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Portability of Coverage: HIPAA and COBRA

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For the majority of Americans who have health care coverage as part of a benefits package offered by their employers, leaving one's place of employment results, at a minimum, in the need to find new health insurance. If an individual does not find a new job or finds one that does not offer insurance, the result could be a loss of coverage altogether. Thus, health coverage is not really "portable" for most Americans—they cannot take their employer's coverage with them when they leave a job, or be assured of finding comparable coverage.

Two federal laws provide a limited measure of protection for workers who lose health coverage as a result of job changes. The Health Insurance Portability and Accountability Act (HIPAA), passed in 1996, restricts the extent to which insurers can limit coverage for preexisting medical conditions and prevents insurers from denying coverage because of past or present conditions. It also guarantees workers leaving a job with employer-sponsored health coverage the right to purchase coverage on their own.

The Consolidated Omnibus Budget Reconciliation Act (COBRA), passed in 1985, allows workers leaving employer-sponsored group coverage to buy into that coverage for up to 18 months.¹ COBRA thus helps some workers and their families maintain health coverage during times of job transition or loss.

Both of these federal laws have serious limitations, however. HIPAA ensures that workers moving from group to individual coverage will have access to some type of insurance protection. It does not help individuals

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who had been working for a company that did not offer coverage; nor does it help employees whose employers impose waiting periods before insurance takes effect (three-month waiting periods are common, and some firms impose longer periods). Moreover, there are no limits on the premiums that insurers can offer. For workers with lower incomes or poor health, the law provides no practical guarantee of health insurance: the coverage offered may be unaffordable, or may not be comparable in terms of services covered or provider networks included. Under COBRA, an employee must pay the full cost of coverage, plus a 2 percent administration fee; COBRA premiums for individuals and families combined averaged about \$400 per month in 2000. Moreover, many workers are simply not eligible for COBRA. Only previously insured workers have access to the program, and workers previously insured by firms with less than 20 employees are ineligible. Considering the program's many restrictions and its prohibitive costs, it is not surprising that, in 1999, COBRA enrollment among all unemployed workers was at 7 percent and, among the unemployed with incomes less than 200 percent of the federal poverty level, at only 5 percent (Kaiser Commission 2001).

In recent years, public officials have become concerned about the lack of a health insurance safety net for workers. There have been efforts at the state and federal level to make employer-sponsored health coverage more portable. Lawmakers have made limited reforms in the group and individual health insurance markets to make it easier for those who change or lose jobs to retain health care coverage. Some private organizations have set up purchasing cooperatives for small firms. In spite of these efforts, the fact remains that, while workers usually have access to some form of coverage when they lose their jobs, there is no assurance that the options presented to them will be affordable. This brief describes the reach and limitations of recent federal and state initiatives to improve the portability of health coverage.

WHAT IS PORTABILITY?

Portability generally refers to the ability of an individual covered by an employer-sponsored plan to retain coverage or obtain new coverage at an affordable price after he or she is no longer working for that employer. Individuals may leave an employer for many reasons, including taking a position with a new organization, being laid off or fired, or voluntarily leaving the workforce. When any of these events occur, most individuals want to retain some form of health coverage.

In its fullest sense, portability means being able to keep the same health coverage (e.g., same plan, same benefits) at the same price. More realistically, portability might be defined as the ability to secure comparable coverage at a comparable price after leaving an employer-sponsored plan. At a bare minimum, portability means having an option to keep some level of coverage at some price when leaving an employer-sponsored plan.

WHY IS PORTABILITY IMPORTANT?

