Protecting Your Health Insurance Coverage

This booklet explains . . .

- **Your rights and protections under recent Federal law**
- **How to help maintain existing coverage**
- **Where you can get more help**

HCFA
Health Care Financing Administration

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Table of Contents

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Life is filled with a variety of events that may affect the health insurance coverage you need or that you have available to you. Each year millions of Americans face life events, which can vary from the birth of a baby, the onset of a chronic condition or disabling disease, to divorce, changing jobs or a business closing, cutting back on staff or reducing the number of hours you work.

You need to know how these and other life events affect your health insurance coverage. Your ability to get and keep health insurance coverage may be of special concern if you or your family members have a history of medical problems.

Recent changes in Federal law now give additional – though limited – protections to you and your family members when you need to buy, change, or continue your health insurance. These important laws can affect the health benefits of millions of working Americans and their families. Understanding these new protections, as well as laws in your State, can help you make a more informed choice if you need to make a change in health coverage. It also can help you better understand the health coverage protections you have under the law.

Understanding these protections, as well as laws in your State, can help you make a more informed choice if you need to make a change in health coverage.

The purpose of this booklet is to give you an overview of how you may be affected by health insurance coverage changes found in four Federal laws:

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- The Mental Health Parity Act of 1996 (MHPA);
- The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA); and
- The Women's Health and Cancer Rights Act of 1998 (WHCRA).

This booklet does not cover all the details of these laws. But it does give you and your family information about your rights and protections under these laws. As you read this booklet, it is important to remember that health insurance laws in your State may provide you even greater protections to buy, change, or continue health coverage. Thus, the information in this booklet is a general guideline. If you have detailed questions about coverage

guidelines and protections in your State, please contact one of sources listed in the back for more information (see page 40).

As you read this booklet, it also is important to remember that health insurance coverage is a complex issue. Your coverage and protections will depend on your specific situation. For example, you may have access to different health coverage protections depending on if you work and get insurance through your workplace, or if you have individual coverage. To help you better understand this and other issues, this booklet includes general information about the four Federal laws and some frequently asked questions and answers about them. In addition, health coverage can be difficult to understand because of the different words and phrases used to describe the coverage. Thus, you will find a list of terms used in the booklet (marked in **bold face type)** and a list of places to go for more information.

Health insurance coverage is a complex issue. Your coverage and protections will depend on your specific situation.

HIPAA Helps You Get and Keep Health Insurance Coverage

Overview

The Health Insurance Portability and Accountability Act of 1996, known as HIPAA, includes important new – but limited – protections for millions of working Americans and their families. HIPAA may:

- Increase your ability to get health coverage for yourself and your dependents if you start a new job;
- Lower your chance of losing existing health care coverage, whether you have that coverage through a job, or through individual health insurance;
- Help you maintain continuous health coverage for yourself and your dependents when you change jobs; and
- Help you buy health insurance coverage on your own if you lose coverage under an employer's group health plan and have no other health coverage available.

Among its specific protections, HIPAA:

- Limits the use of pre-existing condition exclusions;
- Prohibits group health plans from discriminating by denying you coverage or charging you extra for

coverage based on your or your family member's past or present poor health;
- Guarantees certain small employers, and certain individuals who lose job-related coverage, the right to purchase health insurance; and
- Guarantees, in most cases, that employers or individuals who purchase health insurance can renew the coverage regardless of any health conditions of individuals covered under the insurance **policy**.

In short, HIPAA may lower your chance of losing existing coverage, ease your ability to switch health plans and/or help you buy coverage on your own if you lose your employer's plan and have no other coverage available.

Policy
An insurance policy or any other contract (such as an HMO contract) that provides you or your group health plan with health insurance coverage.

MISUNDERSTANDINGS ABOUT HIPAA

Although HIPAA helps protect you and your family in many ways, you should understand what it does NOT do.

- HIPAA does NOT require employers to offer or pay for health coverage for employees or family coverage for their spouses and dependents;
- HIPAA does NOT guarantee health coverage for all workers;
- HIPAA does NOT control the amount an insurer may charge for coverage;
- HIPAA does NOT require group health plans to offer specific benefits;
- HIPAA does NOT permit people to keep the same health coverage they had in their old job when they move to a new job;
- HIPAA does NOT eliminate all use of pre-existing condition exclusions; and
- HIPAA does NOT replace the State as the primary regulator of health insurance.

5 Steps to Understanding How HIPAA May Affect You

To understand if and how HIPAA may help you, there are five steps you should take. These steps generally mean you need to:

1. Understand the different types of health insurance and group health plan coverage that are affected by HIPAA;
2. Evaluate the impact of a **pre-existing condition** that you have which may trigger the need for HIPAA's limited protections;
3. Determine how much – if any – creditable coverage you have;
4. Understand the other HIPAA coverage protections you have; and
5. Know where to go for more information if you have questions.

☑ *Step 1: Understand the Various Types of Health Coverage*

Group Health Plan
A group health plan is an employee welfare benefit plan maintained by an employer or union that provides medical care to employees and often to their dependents as well.

Before you can understand how HIPAA may help protect your health coverage, you must understand what the various types of health coverage are. This is important because the law provides different protections depending on the type of health coverage you have or wish to apply for.

Types of Coverage

HIPAA generally applies to the following three types of coverage:

1. **Group Health Plans.** A group health plan is health coverage sponsored by an employer or union for a group of employees, and possibly for dependents and retirees as well. To understand your rights, you will need to know the following things about your group health plan.
    - Does a State or local governmental employer sponsor the plan?
    - Does a church or group of churches sponsor the plan?
    - Does the plan cover fewer than two current employees?
    - Does a small employer or a large employer sponsor the plan?
    - Is the plan an **insured plan** that purchases health insurance coverage from an HMO or

Insured Plan
An insured plan is a group health plan under which the benefits are provided by the sponsoring employer or union through the purchase of health insurance coverage from an HMO or an insurance company.

other **health insurance issuer**, or is it a **self – insured plan**?

2. **Individual Health Insurance.** Individual health insurance coverage is insurance coverage that is sold by HMOs or other health insurance issuers to individuals who are not part of a group health plan. Even though health coverage might be provided through an association or other group, such as groups of college students or self-employed individuals, it is still considered to be "individual" health insurance <u>if</u> it is not provided through a group health plan.

3. **Comparable Coverage through a High-risk Pool.** Some States have set up high-risk pools to provide health coverage for people who cannot otherwise obtain health insurance coverage in the individual market.

<u>Eligibility for HIPAA Protections</u>

If you are <u>not</u> currently covered by a particular type of plan or insurance, you need to determine what you may be eligible for.

1. Your eligibility to enroll in a group health plan is determined by the rules of the group health plan and the contract terms of any insurance purchased by an insured plan.
2. Your eligibility to have HIPAA guarantee you the right to purchase individual health insurance coverage (which, in some States, will be through a high-risk pool) depends on your ability to meet ALL of the following requirements:
   - You have at least 18 months of **creditable coverage** without a significant break in coverage – a period of 63 or more days during all of which you had no coverage. If you get coverage by midnight of the 63rd day, you have not incurred a significant break;
   - Your most recent coverage must have been through a group health plan (through your or a family member's employer or union);
   - You are not eligible for coverage under any other group health plan;

Health Insurance Issuer
Any company that sells health insurance is a health insurance issuer. Insurance companies and HMOs are both health insurance issuers.

Self-Insured Plan
A self-insured (or self-funded) plan is a group health plan under which the risk for the cost of the benefits provided is borne by the sponsoring employer or union.

Creditable Coverage
Creditable coverage is prior health care coverage that is taken into account to determine the allowable length of pre-existing condition exclusion periods (for individuals entering group health plan coverage) or to determine whether an individual is a HIPAA eligible individual .

- You are not eligible for Medicare or Medicaid;
- You do not have other health insurance;
- You did not lose your insurance for not paying the premiums or for committing fraud; and
- You accepted and used up your COBRA continuation coverage (See page 12 for more details) or similar State coverage if it was offered to you.

If you meet these requirements, then you become a **HIPAA eligible individual.**

HIPAA Eligible Individual
A HIPAA eligible individual means a person who is guaranteed the right under HIPAA to purchase individual health insurance coverage with no pre-existing condition exclusions.

Once you know what kind of health care coverage you have, or would like to apply for, you can begin to understand how HIPAA may protect you and your family.

