

Health Insurance Portability and Accountability Act

The **Health Insurance Portability and Accountability Act (HIPAA)** was enacted by the [U.S. Congress](#) in 1996. According to the [Centers for Medicare and Medicaid Services \(CMS\)](#) website, Title I of HIPAA protects [health insurance](#) coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers.-

The Administrative Simplification provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of [electronic data interchange](#) in the US health care system.

Title I: Health Care Access, Portability, and Renewability

Title I of **HIPAA** regulates the availability and breadth of group health plans and certain individual health insurance policies. It amended the [Employee Retirement Income Security Act](#), the [Public Health Service Act](#), and the Internal Revenue Code.

Title I also limits restrictions that a group health plan can place on benefits for preexisting conditions. Group health plans may refuse to provide benefits relating to preexisting conditions for a period of 12 months after enrollment in the plan or 18 months in the case of late enrollment.^[1] However, individuals may reduce this exclusion period if they had group health plan coverage or health insurance prior to enrolling in the plan. Title I allows individuals to reduce the exclusion period by the amount of time that they had “creditable coverage” prior to enrolling in the plan and after any “significant breaks” in coverage.^[2] “Creditable coverage” is defined quite broadly and includes nearly all group and individual health plans, [Medicare](#), and [Medicaid](#).^[3] A “significant break” in coverage is defined as any 63 day period without any creditable coverage.^[4]

Some health care plans are exempted from Title I requirements, such as long-term health plans and limited-scope plans such as dental or vision plans that are offered separately from the general health plan. However, if such benefits are part of the general health plan, then HIPAA still applies to such benefits. For example, if the new plan offers dental benefits, then it must count creditable continuous coverage under the old health plan towards any of its exclusion periods for dental benefits.

However, an alternate method of calculating creditable continuous coverage is available to the health plan under Title I. That is, 5 categories of health coverage can be considered separately, including dental and vision coverage. Anything not under those 5 categories must use the general

calculation (e.g., the beneficiary may be counted with 18 months of general coverage, but only 6 months of dental coverage, because the beneficiary did not have a general health plan that covered dental until 6 months prior to the application date). Unfortunately, since limited-coverage plans are exempt from HIPAA requirements, the odd case exists in which the applicant to a general group health plan cannot obtain certificates of creditable continuous coverage for independent limited-scope plans such as dental to apply towards exclusion periods of the new plan that does include those coverages.

Hidden exclusion periods are not valid under Title I (e.g., "The accident, to be covered, must have occurred while the beneficiary was covered under this exact same health insurance contract." Such clauses must not be acted upon by the health plan and also must be re-written so that they comply with HIPAA.

To illustrate, suppose someone enrolls in a group health plan on [January 1, 2006](#). This person had previously been insured from [January 1, 2004](#) until [February 1, 2005](#) and from [August 1, 2005](#) until [December 31, 2005](#). To determine how much coverage can be credited against the exclusion period in the new plan, start at the enrollment date and count backwards until you reach a significant break in coverage. So, the five months of coverage between [August 1, 2005](#) and [December 31, 2005](#) clearly counts against the exclusion period. But the period without insurance between [February 1, 2005](#) and [August 1, 2005](#) is greater than 63 days. Thus, this is a significant break in coverage, and any coverage prior to it cannot be deducted from the exclusion period. So, this person could deduct five months from his or her exclusion period, reducing the exclusion period to seven months. Hence, Title I requires that any preexisting condition begin to be covered on [August 1, 2006](#).