Approved: March 6, 1997

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Carlos Mayans, at 1:30 p.m. on March 5, 1997 in Room 423-S of the State Capitol.

All members were present.

Committee staff present: Lois Hedrick, Committee Secretary

Conferees appearing before the committee:
Bill Wolff, Ph.D., Kansas Legislative Researcher
Tom Wilder, Chief, Government and Public Affairs Division, Kansas Insurance Department

Others attending: See Guest List (Exhibit 1).

The minutes of the committee meetings held on February 17, 18, 19, 20, and 24, 1997, were approved.

Chairperson Mayans introduced Dr. Bill Wolff, Kansas Legislative Researcher, who presented an outline of the provisions of the Health Insurance Portability and Accountability Act of 1996, commonly called the Kassebaum/Kennedy bill (see Exhibit 2). Dr. Wolff described the various Kansas statutes needing amendments this session to assure qualifying requirements for health insurance plans available to be sold in Kansas meet the provisions of the new federal law. If Kansas does not meet the new federal requirements, the federal law will rule. The Insurance Department's suggested amendments are put forth in **SB 204** (health insurance reform act), which has been amended and passed by the Senate and is now in the House Insurance Committee for consideration.

Chairperson Mayans noted the differences concerning individual long-term care policies in the current Kansas law and the Kassebaum/Kennedy law, stating that for placement in a long-term care facility the patient currently needs only a certification from a physician. The new federal law requires that a patient be unable to perform two activities (like eating or bathing themselves) in order to enter such a care facility. Chairperson Mayans stated this is an important consideration for seniors; and pointed out that other states have looked at Kansas with envy as this state takes care of our seniors under the current law. With this reform, Kansas may change that requirement and seniors will be hurt in the change.

Tom Wilder, of the Kansas Insurance Department, presented an overview of the provisions of the Kassebaum/Kennedy act (see Exhibit 3) listing the areas of reform which causes Kansas to consider amendments to its laws relating to health insurance. Mr. Wilder directed attention to the overview of **SB 204** (see Exhibit 4).

Mr. Wilder also directed attention to the chart concerning the new federal act, comparing the various provisions as they apply to large and small groups and to individuals (see Exhibit 5). Mr. Wilder also noted the chart (Exhibit 6) setting out the options states have in deciding the changes needed to be made to meet the federal law and the various mechanisms to be considered.

Chairperson Mayans thanked Dr. Wolff and Mr. Wilder for their presentations.

Chairperson Mayans noted that **HB 2377 - Licensing of acupuncture practitioners** - was withdrawn from this committee and referred to the House Federal and State Affairs Committee on February 28, 1997.

The meeting was adjourned at 3:00 p.m.

The next meeting is scheduled for March 6, 1997.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES COMMITTEE GUEST LIST
MARCH 5, 1997

NAME	REPRESENTING
Kay Calvert	League of Women Voters of KS
Sandra Loebel	SRS Adult & Medical Services
Patty Donnelly	United Health Care
Danielle Noe	Governor's Office
HAROLD PITTS	KCOA
Meggan Griggs	CIGNA
Robert Epps	HCFA
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Marty Yost	Ks Health Care Assn
Gerard Grimaldi	Kaiser Permanente
Jim Schwartz	KECH
Dennis Tietze	KAFP DOM
Josie Torrez	Families Together
Bruce Dimmitt	Independent
Susan M. Baker	Hein & Weir
Bernie Koch	Wichita Chamber
LARRY BUENING	BD OF HEALING ARTS
Dawn Reid	KSNA
Bruce Witt	Preferred Health Systems

HOUSE HEALTH/HUMAN SERVICES
Attachment 1-1
3-5-97

HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES COMMITTEE GUEST LIST
MARCH 5, 1997

NAME	REPRESENTING
Tom Bell	Ks. Hosp Assn.
Bill Fuller	Kansas Farm Bureau
Michelle Peterson	Peterson Public Affairs

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March 4, 1997

Kassebaum/Kennedy: Federal Health Insurance Reform

The Health Insurance Portability and Accountability Act of 1996, commonly referred to as "Kassebaum/Kennedy" provides for reform of the insurance marketplace in several ways. This memorandum is an attempt to set out those reforms as they affect group plans, individual policy forms, and long-term care insurance.

