

National Patient Advocate Foundation

Health Insurance Portability and Accountability Act (HIPAA)

Background and Analysis of Achievements and Gaps

Background on Health Insurance

Health insurance in America is provided through a patchwork of private plans and public programs. According to the U.S. Census Bureau, in 2005, approximately 60 percent of Americans had group health insurance coverage (generally employment-based, the vast majority through self-insured plans) and nine percent had directly purchased health insurance through the individual market. Additionally, roughly 27 percent of the population had government benefits, including 13 percent with Medicaid/State Children's Health Insurance Program (SCHIP), 14 percent with Medicare, and four percent with military health insurance. In total, approximately 16 percent of the population was uninsured.¹

Historically, regulation of insurance has been a state responsibility. The McCarran-Ferguson Act of 1945 reaffirms the power of the states to tax and regulate the business of insurance and provides that only those federal laws that directly relate to the business of insurance can invalidate state laws relevant to the regulation or taxing of insurance. All states have established laws and regulations concerning the provision of health insurance.

While states retain regulatory authority over the business of insurance, the federal government plays a significant role in ensuring the availability, affordability, and adequacy of health insurance through public programs, tax preferences, and regulatory policy. The federal government's public programs include Medicare, Medicaid, SCHIP, and military health insurance. Individuals must qualify for these programs through age, income or disability. States must provide matching funds for the Medicaid and SCHIP programs.

Generally, the federal government often uses tax policy to increase access to private insurance. The most significant federal tax policy affecting access to private health coverage is the longstanding federal policy to exclude from taxable income employer-paid insurance premiums.² Neither employer nor employee must pay income or employment taxes on these costs. Other tax benefits include an allowance for individuals who itemize to deduct health insurance premiums and other costs that exceed 7.5 percent of adjusted gross income, and several tax advantaged accounts to pay for qualified medical expenses, generally through a high-deductible health plan. In addition, self-employed individuals can deduct 100 percent of their health insurance premiums.

The federal government from time to time has passed legislation directly affecting and regulating the business of insurance. The Employee Retirement Income Security Act of 1974 (ERISA) provided for minimum federal standards for private-sector, employer-sponsored, self-

¹ These numbers do not add up to 100 percent because some people have more than one type of coverage.

² On January 23, 2007, President George W. Bush announced his health care initiative during the State of the Union address, "The president's plan includes two parts: reforming the tax code with a standard deduction for health insurance so all Americans get the same tax breaks for health insurance and helping states make affordable private health insurance available to their citizens." - *According to the White House State of the Union Fact Sheet*

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insured health plans.³ ERISA pre-empts state laws for issues that relate to employee benefit plans.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides an opportunity to individuals who have lost their health insurance coverage due to a change in work or family status to purchase continuation of coverage for a limited period of time. The law requires an employer with 20 or more employees to provide the option to affected individuals to purchase 18 to 36 months of coverage. Employers are not required to pay for the coverage, and the beneficiary can be charged up to 102 percent of premiums.

HIPAA and Its Achievements

The most recent significant federal attempt to regulate health insurance came through the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). This law guarantees the availability and renewability of health insurance coverage for certain employees and individuals and limits the use of preexisting condition restrictions. HIPAA establishes federal standards for insurers, health maintenance organizations (HMOs), and employer-provided health plans, irrespective of whether they are self-insured. However, it provides significant state flexibility in enforcing compliance with the requirements imposed on insurers.

HIPAA's primary accomplishments related to health insurance portability include the following:

- (1) *Ensures that individuals changing jobs or losing their jobs are not denied health insurance because they have preexisting medical conditions.*

Group plans, including self-insured plans, may not prohibit an individual from receiving health coverage on the basis of health status or require such individuals to pay premiums or contributions that are greater than similarly situated individuals. HIPAA requires similar availability for *certain eligible individuals* seeking to move from the group market to the individual market. **An eligible individual must have: creditable health insurance coverage for 18 months or longer with the most recent coverage under a group health plan, exhausted any COBRA coverage, no eligibility under an employment-based plan or government plan, and no breaks in coverage of 63 days or greater.**

- (2) *Limits the length of the period prior to when a plan must begin to cover preexisting medical conditions for participants and beneficiaries in group health plans.*

HIPAA has several provisions that address these issues. First, HIPAA establishes the concept of creditable coverage, that is, credit for previous insurance when applying for a

³ Employer-sponsored, self-insured health plans are plans in which employers pay insurance claims directly out of company funds.

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new plan. Creditable coverage is defined as coverage under a variety of public and/or private health plans without a break in coverage of 63 or more days. Second, it permits a “look-back” period of six months prior to the enrollment date to identify a preexisting illness.

