

The Basics

HIPAA Coverage Provisions

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was signed into law by President Clinton in August 1996 after virtually unanimous passage by the House and Senate. The legislation's overall aim was to improve the availability of health insurance for working Americans and their families by establishing new protections for those who change jobs, are self-employed, or have pre-existing medical conditions. Title I, summarized here, concerns access, portability, and renewability of insurance coverage. Title II, not addressed here, relates to privacy, fraud and abuse, and administrative simplification.

The coverage provisions:

- Guarantee availability of health insurance for small employers (2 to 50 employees)
- Guarantee that people who lose group coverage will have access to some form of individual coverage, whether an individual policy or an alternative arrangement such as a state high-risk pool, for a 63-day period after losing group coverage (see below)
- Require insurers to renew any policy they have sold to a group or an individual, regardless of health status
- Place limits on a group health plan's ability to exclude pre-existing medical conditions from insurance coverage (see below)
- Prohibit discrimination in enrollment and premiums among members of a group health plan (see below)
- Confirm states' authority to regulate health insurance, including their right to provide greater protections than those available under federal law

Limited guaranteed issue rights — People who lose their insurance because of a job change and have no opportunity to enroll in another employer's group plan may seek individual coverage as guaranteed by HIPAA only after they have first exhausted benefits that may be available to them under the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA permits continued participation in the former employer's plan at the individual's expense—up to 102 percent of the total premium—without financial contribution by the employer, for a period of up to 18 months. COBRA benefits generally apply to health

plans sponsored by employers with more than 20 employees. At state option, ensuing individual coverage may be in the commercial market or through the state's high-risk pool.

Pre-existing condition exclusions — A pre-existing condition exclusion is a provision that for some period of time denies insurance coverage for conditions for which medical advice, diagnosis, or treatment was received during the six months prior to a person's enrolling in a group health insurance plan. Under HIPAA, the exclusion period is limited to 12 months (or 18 months for late enrollees, that is, those who initially declined coverage but were permitted to enroll later because they lost other coverage). Pregnancy may not be deemed a pre-existing condition.

A new employer's plan must give the enrollee credit for the length of time he or she had coverage under another insurance plan without a break of 63 days or more. Depending on how long this "creditable coverage" lasted, it will reduce or eliminate the 12-month exclusion period. The following count toward creditable coverage: prior coverage under a group health plan, an individual health insurance policy, continuation coverage under COBRA, or a government-sponsored plan such as Medicaid.

Certificates of creditable coverage must be provided by the plan or other issuer when a person loses coverage.

Nondiscrimination provisions — Health status factors may not be taken into consideration when determining whether a person is eligible for group or guaranteed-issue individual insurance. Although a plan may request that a prospective enrollee complete a medical questionnaire or health assessment, the carrier or administrator may not deny eligibility on the basis of information provided therein. Late enrollees may not be required to furnish evidence of insurability in order to qualify.

HIPAA does not require a group health plan to provide coverage for any particular service or medical condition. However, any benefits that the plan elects to provide must be uniformly available to all similarly situated individuals. A plan may include limits on various benefits provided they are applied uniformly. It may exclude coverage for certain accidental injuries (resulting from bungee jumping, for example), but it must cover injuries that arise from domestic violence or from a physical or mental medical condition.

Wellness, health promotion, and disease prevention programs receive special attention in HIPAA regulations. If an incentive is provided simply to encourage participation, both benefit and contribution differences are permitted. If the incentive is designed to reward achievement with respect to a specified health factor, other considerations come into play. The reward may not exceed 20 percent of the employee premium contribution, the requirements must not be overly burdensome on participants, and there

National Health Policy Forum

Facilitating dialogue.
Fostering understanding.

2131 K Street NW, Suite 500
Washington DC 20037

202/872-1390
202/862-9837 [fax]
nhpf@gwu.edu [e-mail]
www.nhpf.org [web]

must be a reasonable alternative means of obtaining the reward for those with a medical condition that makes attainment of the standard unreasonably difficult or medically inadvisable.

Cost of Coverage

HIPAA coverage provisions do not eliminate insurers' ability to underwrite, that is, set plan premiums to reflect expected costs. One individual in a group plan cannot be charged more than his or her coworkers, but if that person has an expensive medical condition, the rate charged the group as a whole will be higher. Rates in the individual market are generally a function of individual risk. HIPAA (and federal law generally) is silent on what coverage may cost.

HIPAA Administration

Three federal agencies were jointly charged with developing regulations to implement HIPAA, and severally made responsible for ensuring compliance. States have primary enforcement responsibility. However, the Department of Labor monitors compliance on the part of group health plans, an extension of its oversight under the Employee Retirement Income Security Act of 1974 (ERISA). The Department of the Treasury may impose excise taxes on employers or health plans that are out of compliance. The Department of Health and Human Services was tasked with stepping in to enforce HIPAA in cases where a state fails to adopt and enforce HIPAA protections.

Prepared by Lisa Sprague. Please direct questions to lsprague@gwu.edu.



The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at www.nhpf.org.