August 28, 1997

TO:

COMPANY PRESIDENTS
ALL COMPANIES (INDEMNITY AND HMOs) WRITING HEALTH INSURANCE BUSINESS

FROM:

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RE:

COMPANY BULLETIN #97-4
HIPAA QUESTIONS AND ANSWERS - SET #1

The following department policies have been developed in response to inquiries regarding implementation of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-911, and Illinois Senate Bill 802, now Public Act 90-30. These Acts are referred to as HIPAA in the following material. Additional questions and answers will be released in the future as necessary.

UNFAIR TRADE PRACTICES

1A. Q. Is it permissible for issuers not to pay commissions or to substantially reduce commissions to insurance producers who market "guaranteed issue" products? Can an issuer make a distinction for commission payment levels based upon a "good risk" or a "bad risk"?

A. No. Paying no commission or a reduced commission to discourage insurance producers from placing "bad risks" (those with substandard expected loss ratios due to health status factors) is an unfair trade practice which circumvents HIPAA. It is acceptable to have varied commission schedules based on group size or number of sales or to pay commissions only on the standard portions of the premium and not on surcharges for smokers or other substandard underwriting risk factors. Reference: 215 ILCS 5/421 et. seq.

1B. Q. Can an issuer automatically charge 200% of the standard rate to a nonstandard risk that is rated 125% of the standard rate?

A. No. This or similar rate gouging is an unfair trade practice which will lead to lack of availability or accessibility in the market. Reference: 215 ILCS 5/421 et. seq.

ALL PRODUCTS ISSUES

2A. Q. If an issuer marketing in the small group market prior to 7/1/97 offers only products A and B to groups of 2-25 and only products C and D to groups of 26-50, under HIPAA requirements, will the issuer be required to guarantee issue all products (A, B, C, and D) to all groups between 2-50?

A. Yes. It is a requirement that the issuer offer all products that are approved for sale in the small group market to all small employers. For managed care products, if the issuer does not have a network in a particular area, it would not be required to offer the product in that area. The issuer would not have to establish a network. Reference: Interim Rules, Section 45 CFR 146.150(a)(1) and Section 146.150(c)(1)(i).

2B. Q. Does it make a difference if the issuer uses different underwriting guidelines or distribution methods, etc.?

A. No. Such differences do not affect the guaranteed issue requirement. Reference: Interim Rules, Section 45 CFR 146.150.

2C. Q. According to Illinois Statute, certain benefits such as infertility are mandated for employer groups of more than 25 employees. "Bare bones" or "no frills" policies are allowed for groups 25 and under. HIPAA contains an "all products guarantee" in the small group market. Would this require that mandated benefits and bare bones policies be offered to all small employer groups of 2-50?

A. Issuers may include variable language in their small group products to address infertility coverage. Issuers must offer all products with all mandates included to groups of 2-50. Issuers are only required to sell infertility coverage to employers with more than 25 employees. To avoid the conflict between the infertility mandate and bare bones policies, companies may voluntarily withdraw their existing bare bone policies or the Department will disapprove them. (Currently there are approximately 20 bare bone policies approved by the Department, but only a handful have been sold.)

2D. Q. What about federal mandated benefits such as maternity for groups 15 and over?

A. Federal mandates require the employer to include certain benefits in their plans. These federal mandates must be offered to all small groups by the issuer. Since the onus for compliance is on the employer, the federal mandated benefits do not have to be included in plans to which the federal law does not apply.

DISCONTINUANCE AND REPLACEMENT

3A. Q. In a replacement situation, at what point does the succeeding carrier become liable for health coverage for an employee?

A. The succeeding carrier would be liable for all expenses covered under its policy, except those excluded by unsatisfied preexisting conditions exclusions, as of the effective date of the new policy. Reference: 215 ILCS 5/367i.

3B. Q. Can plans still use the "Actively At Work" clause?

A. Yes. But this clause cannot be used to deny eligibility when the employee is not working because of a health related condition.

3C. Q. If there is an extension of benefits provision, for what coverage does the prior carrier remain liable?