Group Market Reforms
(All Large Groups Including ERISA)

Briefly, Kassebaum/Kennedy:

- defines a preexisting condition exclusion as one relating to a condition, physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;
- limits an exclusion for a preexisting condition to a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date;
- allows a health maintenance organization (HMO) to impose an "affiliation period," applied uniformly to all enrollees regardless of health status and for a period not to exceed two months, three months for late enrollees (an affiliation period is that period of time that must expire before the HMO coverage becomes effective);
- prohibits the establishment of rules for eligibility based upon health status-related factors [health status, medical condition (physical and mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, and disability];
- prohibits the imposition of any preexisting condition exclusion for newborns and adopted children within 30 days of birth or adoption;
- prohibits the imposition of a preexisting condition exclusion for pregnancy;
- limits the use of genetic information to those conditions actually diagnosed as a preexisting condition;

HOUSE HEALTH/HUMAN SERVICES
Attachment 2-1
3-5-97

- requires the portability of coverage provided there is not more than a 63-day period during which a person had no coverage (defines how coverage is to be credited—"creditable coverage"); and

- guarantees renewability of coverage, except for nonpayment of premiums, fraud, violations of participation or contribution rules, termination of coverage, movement outside of the service area, or the association membership ceases.

Small Group Market

Kassebaum/Kennedy:

- defines "small employer" as an employer who employed an average of at least two but not more that 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year;

- would permit a state to elect to include a group health plan that has fewer than two participants as current employees under coverage in the small group market;

- allows for the imposition of a preexisting condition exclusion only if it related to a condition, physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

- limits an exclusion for a preexisting condition to a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date;

- prohibits the imposition of any preexisting condition exclusion for newborns and adopted children within 30 days of birth or adoption;

- prohibits the imposition of a preexisting condition exclusion for pregnancy;

- limits the use of genetic information to those conditions actually diagnosed as a preexisting condition;

- requires the portability of coverage provided there is not more than a 63-day period during which a person had no coverage (defines how coverage is to be credited—"creditable coverage");

- requires health insurance issuers offering health insurance coverage in the small group market to accept every small employer that applies; and

- requires a health insurance issuer to renew or continue in force coverage at the option of the plan sponsor, except for nonpayment of premiums, fraud, violations of participation or contribution rules, termination of coverage, movement outside of the service area, or the association membership ceases.

Individual Market Reforms

Kassebaum/Kennedy:

- provides that insurers may not decline to offer coverage to or deny enrollment of an eligible individual or impose any preexisting condition exclusions to such coverage;

- defines "eligible individual"

  - as one who has 18 or more months of coverage and whose most recent coverage was under a group, governmental, or church health plan;

  - who is not eligible for other types of coverages enumerated in the Act;

  - who did not lose coverage because of nonpayment of premium or for fraud; and

  - who had been offered coverage under COBRA, elected the continuation coverage, and exhausted that coverage.

- permits insurers to offer alternative types of coverage, including:

  - a choice of a policy which has the largest or next to the largest premium volume of all such policies offered by the insurer in the state; or

  - a choice of a lower-level coverage policy and a higher-level policy form, each of which includes benefits substantially similar to other individual coverages offered by the insurer in the state.

- guarantees renewability of coverage at the option of the individual with certain exceptions, *e.g.*, nonpayment of premium or fraud;

- allows states to implement an "acceptable alternative mechanism" to coverage described above for eligible individuals in which all eligible individuals are provided a choice of health insurance coverage which imposes no preexisting condition exclusions; includes at least one policy form of coverage that is comparable to a comprehensive health insurance coverage offered in the individual market in the state or is comparable to a standard option of coverage available under the group or individual health insurance laws of the state; and is one of the following mechanisms:

- the Small Employer and Individual Health Insurance Availability Model Act adopted by the National Association of Insurance Commissioners (NAIC) on June 3, 1996; or

- the Individual Health Insurance Portability Model Act adopted by the NAIC on the same date; or

- a qualified high risk pool (one that provides to eligible individuals coverage or comparable coverage that does not impose any preexisting condition exclusion and which provides for premium rates and covered benefits for such coverage consistent with standards included in the NAIC Model Health Plan for Uninsurable Individuals Act); or

- other mechanisms (not a well understood option!).

