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The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions

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The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions

Summary

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191), provided for changes in the health insurance market. It guaranteed the availability and renewability of health insurance coverage for certain employees and individuals, and limited the use of preexisting condition restrictions. The Act created federal standards for insurers, health maintenance organizations (HMOs), and employer-provided health plans, including those that self-insure. It permitted, however, substantial state flexibility for compliance with the requirements on insurers.

HIPAA also included tax provisions relating to health insurance. It permitted a limited number of small businesses and self-employed individuals to contribute to tax-advantaged medical savings accounts (MSAs) established in conjunction with high-deductible health insurance plans. It increased the deduction for health insurance that self-employed taxpayers may claim. In addition, it allowed long-term care expenses to be treated like deductible medical expenses and clarified the tax treatment of long-term care insurance.

Finally, the Act included administrative simplification and privacy provisions instructing the Secretary of HHS to issue standards addressing the electronic transmission of health information and the privacy of personally identifiable medical information.

Since the passage of HIPAA, there have been subsequent amendments. In 1996, new provisions required group health plans and insurers to cover minimum hospital stays for maternity care and for a limited period, to provide parity in certain mental health benefits. Parity was later extended for one year. In 1998, a provision was passed requiring health plans that cover mastectomy to also offer reconstructive breast surgery. Amendments have also increased the tax deduction for premiums paid by self-employed taxpayers.

The Act, as amended, continues to generate numerous questions. What kinds of policies does it cover? Does it help people who are currently uninsured? Does it help people with preexisting medical conditions? How does it affect health insurance premiums? How do its requirements interact with the Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage? Answers to those questions, as well as other commonly asked questions, are provided, as well as descriptions of each of the major sections of HIPAA.

Some of the answers provided may not be definitive. This is because, in some cases, final regulations have not yet been promulgated. Other regulations, such as those defining the administrative simplification provisions, remain under development. In addition, the answer to many questions about the requirements on the individual health insurance market depend upon particular state responses to the Act. For some provisions, states were allowed the choice of implementing the HIPAA requirements ("the federal fallback") or establishing acceptable alternative mechanisms.

Contents

Part I. The Act in General	1
Does HIPAA help individuals who are uninsured?	2
Are employers required to offer health insurance as a benefit?	3
Part II. Health Insurance Reforms	3
Portability	3
What is creditable coverage?	3
What is a preexisting medical condition?	4
What is a preexisting medical condition limitation period?	4
Portability in the Group Market	4
How do people take full advantage of the portability provisions of the act?	5
How long can a group health plan restrict coverage for a preexisting medical condition?	5
What is late enrollment?	6
What is a waiting period? How does it differ from a preexisting condition limitation period?	6
Do plans and issuers have any discretion in the method of crediting prior coverage?	6
Do these protections apply to an individual's spouse and children?	7
Portability and Guaranteed Availability in the Individual Insurance Market	7
Who is eligible for group to individual market portability and guaranteed availability under the Act?	8
What are the limitations of the group-to-individual portability and guaranteed availability protections?	8
What are the requirements for an acceptable alternative state mechanism?	8
How have states implemented this provision?	9
Special Enrollment Periods in the Group Market	13
Non-Discrimination in the Group Market	14
Can a group health plan refuse to enroll individuals with a history of illness or disability or high medical expenses? Can it drop someone from coverage who becomes sick or starts using a lot of medical care?	14
Can an employer condition coverage under its health plan on passing a physical examination?	14
Can a group plan refuse to enroll individuals who engage in high risk recreational activities?	14
Can a group plan exclude coverage of treatments for injuries obtained while engaging in high risk recreational activities?	15
Do these non-discrimination protections apply to an individual's spouse and children?	15
Does the Act restrict the premium amounts that an employer can charge for health insurance?	15

Guaranteed Issue and Guaranteed Renewability	15
Can health insurance issuers drop or cancel coverage for groups because of high medical costs?	16
Federally Required Benefits	16
Mental Health Parity	17
Newborns' and Mothers' Health Protection Act	17
Women's Health and Cancer Rights Act of 1998	17
Can an employer exclude coverage for specific types of illnesses, such as cancer, or acquired immune deficiency syndrome (AIDS) or treatment of injuries associated with high risk activities?	18
General Questions About the Health Insurance Reforms	18
Do the requirements of the Act apply to the plans of employers that provide for dental-only coverage or vision-only coverage? ..	18
Do the requirements of the Act apply to association-sponsored group health plans?	18
Can states impose requirements on insurers selling to group health plans that are different from those in the Act?	18
Do the insurance reforms apply to Federal Employee's Health Benefits Plans (FEHBP)?	19
Does the Act regulate the premium amount that an issuer can charge an eligible individual?	19
Implementation and Enforcement	19
How are the insurance requirements of the Act enforced?	20
What regulations have been promulgated to define HIPAA?	20
COBRA Continuation Coverage	23
How does COBRA continuation coverage interact with HIPAA? ...	23
Does HIPAA make any changes in COBRA continuation of coverage requirements?	23
Part III. Other Provisions	24
Administrative Simplification	24
Medical Savings Accounts	25
Health Insurance for Self-Employed Taxpayers	25
Long-Term Care	26
Accelerated Death Benefits	27
State Insurance Pools	28
Treatment of Certain Health Insurance Providers	28
IRA Distributions for Medical Expenses and Insurance	29
Organ and Tissue Donation Information	29

List of Tables

Table 1. State Group-to-Individual Insurance Portability Mechanisms	10
Table 2. HIPAA'S Insurance Regulations	21

The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, HIPAA) provided for changes in the health insurance market and imposed certain federal requirements on health insurance plans offered by public and private employers. It guaranteed the availability and renewability of health insurance coverage for certain employees and individuals, and limited the use of preexisting condition restrictions. The Act established federal standards for insurers, health maintenance organizations (HMOs), and employer plans, including those who self-insure. However, it allowed states and sometimes insurers substantial state flexibility for compliance with the federal requirements.

HIPAA also included tax provisions relating to health insurance. It permitted a limited number of small businesses and self-employed individuals to contribute to tax-advantaged medical savings accounts (MSAs) established in conjunction with high-deductible health insurance plans. It increased the deduction for health insurance that self-employed taxpayers may claim. In addition, it allowed long-term care expenses to be treated like deductible medical expenses and clarified the tax treatment of long-term care insurance.

HIPAA amended the Employee Retirement Income Security Act (ERISA), the Public Health Service (PHS) Act, and the Internal Revenue Code (IRC). In general, requirements on employer plans are found in the ERISA and IRC amendments; requirements on health insurance issuers, such as insurance carriers and health maintenance organizations (HMOs) are found in the PHS Act and ERISA amendments. The increased deduction for the self-employed, tax-favored MSAs, and long-term care provisions are amendments to the IRC.

Part I. The Act in General

The basic intent of HIPAA's health insurance provisions is to lower the possibility that people and small employers will lose existing health plan coverage, and to make it easier for individuals to switch plans or to purchase coverage on their own if they lose employer-offered coverage. The health insurance reforms ensure that people who are moving from one job to another or from employment to unemployment are not denied health insurance because they have a preexisting medical condition (portability) and limit the waiting time before a plan covers any preexisting medical condition for participants and beneficiaries in group health plans.

The reforms also guarantee that individuals and employers who choose to purchase coverage are able to find a plan (guaranteed issue) and that individuals already covered, as well as employers that offer coverage to their employees, are able to renew their coverage (guaranteed renewal). Finally, the health insurance provisions prohibit discrimination on the basis of health status (non-discrimination) and require plans to offer special enrollment periods.

Other HIPAA provisions seek to make health insurance more affordable. The Act raised the tax deduction for health insurance premiums paid by the self-employed. MSAs coupled with qualified high deductible health insurance plans were made available on a trial basis to a limited number of individuals. New tax incentives were made available to encourage individuals and employers to purchase long-term care insurance. Finally, the Act included administrative simplification and privacy provisions instructing the Secretary of HHS to issue standards addressing the electronic transmission of health information and the privacy of personally identifiable medical information.

Additional federal protections have been added since the passage of HIPAA. The protections required plans that cover newborn delivery to allow for a minimum 2-day hospital stay under certain conditions, required plans that offer mental health services to offer them subject to similar limitations as other health benefits, and required plans that cover mastectomy to also cover reconstructive surgery. In addition, the deduction allowed for premium costs for the self-employed was changed.

