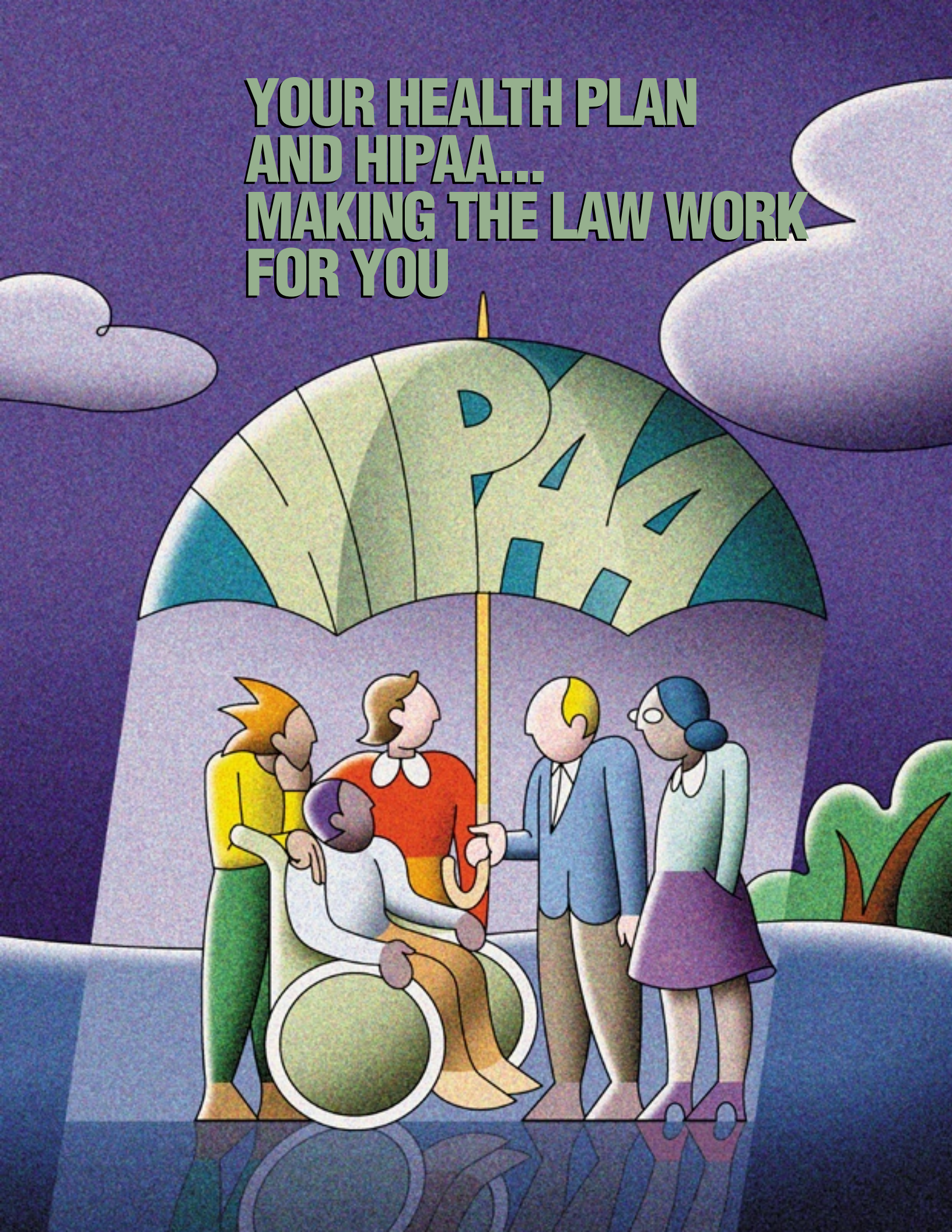
YOUR HEALTH PLAN AND HIPAA... MAKING THE LAW WORK FOR YOU



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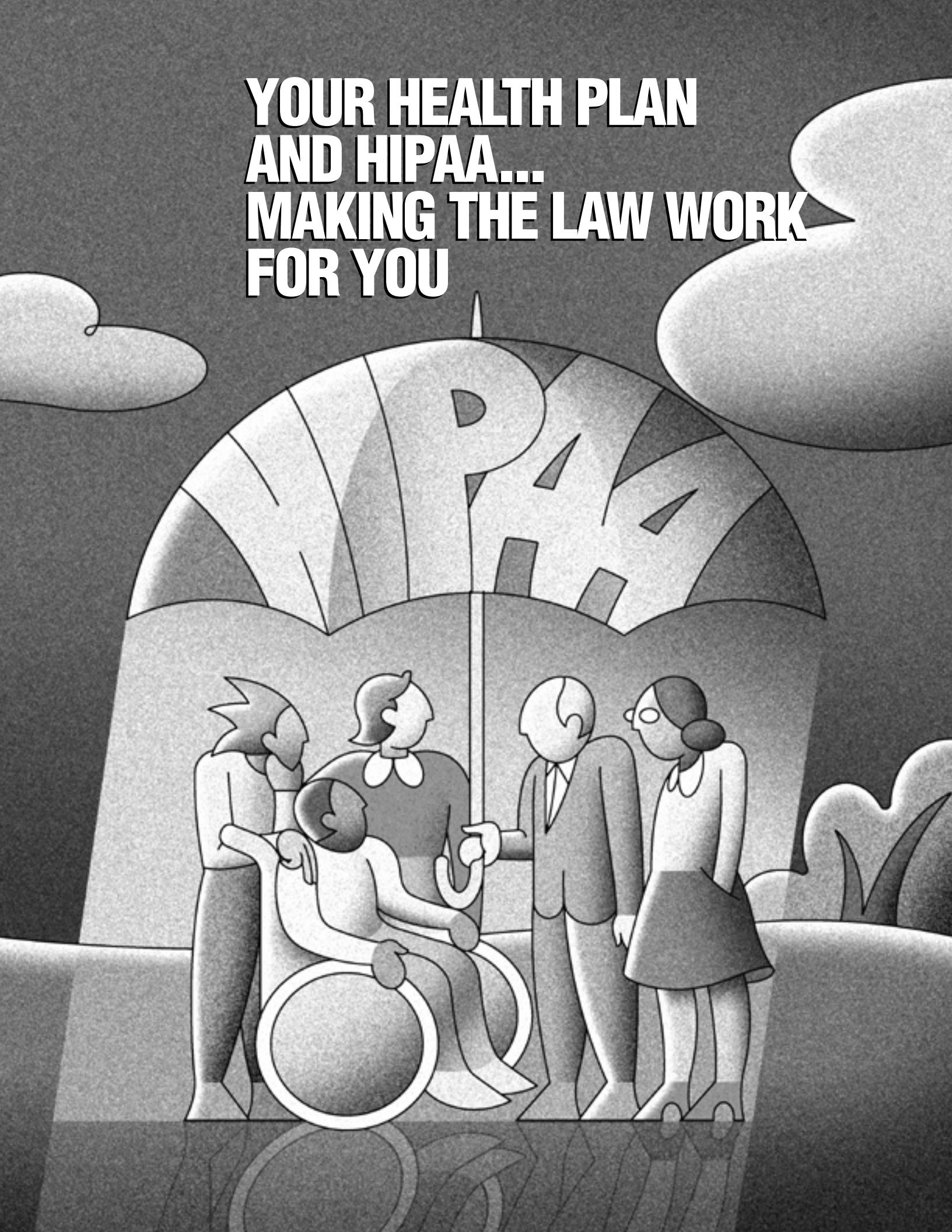
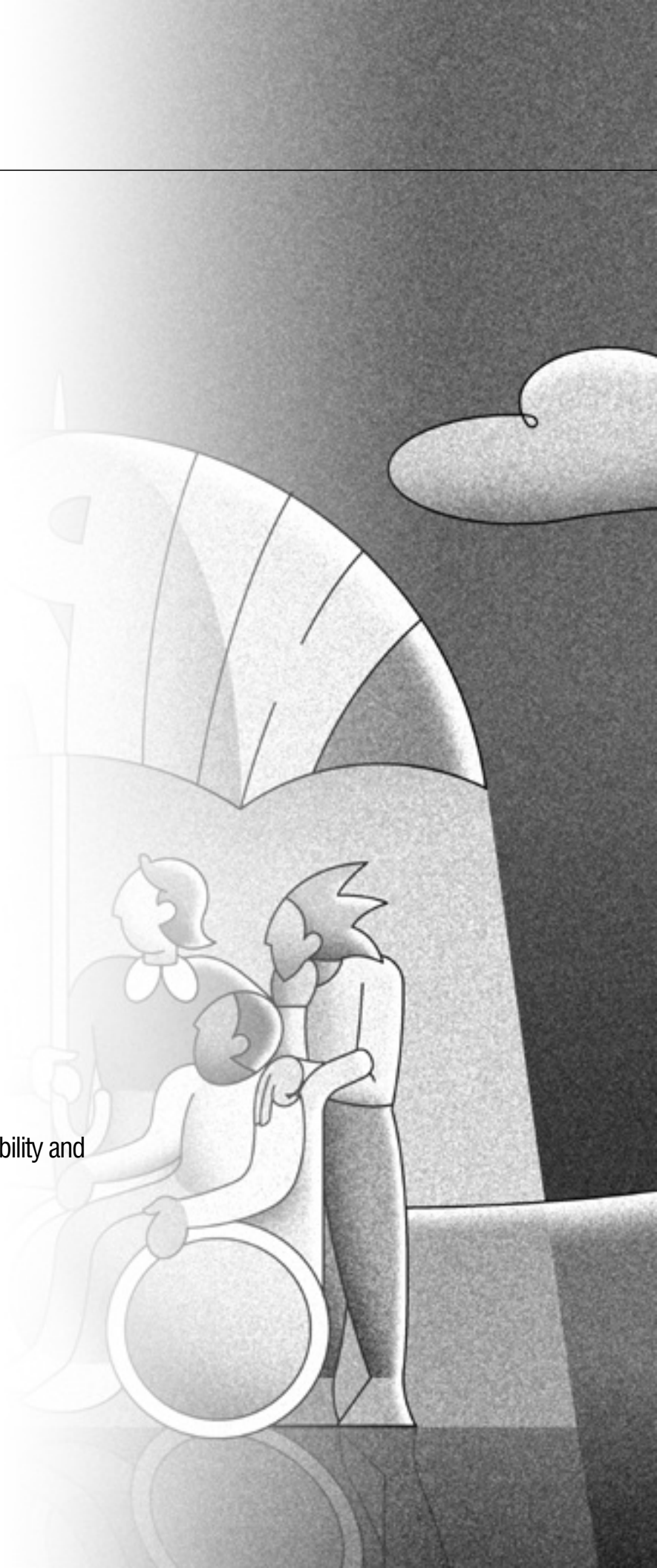