If the state chooses to implement one of the "acceptable alternative mechanisms," it must notify the Secretary of Health and Human Services by April 1, 1997, that the state has enacted, or intends to enact by January 1, 1998, any necessary legislation to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of January 1, 1998, and to provide to the Secretary such information as the Secretary may require to review the mechanism and its implementation.

Long-Term Care

This part of Kassebaum/Kennedy is clearly elective, *i.e.*, nothing in the federal enactment requires the state to change its current regulation of long-term care insurance. Having said that, the long-term care provisions of the Act, if enacted for Kansas, could qualify Kansans purchasing such policies for favorable federal and state tax treatment beginning January 1, 1997.

Kassebaum/Kennedy:

- provides that a qualified long-term care insurance contract shall be treated as an accident and health insurance contract;

- defines "qualified long-term care insurance contract" as a contract that provides insurance protection for long-term care services; is guaranteed renewable; meets certain specified consumer protection standards, including disclosures and a mandatory offer of a nonforfeiture provision;

- defines "qualified long-term care services" to mean necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitating services, and maintenance or personal care services provided to a chronically ill individual as prescribed by a licensed health care practitioner;

- defines "chronically ill individual" as a person unable to perform without substantial assistance at least two activities of daily living (ADL)for a period

of at least 90 days due to a loss of functional capacity (ADLs include eating, toileting, transferring, bathing, dressing, and continence);

- provides that premiums paid for a qualified long-term care insurance contract are tax deductible on those contracts purchased after December 31, 1996, and certain other contracts purchased before that date are "grandfathered" (premiums are deductible on the following schedule: age 40 or less, $200; more than 40 but not more than 50, $375; more than 50 but no more than 60, $750; more than 60 but less than 70, $2,000; and more than 70, $2,500); and

- provides that benefits received from a qualified long-term care insurance contract do not accrue as taxable income.

Other Provisions

Kassebaum/Kennedy also provides for participation in medical savings accounts for 750,000 persons (generally employed or self-employed persons); increases deductions for health insurance costs of self-employed individuals; and changes the tax treatment of accelerated death benefits received under a life insurance contract on the life of an individual who is terminally or chronically ill.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

OVERVIEW OF THE HEALTH INSURANCE PORTABILITY AND AVAILABILITY ACT OF 1996

Health Insurance Portability and Accountability Act of 1996 (HIPAA, or K/K)

- signed by the President on August 21, 1996
- most sweeping health care legislation since passage of Employee Retirement Income Security Act (ERISA) in 1974

General Structure of HIPAA:

1) amendments to ERISA. One reason the law is so sweeping is it affects self-funded plans, and helps level the playing field by imposing standards on plans over which the states have no jurisdiction

2) parallel amendments to the Public Health Service Act (PHSA) that affect health carriers

3) amendments to the tax code for long-term care insurance, medical savings accounts and deductibility for the self-employed

Our bill focuses on number 2 - amendments to our insurance code.

Insurance Code amendments fall into three areas:

- **small group market** reforms
- **large group market** reforms
- **individual market** reforms

HOUSE HEALTH/HUMAN SERVICES
Attachment 3-1
3-5-97

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Essential elements of HIPAA:

Small group market:

1) **guaranteed issue** to

   - **all small employers** (defined as 2 - 50, but states may have groups of one in the small group market, and may go higher than 50)

   - **all eligible employees**

   - **all products** offered by a carrier in the small group market

2) **guaranteed renewability** of all policies with certain enumerated exceptions

3) **preexisting condition exclusion limitations** - limited to 6/12 (lookback, exclusion) with credit for prior coverage as long as there has been no gap in coverage greater than 63 days

Large Group market:

1) **guaranteed renewability** of all policies with certain enumerated exceptions

2) **preexisting condition exclusion limitations** - limited to 6/12 (lookback, exclusion) with credit for prior coverage as long as there has been no gap

The bill calls for a study of availability in the large group market; no guaranteed issue requirements in this market.

Individual market:

1) **guaranteed issue** to eligible individuals (those with 18 months creditable coverage, most recently in a group plan, with no break in coverage greater than 63 days

2) **guaranteed renewability** of all policies with certain enumerated exceptions

3) **no preexisting condition exclusions** may be imposed **on eligible individuals**

Pregnancy is **not allowed as a preexisting condition** in the group market, and is not allowed for eligible individuals in the individual market.

