



## What Is HIPAA?

*Disclaimer: The American Cancer Society does not offer legal advice. This information is intended to provide general background in this area of the law.*

The Health Insurance Portability and Accountability Act of 1996 or HIPAA is a law that protects millions of working Americans and their families who have medical conditions or who might have trouble getting medical insurance because of a medical condition that they had before they tried to buy health insurance (called a *pre-existing condition*).

## Does the 2010 Affordable Care Act affect HIPAA?

The newer Affordable Care Act (ACA) passed in 2010 has or will change the way health insurance companies manage coverage for pre-existing conditions.

- The ACA does not allow insurance companies to deny coverage for pre-existing conditions (such as diabetes or cancer) in children as of September 2010. And starting in 2014, it will not allow denial of coverage of pre-existing conditions in adults
- The ACA says that each state must have a Pre-Existing Condition Insurance Plan (PCIP) for people who have not had insurance for 6 months or more and have cancer or another pre-existing condition. Whether the state or the US Department of Health and Human Services runs the PCIP program depends on the state. The program name and design also may vary depending on which state you live in. (Go to [www.healthcare.gov/law/provisions/preexisting/index.html](http://www.healthcare.gov/law/provisions/preexisting/index.html) for the most current information on what is available in your state.)
- It will require all Americans to buy insurance and guarantee coverage regardless of a person's medical history starting in 2014.

But until 2014, adults with cancer or other pre-existing conditions are protected by the HIPAA laws, which we will explain here.

# How does HIPAA help people with cancer?

The law includes several parts that may help cancer patients:

- It limits what is considered a pre-existing condition. An employer health plan can exclude a medical condition from coverage only if the person had a gap in coverage longer than 63 days, and also had or was recommended to have treatment or medical advice in the 6 months before enrolling in the plan.
- It limits the time a new employer plan can exclude the pre-existing condition from being covered. An employer health plan can avoid covering costs of medical care for a pre-existing condition for no more than 12 months after the person is accepted into the plan.
- It gives certain people the right to buy individual health insurance if no group health plan coverage is available, and the person has exhausted COBRA or other continuation coverage. (For more information on COBRA, see our document *What is COBRA?*) Certain conditions and time limits must be met.
- It does not allow employers or their health insurers to discriminate or act unfairly against employees and their dependents based on their health status or genetic information.
- It guarantees certain people the ability to get or renew individual health insurance coverage.

## HIPAA also protects privacy and gives you more access to your medical records.

In 2002, the HIPAA laws were expanded to give patients greater access to their own medical records. The expanded law also gave patients more control over how their personally identifiable health information is used. In general, health information may not be shared without written permission of the patient. The law requires health care providers and health insurance plans to protect the privacy of patient health information, too. Medical records must be kept under lock and key and are available only on a need-to-know basis.

## HIPAA sets a basic standard for health insurance in the US.

The rest of the information here is about how HIPAA may affect your health insurance. It is important to know that some states have laws that, although similar to HIPAA, may offer more generous protections. While HIPAA requires a minimum standard all over the US, you may want to contact your state insurance commissioner's office to learn more about the law where you live. See the "To learn more" section to get help finding your state's department of insurance or insurance commission.

# What doesn't HIPAA do?

Even though HIPAA offers protections and makes it easier to switch jobs without fear of losing health coverage for a pre-existing condition, the law has limits. For instance, HIPAA:

- Does not require employers to offer health coverage
- Does not require employers that offer coverage for employees to also cover their families or dependents
- Does not guarantee that you can afford the health coverage that is offered
- Does not keep an employer from imposing a pre-existing condition exclusion period if you have been treated for a condition during the past 6 months and have had an interruption in your coverage
- Does not replace your state as the main regulator of insurance where you live

Even so, HIPAA may lower your chance of losing the coverage you have already. It usually makes it much easier to switch health plans or change jobs without losing coverage if you have a health problem. And it may help you buy coverage on your own if you lose your employer's plan and have no other coverage available -- but only if you meet certain requirements and take action in time to qualify.

## HIPAA, pre-existing condition exclusions, and creditable coverage

How does HIPAA limit the pre-existing condition exclusion of group or employer health insurance coverage?

**It counts "creditable" health coverage against the pre-existing condition time.**

Under HIPAA, a group health plan may not impose a pre-existing condition exclusion if the person has had *creditable medical coverage* for at least 12 months as long as the person had no more than 63 days with no coverage. (Creditable coverage refers to health insurance, and includes most health coverage, such as a group health plan, HMO, individual health insurance policy, Medicaid, or Medicare.) If the coverage was for less than 12 months, the pre-existing exclusion period may be reduced by the number of months of prior creditable coverage.

**Example:** Maria completed her cancer treatment 2 months ago. She had health coverage for the 14 months before she left her job 6 weeks ago, which means she would have 14 months of creditable coverage. The 42 days she went without insurance doesn't qualify as a "significant break" in coverage. She would have no pre-existing condition exclusion at

her new job if she signs up for insurance there, but she must sign up before she has had 63 days without insurance.

