



Government of Puerto Rico
OFFICE OF THE COMMISSIONER OF INSURANCE

November 24, 1997

RULING LETTER NO. N-AV-10-90-97

**TO ALL DISABILITY INSURERS, HEALTH SERVICES ORGANIZATIONS,
NONPROFIT HOSPITAL AND/OR MEDICAL-SURGICAL SERVICES
ASSOCIATIONS, FRATERNAL SOCIETIES AND ANY OTHER ENTITIES WHICH
WRITE HEALTH BENEFITS PLANS IN PUERTO RICO**

**Subject: The Health Insurance Portability and Accountability Act of 1996
(HIPAA) (HR3103 PL104-91)**

Ladies and Gentlemen:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA or the Act) enacted on August 21, 1996, establishes federal requirements for the availability and portability of group and individual health plans or insurance coverage which apply to plans providing medical care.

HIPAA requires carriers to:

- 1) limit preexisting conditions waiting periods;
- 2) credit previous coverage; and
- 3) cover all members of a group covered under a previous policy when a group plan is replaced.

The Act also limits insurers issuing or administering health benefit plans from imposing preexisting conditions exclusions or to use an individual's health status to deny coverage.

The Act provides more options for maintaining health plans or insurance for individuals that change jobs (group-to group), or lose jobs, become self-employed, or move to a company which does not provide a health plan or insurance coverage (group-to individual).

When a particular state has higher standards or more stringent requirements than those imposed by the Act, the state law prevails. State laws regulating group health plans or insurance coverage are not preempted except to the extent that any state provision may prevent

the application of a requirement of HIPAA. Nevertheless, if a state law fails to contain the minimum federal requirements and the requirements related to the imposition of preexisting conditions exclusions stipulated in the Act, the state law would be preempted, unless it falls into one of the specified exceptions. If the state law relates to another area covered by the Act, and falls short of the federal requirements, it may be preempted as "preventing the application" of the federal requirement. In fact, the Act does supersede any provision of state law which establishes a standard or requirement which would prevent the implementation of any of the federal provisions.

HIPAA also includes requirements for improving the availability of individual health insurance and to guarantee the renewal of an individual health plan or insurance policy at the option of the individual, subject to certain exceptions described in the Act. Specifically, an individual is eligible to be issued coverage in the individual health coverage market if the individual has had a previous health plan or insurance coverage of the type specified in the Act for the most recent previous 18 months, under a group plan or other specified plan, and has not let that coverage lapse for any period exceeding 63 days.

In the absence of acceptable state reforms or alternative mechanisms, the Act imposes minimum federal requirements which require health insurance carriers participating in the individual health plans or insurance market to offer a choice of at least two policies to qualified individuals, as defined in the Act, without any preexisting condition exclusion.

The Insurance Code of Puerto Rico does not regulate the preexisting exclusions or limitations conditions, nor the guaranteed renewability requirement in the provisions of health benefit services organizations and group and individual health insurance. At this moment, this Office has not implemented either any alternative mechanism for the individual health coverage.

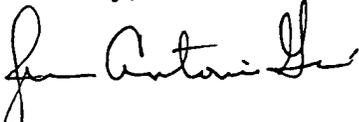
Due to the above, the Act is applicable in our jurisdiction and preempts the Insurance Code of Puerto Rico with regard to the provisions required in the Act, which are not provided in said Code or which are less stringent than the federal requirements. Also, the minimum requirements mentioned in the seventh paragraph of this letter must be complied with.

For more detailed information regarding the provisions of HIPAA, please refer to the enclosed pages of the brochure "A Legislator's Guide to Access, Portability and Renewability Provisions", of May 1997, issued by Milbank Memorial Fund, the National Association of Insurance Commissioners and the National Conference of State Legislatures.

The Departments of Labor, Treasury and Human Services of the United States of America published regulations on HIPAA in the Federal Register, on April 8, 1997. Copies of these regulations may be requested from Milbank Memorial Fund in the following address: 645 Madison Avenue, 15th floor, New York, NY 10022-1095; Telephone Number 212-355-8400; Fax Number 212-355-8599, E-Mail Milwaukee @pipeline.com.

We hereby require strict compliance with the HIPAA provisions. Any violation to this directive, will be considered as a violation to an order of the Commissioner of Insurance of Puerto Rico and, therefore, subject to the sanctions provided by law.

Sincerely,

A handwritten signature in black ink, appearing to read "Juan Antonio García". The signature is fluid and cursive, with a large initial "J" and "A".

Juan Antonio García
Commissioner of Insurance

HEALTH CARE ACCESS, PORTABILITY AND RENEWABILITY

Group Market Rules and Reforms

The Act establishes federal requirements related to portability, access and renewability of health insurance on group health plans and health insurance issuers that provide group health insurance coverage.

Limits on Preexisting Conditions

A group health plan or health insurance issuer may only impose a preexisting condition exclusion if it relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date. When a preexisting condition exclusion is imposed, the exclusion period: (1) is limited to 12 months, or 18 months for late enrollees; and (2) must be reduced by periods of creditable coverage (see explanation of creditable coverage below). Health Maintenance Organizations (HMOs) may use affiliation periods of two months (three months for late enrollees) in lieu of a preexisting condition exclusion. Any waiting or affiliation periods run concurrently with any applicable preexisting condition exclusion period.

Creditable Coverage

Creditable coverage is time spent covered by a health plan, as defined in the Act, which is: (1) counted toward decreasing preexisting condition exclusion periods in the group market; and (2) used as a condition of eligibility in the individual market. The Act permits a lapse of coverage of no more than 63 days before prior coverage is no longer "creditable." Report language establishes that Congress intended the definition of creditable coverage to include short-term, limited coverage. Group plans and issuers are required to count a period of creditable coverage without regard to the specific benefits covered under a previous plan, unless the plan or issuer elects to adopt an alternative method for calculating creditable coverage. (See "Election of an Alternative Method for Counting Creditable Coverage" below).

