

VI. CONCLUSION

HIPAA can claim a number of successes in the group and individual health insurance markets. The law established new Federal standards that apply to group health plans and insurance issuers in both the group and individual health insurance markets. In both the large and small group health insurance markets, the law provides guaranteed renewability for employers who purchase insurance coverage, prohibits discrimination against individual participants based on health status, and restricts the use of exclusion periods for preexisting medical conditions. In addition, HIPAA establishes guaranteed issuance of all products sold in the small group insurance market. In the individual insurance market, HIPAA ensures guaranteed renewal of policies and establishes guarantee access for a defined group of people who have lost group coverage. These provisions may have improved access and lessened the problem of "job-lock," the reluctance to change jobs for fear of losing health care coverage.

In the individual market, HIPAA applies only to a relatively limited universe of individuals and does not limit rates or establish a true minimum Federal standard. Instead, it mandates that the States enact one of several specific types of legislation relating to that market. This report recommends that premium rates for policies sold to HIPAA eligibles be more affordable and that a true minimum Federal standard be established. In addition to these problems, other key structural problems in the law hinder attempts to ensure that all consumers receive the protections Congress intended. First, Federal and State roles are not adequately defined. Although States are given the flexibility to provide broader consumer protections, they are also able, in both the group and individual markets, to choose which provisions of the law they will adopt. Second, in the group health insurance market three different Federal agencies have concurrent enforcement authority.

The result is a complex system of State and Federal regulations that requires consumers to negotiate a maze of State and Federal, including three separate Federal departments. In the long-run, the complexity of the HIPAA structure needs to be addressed. To this end, we recommend the establishment of a new council of Federal and State regulatory officials that will provide a forum for sharing information regarding emerging trends in States' approaches to health care reform and practices for addressing some of the problems discussed in this report.

The Honorable Tony Knowles
P.O. Box 110001
Juneau, AK 99811-0001

Dear Governor Knowles:

I am writing to discuss our shared goal of ensuring that individuals have access to appropriate health coverage. As you may recall, the Congress passed, and President Clinton signed, the Women's Health and Cancer Rights Act of 1998 (WHCRA) (42 U.S.C. sections 300gg-6) in October 1998 to ensure that individuals who need mastectomies receive a full continuum of care.

WHCRA requires health insurance issuers in the group or individual markets that provide a mastectomy benefit to make related follow-up care available. This follow-up care includes breast reconstruction.

After speaking with officials in your state and reviewing the relevant statute and regulations, the Health Care Financing Administration (HCFA) believes there is a reasonable question as to whether Alaska is substantially enforcing the requirements set forth in WHCRA. Federal regulations require me to notify you of this concern, and to ask for your response.

WHCRA does not preempt state laws in effect on October 21, 1998, the date of enactment, that require coverage of at least the coverage of reconstructive breast surgery otherwise required by WHCRA. However, upon review of Alaska's statute, it appears that the state did not have a law in effect as of October 21, 1998 that covered reconstructive breast surgery, nor has Alaska subsequently enacted a law that includes the protections set forth in WHCRA. Thus, HCFA believes there is a reasonable question as to whether your state is substantially enforcing the requirements set forth in WHCRA.

I would appreciate your providing HCFA with any information and/or materials you would like us to consider in making a preliminary determination of whether the state is enforcing the requirements set forth in WHCRA. For example, if your state has recently enacted a law that provides the protections set forth in WHCRA, or if there is other statutory language or legal authority that provides the basis for enforcement of these requirements, please include a copy of the relevant provisions with your formal response to this notice.

Page 2 -- Governor Knowles

The Public Health Service Act provides that states have primary authority to enforce the requirements set forth in WHCRA, as they apply to health insurance issuers in that state. However, if HCFA makes a preliminary determination and a subsequent final determination that a state is not substantially enforcing the requirements set forth in WHCRA, HCFA is required to enforce those requirements in that state.

Under the regulations, if the state does not respond within 30 days, HCFA is required to initiate the steps necessary to make a preliminary determination without the benefit of a response.

Thank you for your prompt attention to this matter. I look forward to continuing to work with you to ensure that these important protections are in place. Your staff may contact Jay Angoff, Director of the Private Health Insurance Group, at (410) 786-9215, with any questions related to this notice.

Sincerely,

Nancy-Ann Min DeParle
Administrator

(202)456-5557

**STATE STATUS ON ENACTMENT OF LEGISLATION REGARDING
CERTAIN HIPAA AMENDMENTS (an "x" indicates the state apparently has
not adopted any relevant law specifically addressing the federal
requirement(s), and will receive a notice indicating that HCFA has a
reasonable question of whether the state is substantially enforcing the
requirement(s))**

	NMHPA	WHCRA	MHP
Alabama		X	X
Alaska		X	
Arizona			
Arkansas			
California			
Colorado		X	
Connecticut			
Delaware		X	
District of Columbia		X	
Florida			
Georgia		X	
Hawaii	X	X	
Idaho		X	X
Illinois			
Indiana			
Iowa		X	

	NMHPA	WHCRA	MHP
Kansas			
Kentucky			
Louisiana			
Maine			
Maryland			
Massachusetts		X	
Michigan	X		X
Minnesota			
Mississippi	X	X	
Missouri			
Montana			
Nebraska	X	X	
Nevada			
New Hampshire			
New Jersey			
New Mexico		X	
New York			X
North Carolina			
North Dakota		X	
Ohio		X	X
Oklahoma			

	NMHPA	WHCRA	MHP
Oregon			
Pennsylvania			
Rhode Island			
South Carolina			
South Dakota		X	
Tennessee			
Texas			
Utah	X	X	X
Vermont			
Virginia			
Washington			
West Virginia			
Wisconsin	X		
Wyoming	X	X	X

HEALTH CARE FINANCING ADMINISTRATION

**ADDRESSEE:***Sevonuk Adler***PHONE:** _____**FROM:***Peter Harbage*
**OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201****PHONE: 202-690-6726****FAX : 202-690-6262****TOTAL PAGES:****ADDRESSEE'S FAX MACHINE NUMBER:****DATE:****REMARKS:**

To Deborah
Fr Peter

Thought you might find this
funny. We printed 70,000 of these
& Distributed them to ROs, I'm
reliably told that 2 of the regions
actually gave it out.

