

Summary of HIPAA & Pre-Existing Conditions

1 What is HIPAA?

The *Health Insurance Portability and Accountability Act of 1996* was signed into law on August 21, 1996. This law includes important new protections for millions of working Americans and their families who have pre-existing medical conditions or who might suffer discrimination in health coverage based on a factor that relates to the individual's health.

HIPAA includes provisions that—

- Limit exclusions for pre-existing conditions
- Prohibit discrimination based on health factor
- Guarantee renewal and availability of health coverage to certain employees and individuals

2 What are the Pre-Existing Exclusion rules?

A group plan or a health insurance issuer offering group health coverage may impose a pre-existing condition exclusion only if the following conditions are satisfied:

The 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 the enrollment

The exclusion may not last more than 12 months (18 months for late enrollees) from the enrollment date.

Note These exclusions are based on Federal law. Each state may be more generous or less restrictive. For example, for NJ Small group, the limitation is only 6 months and the penalty for a late enrollee is that pre-existing applies.

The 12- or 18-month period must be reduced by the number of days of prior creditable coverage, excluding coverage before any break of 63 days or more.

Note The break for NJ Small Group is 90 days.

3 What is meant by "Creditable Coverage"?

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

Certain types of coverage offered through schools are not creditable. You may want to confirm with the insurance carrier.

Note Effective July 1, 2005, previous coverage from socialized medicine from a foreign country is also creditable.

Days in a waiting period are not creditable; however, they are NOT counted against the member in determining a significant break (63 days or more).

4 Are there pre-existing conditions that *cannot* be excluded from coverage?

Yes. An exclusion can never apply to **pregnancy**, regardless of whether the woman had previous coverage (or the size of the group plan).

In addition, a pre-existing condition exclusion cannot apply to a **newborn or child placed in the home for adoption** under age 18 as long as the child became covered within 30 days of birth or placement for adoption, and provided the child does not incur a subsequent 63 day or longer break in coverage.



Note States may vary in the number of days a break in coverage is permitted before the exclusion applies.

5 How does a member prove prior creditable coverage to the new carrier?

Group health plans and health insurance issuers are required to furnish a Certificate of Creditable Coverage (COCC). The certificate must be provided automatically when coverage is lost as well as when COBRA continuation ceases.

A member may also request a certificate, free of charge, until 24 months after the time coverage ends. (A certificate may also be requested even before coverage ends.)

Note The sample COCC is the new 2005 Federal version. Certain states are less restrictive in the number of days considered a "break in coverage."

6 Is a "significant break" in coverage affected by a waiting period that may exist with a new employer?

No. Any waiting period imposed by the employer plan does not count towards the "significant break."

7 What changes were made to Portability of coverage July 1, 2005?

Socialized medicine from foreign countries will count as creditable coverage in the satisfaction of any pre-existing exclusion. Note that time served is credited, not waived.

8 What exactly does "guaranteed renewability" mean in the HIPAA?

The guaranteed renewability requirements apply to employers whose size shifts between small and large group markets after purchasing coverage in one or the other of these markets. Insurance issuers (carriers) must renew plans at the option of the plan sponsor (employer). Generally this means that the employer must remain in exactly the same plan as originally purchased.

An issuer may non-renew only for the following reasons—

- The employer fails to pay premium timely
- There are no longer any plan enrollees living, residing or working in the service area of a plan with a network requirement
- The issuer is ceasing to offer coverage in a market

9 What are the rules with regard to Privacy?

Under the Privacy Rule members and patients must give specific authorization before entities can use or disclose information. It is designed to restrict use and disclosure of health related information to appropriate purposes and to ensure it is not used against individuals in connection with their employment. Privacy relates to Protected Health Information (PHI) which is any information which is individually identifiable and is transmitted in any form.

Covered entities are required to use, disclose and request only the minimum necessary PHI to accomplish the purpose of the request. This concept is called "minimum necessary" under the Privacy Rule.

10 Where can I obtain more information on the HIPAA?

Log onto www.hhs.gov/ocr/hipaa.

Log onto www.hhs.gov/ocr/hipaa/privrulet.txt.

Call **866-627-7748** for privacy information.