An individual will establish creditable coverage by presenting certifications describing previous coverage. A group health plan must provide certification of prior coverage at the time an individual ceases to be covered under the plan; or becomes covered under a COBRA continuation policy; or ceases to be covered under a COBRA continuation policy; or requests a certification, provided that the request is made not later than 24 months after the cessation of coverage or COBRA coverage. Medicare, Medicaid, a program of the Indian Health Service or a tribal organization, and CHAMPUS programs must also provide certifications of previous creditable coverage. Health insurance coverage in periods before July 1, 1996 will be taken into account for purposes of determining creditable coverage, except that the Secretary of the U.S. Department of Labor is required to establish a process for individuals to demonstrate credit for coverage prior to that date.

Creditable coverage includes coverage of the individual under:

- (1) a group health plan, including church plans and governmental plans;
- (2) health insurance coverage, either group or individual insurance;
- (3) Medicare;
- (4) Medicaid;
- (5) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS);
- (6) a program of the Indian Health Service;

- (7) a state health benefits risk pool;
- (8) the Federal Employees Health Benefits Plan;
- (9) a public health plan, as defined in regulations; and
- (10) a health benefit plan under section 5(e) of the Peace Corps Act.

Election of Alternative Method for Counting Creditable Coverage

A group health plan or health insurance issuer may elect to provide credit based on coverage of benefits within certain specific classes or categories of benefits. According to the Conference Report, the Congress intends that the alternative method be available to account for **significant**, not minor, differences in benefits. For example, the absence or presence of a major benefit such as prescription drug coverage would be significant, while a \$50 difference in the deductibles would not.

Anti Discrimination

The law prohibits the establishment of rules for eligibility and continued eligibility based on health status-related factors. Health status-related factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, disability, or evidence of insurability (including conditions arising out of acts of domestic violence). Genetic information would not be considered a preexisting condition in the absence of a diagnosis of the condition related to the genetic information.

Special Enrollment Periods

Employee Coverage

Group health plans and health insurance issuers are required to provide for special enrollment periods when an employee has lost other coverage and meets each of the following conditions:

- (1) the employee or dependent was already covered when the plan was previously offered;
- (2) the employee stated in writing that another source of coverage was the reason for declining enrollment, but only if the plan sponsor or issuer required such a statement and provided the employee with notice of this requirement;
- (3) the person was covered under COBRA continuation coverage that was exhausted, or coverage was not under a continuation provision and was terminated as a result of a loss of eligibility for the coverage, or because employer contributions toward the coverage were terminated; and
- (4) the person requested enrollment no later than 30 days after the loss of other coverage.

Dependent Coverage

If a group health plan offers dependent coverage, it must offer a special enrollment period for persons becoming a dependent through marriage, birth, adoption or placement for adoption.

Preemption of State Laws/State Flexibility

In general, the provisions of the Act do not supersede any provision of state law that establishes, implements, or continues any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage, except to the extent that such a state standard or requirement prevents the application of a federal requirement.

Preemption of State Laws Regarding Preexisting Condition Limitations

State laws related to preexisting conditions limitations that differ from the federal standards are preempted except where they provide for: (1) a shorter lookback period in determination of a preexisting condition exclusion, below the 6 month period established in the Act; (2) a shorter exclusion period for a preexisting condition, below the 12 months for regular enrollees, and 18 months for late enrollees; (3) longer periods for lapses in coverage; (4) longer periods for the enrollment of newborns and adopted children; (5) broader categories or circumstances in which a preexisting condition limitation cannot be imposed; (6) additional special enrollment periods; or (7) a shorter maximum time period for the HMO affiliation period.

Disclosure

Beneficiaries must receive notice of material modifications to a plan, plan descriptions and summaries, as well as a statement of who is responsible for the financing and administration of the plan.

ERISA-covered Plans

The Act amends ERISA requirements related to summary plan descriptions. If there is a material reduction in covered services or benefits, a summary of the changes must be provided to participants within 60 days after the date of its adoption. Alternatively, plan sponsors could provide descriptions at regular intervals of not more than 90 days. The Secretary of the U.S. Department of Labor is directed to promulgate regulations within 180 days of enactment that would provide alternative mechanisms, besides delivery by mail, for plan participants to receive notice of plan changes.

State and Local Government Opt-Out

State and local government plans that are self-insured may elect not to be a group health plan covered under the amendments to the Public Health Service Act. Provisions of the Act regarding limits on preexisting conditions, anti-discrimination and special enrollment periods will not apply to plans making this election. In addition:

- (1) such an election would apply for a single specified plan year or, in the case of a plan governed by a collective bargaining agreement, for the term of the agreement.
- (2) if a state or local government makes this election, it must notify enrollees and must provide certification and disclosure of creditable coverage under the plan to enrollees who leave the plan.

Group Market Reforms

Guaranteed Issue/Small Group Market

The law requires all health insurance issuers that offer small group coverage to accept every small employer in the state that applies for any type of small group coverage. A "small group" is defined as a group with between 2-50 employees. States are permitted to define "small group" more broadly. An exception to the guaranteed availability requirement is authorized in cases where the plan fails to meet the participation or contribution rules of the issuer, provided these rules comply with state law.

Bona Fide Associations

HIPAA allows for the sale of health benefit plans through bona fide associations. A "bona fide association" is one that: (1) has been actively in existence for at least five years; (2) has been formed and maintained in good faith for purposes other than obtaining insurance; (3) does not condition membership on health status-related factors; (4) makes health insurance coverage available to all members regardless of any health status-related factor relating to the members; (5) does not make the health insurance offered through the association available except to members of the association and individuals connected with association members; and (6) meets any additional requirements imposed under state law.

