

**The Health Insurance Portability and
Accountability Act (HIPAA) of 1996**
Helpful Tips

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1. HIPAA health insurance portability --- HIPAA makes health insurance portable by providing 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. (For more information on a HIPAA eligible individual, go to CMS Webpage, Health Insurance Reform for Consumers <http://www.cms.gov/HealthInsReformforConsume/>, scroll down to the Downloads, select “HIPAA Eligibility Criteria for Individual Coverage”.)
- You have individual health insurance coverage or any other type of creditable coverage, and you enroll in a new group health plan.

Misunderstandings about HIPAA:

- 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.
- It does not regulate the cost of health insurance coverage.

Example 1: Jane Smith worked for Company 123 for 18 months. She participated in the group health plan for the entire 18 months and left that company on March 27th. Jane joined Company ABC on April 27th and also enrolled the group health plan. Since Jane had 18 months of creditable coverage without a significant (of 63 or more consecutive days) break in creditable coverage, she was able to enroll in Company ABC's health plan without any preexisting condition exclusions. *For more information on preexisting condition exclusions, see item 7 and for more information on creditable coverage see items 10 – 12.*

Example 2: Jane Smith worked for 18 months for Company ABC, a small company with less than 20 employees. Company ABC went out of business on April 27th. Jane is not eligible for COBRA. It is now March 27th and Jane has not yet had a break of 63 consecutive days without creditable coverage. She may be HIPAA eligible. She should read the information to determine whether she is HIPAA eligible by going to the CMS Webpage, Health Insurance Reform for Consumers <http://www.cms.gov/HealthInsReformforConsume/>, scrolling down to the Downloads, and selecting "HIPAA Eligibility Criteria for Individual Coverage". If she is HIPAA eligible she should contact her state Department of Insurance (DOI), to determine how she can obtain HIPAA individual coverage, by going to the CMS Webpage, Health Insurance Reform for Consumers <http://www.cms.gov/HealthInsReformforConsume/>, scrolling down to the Downloads, and selecting "DOI Contact Information – State Status Chart". If she is not HIPAA eligible, she should still contact DOI to inquire whether she has any additional state protections regarding accessing health insurance.

Example 3: Jane Smith had individual health insurance for 5 years without a significant break in creditable coverage (63 consecutive days). Jane joined Company ABC on April 27th. Since she had at least 18 months of creditable coverage, Company ABC's group health plan cannot impose any preexisting condition exclusion on Jane. *For more information on preexisting condition exclusions, see item 7.*

2. Provisions for group health plans and issuers --- HIPAA provisions are imposed upon group health plans and issuers. Eligibility for an individual's enrollment in a group health plan is determined according to the terms of the health plan and the rules of the issuer, but not according to an individual's health status or that of an individual's dependent. The issuer's rules and terms must also comply with all applicable state laws. To discuss state laws, contact your state Department of Insurance (DOI). Go to CMS Webpage, Health Insurance Reform for Consumers <http://www.cms.gov/HealthInsReformforConsume/>, scroll down to the Downloads, select "DOI Contact Information – State Status Chart".

Example 1: Jane Smith joined Company ABC on April 27th. Company ABC provides group health benefits for full time salaried and full time hourly employees only. Since Jane is a part time hourly employee, she is not eligible to enroll in the group health plan. Company ABC is not violating any HIPAA provisions. However, Jane should contact her State DOI to determine whether she has any additional state protections.

Example 2: Jane Smith worked for Company 123 for 18 months. Both Jane and her daughter Abigail participated in the group health plan for the entire 18 months before Jane left the company on March 27th. Jane joined Company ABC on April 27th and signed up for the group health plan for both herself and her daughter who has a heart condition. Since Jane and Abigail had 18 months of coverage without a break in creditable coverage (of 63 or more consecutive days), Company ABC has to accept both applicants regardless of their health status and also must cover any preexisting condition. *For more information on preexisting condition exclusions, see item 7.*

3. Health insurance benefits --- HIPAA does not require employers to offer a specific level of benefit. The insurance premiums, copayments, and deductibles may differ from plan to plan, or from year to year. Furthermore, HIPAA does not require employers to offer any health insurance benefits to employees.