To learn more,

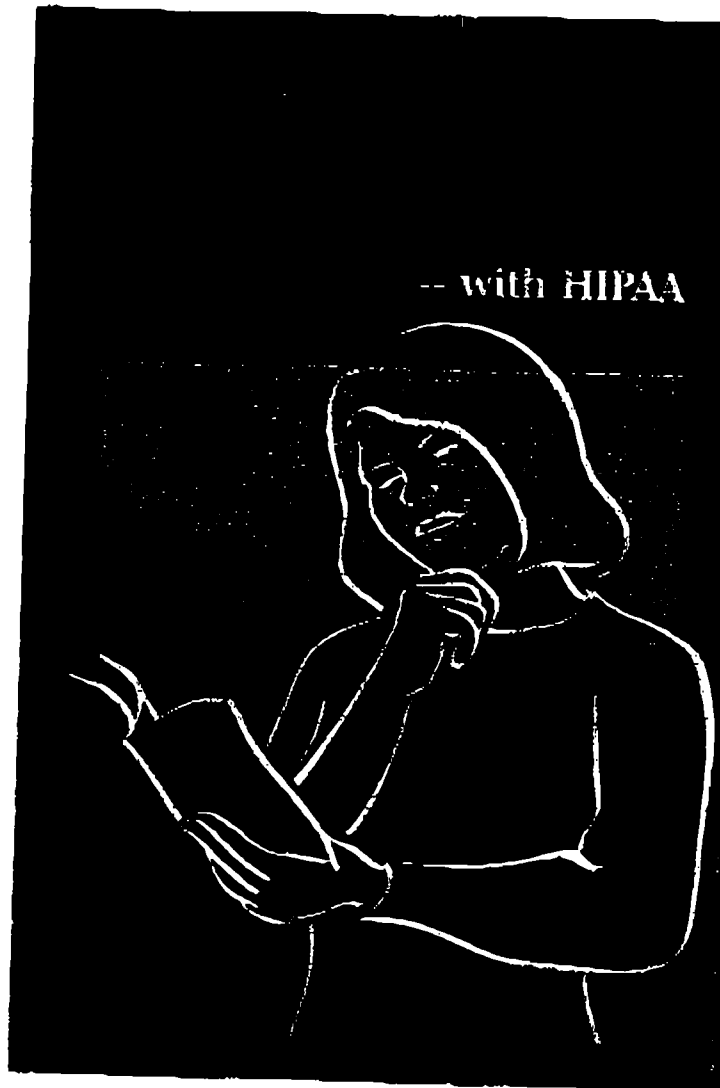
talk with your employer, or contact:

- your state insurance commissioner's office
- the Department of Labor, Pension and Welfare Benefits Administration (PWBA)
200 Constitution Avenue, N.W.
Washington, DC 20210
For a list of PWBA publications, call the Publication Hotline at 1-800-998-7542 or 1-800-326-2577 (TTY).
Or, visit them on the Internet at <http://www.dol.gov/dol/pwba>.
- the Health Care Financing Administration (HCFA)
7500 Security Boulevard
Baltimore, Maryland 21244
1-410-786-3000.
Or, visit them on the Internet at <http://www.hcfa.gov>.

Find out how
HIPAA can
help you!



-- with HIPAA



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Health Insurance Portability and Accountability Act of 1996

What is HIPAA?

It's the Health Insurance Portability and Accountability Act of 1996.

What does HIPAA do?

It helps protect the health insurance benefits of millions of Americans. For example, HIPAA:

- limits insurers' power to deny or delay coverage
- lowers your chances of losing existing coverage
- makes switching health plans easier and less risky
- prohibits insurance discrimination based on health problems
- may give you or your dependents special enrollment rights under your employer's plan if you or your dependents lose other coverage or your family circumstances change.

Other features of HIPAA may help you buy coverage on your own if you lose your employer's plan and have no other coverage available



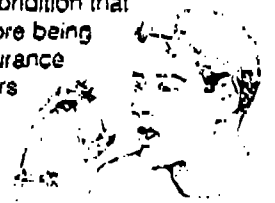
Find out what HIPAA means for you and your coverage!

How does HIPAA benefit me?

HIPAA can reduce or eliminate the time you wait for coverage of a preexisting condition under your employer plan.

What is a "preexisting condition"?

It's any medical condition that a person has before being enrolled in an insurance plan. Many insurers limit or exclude coverage for preexisting conditions



HIPAA limits the time your employer's insurer can deny coverage for preexisting conditions.

An insurer can deny coverage for a preexisting condition only if the employee or dependent is diagnosed, receives care or treatment, or has care or treatment recommended in the 6 months before the enrollment date. (This is known as the "look back" period.)

The exclusion period -- the time coverage can be denied -- can last no longer than 12 months (18 months if you enroll late). This time must be reduced or eliminated if you have prior creditable coverage without a significant break (as discussed later in this brochure).

Your employer's insurer may not apply any preexisting condition exclusion to pregnancy.



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Price List C

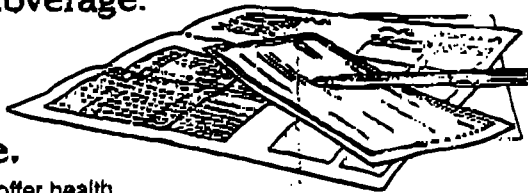
1996 Edition

How does HIPAA affect me as an employee?

HIPAA can make a difference in your coverage.

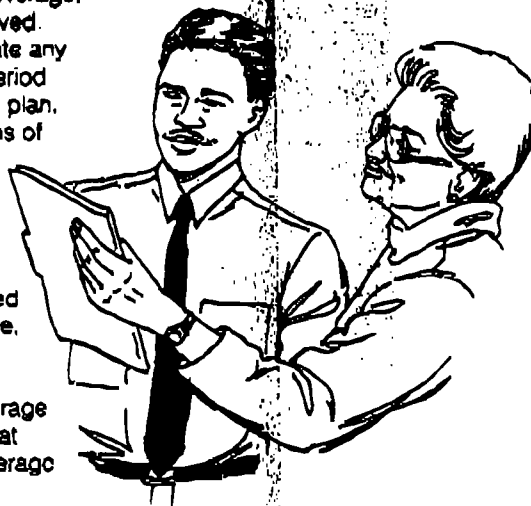
HIPAA can make employer-based coverage available.