Exceptions to the Guaranteed Issue Requirement

Insufficient Financial Reserves - A health insurance issuer may deny coverage in the small group market if the issuer has demonstrated, if required, to the appropriate state authority that it does not have the financial reserves necessary to underwrite additional coverage. If an issuer denies coverage due to a lack of financial capacity, it must apply this limitation uniformly to all small employers without regard to claims experience of these employers or to any health-status related factor of the employer's employees or their dependents. An issuer denying coverage on the basis of insufficient financial reserves may not offer coverage in the small group market in the service area for 180 days or until it has demonstrated to the applicable state authority, if required under state law, that it has sufficient financial reserves to underwrite additional coverage, whichever is later.

Network Plans -

Employees Located Outside the Service Area - Health insurance issuers offering coverage to the small group market through a network plan could limit coverage to employers with employees who live, work, or reside in the service area for the network plan.

Service Capacity Limitations - Health insurance issuers offering coverage to the small group market through a network plan could deny coverage to small employers if the issuer has demonstrated, if required, to the appropriate state authority, the lack of capacity to deliver services adequately to additional groups. If an issuer denies coverage due to lack of capacity, it must apply the capacity limit uniformly to all employers without regard to claims experience or any other health status-related factor. An issuer denying coverage on the basis of insufficient capacity may not offer coverage in the small group market in the service area for 180 days.

Guaranteed Renewability

Health insurance issuers must renew policies. This provision applies to both the small group and large group market.

Exceptions to the Guaranteed Renewability of Coverage Requirements

Exceptions to the guaranteed renewability provisions are provided for one or more of the following circumstances: (1) nonpayment of premiums; (2) fraud; (3) violation of participation or contribution rules; (4) termination of coverage in the market, in accordance with applicable state law; (5) for network plans, when no enrollees connected to the plan live, reside, or work in the service area of the issuer; (6) for coverage through bona fide associations, if the employer's membership in the association ceases, but only if coverage is terminated uniformly without regard to health-related factors regarding any individual.

Discontinuance of a Type of Policy - An issuer may choose to discontinue offering a particular type of group coverage in the small or large group market, so long as the issuer, in accordance with applicable state law: (1) provided at least 90 days' prior notice to each plan sponsor, participants and beneficiaries; (2) gave the plan sponsor the chance to purchase all (or in the case of a large group market, any) other plans offered by the issuer in such market ; and (3) applied the termination uniformly without regard to the claims experience of those sponsors or any health status-related factor of any participants or beneficiaries.

Discontinuance of All Coverage - An issuer may choose to discontinue all coverage in the small or large group market, or both. The issuer must discontinue all coverage in accordance with applicable state law and must provide notice to the insurance commissioner, to each plan sponsor, and to participants and beneficiaries at least 180 days prior to the date of discontinuation. In this case, the issuer could not offer coverage in the market and state involved for five years.

Exceptions to the Requirements Regarding Availability, Renewability, and Portability

Benefits For Medical Care Secondary Or Incidental To Other Insurance Benefits - The requirements of HIPAA regarding portability, guaranteed issue and guaranteed renewability do not apply to the following types of coverage: (1) accident, or disability insurance, or any combination thereof; (2) supplements to liability insurance; (3) liability insurance; (4) workers compensation or similar insurance; (5) automobile medical payment insurance; (6) credit-only insurance; (7) coverage for on-site medical clinics; and (8) other similar coverage as specified in regulations.

Separate Policy, Certificate Or Contract Of Insurance

These requirements also do not apply to: (1) Medicare supplemental health insurance; (2) coverage supplemental to coverage provided under military health care; and (3) similar supplemental coverage provided to coverage under a group health plan.

Separate Policy, Certificate or Contract of Insurance/Benefits are Not an Integral Part of the Group Health Plan

These requirements also do not apply to: (1) limited scope vision and dental benefits; (2) benefits for long term care; (3) nursing home care; (4) home health care; (5) community-based care; (6) or any combination thereof; or similar limited benefits as specified by regulation.

Separate Policy, Certificate, Or Contract Of Insurance/No Coordination Of Benefits

These requirements also do not apply to: (1) coverage limited to a specified disease or illness; or (2) hospital indemnity or other fixed indemnity insurance.

Enforcement

States are authorized to require health insurance issuers to meet the requirements of Title I of HIPAA for the group insurance market. If the Secretary of the U.S. Department of Health and Human Services determines that a state has failed to substantially enforce a provision or provisions of this title, the Secretary is authorized to enforce those provisions. The Secretary of the U.S. Department of Health and Human Services is authorized to promulgate regulations necessary to implement the amendments to the Public Health Service Act made by HIPAA.

Preemption

According to the Conference Report, the Congress intended, "... the narrowest of preemptions." Any provision of state law that establishes, implements, or continues in effect any standard or requirement, solely relating to health insurance issuers in connection with group health insurance coverage would not be preempted unless the standard or requirement prevents the application of a federal requirement. For example, if state law defines "small employer" more broadly than the Act (i.e. between 2-100 employees), the state law definition would prevail over the more limited federal definition (between 2-50 employees).

Disclosure Requirements

Health Plan Issuers - Health plan issuers are required to make the availability of plan information known to small employers and must make certain that the information can be easily understood by the average small employer and is sufficient to inform them of their rights and obligations.

Multiemployer Plans and Multiple Employer Welfare Arrangements

Guaranteed Renewability

Multiemployer plans and multiple employer welfare arrangements (MEWAs) are prohibited from denying an employer continued access (guaranteed renewability) to the same or different coverage under the terms of the plan except: (1) for nonpayment of contributions; (2) for fraud; (3) for noncompliance with plan provisions; (4) because the plan is ceasing to offer any coverage in a geographic area; (5) in the case of a network plan, where there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan, and the plan applies this provision uniformly without regard to health status-related factors; or (6) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining agreement or other agreement that requires authorizing contributions to the plan or to employ employees covered by such an agreement.