HIPAA is the Health Insurance Portability and Accountability Act of 1996

TABLE OF CONTENTS

INTRODUCTION 2

CHAPTER 1
PREEXISTING CONDITIONS, JOB CHANGES, AND GENERAL PROTECTIONS 4

CHAPTER 2
USING PRIOR HEALTH COVERAGE TO REDUCE THE LENGTH OF ANY PREEXISTING CONDITION EXCLUSION PERIOD 7

CHAPTER 3
GETTING AND USING A CERTIFICATE TO SHOW PRIOR HEALTH PLAN COVERAGE 10

CHAPTER 4
TAKING ADVANTAGE OF SPECIAL ENROLLMENT OPPORTUNITIES 13

CHAPTER 5
HIPAA'S PROTECTIONS FROM DISCRIMINATION 16

CHAPTER 6
MORE COVERAGE UNDER HIPAA'S UMBRELLA 20

RESOURCES 24

GLOSSARY 26

INTRODUCTION

Perhaps you have heard of HIPAA – the Health Insurance Portability and Accountability Act – during a visit to your doctor's office. The doctor's staff may have handed you a "HIPAA privacy notice" advising you of protections for your personal health information. But HIPAA covers a lot more than privacy.

For many people, health coverage is an important benefit of their jobs. At the time HIPAA was passed, a lot of people were afraid to switch jobs because they might lose the insurance coverage they needed for their families. This publication will explain how HIPAA's protections make it easier to change employers without losing health coverage for your (and your family's) medical conditions.

HIPAA's umbrella of protection:

—Limits the ability of a new employer plan to exclude coverage for preexisting conditions;

—Provides additional opportunities to enroll in a group health plan if you lose other coverage or experience certain life events;

—Prohibits discrimination against employees and their dependent family members based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information; and

—Guarantees that certain individuals will have access to, and can renew, individual health insurance policies.

HIPAA is complemented by state laws that, while similar to HIPAA, may offer more generous protections. You may want to contact your state insurance commissioner's office to ask about the law where you live. A good place to start is the Web site of the National Association of Insurance Commissioners at www.naic.org .

Before you read on, note that this booklet focuses on HIPAA's coverage as it applies to private-sector group health plans only. State and local government employees should contact the Centers for Medicare and Medicaid Services at the U.S. Department of Health and Human Services (www.cms.hhs.gov) about whether they have comparable protections.

Any terms that are highlighted like this in the text are explained in the Glossary.

YOUR HEALTH PLAN AND HIPAA ... MAKING THE LAW WORK FOR YOU does not cover HIPAA in its entirety; it is an informal explanation of the law and Federal regulations, not a legal interpretation. If you have additional questions, refer to the *Resources* section or contact the EBSA regional office nearest you. For a list of offices, visit the agency's Web site at www.dol.gov/ebsa or call 1-866-444-EBSA (3272) to be connected to a regional office.

CHAPTER 1
PREEXISTING CONDITIONS, JOB CHANGES, AND GENERAL PROTECTIONS

One of the most important protections under HIPAA is that it helps those with preexisting conditions get health coverage. In the past, some employers' group health plans limited, or even denied, coverage if a new employee had such a condition before enrolling in the plan. Under HIPAA, that is not allowed. If the plan generally provides coverage but denies benefits to you because you had a condition before your coverage began, then HIPAA applies.

Under HIPAA, a plan is allowed to look back only 6 months for a condition that was present before the start of coverage in a group health plan. Specifically, the law says that a preexisting condition exclusion can be imposed on a condition only if *medical advice, diagnosis, care, or treatment was recommended or received during the 6 months prior to your enrollment date in the plan.* As an example, you may have had arthritis for many years before you came to your current job. If you did not have medical advice, diagnosis, care, or treatment – recommended or received -- in the 6 months before you enrolled in the plan, then the prior condition cannot be subject to a preexisting condition exclusion. If you did receive medical advice, diagnosis, care, or treatment within the past 6 months, then the plan may impose a preexisting condition exclusion *for that condition (arthritis).*

In addition, HIPAA prohibits plans from applying a preexisting condition exclusion to pregnancy, genetic information, and certain children (see page 5).

If you have a preexisting condition that can be excluded from your plan coverage, then there is a limit to the preexisting condition exclusion period that can be applied. HIPAA limits the preexisting condition exclusion period for most people to 12 months (18 months if you enroll late), although some plans may have a shorter time period or none at all. In addition, some people with a history of prior health coverage will be able to reduce the exclusion period even further using creditable coverage. (Read Chapter 2 to learn more.) Remember, a preexisting condition exclusion relates only to benefits for your (and your family's) preexisting conditions. If you enroll, you will receive coverage for the plan's other benefits during that time.

Although HIPAA adds protections and makes it easier to switch jobs without fear of losing health coverage for a preexisting condition, the law has limitations. For instance, HIPAA:

—Does not require that employers offer health coverage;

—Does not guarantee that any conditions you now have (or have had in the past) are covered by your new employer's health plan; and

—Does not prohibit an employer from imposing a preexisting condition exclusion period if you have been treated for a condition during the past 6 months. (But see Chapter 2 on creditable coverage to reduce or eliminate the exclusion.)

Typical Questions about Preexisting Conditions and HIPAA:

Q Can a plan deny benefits for chronic illnesses or injuries, like carpal tunnel syndrome, diabetes, heart disease, and cancer using a preexisting condition exclusion?

A It depends on whether you received medical advice, care, diagnosis, or treatment within the 6 months prior to enrolling in a new employer's plan. If you did, you can be subject to a preexisting condition exclusion.

Q Are there illnesses or injuries that cannot be subject to a preexisting condition exclusion?

A Yes, as follows:

—Pregnancy, even if the woman had no prior coverage before enrolling in her current employer's plan.

—Conditions present in a newborn or a child under 18 who is adopted or placed for adoption (even if the adoption is not yet final), as long as the child is enrolled in health coverage *within 30 days of birth, adoption, or placement for adoption.* In addition, the child must not have a subsequent, significant break in coverage (defined as 63 days). For instance, a significant break might occur if a parent lost his job and health coverage for himself and his family shortly after a child's birth. This break will be discussed in the next chapter.

—Genetic information. For example, if a woman is found to have a gene indicating she is at a higher risk for breast cancer, she cannot be denied coverage if there is no diagnosis of the disease.

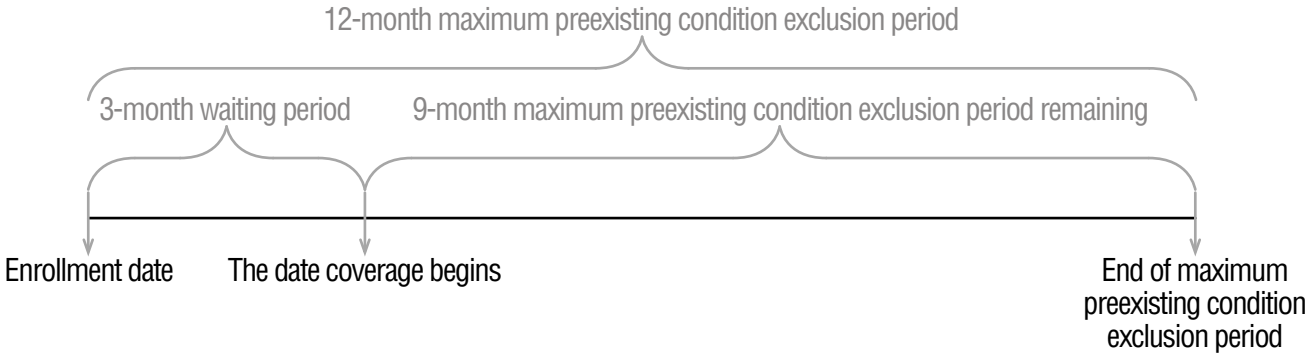
Q I just changed jobs. Seven months ago, I received my last treatment for carpal tunnel syndrome. Can my new employer's plan apply a preexisting condition exclusion?

A No. If your last treatment was more than 6 months before enrollment in your new employer's health plan and you have had no other advice or care relating to your carpal tunnel syndrome in the last 6 months, your condition cannot be subject to a preexisting condition exclusion.

Q My new employer has a waiting period before any new hire can enroll in the group health plan. How does this relate to a preexisting condition exclusion period?

A An employer's health plan may indeed have a waiting period before any employee and his/her dependent family members can enroll. If that is the case, the plan booklet (called a summary plan description (SPD)) will say so.

If a plan has a general waiting period and a preexisting condition exclusion period, both time periods must run concurrently. For example, an employer may impose a 3-month waiting period for all employees to begin health coverage. Some employees



may also be subject to the maximum preexisting condition exclusion period of 12 months. In this example, the maximum preexisting condition exclusion period remaining is 9 months long, as illustrated above.

Be aware that your plan may not have a preexisting condition exclusion period, so be sure you know your new company's policy when you enroll.

Q What happens if I don't enroll in my employer's health plan at the first chance?

A If, for some reason, you did not enroll in your new employer's health plan at the first opportunity but do so at a later time, you are a late enrollee. For example, assume an employee declines coverage in his employer's health plan when he starts his new job. This employee decides to enroll 2 years later during an open enrollment period. At the time the employee wishes to enroll, there is no special enrollment opportunity (the right to enroll regardless of regular enrollment dates. See Chapter 4 for when this right arises.) When the employee elects coverage, he is a late enrollee.