A. By Illinois Statute, the prior carrier remains liable for coverage that had been in force under its policy in instances where there is no "similar" or "like" coverage by the succeeding carrier. Examples would be when the disabled individual does not have enough creditable coverage to waive the succeeding carrier's preexisting condition clause or the new policy does not provide coverage for the disabled person's condition. The statute requires that coverage under the extension continue until the succeeding carrier becomes liable or the extension period ends, whichever is sooner. However, specific extension of benefits language in the prior carrier's contract may result in both the prior carrier and the succeeding carrier being liable for coverage. Reference: 215 ILCS 5/367i.

LATE AND SPECIAL ENROLLMENT

4A. Q. HIPAA has special rules for late enrollees (employees who do not take coverage when first eligible). Under what circumstances can late enrollees in a plan be denied coverage?

A. A determination must be made that either all late enrollees will be accepted by the plan or all late enrollees will be denied by the plan. In no event can a specific employee be denied as a late enrollee, even for a health related condition. Reference: Interim Rules, Section 45 CFR 146.121.

4B. Q. Who decides to accept or deny late enrollees, the employer or the issuer?

A. The issuer is not required to accept late enrollees. At the issuer's option, issuers and employers may negotiate the acceptance of late enrollees by the plan. Reference: Interim Rules, Preamble to Section 45 CFR 146.150.

4C. Q. If an employer offers multiple products such as a straight indemnity product and a HMO product to employees, can late enrollees be denied under one product and not the other (i.e., by product)?

A. No. The determination to accept late enrollees should be done for the entire group plan regardless of the products in the plan. Reference: Interim Rules, Preamble to Section 45 CFR 146.150.

4D. Q. In the event a "special enrollment period" exists due to the exhaustion of COBRA by a dependent, can the dependent enroll in the plan if the employee is not currently covered?

A. No. In order to enroll the dependent, the employee must also enroll in the plan under the special enrollment period rules. Reference: Interim Rules, Section 45 CFR 146.117(b).

HEALTH CONDITIONS

5A. Q. Can issuers require that employees and their dependents within a group complete health condition information forms?

A. Yes. Such information may be collected to determine the premiums for the group. Health condition information may not be used for any underwriting purpose or to exclude or limit coverage.

5B. Q. Can a rider that excludes benefits for a specific individual's condition be attached to the group contract or employee certificate?

A. No. Reference: Interim Rules, Preamble to Section 45 CFR 146.150.

5C. Q. Do riders that exclude benefits for a specific individual's condition that currently are attached to a group contract or employee certificate have to be removed at group renewal or if a new carrier takes over the group?

A. Yes. In either case they must be removed. Reference: Interim Rules, Section 45 CFR 146.111.

5D. Q. In the small group market, are rescissions based on health conditions permitted?

A. No. Issuers are required to guarantee issue in the small group market. As group issue may not be based on health conditions, rescissions based on health conditions are not permitted. When a lower than appropriate premium results from misrepresentation of health conditions, by either the employer or the employee, the appropriate remedy would be to adjust the premium. An issuer could only rescind a small group policy or employee certificate for fraud.

5E. Q. Can a carrier still use Standard Industrial Classifications (SIC) codes for rating purposes (industry loads)?

A. Yes. The codes may only be used to rate the group as a whole and not applied on an individual employee basis.

INDIVIDUAL GUARANTEED RENEWABILITY

6A. Q. May issuers continue to terminate individual policies if an issuer determines there is duplicate coverage, such as in a group plan?

A. No. The guaranteed renewability provisions of HIPAA list specific cases when issuers can terminate an individual policy. It is quite clear that contracts may not be terminated for duplicate coverage because of the guaranteed renewability provisions. Reference: 45 CFR 148.200.

6B. Q. What, if any, coordination with Medicare is permitted in Illinois in the case of individual policies sold prior to Medicare eligibility?

A. The guaranteed renewability provisions and the interim rules allow coordination with Medicare if state law allows coordination. The Illinois Minimum Standards of Individual Accident and Health Insurance (50 Ill. Adm. Code 2007) would appear to allow an exclusion of benefits provided under Medicare (50 Ill. Adm. Code 2007.60(e)(8)). Therefore, if a policy contains such a provision, exclusion of Medicare covered benefits would be appropriate. This is consistent with the anti-duplication provisions of OBRA.