Employers are not required to offer health insurance. But under HIPAA, insurers cannot refuse to sell to small employers and must cover all employees and dependents that are eligible under a small employer's plan. All employers must have the option of continuing coverage for their employees. With few exceptions, insurers cannot cancel coverage sold to an employer.



What if I have a preexisting condition and I switch jobs?

If you have been continuously covered under your old employer's plan or have some other form of "creditable coverage," you will get credit for the time served. That credit may reduce or eliminate any preexisting condition exclusion period imposed by your new employer's plan. If you have had at least 12 months of creditable coverage without a significant break (63 days or more in a row) and you enroll under your new employer's plan when first eligible, no preexisting condition exclusion can be applied to your new coverage. (If available, you may want to buy COBRA continuation coverage from your old employer until your new coverage starts. COBRA is a federal law that enables workers to continue coverage under their old employer's plan.)



More about creditable coverage

Creditable coverage includes most health coverage.

Most coverage under a group health plan (including COBRA), a health insurance policy or an HMO (health maintenance organization), Medicaid, Medicare, the Indian Health Service, TRICARE, the Peace Corps, a state high-risk pool or a state or local governmental public health plan is creditable coverage.



You can request a "certificate of creditable coverage."

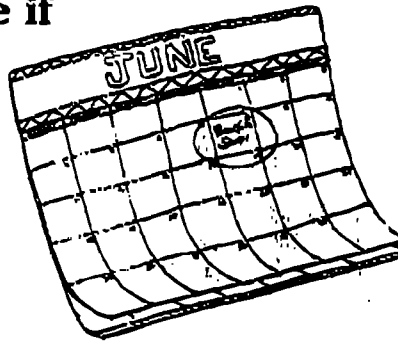
Under HIPAA, whenever you lose coverage, your employer or insurer is required to give you a certificate of creditable coverage. You can also request this certificate within 24 months of loss of that coverage.

If you cannot get a certificate, your new employer must accept other proof, such as pay stubs showing payroll deductions or canceled premium checks.

HIPAA does not ensure the same coverage if you change jobs.

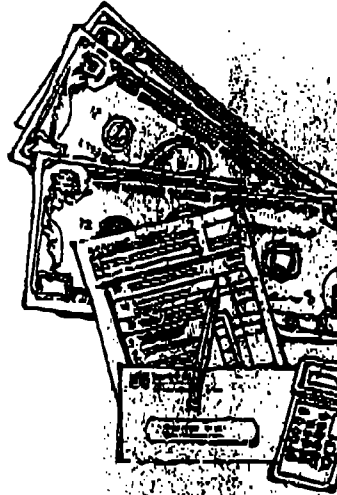
Coverage may be different.

HIPAA does not require a plan to include any specific benefits. Your new employer may also have a waiting period before benefits begin. This waiting period is not considered a break in coverage when determining continuous coverage.



Coverage cost may vary.

HIPAA does not set any cost guidelines for premiums. But, your state may limit premiums. And, under HIPAA, you can't be charged more than others in a health plan because of health conditions.



There may be no coverage.

If you take a job where there is no coverage, you may be able to get COBRA or similar State-mandated continuation coverage from your old employer for a while. When continuation coverage is no longer available, you may be able to purchase coverage on your own under certain HIPAA protections. See your State insurance department for details.



People who don't change jobs may also benefit from HIPAA.

HIPAA affects current employer plans.

HIPAA limits the preexisting condition exclusion period to 12 months (18 months, if you enrolled late). This can include time you have already spent under a plan (or other previous creditable coverage) prior to the date your plan became subject to HIPAA. If you or a family member have been serving a preexisting condition exclusion period, that period may now have ended or be shorter than you were originally told. Also, if you or a family member were previously denied enrollment in your employer's plan because of poor health, the plan may have to accept you or that family member once the plan becomes subject to HIPAA.

It can prevent other abuses.

Your employer or your employer's insurance plan cannot use your genetic information as a preexisting condition. Also, they must inform you immediately if they won't cover a preexisting condition.

States may have stronger protections.

Your state may have rules that:

- shorten the "look back" and/or preexisting condition exclusion period
- allow for more than a 63-day break in coverage
- further limit preexisting condition exclusions or the ways exclusions are applied
- protect employees of small employers not subject to COBRA by requiring some type of continuation coverage

EXECUTIVE SUMMARY

In July of last year, the President requested that the Departments of Labor and Health and Human Services report to him on the successes and shortcomings of HIPAA and also make recommendations for administrative and legislative improvements. In response to the President's directive, the Departments of Labor and Health and Human Services have prepared the following report. This report consists of two parts: the first describes the Department of Labor's (DOL) experience implementing the provisions of HIPAA that amended the Employee Retirement Income Security Act of 1974 (ERISA); the second describes the Department of Health and Human Services' (HHS) experiences with respect to the HIPAA provisions that amended the Public Health Service (PHS) Act.

The organization of this report into two parts reflects the separate jurisdictions of the two Departments. DOL administers ERISA, which governs most private sector employment-based group health plans, regardless of the plan's size or whether the plan is insured or self-insured. Accordingly, Part One of this report addresses DOL's experience with group health plans and not health insurance issuers. In contrast, HIPAA establishes minimum Federal standards with respect to health insurance issuers, but allows the States to enforce these requirements. It is only in the event that a State fails to enforce the HIPAA provisions that HHS is required to enforce the HIPAA requirements with respect to health insurance issuers. HHS does, however, have sole jurisdiction over non-Federal governmental plans. Thus, Part Two of this report addresses HHS' experience with respect to States and health insurance issuers. The Secretaries of Labor and Health and Human Services concur with the recommendations in both parts.

