GUIDE TO HIPAA

The Health Insurance Portability and Accountability Act

What the Health Insurance Reform Law Means For Women & Families

Fourth Edition | 1998
THE NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES
IS A NONPROFIT, NONPARTISAN ORGANIZATION
THAT USES PUBLIC EDUCATION AND ADVOCACY TO
PROMOTE FAIRNESS IN THE WORKPLACE, QUALITY
HEALTH CARE, AND POLICIES THAT HELP WOMEN
AND MEN MEET THE DUAL DEMANDS OF WORK
AND FAMILY. FOUNDED IN 1971 AS
THE WOMEN'S LEGAL DEFENSE FUND, THE
NATIONAL PARTNERSHIP HAS GROWN FROM
A SMALL GROUP OF VOLUNTEERS INTO ONE OF THE
NATION'S MOST POWERFUL AND EFFECTIVE
ADVOCATES FOR WOMEN AND FAMILIES.
WORKING WITH BUSINESS, GOVERNMENT,
UNIONS, NONPROFIT ORGANIZATIONS, AND
THE MEDIA, THE NATIONAL PARTNERSHIP IS
A VOICE FOR FAIRNESS, A SOURCE FOR SOLUTIONS,
AND A FORCE FOR CHANGE.
Introduction

Millions of Americans have medical histories or preexisting conditions that make it difficult to get comprehensive insurance coverage. Forty million have no health insurance at all. Many who now have insurance are effectively "locked" in their jobs, afraid that changing jobs would put their own and their family's coverage at risk. And small businesses, which employ nearly half of working Americans, often have trouble getting group insurance policies when even one employee has a medical problem.

The Health Insurance Portability and Accountability Act (Pub.L. 104-191) has the potential to help millions of women and their families by making it easier to get and keep comprehensive health insurance. The law is often referred to as "HIPAA" or the "Kennedy/Kassebaum" law after its lead co-sponsors, Senators Nancy Landon Kassebaum (R-KS) and Edward Kennedy (D-MA). Passed by Congress and signed by President Clinton in August 1996, the law's key provisions began to take effect on July 1, 1997 and will not be fully implemented until 2000.1

This new law will primarily help people who have access to group insurance coverage through employers or unions. Nearly 90 percent of people who have private insurance get it through an employer or union. The law's group market reforms apply not only to traditional insurance companies but also to health plans operated by employers who self-insure. Since plans operated by self-insured employers are beyond the reach of state insurance laws, federal regulation in this area is particularly critical and overdue. In addition, there are some provisions that have the potential to help people who leave a group plan and seek individual policies for themselves or their families.
In general, this law will make it possible for people to get coverage even when they have past or present medical problems. And it will help people maintain the coverage they need when they change insurance or jobs. It also will make insurance more accessible for those who work in small businesses.

What follows are specific examples of how this law will make a difference in the lives of women and their families:

| 1 | THIS LAW WILL HELP UNINSURED WOMEN WHO START A NEW JOB WITH AN EMPLOYER WHO PROVIDES HEALTH INSURANCE. |

It will mean that an uninsured woman applying for group medical insurance:

- Will not be refused coverage (for herself or her family), or charged a higher premium than others in the group, because of past or present medical problems. For example, she cannot be refused coverage if she has a condition such as heart disease or lupus. She also cannot be refused coverage because she has a family history of breast cancer or has tested positive for the breast cancer gene.

- Will not be discriminated against because she is a victim of domestic violence.

- Will not be denied coverage for a pre-existing condition for more than 12 months (as long as benefits for that condition are otherwise available under the plan). This includes preexisting conditions caused by domestic violence.

- Will not be denied coverage for pregnancy-related care just because she is pregnant when she enrolls.
• Will not be denied coverage for a newborn or newly adopted child’s medical problem, as long as she signs the child up for health insurance within 30 days of birth or adoption (and benefits for the medical problem are otherwise available under the plan).

• Will get coverage for children she already has at the time she enrolls, with no pre-existing conditions excluded, if those children have had Medicaid or other forms of insurance for the last 12 months. (Children under 12 months of age, or newly adopted children get this protection if their insurance coverage began within 30 days of birth or adoption and has been continuous since then.)

This law will help women and their families when they change from one health insurance plan to new group coverage:

• Will not be refused coverage for herself or her family – or charged a higher premium than others in the group – because of past or present medical problems.

• Will not be denied coverage for a pre-existing condition if she (or the relevant family member) has been insured continuously for the past 12 months (as long as benefits for that condition are otherwise available under the plan). This prior insurance can be with another group plan, an individual plan, or a publicly provided plan like Medicaid. If the family has had insurance for less than 12 months before changing plans, preexisting conditions can be excluded for up to a maximum of 12 months, with “credit” for the period of prior coverage. These are the “portability” features of the law.
Example: A woman works at a job with health insurance for ten months. She then changes to a new job that also offers health insurance. She was treated for breast cancer five months before changing jobs. In her new job, she cannot be refused group medical insurance even though she has had breast cancer. Her breast cancer medical expenses cannot be excluded for more than two months because she had continuous health insurance for ten months in her prior job. (If she had not been previously insured, her new employer’s insurance company could have denied coverage for her breast cancer expenses for the full 12 months.)