Your state may provide additional protections for fully insured group health plans or individual market (non-employment based) health coverage. Contact your state Department of Insurance (DOI) for more information. Go to CMS Webpage, Health Insurance Reform for Consumers <http://www.cms.gov/HealthInsReformforConsumers/>, scroll down to the Downloads, select “DOI Contact Information – State Status Chart”.

Note: The Department of Labor (DOL) (866-444-3272) has jurisdiction over self-funded private sector plans. While CMS has jurisdiction of self-funded public sector (non federal governmental) plans.

Example 1: Jane Smith worked for Company 123 and participated in the group health plan. Jane joined Company ABC on April 27th. She enrolled in the group health plan then realized that her level of benefits had significantly decreased. Company ABC did not violate HIPAA since HIPAA does not require a specific level of benefits. Jane may want to contact her plan administrator to determine whether the group health plan is fully insured or self-funded. If it is fully insured, she may want to contact her state DOI to inquire whether she has additional state protections. If the insurance is self-insured she may want to contact DOL to inquire about additional protections.

Example 2: Jane Smith worked for Company 123 and participated in the group health plan. Jane joined Company ABC on April 27th. Her new employer does not offer health insurance benefits. Company ABC has not violated HIPAA since HIPAA does not mandate that an employer provide health insurance to its employees. She may be eligible for COBRA continuation coverage based on her former employment. For more information on COBRA go to <http://www.cms.gov/COBRAContinuationofCov/>. If she is

not eligible for COBRA, she may be a HIPAA eligible individual provided she has at least 18 months of prior creditable coverage without a 63 day break in coverage. She should contact her state DOI to learn of the HIPAA options for coverage in her State and of any additional state protections she may have. Go to CMS Webpage, Health Insurance Reform for Consumers <http://www.cms.gov/HealthInsReformforConsume/>, scroll down to the Downloads, select “DOI Contact Information – State Status Chart”.

4. Special enrollment periods --- In general, a group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan 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 and their dependents will be able to enroll without having to wait until the plan’s next open enrollment period but, in most situations, one must request a special enrollment within 30 days of losing coverage or gaining a new dependent.

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 exclusion period. *For more information on late enrollment, see item 5.*

Self-Funded Non Federal Governmental plans may opt-out of the special enrollment periods. For more information go to <http://www.cms.gov/SelfFundedNonFedGovPlans/>.

Example 1: Jane Smith joined Company ABC on April 27th. She elected not to enroll in the plan during her 30 day initial enrollment period. On June 1st she decided to enroll. Jane has no special enrollment rights given her current circumstances. She will have to wait until the next open enrollment period in order to enroll. She is considered to be a late enrollee. *For more information on late enrollment see item 5.*

Example 2: Jane Smith joined Company ABC on April 27th. Employees have two options, an HMO and an indemnity plan. Jane enrolled in the HMO group health plan, self-only option. Jane decided to adopt a daughter, Abigail. Within 30 days of the placement of adoption, Jane requested enrollment for both her and her daughter into the indemnity plan. Since Jane and Abigail have satisfied the conditions for special enrollment, the plan must allow them into the indemnity plan, effective as of the date of the placement for adoption.

Example 3: Jane Smith joined Company ABC on April 27th. Jane and Bob are married. Bob maintains his self-only policy with his employer, Company 123. Jane enrolled in the Company ABC group health plan and purchased a self-only policy. Beginning June 1, Company ABC will not longer make employer contributions towards Jane’s coverage. Jane may maintain her coverage and pay 100 percent of the cost of the coverage. However, on June 1, Jane will have a 30 day special enrollment period and has the option of requesting enrollment into her husband’s health insurance.

Example 4: Jane Smith joined Company ABC on April 27th. (Company ABC has 20 or more employees.) Jane and Bob are married. Bob maintains his self-only policy with his employer, Company 123. Bob's policy has a \$5,000 deductible and a 50% copay for all items.

Jane is eligible to enroll in her husband's plan, but Company ABC offers better coverage so she enrolled in Company ABC's group health plan. Jane terminated employment with Company ABC and lost eligibility for coverage under that plan. Jane has a special enrollment right to enroll in her husband's plan; however, she is in the process of chemo treatment and does not want to have a 50% copay for all items. Therefore, Jane elects COBRA continuation coverage under Company ABC. Jane exhausts the COBRA coverage and is again entitled to a special enrollment period under her husband's coverage. This time she enrolls under Bob's coverage.

