A Summary of

The Health Insurance Portability & Accountability Act OF 1996

Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

Table of Contents

INTRODUCTION

Recent federal and state laws provide important consumer protections for those who have pre-existing medical conditions and move from one job to another.

The federal law, officially called the "Health Insurance Portability and Accountability Act of 1996" (HIPAA), also referred to as the "Kassebaum-Kennedy Act", was enacted by President Clinton on August 21, 1996.

This booklet is designed to provide a general overview of the HIPAA law and how it interacts with existing state laws.

We hope this booklet will also help correct a few misconceptions about the recent laws.

You may have heard that you'll be able "to take your medical coverage with you." This is only partially true. You do not actually take your exact plan of health benefits with you, but you do get to "take the credit" for time you've been with your former plan to your new employer's plan. In general, the new laws require employer group health plans to cover pre-existing conditions sooner by giving you credit for coverage under your former health plan.

The law applies to most health plans. The "portability" or take it with you concept does not apply if you are changing from one individual health plan to another individual health plan. Pre-existing conditions limits will still apply.

The new laws do not affect all health insurance policies in exactly the same way. Group policies have different rules than policies purchased by individuals.

As a consumer, you need to know what kind of plan you have and which laws apply to your plan. In general, most of the new laws cover group health plans only. Very few changes were made to individual health plans. Tax changes were also made to long-term care plans and medical savings accounts.

GROUP HEALTH PLANS

Employer provided group health plans are either *fully insured* or *self-insured*.

Fully insured group health plans are divided into two categories:

- small employer plans for groups with 2-50 employees or
- large employer plans for groups with 51 or more employees.

Under any fully insured plan, the employer purchases coverage from an insurance company. The insurance company assumes the risk to pay all health claims.

Self-insured group health plans (or self-funded plans) are set-up by employers to pay the health claims of its employees. The *employer* assumes the risk of providing the benefits and is obligated to pay all the claims.

Sometimes self-insured plans are confused with fully insured plans because employers often hire an insurance company or third party administrator to pay the claims. If you do not know what kind of plan you have, ask your employer or plan administrator.

Fully Insured or Self-Insured?

If your health plan is *fully insured*, the Indiana Department of Insurance can help if you have a problem.

Indiana Department of Insurance
311 West Washington St., Suite 300
Indianapolis, IN 46204-2787

(317) 232-2395
1-800-622-4461

If you have a *self-insured* plan, you will need to seek help from the U.S. Department of Labor at the following locations.

Northern Indiana
U.S. Department of Labor Pension and Welfare Benefits Administration
200 West Adams, Suite 1600
Chicago, IL 60606

(312) 353-5155

Southern Indiana
U.S. Department of Labor Pension and Welfare Benefits Administration
1885 Dixie Highway, Suite 210
Fort Wright, KY 41011

(606) 578-4680

HIGHLIGHTS OF CHANGES TO GROUP HEALTH PLANS

Federal and state laws make a number of changes which apply to all group health plans. The health insurance changes required by the new laws include the following:

- Defines pre-existing medical conditions and limits how long plans may exclude these conditions for benefits.
- Pregnancies cannot be considered a pre-existing condition.
- Requires plans to treat all eligible individuals equally. For example, plans may not discriminate against individuals with an unfavorable medical history.
- Requires insurance companies to automatically renew group coverage each year.
- Mandates insurance companies selling coverage to small employers to make all products available to all small employers who apply. Small employer is now defined as 2-50 employees.
- Requires plans to offer special enrollment period for all new dependents due to marriage, birth, adoption or placement for adoption.
- Requires plans to have the same dollar limits on mental conditions as on physical conditions.

Pre-existing medical conditions

The main reason so many consumers have had difficulty changing from one insurance plan to another is because of prior or on going health conditions commonly called "pre-existing medical conditions." Historically, health plans would not cover pre-existing conditions, or limited coverage when you joined the plan, or even refused to give you health insurance. The new laws:

- Define what conditions are considered pre-existing;
- Limit how long coverage may be excluded; and
- Require plans to give you credit for time served under your former health plan.