When You Get a New Job

If you find a new job that offers a group health plan, or, if you are eligible under another family member's group health plan, you first need to determine whether HIPAA applies to the group health plan. For example, if the job is with a church, or with a State or local governmental employer, or with a very small employer, HIPAA protections may be more limited. Ask your new employer for information about HIPAA, or your State Insurance Department listed beginning on page 40.

If HIPAA does apply to your group health plan, then generally it:

- Limits the length of pre-existing condition exclusions that can keep you and your dependents from getting full coverage;
- Generally prohibits the health plan from denying coverage, or charging higher rates based on your or your dependents' current health or health history; and
- May give you a **special enrollment period** for enrolling in the group health plan when you lose other coverage if you chose not to join the health plan when you were first eligible or when you have a new dependent.

Special Enrollment
A special enrollment is an opportunity to enroll in a group health plan without having to wait for an open enrollment period.

When You Leave a Job or Otherwise Lose Group Health Plan Coverage

If you are a HIPAA eligible individual, and you apply for

individual health coverage within 63 days after losing group health plan coverage, HIPAA:

- Guarantees that you will have a choice of at least two coverage options;
- Guarantees that you will be eligible, regardless of any medical conditions you may have, to purchase some type of individual coverage, whether from a health insurance issuer, high-risk pool, or other source designated by your State; and
- Guarantees that you will not be subject to any pre-existing condition exclusions.

HIPAA does NOT limit the amount you can be charged for the policy. However, State law may set limits. Also, if your coverage is through a **network plan**, HIPAA does not guarantee that your policy will be renewed if you move outside the area served by providers under contract with your insurer. In addition, if your coverage is through a high-risk pool, and you move out of the State, HIPAA does not guarantee that your coverage will be renewed.

Network Plan
A network plan is a health insurance policy that provides coverage through a defined set of providers under contract with the insurance issuer.

☑ *Step 2: Determine The Impact of Any Pre-existing Condition*

Traditionally, many employer-sponsored group health plans and health insurance issuers in both the group and individual markets limited or denied coverage of health conditions that an individual had prior to the person's enrollment in the plan. These types of exclusions are known as **pre-existing condition exclusions**.

Pre-existing Condition Exclusion
A pre-existing condition exclusion limits or denies benefits for a medical condition that existed before the date that coverage began.

Although such exclusions were problematic for those trying to secure health coverage in the past, HIPAA and other recent Federal laws bring some relief to this problem in certain situations. To best understand the protections provided by the law, you need to remember two things. First, HIPAA establishes requirements and limits under which a pre-existing condition exclusion can apply. Second, if you have a pre-existing condition, HIPAA helps minimize the impact of that exclusion on your access to health coverage.

Please note: if you are a HIPAA eligible individual in the individual market, no pre-existing condition exclusion can be applied to your coverage.

Medical Condition
A medical condition is any physical or mental condition resulting from an illness, injury, pregnancy, or congenital malformation**.**

Enrollment Date
Your enrollment date is the first day on which you are able to receive benefits under a group health plan, **or** if the plan imposes a waiting period, the first day of your waiting period. Unless you chose not to participate in the plan when you first are hired, your enrollment date usually is the date on which you begin work.

Limits for Pre-Existing Condition Exclusions in the Group Market

Even if your family member had a medical condition in the past, it is possible that the group health plan cannot use it as the basis for a pre-existing condition exclusion. HIPAA limits pre-existing condition exclusions to those **medical conditions** for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period before your **enrollment date —** your first day of coverage or, if there is a waiting period, the first day of your waiting period. This is typically your date of hire. This 6-month period is often called a "look-back" period. Some State laws shorten this look-back period if your group health plan is an insured plan.

Minimizing the Impact of Exclusions

In many instances, HIPAA can reduce the impact of a pre-existing condition exclusion. HIPAA does this in two principal ways. First, the law limits the time over which an exclusion can keep you from getting coverage; and second, HIPAA generally allows your previous health insurance coverage to reduce the amount of time the exclusion can apply, or, in some cases, can totally eliminate such exclusions. In addition, no pre-existing condition exclusion is permitted for newborn and adopted children, who are enrolled within 30 days, or for pregnancy.

The Exclusion Period Begins

The exclusion period must begin on your enrollment date. It can generally last no longer than 12 months. If you do not enroll when you are first eligible and do not enroll when you have special enrollment rights, the plan can refuse to cover pre-existing conditions for up to 18 months after you enter the plan.

Notice Requirements

Before a pre-existing condition exclusion can be applied to your coverage, the plan's consumer materials must tell you if the plan imposes pre-existing condition exclusions. Your group health plan must send you a written notice that an exclusion will be imposed on you. The notice should describe the length of the exclusion period because you do not have enough creditable coverage. The notice also should describe how you can demonstrate how much creditable coverage you have.

Step 3: Determine If You Can Minimize the Length of the Exclusion

Once you understand that you have a pre-existing condition that is subject to an exclusion, it is important to remember that your previous health insurance coverage might reduce or eliminate the length of the pre-existing condition exclusion.

Under HIPAA's group market rules, creditable coverage can be used to reduce or eliminate pre-existing condition exclusions that might be applied to you under a future plan or policy. In general, if you had other health coverage – for example, under another group health plan or under an individual health insurance policy, Medicare, Medicaid, an HMO, or a State high-risk pool – your new plan's pre-existing condition exclusion period must be reduced by the period of your other coverage. This earned credit for previous coverage that can help you reduce your exclusion period is called creditable coverage.

The exclusion period must be shortened by one day for each day of creditable coverage that you have. If the amount of creditable coverage you have is equal to or longer than the exclusion period, no exclusion period can be imposed on you. When figuring out how much creditable coverage you have, however, you receive no credit for previous coverage that has been followed by a **significant break in coverage** – a period of 63 or more full days in a row during which you had no creditable coverage.

Significant Break In Coverage
A significant break in coverage is 63 or more full days in a row without any creditable coverage. Some States, however, may allow a longer break in coverage.

Two examples help illustrate these points.

- Case 1: If you were covered by your old employer's plan for 4 months and your new employer's plan has a 12-month pre-existing condition exclusion, your new employer's plan cannot exclude coverage for you for any pre-existing condition for more than 8 months.

- Case 2: John was covered under his employer's group health plan from January 1, 1998 until March 1, 1999, a period of 14 months. He then dropped that coverage. When he resumed coverage under his employer's plan on July 1, 1999, he had incurred a break of 122 days. From July 1, to August 1 of 1999, John had only 31 days of creditable coverage. His earlier coverage (from January 1, 1998 until March 1, 1999) was followed by a significant break in coverage**.** As a result, the earlier coverage is <u>not</u> counted as creditable coverage.

Know Your State's Law on Coverage

If you are in an insured plan, your State law may let you have a longer break in coverage. If so, you may be able to count creditable coverage even if it is followed by a break of 63 days or more in a row. Your State also may require a shorter exclusion period, or shorter look-back period. State law requirements for pre-existing condition exclusions do not affect those imposed by self-insured plans. For more information contact your State insurance department.

Certificate of Creditable Coverage
A certificate of creditable coverage is a document that describes how much creditable coverage you have, and the date the coverage ended.

Group health plans and health insurance issuers are required to furnish you a **certificate of creditable coverage**. The certificate describes how much creditable coverage you have and the date the coverage ended. Most group health plans and insurance issuers are required to issue certificates automatically shortly after your coverage ends. You also can request a certificate describing particular coverage at any time while the coverage is in effect and within 24 months of the time the coverage ends. Finally, your new health plan can simply call your old plan to inquire about your creditable coverage. If the two plans agree, the plans can exchange the information by telephone.

Plan Administrator
The person responsible for answering any questions you may have about your group health plan. The materials that describe the plan should identify who your plan administrator is.

When you receive a certificate from a former employer, you should make sure the information is accurate. Contact the **plan administrator** of your former health plan or the health insurance issuer if any of the information is wrong.

If you do not receive a certificate from your previous plan or health insurance issuer, your new health plan must accept other documentation that shows you had prior creditable coverage (see Question and Answer on page 21).

Step 4: Understand Your Other Coverage Protections

Understanding how you can best protect your health coverage is not easy. It is complicated because the rules are different depending on your special situation. The fourth step in understanding HIPAA and your protections under the law involves knowing some general information about:

- Special enrollment rights to other group coverage;
- How your health status can affect your access to care;

- Other coverage choices that may help you take advantage of HIPAA protections; and
- Your rights to renew group and individual coverage.

