COMPLIANCE OVERVIEW

HIPAA Special Enrollment Rights

Group health plans often provide eligible employees with two regular opportunities to elect health coverage—an initial enrollment period when an employee first becomes eligible for coverage and an annual open enrollment period before the start of each plan year.

To make health coverage more portable, the Health Insurance Portability and Accountability Act (HIPAA) requires group health plans to provide special enrollment opportunities outside of the plans' regular enrollment periods in certain situations.

Special enrollment must be provided in these situations:

- ☑ A loss of eligibility for other health coverage;
- ☑ Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP);
- ☑ The acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption; and
- ☑ Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP.

LINKS AND RESOURCES

- The Department of Labor's (DOL) compliance assistance guide for health benefits, which covers HIPAA special enrollment rights.
- Federal regulations regarding HIPAA special enrollment rights.
- FAQs regarding special enrollment rights after losing eligibility for individual coverage.

Affected Health Plans

- Both self-insured and fully insured plans must provide special enrollment rights.
- Certain categories of coverage are exempt from HIPAA's special enrollment rules, such as limited-scope vision and dental benefits.
- Retiree-only plans and most health FSAs are also exempt from HIPAA's special enrollment rules.

Special Enrollment Rights

- HIPAA allows eligible individuals to enroll in health plan coverage outside of the regular enrollment periods.
- These special enrollment rights apply to employees and their dependents, depending on the circumstance.
- Most employers allow employees to change their pre-tax benefit elections when they experience a special enrollment event.

Affected Health Plans

HIPAA's special enrollment rules broadly apply to group health plans and health insurance issuers offering group health insurance coverage. However, certain categories of coverage—called "excepted benefits"—are not subject to HIPAA's special enrollment rules. Excepted benefits include, for example, the following:

- Benefits that are generally not health coverage (such as automobile coverage, liability insurance, workers' compensation and accidental death and dismemberment coverage);
- Limited-scope dental or vision benefits; and
- Most health flexible spending accounts (FSAs).

HIPAA also includes an exemption for very small group health plans and retiree-only plans. HIPAA's special enrollment rules do not apply to a plan that, on the first day of the plan year, has fewer than two participants who are current employees.

Deadline Extensions – COVID-19 Pandemic

Various deadlines related to employer-sponsored group health plans were extended during the COVID-19 pandemic, including the deadline for requesting special enrollment under HIPAA. These deadlines were extended by disregarding an "outbreak period." The outbreak period ended on July 10, 2023. This means that health plans can go back to their normal pre-pandemic deadlines for administering special enrollment requests. However, any days during the outbreak period must still be disregarded to determine the deadline that applies to a specific individual.

Special Enrollment Events

LOSS OF ELIGIBILITY FOR OTHER HEALTH COVERAGE	
Compliance Question	**HIPAA Special Enrollment Requirement**

What triggers this special enrollment right?	Current employees and their dependents are eligible for special enrollment if:
	• The employee and dependents are otherwise eligible to enroll in the employer's group health plan;
	• When coverage under the plan was previously offered, the employee (or dependent seeking special enrollment) had coverage under another group health plan or health insurance coverage; and
	• The employee or dependent lost eligibility for the other coverage because:
	  ○ The coverage was provided under COBRA, and the entire COBRA coverage period was exhausted;
	  ○ The coverage was non-COBRA coverage and the coverage terminated because of loss of eligibility for coverage; or
	  ○ The coverage was non-COBRA coverage and employer contributions for the coverage were terminated.

