The Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA), signed into law on August 21, 1996, offers new protections for millions of American workers that improve portability and continuity of health insurance coverage.

HIPAA Protects Workers and Their Families By

- Limiting exclusions for preexisting medical conditions (known as preexisting conditions)
- Providing credit against maximum preexisting condition exclusion periods for prior health coverage and a process for providing certificates showing periods of prior coverage to a new group health plan or health insurance issuer
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married or add a new dependent
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors
- Guaranteeing availability of health insurance coverage for small employers and renewability of health insurance coverage for both small and large employers
- Preserving the states' role in regulating health insurance, including the states' authority to provide greater protections than those available under federal law
- Improving disclosure about group health plans

Effective Date

HIPAA is effective for all plans and issuers with respect to the certification requirements of HIPAA beginning June 1, 1997. However, the other HIPAA provisions are generally effective for plan years beginning after June 30, 1997.

Preexisting Condition Exclusions

- The law defines a preexisting condition as one for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period prior to an individual's enrollment date (which is the earlier of the first day of health coverage or the first day of any waiting period for coverage)
- Group health plans and issuers may not exclude an individual's preexisting medical condition from coverage for more than 12 months (18 months for late enrollees) after an individual's enrollment date
- Under HIPAA, a new employer's plan must give individuals credit for the length of time they had prior continuous health coverage, without a break in

coverage of 63 days or more, thereby reducing or eliminating the 12-month exclusion period (18 months for late enrollees)

Creditable Coverage

- Includes prior coverage under another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state health benefits risk pool, FEHBP, the Peace Corps Act, or a public health plan

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Certificates of Creditable Coverage

- Certificates of creditable coverage must be provided automatically and free of charge by the plan or issuer when an individual loses coverage under the plan, becomes entitled to elect COBRA continuation coverage or exhausts COBRA continuation coverage. A certificate must also be provided free of charge upon request while you have health coverage or anytime within 24 months after your coverage ends
- Certificates of creditable coverage should contain information about the length of time you or your dependents had coverage as well as the length of any waiting period for coverage that applied to you or your dependents
- If a certificate is not received, or the information on the certificate is wrong, you should contact your prior plan or issuer. You have a right to show prior creditable coverage with other evidence — like pay stubs, explanation of benefits, letters from a doctor — if you cannot get a certificate

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Special Enrollment Rights

- Are provided for individuals who lose their coverage in certain situations, including on separation, divorce, death, termination of employment and reduction in hours. Special enrollment rights also are provided if employer contributions toward the other coverage terminates
- Are provided for employees, their spouses and new dependents upon marriage, birth, adoption or placement for adoption

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Discrimination Prohibitions

- Ensure that individuals are not excluded from coverage, or charged more

for coverage offered by a plan or issuer, based on health status-related factors

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Disclosure Requirements

Plans are required to:

- Furnish a summary of any “material reduction in covered services or benefits” generally within 60 days after the change has been adopted by the plan
- If an insurance company is used by the plan, list in the SPD the name and address of the insurer, the services it provides, and an explanation of whether benefits under the plan are guaranteed under an insurance contract or policy
- Include in their SPD information about where participants and beneficiaries can get assistance or information from the Department of Labor about their rights under ERISA, including rights under HIPAA
- The disclosure rules also provide guidance on the use of electronic media (e.g., email) to furnish covered workers with required group health plan disclosures

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