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996 in order to improve the portability of health care coverage for workers who changed jobs and to improve access to and the continuity of health insurance coverage. The law represents the first time that minimum Federal standards concerning portability, renewability, and nondiscrimination apply to group health plans and health insurance issuers. HIPAA also preserves States' traditional role in regulating health insurance by enabling States to build on the Federal floor of minimum standards in the group health insurance market. The law also establishes standards for the individual health insurance market, but provides States with the flexibility to develop a mechanism to implement these standards that is tailored to their specific circumstances.

HIPAA establishes important standards with respect to group health plans and health insurance issuers. First, the law prohibits plans or issuers from denying individuals the opportunity to enroll in a health plan based on their health status. Second, it limits pre-existing condition exclusions to twelve months in order to reduce "job-lock." This period can be further reduced or eliminated if the individual has prior creditable coverage. Third, the law requires guaranteed renewal of policies. Most important, these provisions apply to ERISA plans as well as State licensed insurers and therefore provides greater equity and facilitates worker mobility.

In addition, HIPAA amended ERISA's disclosure provisions to require group health plans to disclose additional information about their plan in a more timely manner. This report describes each of these provisions in more detail.

In addition to these standards, HIPAA requires health insurance issuers to guarantee issue all of their products to small employer groups of between two and 50 employees. Although, most States had previously enacted similar measures in their small group health insurance markets, the importance of HIPAA is that these rights be established on a national basis to ensure equity and consistency across the nation.

The Departments of Labor and Health and Human Services indicate in their respective parts that, overall, implementation of HIPAA's group market provisions has been successful. The Department of Labor (DOL) has not identified prevalent or systemic problems relating to the implementation of HIPAA's provisions with respect to ERISA plans. However DOL presents specific legislative and regulatory recommendations to bolster HIPAA's protections in this area. Specifically, DOL proposes strengthening ERISA's disclosure provisions and further modifying COBRA's disability extension provisions to ensure that consumers receive adequate notice and additional time to exercise their rights under HIPAA. In addition, DOL recommends that HIPAA's break in coverage rule be extended and that the law's special enrollment rights be expanded to provide a longer enrollment period and to extend rights to siblings of new dependents. Finally, DOL recommends requiring issuers to notify individuals before terminating group health insurance coverage in the event that an individual's employer fails to make premium payments. DOL also recommends that, in this situation, the health insurance issuer be prohibited from terminating policies retroactively to the date of nonpayment.

The Department of Health and Human Services (HHS) also reports that HIPAA's group market provisions that apply to health insurance issuers have successfully established a minimum Federal floor based on States' previous reform efforts. HHS concurs with DOL's recommendations and further recommends that purchasing cooperatives be encouraged in an effort to expand access to coverage to more firms, particularly small businesses. This report contains a number of other recommendations intended to correct smaller but not insignificant problems in both the large and small group health insurance markets that would improve the administration of the law and consumer rights consistent with the original intent of HIPAA.

In contrast to the group health insurance market, the individual health insurance market provisions of HIPAA are more problematic. These provisions are discussed in greater detail in Part Two of this report. The major policy innovation in HIPAA was the establishment of the right of certain individuals, the so-called "HIPAA eligibles," to guaranteed access to the individual market. Although this right is potentially important in increasing continuity of coverage, in practice it does not appear to have had much effect. Because of the statutory restrictions imposed, few people potentially qualify. For those who do qualify, the law does not

impose any premium rate restrictions on the individual market policies they purchase, so the coverage may be unaffordable. Indeed, there is anecdotal evidence of HIPAA eligibles being charged 400 percent or more of the standard rate for policies. Moreover, even in States' high-risk pools, the cost of coverage can be as high as 200 percent of the standard rate and the benefits in some high-risk pools are limited. Accordingly, this report makes a number of recommendations to improve this policy area, including rating restrictions on what insurers can charge HIPAA eligibles.

This report also addresses the need to consider broader reforms in the individual market. Currently, almost 11 million people receive their primary health benefit coverage through this market. HIPAA requires guaranteed renewal of individual policies, but in the individual market, unlike the small group market, most States have been slow to consider broader reforms such as guaranteed access and rating restrictions. The steady decline in employer-sponsored coverage in recent years and changing work patterns may make the individual health insurance market more important, and therefore, some policy makers advocate tax credits for people in this market as a means of expanding coverage. The report examines a few of the States that have undertaken significant reforms and recommends that more States explore reform options in the individual health insurance market.

The structure of HIPAA itself creates problems in realizing the rights the law seeks to establish. The State flexibility in the law and the States' ability to pick and choose which provisions they will enforce create a patchwork of laws and regulations that are difficult for consumers to understand and State and Federal administrators to implement. More needs to be done to inform consumers of their rights under the law. The Department of Labor has initiated a public outreach program and has developed a set of compliance materials available to the public. Both Departments have coordinated with the National Association of Insurance Commissioners to disseminate information to State officials and regulators and continue to work together with the Department of the Treasury to promulgate additional regulations and guidance regarding the HIPAA provisions. The Department of Health and Human Services has also established a consumer education campaign and this report recommends that this effort be expanded.

Finally, the report addresses the evolving relationship between the States and the Federal government, particularly HHS, which has the most interaction with the States. The Federal regulatory role in health insurance is essentially a new one, and integrating the Federal role with the States', which themselves are varied, has been a major task underlying all aspects of HIPAA's implementation. To further strengthen the relationship between the States and the Federal government, this report recommends that a council of Federal and State insurance commissioners be established to provide a better structure to identify problems and more systematically resolve them. The council will provide a forum for discussing such issues as enforcement, interpretations, data and information sharing, consumer education and evasive practices.

Comments of the Health Care Financing Administration (HCFA)
on the General Accounting Office (GAO) Draft Report,
“Private Health Insurance: Progress and Challenges in
Implementing 1996 Federal Standards”

Overview

The General Accounting Office’s (GAO’s) report analyzes the implementation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This law provides important protections, including guaranteed availability and portability of health insurance coverage in certain instances. And, although oversight and enforcement of the insurance industry is generally a state function, with respect to the provisions of HIPAA, the Federal government has assumed that responsibility in several states. The Health Care Financing Administration (HCFA) does not assume this responsibility lightly and is committed to the law’s mandate of providing access to health insurance coverage for those in the individual and small group market who may suffer from chronic illnesses. In the absence of HIPAA protections, many people would be frozen out of the health insurance marketplace. We generally agree with GAO’s recommendations.