Guaranteed Issue

Group health plans are specifically exempted from the federal guaranteed issue requirement. As a result, some MEWAs that are employee welfare benefit plans (part of the definition of group health plan) may also be exempt. States can, through state law, require these plans to guarantee issue. MEWAs that are not employee welfare benefit plans are subject to the federal guaranteed issue requirements.

Disclosure Requirements for Multiple Employer Welfare Arrangements That are Not Group Plans

The Secretary of the U.S. Department of Labor is permitted, in accordance with regulations, to require MEWAs that provide medical benefits, but are not group health plans, to report to the Secretary, not more than once a year in order for the Secretary to determine that the provisions of the Act are being carried out.

Enforcement

The Secretary of the U.S. Department of Labor is authorized to promulgate regulations, including interim final regulations, to carry out certain provisions of Title I. The Labor Secretary is not authorized to enforce any requirement against a health insurance issuer offering coverage in connection with a group health plan. A state may enter into an agreement with the Secretary for the delegation of some or all of the Secretary's authority to enforce the requirements as they apply to MEWAs that are not group health plans.

Large Group Market

Guaranteed Availability of Coverage/Large Group Market

There is no provision for guaranteed availability of coverage in the large group market. Instead, the Secretary of the U.S. Department of Health and Human Services is directed to request that the governor of each state submit a report on the access of large employers to health insurance coverage. These reports are to be submitted no later than December 31, 2000 and would be submitted every three years thereafter. Based on the information received from the state reports, the Secretary is directed to report to Congress on the access to health insurance for large employers, every three years. Finally, the Comptroller General is directed to submit a report to Congress, no later than February 2, 1998, on the access of classes of large employers to health insurance coverage in the different states.

Guaranteed Renewability of Coverage for Employers in the Group Market

Health insurance issuers must renew policies. This provision applies to both the small group and large group market. See, "Guaranteed Renewability of Coverage for Employers in the Group Market," for additional details. The rules are the same for small and large employers.

Individual Market Reforms

Standards for the Individual Insurance Market (Federal Fall Back Provisions)

- (1) Guaranteed issue to *eligible individuals*;
- (2) Guaranteed renewability of all policies, with limited exceptions; and
- (3) Prohibition of the imposition of preexisting condition exclusions on eligible individuals.

Eligible Individuals

Under the provisions of the Act, an *eligible individual* is an individual who:

- (1) has 18 or more months of creditable coverage, with the most recent coverage from a group health plan, governmental plan, or church plan, or other group health insurance offered in connection with any such plan;
- (2) is ineligible for group health coverage, Medicare Parts A or B, or Medicaid, including any successor program to Medicaid;
- (3) has no other health insurance coverage and has not been terminated from his or her most recent prior coverage for nonpayment of premiums or fraud;
- (4) has exhausted continuation benefits under COBRA or a similar state program, if he or she was eligible to receive those benefits; AND
- (5) has not gone more than 63 days without creditable coverage.

Qualified Coverage

Individual health insurance issuers are required to offer coverage to eligible individuals under all policy forms (guaranteed issue), with certain exceptions. **An issuer is not required to guarantee issue if the state is implementing an acceptable alternative mechanism.** Under the Federal fall back provisions, if a state is not implementing an acceptable alternative mechanism, an issuer may elect to limit the number of policy forms offered, provided that the issuer offers at least two different policy forms, both designed for and actively marketed in the individual group market. In addition, the policy forms must meet one of the following: (1) the two policy forms with the largest and next to the largest premium volume; or (2) the two policy forms are representative of individual health insurance coverage offered by the issuer. Issuers must apply the election uniformly to all individuals in the state for that issuer, and the election must be effective for at least two years.

Levels of Coverage

The two representative policies would include a lower and a higher level of coverage, each of which has benefits similar to other individual health insurance policies offered by the issuer in the state. The lower-level policy form would have benefits with an actuarial value at least 85 percent, but not greater than 100 percent, of the weighted average benefit. The weighted average benefit may be either: (1) the average actuarial value of the benefits from individual coverage offered by the issuer; or (2) the average actuarial value of the benefits from individual coverage provided by all issuers in the state. The weighted average will be based on coverage provided during the previous year and will exclude coverage of eligible individuals.

The higher-level policy form would have an actuarial value: (1) at least 15 percent greater than the actuarial value of the lower-level policy form; and (2) between 100 and 120 percent of the weighted average benefit.

Guaranteed Renewability

In general, individual health insurance issuers are required to renew coverage. The Act requires guaranteed renewability of all individual policies, not just those held by individuals who qualify for guaranteed issue. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form as long as the modification is consistent with state law and is effective on a uniform basis among all individuals with that policy form.

Exceptions to Guaranteed Renewability

The exceptions to the guaranteed renewability provisions in the individual market are the same as those authorized for the small group market. These exceptions permit nonrenewal if the individual fails to pay premiums or commits fraud; if the issuer ceases to offer a particular type of coverage or withdraws from the market; if the individual no longer lives, resides or works in the service area of a network plan; or if the individual's membership in an association ceases.

Alternative State Mechanisms

The federal individual market reforms (the Federal fall back provisions) do not apply to individual health insurance coverage offered in the individual market in a state that establishes an acceptable alternative mechanism. Such mechanisms include:

- (1) the National Association of Insurance Commissioners' (NAIC) Small Employer and Individual Health Insurance Availability Act (as it applies to individual coverage) or the NAIC's Individual Health Insurance Portability Model Act;
- (2) a qualified high risk pool;
 - A qualified high risk pool is one that provides eligible individuals with health insurance coverage that does not impose any preexisting condition exclusion and provides for premium rates and covered benefits that are consistent with standards included in the NAIC Model Health Plan for Uninsurable Individuals Act.
- (3) an alternative mechanism which includes risk adjustment, risk spreading or a risk spreading mechanism; or provides some financial subsidies for participating insurers or eligible individuals; or
- (4) a mechanism under which each eligible individual is provided a choice of all individual health insurance coverage otherwise available.