COMPLIANCE OVERVIEW

What is a loss of eligibility for coverage?	A loss of eligibility for coverage includes, but is not limited to, the following: • Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of these events; • In the case of coverage offered through a health maintenance organization (HMO) in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, loss of coverage because an individual no longer resides, lives or works in the service area (whether or not within the choice of the individual); • In the case of coverage offered through an HMO in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, loss of coverage because an individual no longer resides, lives or works in the service area (whether or not within the choice of the individual), and no other benefits package is available to the individual; and • A situation where a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual. A loss of eligibility for coverage also occurs if an individual loses eligibility for coverage in the individual market (including coverage purchased through an Exchange), regardless of whether the individual may enroll in other individual market coverage. Loss of eligibility does not include a loss resulting from the failure of the employee or dependent to pay premiums on a timely basis or a termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).
What is the deadline for requesting enrollment?	A plan must allow an enrollment period of at least **30 days** after a loss of eligibility or after the termination of employer contributions to request special enrollment.
Who has special enrollment rights?	The current employee, a dependent of the employee, or both. • If the employee loses coverage, the employee and any dependents (including the spouse) who are eligible under the plan's terms may qualify as special enrollees. • If an eligible dependent loses coverage, that dependent and the employee may qualify as special enrollees. The plan is not required to enroll any other dependent under these circumstances. Some plans go beyond what HIPAA requires and allow the employee's other dependents to also be enrolled. Before implementing a plan design that provides greater enrollment rights to participants and beneficiaries, employers should consult with their health insurance issuers or stop-loss carriers.

What benefit options must be available?	Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible.
When must coverage be effective for special enrollees?	When there is a timely request for special enrollment, the new coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the special enrollment request.

TERMINATION OF MEDICAID OR CHIP ELIGIBILITY

Compliance Question	HIPAA Special Enrollment Requirement
What triggers this special enrollment right?	Employees and their dependents are eligible for special enrollment if: • The employee or dependent is covered by a Medicaid plan or under a state CHIP; • The Medicaid/CHIP coverage of the employee or dependent is terminated as a result of loss of eligibility for the coverage; and • The employee and dependent are otherwise eligible to enroll in the employer's group health plan. The phrase "loss of eligibility" is not defined in the statute, and there are no regulations that define the phrase.
What is the deadline for requesting enrollment?	A plan must allow an enrollment period of at least **60 days** after a loss of eligibility for Medicaid or CHIP coverage.
Who has special enrollment rights?	The employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms).
What benefit options must be available?	No guidance on this specific issue, although it seems reasonable to assume that special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible.
When must coverage be effective for special enrollees?	No guidance on this specific issue, although it may be reasonable to begin coverage no later than the first day of the calendar month after the plan receives a timely special enrollment request.

ACQUISITION OF NEW DEPENDENT

Compliance Question	HIPAA Special Enrollment Requirement
What triggers this special enrollment right?	Group health plans must offer a special enrollment opportunity to certain newly acquired spouses and dependents of participants and to current employees who acquire a new spouse or dependent. This special enrollment right only applies if the group health plan offers dependent coverage and the new dependent is acquired through: • Marriage;

	• Birth; • Adoption; or • Placement for adoption.
Who has special enrollment rights?	The following individuals are eligible to enroll upon the acquisition of a new dependent through marriage, birth, adoption or placement for adoption: • **Current employee** – A current employee who is eligible but not enrolled and who acquires a new dependent through marriage, birth, adoption or placement for adoption. • **Spouse of a participant** – An individual who becomes the spouse of a plan participant, or an individual who is a spouse of a plan participant and the participant acquires a new dependent through birth, adoption or placement for adoption. • **Current employee and spouse** – A current employee and an individual who becomes the spouse of the employee if the employee and spouse become married or the employee and spouse are married and the employee acquires a new dependent through birth, adoption or placement for adoption. • **Dependent of a participant** – An individual who becomes a dependent of a participant through marriage, birth, adoption or placement for adoption. • **Current employee and new dependent** – A current employee and an individual who becomes a dependent of the employee through marriage, birth, adoption or placement for adoption. • **Current employee, spouse and new dependent** – A current employee, the employee's spouse and the employee's dependent, if the employee acquires the dependent through marriage, birth, adoption or placement for adoption. The Employee Retirement Income Security Act (ERISA) defines "participant" to include current and former employees, such as retirees. Only the employee, spouse and any newly acquired dependents receive special enrollment rights. Other dependents (for example, siblings of a newborn child) are not entitled to special enrollment rights upon the acquisition of a new dependent. Some plans go beyond what HIPAA requires and allow the employee's other children to be enrolled in addition the employee, spouse and newly acquired dependents. Before implementing a plan design that provides greater enrollment rights to participants and beneficiaries, employers should consult with their health insurance issuers or stop-loss carriers.
What is the deadline for requesting enrollment?	A plan must allow an enrollment period of at least **30 days** to request enrollment, beginning on the date of the marriage, birth, adoption or placement for adoption.
What benefit options must be available?	Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible.