Does HIPAA help individuals who are uninsured? HIPAA's insurance provisions were designed to help *insured* Americans who have a preexisting medical condition and have stayed in a job because they fear that they would lose coverage for such a condition if they change to a new employer or move to an individual policy. It also would help those who have been denied the option to purchase insurance as an individual or through their employer because of their health status. They do not address the larger problem of the uninsured, estimated to be 41.2 million people in 2001, although other HIPAA provisions, such as the tax deduction for health insurance costs for self-employed, may encourage some uninsured, self-employed individuals to purchase coverage for themselves.

It is also the case that HIPAA largely addresses the availability of insurance and does not regulate the price of health insurance coverage.¹ Some evidence suggests that the cost of health insurance in the individual market for individuals taking advantage of HIPAA's group-to-individual portability provisions is significantly higher than the cost for individuals who could otherwise obtain insurance. This may be discouraging many "HIPAA eligibles" from buying insurance.² Whether this experience continues over the long run remains to be seen.

¹ Insurance that is regulated by state law may be subject to state premium limits. There are no premium limits on self-insured employer plans.

² U.S. General Accounting Office. Health Insurance Standards. *New Federal Law Creates Challenges for Consumers, Insurers, Regulators*. GAO/HEHS-98-67. February 1998.

Are employers required to offer health insurance as a benefit? No, the Act does not require employers to offer or pay for health insurance for their employees. Also, the Act does not require employers to offer or pay for family coverage (spouses and dependents). Finally, the Act does not require employers to cover part time, seasonal, or temporary employees. However, an employer who elects to sponsor a group health plan has to comply with certain requirements of the Act. These requirements: (a) restrict the use of preexisting condition limitation periods; (b) prohibit an employer plan from discriminating on the basis of health status in determining the eligibility of an employee to enroll in a group health plan (and the employee's spouse and dependents if the plan provides family coverage); (c) prohibit an employer plan from requiring an individual to pay premiums or contributions which are greater than those charged to a similarly situated individual on the basis of health status; and (d) mandate documentation of creditable coverage.

Part II. Health Insurance Reforms

Portability

HIPAA's "portability" protection means that once a person obtains creditable health plan coverage, he or she can use evidence of that coverage to reduce or eliminate any preexisting medical condition exclusion period that might otherwise be imposed when moving to another health plan. The protections apply when a person moves from one group health plan to another, from a group health plan to an individual policy, or from an individual policy to a group health plan. The concept of portability is really one of being able to maintain coverage and being given *credit* for having been insured when changing health plans. It does *not* mean that an individual can take a specific health insurance policy from one job to another.

What is creditable coverage? The concept of creditable coverage is that individuals are given credit for previous insurance when applying for a new plan.

Under the Act, creditable coverage is coverage under any of the following: (a) a group health plan; (b) health insurance coverage³, including individual health insurance coverage; (c) Medicare; (d) Medicaid; (e) military health care;⁴ (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) the Federal Employee Health Benefits Program; (i) a public health plan (as defined in regulations); or (j) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).⁵

³ Health insurance coverage is defined as benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract or HMO contract offered by a health insurance issuer.

⁴ Military health care is care described under Chapter 55 of Title 10 of the United States Code.

⁵ Having creditable coverage does not necessarily make an individual eligible for the group
(continued...)

What is a preexisting medical condition? Under the Act, a preexisting medical condition is a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date. The enrollment date is the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.⁶ Pregnancy is not considered a preexisting medical condition. Also, a preexisting medical condition limit or exclusion may not be imposed on covered benefits for newborns who are covered under creditable coverage within 30 days of birth. Finally, a preexisting medical condition limit or exclusion may not be imposed on covered benefits for newly adopted children or children newly placed for adoption, if the child becomes covered under creditable coverage within 30 days of the adoption or placement.

The Act also prohibits the use of genetic information as a preexisting condition, unless there is a diagnosis of a preexisting medical condition related to the information. For example, evidence of a positive test for the gene that predisposes a woman to inheritable breast cancer cannot be treated as a preexisting condition, unless a diagnosis of breast cancer is made within the 6-month period described above.

What is a preexisting medical condition limitation period? During this period, a plan may exclude or restrict coverage of a participant's or beneficiary's preexisting medical condition. Under the Act, a group health plan is prohibited from imposing more than a 12-month preexisting condition limitation period (18 months for late enrollees) on an HIPAA-eligible participant or beneficiary. As described below, that period is reduced by the amount of the individual's creditable coverage. In the individual market, HIPAA-eligible individuals also have portability protection, although the circumstances under which those protections apply are complex as described in more detail below.

Portability in the Group Market

HIPAA requires *group health plans* (plans that are offered to an employment-based group – including both employers and employee organizations) that are covered by the Act to meet the following requirements related to portability:

- When a person with prior creditable coverage first enrolls in a group health plan, the plan cannot impose a limitation period on a preexisting condition that is longer than 12 months (18 months for late enrollees as defined below). The length of the allowed preexisting condition limitation period is based on any *creditable coverage* that an individual may have. The plan cannot apply any preexisting condition waiting period on pregnancy, a covered newborn, or on any covered child under 18 who is adopted (even if the adoption is not finalized). However, the employer may still require individuals to work for

⁵ (...continued)

to individual market protections. See the question discussing the limitations of those protections on page 8.

⁶ See below for more information on limitation and waiting periods.

a period of time before they are allowed to participate in the health plan. This is called a “waiting period” and should not be confused with a “preexisting condition limitation period.”⁷

- Employers who sponsor group health plans are required to provide enrollees with a certificate that states the amount of creditable coverage accumulated and whether or not the enrollee was subject to a waiting period under the employer’s plan. Individuals can use this certificate to demonstrate prior creditable coverage when moving to a new group or individual health insurance plan. The Act does not require an employer to continue offering coverage to enrollees who have left their jobs, except under COBRA continuation provisions as described below.

How do people take full advantage of the portability provisions of the act? To benefit from the Act, individuals should maintain coverage under a health insurance plan without experiencing significant lapses in coverage. Since the portability protection only applies to people with “continuous coverage”, which the statute defines as coverage with no lapses of 63 or more days, individuals should not allow their insurance coverage to lapse for 63 or more days.

How long can a group health plan restrict coverage for a preexisting medical condition? Coverage of a preexisting medical condition may be limited or excluded for up to 12 months for those who enroll in a health plan when first eligible to enroll. In the case of late enrollment, the maximum permitted limitation is 18 months.

For those moving from one group plan to another group plan, or from individual to group coverage, the new plan must reduce any preexisting condition limitation period by 1 month for every month that such individuals had creditable coverage under a previous plan, provided that they enroll when first eligible and had no break in previous coverage of 63 or more continuous days. For example, individuals with 6 months of prior creditable coverage could face a maximum preexisting condition limitation period of 6 months. Individuals with 11 months of prior creditable coverage could face a maximum limitation period of 1 month. Once a 12-month limitation period is met, no new limitation may ever be imposed *as long as continuous coverage is maintained* (that is, there is no break in coverage lasting longer than 62 days), even if there is a change in jobs or health plans. If there is a period of 63 consecutive days during which individuals have no creditable coverage, they may be subject to as much as a 12-month preexisting condition exclusion period (or an 18 month exclusion for late enrollees).⁸

Individuals establish eligibility for a waiver of preexisting condition limitations by presenting certifications that document prior creditable coverage. Health plans and health insurance issuers must supply written certifications of: the period of creditable coverage under the plan; coverage (if any) under COBRA continuation provisions; and any waiting or affiliation periods imposed. The certification must be

⁷ See below for more information on limitation and waiting periods.

⁸ See “What is Late Enrollment?” below.

provided: (1) when a participant is no longer covered under the plan or otherwise becomes covered under a COBRA continuation provision; (2) after termination of COBRA coverage, if applicable; and (3) upon a request which is made not later than 24 months after coverage ends. The interim rules issued by the three agencies administering the Act provide guidance and model certification forms to streamline this process.⁹ In general, the certification must be provided in writing.

What is late enrollment? Late enrollment occurs when an individual enrolls in a group health plan other than during: (a) the first period in which the individual is eligible to enroll under the plan, or (b) a special enrollment period. As described above, a group health plan may require a late enrollee to wait 18 months before a preexisting condition is covered.