5. Late enrollment --- Enrollment of an individual under a group health plan, other than the earliest date on which coverage can become effective for the individual under the terms of the plan, is late enrollment.

Note: A group health plan may impose up to a 12 month preexisting exclusion period for enrollees and up to an 18 month preexisting exclusion period for late enrollees. *For more information on preexisting condition exclusions, see item 7.*

Example 1: Jane joined Company ABC on April 27th. She elected not to enroll in the plan during her initial enrollment period. Jane is a late enrollee. She must read her plan information to determine whether Company ABC allows late enrollees to enroll in the plan. Some companies have an annual open enrollment and allow late enrollees into the plan. Other companies give their employees one opportunity to enroll into the plan, and if the employee does not choose to enroll, that employee has no late enrollment rights except for circumstances permitting special enrollment. *For more information on special enrollment rights, see item 4.*

Example 2: Jane left Company ABC on January 1st. She was not enrolled in the health plan when she left the company. Jane was rehired by Company ABC on April 27th. Jane elected coverage. She is not a late enrollee since she elected coverage during the initial enrollment period upon being rehired by Company ABC.

6. Prohibitions against discrimination based on health status factors --- In general, a group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not establish any rule for eligibility (including continued eligibility) for any individual to enroll for benefits under the terms of the plan or group health insurance coverage that discriminates based on any health status factor that relates to the individual or the dependent of that individual. Group health plans and

issuers also cannot charge higher premiums or alter the level of benefits based on an individual's health status.

Self-Funded Non Federal Governmental plans may opt-out of the prohibitions against discrimination against individual participants and beneficiaries based on health status. For more information go to <http://www.cms.gov/SelfFundedNonFedGovPlans/>.

Example 1: Jane Smith joined Company ABC on April 27th. The group health plan is available to all employees who enroll within the first 30 days of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination. This practice violates the prohibitions against discrimination based on a health status factor.

Example 2: Jane Smith joined Company ABC on April 27th. Employees who enroll during the first 30 days of employment may choose between two benefit packages: an indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.

The requirement to provide evidence of good health in order to be eligible for late enrollment discriminates based on health status factors. If the plan limited late enrollees to the HMO option without asking them to provide evidence of good health, this would not violate any prohibitions against discrimination based on health status factors.

Example 3: Jane Smith joined Company ABC on April 27th. All employees generally may enroll within the first 30 days of employment. However, Jane participates in high risk recreational activity. She drives a motorcycle to work. Consequently, she is excluded from coverage. Excluding individuals from the plan if they participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one or more health factors and violates the prohibitions against discrimination based on health status factors. Company ABC may instead choose to add a clause to the policy stating that individuals participating in high risk recreational activities will be covered; however, injuries resulting from these activities will not be covered.

Example 4: Jane Smith joined Company ABC on April 27th. ABC offers group health coverage for its employees and their dependents. While filing out the health insurance application, she discloses that her daughter Abigail has a chronic heart condition. Company ABC must accept both Jane and Abigail into their group health plan. The plan cannot discriminate based on health status factors.

7. Limitations on preexisting condition exclusion periods --- A "preexisting condition exclusion" is a limitation or exclusion of health benefits based on the fact that a physical or mental condition was present before the first day of coverage. HIPAA limits the extent to which a plan or issuer can apply a preexisting condition exclusion.

For group health plans, a preexisting condition exclusion is limited to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within a maximum of a 6-month period ending on the enrollment date in a plan or policy.

A group health plan can apply a preexisting condition exclusion for no more than 12 months (18 months for a late enrollee) after an individual's enrollment date. Any preexisting condition exclusion must be reduced day-for-day by an individual's prior creditable coverage. No preexisting condition may be applied to an individual who maintains continuous creditable coverage (without a break of 63 or more days) for 12 months (18 months for a late enrollee).