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

The law requires that a state's alternative mechanism:

- (1) provide all eligible individuals with a choice of health insurance coverage;
- (2) provide coverage that does not impose any preexisting condition exclusions;
- (3) provide a choice of coverage that includes at least one policy form that is:
 - comparable to comprehensive health insurance coverage offered in the individual market; or,
 - a standard option of coverage available under the group or individual health insurance laws of the state.
- (4) implement one of the four mechanisms described above.

A state is presumed to be implementing an acceptable alternative mechanism as of July 1, 1997, if the governor of the state notifies the Secretary of the U.S. Department of Health and Human Services by no later than April 1, 1997, that the state has enacted or will have enacted all necessary legislation by the January 1, 1998 deadline established in the Act. The Secretary has 90 days from the date of notification to determine whether the alternative mechanism is an acceptable alternative mechanism. Each state must report to the Secretary every three years to retain the presumption of compliance. If a state submits a notice and information after July 1, 1997, and the Secretary makes no determination within 90 days, the mechanism will be considered acceptable after 90 days.

Failure to Adopt an Acceptable State Alternative Mechanism

If the Secretary of the U.S. Department of Health and Human Services determines that a state mechanism is not acceptable or is not being implemented, the Secretary must notify the state of the preliminary determination and the consequences of failure to comply. The state will then be given a reasonable opportunity to modify its existing mechanism or to adopt a new one. If the Secretary makes a final determination that the state mechanism is not acceptable, the Secretary must notify the state of the effective date of the imposition of the federal requirements for guaranteed availability. Each insurer in the state would then be required to guarantee issue health insurance to any eligible individual according to the provisions of the Act. The authority of the Secretary is limited to determinations based only on whether the state mechanism is acceptable and is being implemented.

Enforcement

States enforce the Act's requirements for health insurance issuers that issue, sell, renew or offer health insurance coverage in the state in the individual market. If a state fails to substantially enforce the requirements, the Secretary of the U.S. Department of Health and Human Services is authorized to enforce them.

Preemption

No state law or requirement for the individual market is preempted unless it prevents the application of a federal requirement. This law's provisions affecting the individual insurance market do not amend or affect ERISA.

Chart 1: HIPAA EFFECTIVE DATES

(Individual Market Provisions)

