STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-0258

December 18, 2000

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Public Health Directors
All County Mental Health Directors

Letter No.: 00-66

INSTRUCTIONS FOR HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA '96)

The purpose of this All County Welfare Directors Letter (ACWDL) is to formally transmit information and instructions regarding HIPAA '96 also know as the Kennedy/Kassebaum Act. Information on HIPAA had previously been shared at California Welfare Director's Association (CWDA) and through E-Mail.

BACKGROUND:

On August 21, 1996, President Bill Clinton signed the HIPAA. This Act seeks to increase the portability of health insurance by guaranteeing both group-to-group and group-to-individual coverage so that people who change or lose their jobs would not lose their health insurance. This bill limits any exclusion for pre-existing medical conditions to 12 months, while also providing that this 12-month period would be reduced by the period of time the person was continuously covered for the pre-existing condition by a health plan at his or her previous employment. ***A pre-existing condition exclusion is a limitation or exclusion of benefits relating to a condition, whether physical or mental, based on the fact that the condition existed before the new enrollment date.*** The portability provisions are intended to help employees who move from a company that has group health coverage to another company that offers group health coverage and not lose time already accumulated toward a waiting period. For purposes of this Act, Medicaid (Medi-Cal in California) is defined as a group health plan.

CERTICATE OF CREDITABLE COVERAGE:

The purpose of the certificate of creditable coverage is to present evidence that the individual had creditable coverage that counts toward reducing or eliminating pre-existing condition exclusions under subsequent health benefit coverage such as the individual may obtain. As long as this creditable coverage is not interrupted by a

significant break, the individual's creditable coverage may be aggregated from several eligibility periods and from different forms of creditable coverage. ***A significant break in coverage means a period of 63 consecutive days during all of which the individual does not have any creditable coverage.*** A waiting period or an affiliation period is not taken into account in determining significant break in coverage. In the group market, group health plans or issuers offering group health insurance coverage, with pre-existing condition exclusions, must reduce the length of any exclusion period by an individual's creditable coverage.

WHO WILL RECEIVE THE CERTIFICATE OF COVERAGE?

The certificates are required to be provided at the request of an individual, the parent, guardian, or authorized representative of the individual, if the request is made not later than 24 months after the individual loses coverage.

WHO IS REQUIRED TO ISSUE THE CERTIFICATE OF COVERAGE?

The Department of Health Services (DHS) is the Medicaid agency with the authority to issue the certificate of coverage. DHS also has the authority to designate another entity. Currently, DHS is working with Data Systems Branch to automatically send a "Certificate of Coverage" when Medi-Cal is discontinued. In the interim, county social service agencies need to issue certificates of coverage upon request. Enclosed is a sample of a "Certificate of Coverage" format (See Attachment No.1) counties can use or they can develop their own format. The information must reflect only the most recent period of creditable coverage. In cases where the individual does not have at least 18 months of continuous creditable coverage, the certificate must disclose the date coverage began and the date coverage ended.

WHAT INFORMATION IS CONTAINED IN THE CERTIFICATE OF COVERAGE?

Certificates issued at request must reflect all periods of coverage which ended during the 24 months that precede the date of request. The certificate must include the following information:

- Certificate issue date.
- The name of the group health plan (Medi-Cal) that provided the coverage described in the certificate.

- The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent.
- The county name, address, and telephone number providing the certificate.
- The telephone number to call for further information regarding the certificate if different (such as the managed care plan) from the information required in the proceeding bullet.
- One of the following:
  - A statement that an individual has at least 18 months of creditable coverage, disregarding days of creditable coverage before a significant break in coverage.
  - The date creditable coverage began and the date creditable coverage ended, or indicates that creditable coverage is ongoing as of the date of the certificate.
  - If the Medi-Cal beneficiary was on a Medi-Cal Managed Care plan, the county must also include the name of the plan and the plan's telephone number, or information regarding the scope of coverage.

QUESTION AND ANSWERS:

Question 1. If Medi-Cal was discontinued due to fraud, do we still issue certificate?

Answer: *No.*

Question 2. Does the certificate specify the scope of coverage the beneficiary is entitled?

Answer: *No. The only time that the scope of coverage would be divulged, would be when the new health insurance issuer is requesting the information. At that point, the county social service agency can charge a fee for the dissemination of the information. Counties can use the attached "Information On Categories Of Benefits" format (See Attachment No. 2) to provide scope of coverage information.*

Question 3. Does the county issue a certificate for QMB-only beneficiaries?

Answer: *No. Medi-Cal only pays for the Medicare premiums.*

Question 4. Does the county issue a certificate for minor consent services?

Answer: *No.*

Question 5. If a Medi-Cal beneficiary is still on Medi-Cal and wants a certificate, does the county have to issue it?

Answer: *Yes. If a beneficiary requests a certificate, the county must issue one.*

Question 6. Does the certificate have to be done in a certain format?

Answer: *No. As long as the information that is pertinent is included.*

Question 7. If the Medi-Cal beneficiary was only covered for emergency services, does the certificate have to be issued?

Answer: *Yes. According to Health Care Financing Administration, emergency services constitutes creditable coverage for purposes of issuing the certificate.*

Question 8. If an individual has a share of cost (SOC) and does not meet the SOC each month, does the county have to issue the certificate?

Answer: *No certificate would be issued if the individual did not meet the SOC in any the last 24 months. However, if the SOC was met in any of the last 24 months and there was a significant break in coverage* ***(for Medi-Cal this 63 day consecutive break equates to three months without meeting the SOC)*** *you would issue the certificate for the months after the last significant break.*

Question 9. What type of benefit information will the county be expected to provide to an insurance company or issuer?

Answer: *The county can issue a standard form with the information regarding the services that pertains to full scope, restricted benefits, etc.*

If you have any questions regarding the issuance of the certificate of coverage, please contact Mr. Chet Heine of my staff at (916) 657-0837.

Sincerely,

ORIGINAL SIGNED BY

Glenda Arellano
Acting Chief
Medi-Cal Eligibility Branch

Enclosure

Attachment No. 1

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
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CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

IMPORTANT: This certificate provides evidence of prior health coverage. You may need to furnish this certificate, if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment to the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: _____

2. Name of group health plan: Medi-Cal (California's Medicaid Program)

3. Name of beneficiary: _____

4. Identification number of beneficiary:_____

5. Name, address, and telephone number of plan administrator or issuer (county) responsible for providing this certificate:

   Name of county:_____

   Address_____

   _____

   Telephone number:_____

6. Name of managed care plan (If applicable):_____

   Telephone number of plan:_____

7. If the individual identified in line 3 has at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here _____ and skip 8 and 9.

8. Date coverage began: _____

9. Date coverage ended: _____(or check if coverage is

   continuing as of the date of this certificate _____).