What is a waiting period? How does it differ from a preexisting condition limitation period? A waiting period is a set amount of time an employee must wait before he or she is eligible to enroll in a health plan. For example, an employer may require an employee to work for 6 months before health insurance benefits become available. The Act does not limit this type of waiting period – employers and health insurance issuers are free to determine the length of a waiting period. However, the Act requires that any waiting period be applied uniformly without regard to the health status of potential plan participants or beneficiaries. Also, days in a waiting period are not taken into account when determining whether an individual has experienced a break in coverage of 63 or more days.

This differs from a preexisting condition exclusion limitation period which allows plans to exclude coverage for certain preexisting health conditions for up to 12 months (or 18 months), as described above. *Any waiting period required before an employee or his or family member can become a plan participant or beneficiary must run concurrently with any preexisting condition limitation period.* For example, if an employer required an employee without any creditable coverage to work for 5 months before he or she could enroll in the firm's health plan, then the preexisting condition limitation period imposed on the coverage of that individual could not exceed 7 months from the date of actual enrollment in the plan. If that individual had 7 or more months of creditable coverage, then no preexisting condition limitation period could be imposed on the coverage under the new plan.

Do plans and issuers have any discretion in the method of crediting prior coverage? Yes, when an individual changes plans, the new benefit package may cover some benefits that were not covered under his or her most recent prior plan, and the law allows the new plan or issuer some discretion in applying prior creditable coverage to those new benefits. Plans and issuers may choose between two alternatives when determining creditable coverage: 1) they can choose to include all periods of coverage from qualified sources and thus not look at any specific benefits; or 2) they can examine prior coverage on a benefit-specific basis, and are allowed to exclude from creditable coverage any categories or classes of benefits not covered under the most recent prior plan. The April 8, 1997 interim rule defines the

⁹ *Federal Register*, April 8, 1997.

categories of benefits that may be considered separately to be: (a) mental health; (b) substance abuse treatment; (c) prescription drugs; (d) dental care; or (e) vision care.¹⁰

Thus, for example, if a prior plan did not cover prescription drugs, and the new plan includes this benefit, the new plan may exclude coverage of prescription drugs for up to 12 months under this second method. If the second method is chosen, plans or issuers must disclose its use at the time of enrollment or sale of the plan, and apply it uniformly.

Do these protections apply to an individual's spouse and children ?

Under a group health plan, an employer is not required to offer coverage to an individual's spouse or children. If the employer does offer family coverage, the same protections apply to a spouse and dependents. Coverage may not be denied because a family member is sick, and preexisting condition restrictions are limited as described above.

Portability and Guaranteed Availability in the Individual Insurance Market

HIPAA guarantees the availability of a plan and prohibits pre-existing condition exclusions for certain eligible individuals who are moving from group health insurance to insurance in the individual market. States have the choice of either enforcing the HIPAA individual market guarantees, referred to as the "federal fallback", or they may establish an "acceptable alternative state mechanism". In states using the federal fallback approach, HIPAA requires all health insurance issuers operating in the individual health insurance market to offer coverage to *all eligible individuals* and prohibits them from placing any limitations on the coverage of any preexisting medical condition.

Issuers can comply with the Act's requirements in three ways:

- (1) they must offer eligible individuals access to coverage to every individual insurance policy they sell in the state; or
- (2) they must offer eligible individuals access to coverage to their two most popular insurance policies (based on premium volume); or
- (3) they must offer eligible individuals access to a lower-level and higher-level coverage. These two policies must include benefits that are substantially similar to other coverage offered by the issuer in the state, and must include risk adjustment, risk spreading, or financial subsidization.

Issuers can refuse to cover individuals seeking portability from the group market if financial or provider capacity would be impaired. This means, for example, that if a network-based plan like an HMO can demonstrate that it is filled to capacity, then it would not have to accept eligible individuals. It would have to apply this exception uniformly, without regard to the health status of applicants.

¹⁰ *Ibid.*, p. 16932, 16945-6, 16961-2.

Who is eligible for group to individual market portability and guaranteed availability under the Act? An *eligible individual* must have:

- creditable health insurance coverage for 18 months or longer;
- most recent coverage under a traditional employer group plan, governmental plan, or church plan;
- exhausted any COBRA (or other continuation) coverage;¹¹
- no eligibility for coverage under any employment-based plan, Medicare or Medicaid; and
- no breaks in coverage of 63 or more days.¹²

Individuals purchasing insurance on their own who do not meet these eligibility criteria, are not protected by HIPAA's portability and guaranteed availability provisions. These individuals may be protected under state laws.

What are the limitations of the group-to-individual portability and guaranteed availability protections? The group-to-individual portability and guaranteed availability protections apply only to individuals whose most recent coverage was provided through traditional employer-based group arrangements, governmental plans or church-sponsored plans. Group plans are defined as those meeting the ERISA definition, which is limited to those sponsored through a traditional employer-employee relationship or an employment-based association. Governmental plans are also defined in ERISA. They are plans that are established or maintained for its employees by the Government of the United States, the government of a state or a political subdivision of a state. This limitation means that people whose most recent coverage was sponsored by the military (CHAMPUS and TRICARE), many college-sponsored student plans, the Peace Corps, the Veterans' Administration, the Indian Health Service, Medicare, Medicaid and SCHIP are not eligible for the federal group-to-individual portability and guaranteed availability protections. (Although states may offer these individuals such protections.)

What are the requirements for an acceptable alternative state mechanism? An acceptable alternative state mechanism for coverage of eligible individuals must:

- provide a choice of health insurance coverage to all eligible individuals;

¹¹ Individuals may have continuation coverage that is not COBRA coverage under FEHBP or under state continuation of coverage laws.

¹² An eligible individual must have 18 months of creditable health insurance coverage, at least the last day of which was under a group health plan. A child is deemed to be an eligible individual if the child was covered under any creditable coverage within 30 days of birth, adoption, or placement for adoption, and the child has not had a break in coverage of 63 or more days. (Issuers are not required, however, to offer family coverage.) *Federal Register*, April 8, 1997. p. 16996.

- not impose any preexisting condition restrictions; and
- include at least one policy form of coverage that is comparable to either comprehensive health insurance coverage offered in the individual market in the state, or a standard option of coverage available under the group or individual health insurance laws in the state.

In addition to these requirements, a state may implement one of the following mechanisms:

- certain National Association of Insurance Commissioners (NAIC) Model Acts¹³;
- a qualified high risk pool¹⁴ that meets certain specified requirements; or
- other risk spreading or risk adjustment approach, or financial subsidies for participating insurers or eligible individuals; or
- any other mechanism under which eligible individuals are provided a choice of all individual health insurance coverage otherwise available.

Examples of potential alternative state mechanisms include health insurance coverage pools or programs, mandatory group conversion policies, guaranteed issue of one or more plans of individual health insurance coverage, open enrollment by one or more health insurance issuers, or a combination of such mechanisms.

How have states implemented this provision? **Table 1** provides information on how each state has implemented the Act's group-to-individual portability provisions. As of December 2001, the District of Columbia and 10 states (Arizona, Delaware, Hawaii, Maryland, Missouri, Nevada, North Carolina, Rhode Island, Tennessee, and West Virginia) utilize the federal fallback mechanism. Missouri is also the only state that does not enforce these standards itself, and as a result CMS is responsible for enforcement in Missouri. As shown in **Table 1**, many states have elected to provide group-to-individual portability through high-risk pools, while others utilize a combination of high-risk pools, existing state insurance reform laws, or other mechanisms. To obtain more information on a state's health insurance regulation of the individual market, individuals may wish to contact that state's department of insurance.

¹³ The NAIC Model Acts include the Small Employer and Individual Health Insurance Availability Model Act, as it applies to individual health insurance coverage, and as revised in state regulations to meet all the necessary requirements and the Individual Health Insurance Portability Model Act, as adopted on June 3, 1996 and revised in state regulation to meet all necessary requirements.

¹⁴ A high risk pool is generally the insurer of last resort, typically for sicker and/or older individuals who: 1) are denied coverage in the private market; 2) are offered only restricted coverage; or 3) cannot find less expensive coverage.