During the preexisting condition exclusion period, the plan or issuer may opt not to cover or pay for treatment of a medical condition based on the fact that the condition was present prior to an individual's enrollment date under the new plan. (The plan or issuer must, however, pay for any unrelated covered services or conditions that arise once coverage takes effect.) The enrollment date is the first day of coverage under the plan or if there is a waiting period before coverage takes effect, it is the first day of the waiting period.

Self-Funded Non Federal Governmental plans may opt out of limitations on preexisting condition exclusion periods. For more information go to <http://www.cms.gov/SelfFundedNonFedGovPlans/>.

Example 1: Jane Smith joined Company ABC on April 27th and enrolled in Insurance XYZ, a group health plan. As a cost savings measure on January 1st, Company ABC switched to Insurance 123.

Insurance 123 excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the Insurance 123 policy. This violates the preexisting condition exclusion because it excludes benefits for conditions that were present before enrollment into the policy regardless of how much prior creditable coverage an individual has earned.

Example 2: Jane Smith joined Company ABC on April 27th and elected the group health plan. The plan generally provides coverage for medically necessary items and services. However, the plan excludes coverage for the treatment of cleft palates. This is not a preexisting condition exclusion because the plan does not cover that service regardless of when the condition arose.

Example 3: Jane Smith joined Company ABC on April 27th and elected the group health plan, Insurance 123. The plan provides coverage for treatment of a cleft palate, but only if the individual being treated has been continuously covered under Insurance 123 from the date of birth. This stipulation violates the limitations on preexisting condition exclusion periods since it is not covering a pre-existing condition regardless of how much prior creditable coverage an individual has.

8. Sample language for preexisting condition exclusion notification --- Plans may use the following language:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior “credible coverage.” Most prior health coverage is credible coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in credible coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your credible coverage, you should give us a copy of any certificates of credible coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have credible coverage. Please contact us if you need help demonstrating credible coverage. All questions about the preexisting condition exclusion and credible coverage should be directed to *(fill in the name of the individual)* at *(fill in the address)* or *(fill in the telephone number)*.

9. Waiting period --- The period that must pass before coverage may become effective for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan. Read your plan materials for information about your specific waiting periods.

For individual market policies, the amount of time it takes to determine whether or not you have been accepted by the issuer is considered to be a waiting period. This time begins upon the submission of a substantially complete application and ends either (a) as a result of coverage or (b) if the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.

Note: A waiting period does not count towards a break in credible coverage. *For more information on HIPAA credible coverage, see item 10.*

Example 1: Jane Smith joined Company ABC on April 27th. Company ABC’s group health plan imposes a 3-month waiting period for everyone enrolling in the plan. Immediately upon being hired, Jane completed and filed all forms necessary to enroll in the plan. Coverage is effective on July 27th. Her enrollment date is April 27th, which is

the first day of the 3-month waiting period and coincides with her date of hire. The waiting period does not count towards a break in creditable coverage. *For more information on creditable coverage, see items 10 – 12.*

Example 2: Jane Smith joined Company ABC on April 27th. Company's ABC's group health plan becomes effective on the first day of the second month following the date the employee becomes eligible for the group health plan. (Company ABC's waiting period is from the date of hire until the date the employee becomes eligible for the group health plan.) Jane's coverage is effective June 1st. Jane's waiting period was from April 27th to May 31st. The waiting period does not count towards a break in creditable coverage. *For more information on creditable coverage, see items 10 – 12.*

Example 3: Jane Smith is in the process of purchasing an individual market (non-employment based) policy. On April 27th, she completed and filed all forms necessary to enroll in an individual market plan. On May 8th, her application resulted in an offer for coverage and she accepted the offer. The time from April 27th to May 8th counted towards the waiting period that is specified in her plan document. This time does not count towards a break in creditable coverage. *For more information on creditable coverage, see items 10 – 12.*

Example 4: Jane Smith lost group health coverage on April 15th. On April 27th, she completed and filed all forms necessary to enroll in an individual market health insurance policy. On May 8th, her application was denied. The time from April 27th to May 8th is counted as a waiting period. The waiting period does not count towards a break in creditable coverage. In order to ensure that she does not have a break of 63 continuous days without creditable coverage, Jane should file another substantially complete application for another individual market policy before June 29th. *For more information on creditable coverage, see items 10 – 12.*