Special Enrollment Rights to Other Group Coverage

Group health plans and health insurance issuers are required to provide special enrollment periods during which individuals who previously declined coverage for themselves and their dependents may be allowed to enroll. Importantly, individuals will be able to enroll without having to wait until the plan's next open enrollment period, but in most situations you must request a special enrollment within 30 days.

A special enrollment period can occur if a person with other health coverage loses that coverage or if a person becomes a new dependent through marriage, birth, adoption or placement for adoption. Special enrollment is NOT late enrollment, which can trigger an 18-month pre-existing condition exclusion period. (See HIPAA Question and Answer section on page 19 for more information on special enrollment. Also see the discussion of COBRA beginning on page 12).

How Your Health Status Can Affect Access to Care

If you are in a group health plan, you cannot be denied coverage based on your health status.

If you are in a group health plan, you cannot be denied coverage based on your health status. A group health plan cannot refuse to enroll you just because of:

- Your health status;
- Physical or mental condition;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability; or
- Disability.

But employers can establish limits or restrictions on benefits or coverage for similarly situated individuals under a group health plan, or charge a higher premium or contribution for similarly situated individuals. In addition, employers may change your plan benefits or covered services if they give you proper notification.

If you are no longer in a group health plan, and you meet the requirements to be a HIPAA eligible individual, you cannot be

denied individual health coverage. However, the choices available to you will depend on the approach your State has taken to make health coverage available to you.

If you are not an eligible individual, State law rather than HIPAA will determine whether you can be denied coverage. Depending on your State's laws, insurers and HMOs offering individual health insurance may be able to deny coverage based on your health status. Federal laws other than HIPAA and some State laws may ensure that certain people who have lost group coverage are guaranteed access to health coverage, at least temporarily, regardless of their health status.

Other Coverage Choices That May Help You Take Advantage of HIPAA Protections

Some key HIPAA protections help you avoid pre-existing condition exclusions on your access to coverage. One Federal law that may help you take advantage of those and other HIPAA protections is the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA Continuation Coverage
Coverage that is offered to you in order to satisfy the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA continuation coverage gives employees and their dependents who leave an employer's group health plan the opportunity to purchase and maintain the same group health coverage for a period of time (generally, 18, 29 or 36 months) under certain conditions. Workers in companies with 20 or more employees generally qualify for COBRA. You may have this right if you lose your job or have your working hours reduced. You also may have this right if you are covered under your spouse's plan and your spouse dies or you get divorced. Children who are born, adopted, or placed for adoption with the covered employee while he or she is on COBRA also will be entitled to coverage.

Some State laws require issuers to provide similar protections for employers with fewer than 20 employees. If you work in a small business, check with your State insurance department to see if your State has such a law.

COBRA May Help When You Change Jobs

If you are between jobs, COBRA continuation coverage or similar State-mandated continuation coverage can help you avoid a significant break in coverage. That, in turn, may allow you to maximize your creditable coverage that can be used to shorten or eliminate your pre-existing condition exclusion period under a new plan.

If you are going to a new job immediately, your new employer might impose a waiting period before you can start getting benefits under the health plan. While days spent in the waiting period will not be counted as a break in coverage, you still will not have health coverage during the waiting period unless you can obtain it from another source. For many people, COBRA may be that source. Taking COBRA from your old plan until coverage under your new plan starts can provide you with continued health coverage.

Taking COBRA from your old plan until coverage under your new plan starts can provide you with continued health coverage.

When you lose eligibility for coverage under one group health plan, you also may be able to special enroll into another group health plan, such as a spouse's plan, under which you originally declined coverage because you already had coverage under your plan. You may want to do this as a temporary measure during a waiting period imposed by an employer plan or as a permanent change. If both COBRA continuation coverage and special enrollment under another plan are available to you, you have two opportunities to request special enrollment:

- When you lose coverage under your old plan; and
- If you elect to take COBRA continuation coverage, when you have exhausted your COBRA coverage.

If you elect COBRA coverage when you lose group health coverage, you will have to exhaust the COBRA coverage before you will be entitled to special enrollment into the other plan. You may need to carefully evaluate whether it is more to your advantage to special enroll into the other plan immediately or to first take COBRA continuation coverage from your old plan.

COBRA as a Bridge into the Individual Market

In addition to helping you avoid a significant break in coverage when you are between jobs or helping you maintain coverage while you are in a waiting period, COBRA can help you – if you want – to buy individual health insurance, which is not connected

to a job. Normally, your decision to buy COBRA coverage – if available to you – is voluntary. However, if you want to protect your right to coverage in the individual market as a HIPAA eligible individual, you must take and exhaust COBRA or similar State continuation coverage that is offered to you.

Exhausting COBRA

*If you lose eligibility for COBRA continuation coverage for any other reason – other than failing to pay **premiums** or asking that it be terminated – the coverage is considered to be exhausted.*

Sometimes there may be a clear advantage to paying insurance premiums for the entire period until COBRA continuation coverage is no longer available to you. (This is called "exhausting" your COBRA coverage.) Continuation coverage is creditable coverage for HIPAA purposes. If you accept continuation coverage, it could help you avoid a significant break in coverage. In turn, that could reduce or eliminate a pre-existing condition exclusion if you later have access to another group health plan. If you reach the end of your COBRA coverage without having access to another group health plan, exhausting COBRA will help you qualify for portability into the individual market as an eligible individual.

There are certain situations in which you may lose COBRA coverage earlier than the end of the usual period. Two examples help illustrate the point.

- Example 1: Your coverage is under a network plan, such as an HMO, you move out of the plan's service area, and there are no other options for continuing COBRA benefits. In this first example, your COBRA continuation coverage is considered to be exhausted.
- Example 2: Your former employer is permitted to terminate continuation coverage in certain situations when you become covered under another group health plan. However, if you have a pre-existing condition, the former employer cannot terminate your COBRA continuation coverage if the new group health plan limits or excludes coverage for your pre-existing condition.

Consider Conversion Options Carefully

Conversion coverage is individual health coverage that might be offered to you when you lose group health plan coverage. Conversion coverage is sometimes offered by a group health plan at the end of COBRA continuation coverage. It also may be offered in place of COBRA or similar State-mandated

continuation coverage. Some States require issuers of group health insurance coverage to offer conversion coverage. A few States also have chosen to use conversion policies as their approach to guaranteeing availability of coverage in the individual market to HIPAA eligible individuals.

If you accept conversion coverage, at the end of coverage under a group health plan or at the end of COBRA or similar State continuation coverage, you might give up some HIPAA protections. These include the ability to qualify as a HIPAA eligible individual. To retain that guarantee, your most recent coverage must have been group health plan coverage.

For HIPAA purposes, conversion coverage is NOT group coverage. Therefore, you can lose your rights as a HIPAA eligible individual if you choose conversion coverage.

Your Rights To Renew Group and Individual Coverage

HIPAA generally gives you the right to renew your group and individual health insurance. But that right varies considerably between group and individual plans based on certain events.

Your right to renew your group and individual health insurance varies considerably between group and individual plans based on certain events.

When the group health plan buys a group insurance policy, coverage generally must be renewed for as long as the employer wants it to be. If your group health plan buys an individual policy for you, it generally must be renewed so long as you want to do so.

Your group coverage is NOT guaranteed to be renewable, however, if the group health plan has:

- Failed to pay premiums for the coverage;
- Committed fraud against the issuer providing the coverage;
- Violated participation or contribution rules that apply to the coverage;
- Terminated the coverage;
- Ended membership in an association (if the coverage is available only to members of the association); or
- If the coverage is a network plan (such as an HMO), the issuer also may terminate or refuse to renew the coverage if all members of the group move outside of the plan's service area.

If you have individual health insurance, generally, your coverage is renewable regardless of whether you are a HIPAA eligible individual**.** Your coverage may be discontinued or non-renewed by your insurance company, only if you:

- Fail to pay your premiums;
- Commit fraud against the issuer;
- Terminate the policy;
- Move outside the service area (if in a network plan);
- Move outside a State (if in a State high-risk pool); or
- End your membership in an association (if the coverage is available only to members of the association).

☑ *Step 5: Know where to go for more information if you have questions*

HIPAA has a number of special rules and its own set of complex terms to describe the limited Federal protections that it may offer you. The information in this booklet covers only basic points about HIPAA. If you want to know more about HIPAA, please refer to the list of information resources beginning on page 39.

Frequently Asked Questions and Answers about HIPAA

About Pre-Existing Condition Exclusions

Q: Are there any situations in which exclusions are completely prohibited?

