Midyear Changes

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Introduction

Questions surrounding the topic of midyear changes to enrollments have consistently been the most common compliance questions posed by employers. We would like to suggest a method to answering these questions, and hope that after reading this issue brief you'll come away with a better understanding of the rules that apply in these situations.

If Adding Coverage: Is the Employer Required to Allow the Change?

If the request is to add someone to a plan, the plan sponsor should ask itself whether it is required to make this addition. In other words, does the individual making this request have what is referred to as a "HIPAA Special Enrollment Right"? HIPAA (the Health Insurance Portability and Accountability Act of 1996) provides opportunities for individuals who have experienced certain life events to enroll in a group health plan in periods other than when they are originally hired or during the plan's annual open enrollment period. These opportunities are referred to as "HIPAA Special Enrollment Rights."

When an individual has a HIPAA Special Enrollment Right, an employer must permit the individual, and in certain cases spouses and dependents, to enroll in any major medical plan offered to other similarly situated individuals. However, employers are never required to enroll individuals in coverage if the individuals are not otherwise eligible for coverage. Employers are permitted to require an employee/participant to alert the plan to the special enrollment right within a specified time after the event takes place. The extent to which employers can limit this notice period differs depending on what triggered the special enrollment right in the first place.

If an individual does not have a HIPAA Special Enrollment right, that does not mean that the employer is prohibited from allowing the person to enroll in coverage midyear. It simply means that the regulations do not require the plan to enroll the person midyear, or to follow the rules that apply specifically to special enrollment rights.

<u>Loss of Other Coverage</u>
An individual does not necessarily have a special enrollment right simply because he or she lost other coverage. Two elements are required to make a loss of other coverage a special enrollment right:

1. The person must have had the other coverage at a time when he or she was previously offered coverage under the employer's plan.
2. The person must have lost coverage because of:
    a. Loss of eligibility for other (non-COBRA) coverage,
    b. Loss of employer contribution to other (non-COBRA) coverage, or
    c. Exhaustion of a COBRA maximum coverage period.

If it was the employee/participant who lost other coverage, any eligible dependent also has a special enrollment right to enroll in the plan. If a specific dependent lost other coverage, that dependent and the employee have HIPAA special enrollment rights, but other dependents do not. However, plans can still permit other dependents to be enrolled in these circumstances. Employers may limit the amount of time an

employee has to request this special enrollment to 30 days following the loss of other coverage (unless the other coverage is Medicaid or CHIP, which we will discuss below).

Acquisition of New Spouse or Dependent

When an employee/participant gains a new spouse or dependent (through marriage, birth, adoption, or placement for adoption), that employee, the employee's spouse (whether newly acquired or not), and the newly acquired dependent have a special enrollment right.

- Example 1: An employee who is not enrolled in the group medical plan is already married and has a new baby by birth. The employee could enroll only himself, himself and his spouse, himself and his new dependent, or all three family members.

- Example 2: Same facts as the example above; however, at the time of the birth of the new dependent, the employee already has another child. In this example, everyone has a special enrollment right – except for the child existing before the new birth. However, just because this child does not have a special enrollment right does not mean the plan could not permit the child to be enrolled as well.

Employers may limit the amount of time an employee has to request this special enrollment to 30 days following the date of birth, marriage, adoption, or placement for adoption. In general, all special enrollment rights are prospective. In other words, the person has a right to be enrolled in the medical plan after making a request to exercise the special enrollment right. However, there is an exception when the special enrollment right is acquisition of a new dependent *through birth, adoption, or placement for adoption*. In this case, the special enrollment right must function retroactive to the date of the event itself. In other words, if the individual alerts the plan of the right within the specified time frame, the coverage must be effective retroactive to the date of the birth, adoption, or placement for adoption.

Medicaid or CHIP

An individual can have a special enrollment right if he or she loses eligibility for Medicaid or CHIP, or gains assistance (to pay for premiums) under Medicaid or CHIP. These special enrollment rights are limited to employees and dependents. However, employers may permit spouses to be enrolled in certain circumstances as well. If either the employee or dependent experiences either of these events, both the employee and the dependent who are not currently enrolled must be permitted to enroll. Employers may limit the amount of time an employee has to request this special enrollment to 60 days following either the loss of coverage or gain of assistance.

Can a Corresponding Change to the Employee's Pre-tax Election Be Made?

If an employer determines that they are required to permit an individual to enroll in coverage midyear due to a special enrollment right, the employer may also permit the employee to pay for that coverage on a pre-tax basis. This is so because the Section 125 regulations specifically permit midyear pre-tax election changes that correspond with HIPAA special enrollment rights.

However, employers are permitted to allow individuals to enroll in coverage midyear even when they don't have a HIPAA special enrollment right. Further, employers are permitted to allow individuals to terminate coverage midyear. In these cases, the next question a plan sponsor should ask itself is whether to permit the requested change to the individual's pre-tax election. Under Section 125 of the tax code, if a person elects to pay for a benefit on a pre-tax basis, that election must be irrevocable for the period of coverage. In other words, the person cannot change the decision about what to pay on a pre-tax basis, until the plan year ends.