3-2

So HIPAA creates federal standards in the area of health insurance - essentially creates a floor in certain areas, below which state standards may not fall.

- state flexibility exists, however
- certain state laws specifically preempted, dealing with preex (such as 12 month lookback period in small group market)

With respect to the individual market, the federal standards will not apply if the state enacts what is called an **acceptable alternative mechanism**. There is a four-pronged test for an acceptable alternative mechanism, and the states are given many options as to how to comply.

HIPAA requires that an **acceptable alternative mechanism** meet **four requirements**:

1. It must provide eligible individuals with a **choice** of coverage;

2. It cannot impose any **preexisting condition exclusions** for eligible individuals;

3. The choice must include **at least one policy form** that is:

   (i) comparable to **comprehensive coverage** in the individual market in the state; **or**
   (ii) comparable to the **standard** plan under the state's small group or individual laws;

   AND

4. The state must be implementing **one of three** things:

   (a) one of the **two NAIC models laws** on individual market reform;

   (b) a qualified **high risk pool** as defined in the law; or

   (c) (i) a mechanism providing for **risk adjustment, risk spreading**, or a risk spreading mechanism or otherwise provides for some **financial subsidization** of eligible individuals; or

   (ii) a mechanism allowing eligible individuals a **choice of all available** individual health insurance coverage.

Additional Health Insurance Requirements

Mental Health "Parity"

- Applies to large group policies and health plans (51+ employees).
- If have caps on mental health benefits and medical and surgical - must use same annual and lifetime limits.
- Company does not have to follow mandate if they can show it would increase cost of coverage by more than 1%.
- Provision sunsets on September 30, 2001.

Mothers and Newborns Protection Act

- Health plan and insurers must provide for minimum hospital stays for mothers and newborn children at least 48 hours after a normal delivery or 96 hours after a cesarean section.
- Mother and child may come home earlier if permitted by the attending physician in consultation with mother.
- Health plan may not offer monetary incentives or rebates to mothers to encourage them to go home early.

Prepared by: Mary Beth Senkewicz (NAIC) (1/9/97)

KANSAS INSURANCE DEPARTMENT
3/3/97

Overview of Senate Bill 204 (Kassebaum/Kennedy)

Section 1 (K.S.A. 1996 Supp. 40-2209) Group Insurance Policies:

- Adopts rule that "late enrollee" does not include anyone who had other health insurance coverage (usually through a spouse), who looses that coverage and now wants to enroll in their own group health plan outside of the normal enrollment period. This is current Kansas law but our statute language does not exactly match the federal act. **The bill was amended by the Senate Committee to further clarify the situations under which an individual may enroll in their group health plan outside of the normal enrollment period.** [HIPAA Sec. 2701(f)(1)].

- Allows for coverage for dependents under a group plan if enrolled within 30 days of birth, marriage or adoption. Kansas has a similar "special enrollment period" for children in another statute (K.S.A. 40-2,102) but the provisions are slightly different. [HIPAA Sec. 2701(f)(2)].

- Adopts the federal act definition of "preexisting condition" and a "preexisting condition waiting period." Does not change the preexisting condition limits for large group policies (90 days/90 days) which are more favorable than Kassebaum/Kennedy. [HIPAA Sec. 2701(a) and (b)].

- Prohibits the use of genetic information as a "preexisting condition" in the, "absence of a diagnosis of the condition related to such information." New law in Kansas. [HIPAA Sec. Section 2701(b)(1)(B)].

- Prohibits the use of pregnancy as a "preexisting condition." New law in Kansas. [HIPAA Sec. 2701(d)(3)].

- Prohibits group health insurers from imposing preexisting condition limits in the case of children who are added to coverage through being adopted or placed for adoption. [HIPAA Sec. 2701(d)(2)]

- Adopts the rule that individuals who enroll in a group health policy get credit against preexisting condition limits for any time they were previously covered under another group policy. This is current law in Kansas but the federal act expands the list of the types of "prior creditable coverage" you can use to credit against preexisting conditions limits. The federal law also allows a 63 day "gap" in coverage between the old and new group policy (Kansas only permits a 31 day gap). [HIPAA Sec. 2701(c)].

