of Tennessee

HIPAA Portability & Accountability: How HIPAA Affects Individual Coverage

The Health Insurance Portability and Accountability Act of 1996, known as HIPAA, affects the way state and federal governments regulate health care benefits for groups and individuals. If you have individual health coverage — or plan to apply for individual coverage in the future — you may have questions about HIPAA and how it affects your situation. These frequently asked questions and answers may help.

What is HIPAA?

HIPAA is a federal law that includes important provisions for people who are self-employed, who move from one job to another, or who have pre-existing medical conditions. It places certain requirements on health plans, on insurance companies and the plans they offer.

Who is affected by HIPAA?

HIPAA regulations affect anyone enrolled in an employer group-sponsored health plan, and people transitioning from a group plan to individual health coverage. HIPAA does not apply when people who already have individual coverage wish to enroll in a different individual plan.

What does HIPAA do?

HIPAA offers several advantages, because it:

- Mandates better access to health plan coverage for people who change or lose their jobs;
- Limits exclusions for pre-existing conditions;
- Prohibits discrimination against employees and dependents based on their health status;
- Guarantees renewability and availability of health coverage to certain employees and individuals.

How does HIPAA help people who lose their employer group health coverage and need individual health coverage?

HIPAA requires individual health plan issuers to offer individual plans that cover a person's pre-existing conditions — as long as the person has been insured for 18 months without a significant break in coverage, the most recent coverage was through the employer group health plan, and all available COBRA or state continuation benefits have been exhausted. The opportunity to purchase that individual coverage is the same — whether the person is laid off, fired, or resigns from a job.

As an example:

Suppose you already have 12 months of continuous group health coverage. But you lose your job and become eligible for COBRA continuation benefits. You need to exhaust your COBRA continuation coverage before you can request individual health coverage that provides immediate benefits for any pre-existing condition.

In this example, as long as certain requirements are met, the new insurer must give you "credit" for the length of time you were continuously covered under your group health plan, plus the COBRA continuation period, before you enrolled in an individual plan.

What is COBRA?

COBRA is the name of a federal law that gives workers and their families the opportunity to extend their employer-sponsored group health coverage for a limited amount of time if they lose their group coverage for certain reasons. Generally, you can receive COBRA continuation benefits for 18, 29, or 36 months if you lose coverage because of specific events, such as termination of employment,

divorce or death. Companies with 20 or more employees (other than government or church plans) must generally offer continued coverage under COBRA.

What if I don't qualify for COBRA or other continuation coverage?

You can purchase individual health plan coverage. But to enroll in a plan that provides immediate benefits for pre-existing conditions, you must first show that you had creditable health coverage for at least 18 months – without a break or lapse in coverage of 63 days or more.

What is creditable coverage?

If you're moving to an individual plan, creditable coverage refers to the length of time you were covered under a health plan. That coverage can include a workplace health plan, COBRA, a federal or state government plan (including TennCare, TRICARE, CHAMPUS or CHAMPVA), church plan coverage, a Tennessee Rural Health plan, or a short-term plan. The most recent creditable coverage must be an employer- sponsored, government or church group health plan.

Does all previous health coverage count as creditable?

No, not all. To be considered creditable, your previous health coverage:

- must have been in place for an aggregate of at least 18 months (with exceptions for some dependent children);
- must not have been canceled for fraud or nonpayment of premiums;
- must not have had more than a 63-day gap between coverages or between the date the other coverage(s) ended and the date you apply for individual coverage.

Additionally:

- you must not be eligible for Medicare A or B, Medicaid, TennCare, or other group coverage, including COBRA;
- your latest coverage must have been from an employer-sponsored group plan; and
- that previous coverage must no longer be available to you.

Does the 18-month rule apply to all dependent children?

In most cases, yes. But there are some exceptions. Dependent children who do not have the required 18 months of creditable coverage can still qualify for a waiver of the pre-existing condition waiting period, as long as they:

- enrolled in a previous creditable plan within 31 days of the date they became eligible for that group coverage; and
- were considered a newborn, newly adopted child or child placed for adoption at the time they enrolled for the coverage.

Can different family members have different pre-existing exclusion periods?

Yes. The amount of creditable coverage for each person in a family is individually verified. One family member with creditable coverage may have no exclusion period for pre-existing conditions. Other family members who do not have creditable coverage may be subject to medical underwriting terms and a standard exclusion period of 12 months. When this happens, members of the same family may be enrolled in different health plans. The plans may have the same benefits, but medical underwriting and exclusion periods may apply to certain family members. Rates for each plan may differ as well, and your costs may be higher for a plan that accepts your creditable coverage and provides immediate benefits for pre-existing conditions.

Even though I have creditable coverage, can I enroll in a less expensive individual plan and waive my rights under HIPAA?

Yes. If you choose to enroll in a lower cost plan, you can waive your right to a guarantee issue HIPAA plan for you and each member of your family. In that case, medical underwriting terms and any waiting periods for pre-existing condition coverage will apply.

What if I have trouble getting coverage documentation from my former employer?

Under HIPAA, insurers and health plans are required to provide you with documents that certify any creditable coverage you have earned. If they fail or refuse to provide the certification, they may be subject to financial penalties under HIPAA. Regulations also require a process that lets you show you are entitled to creditable coverage if you cannot obtain certification from a past employer or health plan. It is important that you keep accurate records (pay stubs, copies of premium payments or other evidence of health care coverage) that can be used to establish periods of creditable coverage in case certification cannot be obtained. Your new health plan or carrier can also help you get your certificate of creditable coverage from your prior carrier.

If I lose my job, am I guaranteed the same benefits under the new plan?

No. When you transfer from one plan to another, the benefits you receive will be those provided under the new plan. The new coverage could provide greater or lesser benefits than a previous health plan.

Can I lose my new coverage if my health status changes or I have too many claims?

No. If your previous coverage counts as creditable and meets HIPAA requirements, individual health plans and insurers cannot

establish enrollment eligibility based on your health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. For example, you cannot be excluded or dropped from plan coverage just because you have a particular illness. However, your coverage may be canceled for the following reasons:

- nonpayment of premiums
- fraud or misrepresentation
- termination of the entire plan through which you are enrolled
- change of residence outside the approved service area
- change in the company's membership standing with the BlueCross BlueShield Association

Can I be charged more than someone else with the same coverage and health conditions?

No. Though a health insurer may establish limits or restrictions on benefits or coverage for similarly situated individuals under a plan, it may not require an individual to pay a premium or contribution that is greater than that of a similarly situated individual, based on health status.

Does HIPAA require a health insurer to provide special benefits?

No. HIPAA does not require specific benefits or prohibit an insurer from restricting the amount or nature of benefits for similarly situated individuals.

of Tennessee

plans for better health. plans for a better life.™

bcbst.com

801 Pine Street
Chattanooga, TN 37402

COMM-377 (6/07)