A high level of health coverage portability is important to employers that offer coverage and employees who receive it, as well as to a strong economy. The strength of the U.S. economy is due in part to the flexibility of labor markets, and portability of coverage plays a role in maintaining that flexibility. American companies are much freer of employment-protection legislation and regulation than their counterparts in other industrial nations (OECD 1994). They are therefore able to maximize efficiency and respond quickly to variations in demand for their products and services by adjusting the size of their workforce as needed—demonstrated by the round of major layoffs that occurred in the wake of the recent economic downturn. Many employers turn on a regular basis to temporary or contract workers. Although employers' readiness to adjust the size of their workforce can create severe hardships for the workers who lose their jobs, the net result of this flexibility is a higher level of productivity, profitability, and growth.

In addition, U.S. workers pride themselves on the ability to seek out new career opportunities when they arise; they frequently change jobs and sometimes leave jobs to pursue entrepreneurial ventures. However, if employees face difficulties retaining health care coverage, they may be hesitant to move to jobs that use their skills more productively or pay better; this phenomenon is often referred to as “job lock.” As a result, businesses may be faced with higher labor costs and lower productivity, especially in difficult economic times.

Thus, portability of employee benefits such as health coverage and pensions can facilitate flexible labor markets. Pension vesting provisions enacted in 1974 as part of the Employee Retirement and Income Security Act (ERISA) help workers retain their contributions to retirement savings when they lose or change jobs. Incorporating a counterpart to this vesting in our health care system would relieve workers of their fears of losing health insurance when their job status changes. Of course, the portability of health care coverage is just one of many factors that influence flexibility in labor markets; voluntary and involuntary changes in job status occur on a broad scale, particularly in difficult economic times, regardless of health care coverage portability. However, the degree of portability of health insurance is an important factor in determining the flexibility of labor markets, affecting the overall productivity and growth of the economy.

For this reason, policymakers have an interest in promoting initiatives designed to ensure that affordable health coverage remains available as individuals move within the labor market. Such policies should encourage employers and employees to take advantage of flexible labor markets and ease the transition for those workers who voluntarily or involuntarily switch jobs.

PRIMARY VEHICLE AT THE FEDERAL LEVEL: HIPAA

HIPAA, signed into law by President Clinton in 1996, is the federal government’s primary vehicle

for promoting the portability of health care coverage. HIPAA applies to the approximately 125 million Americans covered by health plans sponsored by private-sector employers and unions, as well as those covered by most church-sponsored plans and some state and local government-sponsored plans. The law protects employees working for companies that purchase coverage from insurers as well as those working for employers that self-insure. State and local government plans that purchase coverage are subject to HIPAA, while self-insured plans sponsored by state and local governments can and often do elect to opt out of HIPAA. Plans sponsored by the federal government are exempt from HIPAA, but similar standards apply by executive order (Polzer 1999).

HIPAA’s provisions make it somewhat easier to keep comparable health care coverage for most Americans who start a new job or who change or lose jobs. Yet, the law leaves much to be desired in meeting the goal of offering full portability to most Americans.

What Are HIPAA’s Portability Provisions?

HIPAA provisions are designed to assist individuals in two different situations: those who start a new job with an employer offering health care coverage, whether or not they were previously employed or had health care coverage; and those who leave a job providing health care coverage and either do not seek new employment or find a position with a company that does not offer coverage.

Those Starting a New Job That Offers Coverage to Its Employees

With a handful of exceptions, individuals who take a job with an organization offering health coverage will generally find that HIPAA provisions apply to that organization. The primary benefits for this population are as follows:

- HIPAA prevents an insurer from denying coverage or charging higher rates for that coverage because of past or present medical conditions.

- HIPAA restricts the extent to which insurers can limit coverage for preexisting conditions. An individual who has been covered by a group plan for more than a year faces no exclusions for preexisting conditions if he or she takes a new position with an employer offering coverage. For individuals who do not meet this condition, preexisting exclusions are permitted but are limited in certain ways. Preexisting conditions can be excluded only if medical advice, diagnosis, care, and treatment were recommended for the condition within six months of enrollment. For those who did not previously have health insurance coverage, exclusion periods are generally limited to 12 months after enrollment. For those who had group health care coverage before taking the new position for less than a year, the 12-month limit is reduced one day for each day that previous coverage was in place, assuming no break in coverage of longer than 63 days.