**It only allows exclusion of pre-existing conditions for which you were seen or treated in the past 6 months.**

A group health plan may only impose a pre-existing condition exclusion on new enrollees for conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the 6-month period before their enrollment date (called the 6-month "look-back" period). A person's enrollment date is the earlier of either the first day of coverage or the first day of any waiting period for coverage.

If you had a medical condition in the past, but have not received any medical advice, diagnosis, care, or treatment for it within the 6 months before your enrollment date in the plan, that condition cannot be excluded as a pre-existing condition. (Check with your state's Insurance Commissioner's Office to see if a shorter look-back period might apply to you.)

**Example:** Alana was diagnosed with lobular breast carcinoma in situ 4 years ago. She didn't need treatment, but she was told to follow up every year with her oncologist. She saw her doctor a year ago. Then 10 months later, she found a job and signed up for their group insurance. Her breast carcinoma would not be considered a pre-existing condition because she has had no treatment nor was treatment recommended for her in the 6 months before she enrolled. Her break in coverage does not come into play at all because she is not considered to have a pre-existing condition.

**It sets a maximum length of 12 months on pre-existing condition exclusions if you don't enroll late into the new plan.**

HIPAA also sets a maximum of 12 months which a group health plan may impose as a pre-existing condition exclusion period -- even if the person has been uninsured up to this point. This means people will not be punished for getting care for chronic and life-long illnesses in the past.

**Example:** Joseph has been out of work for 5 months, and has been uninsured during that time. Last month, he learned he had prostate cancer. Joseph's prior coverage is not creditable because his break in coverage was more than 63 days. And, since he was given a diagnosis and/or medical advice about it during the past 6 months, his pre-existing cancer can be excluded for up to 12 months. But if he signs up for the health plan, any cancer treatment he gets after the year has passed would be covered.

**Are there "pre-existing conditions" that cannot be excluded from coverage under HIPAA?**

Yes. Pregnancy cannot be considered a pre-existing condition. A pre-existing exclusion period cannot be applied to a newborn or an adopted child under the age of 18. Genetic

information may not be considered a pre-existing condition if no related diagnosis has been made.

## Since I have had cancer I want to focus on a new career path. How do I know if my cancer is subject to a pre-existing condition exclusion period in the plans offered at my new job?

Many plans cover pre-existing conditions right away. A plan must tell you if it has a pre-existing condition exclusion period (and can exclude coverage for a pre-existing condition only after you have been notified). The plan must also tell you about your right to show that you had prior health insurance coverage (creditable coverage) to shorten the pre-existing condition exclusion period.

If the plan does have a pre-existing condition exclusion period, the plan must decide about your insurance coverage and the length of any pre-existing condition exclusion period that applies to you. In general, a plan must make this decision within a reasonable time after you provide a certificate or other information that shows you had prior insurance coverage.

You must be notified of this decision if, after looking at all the evidence of creditable coverage you've had recently, the plan decides to impose an exclusion period for your pre-existing condition. (Creditable coverage includes most health coverage, such as a group health plan, HMO, COBRA, an individual health insurance policy, Medicaid, Medicare, TRICARE, CHAMPUS, Veteran's Health Coverage from the VA, or Indian Health Service. It does not include long-term care policies, dental or vision-only plans, supplemental coverage, or cancer-only policies.) The notice must also tell you the reason for the decision, the information the plan used in making the decision, and any appeals that may be available to you.

The plan may change its first decision if it later finds that you did not have the creditable coverage you claimed. In this case, the plan must tell you about this change. And until a final decision is made, the plan must act according to its first decision about covering medical services.

## How do newly hired employees prove that they had prior health coverage to be credited under HIPAA?

Under HIPAA, an employee's former group health plan and any insurance company or HMO providing such coverage is required to give the employee a statement of prior health coverage. This is called a *certificate of creditable coverage*.

This certificate must be given to you when you lose coverage under the plan or otherwise become eligible for COBRA health insurance coverage. It must also be given to you when you stop working or when your COBRA coverage stops. COBRA (Consolidated Omnibus Budget Reconciliation Act) is the name of a federal law that gives workers or

their family members a chance to buy group health coverage through their employer's health plan for a limited period of time (18, 29, or 36 months) if they lose coverage due to certain events, including the end of employment, divorce, or death. You may request a certificate for up to 24 months after your coverage ended. You also may request a certificate even before your coverage ends.

For more information on COBRA see our document, *What is COBRA?*

## I have my certificate from my former plan. What do I do now?

You should:

- Make sure the information on the certificate is correct. Contact the plan administrator of your former plan if any information is wrong.
- Keep the certificate in case you need it. You will need the certificate if you enroll in a new group health plan that has a pre-existing condition exclusion period or if you buy an individual health policy from an insurance company.

## Can my old plan simply call my new plan to give them information about my creditable coverage for HIPAA?

Yes. If you, your new plan, and your old plan all agree, the information may be transferred by telephone. You are also entitled to ask for a written certificate for your records when your coverage information is given over the phone or by other means.

