

HIPPA - The Health Insurance Portability and Accountability Act of 1996

Introduction

This pamphlet is designed to provide an overview of recent changes in the law that may affect your health benefits. The questions and answers address changes made by the Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996 and the Mental Health Parity Act of 1996.

On April 1, 1997, the Departments of Labor, Health and Human Services and the Treasury issued interim regulations that interpret many of the provisions of the new laws. The Department of Labor's regulations interpret amendments made to the Employee Retirement Income Security Act (ERISA).

This publication is intended to assist employers who sponsor group health plans in understanding their obligations under the law and to educate workers and their families about their rights under the law. It constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

This pamphlet may not address your specific health care questions and is not intended to be relied upon as the official position of the Department of Labor. If you have additional questions, please contact the PWBA Regional Office nearest you or the PWBA Division of Technical Assistance & Inquiries located in our national office in Washington, DC.

If you are in an HMO or if the benefits under your plan are provided through an insurance policy issued by an insurance company, you may also contact your State Insurance Commissioner's Office. As discussed later in this pamphlet, certain of the new federal rules under HIPAA can be changed by state law for insurance companies and HMOs if that law is more protective of individuals.

The Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. This law includes important new protections for millions of working Americans and their families who have preexisting medical conditions or might suffer discrimination in health coverage based on a factor that relates to an individual's health. HIPAA's provisions amend Title I of the Employee Retirement Income Security Act of 1974 (ERISA) as well as the Internal Revenue Code and the Public Health Service Act and place requirements on employer-sponsored group health plans, insurance companies and health maintenance organizations (HMOs). HIPAA includes changes that:

- limit exclusions for preexisting conditions;

- prohibit discrimination against employees and dependents based on their health status;
- guarantee renewability and availability of health coverage to certain employers and individuals; and
- protect many workers who lose health coverage by providing better access to individual health insurance coverage.

The following information provides general guidance on frequently asked questions about HIPAA.

Preexisting Condition Exclusions

Under HIPAA, a group health plan or a health insurance issuer offering group health insurance coverage may impose a preexisting condition exclusion with respect to a participant or beneficiary only if the following requirements are satisfied:

- *a preexisting condition exclusion must relate to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period prior to an individual's enrollment date;*
- *a preexisting condition exclusion may not last for more than 12 months (18 months for late enrollees) after an individual's enrollment date; and*
- *this 12- (or 18-) month period must be reduced by the number of days of the individual's prior creditable coverage, excluding coverage before any break in coverage of 63 days or more.*

How will the new law help people who currently have health coverage and who want to change jobs?

Currently some employer health plans do not cover preexisting medical conditions. HIPAA limits the time period of these restrictions so that most plans must cover an individual's preexisting condition after 12 months. Under HIPAA, your new employer's plan will be required to give you credit for the length of time that you had continuous health coverage that will reduce the 12-month exclusion period.

If, at the time you change jobs, you already have had 12 months of continuous health coverage (without a break in coverage of 63 days or more), you will not have to start over with a new 12- month exclusion for any preexisting conditions.

What is a "preexisting condition"?

A "preexisting condition" is a condition present before your enrollment date in any new health plan.

Under HIPAA, the only preexisting conditions that may be excluded under a preexisting condition exclusion are those for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on your enrollment date.

If you had a medical condition in the past, but have not received any medical advice, diagnosis, care or treatment within the 6 months prior to your enrollment date in the plan, your old condition is not a "preexisting condition" for which an exclusion can be applied.

Are there "preexisting conditions" that cannot be excluded from coverage?

Yes. Preexisting condition exclusions cannot be applied to pregnancy, regardless of whether the woman had previous coverage. In addition, a preexisting condition exclusion cannot be applied to a newborn, adopted child under age 18 or a child under 18 placed for adoption as long as the child became covered under the health plan within 30 days of birth, adoption or placement for adoption, and provided the child does not incur a subsequent 63-day or longer break in coverage.

Can states modify HIPAA's portability requirements?

Yes, in certain circumstances. States may impose stricter obligations on health insurance issuers in the seven areas listed below. States may:

- shorten the 6-month "look-back" period prior to the enrollment date to determine what is a preexisting condition;
- shorten the 12- and 18-month maximum preexisting condition exclusion periods;
- increase the 63-day significant break in coverage period;
- increase the 30-day period for newborns, adopted children and children placed for adoption to enroll in the plan so that no preexisting condition exclusion period may be applied thereafter;
- expand the prohibitions on conditions and people to whom a preexisting condition exclusion period may be applied beyond the "exceptions" described in federal law (the "exceptions" under federal law are for certain newborns, adopted children, children placed for adoption and pregnancy);
- require additional special enrollment periods; and
- reduce the maximum HMO affiliation period to less than 2 months (3 months for late enrollees).

Therefore, if your health coverage is offered through an HMO or an insurance policy issued by an insurance company, you should check with your State Insurance Commissioner's Office to find out the rules in your state.

I changed employment recently. How do I know if I am subject to any preexisting condition exclusion period?

Many plans do not exclude coverage for preexisting conditions. A plan must tell you if it has a preexisting condition exclusion period (and can only exclude coverage for a preexisting condition after you have been notified). The plan must also notify you of your right to show that you have prior creditable coverage to reduce the preexisting condition exclusion period.