A: Under HIPAA's group market rules, there can be no pre-existing condition exclusion for pregnancy, no matter when pregnancy began and whether medical advice, diagnosis, care or treatment was recommended or received for the pregnancy. An exclusion cannot be applied to you even if your previous health plan did not cover pregnancy.

An exclusion cannot be applied just because there is **genetic information** suggesting that you may have a particular condition.

An exclusion cannot be applied at all to a child who was covered by creditable coverage no later than 30 days after birth or after being adopted or placed for adoption with you.

Genetic Information
This term refers to information about genes, gene products, and inherited characteristics that may derive from the individual or a family member.

Q: I had a pre-existing condition exclusion period at my prior employment. Can another exclusion period be applied by my new group health plan?

A: It depends on how much creditable coverage you have. If you were subject to a pre-existing condition exclusion period in the past, it does not itself prevent you from having another one applied now. If you only have a little creditable coverage, a pre-existing exclusion period may still apply to your new coverage.

Q: I am changing from one type of coverage to another, but staying within the same employer's group health plan. Can a pre-existing condition exclusion be applied to my new coverage?

A: It depends on how long you have been in the group health plan. If you sign up at the first opportunity, a pre-existing condition exclusion cannot extend more than 12 months after your enrollment date. Your enrollment date is the first day on which you are able to receive benefits under a group health plan or, if your plan imposes a **waiting period**, the enrollment date is the first day of your waiting period — typically your date of hire.

If less than 12 months have passed, a pre-existing condition exclusion might be applied, but the exclusion cannot last beyond the one-year anniversary of your enrollment date (a total of 12 months). For example:

— Nancy began work on June 1, 1999. She signed up for her employer's group health plan on the same day, as soon as she was eligible to do so. Her employer has no waiting period, so she was able to receive benefits as soon as she signed up. As a result, June 1, 1999 is her enrollment date. On May 1, 2000, Jane changed from one coverage option available under the plan to another.

Because 12 months had not passed since her enrollment date, a pre-existing condition exclusion might be applied to her new coverage option. The exclusion can only be effective, however, until June 1, 2000.

Waiting Period
In the individual market, a waiting period is the time between when your application is filed and your coverage begins. With respect to a group health plan, it is the time that must pass before a new employee becomes eligible for benefits under the plan. The waiting period generally starts on the date of hire.

If an exclusion is applied, it will be reduced one day for each day of creditable coverage that you have as of your enrollment date. For example:

— Betty began work on June 1, 1999 and signed up for her employer's group health plan at the first opportunity. She has no waiting period. As of her enrollment date (June 1, 1999) she has a total of 60 days of creditable coverage from a previous employer. On May 1, 2000, at the first opportunity to do so, Betty changes from one coverage option available under the plan to another. Without taking her creditable coverage into account, the pre-existing condition exclusion period would end on June 1, 2000 (with 30 days remaining). Her 60 days of creditable coverage are enough to eliminate the entire remaining exclusion period. As a result, no exclusion can be applied to her new coverage option.

If more than 12 months have passed since your enrollment date, a pre-existing condition exclusion cannot be applied to your new coverage. For example:

— Dan began work for his current employer on March 1, 1999. He signed up for his employer's group health plan on the same day, as soon as he was eligible to do so. He has no waiting period. As a result, March 1, 1999 is his enrollment date. On April 10, 2000, Dan changed from one coverage option available under the plan to another. Because more than 12 months have passed since his enrollment date, no pre-existing condition exclusion can be applied.

Q: I've lost my job but I haven't found a new one yet. What can I do to retain my protections under HIPAA?

A: Be careful to avoid a significant break in coverage (63 or more full days in a row without any coverage). If offered, decide whether you should accept COBRA continuation coverage. If you had group health plan coverage at your last job, you probably will be offered COBRA continuation coverage (or similar continuation coverage that must be offered to you under State law). If you are eligible for such continuation coverage, it

counts as creditable coverage. In addition, you must accept and exhaust COBRA benefits before you can obtain coverage in the individual market as a HIPAA eligible individual. (You may also have to satisfy other requirements to obtain the coverage.)

About Special Enrollment

Q: What events trigger a special enrollment period?

A: Special enrollment is required in two situations.

- You or your dependent lose other health coverage; and
- You get a new dependent through marriage, birth, adoption, or placement for adoption with you.

You or your dependent lose other health coverage

To get a special enrollment opportunity in this situation, the employee or dependent must earlier have turned down coverage available through the group health plan because he or she had other coverage.

If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA coverage is exhausted.

If the other coverage was NOT COBRA continuation coverage, the individual can request special enrollment when his/her other coverage ends because the individual is no longer eligible for it.

A special enrollment period also must be given if the employer sponsoring the group health plan stops paying its share of the premiums.

You get a new dependent through marriage, birth, adoption, or placement for adoption with you.

If the triggering event is a birth, adoption or placement for adoption, the child, the employee, and the employee's spouse are entitled to special enrollment, either individually or in any combination.

Q: When do I request special enrollment?

A: If a special enrollment period is triggered when an employee or his/her dependent loses other health coverage, the employee must request the special enrollment(s) within 30 days of the loss of coverage. If a special enrollment period is triggered when a new dependent is added, the individual must request the special enrollment(s) within 30 days of the triggering event.

Q: How are pre-existing condition exclusions applied to special enrollees?

A: For each triggering event, a special enrollee is regarded as a regular enrollee and not a late enrollee. Therefore, the maximum pre-existing condition exclusion period that may be applied to a special enrollee is 12 months. The 12 months are reduced, day for day, by the special enrollee's creditable coverage. In addition, a newborn, adopted child or child placed for adoption cannot be subject to a pre-existing condition exclusion period if the child is enrolled within 30 days after birth, adoption or placement for adoption and has no subsequent significant break in coverage after that time.

Q: Are plans and issuers required to notify individuals of their special enrollment rights?

A: Yes. A notice of special enrollment rights must be provided to employees on or before the time they are offered the opportunity to enroll in the group health plan.

Q: When will the new coverage start?

A: When the individual loses other coverage, the new coverage must begin no later than the first day of the first calendar month beginning after the date the employee requests special enrollment.

In the case of marriage, enrollment must be effective not later than the first day of the first calendar month that begins after the date the group health plan receives the completed request for enrollment.

In the case of birth, adoption, or placement for adoption, enrollment is required to be effective not later than on the date of such birth, adoption, or placement for adoption.

About Creditable Coverage

Q: What if I don't receive a certificate, or lose one that I received?

A: In most cases, your first step should be to contact the plan administrator of your prior group plan. Ask for a copy of the certificate; it should be free of charge. If you do not automatically receive a certificate of coverage or receive one before you need it, you should:

- Contact the plan administrator if you have been in a group plan;
- Contact the health insurance issuer if you have had individual coverage.

Because some people have had creditable coverage through multiple sources, you should always check with all sources to be sure you get the credit you deserve.

If you lose your certificate, you can go back and request another one, free of charge. In most cases, even if you do not receive a certificate, you can use other evidence to prove creditable coverage. These include:

- Pay stubs that reflect a premium deduction;
- Explanation of benefit forms;
- A benefit termination notice from Medicare or Medicaid; and
- Verification by a doctor or your former health care benefits provider that you had prior health coverage.

You also can request a certificate describing your coverage under a particular group health plan, policy or contract (free of charge) at any time while you are still covered or up to 24 months after the coverage has ended. Each certificate that you request should describe the creditable coverage you have received for the prior 24 months.

About Portability

Q: What are the circumstances in which I will have portability?

A: HIPAA provides for portability rights in three circumstances:

- When you leave a job where you had group health plan coverage, and move to another job with group health plan coverage. (This also applies if you are covered as a dependent of the person who changes jobs.)
- You lose group health plan coverage, you meet the definition of a HIPAA eligible individual and you wish to purchase individual health insurance coverage.
- You have individual health insurance coverage or any other type of creditable coverage, and you enroll in a new group health plan.

Q: What does portability NOT do?

A: There are three things that portability does NOT do.

- Portability does NOT let you keep your current plan or benefits when you change or lose your job or get a new job.
- It does NOT require your new employer or union to provide health coverage
- It does NOT guarantee that if you move from one plan or policy to another, the benefits you receive will be the same as those that were available to you under your old plan or policy. Coverage under the new plan could be less (or more) generous, and premiums and cost-sharing arrangements (such as deductibles and copayments) may differ.