## My employer has a "waiting period" for enrollment in the health plan. Does this change the pre-existing condition exclusion period under HIPAA?

The HIPAA law does not stop a plan or company from having a waiting period for health insurance enrollment. For group health plans, a waiting period is the period that must pass before an employee or a dependent is eligible to enroll in the health plan. Some plans have waiting periods and pre-existing condition exclusion periods. But if a plan has both a waiting period and a pre-existing condition exclusion period, the pre-existing condition exclusion period begins when the waiting period begins.

**Example:** If your company has a 4-month waiting period and a 6-month pre-existing exclusion period, your pre-existing condition exclusion is still only 6 months total. You have only 2 months of pre-existing exclusion time left if you sign up after the 4-month waiting period. (Of course, if you had prior creditable coverage, you might have no pre-existing exclusion time left after the 4-month waiting period, as noted above.)

## **I changed jobs and my new group health plan imposes a pre-existing condition exclusion period. How does my new plan decide how long my pre-existing condition exclusion period will be under HIPAA?**

Your new health plan may impose a pre-existing condition exclusion period only if you did not have creditable health insurance coverage in your old job, or you were without coverage for more than 63 days.

The maximum length of a pre-existing condition exclusion period is 12 months after the enrollment date, or 18 months in the case of a "late enrollee." (A late enrollee is a person who enrolls in a plan after the earliest date on which coverage can become effective under the terms of the plan. If you enroll during an open enrollment period or due to a family change, you are not considered a late enrollee.) This 12- or 18-month period may be shorter in some states due to differences in state laws. Check with your State Insurance Commissioner's Office to see whether your exclusion period might be shorter.

A plan must shorten a person's pre-existing condition exclusion period by the number of days the person had creditable health insurance coverage before. But if you were without coverage for 63 days or more (called a "significant break in coverage"), HIPAA does not require the new insurance plan to count any days of creditable coverage that came before the break. Keep in mind that some states may require employers to count coverage that came before a break that was longer than 63 days. Check with your State Insurance Commissioner's Office to see whether your state lets coverage count even though it's been a longer time since you had it.

## **I started a new job 45 days after my previous group health plan coverage ended. That coverage lasted 24 continuous months, during which I had cancer treatment. Will any future cancer claims be subject to the 12-month pre-existing condition exclusion period imposed by my new employer's plan?**

Not if you enroll when you are first eligible for the new health insurance plan, as long as you have no future breaks in coverage longer than 63 days. The 45-day break in coverage does not count as a significant break in coverage under HIPAA. Under federal law, a significant break in coverage is at least 63 consecutive days. Since you had more than 12 months of creditable coverage from your previous group plan without a significant break, you would not be subject to the pre-existing condition exclusion period imposed by your new employer's plan if you enroll when you are first eligible.

## How can I avoid a 63-day break in coverage to keep HIPAA protection?

There are some things you can do to avoid coverage breaks.

- If your last coverage was under a group health plan, you may be able to elect COBRA continuation coverage. Workers in companies with 20 or more employees generally qualify for COBRA. Some states have laws much like COBRA that apply to smaller companies.
- If you are married, you may try to get onto your spouse's group policy at work soon after losing your own.
- You also may try to buy an individual health insurance policy.

## **HIPAA, your health history, and health insurance coverage**

Under HIPAA, can I lose or be charged more for coverage if my health changes? I have been treated for cancer and I am worried.

Group health plans and issuers may not set up rules for one person's eligibility (including continued eligibility) to enroll under the terms of the plan based on "health status-related factors." These factors include your health status, medical conditions (physical or mental), past medical claims, receipt of health care, medical history, genetic information, and evidence of insurability or disability. For example, you cannot be excluded or dropped from coverage under your group health plan just because you develop cancer.

Also, group plans and issuers may not require a person to pay a premium or contribution that is greater than that for a similarly situated person based on a health status-related factor. On the other hand, if the employer raised everyone's rates or completely stopped offering health coverage, it would not violate HIPAA.

Can a group health plan or group health insurance issuer require me to pass a physical exam to be eligible to enroll in the plan? I have some side effects from the cancer treatment that may take a long time to go away.

No. A group health plan or group health insurance issuer may not make you pass a physical exam for enrollment. Even if you are a late enrollee, you cannot be required to pass a physical exam to be eligible for coverage.

**My group health plan requires that I complete a detailed health history questionnaire and subtracts Health Points for prior or current health conditions. In order to enroll in the plan, I must score 70 out of 100 total points. I scored only 50 points and was denied eligibility in the plan. Is this allowed?**

No. But the HIPAA non-discrimination provisions do not automatically forbid health care questionnaires. It depends on how the information on them is used. In this case, the plan requires people to score a certain number of Health Points that are related to current medical conditions in order to enroll in the plan. This is not allowed and is considered discrimination in rules for eligibility based on a health factor.

