HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted on August 21, 1996. HIPAA amended the Internal Revenue Code of 1986, the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act of 1974 (PHSA), to provide for, among other things, improved portability and continuity of health coverage. HIPAA contains provisions which:

1. Provide individuals with additional rights through its Pre-Existing Condition, special enrollment, and nondiscrimination requirements,
2. Impose insurance market rules that apply to health insurance carriers which require guaranteed availability and renewability of health insurance plans,
3. Govern the privacy and security of health information, and
4. Require that claims information be exchanged in a standardized format.

The group health insurance provisions within HIPAA went into effect for plan years beginning on or after July 1, 1997.

Insured and self-funded Group Health Plans and health insurance carriers that offer group Health Insurance Coverage must comply with HIPAA's Pre-Existing Condition, special enrollment, and nondiscrimination requirements.

Self-funded, non-federal governmental plans may opt out of HIPAA's portability requirements, but must continue to issue Certificates of Creditable Coverage. Plans wishing to opt out must file the appropriate forms with the Department of Health and Human Services within 30 days prior to the beginning of each plan year.

HIPAA- Wellness Programs

Group Health Plans and Insurers that offer Wellness Programs which condition a reward based on outcome.

Notice Requirement	Summary
Notice of Alternative Standard - Plans and insurers must disclose the availability of an alternative standard in all materials describing the wellness program.	Wellness programs which offer a reward conditioned upon an individual's ability to meet a standard that is related to a health factor will violate HIPAA's nondiscrimination rules unless the program satisfies a number of conditions: • Limit reward to 20% of cost of coverage; • Design to reasonably promote health and prevent disease; • Provide annual opportunity to qualify; • Provide reasonable alternative standard for obtaining the reward for certain individuals; and • Disclose availability of an alternative standard

HIPAA-Privacy

Group health plans, health care clearinghouses, health care providers that transmit any health information electronically, and enrolled sponsors of Medicare prescription drug discount card, unless exception applies.

Notice Requirement	Summary
Notice of Privacy Practices – The plan administrator or insurer must provide the Notice of Privacy Practices when a participant enrolls, upon request and within 60 days of a material revision to the notice. At least once every three years, participants must be notified about the availability of the Notice of Privacy Practices.	HHS regulations require that participants be provided with a detailed explanation of their privacy rights, the plan's legal duties with respect to protected health information, the plan's uses and disclosures of protected health information, and how to obtain a copy of the Notice of Privacy Practices.
Notice of Breach of Unsecured PHI – Covered entities and their business associates must provide notification following a breach of unsecured PHI without unreasonable delay and in no case later than 60 days following the discovery of a breach.	Following a breach of unsecured PHI, covered entities must provide notification of the breach to affected individuals, HHS, and, in certain circumstances, to the media. If the unsecured PHI is held by a business associate, the business associate must notify the covered entity that a breach has occurred.

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HIPAA-Portability
Group health plans and issuers of group health plan insurance coverage, unless exception applies.

Notice Requirement	Summary
Certificate of Creditable Coverage – Plan administrators and issuers must provide automatically when covered individuals lose group health plan coverage, become eligible for COBRA coverage, and when COBRA coverage ceases. A certificate may be requested free of charge any time prior to losing coverage and within 24 months of losing coverage.	Notice from group health plan to individuals who lose coverage, documenting prior group health plan creditable coverage and length of time covered.
General notice of preexisting condition exclusion – Plan administrators and issuers must provide as part of any written application materials distributed for enrollment. If the plan or issuer does not distribute such materials, by the earliest date following a request for enrollment that a plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.	Notice to participants describing a group health plan's preexisting condition exclusion and how prior creditable coverage can reduce the preexisting condition exclusion period.
Individual notice of period of preexisting condition exclusion – Plan administrators and issuers must provide as soon as possible following the determination of creditable coverage.	Notice to an individual that a specific preexisting condition exclusion period applies after consideration of creditable coverage evidence, as well as an explanation of appeal procedures if the individual disputes the plan's determination.
Notice of special enrollment rights – Plan administrators must provide at or before the time an employee is initially offered the opportunity to enroll in the group health plan.	Notice to employees eligible to enroll in a group health plan describing the group health plan's special enrollment rules including the right to enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption, or within 60 days of the loss of coverage under a Medicaid plan or CHIP, or within 60 days of a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP.

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