HOUSE HEALTH/HUMAN SERVICES
Attachment 4-1
3-5-97

- Requires companies to credit the periods of prior coverage under another health plan regardless of the type of benefits that were offered under the other insurance coverage. Companies must credit time spent during any "waiting period" in a policy. [HIPAA Sec. 2701(c)(2) and (c)(3)].

- Requires group health insurers to provide evidence to their insureds of the "prior creditable coverage." The certificate must be made available to the group member when they leave the group, when they exhaust their COBRA benefits or upon request. New law in Kansas. [HIPAA Sec. 2701(e)].

- Requires group insurance carriers to renew a policy unless there is fraud or nonpayment of premiums or if the company decides to either stop offering a particular product or wants to leave the group health insurance market entirely. Kansas only requires guaranteed renewability in the small group market. Insurers that offer services through a network plan can withdraw products if no employer has employees who are within the service area. [HIPAA Sec. 2712(a) and (b)].

- Companies can stop offering a group product if they notify all of their insureds who are covered by such a policy 90 days prior to the date of discontinuation and if the insurer offers to sell the group any of the other products sold by the company. Kansas law only for small employer group market. [HIPAA Sec. 2712(c)(1)].

- Insurers can completely withdraw from the group market if they give notice to their insureds and to the Commissioner at least 180 days prior to discontinuing coverage and if they stay out of the group market for 5 years after that date. Current Kansas statute only covers small employers. [HIPAA Sec. 2712(c)(2)].

- Prohibits group health insurers from discriminating against members based on "health status related factors" which include medical condition, claims experience and disability. New law in Kansas. [HIPAA Sec. 2702].

- Deletes from the statute the use of certain types of conversion policy coverage in group plans. These policies are no longer used. This provision is not part of the Kassebaum-Kennedy legislation but was a recommendation of the Accident and Health Division.

- Allows the Commissioner to promulgate rules and regulations necessary to carry out the provisions of the law.

Section 2. (K.S.A. 1996 Supp. 40-2209d) Small Employer Group Law-Definitions:

- Adopts the federal act definition of "late enrollee." Current Kansas law is similar. **The Senate Committee added to the definition to clarify when someone can enroll in their group health plan outside of the normal enrollment period.** [HIPAA Sec. 2701(f)(1)].

- Uses the federal act definition of "preexisting conditions provision." The Kansas statute is similar to the federal law provision. Does not change the Kansas law that only allows preexisting condition limit for 90 days after the policy starts which is shorter than the limits in Kassebaum-Kennedy. [HIPAA Sec. 2701(a)].

- Defines "small employer" as including self-employed groups of one person. **The bill was amended by the Senate Committee to change the definition so that a "small employer" covers businesses with two to fifty employees. The change will exclude self-employed individuals from access to the small employer group health insurance market.** (HIPAA Sec. 2721(e)(4)].

Section 3. (K.S.A. 1996 Supp. 40-2209f) Small Employer Group Law:

- Uses the Kassebaum-Kennedy law definition of "preexisting condition" which is similar to the current Kansas provision. [HIPAA Sec. 2701(a) and (b)].

- Allows enrollees in a small employer group plan to get credit against the preexisting condition limits in the policy for any periods of "prior creditable coverage" under another group policy. The state law is the same but Kasssebaum-Kennedy adds to the list of the types of prior coverage. The federal act also allows a 63 day "gap" in coverage while the current Kansas provision of 31 days that is less favorable to consumers. [HIPAA Sec. 2701(c)].

- Deletes the provision in the Kansas statute which makes small employer group policies guaranteed renewable. This provision now applies to all group health insurance policies and is now found in Section 1 of S.B. 204.

Section 4. (K.S.A. 1996 Supp. 40-3209) Health Maintenance Organizations:

This section was added to the bill by the Senate Committee at the request of the Insurance Department. It amends the Kansas statutes that govern health maintenance organizations to add them to the group health insurance changes in Kassebaum-Kennedy.

Section 5. (K.S.A. 40-2228) Long Term Care Insurance (S.B. 47):

The Senate Committee amended 1997 Senate Bill 47 into the bill. This bill amends the Kansas Long Term Care Insurance Act to change the preexisting condition limits for such policies. The changes were originally recommended by the Kansas Long Term Care Insurance Task Force that met last year to review the long term care regulations and statutes.

