The Federal Health Insurance Portability and Accountability Act (HIPAA) — Frequently Asked Questions

Important note: Requirements in the Health Insurance Portability and Accountability Act (HIPAA) *don't* apply to every employer or group health plan sponsor. Please contact your benefits office for information about your particular circumstances.

Also, the information in these "Frequently Asked Questions" should not be construed as legal advice on any specific facts or circumstances, and is not intended to replace the advice of independent legal counsel.

Q. What is HIPAA?
A. The Health Insurance Portability and Accountability Act (HIPAA) is federal law originally enacted in 1997. One of HIPAA's primary goals is to protect the health coverage of people who switch from one job to another or leave a job without taking another one. To achieve the goal of making health coverage more "portable," the law limits the use of preexisting condition exclusions, waiting periods and eligibility restrictions based on health status.

HIPAA doesn't require keeping the same health coverage when moving from one employer to another. Instead, under HIPAA's portability provisions, an individual can move more easily from one employer to another when changing jobs or moving into or out of the workforce.

Q. I've heard that HIPAA changed recently. How?
A. In December 2004, the federal government published HIPAA's final regulations. These regulations clarified employee rights and increased group health plan responsibilities. The information below is based on HIPAA's final regulations.

Q. One of my family members has been ill. Will this affect enrollment in my employer's group health plan?
A. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Q. What is a preexisting condition exclusion? Can my employer's group health plan impose one?
A. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." HIPAA allows group health plans to impose preexisting condition exclusions within the limits explained below.

Q. Will a preexisting condition exclusion apply to every health condition?
A. A preexisting condition can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six months before your "enrollment date." Also, a preexisting condition exclusion can't apply to pregnancy and can't apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

Q. What is my enrollment date?
A. Your enrollment date is your first day of coverage under the group health plan, or, if there is a waiting period, the first day of your waiting period. A waiting period is the time period that must pass before an employee or

dependent is eligible to enroll under the terms of a group health plan. Typically, a waiting period begins on your first day of work.

Q. How long can a preexisting condition exclusion period last?
A. A preexisting condition exclusion can't last for more than 12 months after your enrollment date. However, a preexisting exclusion period can last up to 18 months for a late enrollee. A late enrollee is an individual who 1) didn't enroll when first eligible, and 2) hasn't become entitled to enroll because of a "special enrollment event," which is explained below.

Q. What's "creditable coverage" and how can it reduce a preexisting exclusion period?
A. If a group health plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps.

You can add up any creditable coverage you have. However, if at any time you went for 63 calendar days or more without any coverage (called a break in coverage) a group health plan may not have to count the coverage you had before the break. Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break.

Q. How can I prove I have creditable coverage?
A. After your coverage ends, the plan must give you a **certificate of creditable coverage (COCC)**, which includes the beginning and ending dates of your health plan coverage. You may use this COCC as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan. If you do not receive a COCC for past coverage, talk to your new plan administrator.

Q. When should I receive a COCC?
R. An employee or dependent enrolled in the health plan should receive a COCC
   1) When the individual loses coverage under the group health plan or when the individual becomes covered under COBRA.
   2) If an individual has COBRA continuation coverage, when COBRA ends.
   3) On request, while covered or within 24 months after coverage ends.

Q. If I lose my group health plan coverage, can I enroll in other coverage, for example the coverage provided by my spouse's employer?
A. Under HIPAA, if you lose your group health plan coverage, you may request "**special enrollment**" in another plan for which you are eligible, such as a spouse's plan, even if the plan generally does not accept late enrollees.

Q. How can I request a special enrollment?
A. You must request special enrollment with the other group health plan within 30 days of your loss of coverage. Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should *request special enrollment as soon as possible.*

Q. My employer stopped providing health plan coverage. Would this entitle me to a special enrollment opportunity?
A. Various events that cause loss of group health plan coverage give individuals HIPAA special enrollment opportunities. These include, but aren't limited to
   - eligibility status changes such as divorce, legal separation, death and loss of dependent status
   - termination of employment

- reduction in hours of employment
- losing HMO coverage due to moving out of the HMO 's service area
- plan ceases to offer coverage to similarly situated individuals (e.g., if a plan terminated health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees)
- reaching a lifetime maximum on all benefits (i.e. when an individual has a claim denied due to reaching the lifetime limit on all benefits under a plan).

Q. Does HIPAA give me rights to individual health coverage?

A. Under HIPAA, an "eligible individual," has the right to buy certain individual health policies without a preexisting condition exclusion. In Texas, this coverage is offered through a high risk pool.

To be an eligible individual, you must meet the following requirements;

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by a COCC);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job. Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break. States may require insurers and HMOs to provide additional protections to individuals in that state.

Q. Where can I find more information about my rights under HIPAA?

A. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws.) You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at http://www.dol.gov/ebsa, the DOL's interactive web pages – Health Elaws, or http://www.cms.hhs.gov/hipaa/.