FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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Health Insurance Market Reforms: Portability

Overview

What does portability mean in health insurance?

Most Americans have access to health insurance through an employer-sponsored health plan, a fact that has made changing or losing a job a complex issue for the purposes of maintaining health insurance. Moving to a new job can be hard if the employer does not offer health insurance, or if the new employer's health plan is not as generous as the previous employer's plan. And with limited protections for people with pre-existing conditions, many people stay in jobs to keep their insurance rather than risk losing coverage. Portability, in the context of health insurance, describes the ability of an employee to maintain access to health insurance coverage and comprehensive benefits after leaving a job. It also applies to the ability of those purchasing insurance on their own to drop one insurance policy and buy another.

How is portability regulated under current law?

Because many of the Affordable Care Act's (ACA) provisions regarding guaranteed issue and pre-existing conditions do not take effect until 2014, the 1996 federal Health Insurance Portability and Accountability Act (HIPAA) provides the only current federal protections for employees leaving job-based coverage, after they have exhausted their COBRA benefits. Although some states provided portability protections before HIPAA was enacted, people with pre-existing conditions in many states faced outright denials of coverage, policies that excluded coverage for care associated with their pre-existing condition, and premium surcharges based on their health status when they left a job or moved between jobs.

Portability in the Group Market. Under HIPAA, individuals enrolling in a group health plan cannot be denied coverage or face pre-existing condition exclusions if their prior coverage was creditable and continuous. In order to qualify as creditable, the prior coverage must have been through an individual health plan, a group health plan, COBRA continuation coverage, a federal or state employee benefits plan, an HMO plan, an association health plan, a student health plan, a state high-risk pool plan, the Indian Health Service, veterans' benefits, Medicaid or Medicare. Types of plans that do not qualify as creditable include dental and vision insurance, policies that only cover one condition or one care setting, or non-health plans such as accident-only, disability or workers' compensation insurance.

In order to qualify as continuous, the prior coverage must not have been interrupted by a break of more than 63 days in a row, a period known as a lapse period. If an individual goes without coverage for more than 63 days, their coverage is no longer considered creditable. Some states have enacted laws to increase the maximum lapse period from 63 days to 90 or 180 days. Such

measures provide a more forgiving standard for individuals who are joining a new group health insurance plan.[1]

Portability from the Group to the Individual Market: In the individual market, HIPAA's portability protections apply to a much smaller subset of the population, known as federally eligible or HIPAA-eligible individuals. These are people who have at least 18 months of prior health coverage, the last day of which must have been in a group health plan. Before qualifying for such coverage, however, individuals must enroll in and maintain COBRA and any state-based continuation coverage until it is exhausted, and they cannot be eligible for new group coverage or Medicare. Also, federal law does not currently limit the amount insurers can charge in premiums (although it will after January 1, 2014). Often, HIPAA eligible individuals face very high premiums, although 43 states currently do place some limits on what insurers can charge.

Portability between Individual Market Health Plans: HIPAA does not apply to individuals moving between individual market plans, but some states do require individual health insurers to give credit for prior continuous creditable coverage in an individual health plan. In these states, the framework for portability of coverage between health plans is often similar to that provided by HIPAA in the small group market.

How does the Affordable Care Act affect portability?

Beginning January 1, 2014, the ACA requires individual and fully insured small group market health insurers to guarantee issue coverage and eliminate pre-existing condition exclusions, regardless of a person's health status. In addition, insurers can no longer impose premium surcharges because of a person's health status or claims history. Through these measures, the ACA will allow people to change jobs or insurers without danger of losing access to coverage or having benefits excluded because of a pre-existing condition. These provisions greatly increase protections for consumers losing employer-sponsored coverage or wishing to change jobs. By guaranteeing access to health coverage and eliminating insurers' ability to exclude pre-existing conditions, the ACA will make it easier for individuals to maintain coverage when switching jobs. However, people seeking coverage in the individual market may only be allowed to sign up for coverage during an annual open enrollment period.

Current Status and Trends

Group to Group Health Plan Portability

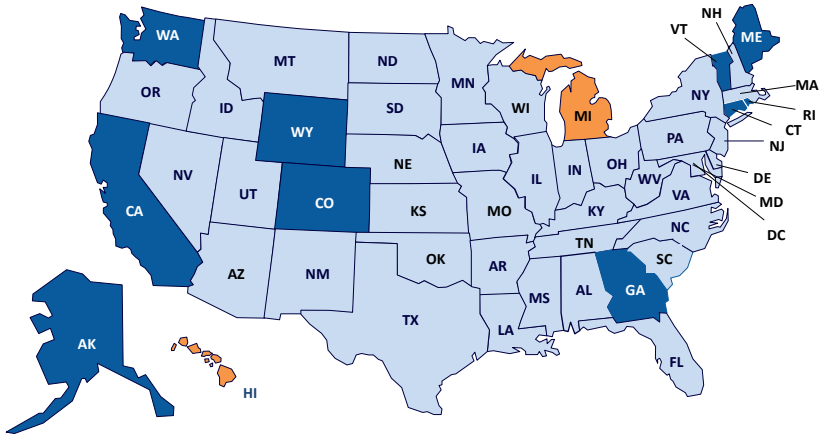
Under HIPAA, individuals in all 50 states and the District of Columbia are guaranteed access to coverage without a pre-existing condition exclusion when they change jobs or lose employer-sponsored insurance, so long as the prior coverage was creditable and not interrupted by a