HIPAA does NOT provide for portability rights when you have individual health insurance coverage and you move to other individual health insurance coverage. However, State law might provide portability rights in this situation.

About Access To Other Coverage Options

Q: I've lost my job, and I am worried about health insurance. Is there any help for me?

A: You may have rights to certain health coverage even if you lose your job. If your company provided a group health plan, you may be entitled to continued health benefits for a period of time under COBRA or a State law. You may also have rights under HIPAA to buy individual health insurance.

Q: If I had health coverage under my or my spouse's old job but I lost that coverage and do not have access to group coverage through my new job, can HIPAA help me as an individual?

A: If you meet the requirements to be a HIPAA eligible individual, you must get a choice of individual coverage with no pre-existing condition exclusion, either through a health insurance issuer or a State's high-risk pool.

Q: Can I keep my doctor?

A: If you are changing from one health plan to another, or from one policy to another, you may have to change doctors**.** It depends on the benefits offered by your new plan or policy. Your need to change doctors is especially true if you join a managed care plan. Check with your plan to understand the extent your choice of doctors may be restricted.

General HIPAA Questions

Q: Do HIPAA's group market protections apply to all group health plans?

A: No, HIPAA's group market protections do not automatically apply to all employment-related group health plans. The following situations trigger some exceptions:

1. Very small plans. In most cases, if you are in a group health plan that only covers one current employee, State law will determine whether you have HIPAA group market protections. Check with your State insurance department to find out if HIPAA group market protections apply to you.
2. Non-federal governmental plans. If your eligibility for your group health plan is based on your or someone else's employment with a State or local

government agency, HIPAA protections should apply to you unless your plan has notified you that it is exempt from some or all HIPAA requirements. However, even if the plan is exempt from other requirements, it must always provide you with a certificate of creditable coverage when your coverage ends. You also can ask your plan administrator if you are not sure which protections apply, or you can check the HIPAA website (http://hipaa.hcfa.gov) for a list of non-federal governmental plans.

3. Federal governmental plans. If your eligibility for your group health plan is based on your or someone else's employment with a Federal government agency, HIPAA itself does not apply directly, but the government affords similar protections.
4. **Church plans**. If your eligibility for your group health plan is based on your or someone else's employment with a church or group of churches, you should check with your plan administrator to find out whether HIPAA's group market protections apply to you.

Church Plan
A church plan is a health plan that is established by a church or other religious organization, or by a convention or association of churches, for its employees. Church plans may include employees of hospitals or universities owned and operated by such religious organizations.

Q: Does HIPAA limit my health insurance premiums?

A: HIPAA generally does not limit premiums. However, when a plan or issuer provides group health plan coverage, HIPAA does not allow the plan or issuer to charge one individual a higher premium based on that individual's health status. For example, individuals with diabetes cannot be charged a higher premium because of that medical condition. An individual must be charged the same premium that is charged to similarly situated individuals for the same coverage. Similarly situated individuals are, for example, other individuals who are in the same employee category, or in the same geographic location. Employee categories may include, for example, full-time employees (or part-time employees), all employees with the same length of service, and current employees (or former employees). Employees' dependents are grouped into categories that are based on the categories used for the employees themselves. For example, if employees are categorized by location, as full-time or part-time, all dependents of part-time employees are similarly situated individuals.

The Mental Health Parity Act

Overview

The Mental Health Parity Act of 1996 (MHPA) is a Federal law that may prevent your group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower – less favorable – than annual or lifetime dollar limits for medical and surgical benefits offered under the plan. For example, if your health plan has a $1 million lifetime limit on medical and surgical benefits, it cannot put a $100,000 lifetime limit on mental health benefits. The term "mental health benefits" means benefits for mental health services as defined by the health plan or coverage.

MHPA does NOT require group health plans and their health insurance issuers to include mental health coverage in their benefits package.

Although the law requires "parity," or equivalence, with regard to dollar limits, MHPA does NOT require group health plans and their health insurance issuers to include mental health coverage in their benefits package. The law's requirements apply only to group health plans and their health insurance issuers that include mental health benefits in their benefits packages.

If your group health plan has separate dollar limits for mental health benefits, the dollar amounts that your plan has for treatment of substance abuse or chemical dependency are NOT counted when adding up the limits for mental health benefits and medical and surgical benefits to determine if there is parity.

Coverage under MHPA

MHPA applies to most group health plans with more than 50 workers. MHPA does NOT apply to group health plans sponsored by employers with fewer than 51 workers. MHPA also does NOT apply to health insurance coverage in the individual market. But you should check to see if your State law requires mental health parity in other cases.

An Example of a Coverage Provision that Violates MHPA Protection

Your plan has a limit of 60 visits per year for mental health benefits, along with a fixed dollar limit of $50 per visit – a total annual dollar limit of $3,000. It places no similar limits on medical and surgical benefits. MHPA does NOT allow this inequality to exist for group health plans covered by the law.

Restrictions Allowed under MHPA

Group health plans may impose some restrictions on mental health benefits and still comply with the law. MHPA does NOT prohibit group health plans from:

- Increasing copayments or limiting the number of visits for mental health benefits;
- Imposing limits on the number of covered visits, even if the plan does not impose similar visit limits for medical and surgical benefits; and
- Having a different cost-sharing arrangement, such as higher coinsurance payments, for mental health benefits as compared to medical and surgical benefits.

Frequently Asked Questions and Answers about MHPA

Q: My plan has a limit of 30 visits per year on mental health benefits and pays 80 percent of the provider's usual, customary, and reasonable (UCR) charges. There is no similar visit limit on medical and surgical benefits. Is this a violation of MHPA?

A: No. A visit limit coupled with UCR charges is not the equivalent of an annual or lifetime dollar limit. As a result, it is NOT a violation of the MHPA requirements. Payments made by the plan on the basis of UCR charges will vary from one case to the next.

Q: I am in a network plan that has an annual limit for mental health benefits received out-of-network. There are no limits for out-of-network medical and surgical benefits. Does MHPA allow this?

A: Yes. As long as there is parity between medical and surgical benefits and mental health benefits received in the network, then out-of-network limits do not violate MHPA.

Q: If a State has a law that provides stronger protections for mental health benefits than MHPA does, which law applies?

A: Group health plans generally are not subject to State insurance laws. State insurance laws, however, do

apply to health insurance issuers, and health insurance issuers must comply with State insurance laws that provide additional consumer protections. If a group health plan provides health coverage to employees and their family members by purchasing insurance for them, health insurance issuers may be required to comply with State insurance laws that provide stronger protections than MHPA. Contact your State insurance department for additional information.

The Newborns' and Mothers' Health Protection Act

Overview

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. The law applies both to persons enrolled in group health plans and to persons who have individual health care coverage. In general, plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

If you deliver in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If you deliver outside the hospital and you are later admitted to the hospital in connection with childbirth, the period begins at the time of the admission.

Although the NMHPA prohibits group health plans and health insurance issuers from restricting the length of a hospital stay in connection with childbirth, the plan or health insurance issuer does not have to cover the full 48 or 96 hours in all cases. If an attending provider, after speaking with you, determines that either you or your child can be discharged before the 48-hour (or 96-hour) period, the group health plan and health insurance issuers do not have to continue covering the stay for whichever one of you is ready for discharge. An attending provider is an individual, licensed under State law, who is directly responsible for providing maternity or pediatric care to you or your newborn child. In addition to physicians, an individual such as a nurse midwife, physician assistant, or nurse practitioner may be an attending provider. A plan, hospital, insurance company, or HMO would NOT be an attending provider.

Coverage under NMHPA

Two key factors determine whether NMHPA protections apply to your health insurance coverage. First, protection depends on whether the benefits under your group health plan or insurance policy include coverage for hospital stays following childbirth. NMHPA does NOT require group health plans and health insurance issuers to provide that kind of coverage.

Second, even if your group health plan or health insurance issuer chooses to cover hospital stays in connection with childbirth, you need to find out how your group health plan provides benefits. Group health plans that provide benefits through insurance are known as insured plans. Group health plans that pay for coverage directly, without purchasing health insurance from an issuer, are called self-insured plans.

Contact your plan administrator to find out if your coverage is insured or self-insured.

If you are in a self-insured group health plan, your health coverage must comply with NMHPA standards. If you are in an insured group plan or if you have individual insurance coverage, the NMHPA might NOT apply if your State has a law with certain protections for hospital stays following childbirth. As of mid-2000, more than 40 states and the District of Columbia had laws that take precedence over NMHPA.

