HEALTH INSURANCE

Health Insurance for Families with Hepatitis

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Health insurance coverage is regulated by both state and federal laws. Together, they extend varying degrees of protection to consumers who have chronic illnesses, such as viral hepatitis.

Parents need to know both their state's regulations and consumer safeguards, as well as federal laws, to know what their insurance plans will and will not cover and where to turn when companies refuse coverage or refuse to pay for certain treatments or tests.

Many Americans have health insurance coverage because a family member has access to group coverage through employment. In this situation, the employer bears all or part of the health insurance cost. Some companies offer a choice of plans, a fee-for-service plan, a health maintenance organization (HMO), or a preferred provider organization (PPO).

If someone leaves a job, is fired or laid off, he or she will lose employer-supported group coverage. Former employees can keep the same policy, but they will have to pay the entire cost of the insurance coverage premiums.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is important to families living with viral hepatitis. It limits the circumstances under which an insurer can refuse to cover pre-existing medical conditions.

For example, if a parent of a child with hepatitis starts a new job and becomes covered by a new health insurance plan, HIPAA prevents the insurer from refusing to insure the family because a child has chronic hepatitis—a known pre-existing condition. All the parent has to do is show proof of prior health insurance coverage and the new insurer must cover the family.

The parent is entitled to a certificate from his or her prior health program which shows evidence of the previous health program coverage. By presenting this certificate to a new insurer, the parent may be eligible for a waiver of their pre-existing clause.

However, HIPAA does not apply to individual health insurance policies, so self-employed people do not enjoy the benefit of waiving pre-existing medical conditions

exclusions. In some cases, states regulate pre-existing conditions in those individual scenarios.

The driving force behind HIPAA is that health insurance companies traditionally tried to hold down costs by invoking a "pre-existing condition" clause that refused coverage of any medical condition that existed before the consumer joined the health plan.

A current health plan might pay for interferon treatment for a child's chronic hepatitis infection and visits to the doctor. But before HIPAA was enacted, if a parent switched to a new health plan, the new insurer could have considered the child's infection a pre-existing condition and refused to pay for treatment.

The frightening prospect of having to pay hundreds or thousands of dollars for medical care is what created job lock and helped fuel the push for legislation banning such practices.

HIPAA imposes protections, but it too has limits. For example, if a parent had health insurance for 12 straight months, with no lapse in coverage for 63 days or more, and he or she switched to a new group health plan, the insurer cannot refuse coverage on any pre-existing conditions at all. It must cover all medical problems upon enrollment in the plan. (Newborns and adopted children who are covered within 30 days are not subject to the 12-month waiting period.)

Most health coverage plans are creditable under HIPAA. They include prior coverage under a governmental or church plan, a group or individual plan, Medicare, Medicaid, a military-sponsored health care program such as TriCare (formerly CHAMPUS), a program of the Indian Health Service, a state high-risk pool, the federal Employees Health Benefit Program, a public health plan established or maintained by a state or local government, and a health benefit plan provided for Peace Corps members.

If parents lack that creditable coverage when they enroll in a new group plan, the insurer could refuse to pay for any of the existing medical problems, but only for a maximum of 12 months. (States may have varying limits on this exclusion period.) Late enrollees in group health plans may have to wait up to 18 months for coverage of pre-existing conditions.

When a family enrolls in an individual or group insurance plan, the insurer usually asks general health questions. Parents must respond honestly with all relevant information. Insurers usually request medical records from about one in five individual applications.

When families apply for health insurance through individual plans, insurers use the application information to decide whether or not to grant insurance coverage.

Insurance companies use the Boston-based organization called the Medical Information Bureau (MIB) to obtain additional information about an individual or family's medical claims history.

Individuals can obtain a free copy of the file that MIB maintains about them or their family member by contacting the bureau directly at Medical Information Bureau, P.O. Box 105, Essex Station, Boston, MA 02112, and asking that a copy be sent to the family's physician.

An individual can appeal the information in the MIB file if he or she feels it is inaccurate.

If parents wish to complain about insurance coverage or a company's refusal to pay for medical treatment, they must contact the agency that regulates the insurance company. Here is a list of agencies that regulate different types of insurance companies:

- Private companies such as Blue Cross/Anthem, Prudential and other private insurers are regulated by a state department, division or bureau of insurance. (See list of state insurance offices.)

- A licensed health care service, such as an HMO, is usually regulated by a state's department of corporations, division of health care service plans.

- A federal HMO is regulated by the U.S. Department of Health and Human Services, Division of Compliance.

- A private employer or union that has a self-insured and self-financed plan is regulated by the U.S. Department of Labor, Office of Pension and Welfare Benefits.

- Medicaid Programs are regulated by the state's department of social or human services.

- Medicare Supplemental Security Income Social Security Benefits is regulated by the U.S. Social Security Administration.

- Veterans Benefits (CHAMPUS) is administered by the Department of Veterans Affairs.