Getting & Keeping Health Insurance – Open Enrollment is Now Mandated for State Bar of Arizona Endorsed Major Medical Insurance Plan

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SYNOPSIS: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that insurance plans renewed after July 1, 1997 include guaranteed access and renewability. To comply with HIPAA guidelines, the major medical health insurance program endorsed by the State Bar of Arizona will be offering a 60 day open enrollment beginning March 1, 1999. Present law requires that all such plans offer limited open enrollment on an annual basis.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA),[1] was signed into law by President Clinton on August 21, 1996 and was slated to become effective for insurance plans renewed following July 1, 1997. The Act affects several different areas of the insurance industry including:

- The individual and group major medical markets related to guaranteed access and guaranteed renewability.
- Establishment of a pilot program with tax credits for medical savings accounts (MSAs).
- Long term care insurance and "federally qualified" plans.
- Preventing fraud and abuse, administrative simplification and medical liability reform.

This article will focus only on the first area addressed, the changes in individual and group insurance related to guaranteed access and guaranteed renewability of coverage.

If you have been following this issue, you may remember it as the Kassebaum-Kennedy Bill. It's primary concern initially was to protect individuals with significant health problems from "job lock," allowing them to maintain health coverage when they change

jobs, lose jobs or leave a group plan to become self employed or to enter a job market where health insurance is not available.

HIPAA was heralded as the first major federal healthcare bill in 30 years which would produce sweeping changes in the U.S. healthcare market for individuals, employers, insurers and healthcare providers. You probably haven't heard much about it since and may be wondering what ever happened to HIPAA.

Actually, a great deal of activity has been going on behind the scenes. Following passage of the bill, the federal government struggled for months to publish interim rules explaining what HIPAA meant. The state insurance departments across the country have been scrambling to maintain control over their bureaucratic domains because the statute provides that the federal government will take over enforcement of HIPAA in any state that fails to substantially enforce the provisions of HIPAA. In Arizona this prompted the passage of SB1321 in the session that ended in April, 1997. The insurance companies are trying to figure out how all the other insurance companies are going to interpret this law in order to avoid being the first on the block to offer coverage to previously uninsurable applicants and to assure that they wind up insuring no more than their "share" of such individuals. Insurers have never stopped being fearful that open enrollment will attract an adverse selection of sick insureds. HIPAA mandates the same rules for all insurers so the playing field should be even. As all of the maneuvering settles out and as actual enforcement and penalties for noncompliance are swinging into place, we will no doubt see the impact of HIPAA more clearly over the next few months.

While HIPAA may do a very good job of alleviating the "job lock" situation for individuals who are already insured in an employer/employee group major medical program, it addresses problems for individuals to a much lesser extent. HIPAA is limited in scope in a number of areas: underwriting is still allowed with regard to setting rates (some states are looking hard at this and a few have restricted rate discrimination); employers are not required by this law to offer coverage; rates are not controlled by HIPAA and rate increases are anticipated as a result of the wider availability of coverage, and eligibility for individuals outside of the employer group context is limited.

One of the areas that will assist insureds in both the group and individual areas, is the

HIPAA definition of a pre-existing condition.

Pre-Existing Conditions

The pre-existing condition limitations in policies prior to HIPAA varied in terms of both the definition of a pre-existing condition itself and the period of time for which the policy might exclude coverage for that pre-existing condition. Typically, a pre-existing condition was defined as a condition for which, within 12 months of the effective date, the individual received medical advice, diagnosis, care or treatment or for which *a prudent person would have sought care prior to the effective date of the insurance*. The policy exclusion for such a condition was typically 12 or 24 months following the effective date of the policy.

HIPAA standardized pre-existing limitations in policies, both group and individual. In compliance with HIPAA, A.R.S. 20-2301 now defines a pre-existing condition as, "A condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under a health benefits plan issued by an Accountable Health Plan. A genetic condition is not a preexisting condition in the absence of a diagnosis of the condition related to the genetic information and shall not result in a preexisting condition limitation or preexisting condition exclusion." In addition, no preexisting condition exclusion may be imposed on pregnancy.

This represents a significant change not only in limiting the definition to conditions treated for six months prior, instead of 12 months prior to the effective date, it also eliminates the "prudent person rule." An applicant can now apply for coverage when symptoms lead them to suspect a medical need. As long as they have not seen a medical professional prior to the effective date of the policy, the condition is not considered to be pre-existing. If a condition is considered pre-existing under the new more limited definition, coverage can be excluded for 12 months under normal policy provisions or for 18 months for an employee who enrolls after their initial eligibility dates.

Waiver of Pre-Existing Limitations

In addition to redefining a pre-existing condition and limiting the period of time that it

can be excluded, HIPAA allows it to be waived altogether under certain circumstances. For employees and their dependents who change jobs, HIPAA requires that the coverage restriction for pre-existing conditions be reduced by the number of days that they had prior "creditable coverage." (Almost anything that looks like health insurance is "creditable coverage.") If the individual has been insured long enough to satisfy the pre-existing limitation with no gaps in coverage of more than 62 days, he or she will be able to transfer to another group policy without having to re-satisfy any pre-existing limitations. (The 62 day gap in coverage does not count any waiting periods required by the employer before eligibility for coverage.)