[1] HIPAA does not, however, require new health plans to provide coverage for benefits that were not offered in an individual's previous health plan. Insurers are allowed to examine whether the previous health plan covered certain broad categories of benefits such as prescription drugs or mental health services, and to impose a pre-existing condition exclusion period on benefits that were not covered under the old plan. Some states have passed laws to limit this practice.

lapse period of more than 63 days (Figure 1). There are, however, ten states that have extended the maximum lapse period allowed between group health plans. Of these states, seven have adopted a lapse period of 90 days. Connecticut has a lapse period of 120 days for most cases; Maine has adopted a lapse period of 90 days, but with 180 days provided for loss of coverage due to unemployment; and California has adopted a lapse period of 180 days for loss of coverage due to unemployment. The lapse period is not applicable in Hawaii and Michigan, because these states prohibit pre-existing condition exclusions in the small group market.[2]

Figure 1

Maximum Lapse Period Allowed, Group Health Plans, January 2012



Meets minimum federal standard of 63 days (39)

Exceeds federal standard (10)

Pre-existing condition exclusions prohibited (2)

Source: Data collection and analysis by Center on Health Insurance Reforms, Georgetown Health Policy Institute. Data available at www.statehealthfacts.org;

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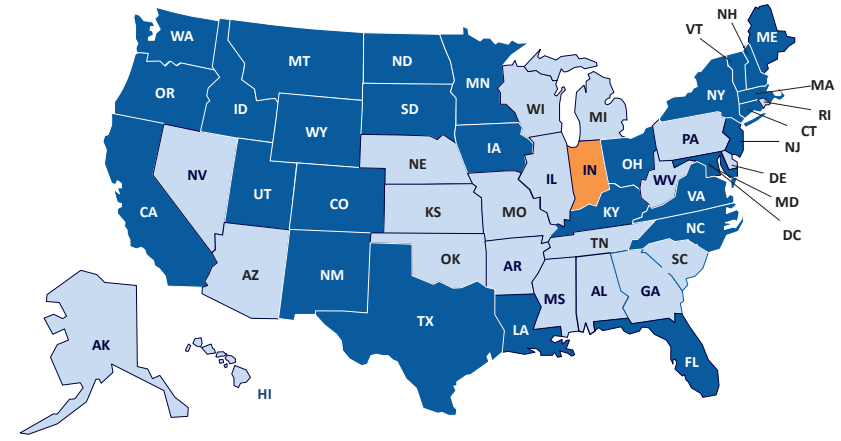
Individual to Individual Health Plan Portability

State laws vary regarding health insurance portability in the individual market. Most states permit insurers to deny coverage or impose benefit exclusions on people with pre-existing conditions. However, 29 states currently require insurers that issue a policy to give individuals moving between individual market plans credit for their prior coverage, allowing them to shorten or eliminate a pre-existing condition exclusion period (Figure 2). Of those states, one of them—Indiana—only allows credit for prior coverage from small group plans. Another 21 states and the District of Columbia do not provide individuals with credit for prior individual market coverage.

[2] All state portability laws apply to fully insured group plans. Under the federal Employee Retirement Income Security Act (ERISA), states are preempted from regulating self-funded group plans.

Figure 2

Credit for Prior Coverage, Individual Health Plan Portability, January 2012



State requires insurers to credit for prior coverage (28)

State does not require insurers to credit for prior coverage (21 + District of Columbia)

State requires insurers to credit only for small group coverage (1)

Source: Data collection and analysis by Center on Health Insurance Reforms, Georgetown Health Policy Institute. Data available at www.statehealthfacts.org;

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Transition to 2014

Individual Market

2014 will bring significant changes to portability rules in the individual market. Those seeking coverage on their own will shift from a system in which the federal government did very little to guarantee portability of health coverage to one in which portability is guaranteed for all individuals. Insurers will also no longer be able to restrict benefits because of a pre-existing condition for individuals who change plans. However, individuals may be required to enroll in coverage during an annual open enrollment period, although special enrollment periods will be available in the wake of certain life circumstances, such as leaving a job or having a baby.

Small Group Market

In the small group market, 2014 will bring smaller, but still significant changes. Individuals who change jobs or lose employer-sponsored coverage will be able to maintain their coverage without having to be concerned about the credibility of their prior coverage or lapse periods.

For both the individual and small group markets, state regulators have the primary role in enforcing these standards and many states may wish to amend their laws in order to provide their regulators with clear authority to enforce the ACA's new standards. Federal insurance regulators are authorized to conduct enforcement in states that do not adopt and enforce these protections.

This fact sheet was prepared for the Kaiser Family Foundation by the Center on Health Insurance Reforms, Georgetown University Health Policy Institute.

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