Example 5: Jane Smith lost group health coverage on April 15th. On April 27th, she completed and filed all forms necessary to enroll in an individual market health insurance policy. On May 8th, her application was accepted but the monthly premium for the policy was too expensive and Jane had to reject the offer. The time from April 27th to May 8th is counted as a waiting period. The waiting period does not count towards a break in creditable coverage. In order to ensure that she does not have a break of 63 continuous days without creditable coverage, Jane should file another substantially complete application for another individual market policy before June 29th. *For more information on creditable coverage, see items 10 – 12.*

10. HIPAA creditable coverage -- The concept of HIPAA creditable coverage is that an individual should be given day-for-day credit for previous health coverage against the application of a preexisting condition exclusion period when moving from one group health plan to another, from a group health plan to individual coverage under certain circumstances, or from an individual policy to a group health plan.

Most health coverage is HIPAA creditable coverage. Creditable coverage includes prior coverage under a group health plan (including a governmental, church plan or a group health plan in a foreign country), health insurance coverage (either group or individual), Medicare, Medicaid, a military-sponsored health care program for members or certain former members of the uniformed services, and for their dependents, a program of the Indian Health Service, a State high risk pool, the Federal Employees Health Benefits Program, a public health plan (including any plan established or maintained by a State, the US Government, a foreign country or any political subdivision of a State, the US Government or a foreign country), a health benefit plan provided for Peace Corps members and title XXI of the Social Security Act (State Children's Health Insurance Program).

An individual will receive credit for previous creditable coverage that occurred without a break of 63 (or more) complete days in a row. However, any creditable coverage occurring prior to a break in creditable coverage of 63 (or more) complete consecutive days would not have to be credited against a preexisting condition exclusion period. Some States' laws may provide greater protections by allowing for a greater break in coverage in counting prior creditable coverage. To find out whether your state has additional protections, contact the Department of Insurance for your state. Go to <http://www.cms.gov/HealthInsReformforConsume/>, scroll down to the Downloads, select "DOI Contact Information – State Status Chart".

Note: Waiting periods do not count as a break in coverage. A group health plan may impose up to a 12 month preexisting exclusion period for enrollees and up to an 18 month preexisting exclusion period for late enrollees. Individuals that meet the eligibility criteria to be a HIPAA eligible individual are protected from pre-existing condition exclusions in certain types of coverage, depending on their states' laws.

Example 1: Jane Smith worked for Company 123 for 2 years and participated in their group health plan. Jane was then unemployed and did not have health coverage for 70 consecutive days. Jane worked for a Temporary agency for 8 months and participated in their group health plan. She then joined Company ABC.

Jane would receive credit against any preexisting condition exclusion only for 8 months of creditable coverage; no credit would have to be given for the 2 years of creditable coverage prior to the break of 63 (or more) complete days in a row.

Example 2: Jane Smith worked for Company 123 for 2 years and participated in their group health plan. Jane was then unemployed as of April 1st. Jane joined Company ABC on April 27th and immediately enrolled in their group health plan. This particular company allows employees to enroll in the group health plan on the date they are hired. Coverage is effective at the beginning of the following pay period. Jane had 26 days (April 1st to April 26th) without creditable coverage. This waiting period (April 1st to April 26th) does not count towards a break in creditable coverage. *For more information on waiting periods, see item 9.*

Jane can use her previous 2 years of creditable coverage to offset any preexisting condition exclusions imposed by the group health plan. A group health plan can apply a preexisting condition exclusion for no more than 12 months (18 months for a late enrollee) after an individual's enrollment date.

Example 3: Jane Smith worked for Company ABC for 18 months and participated in their group health plan (18 months of creditable coverage). She lost her health coverage as of April 27th, is not eligible for COBRA, and decided to purchase an individual market HIPAA policy. Jane is a HIPAA eligible individual. She filled out a substantially complete application for a HIPAA policy on May 1st (4 complete days without creditable coverage, April 27th to April 30th). Issuer 123 responded to Jane's application for insurance on May 31st with a quote of \$870 per month for an individual market self-only policy. Jane rejected this offer on June 2nd (waiting period from May 1st to June 2nd).

