Bulletin 86

COMPLIANCE WITH
THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

September 5, 1997

This Bulletin is directed to all group health plans, health insurance carriers, health maintenance organizations, and all other entities providing health insurance in the state of Indiana. The Department of Insurance will be enforcing the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Under HIPAA, 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 and group plan sponsors, in connection with group health insurance coverage, is not preempted unless the standard or requirement prevents the application of a federal requirement.

While this Bulletin is not intended to be inclusive of all HIPAA requirements, it does provide guidance on specific provisions. Group health plans ("Plans") and health insurance issuers ("Issuers") should refer to HIPAA for specific guidelines on the provisions summarized below.

I. Group Plans

A. Preexisting Condition Defined -- A condition that required medical advice, diagnosis, care, or treatment within the 6-month period ending on the enrollment date. This affects Indiana law at IC 27-8-5-19(b)(5).

1. A preexisting pregnancy cannot be subject to a preexisting condition exclusion.

2. A preexisting exclusion cannot be applied to newly born and adopted children if the child is added to the coverage within thirty (30) days of birth or placement.

B. Preexisting Condition Exclusion -- Preexisting condition exclusion periods are limited by creditable coverage. Coverage is no longer creditable after a sixty-three (63) day lapse in coverage. A preexisting condition exclusion is limited to twelve (12) months or eighteen (18) months for late enrollees. This affects Indiana law at IC 27-8-5-19(b)(5).

C. Special Enrollment Periods

1. Issuers and Plans are required to provide special enrollment to employees who meet the following criteria:

a) The employee or dependent was already covered when the plan was offered;
b) The employee or dependent stated in writing that coverage was declined because of other coverage (only if employee was notified by plan sponsor or issuer that such a statement was required);
c) The individual exhausted his/her COBRA benefits or the individual lost eligibility for some other coverage; and
d) Enrollment is requested for the group plan within thirty (30) days of loss of coverage.

2. Dependents -- If a plan offers dependent coverage, the plan shall provide a special enrollment period when a person becomes a dependent through marriage, birth, adoption, or placement for adoption.

D. Issuers and Plans are prohibited from establishing rules for eligibility or continued eligibility based on health status related factors, which include:

1. health status;
2. medical condition;
3. claims experience;
4. receipt of health care;
5. medical history;
6. genetic information;
7. evidence of insurability (including conditions arising out of acts of violence); and
8. disability.

E. Guaranteed Renewability -- Issuers must renew policies with the following exceptions:

1. nonpayment of premiums;
2. fraud;
3. violation of participation or contribution rules;
4. termination of coverage; or
5. movement outside service area.

F. Methods of Assessing Creditable Coverage -- Preexisting condition exclusion periods are limited by periods of creditable coverage. HIPAA requires one of two methods of assessing creditable coverage.

1.Standard method -- A Plan or Issuer shall count a period of creditable coverage without regard to the specific benefits covered during the period. The Plan or Issuer can disregard specific benefits covered and include all periods of coverage from qualified sources.

2.Alternative Method -- By electing the alternative method, a Plan or Issuer can examine prior coverage on a benefit-specific basis and exclude from creditable coverage for the allowable exclusion period any categories or classes of benefits not covered under the most recent prior plan. If the alternative method is chosen, Plans or Issuers must disclose its use at the time of enrollment or sale of the plan, and apply it uniformly.

a) When using the alternative method, a Plan or Issuer may credit coverage for any or all of the following five categories of benefits:

(1) Mental health;
(2) Substance abuse treatment;
(3) Prescription drugs;
(4) Dental care; and
(5) Vision care.

b) When using the alternative method, the Plan or Issuer determines if an individual has coverage within a category of benefits, regardless of the specific level of benefits provided within that category.

II. Small Group Plans -- HIPAA contains additional provisions applicable to the small group market

A. Small Group Defined -- groups with two (2) to fifty (50) employees on a typical business day. This affects Indiana law at IC 27-8-15-14.

B. Preexisting Condition Exclusions -- Limited to nine (9) months or fifteen (15) months for late enrollees. This affects Indiana law at IC 27-8-15-27 and IC 27-8-15-28(b).

C. Guaranteed Issue in the Small Group Health Insurance Market

1.Issuers must make available all actively marketed products offered by the Issuer in the small group market.
2.Issuers shall provide to the Department of Insurance, on or before 10/1/97, a file-stamped copy of all forms that were actively marketed on July 1, 1997.

III. Individual Market

A. Alternative Mechanism -- The Indiana Comprehensive Health Insurance Association ("ICHIA") has been determined to be an acceptable alternative mechanism. Thus, the guarantee issue requirements of HIPAA do not apply to the individual market in Indiana. Pursuant to state regulation, individuals who are "federally eligible" as defined HIPAA qualify for an individual health insurance policy through ICHIA.

B. Individual Guaranteed Renewability -- Issuers are required to renew coverage. At the time of coverage renewal, an Issuer may modify the 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.

IV. Certificate of Creditable Coverage -- Creditable coverage gives credit for previous health coverage against the application of a preexisting condition exclusion period when moving from one group health plan to another, or from an individual policy to a group health plan. Plans and Issuers in the group and individual market are required to issue certificates.

A. No certificate is required to reflect periods of coverage before July 1, 1996. Beginning on July 1, 1996, Plans and Issuers are required to maintain coverage information.

B. For individuals who cease coverage from July 1, 1996, through September 30, 1996, Plans and Issuers are only required to provide certificates upon written request.

C. For individuals who cease coverage beginning October 1, 1996, HIPAA requires Plans and Issuers to provide certificates automatically as follows:

1. From October 1, 1996, through May 31, 1997, Plans and Issuers have the flexibility to issue a certificate or to provide individuals, with a " notice in lieu" of a certificate; and
2. Beginning June 1, 1997, Plans and Issuers must provide certificates for individuals upon termination.

D. Issuance of Certificates

1. Automatic issuance shall occur in each of the following events:
    a) Upon termination of life health plan without regard to qualification for COBRA continuation coverage; or
    b) Exhaustion of COBRA continuation coverage.
2. Certificates shall be issued upon request within a reasonable time period.

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