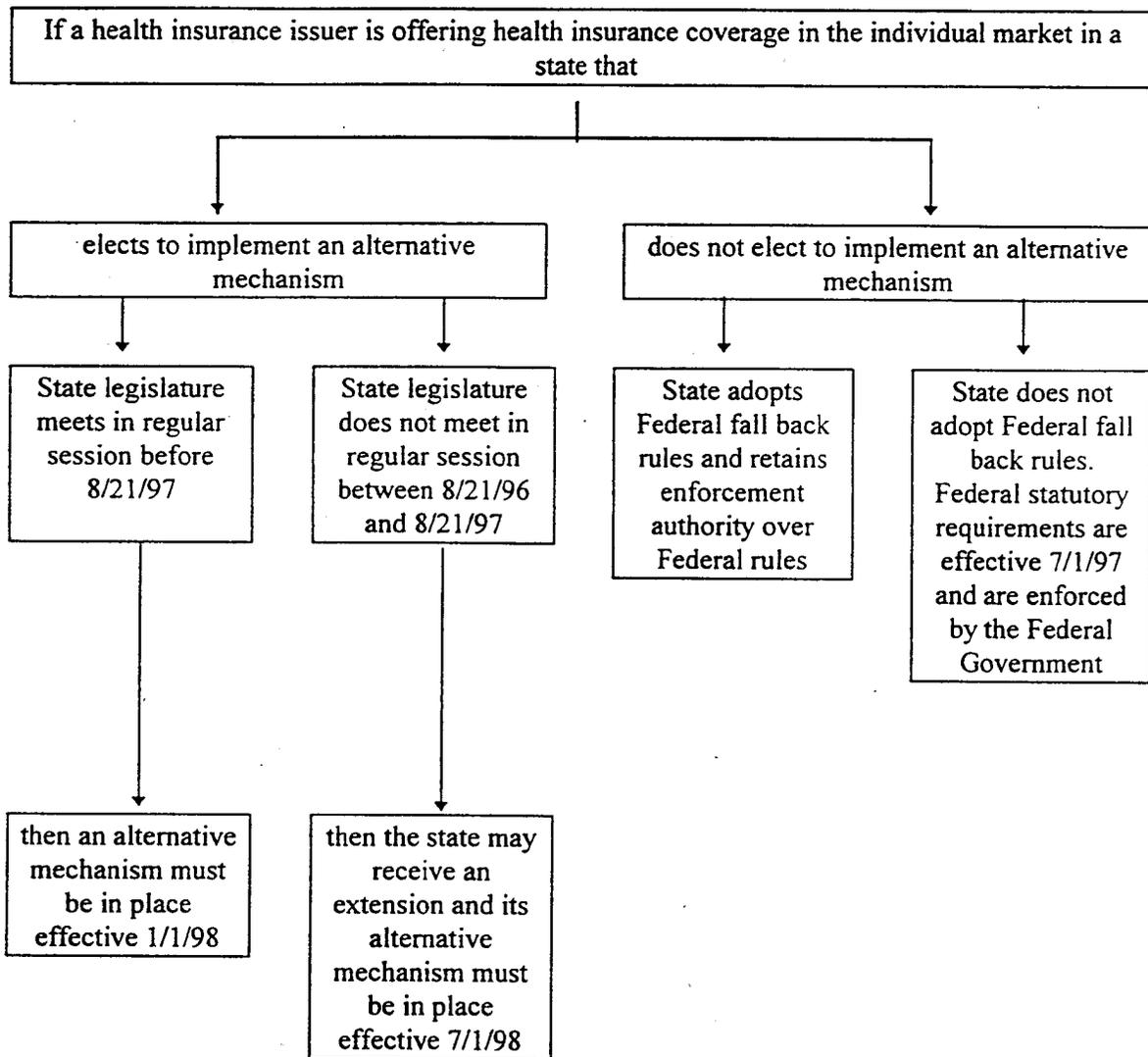
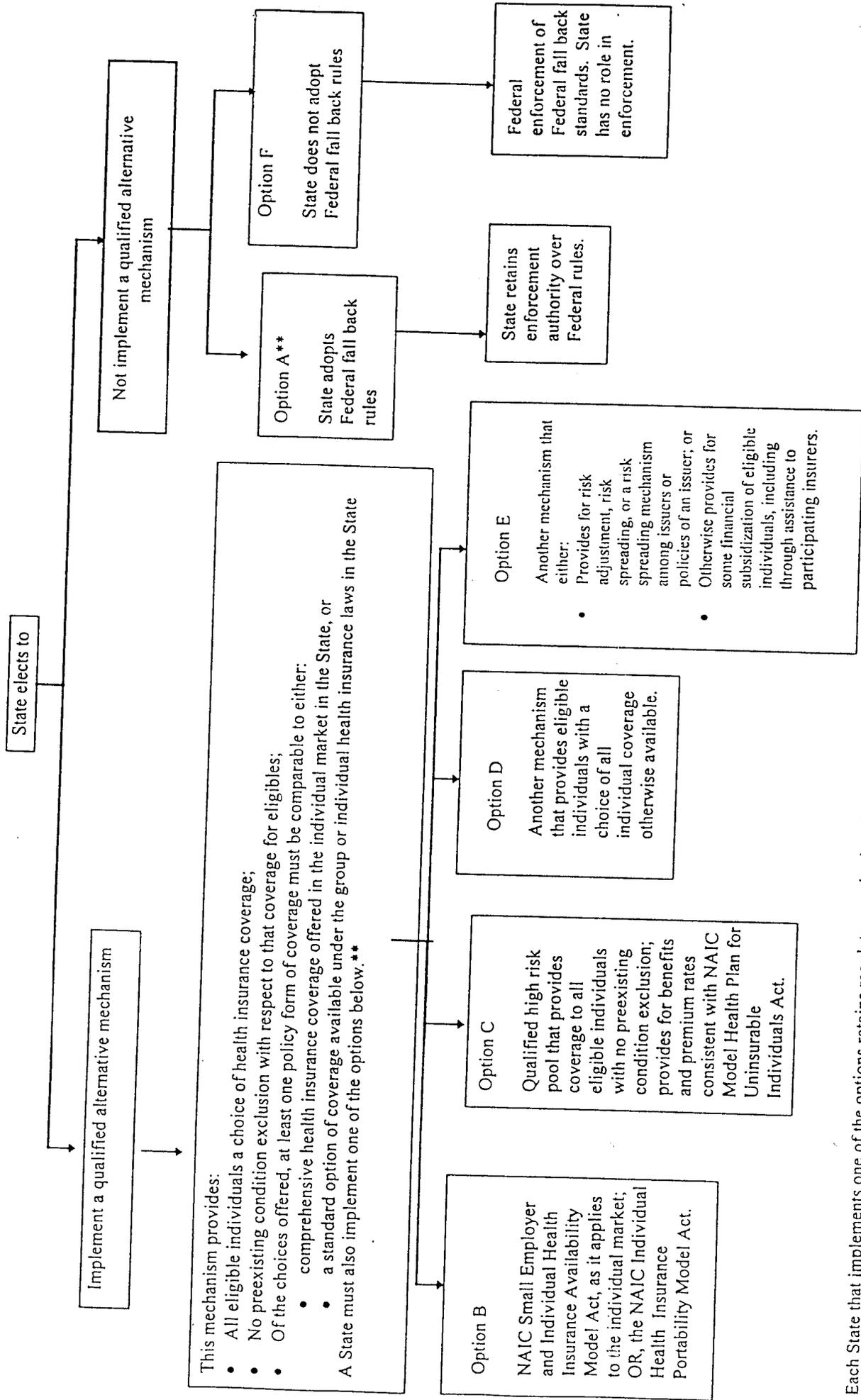


Chart 2: Flow Chart of State Individual Market Reform Implementation Options



** Each State that implements one of the options retains regulatory authority with respect to these requirements.

REVIEW OF STATE OPTIONS: IMPLEMENTING THE INDIVIDUAL MARKET REFORMS**

Option A: Federal Fallback Standards

Guaranteed Availability

A health insurance issuer may elect to limit coverage to eligible persons to a choice of two different policy forms, both of which must:

- (1) be designed for, made generally available to, actively marketed to, and enroll both eligible and other individuals; and
- (2) be either:
 - a) the “most popular policy forms,” the forms with the largest and second largest premium volume in the state or applicable marketing or service area (as defined in regulation); or
 - b) the “policy forms with representative coverage”, a lower level and a higher level form, each of which contains benefits substantially similar to other individual coverage offered by the issuer and each of which is covered under some risk spreading mechanism.
 - Lower level coverage is defined as having an actuarial value of 85–100% of the weighted average;
 - Higher level coverage is defined as having an actuarial value of at least 15% greater than lower level coverage and between 100–120% of the weighted average;

A risk spreading mechanism must provide for risk adjustment, risk spreading, or a risk spreading mechanism (either among issuers or among the policies of an issuer); or must otherwise provide for some financial subsidization for eligible individuals, including through assistance to participating issuers. Policy forms which have different cost-sharing arrangements or different riders shall be considered different policy forms.