HIPAA requires insurers that sell health insurance coverage in the small group market to accept every small employer that applies for such coverage, even if that employer group includes individuals with serious medical problems. A small group employer is defined as one having between two and 50 workers. HIPAA limits pre-existing condition exclusion periods and requires that previous coverage be credited toward reducing or eliminating any pre-existing condition exclusion period that a new employer’s health plan may impose. States may choose to enforce HIPAA provisions. However, if a state fails to substantially enforce the provisions, the statute provides for Federal enforcement. In the small group market, HCFA shares enforcement jurisdiction with the Department of Labor (DOL) and the Department of Treasury.

In the individual market, HIPAA also establishes minimum standards that insurers in all states must meet and requires enforcement by the Federal government when states do not enact HIPAA’s standards. In the individual market, HCFA alone bears responsibility for enforcement when states fail to act.

When HIPAA was enacted, few expected the Federal government to be required to directly enforce the law. However, three states--Missouri, Rhode Island, and California--have not enacted part or all of HIPAA’s protections, and HCFA is therefore directly enforcing the law in those states. In addition, HCFA has begun the process that could result in HCFA directly enforcing certain provisions of HIPAA in two other states--

Michigan and Massachusetts.

Since the time GAO's research for this report was completed, we have taken several steps regarding enforcement of HIPAA provisions including:

- **Developing Regulations.** The HIPAA enforcement regulation should be published in the near future.
- **Initiating Review of Insurers' Practices.** HCFA is preparing its first "market conduct" examination--an examination of an insurer's records to determine the extent to which its marketing practices comply with the law. The report notes that in the states in which HCFA directly enforces HIPAA, HCFA must assume the responsibilities typically undertaken by state insurance departments, including monitoring carrier marketing practices. HCFA will work with insurers who are found out of compliance to ensure that practices are changed. HCFA has the authority to impose civil monetary penalties against those that violate the law and we will use this authority where appropriate.
- **Increasing Review of Insurers' Forms.** HCFA has increased its review of insurers' policies (known in the industry as a policy "form".) The report notes that reviewing carrier policy forms is another responsibility typically undertaken by state insurance regulators that HCFA must now undertake in states in which it directly enforces the law. By reviewing forms, HCFA will strengthen its ability to make sure that insurer's are in compliance with HIPAA. We have been the most active in Missouri, where we are enforcing HIPAA in both the individual and small group market. Since enactment of HIPAA, HCFA has been working particularly closely and cooperatively with the state insurance department. Eighty-six companies (accounting for the overwhelming majority of both the individual and small group markets) have submitted a total of 120 policy forms for our review; 30 have been accepted; 17 have been withdrawn; and 73 are currently pending. In addition, HCFA's San Francisco regional office began reviewing policy forms and related marketing materials in California (where we are enforcing the individual market standards), and our Boston regional office will begin reviewing policy forms in Rhode Island in May. To the extent the report suggests that the "minimalist approach" under which HCFA merely reacts to complaints was inadequate, we agree. HCFA can not carry out direct enforcement in states unless it proactively reviews policy forms to determine whether they comply with HIPAA.

- **Strengthening Oversight of State Activities.** HCFA is reviewing the individual and small group market provisions of state laws to determine the extent to which they comply with HIPAA. Although HIPAA required states that intended to enact so-called “acceptable alternative mechanisms” to submit those proposals by April 1, 1997, HIPAA did not require any submissions by states enacting the individual market minimum standard, nor did it require any submissions at all regarding the small or large group markets. Nevertheless, we are analyzing the individual, small group and large group market laws of each state, as well as analyzing each state law to determine the extent to which it complies with the various amendments that have been made to the provisions originally enacted by HIPAA.
- **Creating Needed Tracking Systems.** HCFA has improved the tracking of complaints. In order to collect all appropriate characteristics of complaints and inquiries on a consistent basis among our regional offices, we developed a complaint data form that is now being used by all HCFA offices. Information that was captured on old complaints will be compiled using the new format to the extent possible. The complaint information will be invaluable to insurance regulators (HCFA, state governments, DOL) for identifying problems. HCFA will use this information and will act upon it as appropriate.
- **Developing and Implementing Education Programs.** HCFA has an organized consumer outreach program, and HCFA is targeting our educational efforts to those individuals who are changing jobs. On April 27, 1999, we are hosting a national conference for consumer advocates, representatives of state health insurance programs, state regulators and others. This conference will focus on identifying key information needed by those eligible for HIPAA protections and how to most effectively get that information to them. We are also developing training CD’s, web-based materials, public service announcements, videos and audio training tapes, and a comprehensive, consumer-oriented Internet site.
- **Putting the Right Team in Place.** In January we hired a former state insurance commissioner to take charge of our HIPAA enforcement efforts. Because insurance has traditionally been regulated by the states, his expertise and experience will be invaluable to HCFA. In addition, as a result of the 1998 supplemental appropriation, we were able to hire an additional 24 FTEs (The report refers to 22 FTEs which was the allocation for regional staff. We also hired two FTEs in central office for a total of 24 FTEs). HCFA made a significant effort to hire people with insurance industry experience and to place the increased staffing in the regions where we had direct enforcement responsibilities. The

additional staff have been working with the states in tracking and resolving consumer complaints, analyzing state legislation, preparing and initiating market conduct reviews and, in three regions, reviewing policy forms.

HIPAA promised Americans increased access to, and portability of, health insurance. This is a promise that will be kept --even if it means the Federal government must step into territory traditionally reserved for the states. Although unanticipated, HCFA has nevertheless assumed this task in three states, issued initial regulations, reviewed states' alternative mechanisms, begun development of additional regulations, and built the necessary internal systems required to fully enforce this law. The process where a large organization steps into new territory can sometimes occur slowly. However, as shown above, HCFA has made substantial progress on enforcement of HIPAA and will continue to do so. GAO's reviews will continue to be helpful to us as a benchmark as we carry out our responsibilities in the future. HCFA's specific comments on the report's recommendations follow.