If the plan does apply a preexisting condition exclusion period, the plan must make a determination regarding your creditable coverage and the length of any preexisting condition exclusion period that applies to you. Generally, within a reasonable time after you provide a certificate or other information relating to creditable coverage, a plan is required to make this determination.

You are required to be notified of this determination if, after considering all evidence of creditable coverage, the plan will still impose a preexisting condition exclusion period with respect to any preexisting condition you may have. The notice must also tell you the basis of the determination, including the source and substance of any information on which the plan relied and any appeals procedure that is available to you.

The plan may modify its initial determination if it later determines that you do not have the creditable coverage you claimed. In this circumstance, the plan must notify you of its reconsideration, and until a final determination is made, the plan must act in accordance with its initial determination for purposes of approving medical services.

I changed employment and my new group health plan imposes a preexisting condition exclusion period. How does my new plan determine the length of my preexisting condition exclusion period?

A plan can exclude coverage for a preexisting condition only if it relates to a condition (whether physical or mental, and regardless of the cause of the condition) for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month "look-back" period ending on an individual's "enrollment date." Your "enrollment date" is your first day of coverage, or if there is a waiting period, the first day of your waiting period (typically, your date of hire).

The maximum length of a preexisting condition exclusion period is 12 months after the enrollment date (18 months in the case of a "late enrollee"). A late

enrollee is an individual who enrolls in a plan other than on either the earliest date on which coverage can become effective under the terms of the plan or on a special enrollment date.

A plan must reduce an individual's preexisting condition exclusion period by the number of days of an individual's creditable coverage. However, a plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more ("significant break in coverage"). A plan generally receives information about an individual's creditable coverage from a certificate furnished by a prior plan or issuer (e.g., an insurance company or HMO).

A certificate of creditable coverage must be provided automatically to you by the plan or issuer when you lose coverage under the plan or become entitled to elect COBRA continuation coverage and when your COBRA continuation coverage ceases. You also have a right to receive a certificate when you request one from your previous plan or insurance company within 24 months of when your coverage ceases.

If you do not have a certificate, you may present other evidence of creditable coverage.

I am not changing jobs. How do the HIPAA provisions apply to me?

On the date your plan becomes subject to the HIPAA provisions, the plan may not exclude coverage for any preexisting condition for more than 12 months after your enrollment date (18 months for a late enrollee). This period may have already passed.

If this period has not passed, your plan is required to use any creditable coverage that you had accumulated prior to your enrollment date to reduce your remaining preexisting condition exclusion period.

Finally, your plan must comply with the rules that prohibit discrimination in eligibility and continued eligibility to enroll and remain enrolled under the plan, and in setting premiums and contributions, based on a health status-related factor.

My employer has a waiting period for enrollment in the plan. How does this relate to the preexisting condition exclusion period?

HIPAA does not prohibit a plan or issuer from establishing a waiting period. However, if a plan has a waiting period and a preexisting condition exclusion period, the preexisting condition exclusion period begins when the waiting period begins.

For group health plans, a waiting period is the period that must pass before an employee or a dependent is eligible to enroll under the terms of a group health plan. However, if the employee or dependent is a late enrollee or a special enrollee, any period before such late or special enrollment is not a waiting period.

If an individual seeks and obtains coverage by purchasing an individual insurance policy, the period between the date the individual files a substantially complete application for coverage and the first day of coverage is a waiting period.

I have an ongoing medical condition and have been subject to a preexisting condition exclusion period under my current employer's health plan. I have been continuously enrolled in the plan for more than 12 months. Will HIPAA help me obtain coverage for this condition?

Yes. As long as benefits for the condition are otherwise covered under the terms of the plan, a preexisting condition exclusion period may generally not last longer than 12 months. Because you have been covered by your current plan for at least 12 months without a 63-day break in coverage, your employer will no longer be able to impose the preexisting condition exclusion period when HIPAA becomes effective for your plan.

I recently changed jobs. Seven months ago I received my last treatment for carpal tunnel syndrome. I have not received any medical advice, diagnosis, care or treatment regarding this condition since that time. Can my employer impose a preexisting condition exclusion period for this illness?

No. Your employer may not impose a preexisting condition exclusion period with respect to any condition for which no medical advice, diagnosis, care or treatment was recommended or received more than 6 months prior to your enrollment date.

I have had coverage under my new employer's health plan for 6 months, and I have no prior creditable coverage. My new plan has no waiting period but applies a 12-month exclusion period for preexisting conditions. I have asthma and received treatment for it several times during the 6-month period prior to my enrollment date in my new employer's health plan. I was recently hospitalized as a result of my asthma. Is my new plan required to cover this hospitalization?

No. You are subject to the remaining 6 months of the 12-month preexisting condition exclusion period applied by your plan because you did not have any previous creditable coverage and because you had received treatment for the condition within the 6-month period prior to your enrollment date in the new plan.

Crediting Prior Health Coverage For Purposes of Reducing A Preexisting Condition Exclusion Period

A preexisting condition exclusion period is not permitted to extend for more than 12 months (or 18 months for late enrollees) after an individual's enrollment date in the plan. The period of any preexisting condition exclusion that would apply under a group health plan is generally reduced by the number of days of creditable coverage.