Those Leaving a Job That Provides Coverage (With No Option for New Group Coverage)

HIPAA guarantees some individuals who leave a job where they received health coverage the right to purchase insurance in the individual market. This right is available only for those individuals who have had 18 months of “creditable, continuous coverage” through a group health plan (without a break of 63 or more days), assuming the individual is not otherwise eligible for coverage under any other group plan, Medicare, or Medicaid. In addition, these individuals must have exhausted any available benefits under COBRA, which allows employees (and their dependents) of firms with 20 or more employees who leave their employer’s group health plan to purchase, out of their own pockets, the same coverage for 18 to 36 months, depending on the circumstances.

Once COBRA benefits are exhausted, HIPAA guarantees that qualified individuals, regardless of medical condition, will have a choice of at least two coverage options that provide some

type of individual coverage, whether from a private health insurer, high-risk pool, or some other source designated by the state. Furthermore, these options cannot exclude coverage for any preexisting conditions. Most important, however, HIPAA places no limits on what an individual may be *charged* for this coverage.

What HIPAA Does Not Do

As the above description makes clear, HIPAA protections, while significant, fall well short of offering full portability of coverage—in practice, very few workers have the right to take their existing coverage with them when they switch jobs or become unemployed. HIPAA falls short of assuring affordable or comparable coverage as well. (COBRA does allow for 18 months of continuing coverage for those who can afford the full premium, though in most cases this expense is not tax-deductible.)

For those taking a new job that offers insurance, HIPAA does guarantee coverage and ensure that exclusions for preexisting conditions are limited. But there is no guarantee that the new health plan will be comparable in terms of benefits, out-of-pocket costs, or choice of providers. New employees could easily find themselves with coverage that gives them fewer benefits, costs more, and/or requires them to choose a new set of providers.

For those who leave the workforce or take a new position where insurance is not offered, HIPAA guarantees access to some type of coverage but also mandates that individuals first exhaust COBRA coverage, which is often very expensive. Assuming individuals clear the COBRA eligibility hurdle, they may find limited options and high prices in the individual market, where HIPAA offers no price protection. To make matters worse, the cost of health insurance in the individual market is not tax-deductible until it exceeds 7.5 percent of adjusted gross income. (In the group market, health insurance can be paid with pre-tax dollars.)

STATE ACTIVITIES TO ENHANCE PORTABILITY

States have been active in regulating both the individual and small-group markets to enhance the portability of health coverage. Most of these efforts have either expanded HIPAA protections to new populations or augmented protections that are part of HIPAA.

Activities at the State Level

Perhaps the most important thing to note about state-level reform is that it applies to only a portion of the insurance market—the individual market and the small-group market, generally defined as employers with between two and 50 employees. Most large firms (e.g., 500 or more workers) are self-insured, and federal law (the Employment Retirement Income Security Act) prohibits states from regulating health benefit plans of self-insured firms. Thus state law generally does not apply to large firms, which cover approximately 50 million individuals. For these individuals, federal law or private-sector reform remain the only routes to enhanced portability of coverage.

State Regulation of the Individual Insurance Market

Many states have intervened in the individual health insurance market to bolster HIPAA protections for eligible individuals as well as to extend HIPAA-like protections to all individuals who might want to purchase insurance, including those not employed by firms subject to this federal law. The expansion of protections to individuals not covered by employer-sponsored plans is especially important, since only two-thirds of nonelderly people receive health insurance through their employers. These state provisions are designed to do the following:

- **Make health care coverage available.**

Roughly 20 states require insurers to sell at least some types of plans to qualifying individuals who want to buy them, regardless of whether they are eligible for HIPAA. In some of these states, individuals with serious health conditions or those who have not had prior coverage will

have fewer options than those who are in good health or who have had previous coverage.