Being a late enrollee will not cause you to lose HIPAA's protections. One immediate consequence, however, is that the maximum preexisting condition exclusion period is 18 months, rather than the 12 months for those who enroll at the first chance.

Q Are all family members, including a spouse, covered by HIPAA?

A If your group health plan permits coverage of family members ("dependents"), and if they participate in the plan, then they will have the same HIPAA protections as employees, described above.

Q Are there protections on discrimination in pricing if I have a preexisting condition?

A Yes. Protections against discrimination will be discussed in Chapter 5.

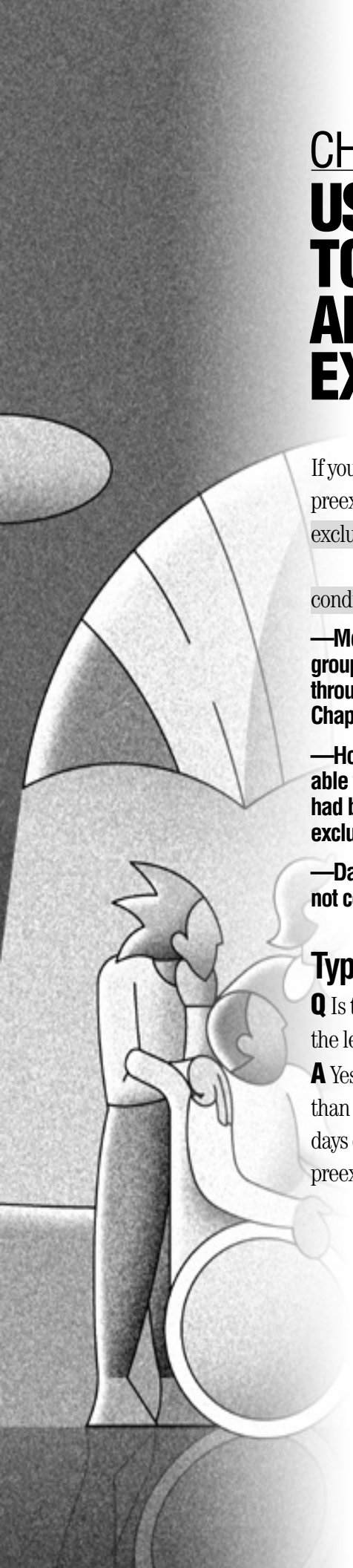
TIPS

—Even if your plan applies a preexisting condition exclusion, you are still covered for the plan's other benefits – as long as you enroll.

—If you have a baby or adopt a child, enroll the child in health coverage *within 30 days.*

—Remember, a new health plan can look back 6 months when reviewing for a preexisting condition, and the maximum amount of time of a preexisting condition exclusion period is usually 12 months (18 months for late enrollees).

—If you have a preexisting condition, try to avoid a 63-day significant break in coverage. If you can do so, you may be able to reduce the amount of time of a preexisting condition exclusion in a new employer's plan. (Read Chapter 2 to learn more about reducing a preexisting condition exclusion with creditable coverage.)



CHAPTER 2

USING PRIOR HEALTH COVERAGE TO REDUCE THE LENGTH OF ANY PREEXISTING CONDITION EXCLUSION PERIOD

If you change jobs or begin new health coverage, and you or a dependent family member have a preexisting condition, Chapter 1 discussed how HIPAA limits the maximum preexisting condition exclusion to 12 months (18 months if you are a late enrollee).

This chapter covers how an individual can reduce or eliminate this maximum preexisting condition exclusion period if she can show creditable coverage.

—Most health coverage can be used as creditable coverage, including participation in a group health plan, COBRA continuation coverage, Medicare and Medicaid, as well as coverage through an individual health insurance policy. (Read more about COBRA and HIPAA in Chapter 6.)

—However, you should try to avoid a significant break in coverage (63 days) if you want to be able to count your previous coverage. If you have a break shorter than 63 days, coverage you had before that break is creditable coverage and can be used to offset a preexisting condition exclusion period.

—Days spent in a waiting period for coverage cannot be used as credit. But, they also are not counted toward the significant break (63 days) you are trying to avoid.

Typical Questions about Creditable Coverage:

Q Is there a limit to the period of time I can go without coverage between jobs if I want to reduce the length of a preexisting condition exclusion?

A Yes. The break in coverage between one period of health coverage and another can be no longer than 63 days (just over 2 months). If you are between jobs and do not have health coverage for 63 days or more, then you may lose the ability to use the coverage you had before the break to offset a preexisting condition exclusion period in a new health plan.

Q I began working for a new employer 45 days after my prior group health plan was terminated. I had continuous coverage in my former employer's plan for 24 months with no other coverage between jobs. Can I be subject to a preexisting condition exclusion period?

A No, not if you enroll when you are first eligible. Those 45 days do not count as a significant break in coverage. Also, since you have more than 12 months of continuous coverage in a prior health plan, it can be used to fully offset and eliminate the maximum preexisting condition exclusion period under a new plan.

Q I have a preexisting condition. I began employment at my current job 100 days after I resigned from my previous job. I had continual coverage in my previous employer's health plan for 36 months but none between jobs. Can I be excluded from coverage?

A Possibly. Remember that under HIPAA, health coverage prior to a significant break cannot be used to offset a preexisting condition exclusion period. However, your state law may be more generous if you have coverage with an insured plan. If your state lengthened the significant break from 63 days to, for instance, 120 days, then you can use your prior coverage from a previous job as creditable coverage. Check your plan's summary plan description (SPD) to see if your plan is insured. If it is, check with your state insurance commissioner's office at www.naic.org to see what your state law provides.

Q How do I calculate the length of a preexisting condition exclusion in a new employer's health plan?

A Suppose an employee had coverage for 2 years, followed by a break of 70 days. The employee then resumes coverage for 8 months before moving to a new job, with no time off between jobs. He enrolls in the health plan at the new job as soon as possible.

A preexisting condition exclusion can last 12 months at most, if the person enrolls when first eligible. This employee has 8 months of creditable coverage. His earlier 2 years of health coverage are not creditable because he had a break in coverage that was more than the 63 days allowed under the law. His preexisting condition exclusion will last 4 months after he enrolls in the employer's health plan.

If the same employee had a break in coverage of only 60 days, his story would be different. This would not be a significant break and he could use the earlier 2 years of coverage to completely offset the preexisting condition exclusion period.

Q How do I avoid a 63-day significant break in health coverage?

A There are several ways:

—If a spouse has coverage in a health plan that allows family members to join, you may want to enroll. (For a discussion of special enrollment, see Chapter 4.)

—If your last coverage was in a group health plan, you may want to sign up for COBRA continuation coverage. While you (and your family members, if they were also part of your prior plan) will have to pay for this temporary coverage, COBRA can prevent or reduce a break in coverage. (Learn more about COBRA in Chapter 6.)

—You can buy an individual health insurance policy if you think you would otherwise have a break of 63 days or more.

—Some states have high-risk pools for people who cannot otherwise get health benefits. Your state insurance commissioner's office can tell you if such a pool exists where you live.

Q Is there anything I can do if I have a preexisting condition and the credit I received from my last health plan does not cover my new employer's preexisting condition exclusion period?

A Yes. You can look into:

—Electing COBRA coverage from your former employer's plan;

—Buying an individual health insurance policy; or

—Checking with another plan you're eligible for, such as a spouse's plan, to see if you can enroll.

Q How do I prove my creditable coverage?

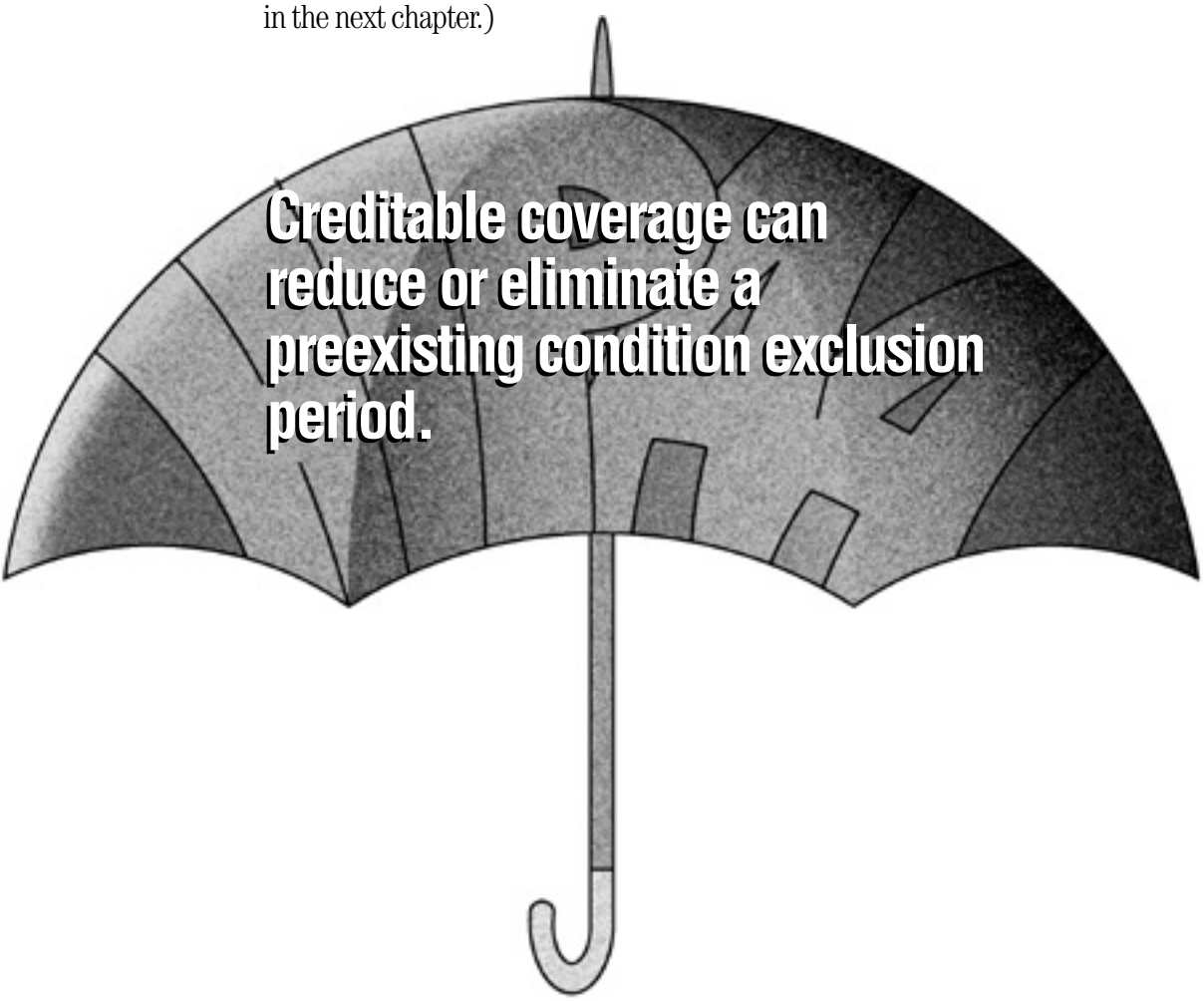
A Usually, the information is given in a certificate of creditable coverage. (Learn more about the certificate in the next chapter.)