As of mid-2000, more than 40 states and the District of Columbia had laws that take precedence over NMHPA.

Contact your State insurance department to find out what requirements exist under State law for benefits related to hospital stays following childbirth.

Frequently Asked Questions and Answers about NMHPA

Q: Does the 48-hour period (or 96-hour period) apply only to me, or does it also apply to my newborn child?

A: The 48-hour period (or 96-hour period) applies to your newborn child and is independent of the period that applies to you. This means that the plan or issuer might pay for a different amount of time for you than for your child, depending on the attending provider's decision to discharge one of you before the other. The

attending provider will make that decision in consultation with you.

Q: May a plan or a health insurance issuer require me to get permission for a 48-hour or 96-hour hospital stay?

A: No. A plan or health insurance issuer cannot require you or your attending provider to show that the 48-hour (or 96-hour) stay is medically necessary. However, a plan or health insurance issuer may require you to get permission – sometimes called prior authorization or precertification based upon medical necessity – for any portion of a stay after the 48 hours (or 96 hours). In addition, a plan or health insurance issuer generally can require you to notify the plan or issuer of the pregnancy in advance of an admission if you wish to use certain providers or facilities, or to reduce your out-of-pocket costs.

Q: May plans or health insurance issuers impose deductibles or other cost-sharing arrangements for hospital stays in connection with childbirth?

A: Yes, but only if the deductible, coinsurance, or other cost-sharing amounts for the later part of the protected 48-hour (or 96-hour) stay are not greater than those imposed for the earlier part of the stay. For example, with respect to a 48-hour stay, a plan is permitted to cover only 80 percent of the cost of the hospital stay. However, a plan that covers 80 percent of the cost for the first 24 hours cannot reduce coverage to 50 percent for the second 24 hours.

Q: May I be offered incentives to shorten my hospital stay or my newborn's hospital stay? May my doctor be offered incentives to discharge us?

A: No. Plans and health insurance issuers cannot give you payments (including payments-in-kind such as baby supplies) or rebates in return for your agreeing to an early discharge. Plans and health insurance issuers are prohibited from pressuring you to agree to an early discharge. They may not deny you or your newborn child eligibility or continued eligibility to enroll or

renew coverage under your plan or individual policy. Plans and health insurance issuers cannot pressure attending providers to discharge you or your newborn child early by giving them financial or other incentives. Such illegal incentives would include reducing or limiting their compensation or by penalizing them, for example, by taking disciplinary action against them.

Q: Is my health plan required to give me notice about my rights under NMHPA?

A: Yes. Group health plans and health insurance issuers are required to provide you with notice about your rights under this law. If you are in a group health plan, the notice will usually be included in the plan document (sometimes referred to as the "Summary Plan Description") that provides a description of the benefits covered under your plan. If you have individual health insurance coverage, the notice of your rights under NMHPA will generally be included in your insurance contract.

Women's Health and Cancer Rights Act

Overview

WHCRA does NOT require health plans or health insurance issuers to pay for mastectomies.

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a Federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

If WHCRA applies to you and if you are receiving benefits in connection with a mastectomy and you elect breast reconstruction, coverage must be provided for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses (e.g., breast implant); and
- Treatment for physical complications of the mastectomy, including lymphedema.

Coverage under WHCRA

Whether WHCRA or a State law that affords you the same coverage as WHCRA applies to your coverage will depend on your situation. Generally, WHCRA applies if you are in a self-insured plan. Your State law will determine whether WHCRA will apply to coverage under an insured group plan, or to individual health insurance coverage.

Contact your State's insurance department to find out about whether WHCRA will apply to your coverage if you are NOT in a self-insured health plan.

Frequently Asked Questions and Answers about WHCRA

Q: Under WHCRA, may group health plans and health insurance issuers impose deductibles or coinsurance for reconstructive surgery in connection with a mastectomy?

A: Yes, but only if the deductibles and coinsurance are consistent with the cost-sharing arrangements that apply to other benefits under the plan or coverage.

Q: Are health plans required to give me notice of WHCRA benefits?

A: Yes. Both group health plans and health insurance issuers are required to provide you notice of WHCRA benefits upon enrollment and annually thereafter.

Q: Does WHCRA affect the amount that my health plan will pay my doctors?

A: No. WHCRA does not prevent a plan or health insurance issuer from negotiating the level and type of payment with attending providers. However, the law prohibits plans and issuers from penalizing attending providers or providing incentives that would induce a provider to provide care that is inconsistent with WHCRA.

Terms We Use

AFFILIATION PERIOD
If your group health plan provides coverage through a contract with an HMO, an affiliation period is the length of time an HMO may make you wait before you can receive benefits. During this time, you cannot be charged a premium. Under HIPAA, an affiliation period may not last longer than two months (three months if you are a late enrollee), and it must begin on your enrollment date under the group health plan. As a result, if you switch to HMO coverage more than 3 months after your enrollment date, the HMO cannot impose an affiliation period on you. Affiliation periods are an alternative to pre-existing condition exclusions; an HMO cannot impose both, even on different individuals.

CERTIFICATE OF CREDITABLE COVERAGE
A certificate of creditable coverage is a document that describes how much creditable coverage you have, and the date the coverage ended. Most group health plans and insurance issuers are required to issue certificates automatically shortly after your coverage ends. You also can request a certificate describing particular coverage at any time while the coverage is in effect and within 24 months of the time the coverage ends.

CHURCH PLAN
A church plan is a health plan that is established by a church or other religious organization, or by a convention or association of churches, for its employees. Church plans may include employees of hospitals or universities owned and operated by such religious organizations.

COBRA CONTINUATION COVERAGE or **COBRA**
COBRA continuation coverage is coverage that is offered to you in order to satisfy the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA requires employers to permit employees or family members to continue their group health coverage at their own expense, but at group rates, if they lose coverage because of a loss of employment, reduction in hours, divorce, death of the supporting spouse, or other designated events.

CONVERSION COVERAGE
Conversion coverage is individual health coverage that might be offered to you when you lose group health plan coverage.

CONVERSION POLICY
A conversion policy is an individual health insurance policy that you may be able to get after losing group coverage. A health insurance issuer may allow you to "convert" to an individual policy once you have lost group coverage. This means you would still have a policy generally with the same issuer, but it will be an individual policy. The benefits offered by the conversion policy may not be

the same as those under your group policy. Generally, the premiums for a conversion policy will be more expensive.

CREDITABLE COVERAGE
Creditable coverage is prior health care coverage that is taken into account to determine the allowable length of pre-existing condition exclusion periods (for individuals entering group health plan coverage) or to determine whether an individual is a HIPAA eligible individual (when the individual is seeking individual health insurance coverage.) Most health coverage is creditable coverage, including coverage under any of the following:

- a group health plan (related to employment).
- a health insurance policy; including short-term limited duration policies.
- Medicare Part A or Part B;
- Medicaid;
- a medical program of the Indian Health Service or tribal organization;
- a State health benefits risk pool;
- TRICARE (the health care program for military dependents and retirees);
- Federal Employees Health Benefit Plan;
- a public health plan; or
- a health plan under the Peace Corps Act.

ENROLLMENT DATE
Your enrollment date is the first day on which you are able to receive benefits under a group health plan, or if the plan imposes a waiting period, the first day of your waiting period. Unless you chose not to participate in the plan when you first are hired, your enrollment date usually is the date on which you begin work.

ERISA
The Employee Retirement Income Security Act (ERISA) is a law that provides protections for individuals enrolled in pension, health, and other benefit plans sponsored by private-sector employers. The US Department of Labor administers ERISA.

GENETIC INFORMATION
This term refers to information about genes, gene products, and inherited characteristics that may derive from the individual or a family member.

GROUP HEALTH PLAN
A group health plan is an employee welfare benefit plan maintained by an employer or union that provides medical care to employees and often to their dependents as well.

HEALTH INSURANCE ISSUER
Any company that sells health insurance is a health insurance issuer. Insurance companies and HMOs are both health insurance issuers.

HIGH-RISK POOL
A high-risk pool is any arrangement established and maintained by a State primarily to provide health insurance benefits to certain State residents who, because of their poor health history, are unable to purchase coverage in the open market or can only acquire such coverage at a rate that is substantially above the rate offered by the high-risk pool. Coverage offered by a high-risk pool is comparable to coverage available in the open market, but the risk for that coverage is borne by the State, which generally supports the losses sustained by the pool through assessments on all health insurers doing business in the State, based on their relative market shares, and/or through general tax revenues.