Table 1. State Group-to-Individual Insurance Portability Mechanisms

State	Group-to-Individual Portability Provision
Alabama	Alternative mechanism – high-risk health insurance pool.
Alaska	Alternative mechanism – high-risk health insurance pool.
Arizona	Federal fall-back.
Arkansas	Alternative mechanism – high-risk health insurance pool.
California	Alternate mechanism – plans must offer two most popular products.
Colorado	Alternative mechanism – high-risk health insurance pool.
Connecticut	Alternative mechanism – high-risk health insurance pool.
Delaware	Federal fall-back.
District of Columbia	Federal fall-back.
Florida	Alternative mechanism – guaranteed issue to HIPAA-eligible persons. Health plans required to offer a choice of conversion plans, one of which must be the state approved “standard policy” currently offered in the small group market.
Georgia	Alternative mechanism – assigned risk pool. HIPAA-eligible persons may apply for coverage to the Insurance Commissioner who then “assigns” eligible individuals to health plans based on a health plan’s pro rata volume of individual health insurance business done in the state.
Hawaii	Federal fall-back.
Idaho	Alternative mechanism – existing state insurance reform laws, including: guaranteed issue of three products (basic, standard, and catastrophic), guaranteed renewal, preexisting condition limitations of 12/6, and also retains pregnancy as a preexisting condition (<i>not in compliance with HIPAA</i>), coverage gap is 63 days, rating bands to limit rate variations to a range of 1.7 to 1 for experience, health status and duration and allows demographic adjustments for age and gender.
Illinois	Alternative mechanism – high-risk health insurance pool.
Indiana	Alternative mechanism – high-risk health insurance pool.
Iowa	Alternative mechanism – high-risk health insurance pool.
Kansas	Alternative mechanism - high-risk health insurance pool.
Kentucky	Alternative mechanism – high-risk health insurance pool.
Louisiana	Alternative mechanism – high-risk health insurance pool.

State	Group-to-Individual Portability Provision
Maine	Alternative mechanism – existing state insurance reform laws, including: guaranteed issue of all products, guaranteed renewal, no preexisting condition waiting period applied to HIPAA-eligibles and 12/6 for non-HIPAA eligibles, coverage gap of 63 days, community rating with adjustments limited to a range of 1.5 to 1 for age, smoking status, industry, and geography.
Maryland	Federal fall-back.
Massachusetts	Alternate mechanism – existing state insurance reform laws, including: guaranteed issue of three products, guaranteed renewal, preexisting condition limitations of 6/6 and coverage gap of 63 days, modified community rating with adjustments for age, geography and benefit level limited to a range of 2 to 1.
Michigan	Alternate mechanism – Blue Cross Blue Shield plan will enroll HIPAA eligibles.
Minnesota	Alternative mechanism – high-risk health insurance pool.
Mississippi	Alternative mechanism – high-risk health insurance pool.
Missouri	Federal fall-back with CMS enforcement.
Montana	Alternative mechanism – high-risk health insurance pool.
Nebraska	Alternative mechanism – high-risk health insurance pool.
Nevada	Federal fall-back.
New Hampshire	Alternative mechanism – high-risk health insurance pool.
New Jersey	Alternative mechanism – existing state insurance law, including: guaranteed issue of five standardized products, guaranteed renewal, no preexisting condition waiting period applied to HIPAA eligibles (for all others preexisting condition limitations of 12/6), coverage gap of 30 days, pure community rating.
New Mexico	Alternative mechanism – HIPAA-eligibles can choose to obtain coverage through either the high-risk health insurance pool or the purchasing alliance.
New York	Alternative mechanism – existing state insurance reform laws, including: guaranteed issue of all products, guaranteed renewal, no preexisting condition waiting period applied to HIPAA eligibles (for all others preexisting condition limitations of 12/6), coverage gap of 63 days, community rating with adjustments permitted for family composition and geographic regions.
North Carolina	Federal fall-back.
North Dakota	Alternative mechanism – high-risk health insurance pool.

State	Group-to-Individual Portability Provision
Ohio	Alternative mechanism – separate open enrollment period for HIPAA eligibles until health plans meet their enrollment caps.
Oklahoma	Alternative mechanism – high-risk health insurance pool.
Oregon	Alternative mechanism – high-risk health insurance pool.
Pennsylvania	Alternative mechanism – Blue Cross and Blue Shield Plans serve as the guaranteed issue carrier.
Rhode Island	Federal fall-back.
South Carolina	Alternative mechanism – high-risk health insurance pool.
South Dakota	Alternative mechanism – existing state insurance reform laws, including: guaranteed issue to HIPAA-eligibles until these enrollees represent 2% of annual earned premium, guaranteed renewal, preexisting condition limitations to 12/6, and also retains pregnancy as a preexisting condition (<i>not in compliance with HIPAA</i>), coverage gap is 63 days, rating reform limits adjustments for health status and claims experience to 2.2 to 1.
Tennessee	Federal fall-back.
Texas	Alternative mechanism – high-risk health insurance pool.
Utah	Alternative mechanism – combines high-risk health insurance pool and existing insurance market guaranteed issue requirement. Individuals who are denied coverage by a plan and then are judged by objective guidelines to be “too healthy” must be covered by the health plan that had previously denied their coverage. Individuals who are not deemed “too healthy” would be eligible for coverage in the high-risk pool.
Vermont	Alternative mechanism – existing state insurance reform laws, including: guaranteed issue of all products, guaranteed renewal, no preexisting condition waiting period applied to HIPAA eligibles (for all others preexisting condition limitations of 12/12), coverage gap of 63 days, community rating with health plans required to limit rating adjustments to a range of 1.5 to 1 for one or more factors approved by the Commissioner.
Virginia	Alternative mechanism – guaranteed issue of all currently offered non-group products to HIPAA eligibles.
Washington	Alternative mechanism – high-risk health insurance pool.
West Virginia	Federal fall-back.
Wisconsin	Alternative mechanism – high-risk health insurance pool.
Wyoming	Alternative mechanism – high-risk health insurance pool.

Source: Blue Cross and Blue Shield Association, *State Legislative Health Care and Insurance Issues. 2001 Survey of Plans*. Washington, December 2001.

Note: (1) For preexisting condition limitations there may be two numbers, such as 12/6. The first number denotes the exclusion period and the second number denotes the allowable look-back period. The federal maximum under HIPAA is 12/6, although states may impose shorter limits. (2) Additionally, for coverage gaps, HIPAA requires that all periods of creditable coverage be aggregated or combined, provided that the lapse between periods of coverage is less than 63 days. Individual states may require health plans to give credit for prior coverage even if the lapse was longer than 63 days. (3) Rating bands are laws that restrict a plan's use of experience, health status or duration of coverage in setting premiums rates for individuals. For example, a state may set the band of 2 to 1 for health status.

Special Enrollment Periods in the Group Market

As an adjunct to its portability requirement, the Act provides for two different special enrollment periods to ensure that people losing group health insurance coverage can more easily obtain other group coverage when it is available. The two special enrollment periods are:

(1) Individual Losing Other Coverage. A group health plan or an issuer offering coverage in connection with a group health plan must allow an employee who is eligible, but not enrolled, to become covered under the plan if the following conditions are met:¹⁵

- The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent. For example, the employee may have been covered by a spouse's employer and declined coverage under his own employer's plan.
- The employee stated in writing at the time of declining enrollment that the reason for declining was that he or she was covered under another health insurance plan. This condition applies only if the plan sponsor or issuer requires such a written statement.
- The employee's or dependent's previous coverage was under a COBRA continuation provision that had become exhausted or was under some other coverage that had been terminated as a result of a loss of eligibility for the coverage (for reasons such as: legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment), or because the employer contribution towards such coverage was terminated.

To take advantage of a special enrollment period, the employee would have to request enrollment no later than 30 days after the date in which his or her prior coverage was exhausted or terminated.

(2) Dependent Beneficiaries. This special enrollment period applies to individuals who become dependents through marriage, birth, adoption, or placement of adoption. Generally, this provision applies if a group health plan makes dependent coverage available, and the new dependent's spouse or parent is either a participant or *eligible* (including meeting any waiting periods) to be a participant under the plan. The

¹⁵ The employee's dependent would also be allowed to enroll, if family coverage is provided under the terms of the plan.

newly dependent individual must be allowed to enroll as a beneficiary under the plan; however, enrollment must be sought within 30 days of the qualifying event (e.g., the marriage). Employees or spouses who are eligible, but not previously enrolled in the plan, may also enroll during this special enrollment. Coverage is effective on the date of the birth, adoption, or placement for adoption. In the case of marriage, coverage is effective no later than the first day of the month beginning after the date the request for enrollment is received.