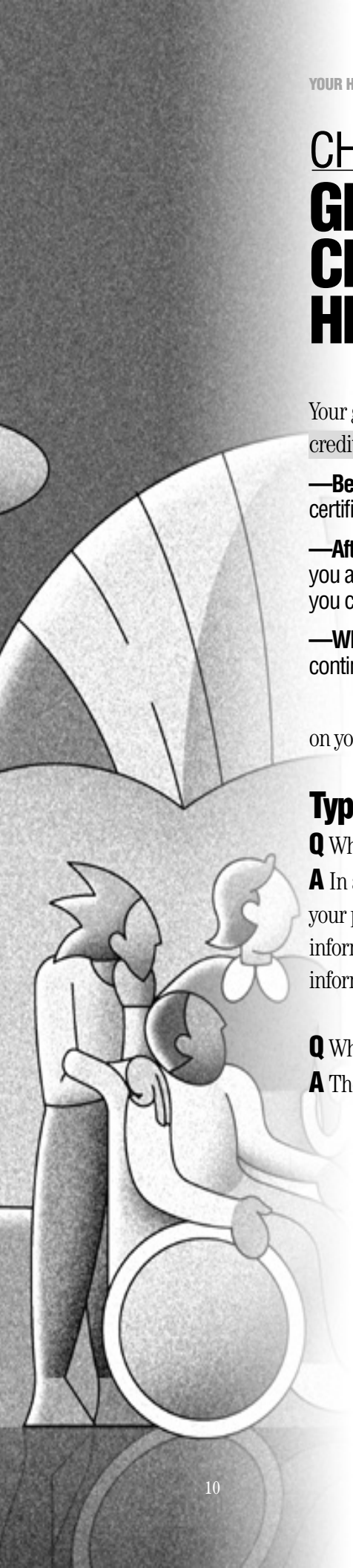
TIPS

—HIPAA allows for short breaks when you are counting back to accumulate creditable coverage. For example, you have a break in coverage of 30 days, followed by more coverage, and then followed by another 30-day break. Both periods of health coverage can be counted as you add up the time spent in prior health plans.

As long as any break is no longer than 63 days, you will not have a significant break. You can continue to count back coverage to accumulate 12 (or 18 for late enrollees) months of total coverage.

—Try to avoid a significant break in coverage. Look to a spouse's plan, COBRA continuation coverage, or an individual policy.





CHAPTER 3
GETTING AND USING A CERTIFICATE TO SHOW PRIOR HEALTH PLAN COVERAGE

Your group health plan, HMO, or health insurance company should provide you with a certificate of creditable coverage, a document that shows your prior periods of coverage in a health plan:

—**Before you lose your present coverage:** If you know you will be leaving a job, you can request a certificate, free of charge.

—**After coverage ends:** You should receive a certificate automatically upon loss of coverage, even if you are also eligible for COBRA continuation coverage. If you don't get one, or if you need a new one, you can request a certificate, free of charge, up to 24 months after prior coverage ends.

—**When COBRA coverage ends:** You should also automatically receive a certificate when COBRA continuation coverage ends.

With your permission, another person can request a certificate of creditable coverage on your behalf.

Typical Questions about Creditable Coverage:

Q What information will be on the certificate?

A In addition to standard identification information, the certificate will include the dates on which your prior health plan coverage began and ended. The certificate also should have contact information so that old and new plans can be in touch if necessary. Finally, there should be information about your HIPAA rights.

Q What amount of time should a certificate cover?

A The amount of time depends on whether you receive the certificate automatically or upon request.

—The automatic certificate should reflect at least the most recent period of continuous coverage.

—The certificate issued at your request or a dependent's should reflect at least each period of creditable coverage within the prior 24 months. The certificate does not have to reflect more than 18 months of continuous health coverage (the longest possible preexisting condition exclusion period) without a significant break.

Q When must my employer provide the certificate?

A —If you're eligible for COBRA, the certificate must be provided no later than your COBRA election notice (generally 44 days after a qualifying event).

—For all other automatic certificates, generally you should receive it within a reasonable amount of time after coverage ends.

—The plan should provide a requested certificate as early as possible.

Also, be aware that health plans must issue certificates, even if they do not exclude coverage for preexisting conditions. While an employee may not need a certificate in a current job, she might if a future employer's plan has a preexisting condition exclusion.

Q What steps should I take if I didn't get a certificate or I lose it? How can I show that I had prior coverage?

A If your new plan imposes a preexisting condition exclusion, your claims processing will go smoother if you don't delay. There is an alternate way to show that you had creditable coverage – you can present evidence of your prior health coverage to your new health plan. Evidence can include:

—Pay stubs that reflect a deduction for health coverage premiums;

—Copies of premium payments or other documents showing evidence of coverage;

—Explanation of benefit forms; and

—Verification by a doctor or your former health plan.

In addition to providing these documents, an individual may be asked to attest to the period of creditable coverage and cooperate with the new plan's reasonable efforts to verify creditable coverage.

You should still get in touch with the old plan's administrator to request a certificate for your records. The administrator's contact information is usually included in the plan brochure you received when you signed up for health coverage.

Q Are health plans required to issue certificates of creditable coverage to dependents?

A Yes. A plan must make every reasonable effort to collect dependent information and then issue certificates to dependents if they are also covered. However, if an employee and a dependent have the same coverage, only one certificate reflecting both individuals may be issued.

Q What are the next steps after I get my certificate?

A First, check it for accuracy. Does it reflect the amount of time you had prior coverage? Does it include the contact information of the issuer in case your old and new plans need to communicate? Is your personal data correct? Second, either give it to your new employer (after you make a copy for yourself) or file it away in a safe place.

TIPS

—In case you lose your certificate or can't get one, make sure you have other documents, such as pay stubs or copies of premium payments, that show you had coverage.

—When you leave a job, you may receive several documents from your previous employer or health plan. Look for the certificate of creditable coverage (it may be identified as a "certificate of group health plan coverage") and file it with other important papers.

CHAPTER 4

TAKING ADVANTAGE OF SPECIAL ENROLLMENT OPPORTUNITIES

Special enrollment allows individuals who previously declined health coverage to enroll for coverage. Special enrollment rights arise regardless of a plan's open enrollment period.

There are two types of special enrollment – upon loss of eligibility for other coverage and upon certain life events. Under the first, employees and dependents who decline coverage due to other health coverage and then lose eligibility or lose employer contributions have special enrollment rights. For instance, an employee turns down health benefits for herself and her family because the family already has coverage through her spouse's plan. Coverage under the spouse's plan ceases. That employee then can request enrollment in her own company's plan for herself and her dependents.

Under the second, employees, spouses, and new dependents are permitted to special enroll because of marriage, birth, adoption, or placement for adoption.

For both types, the employee must request enrollment within 30 days of the loss of coverage or life event triggering the special enrollment.

A special enrollment right also arises for employees and their dependents who lose coverage under a State Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

Typical Questions about Special Enrollment:

Q What are some examples of events that can trigger a loss of eligibility for coverage?

A Loss of eligibility for coverage may occur when:

—Divorce or legal separation results in you losing coverage under your spouse's health insurance;

—A young dependent, because of age, work, or school status, is no longer a covered "dependent" under a parent's plan;

—Your spouse's death leaves you without coverage under his or her plan;

—Your spouse's employment ends, as does coverage under his employer's health plan;

—Your employer reduces your work hours to the point where you are no longer covered by the health plan;

—Your plan decides it will no longer offer coverage to a certain group of individuals (for example, those who work part time);

—You no longer live or work in the HMO's service area;

—You have a health claim that would meet or exceed the plan's lifetime limit on all benefits.

These should give you some idea of the types of situations that may entitle you to a special enrollment right.

Q How long do I have to request special enrollment?

A It depends on what triggers your right to special enrollment. The employee or dependent must request enrollment *within 30 days* after losing eligibility for coverage or after a marriage, birth, adoption, or placement for adoption.

The employee or dependent must request enrollment *within 60 days* of the loss of coverage under a State CHIP or Medicaid program or the determination of eligibility for premium assistance under those programs.

Q After I request special enrollment, how long will I wait for coverage?

A It depends on what triggers your right to special enrollment. Those taking advantage of special enrollment as a result of a birth, adoption, or placement for adoption begin coverage no later than the day of the event.

For special enrollment due to marriage or loss of eligibility for other coverage, your new coverage will begin on the first day of the first month after the plan receives the enrollment request. If the plan receives the request on January 3, for example, coverage would begin on February 1.

Q What coverage will I get when I take advantage of a special enrollment opportunity?

A Special enrollees must be offered the same benefits that would be available if you are enrolling for the first time. Special enrollees cannot be required to pay more for the same coverage and cannot have longer preexisting condition exclusion periods.

Q What happens if a special enrollee has a preexisting condition?