New Section 6. Guaranteed Availability For Small Employers (New Law):

- Requires accident and health insurers to make all insurance products sold in the small employer market (up to 50 employees) to all small employer applicants. Under current Kansas law, the insurer only has to make a "basic" and "standard" plan available to small employers who want coverage. [HIPAA Sec. 2711(a)].

- Allows insurers who make coverage available through a provider network to limit the sale of products to only those employers whose employees live in the network service area. [HIPAA Sec. 2711(c)].

- Insurers can deny coverage to a small employer group if they demonstrate to the Commissioner that they do not have sufficient financial reserves to underwrite additional insurance. [HIPAA Sec. 2711(d)].

- Defines "dependent," "employee," "employer contribution rule," "group participation rule" and "health status related factor." Definitions are taken from existing Kansas statute and the federal act.

New Section 7. Guaranteed Availability For "Eligible Individuals" (New Law):

- Requires health insurers that offer individual health insurance policies to provide coverage to any "eligible individual" who had 18 months of prior health insurance coverage. The last portion of that coverage must be through a government, group or church health insurance plan. The person must first exhaust all available COBRA or state continuation benefits prior to being eligible for the guarantee issue of individual health insurance. [HIPAA Sec. 2741(a) and (b)].

- Companies can not impose preexisting condition limits on "eligible individuals." New law in Kansas. [HIPAA Sec. 2741(a)].

- Insurers must offer the eligible individuals a choice of either (a) their two most popular individual policy forms or (b) a "high benefit" or "low benefit" policy. [HIPAA Sec. 2741(c)].

- Carriers that offer individual health insurance coverage through a network plan can limit enrollment to persons who live in the network service area. Companies can limit coverage under a network plan if they provide evidence to the Commissioner that they will harm existing group and individual clients if additional insureds are added to the network. [HIPAA Sec. 2741(d)].

- Allows companies to not offer additional coverage in the individual market to eligible individuals if the company demonstrates to the Commissioner that they do not have the necessary financial reserves to underwrite additional coverage. [HIPAA Sec. 2741(e)].

New Section 8. Guaranteed Renewability of Individual Policies (New Law):

- Companies that offer individual health insurance coverage must renew the policies unless there is fraud or nonpayment or if the company decides to no longer sell a particular product or they decide to withdraw entirely from the market. New law in Kansas. [HIPAA Sec. 2742(a) and (b)].

- Companies that offer individual coverage through a network plan or an association membership do not have to provide individual insurance if no eligible individuals are in the service area or are members of the association. [HIPAA Sec. 2742(b)].

- Insurers can pull a particular product off the market if they give policyholders notice at least 90 days prior to the date of discontinuance. The carrier must also offer the individuals the opportunity to purchase any other individual health policy which they sell. [HIPAA Sec. 2742(c)].

- Allows insurers to withdraw from the market if they provide notice to policyholders and the Commissioner at least 180 days before discontinuing all policies. The insurer is precluded from selling products in the individual market for at least five years after they leave the individual market in the state. [HIPAA Sec. 2742(c)].

New Section 9. Mental Health Coverage (New Law):

- Requires insurers that offer mental health benefits to have the same annual or lifetime benefit caps for medical and surgical benefits and for mental health coverage. [HIPAA Amendment Sec. 2705(a)].

- Does not apply to small employer groups (up to 50 employees). [HIPAA Amendment Sec. 2705(c)(1)].

- Does not apply if the health insurer can show that the provision will increase the cost of insurance by more than 1%. [HIPAA Amendment Sec. 2705(c)(2)].

- Provision is effective for policies that are entered into or renewed after January 1, 1998. The law sunsets on September 30, 2001. [HIPAA Amendment Sec. 2705(f)].