Non-Discrimination in the Group Market

Can a group health plan refuse to enroll individuals with a history of illness or disability or high medical expenses? Can it drop someone from coverage who becomes sick or starts using a lot of medical care?

No, the Act prohibits a group health plan and an issuer offering group health coverage from establishing rules for eligibility for any individual to enroll under the plan based on health status-related factors.¹⁶ These factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence) and disability. Group health plans are also prohibited from failing to re-enroll a participant or beneficiary on the basis of health status-related factors. HIPAA also prohibits plans from charging differential premiums for enrollees within a group plan based on these health status-related factors.

Can an employer condition coverage under its health plan on passing a physical examination? No, the Act prohibits employer plans and issuers of group health coverage from establishing rules of eligibility to enroll under the terms of the plan that discriminate based on one or more health-status related factors.

Can a group plan refuse to enroll individuals who engage in high risk recreational activities? No, these individuals cannot be denied enrollment in a group health plan, based on HIPAA's non-discrimination provision. Group plans or issuers offering group health coverage cannot use information about an individual's health status to either deny coverage or charge differential premiums. On January 8, 2001, the Department of Labor issued a preliminary final ruling with comment period, defining the nondiscrimination provisions of HIPAA. In this ruling, health status is defined very broadly to include "evidence of insurability" which in turn includes a provision that prohibits excluding coverage for individuals who participate in high-risk activities.¹⁷ Thus, this broad interpretation extends the

¹⁶ In the individual market there are no federal rules explicitly limiting denials based on health status. On the other hand, portability and guaranteed issue protections may apply (see above section on Portability and Guaranteed Availability in the Individual Insurance Market).

¹⁷ This ruling stems from language in the conference report on HIPAA. "The inclusion of evidence of insurability in the definition of health status is intended to ensure, among other things, that individuals are not excluded from health care coverage due to their participation (continued...)"

nondiscrimination protections to individuals who engage high risk recreational activities.

Can a group plan exclude coverage of treatments for injuries obtained while engaging in high risk recreational activities? HIPAA'S protection extend to enrollment policies and premiums. The protection does not address the benefits that are covered by these plans. Therefore, there is no federal requirement to cover treatments for injuries associated with high risk activities, even if these treatments are otherwise covered under the plan. For example, a plan may exclude coverage for a broken leg, if it occurs as a result of a high risk activity.

Do these non-discrimination protections apply to an individual's spouse and children? Under a group health plan, an employer is not required to offer coverage to an individual's spouse or children. If the employer does offer family coverage, the same non-discrimination protections apply to a spouse and dependents. Coverage may not be denied because a family member is sick, and preexisting condition restrictions are limited as described above.

Does the Act restrict the premium amounts that an employer can charge for health insurance? No, the Act does not restrict premium amounts that an employer or insurer can charge. It also expressly permits an employer or group health insurer to offer premium discounts or rebates, or modify otherwise applicable copayments or deductibles, for participation in health promotion and disease prevention programs. However, the Act does prohibit a health plan from charging an individual a higher premium than the premium charged for another similarly situated individual enrolled in the plan on the basis of any health-related factor, such as a preexisting medical condition.

Guaranteed Issue and Guaranteed Renewability

The Act requires insurers, HMOs, and other issuers of health insurance selling in the *small group market* to accept any small employer that applies for coverage, regardless of the health status or claims history of the employer's group.¹⁸ This requirement is often referred to as "guaranteed issue." The Act defines a small employer as one with two to 50 employees. (If, on the first day of the plan year, the plan has fewer than two participants who are current employees, it is not considered a small group and would not be covered by this "guaranteed issue" requirement.) Under guaranteed issue, the issuer must accept for enrollment under the policy, not just the employer's group, as a whole, but also every eligible individual in the

¹⁷ (...continued)

in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities." (Conference Report, H.Rept.104-736, 104th Cong., 2d Sess. 186 (1996)).

¹⁸ This is consistent with most state health insurance reforms which primarily apply to the small group market (typically defined as 2 to 25, 2 to 35 or 2 to 50 employees). However, some state laws provide for guaranteed issue of groups with as few as one employee.

employers' group who is eligible for and applies for timely enrollment.¹⁹ Exceptions to guaranteed issue are provided in the Act for network plans that might otherwise exceed capacity limits or in the event that the employer's employees do not live, work, or reside in the network plan's area.

Employer groups with more than 50 employees are not protected by this requirement unless otherwise required under state law. In the past, health insurance issuers usually did not examine the health status or medical history of larger employer groups when deciding whether to accept such groups for coverage. The Act requires the Secretary of Health and Human Services (HHS) and the General Accounting Office to report every 3 years, beginning in December 2002, on access to health insurance in the large group market.

Can health insurance issuers drop or cancel coverage for groups because of high medical costs? No, the Act requires all health insurance issuers to continue coverage for any group, regardless of health status or use of services, if the group requests renewal. This requirement is known as guaranteed renewability. An issuer may drop coverage in cases of non-payment of premiums, fraud, or similar reasons not related to health status, such as violation of participation or contribution rules.²⁰ But, there are no limits on amounts insurers may charge.

Federally Required Benefits

As originally passed, HIPAA did not require an employer or issuer of group health insurance to offer specific benefits. Twice since its passage Congress added to HIPAA's protections by mandating specific benefits, but in each case only for plans that cover certain services. Legislation enacted in 1997, as a part of an unrelated appropriations bill,²¹ included provisions that: (1) require plans that cover mental health services to provide limited mental health "parity", and (2) prohibit plans that cover newborn delivery from limiting hospital stays for newborn delivery to less than 2 days. Legislation enacted in 1998 requires plans that cover mastectomy as a treatment for breast cancer to also cover reconstructive surgery.²²

¹⁹ The interim rules interpret the guaranteed issue requirement to apply to all products actively marketed by an issuer in the small group market. *Federal Register*, April 8, 1997, p. 16971.

²⁰ An example of a participation rule is a requirement set by the issuer that 80% of all full time employees participate in the employer's group health plan. An example of a contribution requirement is that all participants in the health plan must pay 20% of the plan premium. These requirements are used to protect the issuer from a selection bias (also known as "adverse selection") in which only sick members of an employer's group sign up for insurance coverage.

²¹ FY1997 appropriations bill for the Departments of Veterans' Affairs and Housing and Urban Development (P.L. 104-204, Title VII).

²² In addition to HIPAA's limited federal protections, most states have their own mandates for insurers operating in their states.

Mental Health Parity. Private health insurers often provide less coverage for the treatment of mental illnesses than they do for the treatment of other illnesses. For example, health plans may limit treatment of mental illnesses by covering fewer hospital days and outpatient office visits, and increase cost sharing for mental health care by raising deductibles and copayments. Twenty-three states have passed full-parity laws that require health plans to impose the same treatment limitations and financial requirements on their mental health coverage as they do on their medical and surgical coverage. Other states have enacted legislation that requires health plans to provide certain specified mental health benefits (but not full parity). However, these laws do not apply to self-insured employers, which are exempt from state regulation under ERISA.

In 1996, Congress passed the Mental Health Parity Act (MHPA), which amended ERISA and the Public Health Service Act to establish new federal standards for mental health coverage offered by employer-sponsored plans.²³ Identical provisions were later added to the Internal Revenue Code.²⁴ The MHPA is limited in scope and does not compel insurers to provide full-parity coverage. For group plans that choose to offer mental health benefits, the MHPA requires parity only for annual and lifetime dollar limits on coverage. Plans may still impose more restrictive treatment limitations and cost sharing requirements on their mental health coverage. The MHPA includes several other limitations. Employers with 50 or fewer employees are exempt from the law. In addition, employers that experience an increase in claims costs of at least 1% as a result of MHPA compliance can apply for an exemption.

In 2001, Congress tried unsuccessfully to enact legislation (S. 543) that would amend and expand the MHPA by requiring plans that choose to offer mental health benefits to provide full-parity coverage. Lawmakers instead reauthorized the MHPA through December 31, 2002. On April 29, 2002, President Bush urged Congress to enact S. 543, which enjoys broad support among lawmakers and patient advocacy groups. Employers and health insurance organizations oppose S. 543 because of concerns that it will drive up health care costs.