**My group health plan has a 12-month pre-existing condition exclusion period but, after the first 6 months, the exclusion period is dropped for people who have not had any claims since enrollment. Is this allowed under HIPAA?**

No. A group health plan may impose a pre-existing condition exclusion period, but the exclusion must be applied in the same way to all similarly situated people. Here, the plan's provisions do not apply uniformly because people who have medical claims in the first 6 months after enrollment are not treated the same as similarly situated people with no claims during that time. This means the plan provision violates the HIPAA non-discrimination provisions.

**My group health plan excludes coverage for benefits for a health condition that I have (no matter whether it pre-existed or not). Is my plan violating HIPAA's non-discrimination provisions by imposing this exclusion?**

Group health plans may decide not to cover a certain disease. They may limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on their decision of whether the benefits are experimental or medically needed. But they can only do this if the benefit restriction is applied uniformly to all people in similar situations and is not directed at anyone in the plan based on a health factor. So, if the same standard applies to everyone in the group, it may be allowed. An example might be coverage of a treatment that has not been scientifically proven.

**My health plan has a \$500,000 lifetime limit on all benefits covered under the plan. The plan also has a \$2,000 annual limit on all benefits provided for one of my health conditions. Are these limits allowed under HIPAA?**

HIPAA no longer covers these issues, but the Affordable Care Act (ACA) passed in 2010 does, and the rules have changed a lot.

The ACA does not allow the use of lifetime limits in health plans and insurance policies issued or renewed on or after September 23, 2010. It will also phase out the use of annual dollar limits over the next 3 years until 2014 when it bans them for most plans. These limits apply to all employer plans and all new individual market plans:

- Plans issued or renewed beginning September 23, 2010 will not be allowed to set annual limits lower than \$750,000.
- The minimum annual limit will be \$1.25 million beginning September 23, 2011.
- The minimum annual limit will be \$2 million beginning on September 23, 2012.
- For plans issued or renewed beginning January 1, 2014, annual dollar limits on coverage of essential health benefits will be not be allowed.

**I love to sky-dive. Can I be excluded from enrolling in my employer's health plan because I sky-dive?**

No. You may not be denied eligibility to enroll in your employer's plan because you sky-dive. But sky-diving injuries may not be covered under your health plan. See below.

**Can my health plan or issuer deny benefits for an injury based on the source of that injury? When my mother developed cancer, I became very depressed and I took an overdose of sleeping pills.**

If the injury results from a medical condition or an act of domestic violence, the health plan or issuer may not deny benefits for the injury, as long as it is an injury the plan would otherwise cover.

For example, a plan may not exclude coverage for self-inflicted injuries (or injuries resulting from attempted suicide) for a person in the plan if the injuries are otherwise covered by the plan and if the injuries are the result of a medical condition, such as depression.

But a plan or issuer is not required to cover injuries that do not result from a medical condition or domestic violence. This means that injuries sustained in high-risk activities, such as bungee jumping, sky-diving, or whitewater rafting, may not be covered. (But the

plan could not exclude people from enrollment in the plan because of their high-risk hobby. And it would still cover treatment for other medical conditions that were not related to the high-risk activity.) Check with your insurance plan about their coverage of injuries.

**I have a history of high claims. As a person with cancer, I have had 3 different types of treatment and many medicines. Can I be charged more than similarly situated individuals based on my claims?**

No. Group health plans and group health insurance issuers cannot charge one person more for coverage than a similarly situated person based on any health factor.

## **Making benefits claims**

**Do you have any tips on filing a health benefits claim?**

Yes. The first step you should take even before filing a claim is to carefully read your health plan's summary plan description (SPD). This is a document that your health plan administrator must give you after you join your health insurance plan. This plan summary will tell you how the plan works, what benefits it provides, and how the benefits may be obtained or the process for filing your claim. It should also describe your rights and protections under ERISA (Employee Retirement Income Security Act).

Each SPD should show you the procedure for filing a claim. Some plans may require you to file a claim (or get *prior authorization*, which is permission for treatment) before you can get medical treatment. Some plans have special rules for urgent (emergency) care. For other plans, you must turn in a claim for reimbursement (to get paid back the covered portion) after you pay for the care yourself.

Follow the steps outlined in your SPD when filing your claim. If you cannot find the steps, or don't understand them, call your plan administrator. You may also contact the Department of Labor's Employee Benefits Security Administration to help you understand your rights.

Your plan should state the time within which it must give you the decision on the claim you turn in. Be sure to look for this time limit in your SPD. When you submit a claim to your plan, note the date and keep track of the time as you wait for a decision. Some plans have different time periods depending on the nature of the benefit claim. For example, the claim for urgent care may be different and the claim may be filed before or after medical care is received. If you do not get a response from your plan within the stated time period, contact your plan administrator. See our document, *Health Insurance and Financial Assistance for the Cancer Patient* for more information.

## What if my claim is denied?

Your plan may deny a claim for many reasons. For example, you may not have yet paid the amount of the yearly deductible. The requested treatment may be something the plan says is not covered or medically needed. Or you may not have filed enough information for the plan administrator to process the claim. Look for the reason and other information provided in the notice of denial so that you can figure out if you want to appeal the decision.