6C. Q. May existing (issued) contracts not containing an exclusion for benefits provided under Medicare be amended at renewal to include the exclusion?

A. Yes. The modification must be consistent with Illinois law and effective uniformly for all individuals with the policy form. Reference: Interim Rules, Section 45 CFR 148.122(g).

PREEXISTING CONDITIONS AND CREDITABLE COVERAGE

7A. Q. While covered under employer A's group plan, an employee becomes pregnant. Employer A's group plan provided maternity benefits. During the 7th month of pregnancy, the employee changes jobs and goes to work for employer B, immediately applying for group coverage even though employer B does not offer maternity coverage. Must employer B's group plan provide maternity benefits?

A. No. As employer B's group plan does not provide maternity coverage, it would not have to provide benefits. HIPAA prohibits pregnancy from being considered as a preexisting condition, but it does not require maternity coverage. Reference: Interim Rules, Section 45 CFR 146.111.

7B. Q. Does an issuer have to reduce the preexisting conditions limitation period because of creditable coverage if the person has duplicate coverage?

A. Yes. HIPAA does not provide exceptions for duplicate coverage.

7C. Q. When should student coverage be considered creditable coverage?

A. Coverage through a student health plan that is considered a bona fide association or an individual association is creditable coverage. Short term coverage is not. Reference: Interim Rules, Preamble to Section 45 CFR 148.

HIPAA CHIP ISSUES

8A. Q. Will application, enrollment procedures and benefits for HIPAA CHIP (federally eligible) enrollees differ from those for original CHIP (non-federally eligible) enrollees?

A. Yes. There will be different applications and eligibility requirements. For instance, federally eligible individuals will not need rejection letters. CHIP has prepared a worksheet for applicants to use in determining which application to complete. Benefits will be essentially the same in both plans. HIPAA CHIP enrollees will not be subjected to a preexisting condition exclusion.

8B. Q. An employee covered under a group plan for 20 months reaches the lifetime maximum benefit amount. The employee is not entitled to either COBRA or state continuation coverage. Assuming the employee applies within 63 days of the date the employee reached the lifetime maximum benefit amount under the group plan, does the employee qualify as a federally eligible individual for coverage in HIPAA CHIP?

A. Yes. Reference: Interim Rules, Section 45 CFR 148.103.

8C. Q. An individual leaves an employer group plan after 3 months and elects a conversion policy. Is this individual subsequently eligible for coverage in HIPAA CHIP?

A. No. A conversion contract (even if issued on a group basis) is considered an individual contract and does not meet the requirements of eligibility for HIPAA CHIP. Reference: Interim Rules, Preamble to Section 45 CFR 148.103.

DISCLOSURES, CERTIFICATIONS AND NOTICES

9A. Q. Should issuers provide a disclosure to applicants for conversion policies or other individual policies?

A. Yes. They should disclose that there is no "individual to individual" portability, and such a coverage choice will eliminate federal eligibility for HIPAA CHIP. While not specifically required by HIPAA, such disclosure fits the spirit of the law. The Department intends to require such a disclosure with a new regulation. In the interim, the Department requests voluntary compliance.

9B. Q. HIPAA requires small group carriers to provide disclosure regarding renewability provisions, benefits, premiums available, etc. for all plans for which the employer is qualified. Is Illinois applying any sort of "fleet rule" to this, wherein products for affiliated companies are required to be disclosed?

A. No.

9C. Q. Within what period of time after termination of coverage should an issuer provide an insured with a certification of creditable coverage?

A. Carriers should provide certifications within 30 days of :

1. receipt of notification of termination of an individual;

2. policy lapse; and/or

3. receipt of request from individual even if coverage has not terminated (see question 11 in model certificate in Interim Rules).

9D. Q. When should the "Notice to Individual of Period of Preexisting Condition Exclusion" be provided?

A. The Interim Rules indicate it should be provided within a reasonable amount of time. The Department considers within 30 days to be a reasonable amount of time. Reference: Interim Rules, Section 45 CFR 146.115.