A A preexisting condition exclusion cannot apply to a special enrollee for longer than 12 months. As with those who signed up with the plan at the first opportunity, a special enrollee can show creditable coverage and reduce or eliminate the maximum preexisting condition exclusion period.

A newborn, an adopted child, or a child placed for adoption cannot have a preexisting condition exclusion, as long as the child is enrolled in health coverage within 30 days of the event, without a subsequent significant break in coverage.

Q Where do I find out more about special enrollment in my plan?

A A description of special enrollment rights should be included in the plan materials you received when initially offered the opportunity to enroll.

Q How will I know if I am eligible for assistance with group health plan premiums under CHIP or Medicaid?

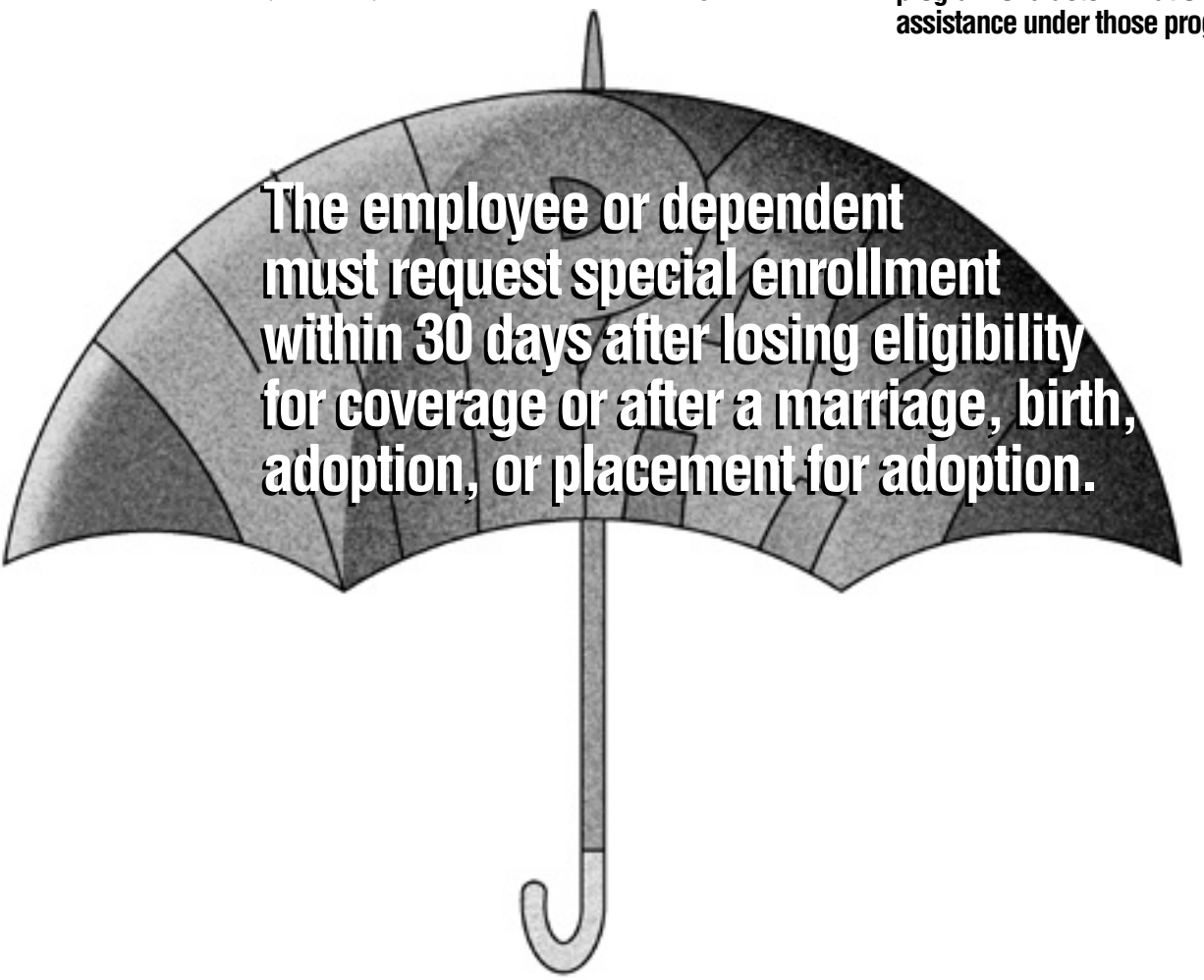
A You need to contact your State's CHIP or Medicaid program to see if your State will subsidize group health plan premiums and to determine if you are eligible for the subsidy under these programs. For information on the program in your State, call 1-877-KIDS NOW (543-7669) or visit www.insurekidsnow.gov on the Web.

If you are eligible for this premium assistance, you need to contact your plan administrator or employer to take advantage of the special enrollment opportunity and enroll in the group health plan.

TIPS

—Become familiar with the events that can trigger a special enrollment right; you must request coverage and you need to act promptly.

—Be sure you request enrollment within 30 days of a marriage, birth, adoption, placement of a child for adoption, or any event that results in a loss of eligibility for health coverage or within 60 days of the loss of coverage under a State CHIP or Medicaid program or a determination of eligibility for premium assistance under those programs.



CHAPTER 5
HIPAA'S PROTECTIONS FROM DISCRIMINATION

The previous chapters explain how to use HIPAA's preexisting condition and special enrollment protections by being aware of their timelines and requirements. The more you know, the better equipped you will be. The same is true for HIPAA and discrimination in health coverage: The more you know about the ways HIPAA prohibits discrimination, the better.

Under HIPAA, you and your family members cannot be denied eligibility or benefits based on certain "health factors" when enrolling in a health plan. In addition, you may not be charged more than similarly situated individuals (see page 17) based on any health factors. The questions and answers below define the health factors and offer some examples of what is and is not permitted under the law.

Typical Questions about Discrimination in Health Care:

Q What are the health factors under HIPAA?

A The health factors are:

—Health status;

—Medical conditions, including physical and mental illnesses;

—Claims experience;

—Receipt of health care;

—Medical history;

—Genetic information;

—Evidence of insurability (see below); and

—Disability.

Conditions arising from acts of domestic violence as well as participation in activities like motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, and skiing are considered "evidence of insurability." Therefore, a plan cannot use them to deny you enrollment or charge you more for coverage. (However, benefit exclusions known as "source of injury exclusions" could affect your benefits. These exclusions are discussed in more detail later in this chapter.)

Q Can a group health plan require me to pass a physical examination before I am eligible to enroll?

A No. You do not have to *pass* a physical exam to be eligible for enrollment. This is true for individuals who enroll when first eligible, as well as for late and special enrollees.

Q Can my plan require me to take a physical exam or fill out a health care questionnaire in order to enroll?
A Yes, as long as it does not use individual health information to restrict enrollment or charge you more.

Q My group health plan required me to complete a detailed health history questionnaire and then subtracted "health points" for prior or current health conditions. To enroll in the plan, an employee had to score 70 out of 100 total points. I scored only 50 and was denied a chance to enroll. Can the plan do this?
A No. In this case the plan used health information to exclude you from enrolling in the plan. This practice is discriminatory, and it is prohibited.

Q My group health plan booklet states that if a dependent is confined to a hospital or other medical facility at the time he is eligible to enroll in the plan, that person's eligibility is postponed until he is discharged. Is this permitted?
A No. A group health plan may not delay an individual's eligibility, benefits, or effective date of coverage based on confinement to a hospital or medical facility at the time he becomes eligible. Additionally, a health plan may not increase that person's premium because he was in a hospital or medical facility.

Q My group health plan has a 90-day waiting period before allowing employees to enroll. If an individual is in the office on the 91st day, health coverage begins then. However, if an individual is not "actively at work" on that day, the plan states that coverage is delayed until the first day that person is actually at work. I missed work on the 91st day due to illness. Can I be excluded from coverage?
A No. A group health plan generally may not deny benefits because someone is not "actively at work" on the day he would otherwise become eligible.

However, a plan may require employees to begin work before health plan coverage is effective. A plan may also require an individual to work full time (say, 250 hours per quarter or 30 hours per week) in order to be eligible for coverage.

Q My group health plan imposes a 12-month preexisting condition exclusion period. After the first 6 months, however, it is waived for individuals who have not had any claims since enrollment. Is this practice allowed?
A No. A group health plan may impose a preexisting condition exclusion period, but it must be applied uniformly. In this case, the plan is not applying its provisions uniformly, since it is treating differently those who had medical claims during the first 6 months of coverage.

Q How do you determine "similarly situated individuals"?
A HIPAA states that plans may distinguish among employees only on "bona fide employment-based classifications" consistent with the employer's usual business practice. For example, part-time and full-time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service can be treated as different groups of similarly situated individuals.

A plan may draw a distinction between employees and their dependents. Plans can also make distinctions between beneficiaries themselves if the

distinction is not based on a health factor. For example, a plan can distinguish between spouses and dependent children, or between dependent children based on their age or student status.

Q My health plan has a $500,000 lifetime limit on all of the benefits covered in the plan. In addition, there is a $2,000 lifetime limit on all benefits provided for one of my health conditions. Can a plan set these kinds of restrictions?

A Yes. A group health plan may apply lifetime limits generally or for a specific disease or treatment – provided the limits are applied uniformly to similarly situated individuals and are not directed at specific employees or dependents based on any health factors they may have.

Q I have a history of high claims. Can I be charged more than others in the plan based on my claims experience?

A No. Group health plans cannot charge an individual more for coverage than a similarly situated individual based on any health factor.

However, be aware that HIPAA does allow an insurer to charge one group health plan (or employer) a higher rate than it does another. When an insurance company establishes its rates, it may underwrite all covered individuals in a specific plan based on their collective health status. The result can be that one employer health plan whose enrollees have more adverse health factors can be charged a higher premium than another for the same amount of coverage.

Think of it this way: HIPAA's protections from discrimination apply within a group of similarly situated individuals, not across different groups of similarly situated individuals. For example, an employer distinguishes between full-time and part-time employees. It can charge part-time employees more for coverage, but all full-time employees must pay the same rate, regardless of health status.