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996* [P.L. 104-191]

	Large Group	Small Group [2 - 50 Employees]	Individual
Guaranteed Issue	No [§2711]**	Yes, of all products sold in small group market to whole group and eligible individuals within the group. [§2711(a)(1)]	Yes, of a limited number of products to eligible individuals. [§2741]
Guaranteed Renewability	Yes, with standard exceptions. [§2712]	Yes, with standard exceptions. [§2712]	Yes, with standard exceptions.[§2742]
Establishes Maximum PreX Exclusion Periods	Yes - 12 months (18 months for late enrollees). [§2701]	Yes - 12 months (18 months for late enrollees). [§2701]	Preexisting condition exclusions are prohibited for eligible individuals. [§2741]
Establishes Maximum Look-Back Periods	Yes - 6 months. [§2701]	Yes - 6 months. [§2701]	Preexisting condition exclusions are prohibited for eligible individuals. [§2741]
Requires Credit for previous PreX	Yes [§2701(c)]	Yes [§2701(c)]	Preexisting condition exclusions are prohibited for eligible individuals. [§2741]
Preemption of State Law in General	No, unless state standard or requirement prevents application of K/K. [§2723(a)]	No, unless state standard or requirement prevents application of K/K. [§2723(a)]	Yes, unless state implements alternative mechanism. [§§2741, 2744]
Preemption of State Law re: PreX	Yes, unless state law fits one of several exemptions for state laws that are more generous re: PreX. [§2723(b)]	Yes, unless state law fits one of several exemptions for state laws that are more generous re: PreX. [§2723(b)]	Yes; for eligible individuals, federal law prevents the application of any PreX exclusion. [§§2741, 2744]
State Enforcement Permitted	Yes, unless state fails to substantially enforce a provision. [§2722]	Yes, unless state fails to substantially enforce a provision. [§2722]	Yes, unless state fails to substantially enforce a provision. [§2745]
Eligible Individual		Is determined in accordance with terms of the plan, under rules of the issuer which are uniformly applicable <u>and</u> which comply with all applicable state laws. [§2711(a)(2)]	-At least 18 months of previous "creditable" coverage; - Most recent coverage in group plan; - No lapse in coverage that exceeds 63 days; - Has no current coverage; -Not eligible for Medicare or Medicaid; -Has exhausted COBRA. [§2741(b)]

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HOUSE HEALTH/HUMAN SERVICES
Attachment 5
3-5-97

	Large Group	Small Group [2 - 50 Employees]	Individual
Maternity Provisions Apply (48-Hour Stay)	Yes [§2704]	Yes [§2704]	Yes [§2751]
Mental Health Parity Provisions Apply	Yes [§2705(a)]	No [§2705(c)(1)]	No [§2705(a)]

*This chart sets forth the minimum standards set forth within the Act. In most areas, state standards can go further than the minimum federal standards.

** All references are to the Public Health Service Act (PHSA), as amended by P.L. 104-191, Title I, Sections 102, 111, and subsequent amendments thereto.

12/12/96

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Each State elects to--

Implement a qualified alternative mechanism (§2741(a)(2))

Under section 2744(a)(1) of the Public Health Service Act, this mechanism provides for the following:

1) All eligible individuals a choice of health insurance coverage
2) No pre-existing condition exclusion with respect to that coverage for eligible individuals
3) Of the choices offered, at least one policy form of coverage must be comparable to either a) comprehensive health insurance coverage offered in the individual market in the State or b) a standard option of coverage available under the group or individual health insurance laws in the State
4) A State must implement one of the following options. (Each State that implements one of these options retains regulatory authority with respect to these requirements.)

- Either 1) NAIC Small Employer and Individual Health Insurance Availability Model Act insofar as it applies to individual health insurance; or 2) Individual Health Insurance Portability Model Act (§2744(c)(1))
- Qualified high risk pool that provides health insurance coverage to all eligible individuals with no pre-existing condition exclusion; provides for benefits and premium rates consistent with NAIC Model Health Plan for Uninsurable Individuals Act (i.e., premium rates do not exceed 200 percent of standard risk rates) (§2744(c)(2))
- A mechanism that provides eligible individuals with a choice of all individual coverages otherwise available (§2744(c)(3)(B))
- A mechanism that either: 1) Provides for risk adjustment, risk spreading, or a risk spreading mechanism among issuers or policies of an issuer; or 2) Otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating issuers (§2744(c)(3)(A))

Not implement a qualified alternative mechanism (§2741(a)(1) and 2761(a))

- State adopts Federal default rules
  - State retains enforcement authority over Federal rules (§2761(a)(1))
- State does not adopt Federal default rules
  - State does nothing to retain control of its regulatory authority with respect to these requirements resulting in Federal enforcement of Federal default rules (§2761(a)(2))

HOUSE HEALTH/HUMAN SERVICES
Attachment 6
3-5-97