Consumer's Guide to

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Wisconsin Insurance Laws

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State of Wisconsin
Office of the Commissioner of Insurance
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Introduction

In the past few years, both the federal government and the state of Wisconsin have enacted important protections for insurance consumers. One of the most important of these protections for health insurance consumers is the federal HIPAA law and the corresponding state legislation. This booklet provides an overview of the federal HIPAA provisions and the corresponding requirements under Wisconsin insurance law.

What Is HIPAA?

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. It seeks to address and standardize a broad range of activities by health insurance companies and health care providers. HIPAA includes five specific provisions, or titles. They are:

Title I - Health care access, portability, and renewability
Title II - Preventing health care fraud and abuse, administrative simplification, and medical liability reform
Title III - Tax-related health provisions
Title IV - Application and enforcement of group health plan requirements
Title V - Revenue offset provisions

The intent of the federal HIPAA laws and corresponding Wisconsin legislation is to decrease the cost of health care and protect the privacy of personal health information. This booklet addresses only the requirements under Titles I and II of HIPAA and corresponding Wisconsin insurance law.

What HIPAA Does Not Provide

- HIPAA does not address the issue of the cost of insurance coverage.
- HIPAA does not require that your employer offer health insurance to its employees.
- HIPAA does not require that your employer offer comparable coverage to the coverage you had in the past.
- HIPAA does not require that an insurance plan cover all your medical costs or cover all your medical conditions.
- HIPAA does not require that health insurance companies accept your application for an individual insurance policy when you do not meet their underwriting standards.

Who Is Affected?

HIPAA applies to health plans and health care providers. Health plans include plans offered by insurance companies, health maintenance organizations (HMOs), and limited service health organizations.

Types of Health Plans

Health insurance coverage is generally available through employer-sponsored, fully-insured group health benefit plans; employer-sponsored, self-insured group plans; nonemployer-sponsored group health plans; and individual health benefit plans.

Employer-sponsored, fully-insured group health benefit plans are health insurance plans in which an employer contracts with an insurance company to provide insurance benefits to its employees. The employer pays or contributes to the cost of the insurance, and the insurance company assumes all of the risk involved in paying claims. Fully-insured group health benefit plans are governed by state insurance laws and are guaranteed renewable. This means that the employer can continue to renew the plan each year as long as premiums continue to be paid in a timely manner, the employer does not perform an act that constitutes fraud, and the employer continues to meet contribution and group participation requirements. Coverage can be terminated if the insurer discontinues offering in the state the particular type of group health benefit plan that was issued to the employer; the insurer discontinues offering all group health benefit plans in the state; the employer ceases to be a member of the association through which the coverage may have been obtained; or, in the case of a network plan, there is no longer an enrollee under the plan who lives or works in the service area in which the insurer is authorized to do business.

Employer-sponsored, self-insured group health plans, often referred to as self-funded plans, are health plans where the employer assumes all the risk of providing health benefits and pays all health claims out of funds set aside for that purpose. Self-insured plans are sometimes confused with fully-insured plans because employers often contract with an insurance company or a third-party administrator to process claims. The federal Employee Retirement Income Security Act of 1974 (ERISA) assigns jurisdiction of most employers' self-insured plans to the U.S. Department of Labor. Although state insurance laws do not apply to most employers' self-insured plans, the plans are subject to the requirements of HIPAA.

Individual health benefit plans and nonemployer-sponsored group health plans provide coverage to persons on an individually underwritten basis. Nonemployer-sponsored group health plan coverage is often obtained by reason of an individual's membership in an association. An insurance company can decide whether to accept or reject an individual's application for coverage based on the individual's health history. Individual health plans and nonemployer-sponsored group health plans are governed by state insurance laws. The plans are guaranteed renewable as long as premiums continue to be paid in a timely manner and the individual does not perform an act that constitutes fraud. Coverage can be terminated if the insurer discontinues offering in the state the particular type of health benefit plan that was issued to the individual; the insurer discontinues offering all individual health benefit plans in the state; an individual ceases to be a member of the association through which the coverage may have been obtained; or, in the case of a network plan, the individual no longer lives or works in the service area in which the insurer is authorized to do business.