HIPAA ELIGIBLE INDIVIDUAL In this booklet, a HIPAA eligible individual means a person who is guaranteed the right under HIPAA to purchase individual health insurance coverage with no pre-existing condition exclusions. If you meet all the following requirements, you are an "eligible individual" and HIPAA guarantees your right to purchase individual coverage:

- You don't have, or will be losing, coverage under a group health plan or an individual health insurance policy.
- You have at least 18 months of creditable coverage without any significant break. (A significant break is a period of 63 or more days during all of which you had no coverage. If you get coverage by midnight of the 63rd day, you have not incurred a significant break in coverage).
- Your most recent coverage must have been a group health plan (through your or a family member's employer or union).
- You are not eligible for Medicare or Medicaid.
- You do not have other health insurance.
- You did not lose your insurance for not paying the premiums or for committing fraud.
- You accepted and exhausted your COBRA continuation coverage or similar State coverage if it was offered to you.

INDIVIDUAL MARKET
This refers to health insurance that is made available to individuals and their dependents other than in connection with a group health plan.

INSURED PLAN
An insured plan is a group health plan under which the benefits are provided by the sponsoring employer or union through the purchase of health insurance coverage from an HMO or an insurance company. In exchange for a premium or contribution paid by the employer or union and/or its employees or members, the HMO or the insurance company bears full risk for the cost of the benefits provided.

LARGE EMPLOYER
A large employer has at least 51 employees.

LATE ENROLLEE
A late enrollee is an individual who does not enroll in a group health plan at the first opportunity, but enrolls later if the plan has a general open enrollment period. A late enrollee is different from a special enrollee.

MEDICAL CONDITION
A medical condition is any physical or mental condition resulting from an illness, injury, pregnancy, or congenital malformation**.**

NETWORK PLAN
A network plan is a health insurance policy that provides coverage through a defined set of providers under contract with the insurance issuer.

PLAN ADMINISTRATOR
The person responsible for answering any questions you may have about your group health plan. The materials that describe the plan should identify who your plan administrator is.

POLICY
An insurance policy or any other contract (such as an HMO contract) that provides you or your group health plan with health insurance coverage.

PRE-EXISTING CONDITION EXCLUSION
A pre-existing condition exclusion limits or denies benefits for a medical condition that existed before the date that coverage began. A "medical condition" is any physical or mental condition resulting from an illness, injury, pregnancy, or congenital malformation. HIPAA limits the use of pre-existing condition exclusions and establishes requirements that a pre-existing condition exclusion must satisfy.

PREMIUMS
Premiums refer to the amount that you contract to pay an insurance issuer or HMO, generally on a periodic basis, in return for health coverage.

SELF-INSURED (OR SELF-FUNDED) PLAN
A self-insured (or self-funded) plan is a group health plan under which the risk for the cost of the benefits provided is borne by the sponsoring employer or union. The employer or union may hire a third party administrator to perform such services as paying claims, collecting premiums, or supplying other administrative services), but the financial liability for the cost of the benefits provided remains with the employer or union. Typically, a self-insured plan will purchase stop-loss insurance to limit its financial liability to a certain level.

SHORT-TERM LIMITED DURATION INSURANCE
Short-term limited duration insurance is a health insurance contract that expires within 12 months and cannot be renewed beyond that point.

SIGNIFICANT BREAK IN COVERAGE
A significant break in coverage is 63 or more full days in a row without any creditable coverage. Some States, however, may allow a longer break in coverage.

SMALL EMPLOYER
A small employer has at least two but not more than 50 employees. Some States, however, may consider a business with only one employee a small employer.

SPECIAL ENROLLMENT
A special enrollment is an opportunity to enroll in a group health plan without having to wait for an open enrollment period. A group health plan must provide you with an opportunity for special enrollment if you declined coverage under the plan because you had alternative coverage but since have lost that alternative coverage, or if you have new dependents (through marriage, birth or adoption).

WAITING PERIOD
In the individual market, a waiting period is the time between when your application is filed and your coverage begins. With respect to a group health plan, it is the time that must pass before a new employee becomes eligible for benefits under the plan. The waiting period generally starts on the date of hire.

Where To Find More Information

About Certificates of Creditable Coverage
If you do not receive a certificate of creditable coverage or lose one that you received, in most cases, contact the plan administrator of your prior group plan or your health insurance company if you have an individual policy

About Church Plans
To learn more about the essential features of church plans, contact the Department of Labor's publication hotline (1-800-998-7542) for a reference booklet entitled, "Questions and Answers: Recent Changes in Health Care Law."

About COBRA
To learn more about COBRA continuation coverage in relation to HIPAA, contact the Department of Labor's publication hotline (1-800-998-7542) for a reference booklet entitled, "Questions and Answers: Recent Changes in Health Care Law."

For detailed on-line information about COBRA, log on to the Department of Labor's Internet Website. The address is: http://www.dol.gov/dol/pwba/public/health.htm

About Health Insurance Portability and Accountability Act (HIPAA)
The Health Care Financing Administration maintains a telephone help line for questions about HIPAA. This is NOT a toll-free number. The HIPAA Help Line can be reached by dialing 410-786-1565.

You can get additional information about HIPAA by logging on to the Health Care Financing Administration's Internet Website. If you also want more detailed information about your individual health insurance situation, click on "HIPAA OnLine" at http://hipaa.hcfa.gov

About Mental Health Parity Act (MHPA)
You can get additional information about MHPA by logging on to the Health Care Financing Administration's Internet Website. The address is: http://hipaa.hcfa.gov

About Newborns' and Mothers' Health Protection Act (NMHPA)
You can get additional information about NMHPA by logging on to the Health Care Financing Administration's Internet Website. The address is: http://hipaa.hcfa.gov

About Pre-Existing Condition Exclusions
If you have questions about pre-existing condition exclusions under your employer's group health plan, contact the plan administrator.

About Women's Health and Cancer Rights Act (WHCRA)
You can get additional information about WHCRA by logging on to the Health Care Financing Administration's Internet Website. The address is: http://hipaa.hcfa.gov

About State Insurance Department HIPAA Contacts

State laws often provide you greater health insurance coverage protections than do Federal laws. Therefore, in many instances, it is important that you contact your State insurance department listed below for information about insurance protections in your State.

Alabama
Alabama Department of Insurance
201 Monroe Street, Suite 1700
Montgomery, Alabama 36104
334-241-4141
Fax 334-241-4192

Alaska
Alaska Department of Commerce &
Economic Development
Division of Insurance
3601 C Street, Suite 1324
Anchorage, AK 99503-5948
907-269-7900
800-467-8725 (Alaska)
Fax 907-465-3422

American Samoa
Office of the Governor
American Samoa Government
Pago Pago, American Samoa 96799
011-684-633-4116
Fax 011-684-633-2269

Arizona
Arizona Department of Insurance
2910 North 44th Street, Suite 210
Phoenix, AZ 85018-7256
602-912-8446
800-325-2548 (Arizona)
Fax 602-954-7008

Arkansas
Arkansas Department of Insurance
1200 West 3rd Street
Little Rock, AR 72201-1904
501-371-2640
800-852-5494
Fax 501-371-2629

California
California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, CA 90013
213-897-8921
800-927-4357
Fax 916-322-7294

California Dept. of Managed Health Care
980 9th Street
Sacramento, CA 95814
800-400-0815

Colorado
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202
303-894-7490
800-930-3745 (Colorado)
Fax 303-894-7455

Connecticut
Connecticut Department of Insurance
P.O. Box 816
135 Market Street
Hartford, CT 06142-0816
860-297-3802
800-203-3447 (Connecticut)
Fax 860-566-7410

Delaware
Delaware Department of Insurance
841 Silver Lake Boulevard
Dover, DE 19904
302-739-4251
Fax 302-739-5280

District of Columbia
Insurance Administration
810 First Street, NE, Suite 701
Washington, DC 20002
202-727-8000 Ext. 3018
Fax 202-535-1198

Florida
Florida Department of Insurance
Bureau of Consumer Affairs
200 E. Gaines Street
Tallahassee, FL 32399-0300
850-922-3132
800-342-2762 (Florida)
Fax 850-488-2349

Georgia
Georgia Department of Insurance
2 Martin L. King, Jr. Dr.
Floyd Memorial Bldg., 716 W. Tower
Atlanta, GA 30334
404-656-2070
800-656-2298 (Georgia)
Fax 404-657-8542