What is "creditable coverage"?

Most health coverage is creditable coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO, individual health insurance policy, Medicaid or Medicare.

Creditable coverage does not include coverage consisting solely of "excepted benefits," such as coverage solely for dental or vision benefits.

Days in a waiting period during which you have no other coverage are not creditable coverage under the plan, nor are these days taken into account when determining a significant break in coverage (a break of 63 days or more).

How does "crediting" for prior coverage work under HIPAA?

Most plans will use the "standard method" of crediting coverage.

Under the standard method, you will receive credit for your previous coverage that occurred without a break in coverage of 63 days or more. Any coverage occurring prior to a break in coverage of 63 days or more will not be credited against a preexisting condition exclusion period.

To illustrate, suppose an individual had coverage for 2 years followed by a break in coverage of 70 days and then resumed coverage for 8 months. That individual would only receive credit for 8 months of coverage; no credit would be given for the 2 years of coverage prior to the break in coverage of 70 days.

It is also important to remember that during any preexisting condition exclusion period under a new plan you may be entitled to COBRA continuation coverage under your former plan. "COBRA" is the name for a federal law that provides workers and their families the opportunity to purchase group health coverage through their employer's health plan for a limited period of time (generally 18, 29 or 36 months) if they lose coverage due to specified events including, termination of employment, divorce or death. Workers in companies with 20 or more employees generally qualify for COBRA. Some states have laws similar to COBRA that may apply to smaller companies.

Is there another way that a group health plan or issuer can "credit" coverage under HIPAA?

Yes, a plan or issuer may elect the "alternative method" for crediting coverage for all employees.

Under the alternative method of counting creditable coverage, the plan or issuer determines the amount of an individual's creditable coverage for any of the five specified categories of benefits. Those categories are mental health, substance abuse treatment, prescription drugs, dental care and vision care. The standard method (described above) is used to determine an individual's creditable coverage for benefits that are not within any of the five categories that a plan or issuer may use. (The plan or issuer may use some or all of these categories.)

When using the alternative method, the plan or issuer looks to see if an individual has coverage within a category of benefits (regardless of the specific level of benefits provided within that category).

For example, if an individual has 12 months of creditable coverage, but coverage for only 6 of those months provided benefits for dental care, a preexisting condition exclusion period may be imposed with respect to that individual's dental care benefits for up to 6 months (irrespective of the level of dental care benefits).

If your new employer's plan requests information from your former plan regarding any of the five categories of benefits under the alternative method, your former plan must provide the information regarding coverage under the categories of benefits.

Can I receive credit for previous COBRA continuation coverage?

Yes. Under HIPAA any period of time that you are receiving COBRA continuation coverage is counted as previous health coverage as long as the coverage occurred without a break in coverage of 63 days or more.

For example, if you were covered continuously for 5 months by a previous health plan and then received 7 months of COBRA continuation coverage, you would be entitled to receive credit for 12 months of coverage by your new group health plan.

I began employment with my current employer 45 days after my previous group health plan coverage terminated. I had coverage under my previous employer's plan for 24 continuous months prior to the termination. I had no other coverage before my enrollment date in my new plan. Will I be subject to the 12-month preexisting condition exclusion period imposed by my new employer?

Not if you enroll when you are first eligible. The 45-day break in coverage does not count as a significant break in coverage under HIPAA. Under federal law, a significant break in coverage is a break in coverage of at least 63 days. Since you had over 12 months of creditable coverage from your previous group plan without a significant break, you would not be subject to the preexisting condition exclusion imposed by your new employer's plan if you enroll when you are first eligible.

As mentioned earlier, the length of time that passes before a significant break in coverage is reached may be longer under state law for HMOs and "insured plans." An "insured plan" provides benefits through an insurance policy issued by an insurance company.

I began employment with my current employer 100 days after my previous group health plan coverage terminated. I had been covered by my previous employer's plan for 36 continuous months prior to termination. I had no other coverage before my enrollment date in my current employer's plan. Will I be subject to the 12-month preexisting condition exclusion period imposed by my current employer's plan?

Yes. Your break in coverage of 100 days is a significant break in coverage under federal law. Therefore, unless the plan is an insured plan subject to a state law that provides a longer break rule, you will not be able to count the 36 months of previous coverage as "creditable" coverage.

You may avoid a significant break in coverage if when your previous coverage is scheduled to terminate, you instead continue your coverage (for example, through COBRA) or if you purchase an individual health insurance policy when the coverage terminates.

Certification of Creditable Coverage

Group health plans and health insurance issuers are required to furnish a certificate of coverage to an individual to provide documentation of the individual's prior creditable coverage. A certificate of creditable coverage:

- must be provided automatically by the plan or issuer when an individual either loses coverage under the plan or becomes entitled to elect COBRA continuation coverage and when an individual's COBRA continuation coverage ceases;
- must also be provided, if requested, before the individual loses coverage or within 24 months of losing coverage; and

How will newly hired employees prove that they had prior health coverage that should be credited?