Special Rules for Network Plans

A network plan may:

- (1) limit enrollees to those who live, reside or work in the service area;
- (2) deny coverage based on the plan’s enrollment capacity limits, as long as coverage is denied uniformly without regard to health status-related factors;

If coverage is denied based on service capacity, the issuer is suspended from offering new individual coverage in the service area for 180 days;

** Each State that implements one of the options retains regulatory authority with respect to these requirements.

Exception for Financial Capacity

A health insurance issuer may deny health insurance coverage in the individual market to an eligible individual if the issuer demonstrates to the commissioner that:

- (1) It lacks financial reserves necessary to underwrite additional coverage; **and**
- (2) Is applying this denial uniformly to all individuals in the state's individual market, consistently with state law and without regard to health status-related factors and without regard to whether individuals are eligible individuals.

If an issuer denies coverage based on financial capacity, it is suspended from offering coverage in the individual market in that service area for the later of: 180 days from the date of denial; or until the issuer demonstrates to the commissioner, if required under state law, that it has sufficient financial reserves to underwrite additional coverage.

Option B: Adopt one of the two NAIC individual market models.

The Act references the two NAIC models addressing individual market reform: (1) the Small Employer and Individual Health Insurance Availability Model Act, as it relates to the individual market ("Availability" Model); and (2) the Individual Health Insurance Portability Model Act ("Portability" Model). Adoption of one of these models will constitute an acceptable alternative mechanism, if: (1) all eligible individuals are provided a choice of health insurance coverage; (2) such coverage does not impose any preexisting condition exclusions; and (3) the choice of coverage includes at least one policy form of coverage that is comparable to comprehensive health insurance coverage offered in the individual market; or, a standard option of coverage available under the group or individual health insurance laws of the state.

General Structure of the Availability Model

The individual market provisions of the Availability Model require:

- (1) guaranteed issue of all products, including a standard and basic plan, but sets out two options:
 - a) a year-round guaranteed issue requirement, or
 - b) a rolling open enrollment option which guarantees an individual one month each year in which to obtain a product.
- (2) adjusted community rating, with variations allowed only for geographic area, family composition, and age.
- (3) guaranteed renewability for individual products, subject to standard exceptions such as fraud or misrepresentation, nonpayment of premiums, etc.

In general the Availability Model's provisions for preexisting condition exclusions, definition of preexisting condition, eligible individual, etc. are similar to the requirements of the federal law. However, it allows a twelve-month preexisting condition exclusion and therefore must be modified to prohibit any exclusions for federally defined eligible individuals. Also, there are some differences between the federal law's definitions and those contained in the Availability Model. Because of the very preemptive language of the federal law for state provisions that address preexisting condition exclusions, some revisions have been made to the language of this model.

General Structure of the Portability Model

The Portability Model addresses only the individual market. It requires guaranteed issue of a basic and a standard plan by all health carriers doing business in the state's individual market. The commissioner establishes by regulation the form and level of coverage of the basic and standard health benefit plans. It permits rating bands, subject to certain requirements. The Portability Model requires guaranteed renewability of individual health benefit plans. It allows a twelve-month preexisting condition exclusion and therefore must be modified to prohibit any exclusions for federally defined eligible individuals.

Option C: High risk pool.

The federal law defines a qualified high risk pool as one that:

- (1) provides coverage to all eligible individuals;
- (2) does not impose a preexisting condition on an eligible individual;
- (3) provides for premium rates and covered benefits for such coverage consistent with the NAIC's Model Health Plan for Uninsurable Individuals Model Act (i.e., premium rates do not exceed 200 percent of standard risk rates).

States that choose this option will have to make sure that their risk pool meets the requirements above.

Option D: Guaranteed issue of all products in the individual market.

States that already have guaranteed issue of all products in the individual market will have to do little to comply with the federal law's requirements, but all States must review their statutes to ensure compliance with the federal law. Unless the state is implementing an alternative mechanism, federal law requires guaranteed issue of all products to eligible individuals and prohibits the imposition of preexisting condition exclusions on eligible individuals. State laws affecting individuals who are eligible for guaranteed issue under the federal law must be revised to comport with the federal law.

Option E: Other Alternative Mechanisms

This option is not clearly defined in the law, but includes mechanisms that provide for risk adjustment, risk spreading, or a risk spreading mechanism among issuers or policies of an issuer. It also includes mechanisms that provide some financial subsidization of eligible individuals, including through assistance to participating insurers. The examples below are approaches that may be considered.

(1) Mandatory group conversion policies.

States with mandatory group conversion policies should note that they will not apply to individuals covered by self-funded ERISA plans. Therefore, such laws alone will not enable a state to comply with the Act because they will not protect many individuals who are entitled to protection under the federal law.

(2) Open enrollment by one or more health insurance issuers.

States that have implemented open enrollment by one or more insurers have in place a broader protection than that afforded by the rolling open enrollment option of the NAIC Availability Model. However, the rolling open enrollment option as set forth in the revised NAIC model is sufficient for compliance with the Act's guaranteed issue requirements because it would allow federally defined eligible individuals to have 63 days to obtain coverage and would not require them to wait until the month of their birthday. Under the NAIC model, other individuals with previous coverage could obtain coverage within 31 days of the termination of the previous coverage.

(3) Some combination of the options above.

The federal law permits states to have some combination of permissible mechanism. The law does not specify whether a state must offer every eligible individual the same choices, or whether it may provide different groups of eligible individuals with different choices. Another point is that some mechanisms already contained in state law will not protect individuals whose previous coverage was in a self-funded ERISA plan.