- **Make health care coverage affordable.**

Twenty-nine states use some form of community rating or other mechanisms to set limits on the amount by which insurers can vary premiums based on the level of risk of individuals purchasing insurance on their own. Most of these states use modified community rating. Full community rating means that all policyholders pay the same premiums, regardless of age, sex, or other risk factors. Almost all of the states that use community rating allow insurers to vary premiums across five-year age brackets. In addition, more than 30 states have set up high-risk pools for individuals who cannot otherwise get insurance. Although the premiums in the high-risk pools are substantially higher than what a person of average risk would pay in the unsubsidized market, the state subsidies provide a modest amount of price relief for those without other options. The level of subsidy varies dramatically from state to state. Minnesota has one of the more generous programs for the high-risk pool. Minnesota caps premiums at 125 percent of standard individual market rates, compared with Florida, which allows premiums as high as 250 percent of standard rates. As a result of high premium costs, restrictions on benefits, and waiting periods, state high-risk pools insure only an average of 1.2 percent of those covered by individual insurance, and only three states (Minnesota, Nebraska, and Oregon) have more than 2 percent of this population enrolled (Achman and Chollet 2001).

- **Limit exclusions on preexisting conditions, as well as exclusion periods.**

Within the individual market, the majority of states place limits on the preexisting condition exclusion period and the “look-back period,” or how far back in an individual’s medical history insurers can look for evidence of a preexisting condition.

These provisions bolster access to coverage for non-HIPAA-eligible persons. While in some cases the exclusion and look-back period can be several years, most states that have limits in place have set them at 12 months or less, with a handful limiting the period to three or six months for individuals with prior coverage. A few states (for example, Maryland, Oklahoma, and Oregon) allow no exclusion or look-back period in certain situations. In addition, many of the same states give individuals credit for prior coverage when calculating the exclusion period, and a few consider individuals to have had continuous coverage even if they have had a break in coverage that was longer than 63 days (the maximum under HIPAA).

- Make it easier to keep existing coverage for a longer period of time after leaving a job.** Some states mandate that issuers of group health insurance offer “conversion” coverage to individuals who leave their jobs; such provisions may extend the amount of time that coverage is available. (People who accept conversion coverage give up HIPAA eligibility.) The New Mexico Health Insurance Alliance (NMHIA) was created in 1994 to make coverage more affordable for businesses with two to 50 employees, self-employed individuals, and employed and unemployed individuals who have lost their group health coverage. These individuals are eligible to buy into an NMHIA plan if they meet HIPAA eligibility requirements related to “creditable, continuous coverage” and are not eligible for employer-sponsored coverage. The NMHIA contracts with multiple insurance carriers to offer a choice of managed care and indemnity plans to small firms and eligible individuals. Small firms must be offered health insurance regardless of the health risks of their workers, and this has helped them gain affordable coverage. The program is financed through a premium assessment on all health insurance carriers in the state.

State Regulation of the Group Health Insurance Market
As noted, state law within the group health market applies only to fully insured plans, which represent roughly 75 million individuals. States have focused their group reform efforts on the small-group health market, and the reforms parallel the provisions within the individual market. All states require insurers to guarantee issuance of all health insurance products (as required by HIPAA), and almost all states place limits on the extent to which premiums may vary from group to group. Some states extend guaranteed-issue and rate-band benefits to self-employed individuals (or “groups of one”). For example, Colorado allows self-employed individuals to buy small-group coverage at modified community rates during a 30-day annual open enrollment period, with their choice limited to a basic and standard plan.

The vast majority of states limit preexisting condition exclusions to 12 months and the look-back period to six months (the maximum allowed by HIPAA); in a handful of states, these periods are even shorter. While most adopt the HIPAA standard allowing no more than a 63-day gap in coverage to qualify as having continuous coverage, some states are more lenient, allowing longer breaks (90 to 180 days, for example) for those enrolling in fully insured plans. In addition, roughly 35 states offer some sort of COBRA-like option for individuals who work for employers with less than 20 employees and lose their group insurance, with the entitlement period running from as little as 30 days to 18 months. (COBRA applies only to organizations with 20 or more employees.)