Also, take note that, for insured plans, state law may require the use of other methods for setting rates for health coverage. More information is available at www.naic.org.

Q I am an avid skier. Can my employer's plan exclude me from enrollment because I ski?

A No. Participation in activities such as skiing would be "evidence of insurability," which is a health factor. Therefore, it cannot be used to deny eligibility.

Q Can my health plan deny benefits for an injury based on how I got it?

A Maybe. A plan can deny benefits based on an injury's source, unless an injury is the result of a medical condition or an act of domestic violence.

Therefore, a plan cannot exclude coverage for self-inflicted wounds, including those resulting from attempted suicide, if they are otherwise covered by the plan and result from a medical condition (such as depression).

However, a plan may exclude coverage for injuries that do not result from a medical condition or from domestic violence. For example, a plan generally can exclude coverage for injuries in connection with an activity like bungee jumping. While the bungee jumper may have to pay for treatment for those injuries, her plan cannot exclude her from coverage for the plan's other benefits.

Q My group health plan says that dependents are generally eligible for coverage only until they reach age 25. However, this age restriction does not apply to disabled dependents, who seem to be covered past age 25. Does HIPAA permit a policy favoring disabled dependents?

A Yes. A plan can treat an individual with an adverse health factor (such as a disability) more favorably by offering extended coverage.

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) expands the HIPAA nondiscrimination provisions discussed above by generally prohibiting the use of genetic information to adjust group premiums or contributions, the collection of genetic information and requests for individuals to undergo genetic testing. GINA is effective for plan years beginning after May 21, 2009 (January 1, 2010 for plans using a calendar year).

TIP

—Call EBSA toll free at 1-866-444-EBSA (3272) or contact us electronically at www.askebsa.dol.gov if you believe you are the subject of discrimination due to a health factor or for questions on GINA.

HIPAA and Wellness Programs

More and more employers are establishing wellness programs that encourage employees to work out, stop smoking, and generally adopt healthier lifestyles. HIPAA encourages group health plans to adopt wellness programs but also includes protections for employees and dependents from impermissible discrimination based on a health factor. The questions and answers below provide some guidance regarding wellness programs.

Q I belong to a group health plan that rewards individuals who volunteer to be tested for early detection of health problems, such as high cholesterol. Can a plan do this?

A Yes, as long as the health plan offers the reward based on participation in the program and not on test results. For instance, a health plan might offer a premium discount for those who voluntarily test for cholesterol. The discount would be available to everyone who takes the test, not just those who get a certain result.

Q Can a plan charge a lower premium for nonsmokers than it does for smokers?

A For wellness programs where the plan offers a reward based on an individual's ability to meet a standard related to a health factor (such as a standard related to smoking/nicotine addiction), the rules require that:

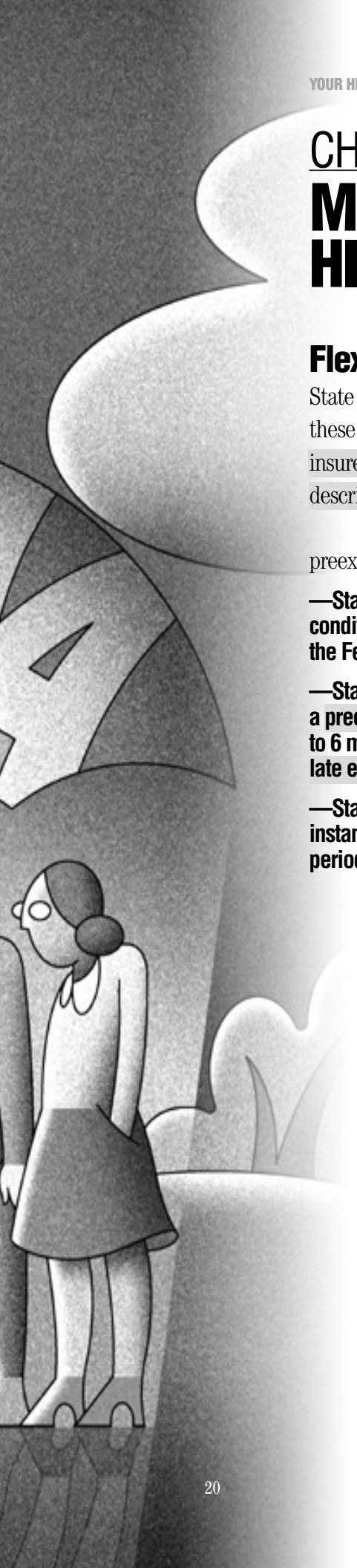
—The reward, such as a premium differential, must generally not exceed 20 percent of the cost of employee-only coverage under the plan. If the program allows an employee's dependents (such as spouses or children) to participate, then the reward must not exceed 20 percent of the cost of the coverage in which the employee and any dependents are enrolled;

—The program must be designed to promote good health or prevent disease;

—Individuals must have a chance to qualify for the nonsmoker's premium discount at least once a year;

—The program must accommodate those for whom it is unreasonably difficult to quit using tobacco (for example, due to nicotine addiction) by providing a reasonable alternative standard (such as a discount in return for attending educational classes or for trying a nicotine patch); and

—Plan materials describing the wellness program must disclose the availability of a reasonable alternative standard to qualify for the lower premium.



CHAPTER 6
MORE COVERAGE UNDER HIPAA'S UMBRELLA

Flexibility in State Laws

State laws may complement HIPAA by allowing more protections than the Federal law. However, these state laws only apply if your plan provides benefits through an insurance company or HMO (an insured plan). To determine if your plan offers insured coverage, consult your summary plan description (SPD) or contact your plan administrator.

The list below summarizes those areas where state laws can complement HIPAA's preexisting condition and special enrollment provisions:

—States may reduce the number of months a plan can look back to determine a preexisting condition. For instance, a state's law may have a look-back period of 3 months instead of the 6 in the Federal law. The look-back period begins on the day you enroll in a plan.

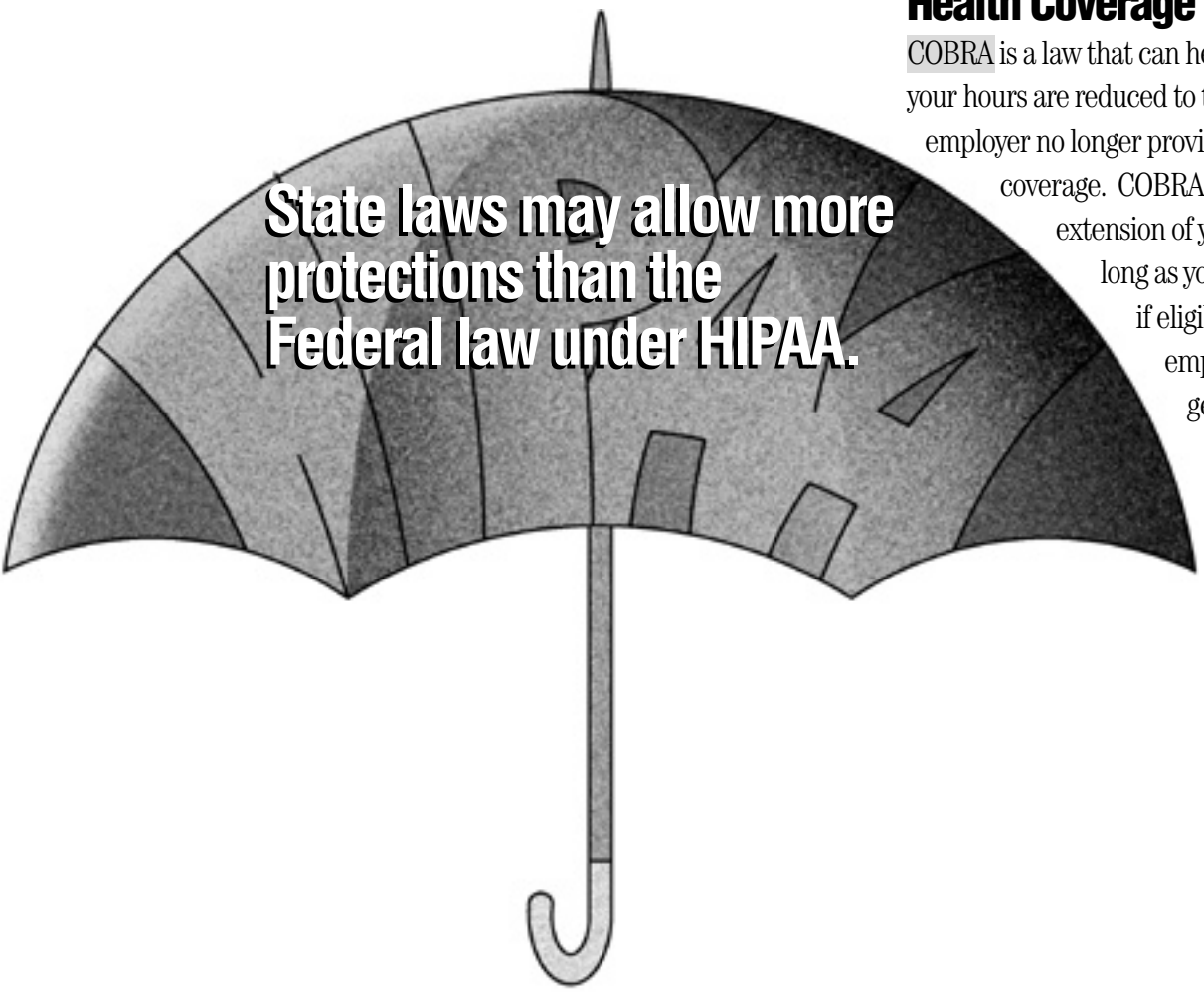
—States may decrease the number of months a new employee or dependent may be subject to a preexisting condition exclusion period. For example, state laws may limit the exclusion period to 6 months rather than 12. They may also reduce the maximum 18-month exclusion period for late enrollees.

—States may increase the number of days that constitute a significant break in coverage. For instance, instead of 63 days, a state may allow someone to have a break of 120 days between periods of health coverage.