A pre-existing medical condition is defined as a physical or mental condition for which medical advice, diagnosis, care or treatment is recommended or received prior to your date of hire, or the date your coverage begins (depending on the plan).

The pre-existing condition limits vary depending on the type of group health plan that you have.

Pre-existing exclusion periods:

A fully insured small employer plan (2 to 50 employees) can exclude coverage for pre-existing conditions for up to 9 months. Your pre-existing condition must meet the new definition and must have occurred within *6-months* prior to your effective date of coverage.

A fully insured large employer plan (51 or more employees) can exclude coverage for pre-existing conditions for up to 12 months. Your pre-existing condition must meet the new definition and must have occurred within 6 months prior to your effective date of coverage.

A self-insured plan can exclude coverage for your pre-existing conditions for up to *12 months*. Your pre-existing condition must meet the new definition and must have occurred within *6 months* prior to your hire date.

Conditions which may not be considered "pre-existing"

- Pregnancy is no longer a pre-existing condition in fully insured plans and self-insured plans. In other words, if you're pregnant when you join your new health plan your pregnancy must be covered.
- Genetic information may not be considered a pre-existing condition if there is no specific diagnosis of a current disease or medical problem related to the genetic test.

PORTABILITY: Moving from Plan to Plan

Group to Group

The laws add another very important provision to help make it easier for you when changing health plans. You get credit for your time served under the former health plan. This credit is "portable," that is, you take it with you as you move from plan to plan.

If your new group health plan has limits on coverage for pre-existing medical conditions, they must give you credit for any prior health coverage that you had. The law calls this credit "prior creditable coverage."

For example, let's assume your new group health plan has a 6 months pre-existing condition exclusion period. Your new plan must give you credit for time served under your prior health plan. If your prior coverage was for at least 6 months, the plan must give you full credit which means all pre-existing conditions would be covered under your new plan. If your prior coverage was for 60 days, the plan can only impose a 120 day exclusion for pre-existing conditions.

Qualifying for prior coverage

To qualify for prior coverage credit:

- You must not have a gap of more than 62 days between the prior coverage and your new group health plan. (Your new coverage must be in place on the 63rd day to avoid a gap in coverage.) *AND*
- You must have had coverage under a qualified health plan which includes fully insured employer health plans, individual health insurance, government health plans such as Medicaid and Medicare; state and federal government employee health plans; coverage through state "high-risk" pools; and the Indian Health Service.

You do get credit if you move from an individual health plan to a group health plan.

Plans that do not qualify for "prior creditable coverage"

You cannot get credit for coverage under non-medical coverages such as dental or vision plans; specified disease policies such as cancer or disability insurance; or workers compensation coverage.

You cannot get credit moving from one individual health plan to another individual health plan.

PORTABILITY: Moving from Plan to Plan

Group to Individual State "High Risk" Pool

You can move from a group plan to the state "high risk pool" (Indiana Comprehensive Health Insurance Association) without pre-existing conditions being applied if:

- You were covered by one or more group health insurance plans (group, church, or employer plan) for at least 18 months before seeking individual coverage *AND*
- you have exhausted your COBRA or your state continuation benefits and join the pool within 63 days of losing prior coverage *AND*
- the plan you were covered under did not terminate for non-payment of premium or for fraud *AND*
- you are not covered under Medicare or Medicaid *AND*
- you have not obtained new group coverage.

If you fulfill these requirements, you are considered a "federally eligible individual." A federally eligible individual qualifies for a guaranteed issue policy with the Indiana Comprehensive Health Insurance Association without pre-existing condition exclusions.

The Indiana Comprehensive Health Insurance Association ("state high risk pool") was created by the Indiana legislature in 1981 to provide health insurance coverage to consumers who are unable to obtain health insurance in the private market.