Before you appeal, you may want to take these steps:

- Ask for a full explanation of why the claim was denied.
- Review your health insurance plan's benefits.
- Contact your health plan administrator to find out more about the refusal.
- Ask the doctor to write a letter explaining or justifying what was done or what is being requested.
- Talk to your state insurance department or commission to learn more (Check the blue pages of your local phone book or visit the National Association of Insurance Commissioners on the Internet at: [http://naic.org/state\\_web\\_map](http://naic.org/state_web_map).)

You can then re-submit the claim with a copy of the denial letter and your doctor's explanation, along with any other written information that supports using the test or treatment that has been denied. Sometimes the test or service will only need to be "coded" differently to be paid.

When you are informed that your claim has been denied, your plan administrator also must tell you how to appeal your denied claim for a full and fair review. Your plan will tell you how long you have to file your appeal. Put this date on your calendar. When you appeal a denial, be sure to include any new information or evidence needed to support your claim, and get it to the right person and address within the time limit.

The plan's claims procedure should also tell you how long the plan has after you file to make a decision on your appeal. Make a note of this date, too.

You must be told when the decision is made on your appeal. If your claim is denied, you must be told the reason and the plan rules upon which the decision was based. This must be in writing and in language you can understand.

If you disagree with the final decision on your appeal or if your plan fails to make a timely decision, you have the right to file a lawsuit in court to get your benefits. The plan's explanation of denial should describe this right. You also may wish to get in touch with the Department of Labor's Employee Benefits Security Administration about your rights under ERISA. You might want to read more about claim denials in our document called *Health Insurance and Financial Assistance for the Cancer Patient*.

## **HIPAA and certain policy provisions**

Is it OK for a health insurance issuer to charge a higher premium to one group health plan that covers people with costly health problems, than it charges another employer for their group health plan which covers fewer people with costly health problems?

Yes. HIPAA does not restrict a health insurance issuer from charging a higher rate to one group health plan (or employer) over another. An issuer may take health factors of the people to be covered into account when setting blended rates for group health plans (or employers). This may result in one health plan (or employer) being charged a higher premium than another for the same coverage through the same insurance issuer.

My group health plan has a "non-confinement provision." It states that if a person is confined to a hospital at the time they would normally become eligible for enrollment, they aren't eligible until they leave the hospital. What if I am in the hospital with a low white cell count due to chemotherapy at the time I become eligible for enrollment? Is this allowed?

No. A group health plan may not restrict a person's eligibility, benefits, or the effective date of coverage based on the person being in a hospital or other health care facility. Also, a health plan may not set a person's premium based on their being in the hospital.

My group health plan says that dependents are eligible for coverage only until age 26. But this age restriction does not apply to disabled dependents, who may keep health coverage past age 26. Are they allowed to favor disabled dependents?

Yes. It is OK for a plan or issuer to treat a person with an adverse health factor more favorably by offering extended coverage.

# Information sharing

## What kinds of information do group health plans have to give to participants and beneficiaries under HIPAA?

HIPAA and other laws have made important changes under the Department of Labor disclosure rules. Under these rules, group health plans must improve the documents employers are required to give to employees at certain key intervals, such as summary plan descriptions (SPDs) and summaries of material modifications (SMMs) to make sure they:

- Inform participants and beneficiaries of "material reductions in covered services or benefits" (for example, reductions in benefits or increases in deductibles and co-payments), generally within 60 days after the change is adopted.
- Give participants and beneficiaries information about the role of issuers (such as insurance companies and HMOs) with respect to their group health plan. For instance, they must include the name and address of the issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer, and the nature of any administrative services (for example, payment of claims) the issuer provides.
- Tell participants and beneficiaries which Department of Labor office they can contact for help or information on their rights under ERISA (Employee Retirement Income Security Act) and HIPAA.
- Tell participants and beneficiaries that federal law generally prohibits the plan and health insurance issuers from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections.

## Can employers use e-mail to give this information to employees? If so, do employees still have a right to get a paper copy of their health plan information?

Yes to both questions. The disclosure rules provide a "safe harbor" for using electronic media (e-mail) to furnish summary plan descriptions (SPDs) and summaries of material modifications (SMMs). But employees must be able to get the electronic documents at their worksite (there are also some other requirements). Participants also keep the right to get the information on paper free of charge when they ask for it.

## Who enforces HIPAA?

States enforce the legal requirements on health insurance issuers. If a state does not act in its areas of responsibility, the Secretary of Health and Human Services may decide that the state has failed to "substantially enforce" the law. Federal authority can be used,

through the Centers for Medicare and Medicaid Services, to enforce the law and penalize the insurers.

The Secretary of Labor also has the authority to enforce the health care portability requirements on group health plans under ERISA (Employee Retirement Income Security Act), including self-insured arrangements. And, participants and beneficiaries can file lawsuits to enforce their rights under ERISA, as amended by HIPAA.