For an individual joining an employer's major medical plan from an individual plan, credit for continuous coverage under the prior individual plan will be given toward pre-existing conditions under the new plan.

For a person who has individual coverage and loses that coverage or wants to change that coverage to another individual plan, the options are considerably more limited. That individual can move to a new group, employer/employee, insurance program without having to re-satisfy the pre-existing condition, assuming he or she has had coverage for 12 or 18 months without a gap of more than 62 days. However, such an individual cannot change to another individual policy under the HIPAA statute without re-satisfying the pre-existing limitation. Individual policies are only required to waive the preexisting limit for "Eligible Individuals." An "Eligible Individual" is one who formerly had *group coverage* and who has an aggregate of at least 18 months of "creditable coverage" with no breaks in coverage that exceeds 62 days. In addition, he or she must have exhausted any available COBRA coverage.

Underwriting Based on Health History

Carriers who offer policies to small groups (defined in Arizona as 2-50 members) must offer all of their small group products to all groups regardless of the health histories of individuals within the group. As it stands now, small group carriers can charge higher rates for the group based on health history, but cannot increase rates for an individual within the group.

Individual insurance carriers must offer all their products, or their two most popular products, or one high end and one low end product without underwriting, but only to

"Eligible Individuals." In other words, only if you had former *group coverage* and you have exhausted any available COBRA coverage will you qualify without underwriting. That will allow someone retiring from a firm with prior coverage to retire or to go into a smaller practice without losing coverage. However, it is small comfort for anyone with individual coverage who wants to change carriers or who loses their individual policy for any reason.

Renewability

For companies offering coverage to small groups, they must renew all groups regardless of their claims experience unless they withdraw completely from the market in that state. Any carrier who leaves the market would have a five year ban on re-entry into that state. Likewise, all insurance offered in the individual health insurance market will be guaranteed renewable. The only way that an individual policy could be terminated is for: (1) Nonpayment of premiums, (2) Fraud, (3) Intentional misrepresentations, (4) Moving outside of the service area, (5) Termination of membership in any applicable association, if the plan is offered through the association or (6) Termination of all individual health coverage offered by that carrier in the state.

Association Group Insurance Programs

Whether intentional or unintentional, the HIPAA legislation will provide association group programs with a unique opportunity to expand coverage for association members. The aspects of HIPAA that address guaranteed access, pre-existing conditions and guaranteed renewability are distinctly divided into application for the individual market and the group market. The group market refers to employer/employee insurance programs in which the carrier can require a specific percentage of participation by all members of the firm. Although most association programs are written on a "group" form, HIPAA specifically provides that "association" business will follow the rules of the individual market with regard to HIPAA. Based on those guidelines, association group programs therefore would only have to accept "Eligible Individuals."

However, HIPAA goes on to define a "Bona Fide Association" to include only associations that meet the following criteria:

- Actively in existence for five years:
- Formed and maintained in good faith for purposes other than obtaining insurance:
- Membership is not conditional on any “health status related factors”:
- Coverage is available to all members regardless of any “health status related factors”:
- There are no conditions for health coverage other than association membership:
- Any other state imposed requirements:

By requiring that a Bona Fide Association must offer coverage to all members regardless of any “health status related factors,” HIPAA places association group plans in a unique position with regard to the ability to offer coverage to individuals who were not previously covered under group or individual medical plans.

Most association programs are addressing the requirement that they accept all applicants regardless of prior health history, by continuing to underwrite applicants, but only with regard to the rate category for which they will qualify. Association carriers will no longer be able to discriminate with regard to eligibility for the program, nor can they place a rider excluding a specific condition. Preferred, standard and substandard rate tiers will be established to provide a rate for individuals based on their past medical history. Substandard rate classes will apply for individuals who would not qualify for standard insurance or who would have been previously declined for coverage. The important thing is that these high risk people will have access to health insurance.

Most such carriers will also limit availability of the program to specified open enrollment periods. Usually this will be a period of 60 to 90 days during which any member of the association can apply and qualify for coverage. Outside of the open enrollment, members will be able to apply for coverage only if they experience what HIPAA defines as a life change situation. This will include termination of employment, termination of COBRA coverage, marriage, the addition of a new dependent child or the loss of coverage due to divorce, annulment, separation or death of a spouse. In the absence of one of these life change situations, applicants will be able to join the association plans only during the open enrollment.

The association group carrier would still have the option under HIPAA to require

satisfaction of a pre-existing condition limitation as defined under HIPAA unless the applicant is an “Eligible Individual.” In other words, they could exclude, for up to 12 months, any condition for which you had been treated six months prior to the effective date. However, they would not be able to decline or restrict coverage for any specific condition regardless of health history.

The State Bar of Arizona Insurance Committee is very pleased to announce that the State Bar’s endorsed association health insurance program will be offering a 60 day open enrollment under the new HIPAA guidelines to all members effective March 1, 1999.

ENDNOTES:

[1] Pub. L. No. 104-191, 110 Stat. 1939, and amended Pub. L. No. 104-204, 110 Stat. 293(1196), codified at 29 U.S.C. §1181 and miscellaneous sections throughout.