

ALL ABOUT HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides rights and protections for participants and beneficiaries in group health plans. HIPAA includes protections for coverage under group health plans that limit exclusions for preexisting conditions; prohibit discrimination against employees and dependents based on their health status; and allow a special opportunity to enroll in a new plan to individuals in certain circumstances.

HIPAA provisions are imposed upon group health plans and issuers. Eligibility for an individual's enrollment in a group health plan is determined according to the terms of the health plan and the rules of the issuer, but not according to an individual's health status or that of an individual's dependent. These rules and terms must comply with all applicable State laws.

HIPAA Administrative Simplification Compliance Deadlines

Date	Deadline
April 20, 2005	Security Standards - all covered entities except small health plans.
August 1, 2005	Employer Identifier Standard - small health plans.
April 20, 2006	Security Standards – small health plans.
May 23, 2007	National Provider Identifier - all covered entities except small health plans
May 23, 2008	National Provider Identifier - small health plans

Portability

"Portability" in HIPAA means that once an individual has health coverage, this coverage may be used to reduce or eliminate any pre-existing condition exclusion that might be applied to an individual who moves to another employer's group health plan.

The concept of portability is really one of an individual receiving credit for maintaining health coverage, even though it may be under different health plans or policies.

Portability does not mean that individuals can carry current health benefits or their current plan or policy with them when moving from one health plan or policy to another (such as when changing or losing jobs).

Pre-Existing Condition

A "pre-existing condition exclusion" is a limitation or exclusion of health benefits based on the fact that a physical or mental condition was present before the first day of coverage. However, HIPAA limits the extent to which a plan or issuer can apply a preexisting condition exclusion.

A pre-existing condition exclusion is limited to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date in a plan or policy.

During the pre-existing condition exclusion period, the plan or issuer may opt not to cover or pay for treatment of a medical condition based on the fact that the condition was present prior to an individual's enrollment date under the new plan or policy. (The plan or issuer must, however, pay for any unrelated covered services or conditions that arise once coverage has begun.) The enrollment date is the first day of coverage, or if there is a waiting period before coverage takes effect, the first day of the waiting period.

A group health plan can apply a pre-existing condition exclusion for no more than 12 months (18 months for a late enrollee) after an individual's enrollment date. Any pre-existing condition exclusion must be reduced by an individual's prior creditable coverage. No pre-existing condition may be applied to an individual who maintains continuous creditable coverage (without a break of 63 or more days) for 12 months (18 months for a late enrollee).

Creditable Coverage

The concept of creditable coverage is that an individual should be given credit for previous health coverage against the application of a pre-existing condition exclusion period when moving from one group health plan to another, from a group health plan to an individual policy, or from an individual policy to a group health plan.

Individual will receive credit for previous coverage that occurred without a break of 63 days or more. However, any coverage occurring prior to a break in coverage of 63 days or more would not have to be credited against a preexisting condition exclusion period. (However, some States' laws may provide greater protections.) *For example, John Doe had coverage for two years followed by a break in coverage for 70 days, and then resumed coverage for eight months. He would receive credit against any preexisting condition exclusion only for eight months of coverage; no credit would have to be given for the two years of coverage prior to the break of 63 days or more.*

Most health coverage is creditable coverage, including prior coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual), Medicare, Medicaid, a military-sponsored health care program such as CHAMPUS, a program of the Indian Health Service, a State high risk pool, the Federal Employees Health Benefit Program, a public health plan established or maintained by a State or local government, and a health benefit plan provided for Peace Corps members. An A "Certificate of Creditable Coverage" is a written document specifying the period of an employee's creditable coverage. In certain circumstances, the certification information may be provided by telephone if that is acceptable to the new plan or issuer, the individual, and the source of prior coverage.

For example, Jane Doe gets a new job a week after quitting her old job. Her previous health plan has not yet issued a Certificate of Creditable Coverage and her new plan wonders if it's OK to call and verify her creditable coverage in order to speed up the paperwork. This is fine with Doe and the previous plan, which has the capability of providing the necessary information over the telephone.

All employees must be given a Certificate of Creditable Coverage by you, if you are self insured, or through the issuer offering health coverage.

A Certificate of Creditable Coverage must be provided without charge and generally within a reasonable time period.

Automatic Certificates:

The certificate must be furnished automatically to an:

- Individual whose group coverage has ended, such as when they leave or quit a job. The certificate then must be provided within a reasonable length of time.
- Individual who loses health coverage and who is not entitled to elect COBRA continuation coverage. Then, the certificate must be provided within a reasonable time after coverage ceases. (Typically, this would happen in small-employer plans that are not subject to COBRA.) The certificate must be provided no later than when a notice would be provided under an applicable State program that is similar to COBRA. A certificate also must be provided promptly in States that do not have such a law.
- Individual who is qualified for COBRA and has elected COBRA continuation coverage or after the expiration of any grace period for the payment of COBRA premiums.

Certificates on request:

- Employees and their dependents also can ask for a certificate, which can be done any time within the 24 months following loss of coverage. The plan or issuer must provide certificates at the earliest feasible time after they are requested.

HIPAA Privacy

The privacy provisions of HIPAA apply to health information created or maintained by health care providers who engage in certain electronic transactions, health plans, and health care clearinghouses.

The Department of Health and Human Services (HHS) has issued the regulation, "**Standards for Privacy of Individually Identifiable Health Information**," applicable to entities covered by HIPAA. The Office for Civil Rights (OCR) is the Departmental component responsible for implementing and enforcing the privacy regulation. (See the [Statement of Delegation of Authority](#) to the Office for Civil Rights, as published in the Federal Register on December 28, 2000.)

The privacy standards contain three basic sections:

1. Restriction on the use and disclosure of certain health information;
2. Establishment of individual rights regarding health information; and
3. Establishment of administrative requirements to ensure confidentiality and appropriate use of health information.

Information protected by the [HIPAA privacy regulations](#) is called "**Personal Health Information**" or PHI. The privacy standards apply to any information--whether paper or electronic--that describes an individual's health status, or other characteristics that identify, or could be used to identify, that individual. This information includes not only the patient's name and address and specific treatment information, but also sex, ethnicity, and age.

The Privacy Rule establishes a federal requirement that most doctors, hospitals, or other health care providers obtain a patient's written consent before using or disclosing the patient's personal health information to carry out Treatment, Payment, or health care Operations (TPO).

Today, many health care providers, for professional or ethical reasons, routinely obtain a patient's consent for disclosure of information to insurance companies or for other purposes. The Privacy Rule builds on these practices by establishing a uniform standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out TPO.