



LEGAL HOTLINE FOR TEXANS

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HIPAA

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The pamphlets of the Legal Hotline for Texans are general in nature and should not be relied on as advice for your particular circumstances. For advice that is specific to your particular circumstances, you should consult a lawyer.

The Legal Hotline for Texans (LHT) is a telephone hotline providing free legal advice and consultation and other free legal services to Texans Age 60 and Older or Eligible for Medicare; Crime Victims Age 60 and Older and their Family Members and Authorized Claimants; and Pension and Retirement Plan Employees, Participants and Beneficiaries.

Eligible Clients can consult with an attorney of the Legal Hotline for Texans free of charge by calling one of the phone numbers listed above. If clients would like to consult with an attorney in their communities, or if ongoing representation by an attorney is needed, the Legal Hotline for Texans may be able to make a referral.

Depending on individual circumstances and local availability, such a referral may be to an organization providing free attorneys to low income persons, or may be to an attorney on the Legal Hotline for Texans' reduced-fee panel, or may be to a statewide or local lawyer referral service.

The Legal Hotline for Texans is a project of the Texas Legal Services Center with support from the Texas Department of Aging and Disability Services (DADS), the U.S. Centers for Medicare and Medicaid Services (CMS), the U.S. Administration on Aging (AoA), and the Texas Equal Access to Justice Foundation through the Texas Basic Civil Legal Services Program (BCLS) and the Texas Crime Victims Civil Legal Services Program (CVCLS).

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The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996, known as HIPAA, includes important protections for families. First, the law limits the ability of insurance companies to not provide health coverage because a person has an existing medical problem, and prohibits insurance companies from discriminating against people and their families based on their current health status. HIPAA also includes guarantees that allow people to renew health coverage after they lose their jobs.

And as substantial as those promises are, the law does even more. HIPAA also includes the first-ever national health information privacy standards. The regulations put in place protect your medical information and records, whether it is on paper, in a computer, or just spoken the nurse at your doctor's office. Finally, HIPAA included provisions that require the adoption of a national set of standards of medical coding to make electronic transmission of health care information more uniform and secure.

Preexisting Conditions

In the past, insurance companies were allowed to deny health insurance to people who had "preexisting conditions." Group health plans would not cover such conditions – ever. HIPAA changed that dramatically. Now a health plan offering group coverage (which is the type of coverage most people get at their jobs) can impose a preexisting condition exclusion only if the person has received advice or treatment for the condition in the last six months. And even then, the exclusion generally cannot last more than 12 months, and the insurance carrier must allow credit for the time that the person had health coverage prior to applying for the new coverage. The bottom-line effect of the new law is that people are no longer forced to keep bad jobs for fear of losing health insurance.

Under HIPAA, a "preexisting condition" is specifically defined as any medical condition you had before you apply for group health insurance, IF you received medical advice, diagnosis, care, or treatment during the six months just prior to your enrollment with the new insurance. If you had a condition 6 or 7 years ago, but have not received any treatment for it in the last 6 months, then, under HIPAA, that condition cannot be considered a preexisting condition that can be used to limit your health insurance coverage.

And in some cases, even conditions you have received treatment for in the last 6 months cannot be excluded from your coverage. For example, pregnancy cannot be excluded. Again, the effect being that now, a woman who happens to be pregnant is not required to keep a job she would like to leave because of her fear of losing health insurance. Nor does a couple considering adopting a child need be concerned about any preexisting conditions preventing insurance coverage.

If you have a medical condition that you have received treatment for in the last 6 months, then if you change group health plans, the insurance company may not cover treatment for that condition for a period of time. The same is true for your dependents. But, even if the exclusion

applies, it generally will not be for any more than 12 months, and you have to be given credit for “creditable coverage” you had before getting the new coverage.

What is “creditable coverage”? Any coverage you may have had under a previous group health plan (including COBRA coverage), coverage you may have had with an individual policy, and also Medicaid or Medicare coverage. But, only so long as there has not been a “significant break” in coverage, which generally means 63 days. The net effect of the “significant break” rules is that in many cases, if you lose a job and the employer provided health insurance, extending coverage through COBRA should be strongly considered to avoid a 63 day break in coverage.