Under HIPAA, providing information about an employee's prior health coverage is the responsibility of an employee's former group health plan and/or the insurance company providing such coverage.

HIPAA sets specific disclosure and certification requirements for group health plans, insurance companies and HMOs.

A certificate stating when you were covered under the plan must be provided automatically to you when you lose coverage under the plan or otherwise become entitled to elect COBRA continuation coverage as well as when COBRA continuation coverage ceases.

You may also request a certificate, free of charge, until 24 months after the time your coverage ended. For example, you may request a certificate even before your coverage ends.

I received a certificate from my former plan. What do I do now?

You should:

- ensure that the information is accurate. Contact the plan administrator of your former plan if any information is wrong.
- keep the certificate in case you need it. You will need the certificate if you leave your health plan and enroll in a subsequent plan that applies a preexisting condition exclusion period or if you purchase an individual insurance policy from an insurance company.

What if I have trouble getting a certificate from my former employer's plan?

Under HIPAA, group health plans and insurers are required to provide documentation that certifies the creditable coverage you have earned. Group health plans and insurers that fail or refuse to provide such certificate are subject to penalties under HIPAA.

Under HIPAA, individuals can show they are entitled to creditable coverage in situations where they cannot obtain a certificate from a group health plan or insurer.

It is important, therefore, for individuals to keep accurate records (*e.g.*, pay stubs, copies of premium payments or other evidence of health care coverage) that can be used to establish periods of creditable coverage in the event a certification cannot be obtained from a group health plan or insurer.

What steps should I take if I am not provided a certificate by my plan or issuer?

If you do not receive a certificate by the time you should have received it or by the time you need it, your first step should be to contact the plan administrator of the plan responsible for providing the certificate and request a copy. If any part of your creditable coverage was through an insurance company, you can also contact the insurance company for a certificate that reflects that part of your creditable coverage as long as you make the request within 24 months of your coverage ceasing under the insurance policy.

In any event, if you do not receive a certificate, you may demonstrate to your new plan that you have creditable coverage (as well as any waiting periods) by producing documentation or other evidence of creditable coverage (such as pay stubs that reflect a deduction for health insurance, explanation of benefits forms (EOBs) or verification by a doctor or your former health care benefits provider that you had prior health insurance coverage). Accordingly, you should keep these records and documentation in case you need them.

Do plans that do not impose a preexisting condition exclusion period (and the issuers that provide coverage under these plans) have to provide certificates?

Yes.

Can plans contract with an issuer to provide the certificates for their employees?

Yes. To avoid duplication of certificates, a plan may contract with the issuer to provide the certificate. Furthermore, if any entity (including a third-party administrator) provides a certificate to an individual, no other party is required to provide the certificate.

When must group health plans and issuers provide the certificates?

Plans and issuers must furnish the certificate automatically to:

- an individual who is entitled to elect COBRA continuation coverage, at a time no later than when a notice is required to be provided for a qualifying event under COBRA;
- an individual who loses coverage under a group health plan and who is not entitled to elect COBRA continuation coverage, within a reasonable time after coverage ceases; and
- an individual who has elected COBRA continuation coverage, either within a reasonable time after the plan learns that COBRA continuation coverage ceased or, if applicable, within a reasonable time after the individual's grace period for the payment of COBRA premiums ends.

Plans and issuers must also generally provide a certificate to you if you request one, or someone requests one on your behalf (with your permission), at the earliest time that a plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate.

Can my old plan simply call my new plan to relay information about my creditable coverage?

Yes, if you, your new plan and your old plan all agree, the information may be transferred by telephone.

You may always request a written certificate for your records in addition to a telephonic transmission of information between plans.

What if the plan or issuer cannot identify employees' dependents or their coverage information?

A plan or issuer must make reasonable efforts to collect the necessary information for dependents and include it on the certificate. However, an automatic certificate for a dependent is not required to be issued until the plan or issuer knows (or, making reasonable efforts, should know) of the dependent's loss of coverage. This information can be collected annually, such as during an open enrollment period.

Through June 30, 1998, a plan or issuer may satisfy its obligation to provide a written certificate regarding the coverage of a dependent by providing the name of the participant covered by the plan and specifying the type of coverage provided (such as family coverage or employee-plus-spouse coverage). However, if requested to provide a certificate relating to a dependent, the plan must make reasonable efforts to obtain and provide the name of the dependent.

What is the minimum period of time that should be covered by the certificate?

It depends on whether the certificate is issued automatically or upon request —

- for a certificate that is issued automatically, the certificate should reflect the most recent period of continuous coverage.
- for a certificate that is issued upon request, the certificate should reflect each period of continuous coverage ending within 24 months prior to the date of request.

At no time must the certificate reflect more than 18 months of creditable coverage that is not interrupted by a break in coverage of 63 days or more.

When do group health plans and issuers start providing certificates of creditable coverage?

Group health plans and issuers are not required to provide certificates before June 1, 1997. Generally, the certification requirements apply to periods of coverage that occur after June 30, 1996, and certificates must be provided when your coverage ceases under the plan.

In general, by June 1, 1997, plans or issuers must send certificates (or notices as discussed in the next question) to individuals who lost coverage or became eligible for COBRA between October 1, 1996 and May 31, 1997.