Guaranteed Issue

An employer that employs at least 2 but not more than 50 employees is considered a small employer. Insurance companies that market group health insurance coverage to small employers are required to accept every small employer that applies for a group health benefit plan. Although coverage is guaranteed, the cost of group coverage is reflective of the health experience of the group.

HIPAA provides employee protections that:

- **Prohibit discrimination against employees and dependents based on their health status**
- **Provide availability of health coverage to certain employees**
- **Limit the exclusion period for preexisting conditions**

Discrimination Prohibited

An insurer may not impose any restrictions on an employee or dependent in a group health benefit plan or establish eligibility standards that are based on an individual's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, or evidence of insurability, including conditions arising out of acts of domestic violence. Riders that exclude coverage for specific medical conditions cannot be added to an individual's coverage under a group health benefit plan.

Coverage Must Be Offered To All "Eligible Employees"

Under Wisconsin insurance laws, if an insurance company offers a group health benefit plan to an employer, the insurer must offer coverage to all of the "eligible employees" of the employer and their dependents. An insurer may not offer coverage to only certain members in the group or to only part of the group, except for an "eligible employee" who has not yet satisfied an applicable waiting period, if any. An "eligible employee" means an employee who works on a permanent basis and has a normal work week of 30 or more hours. It does not include an employee who works on a temporary or substitute basis.

Insurers may allow eligible employees of a small employer and their dependents to decline or waive coverage under a group health benefit plan in only certain cases, such as when an individual has coverage under another health benefit plan other than the Health Insurance Risk-Sharing Plan (HIRSP), the annualized premium to be paid by an eligible employee would exceed 10% of the

annualized gross earnings of the eligible employee, or when an individual does not have a risk characteristic that would be the sole cause for the insurer to make a decision with respect to premiums for a policy that is adverse to the small employer.

In addition, an insurer must offer coverage to new "eligible employees" who become eligible for coverage after the commencement of the employer's coverage and to their dependents regardless of health condition or claims experience, except for an "eligible employee" who has not yet satisfied an applicable waiting period, if any.

Preexisting Conditions

A group health benefit plan can impose a preexisting condition waiting period only if it defines a preexisting condition as a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received in the six-month period prior to an individual's enrollment date under the group health benefit plan. Pregnancy cannot be considered a preexisting condition, nor can genetic information be treated as a preexisting condition without a diagnosis of a condition related to the information. Newborns, adopted children, and children placed for adoption under age 18 are not subject to a preexisting condition waiting period when enrolling in a group health benefit plan if the child was covered under other creditable coverage within 30 days of birth, adoption, or placement for adoption and the child has not had a break in coverage longer than 62 days.

A group health benefit plan may not impose a preexisting condition waiting period longer than 12 months except when an individual is a "late enrollee." A "late enrollee" means an individual who enrolls under a group health benefit plan at any time other than when first eligible to enroll. Individuals who enroll during a special enrollment period, or after previously waiving coverage because they were covered under other health insurance coverage, are not considered "late enrollees." This is described more completely in the section titled, "Special Enrollment Periods."

Although Wisconsin insurance laws require that a "late enrollee" be offered coverage, an insurer may postpone coverage for no more than 18 months for a "late enrollee" who elects coverage, require the "late enrollee" to meet an 18-month preexisting condition waiting period, or apply a combination of the two restrictions, not to exceed 18 months. As described in the section titled, "What Is Portability?," a preexisting condition waiting period may be reduced.

Individual health plans may define a preexisting condition differently than group health benefit plans. Generally, individual health plans cannot impose a preexisting condition waiting period of more than two years from the date of policy issue, unless the policy specifically excludes the named condition from coverage by rider.

