

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Overview of HIPAA, Title I through Title V

April, 2002

This document was developed to assist the state agencies of Ohio in understanding the obligations imposed by the Health Insurance Portability and Accountability Act (HIPAA). The State of Ohio provides no guarantee of accuracy or warranties of any kind. Utilization of this information is at the sole risk of the user. As with any matter of law, independent legal counsel should be consulted regarding compliance with the requirements of the HIPAA.

The Health Insurance Portability and Accountability Act (HIPAA), enacted in August of 1996, amends the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and the Public Health Service Act. HIPAA was passed by Congress to reform the insurance market and simplify health care administrative processes. Its purpose is to improve the portability and continuity of health insurance coverage for individuals and groups, to combat fraud and abuse in the health care industry, to promote the use of medical savings accounts, to improve access to long-term care, and to enhance health care insurance and delivery systems by making them more efficient, simpler, and less costly. HIPAA is the single most significant federal legislation affecting the health care industry since the creation of the Medicare and Medicaid programs in 1965. HIPAA consists of the five titles listed below.

Title I: Health Care Access, Portability, and Renewability

Title I includes provisions for certificates of coverage and portability of health insurance. Title I prohibits discrimination in enrollments and in premiums charged to employees and their dependents based on health status related factors. Its provisions primarily affect employers and health insurers and are currently in effect.

Title II: Preventing Fraud and Abuse; Administrative Simplification

- *Fraud and Abuse:* Establishes several health care fraud and abuse programs and revises sanctions for pre-existing fraud and abuse laws.
- *Administrative Simplification:* Requires that specified covered entities use designated standard transaction formats and code sets for the electronic transmission of health information. In addition, Title II establishes standards for the protection and security of individually identifiable health information, and provides penalties for its wrongful disclosure. (It is Administrative Simplification that is being implemented through the HIPAA Statewide Project and by the State of Ohio agencies impacted by its provisions).
- *Duplication and Coordination of Medicare-Related Plans:* Under certain conditions, specifies that certain long term care health insurance policies are not considered to duplicate Medicare or Medicaid benefits.

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Title III: Tax-Related Health Provisions

Title III provides for certain deductions for medical insurance, and makes other changes to health insurance law.

Title IV: Application and Enforcement of Group Health Plan Requirements

Title IV specifies conditions for group health plans regarding coverage of persons with pre-existing conditions, and modifies continuation of coverage requirements.

Title V: Revenue Offsets

Title V includes provisions related to company-owned life insurance, treatment of individuals who lose U.S. citizenship for income tax purposes and repeals the financial institution rule to interest allocation rules.