—States may increase the number of days (30 under Federal law) parents have to enroll newborns, adopted children, and children placed for adoption without a preexisting condition being excluded.

—Under Federal law, certain preexisting conditions cannot be excluded from coverage (pregnancy; newborns, adopted children, and children placed for adoption within 30 days; and genetic information in the absence of a diagnosis). States may add to this list. For example, a state may add cancer, so that plans cannot exclude it from coverage, even if you received treatment during the 6 months before enrolling in a new plan.

—States may require additional circumstances that entitle you to special enrollment periods beyond those in the Federal law.



—States may reduce an HMO's affiliation period prior to enrollment (similar to a group health plan's waiting period) to fewer than 2 months (3 months for late enrollees).

In other areas of HIPAA, such as protections from discrimination, state laws may also supplement HIPAA's protections if the coverage is through an insured plan. Check your SPD to see if your plan is insured and visit your state insurance commissioner's office or the National Association of Insurance Commissioners' Web site at www.naic.org (click on your state) for more information.

Using COBRA to Extend Your Health Coverage

COBRA is a law that can help if you lose your job or if your hours are reduced to the point where the employer no longer provides you with health coverage. COBRA can provide a temporary extension of your health coverage – as long as you and your family members, if eligible, belonged to the previous employer's health plan and generally the employer had 20 or more employees. Usually, you pay the entire cost of coverage (both your share

and the employer's, plus a 2 percent administrative fee). As long as the prior plan exists, COBRA coverage lasts up to 18 months for most people, although it can continue as long as 36 months in some cases.

There are several ways to use COBRA in conjunction with HIPAA:

—COBRA coverage can help you avoid a significant break between periods of health plan coverage. For example, if you expect to have a 6-month interruption between jobs and health plans, you can purchase COBRA coverage during that time.

—COBRA coverage can be counted as creditable coverage – as long as there is no significant break after your COBRA coverage ends. Creditable coverage can be used to offset any preexisting condition exclusion period you or a family member might have.

—COBRA continuation coverage can be used as a bridge to ensure that you remain covered during a waiting period or a preexisting condition exclusion period.

—If you have COBRA and become covered under other group health plan coverage that is not subject to a preexisting condition exclusion period, your COBRA coverage can be cut off.

—Once you are no longer eligible for COBRA coverage, you will get a special enrollment opportunity for any other coverage for which you are eligible. However, if you voluntarily stop COBRA coverage or stop paying your COBRA premiums, that will not trigger a special enrollment right based on loss of eligibility for coverage.

TIPS

—Your COBRA plan and other available health coverage may be different in terms of their cost, scope of benefits, or level of coverage.

—COBRA can be used instead of, or in addition to, your new health coverage, if you are subject to a preexisting condition exclusion period. When deciding whether to choose COBRA, consider the length of your preexisting condition exclusion period, whether you are likely to need treatment for your preexisting condition during this time, and the costs and benefits of COBRA coverage.

—Whether you elect COBRA coverage is an individual decision. Taking into account this information, you can make a decision that is best for the health of you and your family.

Changing from Group Health Coverage to an Individual Insurance Policy

HIPAA also protects those who are otherwise unable to get group health insurance.

The law guarantees access to individual insurance policies and state high-risk pools for eligible individuals. They must meet all of the following criteria:

—Had coverage for at least 18 months, most recently in a group health plan, without a significant break;

—Lost group coverage but not because of fraud or nonpayment of premiums;

—Are not eligible for COBRA coverage; or if COBRA coverage was offered under Federal or state law, elected and exhausted it; and

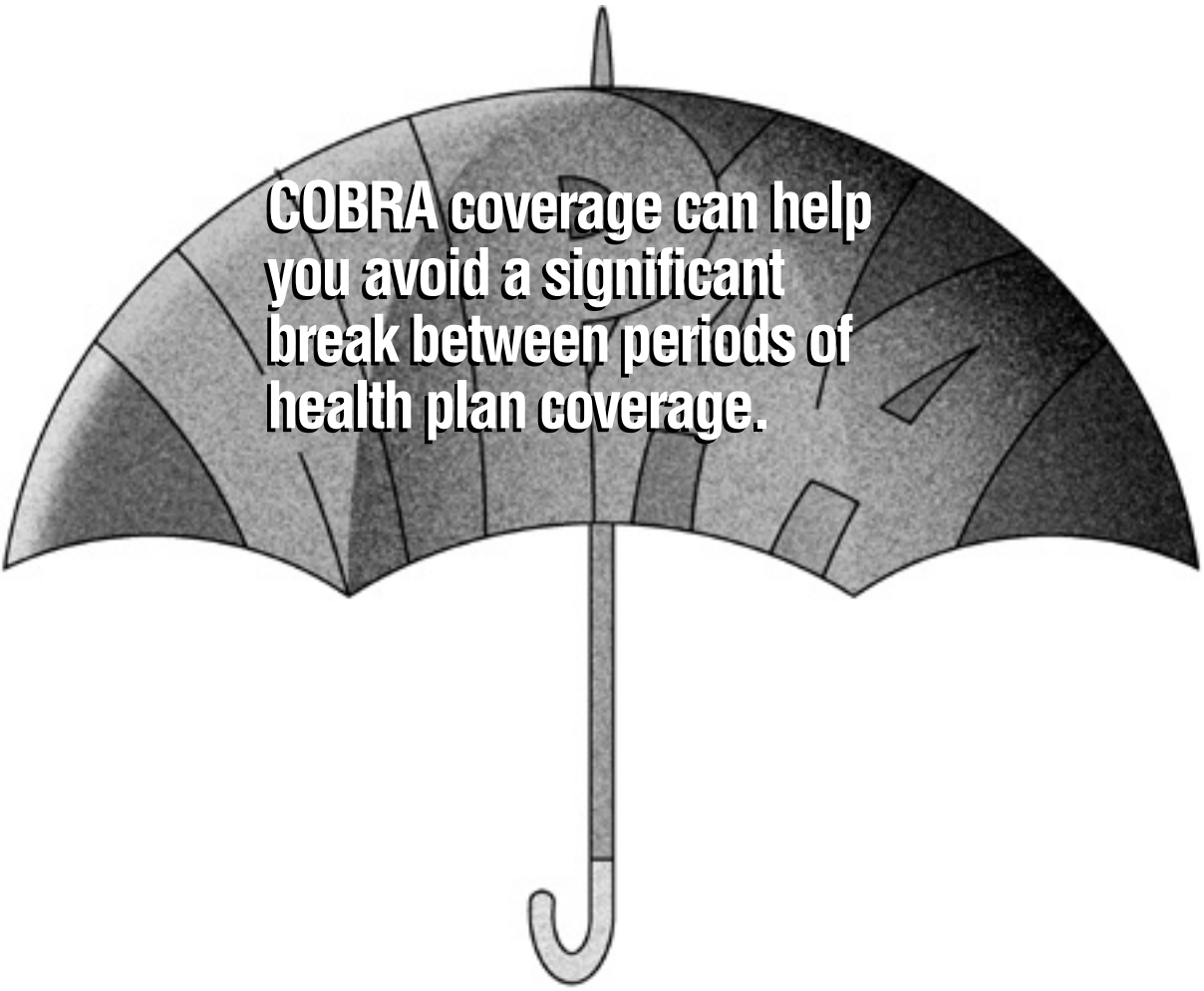
—Are not eligible for coverage under another group health plan, Medicare, or Medicaid; or have any other health insurance coverage.

The opportunity to buy an individual policy is the same whether a person quits a job, was fired, or was laid off.

Health coverage is also available through Medicaid and CHIP, which provide coverage to individuals and their families who experience significant reductions in income. For more information on how Medicaid and CHIP can help trigger special enrollment rights, see Chapter 4.

TIP

—Ask your state insurance commissioner's office about high-risk pools and individual insurance policies. Look up the office at the NAIC Web site (www.naic.org) or in your phone directory.



RESOURCES

Find out more about HIPAA, COBRA, and other laws that pertain to health care. The publications and Web sites below will help.

The following publications are available from the Employee Benefits Security Administration's toll-free publications request line–1-866-444-EBSA (3272)–or on the Web at www.dol.gov/ebsa (click on "Publications/Reports"):

An Employee's Guide to Health Benefits under COBRA: The Consolidated Omnibus Budget Reconciliation Act

Retirement and Health Care Coverage ... Questions and Answers for Dislocated Workers

Your Rights after a Mastectomy ... Women's Health and Cancer Rights Act of 1998

Protections for Newborns, Adopted Children, and New Parents: The Newborns' and Mothers' Health Protection Act of 1996

Top 10 Ways to Make Your Health Benefits Work for You

Life Changes Require Health Choices: Know Your Benefit Options

Work Changes Require Health Choices: Protect Your Rights

Other Web Sites and Publications on HIPAA

Protecting Your Health Insurance Coverage – View this publication, from the Centers for Medicare and Medicaid Services, at www.medicare.gov (enter the name of the publication in the blank space provided for searches).

Your Health Information Privacy Rights – View this fact sheet at the Department of Health and Human Services' HIPAA Web site (www.hhs.gov/ocr/privacy), or receive a copy by calling toll free 1-866-627-7748.

National Association of Insurance Commissioners – Visit the Web site at www.naic.org and then click on "NAIC States and Jurisdictions Map" to find your state insurance commissioner's office.

HIPAA: Protecting Your Right to Health Insurance – You can view this AARP-sponsored publication at www.aarp.org/health/insurance.

A Consumer's Guide for Getting and Keeping Health Insurance – Visit the Georgetown University Health Policy Institute's Web site at www.healthinsuranceinfo.net , then select your state for information on its HIPAA law.

Other Consumer Health Web Sites:

The following Web sites offer information on health-related topics, quality assurance in health care, and women's health. Click on each site, then choose a topic of interest to you.