After June 1, 1997, plans or issuers must provide certificates to individuals as they lose coverage or begin COBRA in the manner set forth in the interim regulations (see section relating to "Crediting Prior Health Coverage For Purposes of Reducing a Preexisting Condition Exclusion Period").

Are there any interim or transitional rules to help group health plans and issuers comply with the law while updating their systems?

Yes. There is a transitional rule for certifying dependent coverage through June 30, 1998 (See above).

In addition, there is a transitional model notice. For certification events occurring on or after October 1, 1996, but before June 1, 1997, a plan or issuer can satisfy its certification obligation by providing, no later than June 1, 1997, a written notice informing individuals of their rights to certification

Nondiscrimination Requirements

Individuals may not be excluded from coverage under the terms of the plan, or charged more for benefits offered by a plan or issuer, based on specified factors related to health status.

Can I lose coverage if my health status changes?

Group health plans and issuers may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on "health status-related factors." These factors are your health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. For example, you cannot be excluded or dropped from coverage under your health plan just because you have a particular illness.

Plans may establish limits or restrictions on benefits or coverage for similarly situated individuals.

In addition, plans may change covered services or benefits if they give participants notice of such "material reductions" within 60 days after the change is adopted.

Also, plans may not require an individual to pay a premium or contribution greater than that for a similarly situated individual based on a health status-related factor.

My employer sponsors a group health plan that is available only to employees who pass a physical examination. Is this requirement that I pass a physical examination permissible?

No. Plans or group health insurance issuers may not establish rules for eligibility to enroll under the terms of the plan that discriminate based on one or more "health status-related factors."

Special Enrollment

Group health plans and health insurance issuers are required to permit certain employees and dependents special enrollment rights. These rights are provided both to employees who were eligible but declined enrollment in the plan when first offered because they were covered under another plan and to individuals upon the marriage, birth, adoption or placement for adoption of a new dependent. These special enrollment rights permit these individuals to enroll without having to wait until the plan's next regular enrollment period.

What are a plan's obligations with respect to special enrollment?

A group health plan is required to provide for special enrollment periods during which certain individuals are allowed to enroll in the plan (without having to wait until the plan's next regular enrollment season).

A special enrollment occurs if an individual with other health insurance coverage loses that coverage or if a person becomes a dependent through marriage, birth, adoption or placement for adoption.

A special enrollee is not treated as a late enrollee. Therefore, the maximum preexisting condition exclusion period that may be applied to a special enrollee is 12 months, and the 12 months are reduced by the special enrollee's creditable coverage. (And, remember, a newborn, adopted child or child placed for adoption cannot be subject to a preexisting condition exclusion period if the child is enrolled within 30 days of birth, adoption or placement for adoption.)

A plan must provide a description of the plan's special enrollment rights under HIPAA to anyone who declines coverage. See the model description in the

Coverage: Additional Information To Help Participants Make Informed Decisions Relating to Their Health Care Coverage

If I change jobs am I guaranteed the same benefits that I have under my current plan?

No. When a person transfers from one plan to another, the benefits the person receives will be those provided under the new plan.

Coverage under the new plan can be different than the coverage under the former plan.

Will I be covered immediately under my new employer's plan?

Not necessarily. Plans may set a waiting period before individuals become eligible for benefits. HMOs may have an "affiliation period" during which an individual does not receive benefits and is not charged premiums. Affiliation periods run concurrently with any waiting period under a plan, may not last for more than 2 months (3 months for late enrollees) and are only allowed for HMOs that do not impose preexisting condition exclusion periods.

Does HIPAA require employers to offer health coverage or require plans to provide specific benefits?

No. The provision of health coverage by an employer is voluntary. HIPAA does not require specific benefits nor does it prohibit a plan from restricting the amount or nature of benefits for similarly situated individuals.

What if my new employer does not provide health coverage?

There is no requirement for any employer to offer health insurance coverage. If your new employer does not offer health insurance, you may be able to continue coverage under your previous employer's plan under COBRA continuation coverage.

What if I am unable to obtain group coverage?

You may be able to obtain coverage under an individual insurance policy issued by an insurance company. HIPAA guarantees access to individual insurance to "eligible individuals." Eligible individuals:

- have had coverage for at least 18 months where the most recent period of coverage was under a group health plan;
- did not have their group coverage terminated because of fraud or nonpayment of premiums;

- are ineligible for COBRA continuation coverage or have exhausted their COBRA benefits (or continuation coverage under a similar state provision); and
- are not eligible for coverage under another group health plan, Medicare or Medicaid or any other health insurance coverage.

The opportunity to buy an individual insurance policy is the same whether the individual is laid off, is fired or quits his or her job. For information on individual insurance policies you should contact your State Insurance Commissioner's Office.

What if I cannot afford the premiums for health coverage?

HIPAA does not set premium rates but it does prohibit plans and issuers from charging an individual more than similarly situated individuals in the same plan because of health status. Plans may offer premium discounts or rebates for participation in wellness programs.

In addition, many states limit insurance premiums and HIPAA does not preempt current or future state laws regulating the cost of insurance.

I terminated employment but I haven't found a new job yet. What can I do to retain my protections under HIPAA?