When must coverage be effective for special enrollees?	• For a new spouse or a dependent acquired by marriage, coverage must be effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption or placement for adoption, coverage must be effective retroactively to the date of birth, adoption or placement for adoption. If dependent coverage is not made generally available at the time of the birth, adoption or placement for adoption, then coverage must begin when the plan makes such dependent coverage available.

ELIGIBILITY FOR PREMIUM ASSISTANCE SUBSIDY	
Compliance Question	**HIPAA Special Enrollment Requirement**
What triggers this special enrollment right?	Group health plans must offer a special enrollment opportunity if an employee or dependent becomes eligible for a premium assistance subsidy through a Medicaid plan or a state CHIP.
What is the deadline for requesting enrollment?	The group health plan must allow an enrollment period of at least 60 days after eligibility for a premium assistance subsidy is determined.
Who has special enrollment rights?	The employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms).
What benefit options must be available?	No guidance on this specific issue, although it seems reasonable to assume that special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible.
When must coverage be effective for special enrollees?	No guidance on this issue, although it may be reasonable to begin coverage no later than the first day of the calendar month after the plan receives a timely special enrollment request.

Cafeteria Plan Issues

Mid-year Election Change Rules

Many employers sponsor cafeteria plans (or Section 125 plans) to allow employees to pay for their health coverage on a pre-tax basis. As a general rule, participant elections under a cafeteria plan must be made on a prospective basis and cannot be changed until the beginning of the next plan year. However, cafeteria plans may recognize certain mid-year election change events to allow employees to make election changes during a plan year.

A cafeteria plan **may be designed to permit mid-year election changes that correspond with HIPAA's special enrollment rules.** This allows participants to pay for their health coverage on a pre-tax basis when they obtain coverage during a special enrollment period. If a cafeteria plan does not allow mid-year election changes for HIPAA special enrollment events, eligible employees and dependents must still be allowed to enroll in health plan coverage and pay their premiums on an after-tax basis.

Application to Other Dependents

HIPAA's special enrollment rights do not always apply to all of the employee's dependents. For example, under the special enrollment event for acquiring a new dependent, only the employee, spouse and any newly acquired dependents receive special enrollment rights. Other dependents (for example, siblings of a newborn child) are not entitled to special enrollment rights upon the acquisition of a new dependent. Some plans go beyond what HIPAA requires and allow employees to enroll all of their eligible dependents during the special enrollment window.

The cafeteria plan rules permit midyear election changes for dependents who have special enrollment rights. In addition, the cafeteria plan rules go beyond HIPAA and permit election changes to add other dependents at the same time. This accommodates plan designs that are more generous than what is required under HIPAA's special enrollment rules.

Retroactive Coverage

The cafeteria plan rules include an exception to the general rule prohibiting retroactive election changes. If a newborn child, an adopted child or a child placed for adoption is enrolled within the HIPAA special enrollment period, the child's coverage (and the coverage of any others who can be added under this special enrollment event) must be retroactive to the date of birth, adoption or placement for adoption. The cafeteria plan rules provide that a cafeteria plan may permit the employee to change his or her salary reduction election (for future pay periods) to pay for the extra cost of the coverage retroactive to the date of birth or adoption.