If you do change jobs and need to get show your new group health insurance company that you had “creditable coverage” you will need to give the new carrier a certificate. Under HIPAA, your former insurance carrier is required to give you a statement that shows your prior health coverage. This statement is commonly referred to as a certificate of creditable coverage.

All health plans must tell you, within a reasonable time, if you are going to be part of a preexisting condition exclusion period. And recall that generally the exclusion period will not be for more than 12 months, and must give you credit for earlier coverage. If you change jobs and your new employer has a waiting period before you can get health insurance coverage, the preexisting period begins when the waiting period begins, not when the waiting period ends.

Finally, keep in mind that many health plans do not seek to exclude coverage for preexisting conditions.

Nondiscrimination Requirements

In addition to limiting the ability of insurance companies to not provide health coverage because a person has an existing medical problem, HIPAA also prohibits insurance companies from discriminating against people and their families based on their current health status. Individuals cannot be excluded or charged more for benefits because of their current health status.

Group health plans cannot have eligibility rules related to your health status (physical or mental), previous health claims, genetic information, or disability, even if you are a late enrollee. Nor are insurance companies allowed to drop your coverage based on these factors. For example, you cannot be dropped because you have a particular illness. This does not mean that insurance plans cannot establish group limits or restrictions for benefits, they can. What it means is that the restrictions must apply across the whole group, and cannot be applied just to you. In addition, you cannot be required to pay an extra premium because of your health status.

One of the bottom line effects of this law is that employers can no longer require you to pass a physical exam before providing coverage. Plans cannot set up eligibility rules that discriminate based on health related factors. Requiring a person to pass a physical would be such a rule, and is therefore not allowed.

The HIPAA Privacy Rule

HIPAA also established “Standards for Privacy of Individually Identifiable Health Information.” Translation: there are now, for the first time, national rules set up to protect the privacy of your health information, and also to allow you access to that information. These privacy rules apply to health plans, health care “clearinghouses,” and to any health care provider that sends information electronically. (Health care clearinghouses are entities that process information they receive from other health entities; medical billing service companies, for example.)

The HIPAA privacy rules protect “individually identifiable information.” This includes all such information, not matter what the format. Information transmitted electronically, information on paper, and even information transmitted orally. The protected information may sometimes be referred to as “PHI,” or protected health information.

What is “individually identifiable information”? That is any information that is related to your past, present, or future health condition. It also includes information about health care you may have received, and payment you may have made for that care. When this information identifies you as an individual, or can be used to identify you as an individual, generally, it is included as “individually identifiable information” protected by privacy rules.

The basic purpose of the rules is to limit access to protected information, and require individual authorizations in writing. That does not mean however that the information can *never* be disclosed. First and foremost, covered entities *must* disclose your health information to you, and your personal representative. The privacy rules also permits covered entities to disclose information, without authorization, to allow for treatment and health care, for public health, and in some cases for research.

For example, your doctor is allowed to disclose protected information to the hospital that will be doing your surgery, or to a specialist that is going to be treating you. She may also disclose protected information to get payment for her services. But, covered entities must get written authorization for any use or disclosure that is not for treatment, payment, or otherwise specifically allowed. And the authorization must be in writing, and in specific terms. For example, a written authorization is necessary before any disclosure be made to a life insurance company.

Another fundamental principle of the rules is that, when your health information is disclosed, only the minimum necessary should be used or disclosed, and the covered entity must take reasonable steps prevent unwarranted disclosures. For example, the entity has to have clear policies and procedures in place, and must train its staff on these procedures so that even when your information needs to be released, it is given out only as necessary. And in many cases, you are allowed to ask for an accounting of disclosures that have been made of your health information, and health care providers must give you notice of how they may use protected information.

Federal law now also specifically provides that you should generally be able to see and get copies of your medical records, and to request corrections if you find mistakes. The same is true

for your designated representative (the holder of a health care power of attorney, for example), which means your pharmacist is allowed to let someone pick-up your prescriptions. The privacy rules also allow parents to see their children's medical records, with some exceptions, such as when the child consents to the care and parental consent is not required.

Finally, if you believe that someone covered by the HIPAA privacy rules has violated your health information privacy, you can file a complaint with the United States Department of Health and Human Services. The law provides for civil and criminal penalties, up to and including imprisonment.