Starting in 1997, the risk pool plan must offer enrollees a choice of at least three (3) deductibles and co-payment plans. Lifetime benefit maximums are unlimited. The plan allows dependent coverage.

Employee Rights

When you leave a plan

A must give you a certificate that shows how many months of coverage you had under their plan. "This certificate of "prior creditable coverage" must be provided to you when:

- You leave your job *or*
- You exhaust your COBRA benefits *or*
- You ask for it within 24 months after leaving the plan.

When you enroll in a new plan

All group health plans must tell you about any pre-existing condition limits in their plan.

They must tell you what will be required to show proof of prior coverage.

After receiving proof of prior coverage, the plan must advise you if any conditions you have will be excluded as a pre-existing condition.

Discrimination based on medical history prohibited

The new laws prohibit all group health plans from discriminating against you based on your health status. In other words, the plan can not treat you any differently from other individuals covered under your plan because you have a medical condition (such as cancer or a disability) or have a history of filing medical claims.

Employer (Or Plan) Responsibilities

Prior Coverage Certification

All group health employer plans must provide written certification of prior coverage to all individuals losing coverage after June 1, 1997. The certificate must identify the covered person, period of coverage, and waiting periods (if any). It should be sent by first class mail to the employee's last known address. The plan must also provide specific benefit information upon request to another employer's plan.

Notice of Pre-existing Condition Exclusion

Certain information must be made available to employees notifying them of their right to:

- Receive notice of the pre-existing condition exclusion.
- Receive credit for prior coverage.
- Request certificates of coverage from previous plan. The notice also must say the plan will help the participant get their certificates, if necessary.

Special Enrollment Periods

Plans must provide a special enrollment period:

- For individuals who become dependents by marriage, birth or adoption. At that time, the employee or spouse may also elect coverage, if not already covered.
- For employees / dependents who initially decline your plan coverage because they were covered under another plan. (For example, the employee is covered through their spouse and then loses that coverage.)

Disclosure Requirements (for self-insured plans only)

Plans must provide notice of material reduction in benefits or services within 60 days.

The Summary Plan Description must include information about the third-party administrators of the plan.

Employer Rights

The laws also grant employers certain rights.

Some important examples:

- Guaranteed renewability for all fully insured group plans. Insurance companies are required to automatically renew your group coverage each year.
- Guaranteed availability for small employers. Health insurers in this market must make all their health plans available to all small employer groups that apply.
- Upon written request, the insurance company must provide the employer a written outline of all group health plans offered.

Mental Health Coverage

Large employer and self-funded health plans are prohibited from imposing different annual or lifetime dollar limits on benefits provided for mental health conditions than for medical and surgical coverage. In other words, if your plan has a $50,000 annual limit on benefits for medical conditions, it must have the same annual limit for mental health coverage.

There is an exception to this rule. A plan can opt out, i.e. not provide this coverage, if they can show that their plan costs would increase by 1%.

48-Hour Coverage for Maternity

All group health plans are required to pay for minimum hospital stays for the mother and her newborn child after delivery. They must provide coverage for at least 48 hours in the hospital after a normal delivery and 96 hours after a cesarean section delivery.

Individual Health Plans

Individual health insurance policies must be guaranteed renewable. However, policies still may be canceled for non-payment of premiums or fraud.

Tax Benefits

Long-term Care Insurance

HIPAA provides for favorable tax treatment for "qualified long-term care plans." If you have a qualified plan:

- You may deduct all or part of the premium as a medical expense.
- Benefits paid out by the policy will generally not be taxable as income.

Long term care policies sold before January 1, 1997 are "grandfathered" as tax qualified. All policies sold after January 1, 1997, must be identified as either tax qualified or non-tax qualified in the policy contract.