## Can states change HIPAA's insurance requirements?

Yes, in certain circumstances. States may impose stricter requirements on health insurance issuers in the 7 areas listed below. States may:

- Shorten the 6-month "look-back" period before the enrollment date to decide what is a pre-existing condition
- Shorten the 12-month maximum pre-existing condition exclusion periods (or the late enrollee's 18-month maximum condition exclusion)
- Count prior insurance coverage as creditable even though there has been more than a 63-day break in coverage
- Increase the 30-day period for newborns, adopted children, and children placed for adoption to enroll in the plan so that no pre-existing condition exclusion period may be applied thereafter
- Further limit the circumstances in which a pre-existing condition exclusion period may be applied beyond the "exceptions" described in federal law (the "exceptions" under federal law are for certain newborns, adopted children, children placed for adoption, pregnancy, and genetic information in the absence of a diagnosis). Remember also that the new Affordable Care Act law will not allow insurance plans to deny coverage based on pre-existing conditions to Americans of all ages starting in 2014.
- Require more periods of special enrollment
- Reduce the maximum HMO affiliation period to less than 2 months (3 months for late enrollee)

States may sometimes impose other requirements with respect to insurance companies and HMOs. If your health coverage is offered through an HMO or an insurance policy issued by an insurance company, you should check with your state insurance department's office to find out the rules in your state. Find your State Insurance Department in the blue pages of your local phone book, or visit the National Association of Insurance Commissioners on the Web at [www.naic.org/state\\_web\\_map.htm](http://www.naic.org/state_web_map.htm).

# Getting and keeping health insurance coverage under HIPAA

## What if I am unable to get group coverage?

HIPAA guarantees access to an individual insurance policy issued by an insurance company to certain "eligible individuals." The Affordable Care Act of 2010 also provides Pre-Existing Condition Insurance Plans in each state. These plans may be state or federal plans.

You may have the chance to buy an individual insurance policy whether you are laid off, fired, or quit your job. For information on individual insurance policies or Pre-Existing Condition Insurance Plans, contact your State Insurance Department. For more on "eligible individuals", see the next question.

## If I can't get group coverage and have no other options, what do I do?

There is a special provision of the HIPAA law, which is intended to allow people to get health coverage after other options are exhausted. But before HIPAA can help a person with no insurance options get coverage, special requirements must be met, and you have to act quickly after you lose your coverage:

- You need to have had 18 months of group health coverage without a break of more than 63 days and your most recent coverage must have been through a creditable health plan.
- You cannot be eligible for Medicare or Medicaid, or be eligible for a group health insurance plan.
- You need to have elected and exhausted (used up) your COBRA coverage or any similar ongoing coverage, or you are not eligible for COBRA continuation coverage (or continuation coverage under a similar state program).
- You did not lose your group coverage because of fraud or non-payment of premiums.

People who meet these requirements are called "HIPAA eligible individuals." If you are eligible and act within 63 days of losing your coverage, HIPAA guarantees that you can buy some type of coverage and that you will have a choice of at least 2 options. This may include Pre-Existing Condition Insurance Plans set up by the Affordable Care Act. HIPAA can help those left out of health coverage after they've lost eligibility for group plans and COBRA.

HIPAA does not limit what health insurance companies charge (although some state laws do), but it can be sure that some coverage is offered. Again, depending on the health plan and the situation, HIPAA prevents an insurance plan from denying coverage based on a person's health history or a pre-existing condition.

People often do not take advantage of this because they don't know that they are eligible. Sometimes people find out they would have been eligible, but it may not help if the 63-day time limit has passed. If you think you might qualify for this, contact your state insurance department or commission right away to find out what is available to you. You can find your State Insurance Department in the blue pages of your phone book, or visit the National Association of Insurance Commissioners on the Internet at [www.naic.org/state\\_web\\_map.htm](http://www.naic.org/state_web_map.htm).

Keep in mind that the Affordable Care Act has created special insurance for all states, and it is available to "eligible individuals." These may be other options you can look into. See the section called "Does the 2010 Affordable Care Act affect HIPAA?" for more information on this.

## What if I can't afford the premiums for an individual insurance policy? Things have been pretty tight since my wife has been diagnosed with cancer.

HIPAA does not limit premium rates. HIPAA does not have control over state laws that regulate the cost of insurance. But some states limit insurance premiums. For information on how your state law may limit premium rates for individual insurance policies or for information on state high-risk pools, contact your State Insurance Commissioner's Office. You can also find more information in our document, *Health Insurance and Financial Assistance for the Cancer Patient*.

## Is my individual insurance policy renewable? Can it be taken away?

It is generally your option to renew or continue individual health coverage. Most individual health insurance policies expire each year and must be renewed. Federal and state laws do not allow insurers to refuse to renew health insurance policies because of the health status of the individual. Note that this is not true of short-term policies that are sold as non-renewable (see below).

There are some exceptions to the guaranteed renewability of a policy if the insurer is unable to meet their financial obligations or leaves the market. It may also be canceled or discontinued if you failed to pay premiums, committed fraud, terminated the policy, moved outside the service area, or ended the membership in the association that is part of the group policy.