Strengths and Weaknesses of the States’ Approach
Without question, state-initiated reform of the individual and group health market has helped in small ways to enhance portability of coverage. Many states have gone beyond HIPAA’s provisions to afford greater protections with respect to excluding preexisting conditions and limiting price variation. Many have also introduced protections

in the individual market that serve to expand HIPAA-like protections to individuals who would not otherwise be eligible for HIPAA.

Yet, all of these activities really amount to tinkering at the margins. No state has gone significantly beyond HIPAA in terms of promoting portability of coverage. Only slightly more than half of the states have set any limits on what someone in the individual market can be charged for insurance, resulting in costs that are often prohibitive, especially for unhealthy individuals. (A recent report found that people denied private health coverage often cannot afford the premiums, deductibles, and copayments charged by state-run high-risk insurance pools [Achman and Chollet 2001].) It is also important to remember that these state laws do not apply to the 50 million Americans employed by large organizations that self-insure their plans.

Even in states offering the most aggressive protections to workers, the combination of HIPAA and state laws still falls far short of offering full portability—workers who change or lose jobs are generally not able to retain the same health coverage they had (except those who temporarily retain such coverage through COBRA), and no workers get the same coverage at the same out-of-pocket costs they enjoyed at their previous place of employment.

Activities Within the Private Sector

Some insurers have taken it upon themselves to improve and expand upon the protections of HIPAA. For example, in Hawaii, Kaiser and other large insurers have taken a variety of steps in the individual market to improve portability and access to coverage. These insurers guarantee issue, do not exclude preexisting conditions from coverage, and use community rating to set premiums. In Pennsylvania, Blue Cross Blue Shield uses community rating in the individual market as a matter of practice. Yet, these private-sector initiatives are rare, and have an impact on only a small percentage of the population.

One reason such policies are the exception rather than the rule is because of the adverse selection problems inherent to the individual market. Selling individual coverage on a guaranteed-issue, community-rated basis creates strong incentives for individuals to wait to buy coverage until they know they will need expensive care. For example, individuals may buy coverage when they anticipate having a baby or undergoing elective surgery. Even when insurers are able to perform medical underwriting, reject high-risk applicants, or charge such applicants higher rates, adverse selection remains a problem. If protections against adverse selection were set aside, there would be even less of an incentive for individuals to buy coverage until they actually need care. The insurance principle of spreading risk among high- and low-risk individuals would be violated, and the financial system would break down. Even when states require *all* insurers to offer individual coverage on a guaranteed-issue, community-rated basis, problems with adverse selection arise. It would therefore be unsustainable for a *single* company to offer individual coverage on this basis when others are not following suit; the insurer would end up supporting a large proportion of all high-risk individuals.

SUMMARY

HIPAA affords a measure of health insurance protection for workers who leave their jobs. It assures access to some form of health coverage in the individual market for workers who exhaust their COBRA benefits and have not acquired a new job with employer-sponsored coverage. It also places limits on the use of exclusions for preexisting conditions. But HIPAA does not ensure that workers will be able to find *affordable* coverage. Achieving this objective will probably require regulatory reform in the health insurance market. This could entail an obligation for employers to continue their contributions for former workers for some amount of time. It will most likely also require some form of subsidy through direct government outlays or tax credits.

NOTE

¹ A disabled person meeting Social Security Administration criteria can extend COBRA for up to 11 additional months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. For more information, see *Health Benefits Under the Consolidated Omnibus Budget Reconciliation Act (COBRA)* (Washington, D.C.: U.S. Department of Labor, Pension and Welfare Benefits Administration, revised July 1999). Available online at <http://www.dol.gov/dol/pwba>.

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