Newborns' and Mothers' Health Protection Act. The Newborns' and Mothers' Health Protection Act was also passed as part of P.L. 104-204. This Act prohibits group health plans and issuers offering group coverage from restricting the hospital length of stay for childbirth for either the mother or newborn child to less than 48 hours for normal deliveries and to less than 96 hours for caesarian deliveries.

Women's Health and Cancer Rights Act of 1998. Enacted in 1998, Title IX of H.R. 4328, the Omnibus Appropriations bill for fiscal year 1999²⁵ required group plans and health insurance issuers providing coverage in connection with a group plan that provide medical and surgical benefits related to mastectomy to cover

²³ P.L. 104-204, Title VII, codified at 29 U.S.C. 1185a and 42 U.S.C. 300gg-5. These provisions were part of the FY1997 VA-HUD appropriations bill.

²⁴ P.L. 105-34, Section 1531(a)(4), codified at 26 U.S.C. 9812.

²⁵ P.L. 105-277, Title IX: Women's Health and Cancer Rights.

breast reconstruction procedures, as well. The provision included a requirement that beneficiaries be notified of available coverage for prostheses and treatment of physical complications of reconstructive procedures.

Can an employer exclude coverage for specific types of illnesses, such as cancer, or acquired immune deficiency syndrome (AIDS) or treatment of injuries associated with high risk activities? Federal law does not prohibit employers from excluding treatment of specific illnesses or conditions from their health benefit plans. On the other hand, a number of factors limit certain employers' ability to exclude specific illnesses from coverage. Most states have enacted legislation requiring that specific benefits or coverage be included in insured products. In addition, employers purchasing insurance products often have little or no discretion in choosing or excluding specific types of services or procedures. This is because many insurance companies and HMOs have a set menu of products that do not vary considerably from one employer group to another. For self-funded plans, however, ERISA prevents state laws from applying and benefits are crafted by each individual employer plan. Thus only the few federal requirements enacted in HIPAA and its amendments (described above) place specific coverage requirements on these self-funded plans.

General Questions About the Health Insurance Reforms

Do the requirements of the Act apply to the plans of employers that provide for dental-only coverage or vision-only coverage? No, such specific benefit plans do not have to comply with the requirements of the Act if they meet certain conditions spelled out in the Act. To be exempt, for example, the dental-only policy would have to be provided under a separate policy, certificate, or contract of insurance or not otherwise be an integral part of the plan.

Do the requirements of the Act apply to association-sponsored group health plans? Yes, association plans must comply with the various requirements of the Act relating to group health coverage. For example, the sponsor of an association plan cannot drop a group from coverage because of the use of medical services by the group's members. Moreover, the association plan must comply with the restrictions on the use of preexisting medical condition limitation periods, provide for creditable coverage, and renew coverage except in limited cases. However, nothing under the Act requires that an association plan accept for coverage individuals who are *not* members of the association.

Can states impose requirements on insurers selling to group health plans that are different from those in the Act? Yes, states may impose their own requirements. But HIPAA ensures that state laws do not prevent the application of its consumer protections. For example, state laws regulating rating continue to apply because the Act generally does not address rating practices. On the other hand, the Act's provisions relating to portability, such as restrictions on the use of preexisting medical condition limitation periods override state laws. Exceptions include specific types of state laws that provide for *greater portability*, such as state laws that:

- define a preexisting medical condition to be one that existed for less than 6 months prior to becoming covered (instead of the 6 months required under the Act);
- provide for preexisting medical condition limitation periods shorter than 12 (and 18) months in the Act; and
- allow for breaks in continuous coverage longer than the 62-day period specified under the Act.²⁶

Thus, for example, a state may prohibit issuers selling to group health plans from imposing more than a 6-month preexisting medical condition limitation period on enrollees, instead of the 12-month limit in the Act. However, state laws that allowed such limitation periods in excess of 12 months would be overridden by the requirement of the Act.

Do the insurance reforms apply to Federal Employee’s Health Benefits Plans (FEHBP)? While there are no specific references in HIPAA or the subsequent benefits mandates that apply the requirements specifically to FEHBP, the plans provided by the FEHBP program are presumed to fall under the HIPAA definition of “group health plan.” As a result, the federal Office of Personnel Management, which administers the FEHBP program, complies with the HIPAA requirements.

Does the Act regulate the premium amount that an issuer can charge an eligible individual? No, the Act does not place any restrictions on the premium amount that issuers can charge. However, some states limit insurance premiums in the individual market and more may decide to do so in the future. Such limits would then apply because the Act does not preempt or override either current or future state laws regulating the cost of insurance.

Implementation and Enforcement

The Secretaries of HHS, Labor, and Treasury are required to jointly enforce the provisions of the Act. The Secretary of Labor enforces the requirements on employer plans under Title I of ERISA. The Secretary of Labor is also generally given authority to promulgate regulations necessary to carry out the provisions of the Act relating to group health plans and health insurance issuers in connection with any group health plan. The Secretary of Treasury enforces requirements on all group health plans under the Internal Revenue Code. Requirements on health insurance issuers (such as insurance carriers and HMOs) are enforced by the Secretary of HHS to the extent that such requirements are not enforced by the states. The Secretaries are required to coordinate their activities to avoid duplication of effort.

States have the primary responsibility for enforcing HIPAA’s access, portability and renewability standards applying to insurers in both the group and individual

²⁶ Other possible types of state laws providing for greater consumer protections are also specified in the Act.

markets. If they do not pass laws that substantially enforce these standards, however, DHHS must do the enforcing itself. As of 2001, only Missouri had not enacted enabling legislation.

How are the insurance requirements of the Act enforced?

Noncomplying group health plans covered under ERISA may be subject to civil money penalties, and both plans and issuers can be sued by participants and beneficiaries to recover any benefits due under the plan. The Secretary of Labor has the investigative authority to determine compliance with the law's requirements. For group health plans, generally the IRS can fine a noncomplying employer \$100 per day per violation.

Requirements on issuers will be enforced by the states. For Missouri, the Secretary of HHS enforces the provisions. The Secretary may impose a fine of \$100 for each day the entity (the issuer or a nonfederal governmental plan)²⁷ is out of compliance. The Act gives the Secretary of HHS the authority to promulgate regulations needed to carry out the provisions of the Act relating to requirements on issuers of coverage.

What regulations have been promulgated to define HIPAA? The following table lists the regulations regarding HIPAA's insurance provisions. For regulations on HIPAA's administrative simplification and privacy provisions see CRS Report RL30620, *Health information standards, privacy and security: HIPAA's administrative simplification regulations*, by Stephen Redhead.

²⁷ "A nonfederal governmental plan" is a plan sponsored by a state or local governmental entity.

Table 2. HIPAA'S Insurance Regulations

Date of Issue	Title	Purpose	Status	Citation
April 8, 1997	Health Insurance Portability for Group Health Plans; Interim Rules and Proposed Rule	Interim rules governing access, portability and renewability requirements for group health plans and issuers of health insurance coverage offered in connection with a group health plan.	Comment period ended July 7, 1997	Internal Revenue Service (IRS): 26 CFR Part 54 Pension Welfare Benefits Administration (PWBA): 29 CFR Part 2590 Health Care Financing Administration (HCFA): 45 CFR Subtitle A, Parts 144 and 146, 45 CFR Part 148
April 8, 1997	Individual Market Health Insurance Reform; Interim final rule with comment period	Portability from group to individual coverage; federal rules for access in the individual market; state alternative mechanisms to federal rules	Comment period ended July 7, 1997	Health Care Financing Administration (HCFA): 45 CFR Part 148
December 22, 1997	Mental Health Parity; Interim Rules HIPAA Mental Health Parity Act; Proposed Rule	Interim rules governing parity between medical/surgical benefits and mental health benefits in group health plans and health insurance coverage offered by issuers in connection with a group health plan.	Comment period ended on March 23, 1998	IRS: 26 CFR Part 54 PWBA: 29 CFR Part 2590 HCFA: 45 CFR Part 146
December 29, 1997	Application of HIPAA Group Market Portability Rules to Health Flexible Spending Arrangements; Final Rule Application of HIPAA Group Market Rules to Individuals Who Were Denied Coverage Due to a Health Status-Related Factor; Final Rule	Clarification of regulations with respect to treatment of benefits under flexible spending arrangements for the purposes of group market portability.	Final (clarifies regulation issued April 8, 1997)	IRS: 26 CFR Part 54 PWBA: 29 CFR Part 2590 HCFA: 45 CFR Parts 144 and 146
October 27, 1998	Group Health Plans and Health Insurance Issuers Under the Newborns' and Mothers' Health Protection Act; Joint Interim Rule	Interim rules providing guidance to employers, group health plans, health insurance issuers, and participants and beneficiaries relating to new requirements for hospital lengths of stay in connection with childbirth.	Comment period ended January 25, 1999	IRS: 26 CFR Part 54 PWBA: 29 CFR Part 2590 HCFA: 45 CFR Parts 144, 146 and 148