GAO Recommendation

HCFA and the Department of Labor should revise the model certificate of health plan coverage to more explicitly inform consumers of their new rights under HIPAA. At a minimum, the model certificate should inform consumers about appropriate contacts for additional information about HIPAA and highlight key provisions and restrictions, including:

- the limits on preexisting condition exclusion periods and the guaranteed renewability of all health coverage,
- the reduction or elimination of preexisting condition exclusion periods for employees changing jobs,
- the prohibition against excluding an individual from an employer health plan based on his or her health status, and
- the guarantee of access to insurance products for certain individuals losing group coverage and the restrictions placed on that guarantee

HCFA Comment

HCFA concurs. Those in the public must have timely and accurate information about their rights and protections under the law. We plan to work closely with DOL to improve the utility of the certificate of coverage. Furthermore, we intend to explore (as previously discussed) a number of mechanisms that can be used to educate the public.

GAO Recommendation

To assure that HCFA is able to fully perform its new oversight role under HIPAA, we recommend that the agency promptly promulgate enforcement regulations.

HCFA Comment

HCFA concurs. HCFA has devoted a significant amount of time and effort toward the development of the enforcement regulations. We expect it to be published in the near future.

①

affordability HIPAA

elig. charged

high rates

300-464%

standard rates

②

can't legally

HIPAA REPORT TO THE PRESIDENT, DRAFT, 5/6/99
DEPARTMENT OF LABOR INTERNAL DRAFT IS FOR INTERNAL DISTRIBUTION ONLY

APPENDICES

LIST OF APPENDICES

Appendix I - President's Directive of July 7, 1998

Appendix II - Accomplishments

Appendix III - Policy Issues

Appendix IV - Results of Phone Survey Conducted by Missouri Department of Insurance

Appendix V - Results of Survey Conducted by Colorado Division of Insurance

HIPAA REPORT TO THE PRESIDENT, DRAFT, 5/6/99
DEPARTMENT OF LABOR INTERNAL DRAFT IS FOR INTERNAL DISTRIBUTION ONLY

APPENDIX I - PRESIDENT'S DIRECTIVE OF JULY 7, 1998

APPENDIX II - ACCOMPLISHMENTS

The Departments of Health and Human Services (HHS), Labor (DOL) and Treasury published an initial body of regulatory guidance in April, 1997 as required by law regarding HIPAA, and subsequently have published other regulatory guidance. HHS has also provided technical assistance to health insurance issuers and States implementing the statute, as well as consumers seeking information about the protections available to them under the law. The agency has played a crucial role in handling consumer complaints and resolving these issues with individual insurers. HCFA has also produced other forms of guidance to the States in the form of bulletins and regulations. These are described briefly below.

A. Regulatory Guidance

The majority of HIPAA's implementing regulations to date have been developed jointly by the Departments of Health and Human Services, Labor, and Treasury. The initial body of interim final regulations was published on April 8, 1997. At the same time, HHS also published regulations implementing separate provisions relating to guaranteed issue and disclosure in the small group health insurance market and guaranteed renewability in both the large and small group health insurance markets. In addition, HHS published regulations implementing HIPAA's individual health insurance market provisions which were also published on April 8, 1997.

This first set of regulatory guidance was followed by interim final regulations published on December 22, 1997 implementing the Mental Health Parity Act of 1996. Further guidance and clarification regarding two HIPAA provisions concerning Flexible Spending Accounts and individuals who had previously been denied coverage was published on December 29, 1997. The three departments also published regulations implementing the Newborns' and Mothers' Health Protection Act of 1996 on October 27, 1998. The Departments of Health and Human Services and Labor are currently drafting additional regulatory guidance regarding HIPAA's non-discrimination provisions and have begun drafting regulations implementing the Women's Health and Cancer Rights Act of 1998, which was enacted on October 21, 1998. The Department of Treasury is participating in the drafting with the expectation that it will receive statutory authority for these provisions as well. The three Departments have executed a Memorandum of Understanding (MOU) as required by HIPAA and are currently drafting additional regulations as a follow-up to the April 8, 1997 regulations. The Departments expect to publish final regulations in the year 2000, since the Department of Treasury's interim final rules published on April 8, 1997 expire on April 8, 2000.

B. Assistance to States and Consumers

As a result of implementation activities concerning both the group and individual

markets, HHS has assumed new roles in relation to the States and their regulation of health insurance. In effect, HIPAA creates a new Federal-State partnership whose success particularly hinges on a cooperative working relationship. In order to strengthen its existing relationships with the States and underscore its commitment to minimizing potential conflicts between State and Federal oversight, HHS has provided technical assistance to States and sponsored conferences and other forums for discussion with States implementing the minimum Federal standard (also known as "Federal Fallback" States).

1. Assistance to States

The Department of Health and Human Services (HHS) has worked closely with the National Association of Insurance Commissioners (NAIC), which represents the insurance commissioners of the 55 States and U.S. territories. The Commissioners meet quarterly to discuss common issues and develop model acts and regulations that are often adopted, in full or in part, by States. HHS staff regularly attend these quarterly meetings to provide guidance on HIPAA issues. Since the Summer meeting in 1997, the NAIC has provided HHS staff time and space at its regular quarterly meetings to meet with insurance officials from those States implementing the Federal provisions of HIPAA as well as other States to listen to questions, concerns, and suggestions regarding HIPAA implementation. HHS has also worked closely with various NAIC working groups, task forces, and committees on issues of common interest.

In addition, HHS has provided a variety of technical support to States in developing their legislation and regulations to assist in smoother implementation of the insurance reform provisions under HIPAA.

- * HHS issued a bulletin in March 1998 regarding agent commissions and processing delays that provided guidance to States to support their effective enforcement. This is the first in a series of such guidance to State insurance departments and the industry to help ensure compliance with the statute. In the States where there is direct Federal enforcement, the bulletin serves as a warning to issuers who may be attempting to circumvent the law.
- * HHS has issued four letters to State Medicaid Directors clarifying policy issues related to HIPAA, such as with the provisions of the Newborns' and Mothers' Health Protection Act, the Mental Health Parity act, and issuance of Certificates of Creditable Coverage for Medicaid participants.
- * HHS reviewed some 40 State Alternative Mechanism submissions as required under the HIPAA statute. However, staff have worked closely with States to provide technical assistance in helping them formulate policy options and ensuring State proposals met applicable statutory and regulatory requirements.