On June 10, Jane filled out a substantially complete application for another HIPAA policy with Issuer 456 (7 complete days without creditable coverage, June 3rd to June 9th). Issuer 456 responded to Jane's application for insurance on July 1st with a quote of \$570 per month for an individual market self-only policy (waiting period from June 10th to June 30th). Jane accepted this offer on July 7th. Waiting periods are not counted as a break in creditable coverage.

Jane had a 12 day break in creditable coverage. Accordingly, all of her prior 18 months of creditable coverage is still counted and, since Jane is a HIPAA eligible individual, Issuer 456 cannot impose any pre-existing condition exclusions on Jane's policy.

11. Employees - Certificates of creditable coverage --- In general, group health plans and health insurance issuers are required to furnish certificates of creditable coverage upon the termination of coverage. Alternatively, if you need to provide evidence of creditable coverage and you do not yet have your certificate, go to <http://www.cms.gov/HealthInsReformforConsume/>, scroll down to the Downloads, select "Group Market – Evidence of Creditable Coverage" or "Individual Market – Evidence of Creditable Coverage" in order to learn about alternative means of proof of prior creditable coverage.

Example 1: Jane Smith worked for Company 123 and had 5 months of creditable coverage upon leaving the company. That plan sent her a certificate of creditable coverage. Jane had a 20 day break in creditable coverage then joined Company ABC on April 27th. She immediately enrolled in the group health plan. Coverage was effective on May 1st and there was no waiting period. Jane left Company ABC on December 1st (May 1st to November 30th, 7 months of creditable coverage). That plan sent her a certificate of creditable coverage.

On December 15th Jane joined Company 456. There was a 12 month preexisting condition exclusion. Since she never had a break of 63 continuous days without creditable coverage and she provided copies of her certificates of creditable coverage

from Company 123 (5 months) and Company ABC (7 months) to the new group health plan, the 12 month preexisting condition exclusion period was fully offset by her 12 months of creditable coverage.

Example 2: Jane Smith worked for Company 123 and had 5 months of creditable coverage. The plan never sent her a certificate of creditable coverage. Jane had a 20 day break in creditable coverage then joined Company ABC on April 27th. She immediately enrolled in the group health plan. Coverage was effective on May 1st and there was no waiting period. Jane left Company ABC on December 1st (May 1st to November 30th, 7 months of creditable coverage). The plan never sent her a certificate of creditable coverage.

On December 15th Jane joined Company 456. There was a 12 month preexisting condition exclusion. Since she never had a break of 63 continuous days without creditable coverage, Jane needed to provide evidence of creditable coverage to offset the 12 month preexisting condition exclusion.

After several attempts to have the companies/plans send her the proper documentation, Jane decided to provide the new group health plan with evidence of creditable coverage. Jane went to <http://www.cms.gov/HealthInsReformforConsume/>, scrolled down to the Downloads, and selected the appropriate item “Group Market – Evidence of Creditable Coverage” or “Individual Market – Evidence of Creditable Coverage”. After reading the information, she sent the evidence of creditable coverage in the form of Summary Plan Descriptions (SPDs) and Explanation of Benefits (EOBs) she had received from the prior group health plans to the new group health plan and they used her 12 months of creditable coverage to offset the 12 month preexisting condition exclusion.

12. Employers - Certificates of creditable coverage --- If you purchase group health insurance coverage, your insurer should be able to handle HIPAA information collection activities and the issuance of HIPAA certificates of creditable coverage. Talk to your insurer to find out how you can work out the process-related issues together. Alternatively, you can contract out these certification responsibilities. Benefits consulting firms and companies that help employers with COBRA are examples of businesses that can help you.

If you are self insured, you already have assumed a high level of management competency and the necessary systems to take on the responsibilities of self insurance. Handling HIPAA responsibilities should be an extension of what you are already doing. For more information go to 45 CFR §146.115(a)(2)(C)(3) - Form and Content of the Certificate.

13. Enforcement --- States have the primary enforcement responsibility for fully insured group plans as well as the individual market requirements imposed on health insurance issuers, using sanctions available under State law. The US Department of Health and

Human Services has jurisdiction with respect to public sector state and local governmental employers and the group health plans that they maintain. The Department of Labor, Employee Benefits Security Administration (EBSA) and the Internal Revenue Service (IRS) of the Department of the Treasury share jurisdiction with respect to private sector employers and their group health plans.