Some insurers sell short-term policies that are clearly marketed as non-renewable. If you buy a short-term non-renewable policy and then get sick, you will not have the right to renew the policy when it expires.

## If I change jobs, can HIPAA guarantee the same benefits that I have under my current plan?

No. When a person moves into a new plan, the benefits the person receives will be those provided under the new plan. Coverage under the new plan can be different from the coverage under the former plan.

## Does HIPAA require employers to offer health coverage or require plans to provide specific benefits?

No. The employer voluntarily provides health coverage. HIPAA does not require specific benefits nor does it bar a plan from restricting the amount or nature of benefits for groups of people in similar situations.

## Does HIPAA extend COBRA continuation coverage?

In general, no. But HIPAA makes 2 changes to the length of the COBRA continuation coverage period.

- Qualified beneficiaries who are found to be disabled under the Social Security Act within the first 60 days of COBRA continuation coverage will be able to buy an additional 11 months of coverage beyond the usual 18-month coverage period. This extension of coverage is also available to non-disabled family members who are entitled to COBRA continuation coverage.
- COBRA rules now ensure that children who are born or adopted during the continuation coverage period are treated as "qualified beneficiaries" in plans that offer family or dependent coverage.

Even though it doesn't extend COBRA, HIPAA may still help you if you have used all of your COBRA coverage and are not eligible for other kinds of insurance. You may qualify for special HIPAA eligibility for other health coverage. See the section "If I can't get group coverage and have no other options, what do I do?" for more information.

## Does HIPAA apply to self-insured group health plans?

Yes.

## Glossary of terms

**Certificate of creditable coverage:** A written certificate issued by a group health plan or health insurance issuer that shows a person was covered under that health plan. A certificate must be issued automatically and free of charge when an individual loses coverage under a plan, when an individual is entitled to elect COBRA continuation coverage, and when a person loses COBRA continuation coverage. A certificate must also be provided free of charge upon request while the individual has health coverage or within 24 months after their coverage ends. See also *Creditable coverage*.

**COBRA (Consolidated Omnibus Budget Reconciliation Act):** COBRA gives a person who loses their health benefits in certain circumstances the right to choose to keep group health benefits provided by their health plan for a limited time. COBRA allows the employee to buy health insurance back from the employer even though they no longer work there or no longer work full-time. When COBRA coverage runs out, some people have special eligibility for individual health coverage.

COBRA also lets family members choose to keep health insurance after your job loss or other *qualifying event* that would normally cause them to lose the coverage they have through your employer. COBRA applies only to nearly all employers with 20 or more employees. See the section "If I can't get group coverage and have no other options, what do I do?"

**Creditable coverage:** This can be health coverage of an individual under a group health plan, (including while on COBRA continuation coverage), individual health insurance coverage, Medicare, Medicaid, a state health insurance risk pool, a public health plan, and certain other health programs. It may be used to offset time from any pre-existing condition exclusion if no significant break in coverage (generally 63 days) happened before starting a new group health plan.

**ERISA (Employment Retirement Income Security Act of 1974):** ERISA is a federal law that oversees employee benefit plans (such as group health plans) that private sector employers, employee organizations (such as unions), or both, offer to their workers and families.

**Enrollment date:** The first day of coverage or, if there is a waiting period, the first day of the waiting period. For individuals who enroll when first eligible, the enrollment date is often the first day of employment.

**Fully insured group health plan:** A health insurance plan an employer or union buys from an insurance company, an HMO, or a health care service plan. Benefits, premiums and other aspects of the plan are subject to state regulation. Compare with *self-insured group health plan*.

**Genetic information:** Information about genes, gene products, and inherited characteristics that may come from the individual or a family member. This includes information about carrier status and information from lab tests that identify mutations in specific genes or chromosomes, physical medical exams, family histories, and direct testing of genes or chromosomes.

**Group health plan:** An employee benefit plan set up or maintained by an employer or by an employee organization (such as a union), or both, to the extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.

**Health insurance issuer:** An insurance company, insurance service, or insurance organization (including an HMO), that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that oversees insurance.

**Late enrollee:** A late enrollee is a person who does not enroll in a plan on the earliest date on which coverage can become effective under the terms of the plan or does not enroll during a special/open enrollment period. Under HIPAA, a late enrollee may be subject to a maximum pre-existing condition exclusion of up to 18 months.

**Pre-existing condition exclusion:** A limitation or exclusion of health coverage for a condition based on the fact that the condition was present before the first day of coverage.

**Self-insured group health plan:** Plans set up by employers or unions which put aside funds to pay their employees' health claims, i.e., the employer or union is acting as its own insurer. Self-insured plans often hire insurance companies to administer them (for instance, handling enrollment, paying claims, etc.), so the insurance company may be mistaken for being the actual insurer. Employers must let health plan enrollees know if an insurance company is responsible for actually insuring them or only for administering the plan. If the insurer is only administering the plan, it is self-insured. The US Departments of Labor and Treasury regulate self-insured plans under ERISA; they are not subject to state law.