With regard to the group market, a group health plan is prohibited from imposing more than a 12-month preexisting condition limitation period (18 months for late enrollees) for participants or beneficiaries moving from one group plan to another group plan or from individual to group coverage. Furthermore, HIPAA requires that the preexisting condition limitation period be reduced by the amount of an individual’s creditable coverage. However, plans have the option of examining prior coverage on a benefit-specific basis for the following categories of benefits: mental health, substance abuse treatment, prescription drugs, dental care, and vision care.

The rules are far more complex for individuals moving from group coverage to the individual market. In general, HIPAA guarantees the availability of a plan (i.e. guaranteed issue) and prohibits preexisting condition exclusions for certain eligible individuals moving from group health insurance to individual insurance. Enforcement of these provisions is relegated to the states, which have the option of enforcing the HIPAA guarantees (known as federal fallback) or creating an acceptable alternative state mechanism, such as a state high-risk pool.

States that choose federal fallback must require all health insurance issuers operating in the individual health insurance market to offer coverage to all eligible individuals and prohibit the placing of any limitations on the coverage of preexisting conditions. Again, an eligible individual must have: creditable health insurance coverage for 18 months or longer with the most recent coverage under a group health plan, exhausted any COBRA coverage, no eligibility under an employment-based plan or government plan, and no breaks in coverage of 63 days or greater.

A state may choose to meet the HIPAA requirements by implementing a qualified high-risk pool or other mechanism specified in the law. Thirty-three states have implemented a high-risk pool; however, these pools have several limitations. First, many states do not have an established high-risk pool. Second, some states may have a high-risk pool but they may be small and/or unfunded. This exists since high-risk pools are prohibitively expensive despite the fact that most states limit premiums from 125 to 200 percent of market rates. Lastly, even if a state has a high-risk pool, waiting periods still apply and during this time, no reimbursement for services needed in the treatment of a preexisting condition are granted.

- (3) *Provides for limited guaranteed issue for employers who choose to purchase coverage.*

HIPAA requires insurers, HMOs, and other issuers of health insurance selling in the small group market (i.e., selling to employers with two to 50 employees) to accept any small employer that applies for coverage.

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- (4) *Provides for limited guaranteed renewal for employers.*

HIPAA requires all health insurance issuers to continue coverage for any group regardless of health status or utilization if the group requests renewal.

- (5) *Prohibits discrimination on the basis of health status.*

Group health plans are prohibited from refusing to enroll individuals with a history of illness, disability, or high medical expenses and may not drop coverage for someone who becomes sick or begins to increasingly utilize medical care.

HIPAA Gaps

While it has made significant progress in making health insurance available to individuals with chronic illnesses, HIPAA has not provided a comprehensive solution. The most significant gaps in HIPAA are as follows:

- It does not address the growing number of employers that are electing to discontinue offering health insurance to employees. Individuals with preexisting conditions continue to face challenges accessing affordable and adequate health insurance. The legislation does not require employers to offer health insurance.
- It does not address the cost of health insurance, particularly in the individual market, although some states do impose some limits on health insurance premiums. While health insurance is ostensibly available to individuals with preexisting conditions, frequently the cost of an individual plan is prohibitively expensive. In these situations, cost can act as a de facto limitation on the availability of health insurance for individuals with preexisting illnesses.
- Allowing 12-18 month periods when coverage of preexisting conditions is limited can permit life-threatening situations to develop, particularly for those individuals who are chronically ill. Moreover, the six-month “look-back” period that can trigger preexisting condition exclusions from coverage may be inappropriately long for people with chronic conditions.
- In determining whether an individual has prior creditable coverage, plans have the option of examining prior coverage on a benefit-specific basis for five categories of benefits, including prescription drugs, on which virtually every chronically ill person depends. This could lead to individuals being underinsured and lacking coverage for essential benefits and services.
- HIPAA primarily is designed to assist individuals moving from a group plan to a group plan. The protections relative to an individual moving from a group plan to the individual market are substantially weaker, and the law does not provide any

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protections for an individual seeking to move from an individual plan to an individual plan.

- HIPAA requires an individual moving from a group plan to the individual market to exhaust COBRA coverage before becoming eligible for individual coverage under HIPAA. COBRA coverage can be prohibitively expensive. Additionally, many states have elected to satisfy their HIPAA requirements by creating high-risk pools to cover otherwise “uninsurable” individuals. These high-risk pools generally have very long waiting lists and high premiums. The pools also run at a loss, which means that they require significant government subsidies to remain financially viable. (For more information, see the National Patient Advocate Foundation State High-Risk Pool Primer.)
- The “guaranteed issue” provisions of HIPAA apply only to those insurers selling to small employers. Larger employers receive no such protection.