Special Enrollment Periods

Certain individuals who waive coverage when first eligible under a group health benefit plan may later decide to enroll under the plan and not be considered "late enrollees." A special enrollment period is triggered when an eligible employee obtains a new dependent through marriage, birth, adoption, or placement for adoption. If an eligible employee, spouse and/or dependent apply for coverage under a group health benefit plan within 30 days of a marriage, birth, adoption, or placement for adoption, they may not be treated as "late enrollees."

A special enrollment period is also triggered when an eligible employee or dependent who previously waived coverage under a group health benefit plan, because the individual was covered under other health insurance, later loses that other coverage. The individual must request special enrollment within 30 days after the date on which the other coverage is exhausted or terminated. In addition, Wisconsin insurance laws allow an individual who previously waived coverage under a group health benefit plan, because the individual was covered under other health insurance coverage, to later enroll in the plan while the individual is currently covered under the other coverage.

HIPAA provides protections when you change jobs.

What Is Portability?

Portability is designed to keep an individual from having to meet a new preexisting condition waiting period when enrolling in an employer-sponsored group health benefit plan. In situations where an individual changes jobs or has had continuous health insurance or other "creditable coverage" prior to enrolling in an employer-sponsored group health benefit plan, any preexisting condition waiting period under the new group health benefit plan must be reduced by the period of time an individual had prior "creditable coverage" provided there is not a break in coverage longer than 62 days. An employer imposed probationary period before an employee is eligible to enroll for coverage does not count towards a break in coverage. Portability applies to both fully-insured group health benefit plans and to employers' self-insured plans.

Portability does not apply when an individual enrolls for coverage under an individual health plan or a nonemployer-sponsored group health plan except in certain cases when an individual applies for coverage under the state Health Insurance Risk-Sharing Plan (HIRSP). HIRSP's 6-month preexisting condition waiting period will be waived for an eligible individual who has at least 18 months of prior creditable coverage, the most recent coverage under an employer's group health plan, governmental plan, or church plan. In addition, the most recent group coverage cannot have been terminated for any reason relating to fraud or a failure to pay premiums, the individual must have elected and exhausted any continuation rights under the prior group plan, and the individual cannot have other creditable coverage or be eligible for coverage under an employer group health plan, Medicare, or Medicaid.

What Is Creditable Coverage?

As described in the section titled, "What Is Portability?," any preexisting condition waiting period under a group health benefit plan must be reduced by the period of time an individual had prior "creditable coverage," provided there is not a break in coverage longer than 62 days. Creditable coverage includes another group or individual health plan, governmental plans including Medicare and Medicaid, military coverage, a state high-risk plan, and coverage provided through the Indian Health Service, the federal Peace Corps Act, and other public health plans. Creditable coverage does not include plans consisting solely of coverage of excepted benefits, such as vision and dental. Periods of creditable coverage are established and portability is obtained under a group health benefit plan when an individual presents the plan a certificate of creditable coverage or other proof of having prior or current creditable coverage, such as premium receipts, pay stubs, etc., at the time of enrollment.

Certificates of Creditable Coverage

Insurers that provide health benefit plan coverage must provide to an individual a certificate of creditable coverage when the individual ceases to be covered under a health benefit plan or when the individual becomes eligible for federal group continuation coverage. A certificate of creditable coverage must again be provided to the individual at the end of federal group continuation coverage and also upon the request of an individual if made within 24 months after an individual's coverage ceases. The certificate of creditable coverage must include the period of time the individual was covered under the health benefit plan and the waiting period, if any, under the plan.

How Does Administrative Simplification Apply to Me?

HIPAA's administrative simplification provisions establish standards regarding electronic transactions, privacy protections of protected health information (PHI), and security protections for electronically maintained information. The administrative simplification requirements are designed to streamline and simplify the health care payment system by requiring that insurance companies and health care providers use the HIPAA standards for transmitting and processing claims. These standards are meant to protect your health information during the handling, storage, and processing of your insurance claims.

HIPAA's privacy requirements apply regardless of whether you have group or individual health insurance coverage.