• Will not be denied coverage for pregnancy-related care just because she is pregnant when she enrolls in the new plan—regardless of how long she was covered under a prior plan.

• Will not be denied coverage for a newborn or newly adopted child’s medical problem—as long as she signs the child up for health insurance within 30 days of birth or adoption (and benefits for the medical problem are otherwise available under the plan).

This law will benefit insured employees (and their dependents) in a number of ways by:

• Prohibiting a plan from continuing to impose a preexisting condition exclusion if the individual has been enrolled in the plan for 12 months when the law takes effect as to that plan.
• Requiring the plan to give "credit" for prior coverage if the individual has been enrolled in the plan for less than 12 months.

• Defining the term "preexisting condition" narrowly: only conditions for which advice, diagnosis, care, or treatment was recommended or received during the six-month period before the individual enrolled in the plan can be excluded as preexisting conditions.

Example: A woman has been enrolled in her employer's health plan for 10 months as of January 1, 1998, when the law took effect as to her plan. The plan has been refusing to cover ongoing expenses related to a back condition because she had injured her back three years before joining this plan, and the plan considered her back condition a preexisting condition. She did not receive advice, diagnosis, care, or treatment for her back condition in the six-month period before joining this plan. As of January 1, 1998, the plan can no longer refuse to cover expenses related to her back condition because it does not fit the narrow definition of what can constitute a preexisting condition. (In addition, the plan could only refuse to cover other legitimate preexisting conditions for two more months.)
This law will help women who run or work in small businesses, which often have difficulty obtaining insurance, especially if one employee has medical problems. It will also help women who are self-employed.

It will help women in small businesses or who are self-employed by:

• Giving "small" businesses (those with between two and 50 employees) guaranteed access to insurance coverage and guaranteed renewability of insurance plans.

• Prohibiting insurance companies from denying coverage to a small business due to any employee's (or dependent's) past or present medical problems. This law does not prohibit insurance companies from charging the entire group more than another group because of past or present medical problems. Therefore, while coverage may theoretically be "available," it may still be too expensive.

• Phasing in a health insurance tax deduction for the self-employed. People who are self-employed and pay for their own insurance will be able to deduct 40 percent of the cost of their premiums in 1997. The deduction will increase periodically, reaching 100 percent in 2007.
This law will help women who lose their jobs and can afford to continue their group coverage under COBRA.

It will ensure that a woman who continues group coverage under COBRA:

- Can get immediate coverage for a newborn or adopted child under her COBRA policy without waiting for the group’s open enrollment period.
- Will be able to extend COBRA coverage an additional 11 months (beyond 18 months) if she or a family member becomes disabled during the first 60 days of COBRA coverage.

This law will benefit some women who leave the group market to start their own businesses or take a new job (including a part-time one) with more flexible hours but fewer benefits.

It will allow a woman leaving the group market and seeking individual coverage:

- To qualify for coverage in the individual market regardless of past or present medical problems under limited circumstances. Unfortunately, these changes in the law will only help those who have had prior coverage for 18 months (most recently with a group health plan, governmental plan, or church plan) and can afford to maintain any COBRA coverage available to them for another 18 to 36 months.
These and other conditions in the new law will be difficult for many women to satisfy. But those who can will have an easier time qualifying for individual insurance.\textsuperscript{13}

It will not, however, ensure that individual coverage is affordable:

- In a major shortcoming, this law does not prevent plans from taking the person's medical situation into consideration when setting premiums.\textsuperscript{14} Therefore, while coverage may theoretically be "available," many may find that it is just too expensive.

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\begin{itemize}
\item A four-year, enrollment-limited "demonstration project" for medical savings accounts (MSAs) that will allow up to 750,000 people/year to obtain tax-advantaged MSAs linked to high-deductible insurance policies. Only those who work in small businesses and the self-employed are eligible to participate.\textsuperscript{15}
\item Favorable tax treatment for some long-term care expenses not covered by insurance, and for long-term care insurance premiums.
\item Penalty-free withdrawals from Individual Retirement Accounts (IRAs) to cover high medical bills.
\item Penalty-free withdrawals from IRAs to cover health insurance premiums for people who receive unemployment compensation for at least 12 weeks and for some self-employed people.
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Unfinished Business

This law is an important breakthrough for women and families. But it has significant limitations, and many women will not benefit from it. There are also concerns that the new data collection and transfer provisions in this law could impair confidentiality of people’s medical records.
• Uninsured women applying for coverage in the individual market.

• Women who work in jobs that do not provide health insurance (whether they work full-time, part-time, seasonally, or erratically) and, if married, have spouses who also lack access to group insurance.

• Women who leave their employer and the group insurance market but are unable to afford continuation coverage under COBRA.
If you have employment-based health coverage (through your employer or a union) and have specific questions about your rights under the new law, contact the national office of the U.S. Department of Labor’s Pension and Welfare Benefits Administration (PWBA) or the regional PWBA office nearest you; addresses and phone numbers are listed on the next page. If you do not have employment-based coverage and have questions about the law, contact your state insurance department.