To retain HIPAA's protections, you should avoid a 63-day break in coverage. If you incur such a break, all previous creditable coverage may be disregarded for purposes of reducing any future preexisting condition exclusion period that may apply to you under any new plan.

If you have 18 months of creditable coverage already, you may be an "eligible individual" entitled to buy an individual health insurance policy from a health insurance issuer without a preexisting condition exclusion period.

Whether or not you have 18 months of creditable coverage, you may consider electing COBRA continuation coverage or continuation coverage under a similar state provision.

You may need to elect COBRA continuation coverage (or continuation coverage under a similar state provision), if available, in order to avoid a 63-day break in coverage or to qualify as an eligible individual who may obtain coverage without a preexisting condition exclusion period if you buy health insurance other than through an employer group health plan.

However, if you elect COBRA continuation coverage it is important to remember that you may have to pay premiums for the entire maximum continuation period

(referred to as "exhausting COBRA") to have a special enrollment right under any new group health plan or to be eligible to purchase an individual insurance policy.

Does HIPAA extend COBRA continuation coverage?

Generally no. However, HIPAA makes two changes to the length of the COBRA continuation coverage period.

Effective January 1, 1997, qualified beneficiaries who are determined to be disabled under the Social Security Act within the first 60 days of COBRA continuation coverage will be able to purchase an additional 11 months of coverage beyond the usual 18-month coverage period. This is a change from the old law which required that a qualified beneficiary be determined to be disabled at the time of the qualifying event to receive 29 months of COBRA continuation coverage.

This extension of coverage is also available to nondisabled family members who are entitled to COBRA continuation coverage.

COBRA rules are also modified and clarified to ensure that children who are born or adopted during the continuation coverage period are treated as "qualified beneficiaries." A model notice discussing these changes appears at the end of this publication.

If coverage under my health plan is provided through an HMO or an insurance policy of an insurance company licensed in my state, are there any state offices that I can contact if I have questions about my plan's insurance policy?

Yes. The state Insurance Commissioner's office can assist you in matters involving a group or individual health insurance policy offered by an insurance company licensed in your state. In most states, this includes managed care coverage offered by HMOs.

Additional Information for Group Health Plans and Issuers

I am an employer who provides group health insurance coverage through an issuer. Is this policy renewable? Can it be terminated?

At your option (as the plan sponsor), the issuer offering your group health insurance coverage must renew or continue in force your current coverage.

However, the group health insurance coverage may not be renewed or may be discontinued because of nonpayment of premiums, fraud, violation of participation or contribution rules, the issuer ceasing to offer that particular

coverage, or movement outside the service area or association membership cessation.

I have a small business and I sponsor a group health plan. Does HIPAA apply to me?

The HIPAA health portability provisions apply to group health plans with two or more participants who are current employees. However, your state may elect to regulate smaller groups.

Does HIPAA apply to self-insured group health plans?

Yes.

Disclosure Requirements

What new kinds of information do group health plans have to give to participants and beneficiaries?

HIPAA and other recent legislation made important changes in ERISA's disclosure requirements for group health plans. The Department of Labor issued interim disclosure rules in April 1997 to implement those changes. Under the new interim disclosure rules, group health plans must improve their summary plan descriptions (SPDs) and summaries of material modifications (SMMs) in four major ways to make sure they:

- notify participants and beneficiaries of "material reductions in covered services or benefits" (for example, reductions in benefits and increases in deductibles and co-payments) generally within 60 days of adoption of the change. This compares to current requirements under which plan changes can be disclosed as late as 210 days after the end of the plan year in which a change was adopted.
- disclose to participants and beneficiaries information about the role of issuers (e.g., insurance companies and HMOs) with respect to their group health plan. In particular, the name and address of the issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer and the nature of any administrative services (e.g., payment of claims) provided by the issuer.
- tell participants and beneficiaries which Department of Labor office they can contact for assistance or information on their rights under ERISA and HIPAA.
- tell participants and beneficiaries that federal law generally prohibits the plan and health insurance issuers from limiting

hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections.

What is the definition of a "material reduction in covered services or benefits" that is subject to the new 60-day notice requirement?

Under the interim disclosure rules, a "material reduction in covered services or benefits" means any modification to a group health plan or change in the information required to be included in the summary plan description that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average plan participant to be an important reduction in covered services or benefits under the group health plan.

The interim rules cite examples of "reductions in covered services or benefits" as generally including any plan modification or change that:

- eliminates benefits payable under the plan;
- reduces benefits payable under the plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations;
- increases deductibles, co-payments or other amounts to be paid by a participant or beneficiary;
- reduces the service area covered by a health maintenance organization; or
- establishes new conditions or requirements (*e.g.*, preauthorization requirements) to obtain services or benefits under the plan.

Can employers use e-mail systems to communicate these new disclosures to employees, and if so, do employees have a right to get a paper copy of the information from their plan?

Yes. The interim disclosure rules provide a "safe harbor" for using electronic media (*e.g.*, e-mail) to furnish group health plan SPDs, summaries of "material reductions in covered services or benefits" and other SMMs (summaries of plan modifications and SPD changes). To use the "safe harbor," among other requirements, employees must be able to effectively access at their worksite documents furnished in electronic form. Participants also continue to have a right to receive the disclosures in paper form on request and free of charge.