Date of Issue	Title	Purpose	Status	Citation
August 20, 1999	Federal Enforcement in Group and Individual Health Insurance Markets; Interim Rule	Details procedures for enforcing Title XXVII of the Public Health Service Act as added by HIPAA and as amended, in states that do not enforce the requirements of these acts. Delineates the process for taking enforcement actions against non-federal government plans, and, in those states in which HCFA (now named CMS) is directly enforcing the requirements, health insurance issuers that are not complying with the requirements.	Comment period ended October 19, 1999	HCFA: 45 CFR Parts 144, 146, 148 and 150
October 25, 1999	Health Insurance Portability; Final Rule	Solicitation of additional comments on interim rules published on April 8, 1997 regarding a number of portability, access and renewability provisions as well as comments reflecting the experience that interested parties have had with the interim regulations. Also clarifies definition of late enrollee for purposes of applying pre-existing exclusion period.	Comment period ended January 25, 2000	IRS: 26 CFR Part 54 PWBA: 29 CFR Part 2590 HCFA: 45 CFR Subtitle A, Parts 144 and 146
January 8, 2001	Nondiscrimination in Health Coverage in the Group Market; Interim Final Rules and Proposed Rules	Interim rules regarding provisions prohibiting discrimination based on a health factor for group health plans and issuers of health insurance coverage in connection with a group health plans. Proposed standards for defining bona fide wellness programs.	Comment period ended April 9, 2001	IRS: 26 CFR Part 54 PWBA: 29 CFR Part 2590 HCFA: 45 CFR Part 146
March 9, 2001	Interim Final Rules for Nondiscrimination in Health Coverage in the Group Market	Delays for 60 days, the effective dates for the nondiscrimination rule published on January 8, 2001	Final	IRS: 26 CFR Part 54 PWBA: 29 CFR Part 2590 HCFA: 45 CFR Part 146

Source: Congressional Research Service

COBRA Continuation Coverage

How does COBRA continuation coverage²⁸ interact with HIPAA? A person's COBRA continuation coverage is considered *creditable coverage* in the case of an individual who moves from one group policy to another group policy or from a group policy to an individual policy. This allows an individual to move from COBRA to a new health plan without having to wait for coverage of any preexisting medical condition under the new plan, providing the individual does not have a lapse in coverage of 63 or more days.

With respect to HIPAA's individual market protections, the situation is somewhat more complex. One of the requirements for eligibility for guaranteed availability and portability in the individual market is that an individual must first have elected and exhausted any available COBRA or other continuation coverage. Eligible individuals who do not have access to COBRA or other continuation coverage may move directly to the individual market. Additionally, in the individual market, it is important to note that the insurer accepting the eligible individual for coverage can charge whatever rate is allowed under state law. (The Act does not limit the premiums that insurers can charge.)

Does HIPAA make any changes in COBRA continuation of coverage requirements? Yes, the Act makes several changes to the laws providing for COBRA continuation of coverage. It provides:

- a clarification that a disabled qualified beneficiary and all other qualified family members of the beneficiary are also eligible for the additional 11 months of COBRA;
- that the qualifying event of disability applies in the case of a qualified beneficiary who is determined under the Social Security Act to be disabled during the first 60 days of COBRA coverage;
- that a qualified beneficiary for COBRA coverage includes a child who is born to, or placed for adoption with, the covered employee during the period of COBRA coverage; and
- that COBRA can be terminated if a qualified beneficiary becomes covered under a group health plan which does not contain any exclusion or limitation affecting a participant or his or her beneficiaries because of the requirements of the Act.

It should also be noted that under the Medical Savings Account (MSA) provisions of the Act (see below), individuals may withdraw funds from their MSAs without penalty to pay their COBRA premiums.

²⁸ The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) requires employers with 20 or more employees to offer continued group health insurance coverage to employees and their dependents after certain events. See CRS Report RL30626, *Health Insurance Continuation Coverage under COBRA*, by Heidi G. Yacker.

Part III. Other Provisions

In addition to the insurance provisions discussed above, HIPAA includes other provisions affecting health care. This section briefly summarizes these provisions and refers readers to other CRS reports where available.²⁹

Administrative Simplification

In addition to provisions relating to private health insurance, HIPAA directed the Secretary of HHS to issue standards to support and promote the electronic transmission of health care information between payers and providers. The standards specify the content and format of electronic health care claims and other common administrative and financial health care transactions (e.g., health plan enrollment, referrals). They are intended to streamline administrative operations within the health care system, which currently stores and transmits health information in numerous paper and electronic formats. HIPAA's administrative simplification provisions also instructed the Secretary of HHS to develop security standards and safeguards, which health plans and providers must incorporate into their operations to protect health information from unauthorized access, use, and disclosure. Finally, the Secretary was directed to develop standards for unique identifiers (i.e., ID numbers) for patients, employers, health plans, and providers.

The growing use of information technology in the management, administration, and delivery of health care has led to increasing public concern over the privacy of medical information. Patients are worried about who has access to their medical records without their express authorization. They fear that their personal health information will be used against them to deny insurance, employment, and housing, or to expose them to unwanted judgment and scrutiny. Lawmakers addressed these concerns by including in HIPAA's administrative simplification provisions a timetable for developing standards to protect the privacy of health information. HIPAA gave Congress until August 21, 1999, to enact comprehensive health privacy legislation, otherwise the Secretary was instructed to develop privacy standards. Congress was unable to meet its own deadline and so the Secretary proceeded to develop a health information privacy rule. The final rule was issued on December 28, 2000, and modifications to the rule were published on August 14, 2002. The compliance deadline for most covered entities is April 14, 2003.

For more information on the privacy rule, see CRS Report RS20500, *Medical Records Privacy: Questions and Answers on the HIPAA Final Rule*. Information on the status and implementation of all the HIPAA administrative simplification standards is at [<http://aspe.os.dhhs.gov/admsimp>].

²⁹ Not included in this summary are HIPAA provisions that were revenue raisers; these related to company-owned life insurance, individuals who lose U.S. citizenship or who were long-term residents and terminate U.S. residency, and interest allocation rules for financial institutions.

Medical Savings Accounts

HIPAA authorized tax-advantaged medical savings accounts (MSAs) under a demonstration that began in 1997.³⁰ MSAs (now formally called Archer MSAs) are personal savings accounts for unreimbursed medical expenses. They can be used to pay for health care not covered by insurance, including deductibles and copayments. Currently, a limited number of MSAs may be established by taxpayers who have qualifying high deductible insurance (and none other, with some exceptions) and who either are self-employed or are employees covered by the high deductible plan established by their small employer.

Employer contributions to MSAs are not subject to either income or employment taxes, while contributions made by individuals – allowed only if the employer does not contribute – are allowed as an above-the-line deduction (not limited to itemizers). MSAs are held in trust by insurance companies, banks, and other financial institutions, and whatever earnings they have are exempt from taxes. Withdrawals are not taxed if they are for medical expenses unreimbursed by insurance or otherwise, while other distributions, being non-qualified, are included in gross income and subject with some exceptions to an additional 15% penalty.

The IRS has estimated that 62,232 MSAs received contributions in tax year 2000 and that an additional 22,640 were established prior to July 1, 2001; the total is far lower than the 750,000 statutory ceiling.³¹ The slow growth can be attributed to a number of factors including product familiarity, consumer aversion to financial risk, and the reluctance of insurance agents to sell lower-priced policies; however, statutory restrictions undoubtedly have played some role.