How Do the Privacy of Health Information Provisions Affect Me?

Both federal and state laws offer some protection of your personal medical information. The federal privacy laws apply to both health care providers and insurance companies. More information on the federal privacy laws can be obtained by visiting the United States Department of Health and Human Services Web site at www.hhs.gov/ocr/hipaa.

Wisconsin insurance law includes requirements that insurance companies must meet when obtaining and using your personal medical information. Insurance companies may require your personal medical information in two situations. First, it is often necessary for an insurance company to review your medical records to determine the risk (how much it will cost to pay potential claims) associated with offering insurance coverage to you. Second, it is often necessary for an insurance company to review your medical records to determine whether the claims you submit for payment are eligible for coverage under the terms of the policy.

An insurance company cannot obtain your personal medical information without your written consent. An insurance company can either request written consent at the time of your application for coverage or as it finds necessary for the processing of a claim for benefits under your policy. If an insurance company obtains a signed disclosure authorization as part of the application for coverage, it must indicate in the disclosure authorization the purposes for which the disclosed personal medical information will be used. A disclosure authorization authorizing the company to obtain personal medical information for the purpose of making coverage decisions cannot be valid for longer than 30 months from the date on which it is signed. However, an authorization authorizing the company to obtain personal medical information in connection with a claim for benefits is valid for as long as your policy is in force and until all claims pending under the policy are processed. *If an insurance company requests written consent to obtain your personal medical information only as it finds necessary for the processing of a particular claim or claims, it must obtain a signed disclosure authorization each time it requires an individual's personal medical information.*

What Are My Rights?

- You have the right to refuse an insurance company access to your personal medical information. However, doing so may result in the insurance company having insufficient information to determine eligibility for coverage, premium rates, or policy benefits.

- You have the right to request all personal medical information regarding you and your minor dependents in an insurance company's possession.

- You have the right to request the correction, amendment, or deletion of any personal medical information regarding you or your minor dependents in an insurance company's possession.

What Other Consumer Protections Exist?

- The *Women's Health and Cancer Rights Act (WHCRA)* is a federal law that includes protections for individuals who elect to undergo breast reconstruction following a mastectomy. More information is available on the U.S. Department of Labor Web site at www.dol.gov/dol/topic/health-plans/womens.htm.

- The *Mental Health Parity Act of 1996 (MHPA)* is a federal law that may prevent your group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower than annual or lifetime dollar limits for medical and surgical benefits offered under the plan. More information is available on the Centers for Medicare and Medicaid Web site at www.cms.hhs.gov/HealthInsReformforConsume/.

- The *Newborns' and Mothers' Health Protection Act (Newborns' Act)* is a federal law that requires group health plans that offer maternity coverage to pay for at least a 48-hour hospital stay following normal childbirth and at least a 96-hour stay in the case of Cesarean section. More information is available on the U.S. Department of Labor Web site at www.dol.gov/dol/topic/health-plans/newborns.htm.

- The *Consolidated Omnibus Budget Reconciliation Act (COBRA)* is a federal law that, under certain circumstances, gives you the right to continue coverage under your group health plan for a limited period of time after your eligibility for coverage terminates. More information is available on the U.S. Department of Labor Web site at www.dol.gov/dol/topic/health-plans/cobra.htm.

Where Can I Obtain Additional Information?

- U.S. Department of Labor (U.S. DOL)
  1-866-4-USA-DOL (toll-free)
  www.dol.gov

- Centers for Medicare and Medicaid (CMS)
  1-877-267-2323 (toll-free)
  www.cms.hhs.gov

- U.S. Department of Health and Human Services (HHS)
  1-877-696-6775 (toll-free)
  www.hhs.gov

- Office for Civil Rights
  1-877-696-6775 (toll-free)
  www.hhs.gov/ocr

- Health Insurance Risk-Sharing Plan (HIRSP)
  1-800-828-4777 (toll-free)
  www.hirsp.org