You should consult with your attorney, accountant, or tax advisor regarding the tax implications of purchasing long-term care insurance. For more information about long-term care insurance in Indiana, please call the Senior Health Insurance Information Program (SHIIP) at the Indiana Department of Insurance, 1-800-452-4800 or (317) 233-3475.

Medical Savings Accounts

HIPAA also establishes a program for tax exempt medical savings accounts (MSAs). MSAs are savings accounts set up to pay for medical expenses such as health insurance premiums and the cost of doctor visits. The MSA must be set up to pay for medical expenses such as health insurance premiums and the cost of doctor visits. The MSA must be in connection with the purchase of a high deductible health insurance policy approved by the Indiana Department of Insurance.

Who Enforces the Law?

Most of the provisions in the law are the same whether they come under the federal HIPAA or are covered by Indiana law. The main difference is in who will enforce the law.

Fully insured
Group Health Plans

Fully insured group health plans are subject to state laws and compliance is enforced by the Indiana Department of Insurance.

Self-insured
Group Health plans

Self-insured group health are not governed by state laws, but by a federal law called the Employee Retirement Income Security Act (ERISA).

If your plan is self-insured, it must follow the new federal laws (HIPAA). The U.S. Department of Labor (Pension and Welfare Benefits Administration) is enforcing these new rules.

Self-insured plans not complying with the new guidelines may be subject to an excise tax imposed by the Internal Revenue Service of $100 per day per violation. Non-compliance also means the possibility of lawsuits from plan participants or the U.S. Department of Labor.

If you should have questions regarding any of these changes you will need to contact the U.S. Department of Labor as listed on Page 2.

Individual Health Plans

If you have an individual health plan, your plan is governed by state law and is enforced by the Indiana Insurance Department. If you have questions, please contact the Department.

Medical Savings Accounts

HIPAA makes changes to federal tax laws to provide a tax exemption when a medical savings account is set-up in connection with the purchase of a high deductible health insurance plan. The Internal Revenue Service will enforce this portion of the law.

Long-term Care Insurance

HIPAA provides for favorable tax treatment for "qualified long-term care plans." Any questions regarding the tax qualification of a long-term care policy will be determined by the Internal Revenue Service. See Page 9.

When Plans Must Comply

The federal HIPAA law and the state laws have different starting dates for various provisions.

Changes to existing group health plans will be phased in from group to group over the next year. All group health plans must be in compliance by July 1, 1998.

Existing plans implement changes on their first plan anniversary following July 1, 1997. New group health plans starting on July 1, 1997 or later need to be in compliance from their start date.

Mental health parity must be in place by January 1, 1998. The chart below summarizes these dates.

Summary of Compliance Dates

Type of Coverage	Effective Date of Change	Federal or State Law	Who will enforce the laws
Fully Insured Group Health Plans	July 1, 1997*	Federal	Indiana Dept. of Insurance
Individual Health Plans	July 1, 1997*	State	Indiana Dept. of Insurance
Self-insured Plans	July 1, 1997*	Federal	U.S. Dept. of Labor
Access to Indiana Comprehensive Health Insurance	July 1, 1997	State	Indiana Dept. of Insurance
Mental Health Parity[1]	July 1, 1998 January 1, 1998	State Federal	Indiana Dept. of Insurance
Medical Savings Accounts	January 1, 1997	Federal	Dept. of Treasury (IRS)
Long Term Care Insurance	January 1, 1997	Federal	Dept. of Treasury (IRS)

* *Existing Group Health Plans must implement changes on first plan anniversary following July 1, 1997. All plans must be in compliance no later than July 1, 1998.*

[1] *Law covers groups of 50 employees or more*

Indiana Department of Insurance
Sally McCarty
Commissioner of Insurance
Consumer Services Division
TOLL-FREE NUMBER
1-800-622-4461
or (317) 232-2395
www.ai.org/idoi

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Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204-2787

Phone: (317) 232-2385 FAX: (317) 232-5251