For more information about MSAs, see CRS Report 96-500, *Flexible Spending Accounts and Medical Savings Accounts: A Comparison*, by Bob Lyke. For current legislative activity, see CRS Issue Brief IB98037, *Tax Benefits for Health Insurance: Current Legislation*, also by Bob Lyke. Both products are updated regularly.

Health Insurance for Self-Employed Taxpayers

HIPAA increased the portion of premiums that self-employed taxpayers may deduct from income for the purposes of determining federal taxes owed. Under prior law the deduction was 30% of health insurance costs; HIPAA increased it to 40% in 1997; 45% in 1998 through 2002; 50% in 2003; 60% in 2004; 70% in 2005; and 80% in 2006 and thereafter. Subsequent legislation (P.L. 105-34 and P.L. 105-277) accelerated and increased the percentages set by HIPAA. Today the deduction is set

³⁰ Under HIPAA, no new MSAs (with some exceptions) were to be established after December 31, 2000; the cut-off would have been earlier had thresholds on the number of accounts been exceeded. P.L. 106-554 extended the deadline for new accounts to December 31, 2002.

³¹ IRS Announcement 2000-99, October, 2001. MSAs are not counted toward the statutory ceiling if the owners were previously uninsured; moreover, all accounts established by an individual are added together and married individuals opening separate accounts are treated as having one account.

at 70% in 2002, and will rise to 100% in 2003 and thereafter. As discussed in the following section, the legislation also allowed self-employed taxpayers to take account of long-term care insurance premiums in making this deduction.

In addition, HIPAA provided that payments for personal injury or sickness through an arrangement having the effect of accident or health insurance are excluded from gross income (that is, they are exempt from taxation), provided the arrangement has adequate risk shifting and is not merely a reimbursement arrangement. Thus with respect to taxes, payments from self-insured plans covering self-employed individuals are treated like payments from commercial insurance.

For more information about the self-employed deduction, see CRS Report 98-515, *Tax Treatment of Health Insurance Expenditures by the Self-Employed: Current Law and Selected Economic Effects*, by Gary Guenther. For current legislative activity, see CRS Issue Brief IB98037, *Tax Benefits for Health Insurance: Current Legislation*, by Bob Lyke and Chris Sroka.

Long-Term Care

HIPAA established new rules regarding the tax treatment of long-term care insurance and expenses, effective January 1, 1997. Qualified long-term care insurance is treated as accident and health insurance, and benefits are treated as amounts received for personal injuries and sickness and reimbursement for medical expenses actually incurred. As a consequence, benefits are excluded from gross income (that is, exempt from taxation). The exclusion for benefits paid on a per diem or other periodic basis is limited to the greater of (1) \$220 a day (in 2003) or (2) the cost of long-term care services.³²

Employer contributions to the cost of qualified long-term care insurance premiums are excluded from the gross income of the employee. The exclusion does not apply to insurance provided through employer-sponsored cafeteria plans or flexible spending accounts.

Unreimbursed long-term care expenses are allowed as itemized deductions to the extent they and other unreimbursed medical expenses exceed 7.5% of adjusted gross income. Long-term care insurance premiums can be counted as these expenses subject to age-adjusted limits. In 2003, these limits range from \$250 for persons age 40 or less to \$3,130 for persons over age 70.

Self-employed individuals are allowed to include long-term care insurance premiums in determining their above-the-line deduction (not limited to itemizers) for health insurance expenses. Only amounts not exceeding the age-adjusted limits can

³² Treating long-term care insurance as accident and health insurance and excluding benefits from gross income also exempts the inside buildup of the insurance from taxation. Long-term care insurance usually has premiums that do not increase with age (aside from optional inflation adjustments for some policies); premiums for early years of a policy and the earnings on them (the inside buildup) help pay for costs later on. The tax treatment of *nonqualified* long-term care insurance remains uncertain.

be included. As described in the previous section, this deduction is limited to 60% in 1999 through 2001, 70% in 2002, and 100% in 2003 and thereafter.

Qualified long-term care insurance is defined as a contract that covers only long-term care services; does not pay or reimburse expenses covered under Medicare; is guaranteed renewable; does not provide for a cash surrender value or other money that can be paid, assigned, or pledged as collateral for a loan, or borrowed; applies all refunds of premiums and all policy holder dividends or similar amounts as a reduction in future premiums or to increase future benefits; and meets certain consumer protection standards. Policies issued before January 1, 1997, and meeting a state's long-term care insurance requirements at the time the policy was issued are considered qualified insurance for purposes of favorable tax treatment.

Qualified long-term care services are defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which are required by a chronically ill individual, and are provided according to a plan of care prescribed by a licensed health care practitioner. However, amounts paid for services provided by the spouse of a chronically ill person or by a relative directly or through a partnership, corporation, or other entity will not be considered a medical expense eligible for favorable tax treatment, unless the service is provided by a licensed professional.

Chronically ill persons are defined as those individuals:

- unable to perform without substantial assistance from another individual at least two of the following activities of daily living (ADLs) for a period of at least 90 days due to a loss of functional capacity: bathing, dressing, transferring, toileting, eating, and continence;³³
- having a level of disability similar to the level of disability specified for functional impairments (as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services); or
- requiring substantial supervision to protect them from threats to health and safety due to severe cognitive impairment.

HIPAA required that a licensed health practitioner (physician, registered professional nurse, licensed social worker, or other individual prescribed by the Secretary of the Treasury) certify that a person meets these criteria within the preceding 12-month period.

Accelerated Death Benefits

HIPAA clarified that accelerated death benefits (that is, benefits paid before death) received under a life insurance contract on the life of an insured terminally or chronically ill individual are excluded from gross income. Also excluded are amounts received from a viatical settlement provider for the sale or assignment of a

³³ A qualified long-term care insurance contract must take into account at least five of these six activities.

life insurance contract.³⁴ These exclusions do not apply to amounts paid to persons other than the insured if they have an insurable interest in the insured for business reasons.

A terminally ill individual is one who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death within 24 months of the date of certification.

A chronically ill individual is defined the same way as for long-term care (see the previous section). In this case, the exclusion of accelerated death benefits is limited to the actual costs of long-term care incurred by the individual that are not compensated by insurance or otherwise. The exclusion for benefits paid on a per diem or other periodic basis is limited to the greater of (1) \$200 a day (in 2001) or (2) the costs of long-term care services.³⁵ Contracts must not pay or reimburse expenses which are reimbursable under Medicare or would be but for the application of a deductible or coinsurance amount. In addition, contracts are subject to the consumer protection provisions specified in the tax code for long-term care insurance, except for analogous standards specifically applying to chronically ill individuals that are adopted by the National Association of Insurance Commissioners or the state in which the policyholder resides.

State Insurance Pools

HIPAA added two types of organizations to the list of those expressly exempt from the federal income tax: (1) state-sponsored membership organizations that provide insurance coverage or medical care to high-risk individuals, and (2) state-sponsored workmen's compensation reinsurance organizations. Organizations in either classification must meet a number of requirements.

Treatment of Certain Health Insurance Providers

HIPAA allowed health insurance providers (other than health maintenance organizations) that are organized and governed under state laws specifically and exclusively applying to not-for-profit health insurance or service organizations to deduct 25% of claims and expenses incurred during the year, less adjusted surplus. Previously this tax treatment applied only to Blue Cross and Blue Shield organizations.

³⁴ Viatical settlement providers must be regularly engaged in the business of purchasing or accepting assignment of life insurance contracts on the lives of terminally or chronically ill individuals. They must be licensed in the state where the insured individual resides or meet certain National Association of Insurance Commissioners standards.

³⁵ Excess per diem or other regular payments are not taken into account if the individual has been certified as terminally ill.

IRA Distributions for Medical Expenses and Insurance

HIPAA provided that the 10% early withdrawal penalty would no longer apply to individual retirement account (IRA) distributions used to pay medical expenses in excess of 7.5% of adjusted gross income. In addition, it provided that the penalty would not apply to IRA distributions used to pay health insurance premiums after separation from employment in the case of an individual who receives 12 consecutive weeks of unemployment compensation.

Organ and Tissue Donation Information

HIPAA required the Secretary of the Treasury to include organ and tissue donor information, to the extent practicable, in the mailing of individual income tax refunds from February 1, 1997 through June 30, 1997.