HIPAA Special Enrollment

Eligible employees are typically offered two opportunities to enroll in group health coverage. The first is the initial enrollment period when an employee first becomes eligible for coverage. The second is the annual open enrollment period. Eligible employees who do not elect coverage when initially eligible must wait until the annual open enrollment period to elect coverage.

The Health Insurance Portability and Accountability Act (HIPAA) added other opportunities to make mid-year changes, called special enrollment events. This change was made to allow coverage to be portable and to prevent what was known as “job lock”.

A special enrollment event must be available in the following situations:

- Individuals who lose group health plan or health insurance coverage;
- Individuals who become eligible for state premium assistance subsidy;
- The termination of eligibility for Medicaid or state child health insurance plan (CHIP); and
- Acquisition of a new dependent through marriage, birth, adoption or placement for adoption.

A plan or insurer must generally allow employees and their dependents a period of 30 days after a loss of group health plan or other health insurance coverage, or the acquisition of a new dependent, to request special enrollment. However, if the special enrollment event results from a loss of eligibility for Medicaid or CHIP coverage, employee and dependents must be provided at least a 60 day window to request special enrollment. A plan may allow longer periods if the plan document provides for it, but may not allow lesser timeframes. Coverage must be effective no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

HIPAA does not define a dependent. To determine who is eligible for special enrollment, look to the definition of dependent in the eligibility provisions of the underlying health plan. An employee may be allowed to enroll a domestic partner, due to a loss of coverage, if defined as an eligible dependent by the plan terms. However, a plan would not be required to offer special enrollment to an employee’s domestic partner due to childbirth, as the domestic partner is not recognized as a spouse under federal law.

The HIPAA regulations require group health plans to furnish a notice of special enrollment rights. A model notice is provided which may be used to satisfy the requirement to notify. This notice does not provide language for special enrollment due to eligibility for premium assistance nor a loss of eligibility for Medicaid or CHIP. Health plans are still required to provide a comprehensive notice, which includes the additional timeframes for Medicaid or CHIP coverage. The notice, known as the Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP) notice, should be provided at or before an employee is initially offered the opportunity to enroll in the group health plan.

Certain categories of coverage, known as excepted benefits, are not subject to the HIPAA special enrollment provisions. These include limited-scope dental or vision benefits, most health flexible spending accounts (FSAs) and benefits that are not health coverage such as automobile, disability income coverage, worker’s compensation, accidental death and dismemberment coverage or retiree only coverage. A health FSA may be excepted if it satisfies two conditions. The first is that the maximum payable to any participant for the year may not exceed two times the employee’s salary reduction election under the health FSA, or if greater, the amount of the employee’s salary reduction election for the health FSA plus $500. If an employer matches employee salary reduction
contributions, the employer’s matching contribution must not exceed the greater of the participant’s salary reduction election or $500. A health FSA funded exclusively by employee salary reduction contributions will, by definition, satisfy the maximum benefit condition. The second condition is that other nonexcepted group health plan coverage (e.g. major medical) must be made available. A limited-scope dental or vision plan may be excepted if it provides limited benefits (1) under a separate policy, certificate, or contract of insurance; or (2) that are not an integral part of the plan. To meet the condition for not being an integral part of the plan, participants must be allowed to decline coverage, or the benefit claims must be administered under a contract separate from the health plan.

HIPAA special enrollment must be allowed. An employer who offers a Cafeteria/Section 125 plan, may design it to allow mid-year election changes that correspond with the HIPAA special enrollment rules to allow coverage to be obtained on a pre-tax basis. However, as a general rule cafeteria plan mid-year election changes are optional and participant elections must be made on a prospective basis. The only exception to the rule is for a newborn child, adopted child or child placed for adoption that is enrolled within the HIPAA special enrollment period. The child’s coverage must be retroactive to date of birth, adoption or placement for adoption. A cafeteria plan may also allow other eligible dependents to enroll during a special enrollment event (e.g. child previously eligible but not covered, allowed to enroll with birth of new child). This is commonly called the “tag-along rule” and is not required by HIPAA but may be allowed by the cafeteria plan.

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