If the States do not act in the areas of their responsibility, the Secretary of HHS may make a determination that the State has failed "to substantially enforce" the law, assert Federal authority to enforce, and can impose sanctions on insurers as specified in the statute, including civil monetary penalties.

The Secretary of HHS has enforcement responsibility for self-funded and insured non federal governmental plans and can impose sanctions on plans or plan sponsors as specified in the statute, to include civil money penalties. States also have jurisdiction over group health insurance issuers that have contracts with insured non federal governmental plans. Self-Funded Non Federal Governmental plans may opt-out of the HIPAA provisions except for providing certificates of creditable coverage and the requirements imposed by the Genetic Information Nondiscrimination Act (GINA). For more information go to <http://www.cms.gov/SelfFundedNonFedGovPlans/>.

The Secretary of Labor enforces requirements on employment-based group health plans including insured and self-funded arrangements under ERISA. In addition, individual employees can file suit to enforce ERISA.

The Secretary of the Treasury can impose tax penalties on employers or plans that are found to be out of compliance with HIPAA. The tax code creates an obligation to pay the excise tax whether or not Treasury has taken any enforcement action.

Example 1: Jane Smith works for a public high school and has group health coverage through her employer. She is a public sector state and local government employee. The US Department of Health and Human Services (HHS) has jurisdiction with respect to public sector state and local governmental employers and the group health plans that they maintain. Jane should contact her employer/plan to discuss questions and concerns. If she continues to have unresolved issues she should contact HHS, CMS

Example 2: Jane Smith works for Company ABC. The company has a fully insured group health plan. Jane should contact her employer/plan to discuss questions and concerns. If she continues to have unresolved issues she should contact the Department of Insurance for the state in which she resides. Go to the CMS Webpage, Health Insurance Reform for Consumers <http://www.cms.gov/HealthInsReformforConsume/>, scroll down to the Downloads, and selecting "DOI Contact Information – State Status Chart".

Example 3: Jane Smith works for Company ABC. The company has a self funded group health plan. Jane should contact her employer/plan to discuss questions and concerns. If she continues to have unresolved issues she should contact the Department of Labor

(DOL 866-444-3272) since DOL has jurisdiction over private sector self-funded group health plans. The Secretary of the Treasury can impose tax penalties on employers or plans that are found to be out of compliance with HIPAA.

14. Group market rules --- HIPAA's group market rules apply to every large and small employer. A large employer has an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. A small employer has an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. States may opt to apply the large and small employer rules to groups of 1. To find out whether this applies to your state, contact the Department of Insurance for your state. Go to <http://www.cms.gov/HealthInsReformforConsume/>, scroll down to the Downloads, select "DOI Contact Information – State Status Chart".

Note: Insurers are required to renew coverage to all groups, regardless of the health status of any group member with some exceptions including nonpayment of premiums.

Example 1: Jane Smith joined Company ABC which has some seasonal workers. When she joined the company on April 27th there were 40 full time employees. However, there were an average of at least 51 employees on business days during the preceding calendar year. Therefore, Company ABC's coverage is considered to be a large group health plan for HIPAA purposes.

Example 2: Jane Smith joined Company ABC which has some seasonal workers. When she joined the company on April 27th there were 40 full time employees. There were an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and Company ABC employed at least 2 employees on the first day of the plan year. Therefore, the HIPAA small group provisions apply to Company ABC.

15. Guaranteed availability for small group markets --- Generally, HIPAA guarantees access to health coverage for small employers. HIPAA ensures that every issuer in the small group market must make every product available to every small employer. A small employer has an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year, unless otherwise provided under State law. States may opt to apply the small employer rules to groups of 1. To find out whether this applies to your state, contact the Department of Insurance for your state. Go to <http://www.cms.gov/HealthInsReformforConsume/>, scroll down to the Downloads, select "DOI Contact Information – State Status Chart". Insurers are required to renew coverage to all groups, regardless of the health status of any member.