There are certain exceptions to this general irrevocability rule, where changes are permitted under the Section 125 regulations. Often, these permitted changes are referred to as "status changes."[1] In order to permit a requested change to a pre-tax election, plan sponsors should ensure that the event that occurred is listed in the Section 125 regulations, and that the requested change is consistent with the event.

Is This an Event Listed in the Section 125 Regulations?

There are several events in the regulations that permit a participant in a cafeteria plan to make a change to his or her pre-tax election. Some of these events are referred to as "life events" and include things like birth, marriage, adoption, death of dependent, and a dependent "aging out of" a plan. Other events are related to a change in the coverage offered to the participant, such as a cost or coverage change.

Finally, changes are permitted for events that occur outside of the employer's plan, such as court orders, changes in other employer's plans (such as spouse's plans), and certain leaves (such as leaves under the FMLA (Family Medical Leave Act) and USERRA (Uniformed Services Employment and Reemployment Rights Act)).

Is the Requested Change Consistent with the Event?

If it is determined that the event experienced by an individual is listed in the Section 125 regulations, the next question is whether the change that is being requested is consistent with the event the individual experienced. Consistency can be a complicated question, since there are many factors to consider. We have attempted to break these factors up into four questions.

1. *What coverage type is the request attempting to change?*
   When the event that occurs is a change in legal marital status, change in number of dependents, change in employment status, dependent satisfying or ceasing to satisfy eligibility criteria, or a residence change, there are specific consistency rules for certain types of coverages. These coverages are group-term life insurance, dismemberment, or disability policy; or a dependent care assistance or adoption assistance plan.

   Under the special rule for group term life insurance, dismemberment, or disability policies, any of the above-listed events will permit any change to be made to these coverages. This is the case even where eligibility for these coverages is not affected by the change, which is normally a requirement under the consistency requirement for other coverages. Under the special rule for dependent care assistance plans (DCAPs) or adoption assistance plans, any change to the eligibility for tax exclusion of expenses arising from one of the events listed above is considered consistent. In other words, a person does not have to lose eligibility to participate in the DCAP or adoption assistance plan specifically, if there will be an impact on the eligibility of expenses the person is submitting to be reimbursed on a tax-free basis.

2. *Is the change specifically addressed in the regulations?*
   In general, consistency is a topic that needs to be analyzed on a case-by-case basis, given that the Section 125 regulations do not provide an overall guide for every possible scenario and whether consistency is achieved. However, there are several specific scenarios in the regulations that can be applied directly. First, if a spouse or dependent loses eligibility under an employer's plan, it is consistent for the coverage of *only* that specific spouse or dependent to be canceled. Second, if an individual becomes eligible for coverage under another employer's plan, a revocation of that person's coverage is

[1] The terms "status change" and "special enrollment" are often used interchangeably. However, "status change" refers to a plan sponsor's ability to make a change to a participant's pre-tax election, and "special enrollment" refers to a person's right under HIPAA to be *added* to a medical plan midyear.

consistent only if the person enrolls in (or increases coverage in) the other employer's plan. Where these specific rules apply, a person does not have to ask whether the requested change is "on account of" the event (question #3, below).

3. *Is the change "on account of" the event?*
   There are two general principles that are applied throughout the examples in the regulations that are meant to illustrate whether a change is "on account of" an event. The first principle is that if an individual loses or gains eligibility for a specific type of coverage, the change is "on account of" the event only if the change is made to that specific type of coverage. Finally, a change to a plan type (for example PPO to HMO) is only "on account of" an event if the coverage tier also changes (for example, employee only to employee plus spouse).

4. *Does the change "correspond with" the event?*
   The final consistency requirement is that the requested change must correspond with the event. This essentially means that the change should not occur after too much time has elapsed from the date of the event on which the requested change is based. There is no deadline in the regulations that can be applied regarding how much time is too much time. However, the most common timelines are 30 or 60 days. Most often, plans will incorporate one of these deadlines into their Section 125 plan document so that there is a uniform requirement for all events. Whatever timeline the Section 125 plan document adopts should be enforced consistently.

If a Pre-tax Change Is Not Permitted: Could the Change Be Permitted on a Post-tax Basis?

If the request is to add someone to a benefit plan midyear, and a change to the individual's pre-tax election is not permitted, the employer could decide to permit the change on a post-tax basis. In other words, the employer could decide to permit an individual to pay for the additional coverage on a post-tax basis. The employer should be sure to determine whether the plan allows for payment on a post-tax basis in general before permitting this. Further, the employer should check carrier/stop-loss carrier contracts to be sure that the individual's claims will be covered.

Plan Documents

If the change is permitted under the regulations, the last question to ask is whether the change is permitted under the relevant plan documents. The Section 125 regulations outline changes that are permitted to be made midyear to a pre-tax election. However, a Section 125 plan does not have to permit all, or any, of the events that are listed in the regulations. Additionally, even though a plan may be compelled under HIPAA to permit a person to enroll in a benefit midyear if the person has a special enrollment right, the plan is not required to permit a corresponding pre-tax election change. The Section 125 pre-tax document outlines which events it recognizes that would permit a pre-tax election change midyear.

Conclusion

When a request to make a midyear enrollment change is received, it can be hard to know where to start. We hope that this explanation can function as a tool to walk you through the decision-making process. If each question is asked and answered, it should be possible to come away with the correct answer.