**Significant break in coverage:** As defined by HIPAA, a break in coverage of 63 days or more. May be longer if your state law allows the break in coverage to be longer while still counting the previous creditable coverage time.

**SPD:** A **summary of the plan description** of the health insurance policy.

**SMM: Summary of material modifications** is information (often a document) that employers are required to give to employees. The SMM informs participants and beneficiaries of "material reductions in covered services or benefits" (for example, reductions in benefits or increases in deductibles and co-payments), generally within 60 days of putting the changes into practice.

**Waiting period:** The period of time that an employer sets, which must pass before an employee or dependent is eligible to be covered under the terms of a group health plan.

## To learn more

### More information from your American Cancer Society

The following related information may also be helpful to you. These materials may be ordered from our toll-free number, 1-800-227-2345 or found on our Web site, [www.cancer.org](http://www.cancer.org).

Health Insurance and Financial Assistance for the Cancer Patient (also available in Spanish)

The Affordable Care Act: How It Helps People With Cancer and Their Families

Prescription Drug Assistance (also available in Spanish)

What Is COBRA? (also available in Spanish)

Medicare Part D: Things People With Cancer May Want To Know

Children Diagnosed With Cancer: Financial and Insurance Issues

Clinical Trials: State Laws Regarding Insurance Coverage

Americans With Disabilities Act: Information for People Facing Cancer

Family and Medical Leave Act (FMLA)

Financial Guidance for Cancer Survivors and Their Families: How to Find a Financial Planner Sensitive to Cancer Issues

Financial Guidance for Cancer Survivors and Their Families: In Treatment (also available in Spanish)

Financial Guidance for Cancer Survivors and Their Families: Off Treatment

Financial Guidance for Cancer Survivors and Their Families: Advanced Illness

Financial Guidance for Families: Coping Financially With the Loss of a Loved One

Medicare Coverage for Cancer Prevention and Early Detection (also available in Spanish)

Financial Guidance for Those With Concerns About Cancer: Can I Be Prepared If Cancer Occurs?

Patient's Bill of Rights (also available in Spanish)

Women's Health and Cancer Rights Act (also available in Spanish)

After Diagnosis: A Guide for Patients and Families (also available in Spanish)

## National Organizations and Web Sites\*

Along with the American Cancer Society, other sources of information and support include:

### **Americans with Disabilities Act Information Technical Assistance**

Toll-free number: 1-800-514-0301

TTY: 1-800-514-0383

Web site: [www.ada.gov](http://www.ada.gov)

Has publications and answers questions about the Americans with Disabilities Act (ADA)

### **Cancer Legal Resource Center (CLRC)**

Toll-free number: 1-866-843-2572 (may need to leave a number for a call back)

TTY: 213-736-8310

Web site: [www.cancerlegalresourcecenter.org](http://www.cancerlegalresourcecenter.org)

Provides free and confidential information and resources on cancer-related legal issues, including health insurance coverage and denial of benefits, to cancer survivors, their families, friends, employers, health care professionals, and others coping with cancer

**Department of Health and Human Services**

Toll-free number: 1-877-696-6775

Web site: [www.hhs.gov](http://www.hhs.gov)

This federal agency is responsible for protecting the health of all Americans and providing essential human services; offers information on the Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration (HRSA), and Indian Health Service (IHS)

**Health Insurance Info, Georgetown University Health Policy Institute**

Web site: [healthinsuranceinfo.net](http://healthinsuranceinfo.net)

Offers guides for getting and keeping health insurance that are based on federal and state law

**National Cancer Institute**

Toll-free number: 1-800-422-6237 (1-800-4-CANCER)

TTY: 1-800-332-8615

Web site: [www.cancer.gov](http://www.cancer.gov)

Provides accurate, up-to-date information about cancer for patients, their families, health professionals, and the general public

**National Association of Insurance Commissioners**

Toll-free number: 1-866-470-6242

Web site: [http://naic.org/state\\_web\\_map.htm](http://naic.org/state_web_map.htm)

Has information on how to find your state's Insurance Commissioner, information about insurance and insurance companies, and how to file a consumer complaint with state insurance departments

**US Department of Health & Human Services**

Web site: [www.healthcare.gov](http://www.healthcare.gov)

For the most current information on health care laws and how they might affect you

**US Department of Labor, Employee Benefits, Security Administration (EBSA)**

Toll-free number: 1-866-444-3272 (1-866-444-EBSA)

Web site: [www.dol.gov/ebsa](http://www.dol.gov/ebsa)

For information on COBRA, FMLA, and HIPAA requirements of employer-based insurance coverage; self-insured health plans; and information for military reservists who must leave their private employer for active duty

*\*Inclusion on this list does not imply endorsement by the American Cancer Society.*

No matter who you are, we can help. Contact us anytime, day or night, for information and support. Call us at **1-800-227-2345** or visit [www.cancer.org](http://www.cancer.org).

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1 · 800 · ACS-2345 or [www.cancer.org](http://www.cancer.org)