Although the interim rule is not the exclusive means by which electronic media can be used to lawfully communicate plan information, the HIPAA "safe harbor" is limited to group health plans. The Department of Labor is considering extending the rule to other plans, including pension plans, and to other plan disclosures, but is exploring whether special precautions are necessary to ensure

the confidentiality of electronically transmitted individual account or benefit-related information.

Implementation Timetable

When will the changes in HIPAA affect my health plan?

Most of HIPAA's requirements will not take effect until after June 30, 1997. Group health plans must comply with all nondiscrimination, preexisting condition and crediting of prior health coverage requirements at the beginning of the first plan year starting after June 30, 1997. For example, if your employer's plan starts a new plan year on January 1, HIPAA's provisions will apply beginning on January 1, 1998.

There is a special rule for group health plans maintained pursuant to collective bargaining agreements, ratified before August 21, 1996, that delays the effective date of HIPAA. HIPAA's provisions apply to these plans on the first day of the plan year beginning on or after either the date on which the last collective bargaining agreement ends or July 1, 1997, whichever comes later.

Are there any provisions that apply immediately?

Health insurance coverage without a significant break that you have after July 1, 1996, should count as "creditable coverage" and thus help reduce any preexisting condition exclusions after HIPAA's effective date either in your current plan or any new plan you join if you change jobs. If you need to, you may also present documents showing that you had creditable coverage before July 1, 1996.

Enforcement

Who will enforce HIPAA?

The Secretary of Labor enforces the health care portability requirements on group health plans under ERISA, including self-insured arrangements. In addition, participants and beneficiaries can file suit to enforce their rights under ERISA, as amended by HIPAA.

The Secretary of the Treasury enforces the health care portability requirements on group health plans, including self-insured arrangements. A taxpayer that fails to comply may be subject to an excise tax.

States also have enforcement responsibility for group and individual requirements imposed on health insurance issuers, including sanctions available under state law. If a state does not act in the areas of its responsibility, the Secretary of Health and Human Services may make a determination that the

state has failed "to substantially enforce" the law, assert federal authority to enforce, and can impose sanctions on insurers as specified in the statute, including civil money penalties.

Appendices

National PWBA Field Offices

Office of Enforcement
Room N-5702
200 Constitution Ave., N.W.
Washington, DC 20210
Phone: 202/219-8840

Division of Technical Assistance & Inquiries
Room N-5625
200 Constitution Ave., N.W.
Washington, DC 20210
Phone: 202/219-8776

State Insurance Commissioners

Alaska Division of Insurance
Department of Commerce & Economic
P.O. Box 110805
Juneau, AK 99811-0805
Phone: 907/465-2515

Alabama Department of Insurance
135 South Union St.
Montgomery, AL 36130
Phone: 334/269-3550

Arkansas Department of Insurance
1200 West 3rd St.
Little Rock, AK 72201-1904
Phone: 501/371-2600

Office of the Governor
American Samoa Government
Pago Pago, AS 96799
Phone: 011/684-633-4116

Arizona Department of Insurance
2910 North 44th St.

Suite 210
Phoenix, AZ 85018-7256
Phone: 602/912-8400

California Department of Insurance
300 Capitol Mall
Suite 1500
Sacramento, CA 95814
Phone: 916/492-3500

Colorado Division of Insurance
1560 Broadway
Suite 850
Denver, CO 89292
Phone: 303/894-7499

Connecticut Department of Insurance
P.O. Box 816
Hartford, CT 06142-0816
Phone: 860/297-3802

Insurance Administration District of Columbia Government
441 Fourth St., N.W.
8th Fl., North
Washington, DC 20001
Phone: 202/727-8000 x3018

Delaware Department of Insurance
Rodney Building
841 Silver Lake Blvd.
P.O. Box 7007
Dover, DE 19903
Phone: 302/739-4251

Florida Department of Insurance
State Capitol
Plaza Level Eleven
Tallahassee, FL 32399-0300
Phone: 904/922-3101

Georgia Department of Insurance
2 Martin L. King, Jr.
Dr. Floyd Memorial Bldg.
704 West Tower
Atlanta, GA 30334
Phone: 404/656-2056

Department of Revenue & Taxation Government of Guam
Mariner Ave.
Building 13-1, 2nd Fl.
Tiyán, Barrigada, Guam 96913
Phone: 011/671-475-1817

Hawaii Insurance Division
Department of Commerce & Consumer Affairs
250 S. King St.
5th Fl.
Honolulu, HI 96813
Phone: 808/586-2790

Iowa Division of Insurance
Lucas State Office Building
6th Fl.
Des Moines, IA 50319
Phone: 515/281-5705

Idaho Department of Insurance
700 West State St.
3rd Fl.
Boise, ID 83720-0043
Phone: 208/334-4250

Illinois Department of Insurance
320 West Washington St.
4th Fl.
Springfield, IL 62767
Phone: 217/785-0116

Indiana Department of Insurance
311 W. Washington St.
Suite 300
Indianapolis, IN 46204-2787
Phone: 317/232-2385

Kansas Department of Insurance
420 S.W. 9th St.
Topeka, KS 66612-1678
Phone: 913/296-7801

Kentucky Department of Insurance
P.O. Box 517
215 West Main St.

