

YOUR HIPAA RIGHTS AND GUIDE TO INDIVIDUAL HEALTH INSURANCE

WHAT IS INDIVIDUAL HEALTH INSURANCE?

Individual health insurance is coverage offered to individuals and their dependents. Specifically, an individual purchases health insurance coverage directly from the insurance company (not through an employer group or association group arrangement).

WHAT RIGHTS DO I HAVE TO OBTAIN INDIVIDUAL HEALTH INSURANCE?

In North Carolina, as in most other states, your right to obtain individual health insurance is limited. Companies that sell individual health insurance are permitted to review your health status and other factors to determine whether you meet the company's underwriting requirements.

When applying for individual coverage, you may be asked questions about health conditions you have or may have had in the past. Depending on your health status and the company's underwriting guidelines, insurers might refuse to sell you coverage, or offer to sell you a policy that has limitations on what medical conditions it covers.

However, there is one important exception to an insurer's ability to decline coverage. This exception applies to a "HIPAA eligible individual". All private insurance companies that sell individual health insurance must offer you a choice of at least two plans if you qualify as a HIPAA eligible individual. Those two plans must contain benefits that are similar to the insurer's other plans. Companies that choose not to designate two plans for HIPAA eligible individuals must offer them a choice of all their individual insurance policies.

Individual Coverage Through A Conversion Policy

All insurers that sell group health insurance plans must offer an individual conversion policy to individuals who lose coverage under the group plan. Conversion policies cannot exclude benefits for pre-existing conditions covered under the prior group plan.

Premium rates for conversion plans may be substantially more than rates for your previous group plan. Some people may qualify as a HIPAA eligible individual and also be eligible for coverage under an individual conversion policy. If you find yourself having both of these options, you should carefully compare the premiums and benefits, and choose the plan that best meets your needs.

WHO IS A HIPAA ELIGIBLE INDIVIDUAL?

To qualify as a "**HIPAA eligible individual**", you must meet **all** of the following requirements.

- You must have had at least 18 months of continuous "creditable coverage", of which **at least the last day must have been under an employer group health plan.**
- You must have used up any COBRA or state continuation coverage for which you were eligible.

- You must not be currently eligible for coverage under Medicare, Medicaid or another group health plan.
- You must not presently have health insurance. (If, however, you know your group coverage is about to end, you can apply as a HIPAA eligible individual for coverage to go into effect when your group coverage ends.)
- You must apply for health insurance as a HIPAA eligible individual no later than 63 days after losing your group coverage.

WHAT IS CREDITABLE COVERAGE?

For the purpose of obtaining coverage as a HIPAA eligible individual, “**creditable coverage**” is any prior coverage under a group health plan (including COBRA or state continuation), North Carolina’s Health Choice program or comparable children’s health insurance program, or coverage under Medicare or Medicaid. Individual coverage may count as creditable coverage provided the last day of your creditable coverage is under an employer group health plan.

As proof of coverage, employers and/or insurers are required to provide a certificate of creditable coverage to insureds (when their coverage ends) to document the duration of their coverage. That certificate is used to show a new health plan how much pre-existing credit they are entitled to. A person is considered to have been “continuously covered” so long as no break in coverage greater than 63 days has occurred between two “creditable coverage” plans.

HIPAA’s increased portability guarantees that insureds get “credit” for the time covered under a previous plan, provided there is no lapse of more than 63 days. Specifically, insurers must reduce any pre-existing condition limitation periods by the amount of time the insured was covered under prior creditable coverage. Most importantly, employers and/or insurers are required to provide an insured a certificate of creditable coverage whenever their group coverage ends, and insurers are required to issue a certificate of creditable coverage whenever individual health insurance coverage ends. That certificate is used to prove you had creditable coverage.

WHAT ABOUT PRE-EXISTING MEDICAL CONDITIONS?

A “**pre-existing condition**” may be defined as a health condition for which you received medical advice, diagnosis, care or treatment within 12 months immediately prior to the effective date of your plan. The maximum pre-existing conditions waiting period for individual coverage is 12 months in most types of coverage. Pregnancy can be considered a pre-existing condition, provided it meets the above stated definition.

Policies sold to HIPAA eligible individuals cannot exclude coverage for preexisting conditions; however, premium rates may be higher. Other individual policies may not cover pre-existing conditions for up to 12 months after you enroll in the plan (as explained above), or may permanently exclude coverage for pre-existing conditions through a policy rider or endorsement.

WHAT DOES INDIVIDUAL HEALTH INSURANCE COST?

When you apply for coverage, insurers are permitted to consider the status of your health in determining your premium rate. If you or your dependents have health conditions, your individual health insurance premium is likely to be higher than premiums for a healthy person who applies for the same policy. However, once you are covered, you cannot be singled out for rate changes after coverage is issued, regardless of your medical experience or use of health care services. Your family size and the type of policy you purchase will also affect your premiums. Costs may increase when more dependents are covered, as well as when benefits are increased. Also, insurers are permitted to relate costs to age. When you renew your individual coverage, your premiums can increase substantially as your age increases.

However, "HIPAA eligible individuals" must be offered individual coverage and cannot be rated differently than other HIPAA enrollees covered by the same plan. North Carolina statutes require health insurance rates to be justified, and prohibits rates from being unfairly discriminatory.

CAN INDIVIDUAL HEALTH INSURANCE BE CANCELED?

All individual health insurance is guaranteed renewable. "**Guaranteed renewable**" means, insurers cannot cancel your coverage if you get sick or experience high claims. However, your insurer can cancel your individual health insurance plan if you fail to pay the premiums, defraud the company, or, in the case of a managed care plan (HMO), move out of its service area.

Please note, an insurance company may terminate an entire health insurance plan and/or may completely cease operating in the health insurance market, provided proper advance notice is given to its policyholders.

Reminder:

- North Carolina does not require health insurers to sell standardized plans, so the benefits in the plans vary. Because health insurers design and market different plans, it is important that you study them carefully to determine which plan is right for you and your dependents.
- Although the time you are covered under an individual health plan may count toward the requirement for 18-months of continuous creditable coverage, maintaining coverage under an employer group health plan is the best way to protect your ability to qualify as a HIPAA eligible individual, since your last day of continuous creditable coverage must be under an employer group plan.

ARE THERE ALTERNATIVES TO INDIVIDUAL HEALTH INSURANCE?

If you left a job in which you were enrolled under an employer group health plan, you may have a right to continue in that plan for a limited time through federal COBRA continuation laws or State continuation coverage. Not only are you required to exhaust these options in order to qualify as a HIPAA eligible individual. But this coverage is generally much less expensive than individual coverage. You should contact your former employer or the Department of Insurance to discuss your rights under these options.

How to Reach Us

You can reach the North Carolina Department of Insurance (NCDOI), Consumer Services Division at:

800-546-5664 (toll free)

919-807-6750 (outside of North Carolina)

919-715-0319 (TDD) Telephone Device for Deaf Caller

919-733-0085 (Fax)

You can find additional information including our complaint form on the North Carolina Department of Insurance Web site at **www.ncdoi.com**.

The address for the North Carolina Department of Insurance, Consumer Services Division is:

**Consumer Services Division
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201**

Where Can I Find Additional Information?

Centers for Medicare and Medicaid Services (CMS)

- call 1-404-562-7500
- visit the HIPAA web site at www.cms.hhs.gov/hipaageninfo/

US Department of Labor, Employee Benefits Security Administration (for COBRA questions)

- call 1-866-444-3272
- visit USDOL's web site at www.dol.gov/ebsa

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