Guaranteed Renewability

Federal Standards apply REGARDLESS of whether the state is implementing an alternative mechanism for guaranteed issue. All individuals enjoy guaranteed renewability, not just individuals eligible for guaranteed issue.

Exceptions to guaranteed renewability requirement:

- (1) Nonpayment of premiums;
- (2) Fraud or intentional misrepresentation of a material fact by an individual;
- (3) Termination of a product: Issuer must provide notice to enrollee 90 days before termination, offer option to purchase any other individual product offered by the issuer, and act uniformly without regard to health status-related factors;
- (4) Discontinuance of all individual coverage: Issuer must provide notice to the commissioner and enrollees 180 days before termination, must discontinue and nonrenew all coverage in the individual market, and is prohibited from market reentry for 5 years after date of last discontinuation due to nonrenewal.
- (5) Network plans: Issuer may nonrenew if the individual no longer resides, lives, or works in the service area, provided that the issuer nonrenews uniformly, without regard to health status-related factors.
- (6) Association membership ceases: Issuer may nonrenew if the individual ceases to be a member of the association through which coverage is obtained, provided that the issuer nonrenews uniformly, without regard to health status-related factors.
- (7) Modification of coverage: At the time of coverage renewal, issuer may modify the policy form consistent with state law and provided that modification is effective on uniform basis among all individuals having that policy form.

Glossary of Terms

Bona fide association plan - An association that: (1) has been actively in existence for at least five years; (2) has been formed and maintained in good faith for purposes other than obtaining insurance; (3) does not condition membership on health status-related factors; (4) makes health insurance coverage available to all members regardless of any health status-related factor relating to the members; (5) does not make the health insurance offered through the association available other than in connection with a member of the association; and (6) meets any additional requirements imposed under state law.

Consolidated Omnibus Reconciliation Act of 1985 - A provision of the 1985 Act that requires employers of 20 or more employees who offer health insurance as a benefit to continue to offer coverage to most former employees and their dependents for 18 to 36 months or until they become covered under another plan. The employee is responsible for the payment of premiums.

Creditable coverage - Time spent in a health plan as defined by HIPAA which is: (1) counted toward decreasing preexisting condition exclusion periods in the group market; and (2) used as a condition of eligibility in the individual market. Creditable coverage includes coverage under: a group health plan, including church plans and governmental plans; health insurance coverage, either group or individual insurance; Medicare; Medicaid; CHAMPUS; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees Health Benefits Plan; a public health plan, as defined in regulations; and a benefit plan under section 5(e) of the Peace Corps Act.

Employee Retirement and Income Security Act of 1974 - ERISA is a federal law enacted in 1974 that set minimum standards of information disclosure and fiduciary responsibilities in the establishment, operation, and administration of employee benefit plans, including group life, pension, and health plans. Employers that self-insure under ERISA are exempt from state insurance regulation.

Group Health Plan - An employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise and includes governmental and church plans.

Guaranteed issue - Guaranteed issue laws require carriers to offer coverage without regard to any factor.

Guaranteed renewal - Guaranteed renewal laws require carriers to renew coverage unless the employer or individual has breached the contract in specified ways (i.e. nonpayment of premiums, fraud).

Health insurance issuers - An insurance company, insurance service, or insurance organization, including an HMO, which is licensed to engage in the business of insurance in a state and which is subject to state laws that regulate insurance. A health insurance issuer is not a group health plan.

Health Insurance Portability and Accountability Act of 1996 - The Act establishes federal standards for the availability and *portability* of group and individual health insurance coverage. The Act is designed to provide more options for maintaining health insurance for individuals who: change jobs (group-to-group); or lose jobs, become self-employed, or move to a company that does not provide health insurance (group-to-individual). It also limits the ability of employers or insurance issuers to impose preexisting condition exclusions or to use an individual's health status to deny coverage.

Health Maintenance Organization - (1) a federally qualified HMO; (2) an organization recognized under state law as an HMO; or (3) a similar organization regulated under state law for solvency in the same manner and extent as an HMO.

Individual market - Insurance market for health insurance coverage offered to individuals other than in connection with a group health plan.

Large Employer - An employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

Large Group Market - The health insurance market under which individuals obtain health insurance coverage through a group health plan maintained by a large employer.

Multiple Employer Welfare Arrangements - Multiple Employer Welfare Arrangements (MEWAs) provide health benefits for employees of two or more employers who join together to purchase coverage. Health plans offered by trade or industry associations, or Chambers of Commerce are all examples of MEWAs. MEWAs can self-insure or purchase insurance from plans which are regulated by states.

National Association of Insurance Commissioners - The National Association of Insurance Commissioners represents the nation's chief insurance regulatory officials of the 50 states, the District of Columbia, and four U.S. territories.

Network Plan - A network plan refers to health insurance coverage provided by a health insurance issuer, under which the financing and delivery of medical care are provided, in whole, or in part, through a defined set of providers under contract with the issuer.

Portability - Portability laws require carriers to: (1) limit preexisting condition waiting periods; (2) credit previous coverage to reduce any applicable waiting period; and (3) cover whole groups covered under a previous policy when a group plan is replaced.

Preexisting condition - Preexisting condition is any medical condition that has been diagnosed or treated within a specified period immediately preceding the covered person's effective date of coverage.

Small employer - An employer who employed an average of at least 2, but not more than 50, employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. States may define small employer more broadly.

Small group market - The health insurance market under which individuals obtain health insurance coverage through a group health plan maintained by a small employer.

Viatical settlement benefits - Amounts received for the sale or assignment of a life insurance contract to a qualified viatical settlement provider when the insured is either terminally ill or chronically ill. By meeting the requirements set forth in HIPAA, the insured may receive these benefits before dying without incurring federal tax liability.

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