Frankfort, KY 40602-0517
Phone: 502/564-6027

Louisiana Department of Insurance
950 North 5th St.
Baton Rouge, LA 70804-9214
Phone: 504/342-5423

Commonwealth of Massachusetts
Division of Insurance
470 Atlantic Ave.
6th Fl. Boston, MA 02210-2223
Phone: 617/521-7794

Maryland Insurance Administration
501 St. Paul Pl.
Stanbalt Building
7th Fl. South
Baltimore, MD 21202-2272
Phone: 410/333-2521

Maine Bureau of Insurance
Department of Professional & Financial Reg.
State Office Building
Station 34
Augusta, ME 04333-0034
Phone: 207/624-8475

Michigan Insurance Bureau
Department of Commerce
611 W. Ottawa St.
2nd Fl.,
North Lansing, MI 48933-1020
Phone: 517/373-9273

Minnesota Department of Commerce
133 East 7th St.
St. Paul, MN 55101
Phone: 612/296-6848

Missouri Department of Insurance
301 West High St.
6 North
Jefferson City, MO 65102-0690
573/751-4126

Mississippi Department of Insurance
1804 Walter Sillers Building
Jackson, MS 39205
Phone: 601/359-3569

Montana Department of Insurance
126 North Sanders
270 Mitchell Building
Helena, MT 59601
Phone: 406/444-2040

North Carolina Dept. of Insurance
4140 Dobbs Building
P.O. Box 26387
Raleigh, NC 27611
Phone: 919/733-7349

North Dakota Department of Insurance
600 E. Blvd.
Bismarck, ND 58505-0320
Phone: 701/328-2440

Nebraska Department of Insurance
Terminal Building
941 'O' St.
Suite 400
Lincoln, NE 68508
Phone: 402/471-2201

New Hampshire Department of Insurance
169 Manchester St.
Concord, NH 03301
Phone: 603/271-2261

New Jersey Department of Insurance
20 West State St.
CN325
Trenton, NJ 08625
Phone: 609/292-5363

New Mexico Department of Insurance
P.O. Drawer 1269
Santa Fe, NM 87504-1269
Phone: 505/827-4601

Nevada Division of Insurance
1665 Hot Springs Rd.
Suite 152
Carson City, NV 89710
Phone: 702/687-4270

New York Department of Insurance
160 West Broadway
New York, NY 10013
Phone: 212/602-0429

Ohio Department of Insurance
2100 Stella Ct.
Columbus, OH 43215
Phone: 614/644-2658

Oklahoma Department of Insurance
3814 N. Santa Fe
Oklahoma City, OK 73118
Phone: 405/521-2686

Oregon Division of Insurance
Department of Consumer & Business Services
350 Winter St., N.E.
Room 200
Salem, OR 97310-0700
Phone: 503/378-4271

Pennsylvania Insurance Department
1326 Strawberry Sq.
13th Fl.
Harrisburg, PA 17120
Phone: 717/783-0442

Puerto Rico Department of Insurance
Cobian's Plaza Building
1607 Ponce de Leon Ave.
Santurce, PR 00909
Phone: 787/722-8686

Rhode Island Insurance Division
Department of Business Regulation
233 Richmond St.
Suite 233
Providence, RI 02903-4233
Phone: 401/277-2223

South Carolina Department of Insurance
1612 Marion St.
P.O. Box 100105
Columbia, SC 29202-3105
Phone: 803/737-6160

South Dakota Division of Insurance
Department of Commerce & Regulation
500 E. Capitol
Pierre, SD 57501-3940
Phone: 605/773-3563

Tennessee Department of Commerce & Insurance
Volunteer Plaza
500 James Robertson Pkwy.
Nashville, TN 37243-0565
Phone: 615/741-2241

Texas Department of Insurance
333 Guadalupe St.
P.O. Box 149104
Austin, TX 78714-9104
Phone: 512/463-6464

Utah Department of Insurance
3110 State Office Building
Salt Lake City, UT 84114-1201
Phone: 801/538-3800

Virginia Bureau of Insurance
State Corporation Commission
1300 East Main St.
Richmond, VA 23219
Phone: 804/371-9694

United States Virgin Islands
Division of Banking & Insurance
1131 King St. Christiansted
St. Croix, VI 00820
Phone: 809/773-6449

Vermont Division of Insurance
Department of Banking, Insurance & Securities
89 Main St. Drawer 20
Montpelier, VT 05620-3101
Phone: 802/828-3301

Washington Office of the Insurance
14th Ave. & Water Sts.
P.O. Box 40255
Olympia, WA 98504-0255
Phone: 360/753-7301

Office of the Commissioner of Insurance
State of Wisconsin
121 E. Wilson
Madison, WI 53707-7873
Phone: 608/266-0102

West Virginia Department of Insurance
P.O. Box 50540
Charleston, WV 25305-0540
Phone: 304/558-3354

Wyoming Department of Insurance
Herschler Building
122 West 25th St.
3rd East
Cheyenne, WY 82002-0440
Phone: 307/777-7401