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

- Fail to pay your premiums;
- Commit fraud against the insurer;
- Terminate the policy;
- Move outside the service area of a network plan; or
- End your membership in an association if the coverage is only available to members of the association;

The policy can also not be renewed if the insurance company:

- Stops selling the policy in which case it must offer you any other health insurance policy it is still offering in your State; or
- Decides to stop selling all health insurance policies in your State.

Becoming eligible for Medicare is not a valid reason for non-renewing an individual health insurance policy.

Example 1: Jane Smith purchased an individual health insurance policy with Issuer 123. The policy has a contract clause that states that the policy terminates when one becomes eligible for Medicare. The clause is not valid and is not enforceable since it violates the guaranteed renewability requirements of the individual market.

17. HIPAA and COBRA --- HIPAA and COBRA are different laws that may simultaneously apply to an employer's group health plan.

HIPAA responsibilities do not eliminate or replace the employers' responsibilities under COBRA; rather, HIPAA requirements may apply to COBRA continuation coverage to the same extent they apply to regular group health plan coverage.

HIPAA made three changes to COBRA's continuation coverage, as described below. These changes were effective on January 1, 1997, regardless of when the event occurred that entitles the individual to continuation coverage.

(1) If an individual qualifies for COBRA based on termination or a reduction of hours of the covered employee's employment, typically the individual is entitled to 18 months of COBRA continuation coverage. A disabled individual (as determined under the Social Security Act) and covered non-disabled family members may qualify for an additional 11 months for a total of 29 months of COBRA continuation coverage. An individual may qualify for the additional 11 months of COBRA continuation coverage if he or she becomes disabled before the COBRA qualifying event or at any time during the first 60 days of COBRA coverage. (If the individual meets the disability entitlement criteria, the individual must, as provided under prior COBRA law, notify the plan administrator within 60 days of the date of the Social Security disability determination (when the

determination is made during the 18-month period of continuation coverage) in order to receive the additional 11 months of COBRA continuation coverage.)

(2) COBRA continuation coverage generally can be terminated when an individual first becomes covered under another group health plan. However, COBRA coverage cannot be terminated because of other coverage when the plan limits or excludes coverage for any preexisting condition of the individual. HIPAA limits the circumstances under which a plan may impose a preexisting condition exclusion period on individuals. If a plan is precluded under HIPAA from imposing an exclusion period on an individual, i.e., it must cover the individual's preexisting condition, COBRA continuation coverage may be terminated when the individual first becomes covered under that plan after the date of the election of COBRA coverage.

(3) COBRA rules also are modified to provide that children who are born to or placed for adoption with the covered employee during the continuation coverage period are treated as qualified beneficiaries. For more information about COBRA continuation coverage, visit CMS' Website at www.cms.gov/cobracontinuationofcov.

Example 1: Jane Smith joined Company ABC on April 27th as a full time employee. Jane participated in the group health plan. (All full time employees are eligible for the group health plan; whereas, part time employees are not eligible for the group health plan.) Effective September 1st, Jane went from full time status to part time status. She no longer qualified to participate in the group health plan and she qualifies for COBRA based on a reduction of hours of the covered employee's employment. Jane is entitled to 18 months of COBRA continuation coverage. Company ABC has 30 days to notify the plan and the plan has 14 days to send the COBRA paperwork to Jane. Within 44 days, the COBRA paperwork should be sent to Jane.

Example 2: Jane Smith joined Company ABC on April 27th and participated in the group health plan, Insurance 123. Jane had 18 months of creditable coverage before joining Company ABC. Since she did not have a break of 63 continuous days without creditable coverage, Insurance 123 could not impose any preexisting condition exclusions on Jane.

Effective September 1st, Jane no longer qualified to participate in the group health plan due to a reduction in hours and qualifies for COBRA. The COBRA policy cannot impose any preexisting condition exclusions on Jane.

Example 3: Jane Smith has COBRA coverage. Her daughter Abigail was born while Jane had COBRA coverage. Jane must notify her employer of Abigail's birth within the timeframe specified in the plan documents in order for Abigail to be covered under Jane's COBRA policy. It is recommended that Jane notify the plan in writing and have some type of proof (certified return receipt or copy of an email) that she notified the plan within the timeframe specified in the plan documents.