Guam
Department of Revenue & Taxation
Insurance Branch
Government of Guam
Building 13-1, 2nd Floor
Mariner Avenue
Tiyan, Barrigada, Guam 96913
011-671-475-1843
Fax 011-671-472-2643

Hawaii
Hawaii Insurance Division
Dept. of Commerce & Consumer Affairs
250 S. King Street, 5th Floor
Honolulu, HI 96813
808-586-2809
Fax 808-586-2806

Idaho
Idaho Department of Insurance
700 West State Street, 3rd Floor
Boise, ID 83720-0043
208-334-4300
800-721-3272 (Idaho)
Fax 208-334-4398

Illinois
Illinois Department of Insurance
320 West Washington Street., 4th Floor
Springfield, IL 62767
217-785-0116
877-527-9431

Indiana
Indiana Department of Insurance
311 W. Washington Street, Suite 300
Indianapolis, IN 46204-2787
317-232-2395
800-622-4461
Fax 317-232-5251

Iowa
Iowa Division of Insurance
330 E. Maple Street
Des Moines, IA 50319
515-281-5705
877-955-1212 (Iowa)
Fax 515-281-3059

Kansas
Kansas Department of Insurance
420 S.W. 9th Street
Topeka, KS 66612-1678
785-296-3071
800-432-2484 (Kansas)
Fax 785-296-7805

Kentucky
Kentucky Department of Insurance
P.O. Box 517
215 West Main Street
Frankfort, KY 40602-0517
502-564-6088
800-595-6053
Fax 502-564-1453

Louisiana
Louisiana Department of Insurance
Office of Health
P.O. Box 94214
950 North 5th Street
Baton Rouge, LA 70804
225-219-4770
800-259-5301
Fax 225-342-8622

Maine
Maine Bureau of Insurance
Dept. of Professional & Financial Regulation
Consumer Health Care Division
34 State House Station
Augusta, ME 04333-0034
207-624-8475
800-300-5000 (Maine)
Fax 207-624-8599

Maryland
Maryland Insurance Administration
525 St. Paul Place
Baltimore, MD 21202-2272
410-468-2244
800-492-6116
Fax 410-468-2260

Massachusetts
Commonwealth of Massachusetts
Division of Insurance
One South Station, 4th Floor
Boston, MA 02110
617-521-7301
Fax 617-521-7758

Michigan
Michigan Division of Insurance
Policy & Consumer Services
611 W. Ottawa Street, 2nd Floor
Lansing, MI 48933-1020
517-373-2984
877-999-6442
Fax 517-335-1727

Minnesota
Minnesota Department of Commerce
Enforcement Division
133 East 7th Street
St. Paul, MN 55101
651-296-2488
800-657-3602
Fax 651-296-4328

Mississippi
Mississippi Department of Insurance
1804 Walter Sillers State Office Building
550 High Street
Jackson, MS 39201
601-359-3569
800-562-2957 (Mississippi)
Fax 601-359-2474

Missouri
Missouri Department of Insurance
Division of Consumer Affairs
301 West High Street, 5 North
Jefferson City, MO 65102-0690
573-751-2640
800-726-7390
Fax 573-751-1165

Montana
Montana Department of Insurance
126 North Sanders
270 Mitchell Building
Helena, MT 59601
406-444-4613
Fax 406-444-3497

Nebraska
Nebraska Department of Insurance
Terminal Building
941 'O' Street
Lincoln, NE 68508
402-471-0888
877-564-7323
Fax 402-471-4610

Nevada
Nevada Department of Business & Industry
Division of Insurance
788 Fairview Drive, Suite 300
Carson City, NV 89701
775-687-4270
888-872-3234 (Nevada)
Fax 775-687-3937

New Hampshire
Department of Insurance
Consumer Affairs
56 Old Suncook Road
Concord, NH 03301
603-271-2261
800-852-3416
Fax 603-271-1406

New Jersey
New Jersey Department of Insurance
20 West State Street CN325
Trenton, NJ 08625
609-292-5316
Fax 609-292-5865

New Mexico
Public Regulation Commission
Insurance Division
P.O. Box 1269
Santa Fe, NM 87504-1269
505-827-4601
800-927-4722 (New Mexico)
Fax 505-476-0326

New York
New York Department of Insurance
Albany Agency Building One
Empire State Plaza
Albany, NY 12257
518-474-6600
800-342-3736 (New York)
Fax 518-474-2188

North Carolina
North Carolina Department of Insurance
P.O. Box 26387
Raleigh, NC 27611
919-733-3058
Fax 919-733-6495

North Dakota
North Dakota Department of Insurance
600 E. Boulevard
Bismarck, ND 58505-0320
701-328-2440
800-247-0560 (North Dakota)
Fax 701-328-4880

Northern Mariana Islands
Commonwealth of the Northern Mariana Islands
Department of Commerce
Caller Box 10007 CK
Saipan, MP 96950
670-664-3000

Ohio
Ohio Department of Insurance
Consumer Services Division
2100 Stella Court
Columbus, OH 43215-1067
614-644-2673
800-686-1526 (Ohio)
Fax 614-644-3744

Oklahoma
Oklahoma Department of Insurance
2401 N.W. 23rd Street, Suite 28
Oklahoma City, OK 73107
405-521-2828
Fax 405-521-6635

Oregon
Oregon Division of Insurance
Dept. of Consumer & Business Services
350 Winter Street NE, Room 200
Salem, OR 97310-0700
503-947-7205
Fax 503-947-7205

Pennsylvania
Pennsylvania Insurance Department
Bureau of Consumer Services
1321 Strawberry Square, 13th Floor
Harrisburg, PA 17120
717-787-2317
877-881-6388 (Pennsylvania)
Fax 717-787-8585

Puerto Rico
Puerto Rico Department of Insurance
Cobian's Plaza Building
1607 Ponce de Leon Avenue
Santurce, PR 00909
787-722-8686
Fax 787-722-4400

Rhode Island
Rhode Island Insurance Division
Department of Business Regulation
233 Richmond Street, Suite 233
Providence, RI 02903-4233
401-222-2223
Fax 401-222-5475

South Carolina
Consumer Services Division
South Carolina Department of Insurance
P.O. Box 100105
1612 Marion Street
Columbia, SC 29202-3105
803-737-6180
800-768-3467 (South Carolina)

South Dakota
South Dakota Division of Insurance
Department of Commerce & Regulation
118 W. Capitol Avenue
Pierre, SD 57501-2000
605-773-3563
Fax 605-773-5369

Tennessee
Tennessee Dept. of Commerce & Insurance
Volunteer Plaza
500 James Robertson Parkway
Nashville, TN 37243-0565
615-741-2241
Fax 615-532-6934

Texas
Texas Department of Insurance
333 Guadalupe Street
Austin, TX 78701
512-463-6464
800-252-4349
Fax 512-475-1771

Utah
Utah Department of Insurance
3110 State Office Building
Salt Lake City, UT 84114-1201
801-538-3800
Fax 801-538-3829

Vermont
Vermont Division of Health Care
Administration
Dept. of Banking, Insurance & Securities
89 Main Street, Drawer 20
Montpelier, VT 05620-3101
802-828-2900
800-631-7788

Virginia
Virginia Bureau of Insurance
State Corporation Commission
1300 East Main
Richmond, VA 23219
804-371-9074
Fax 804-371-9944

United States Virgin Islands
United States Virgin Islands
#18 Kongens Gade, Charlotte
Amalie St. Thomas, VI 00802
340-774-7166
Fax 340-774-9458

Washington
Washington Office of the Insurance Commissioner
14th Avenue & Water Street
P.O. Box 40255
Olympia, WA 98504-0255
360-753-7301
800-562-6900 (Washington)
Fax 360-586-3535

West Virginia
West Virginia Department of Insurance
P.O. Box 50540
Charleston, WV 25305-0540
304-558-3386
800-642-9004 (West Virginia)
Fax 304-558-4965

Wisconsin
Office of the Commissioner of Insurance
State of Wisconsin
121 E. Wilson
Madison, WI 53702
608-267-1233
800-236-8517 (Wisconsin)
Fax 608-261-8579

Wyoming
Wyoming Department of Insurance
Herschler Building
122 West 25th Street, 3rd East
Cheyenne, WY 82002-0440
307-777-7401
Fax 307-777-5895

U.S. DEPARTMENT OF
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Baltimore, Maryland 21244-1850

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