

# Health Insurance Portability and Accountability Act of 1996 (HIPAA)

## Title I - Health Care Access, Portability, and Renewability

April, 2002

The 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 Act, the Internal Revenue Code of 1986, and the Public Health Service Act. Under the HIPAA Title I nondiscrimination provisions, individuals may not be denied eligibility or continued eligibility to enroll for benefits under the terms of a group health plan based on any health factors. In addition, an individual may not be charged more for coverage than other similarly situated individuals are being charged based on any health factor.

### **General Provisions**

**Discrimination** - Title I prohibits discrimination in enrollments and in premiums charged to employees and their dependents based on health status related factors.

- Health status related factors include: health status, medical conditions (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.
- Group health plans may exclude coverage for a specific disease, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on determination of whether the benefits are experimental or medically necessary, if the benefit restriction is applied uniformly to all similarly situated individuals and is not directed at any individual participants or beneficiaries based on a health factor.
- Group health plans may apply lifetime limits, generally or with respect to benefits for a specific disease or treatment, provided the limits are applied uniformly to all similarly situated individuals and is not directed at any individual participants or beneficiaries based on a health factor.

**Preexisting Condition Exclusion** - Title I limits exclusions for preexisting medical conditions.

- A preexisting medical condition is defined as one for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period prior to an individual's enrollment date.

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- Group health plans and issuers may not exclude an individual's preexisting medical condition from coverage for more than 12 months (18 months for late enrollees) after an individual's enrollment date.
- An employer's plan must give the individual credit for the length of time they had prior continuous health coverage, without a break in coverage of 63 days or more, thereby reducing or eliminating the 12-month exclusion period for individuals with prior "creditable coverage." For example, an individual who was covered by a previous employer's health plan for the past 12 months prior to accepting a position with a new employer would receive credit for that coverage against the new employers' 12 months preexisting condition exclusion. This assumes that there was not a break in coverage greater than 63 days.
  - Creditable coverage includes prior coverage under another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state health benefits risk pool, FEHBP, the Peace Corp Act, or a public health plan.
  - Certificates of creditable coverage must be provided automatically and free of charge by the plan or issuer when an individual loses coverage under the plan, becomes entitled to elect COBRA continuation coverage, or exhausts COBRA continuation coverage.
  - Certificates of creditable coverage must contain information about the length of time the individual and dependents had coverage, as well as the length of any waiting period that applied to the individual and their dependents.

Special Enrollment Rights - Title I provides special enrollment rights for individuals who lose their coverage.

- Special enrollment rights are provided to those individuals who lose their coverage under unique circumstances, including separation, divorce, death, termination of employment and reduction in hours.
- Special enrollments also extend to employees, their spouses, and new dependents upon marriage, birth, adoption or placement for adoption.

*Note: The HIPAA Statewide Project is implementing the administrative simplification provisions contained in Title II of HIPAA. The Title I information presented above has been prepared for information only. Additional information can be provided by the Ohio Department of Insurance.*