A booklet explaining the new rules, entitled Questions and Answers: Recent Changes in Health Care Law, is available at the Department of Labor’s web site at www.dol.gov/dol/pwba or by calling the Department’s toll-free Brochure Hotline at 1-800-998-7542. This PWBA publication also includes information on the Newborns’ and Mothers’ Health Protection Act of 1996 and the Mental Health Parity Act of 1996, which were passed by Congress and signed into law after HIPAA.

And, check out the National Partnership’s web site at www.nationalpartnership.org for the most current HIPAA information and any other new publications.

National PWBA Office
Division of Technical Assistance & Inquiries
Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Room N-5625
Washington, DC 20210
202-219-8776
### Regional PWBA Offices (as of 2/98)*

<table>
<thead>
<tr>
<th>Region</th>
<th>Address</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Atlanta Regional Office</td>
<td>61 Forsyth Street, Suite 7B54, Atlanta, GA 30303</td>
<td>404-562-2156</td>
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<td>Boston Regional Office</td>
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<td>Chicago Regional Office</td>
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<td>312-353-0900</td>
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<td>Cincinnati Regional Office</td>
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<td>313-226-7450</td>
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<td>Los Angeles Regional Office</td>
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<td>Miami District Office</td>
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<td>New York Regional Office</td>
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<td>St. Louis District Office</td>
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<td>206-553-4244</td>
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<td>Washington DC District Office</td>
<td>1730 K Street, NW, Suite 556, Washington, DC 20006</td>
<td>202-254-7013</td>
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* The most current PWBA office information is available at [www.dol.gov/dol/pwba](http://www.dol.gov/dol/pwba)
Endnotes

1 The law takes effect at different times for different plans, depending on when the "plan year" begins. Generally, the law takes effect at the start of the plan year that begins on or after July 1, 1997. More than half of plans have calendar-based "plan years"; for those plans, the law took effect on January 1, 1998.

2 The law prohibits plans from taking into consideration an individual’s health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability in determining eligibility for coverage or in setting premiums. While the law does not regulate how much insurance companies can charge the group as a whole, it does prevent group plans from differentiating between "similarly situated" enrollees within a group on the basis of these factors in setting premiums.

3 The law defines a preexisting condition as "a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period ending on the enrollment date." For people who enroll late in the plan, the maximum exclusion for a preexisting condition is 18 months. The law states explicitly that genetic information shall not be considered a pre-existing condition.

4 Children under 12 months of age – or newly adopted children– will receive the same protection if coverage began within 30 days of birth or adoption and has been continuous since then.

5 The law gives health plans the option of refusing to give complete “credit” for prior coverage that was less comprehensive than the new coverage being sought. Regulations published on April 8, 1997, state that plans can impose separate preexisting condition exclusions for five types of services (mental health services, substance abuse treatment, prescription drugs, dental care, and vision care) if the prior plan did not cover those services. How much of a barrier to comprehensive coverage this will create will depend largely on whether health plans exercise this option.

6 See Endnote one for dates of implementation.

7 Although the law prohibits insurance companies from denying coverage to employees (or their dependents) based on past or present medical problems, it appears that insurance companies that sell plans to small employers are not required to accept people who fail to enroll when they first become eligible to enroll. This means that people who work for small employers who do not qualify to enroll late under the law’s "special enrollment periods" should enroll in their employer-sponsored plan at the first opportunity.
HIPAA raised the deduction over time to 80 percent by 2006; the Taxpayer Relief Act of 1997, signed into law on August 5, 1997, increased the deduction to 100 percent by 2007 and changed the schedule of the phase-in.

For years, a federal law referred to as “COBRA” has allowed people to continue coverage through a group plan if they leave their job or would otherwise have lost their insurance due to death or divorce. Coverage can be continued for 18 to 36 months, depending on the circumstances. This new law will close some gaps in COBRA coverage.

Individual coverage is designed for people who are not eligible to participate in a group-sponsored plan through an employer or union. In the individual market, insurance policies are sold on an individual basis to single people and to families.

It should be noted that these limited provisions will only apply in states that have not adopted other methods of improving access to insurance in the individual market. Nearly all of the states are expected to implement state-adopted mechanisms, in which case the protections of the federal law will not apply.

Under COBRA, beneficiaries must pay the full cost of their insurance coverage without employer contribution (plus a two percent administrative fee) which can make this coverage expensive to maintain and out of reach of many in need.

Plans are also prohibited from denying coverage for preexisting conditions to individuals moving from the group to individual market who meet the conditions set out above.

State law, however, may place limits on premiums that can be charged in the individual market.

The National Partnership opposed broad-scale implementation of an MSA program due to concerns that such a program would attract primarily younger and healthier people, leaving older and sicker people in the traditional insurance market facing potentially skyrocketing insurance premiums. It could also discourage the use of primary and preventive care.

Acknowledgements

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