- * HHS sponsored a successful conference in September 1998 focusing on implementation and enforcement issues in the Federal Fallback States. Participants included State regulators, State legislators, insurers, and members of related constituent groups, such as the National Governors' Association and the NAIC.
- * HHS has met with Congressional delegations to inform them of possible enforcement actions and keep them apprised of major implementation issues.
- * HHS regional office staff in Philadelphia, Pennsylvania sponsored a conference for State insurance departments and Medicaid agencies in the region. HCFA staff provided guidance and training for State representatives. This conference also provided a private forum for discussion of States' implementation issues. This conference may be replicated by other Regional Offices.
- * HHS staff have provided technical assistance and advice to the District of Columbia and Texas insurance departments with regard to association coverage issues. With this support, these States have been taking action against issuers who were attempting to illegally cancel some association policies they had sold in the past.
- * HHS staff have also provided technical assistance to States in developing their legislation and regulations to conform to the HIPAA standards. For example, Kentucky consulted extensively with HHS staff regarding proposed legislation. Many other States--Georgia, Texas, Mississippi, and Alabama--consulted HHS staff regarding their interpretations of the HIPAA provisions while drafting their regulations.

2. Assistance to Consumers

HHS has provided a range of technical support to consumers and other parties regarding individuals' rights under HIPAA in order to ensure consumers receive the protections they are entitled to under HIPAA insurance reform. These activities include:

- * HHS has made a variety of information on HIPAA insurance reform available electronically on the HCFA web page to ensure those affected by insurance reform have the information they need to make informed decisions. This information includes general information on HIPAA's insurance reform regulations, answers to frequently asked questions from consumers and employers, formats for HIPAA certificates of creditable coverage and other related information.
- * HHS conducts case work concerning consumer inquiries in its central and regional offices. Staff have been quite successful in working with insurers to resolve consumer

complaints. From January 1998 to March 1999, HCFA regional office staff in San Francisco, California, where the Department is enforcing HIPAA's individual market requirements fielded approximately 2,220 inquiries related to HIPAA. Staff investigated and resolved 239 allegations of potential violations of HIPAA. In Missouri, where the Department is also enforcing HIPAA's group and individual market provisions, regional office staff in Kansas City has resolved 43 complaints and responded to 426 inquiries since July of 1997. Staff intervened with the issuer on behalf of the consumer in at least 30 of these cases and, in one case, was able to recover unpaid claims for the consumer.⁷⁸

- * HHS staff in ten regional offices throughout the country routinely respond to inquiries and complaints regarding HIPAA issues. In Rhode Island, where the Department is also enforcing HIPAA's group and individual market provisions, regional office staff in Boston handled 106 inquiries related to HIPAA between September 1997 and March 1999; no complaints have been reported. During roughly the same time period (January 1997 to March 1999), HCFA's regional office in Chicago handled 394 inquiries related to HIPAA.
- * HHS staff have conducted briefings for the insurance industry in California, Missouri and Rhode Island concerning HIPAA provisions and enforcement issues.
- * HHS is currently establishing an outreach and education strategy for HIPAA and has invited various interest groups, including employer groups and representatives from advocacy organizations to determine the best way to educate consumers of their rights. HHS staff also participate in numerous consumer and industry activities, such as serving as speakers at professional meetings and panel members at national educational video conferences sponsored by the American Bar Association.

⁷⁸The Missouri Department of Insurance reportedly handles, on average, 75 to 90 consumer inquiries and complaints related to HIPAA on a monthly basis. The Department forwards complex or unresolvable complaints to staff in HCFA's Regional Office in Kansas City, Missouri.

APPENDIX III -- POLICY ISSUES

1. No Guaranteed Availability for Coverage Sold Through Associations

Enforcement of the guaranteed availability requirement as it relates to coverage sold through associations has been problematic. The first problem is that HIPAA does not require an association to be bona fide. Instead, HIPAA relies on market incentives to encourage issuers who sell association products to only sell through bona fide associations. Second, HIPAA does not require a health insurance issuer that sells coverage through associations to accept all bona fide associations. Therefore, the issuer can select only associations with healthy risk profiles, commonly called "cherry picking".

The most frequent reason HHS has encountered for failure of an association to be bona fide is that the issuer of the association coverage medically underwrites the coverage it offers through the association (i.e., cherry picks within the association's membership). Since coverage that is not offered exclusively through bona fide associations is not eligible for the exception from guaranteed availability in the small group market under section 2711, the threat of having to guarantee issue its association products to all small employers should provide incentives to issuers to avoid selling to non-bona fide associations. However, it is unclear whether all States' treatment of "association group" coverage provides for effective enforcement of the small group all-products-guarantee on issuers who sell their association products to at least some associations that are not bona fide.

In contrast, in the individual market, depending upon the method a State has chosen for guaranteeing availability of coverage to eligible individuals, there may be no incentive for issuers to sell only through bona fide associations because no exception from the Federal Fallback guaranteed availability requirements in section 2741 is needed. If a State elects to use a State alternative mechanism (SAM) that relies on a State high-risk pool or issuer of last resort to provide coverage to HIPAA eligible individuals, all issuers in the individual market are relieved of the guaranteed availability requirement. Since an issuer is subject to no penalty for offering coverage through one or more non-bona fide associations, there is no incentive for the issuer to cease cherry picking among association members and every competitive advantage to be gained from continuing to do so.

Alternatively, if the State or HCFA is implementing the Federal Fallback rules, the issuer, if it has other products in the individual market, may be legitimately able to claim that its "association group" products are not what it wants to offer as its two most popular or its two representative policies. Only in the relatively few States that require guaranteed issue of all products do the bona fide association rules operate the way they were perhaps intended to work: to induce all associations to be bona fide and all issuers of coverage to associations to sell only to bona fide associations.

Recommendation

Amend HIPAA to require health insurance issuers offering coverage in the small group or individual health insurance markets to guarantee issue coverage to all bona fide associations.

