, assist pension plans in meeting their obligations. The PBGC acts similarly to the way the FDIC interacts with banks. It is entirely funded by premiums paid by covered pensions. Specifically, PBGC covers defined benefit pensions and guarantees benefits to pensioners to the extent possible in each situation.

The mass movement away from defined benefit plans to defined contribution plans (401(k)s and their brethren) has moved the PBGC into the limelight. With both large and small corporations seeking shelter from the avalanche of baby boomer retirees, the PBGC has had to step in to stem the red ink where it could.

When a defined-benefit pension ends, the PGBC is involved in one of three ways. The first is the standard termination where an employer (or employers) elects to end a pension before it becomes insolvent. The employer must show the PBGC that the plan is capable of paying all benefits owed to participants. The plan then purchases an annuity to cover future benefits, or when allowed by the plan, issues lump-sum settlements to beneficiaries.

In a distress termination, the distressed employer must demonstrate to PBGC or a bankruptcy court that it cannot remain in business if it continues to fund the pension. If the employer makes the case, the PBGC will take over the pension and pay benefits, up to the legal limits, using plan assets and the PBGC guarantee funds.

Sometimes the PBGC initiates the action to end a pension plan. Generally, this is a solution of last resort when the plan is incapable of even paying current benefits. In these cases, the PBGC will step in to prevent any single pension from draining a disproportionate amount from the PBGC fund.

In light of workplace demographics and employer flight from defined-benefit plans, Congress raised PBGC premiums last year. Single employer pension plans will pay $30 a year per participant, up from $19, and multi-employer plans will jump from $2.60 to $8 per participant. Currently, the PBGC is running a $23 billion deficit. ■

Expatriate employees will take a tax hit

Expatriate employees will take a tax hit under the Tax Increase Prevention and Reconciliation Act of 2005 (TIPRA). Starting with the 2006 tax year, employers must report subsidies given to overseas employees, such as housing allowances, as income. While employees may offset this increase by claiming the credit for taxes paid to foreign countries, those living in high-cost, low-tax countries will owe more to Uncle Sam. Employees working in Bermuda, the Middle East, Singapore and Hong Kong can expect to see higher U.S. taxes for the 2006 tax year, while those living in Europe will see little impact because they are already paying high taxes to those countries.

Defined Benefits Disappear

Defined benefit plans are disappearing, even among the Fortune 1000. According to a Watson Wyatt survey, employers in this group are planning to close 113 of their 627 remaining defined-benefit plans. The employers had either frozen, terminated or announced plans to freeze or terminate their plans. Additionally, 49 plan sponsors had closed their plans to new hires.