U.S. Department of Health and Human Services
www.hhs.gov

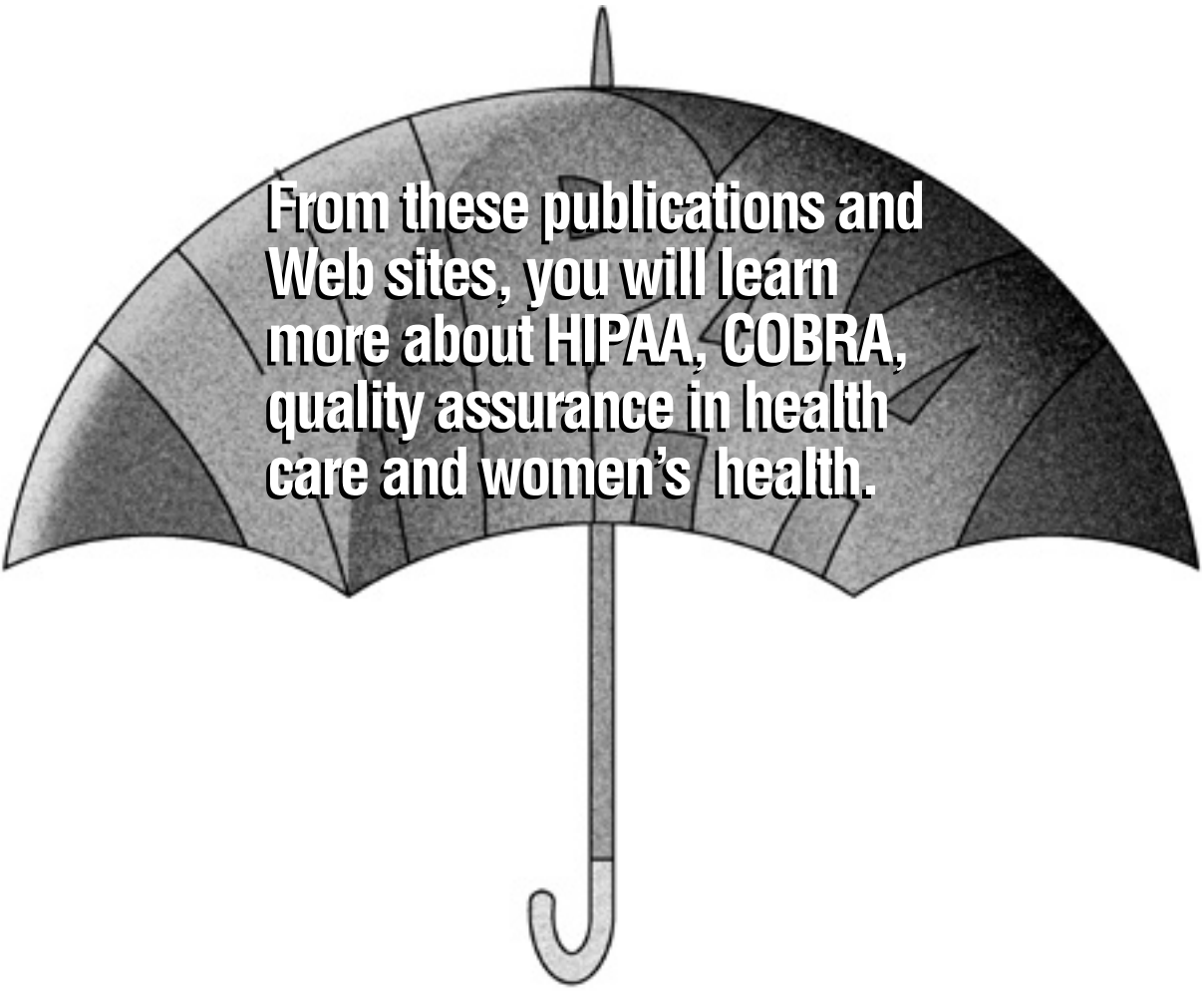
Insure Kids Now
www.insurekidsnow.gov

Agency for Healthcare Research and Quality
www.ahrq.gov/consumer

Healthfinder (Office of Disease Prevention and Health Promotion)
www.healthfinder.gov

The National Women's Health Information Center
www.womenshealth.gov

The Leapfrog Group
www.leapfroggroup.org



GLOSSARY

Certificate of creditable coverage:
A document prepared by a group health plan, HMO, or insurance company that shows prior periods of creditable coverage, used to reduce or eliminate the length of a preexisting condition exclusion period.

COBRA:
An abbreviation for the Consolidated Omnibus Budget Reconciliation Act of 1985, a law that provides for a temporary extension of health plan coverage from a prior group health plan.

Creditable coverage:
A period of prior health coverage, which may be used to offset the length of a preexisting condition exclusion period. This includes coverage under a group health plan, COBRA, Medicare and Medicaid, or an HMO or individual health insurance policy.

Enrollment date:
The first day of coverage or the first day of the waiting period (if applicable).

Insured plan:
A plan which provides benefits through an insurance company or HMO. Check your summary plan description (SPD) to see if your plan is insured.

Late enrollee:
An individual who enrolls in the plan at some time other than when first eligible or a special enrollment opportunity.

Preexisting condition exclusion:
A limitation or exclusion of benefits relating to a condition because that condition was present before the effective date of your health coverage.

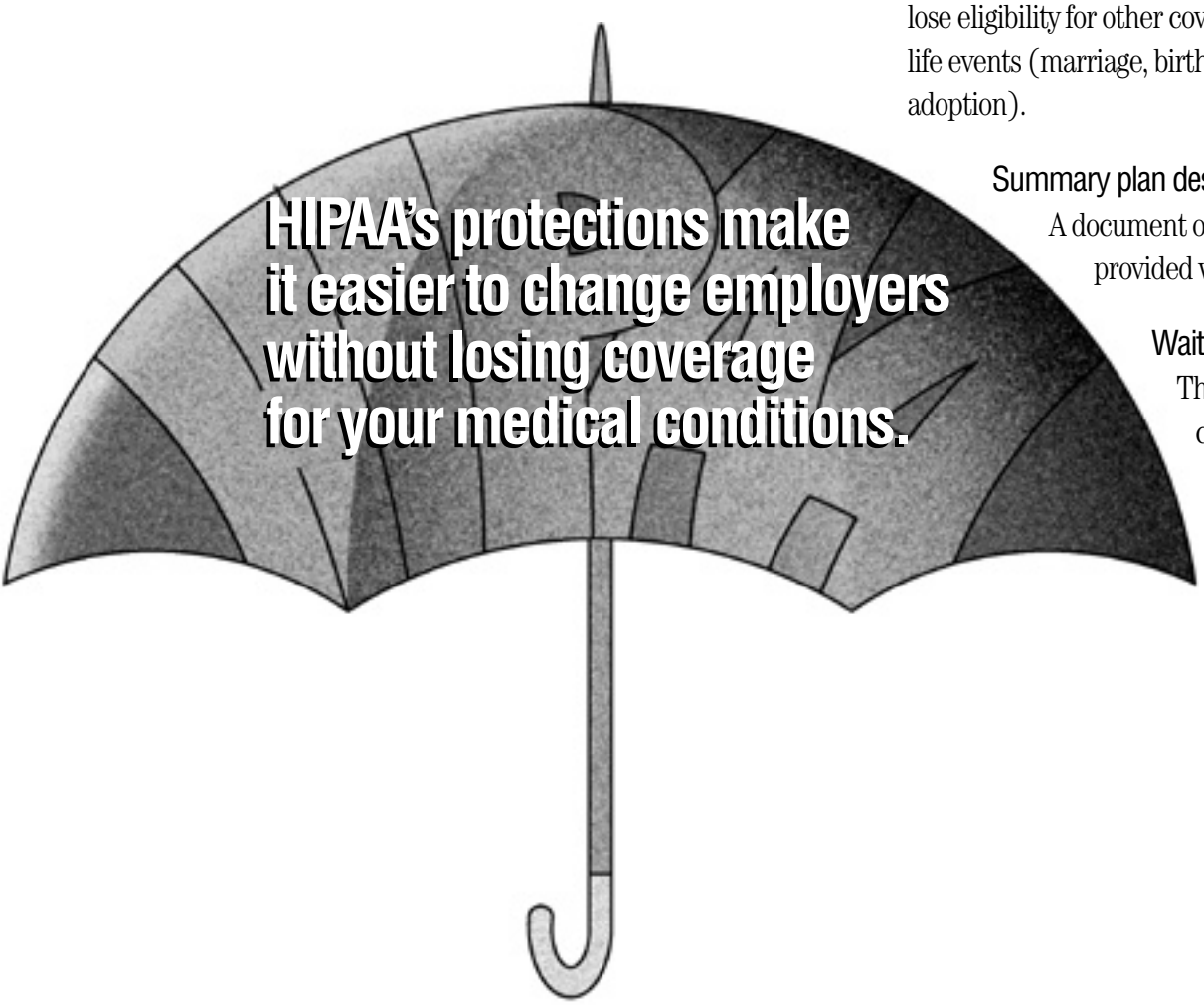
Preexisting condition exclusion period:
The amount of time that you are excluded from coverage of benefits for a preexisting condition (the maximum is 12 months, or 18 months for late enrollees).

Self-insured plan:
A group health plan where the employer assumes the risk of paying the benefits itself. An insurance company may provide administration services to a self-insured plan, such as claims administration, but does not assume any risk to pay claims for benefits.

Significant break:
A break in health coverage for 63 days or more.

Similarly situated individuals:
Permitted distinctions plans may make among individuals, such as groups of employees, if based on "bona fide employment-based classifications" consistent with the employer's usual business practice. For example, part-time and full-time employees can be treated as different groups of similarly situated individuals. In addition, a plan may draw a distinction between employees and their dependents. Plans can also make distinctions between dependents themselves if the distinction is not based on a health factor. For example, a plan can distinguish between spouses and dependent children, or between dependent children based on their age or student status.

Special enrollment:
An opportunity for certain individuals to enroll in a group health plan, regardless of the plan's regular enrollment dates. These opportunities occur when you lose eligibility for other coverage or experience certain life events (marriage, birth, adoption, or placement for adoption).



Summary plan description (SPD):
A document outlining your plan, usually provided when you enroll in the plan.

Waiting period:
The time that must pass before coverage can become effective under the terms of a group health plan.

U.S. Department of Labor
Employee Benefits Security Administration