2. Late Enrollment Not Required

HIPAA does not require health insurance issuers to accept late enrollees. HIPAA's non-discrimination provisions prohibit a health insurance issuer from having rules for eligibility or continued eligibility that are based on a health-status related factor. This new requirement appears to have produced a change in the small group health insurance markets in many States. HHS has learned from a number of sources that certain issuers who have significant market shares in the lower end of the small group health insurance market have responded to the prohibition against underwriting late enrollees by simply ending the practice of accepting any late enrollees. This practice has reduced access to coverage for individuals who, in the past, did not enroll for any reason, including not being able to afford the coverage when they first began their job. Even in the case of young, healthy individuals who reject coverage when it is first offered because they do not think they will need it, there is still some question as to whether they should be permanently denied access to coverage because of an issuer's actions to circumvent a HIPAA requirement.

Recommendation

Require group health plans and health insurance issuers to provide a 30-day annual open enrollment period for those individuals who previously declined health insurance coverage. HIPAA currently allows health insurance issuers to subject late enrollees to an 18-month preexisting condition exclusion period, as opposed to the maximum 12-month period that may be imposed on initial or special enrollees. The late enrollee may have this period reduced by prior creditable coverage. If creditable coverage does not exist, the 18-month exclusion period should serve as a sufficient disincentive to not enrolling timely and thereby reduce the risk of adverse selection. Requiring periodic open enrollment would prevent health insurance issuers from evading the prohibition on underwriting for late enrollment into the plan while allowing them to limit adverse selection to some extent.

3. Coverage Under Medicaid Not Cause for Special Enrollment

HIPAA provides for a special enrollment period for group health plan coverage for individuals who lose other coverage under a group health plan or health insurance coverage. However, loss of Medicaid coverage is not specifically mentioned as a cause for such a special enrollment period. Since Medicaid managed care benefits offered through managed care organizations fit the HIPAA definition of "health insurance coverage," enrollees who lose this

coverage are entitled to a special enrollment period. This is not the case, however, for Medicaid beneficiaries who are under the fee-for-service program.

Recommendation

Amend HIPAA to provide for a 30-day special enrollment period under a group health plan for individuals whose Medicaid coverage terminates regardless of whether that coverage was under fee-for-service or managed care.⁷⁹

4. Employees May Lose Portability Protections Due to Employer's Failure to Pay Premiums

Under HIPAA, if an employer fails to make premium contributions to an issuer thereby causing termination of the employees' group health insurance coverage, employees who want to use the HIPAA portability protections must: 1) request special enrollment into another group health plan within 30 days of the termination of the policy; or 2) apply for an individual policy as an "eligible individual" within 62 days of the termination of the policy. Once this period of non-coverage (either 30 or 62 days) lapses, the employee is no longer protected by the HIPAA portability protections. If the employer does not promptly notify his/her employees that coverage has terminated and there are no claims submitted on behalf of the employee during this period, the employee may not know about the loss of coverage until it is too late to take advantage of HIPAA's portability protections.

Recommendation

Amend HIPAA to begin the time period to request special enrollment into another group health plan or to apply for an individual policy as an "eligible individual" on the day that the employee learns of the termination of coverage, rather than on the actual day that the policy terminates in the event that the termination occurs because the employer failed to make premium contributions to the issuer of the policy.⁸⁰

⁷⁹This recommendation was submitted as a legislative proposal in the President's budget for fiscal year 2000.

⁸⁰This recommendation was submitted as a legislative proposal in the President's budget for fiscal year 2000.

HIPAA REPORT TO THE PRESIDENT, DRAFT, 5/6/99
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APPENDIX IV

HIPAA REPORT TO THE PRESIDENT, DRAFT, 5/6/99
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**Appendix IV - Results of Phone Survey Conducted
by Missouri Department of Insurance in May 1998**

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APPENDIX V

HIPAA REPORT TO THE PRESIDENT, DRAFT, 5/6/99
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**Appendix V - Results of Survey Conducted by
Colorado Department of Insurance in August 1997**

HIPAA REPORT TO THE PRESIDENT, DRAFT, 5/6/99
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TABLES AND FIGURES

LIST OF TABLES AND FIGURES

TABLES

Table 1 - States' Small Group Health Insurance Market Reforms Prior to HIPAA

Table 2 - HIPAA Data Collection Efforts by States

Table 3 - States' Individual Health Insurance Market Reforms Prior to HIPAA

Table 4 - States' Alternative Mechanisms

Table 5 - Sample Rate-Ups for Selected Risk Factors and Rated Up Premiums

Table 6 - Examples of Health Conditions for Which Certain Carriers May Decline Coverage,
Exclude a Condition from Coverage, or Require a Higher Premium

Table 7 - States' High Risk Pool Enrollment

Table 8 - Comparison of New Jersey's Individual Health Coverage Program Premiums and
Average Employer-Group Monthly Premiums

Table 9 - States' Group Market Provisions After HIPAA

FIGURES

Figure 1 - Criteria for State Alternative Mechanism

Figure 2 - Guaranteed Right to Purchase Individual Coverage Under HIPAA (Draft)

Table 5 - Sample Rate-Ups for Selected Risk Factors and Rated Up Premiums

Source: "Understanding Individual Health Insurance Markets: Structure, Practices, and Products in Ten States,"
by Deborah J. Chollet, Ph.D. and Adele Kirk, M.H.A. Kaiser Family Foundation, March 1998.

Table 6 - Examples of Health Conditions for Which Certain Carriers May Decline Coverage, Exclude a Condition from Coverage, or Require a Higher Premium

Source: United States General Accounting Office, "Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-offs," November 1996.

**Table 8 - Comparison of New Jersey's Individual Health Coverage
Program Premiums and Average Employer-Group Monthly Premiums**

Source: "Case Studies of the Individual Market: Lessons from New Jersey's Creation of a
Market for Individual Health Insurance," by Katherine Swartz, Ph.D., and Deborah W. Garnick, Sc.D.,
January 20, 1999. Reprinted with permission from the authors.

Figure 1: Criteria for Alternative Mechanisms

States may meet HIPAA's guaranteed issue requirements by establishing an alternative mechanism in accordance with the following criteria:

The alternative mechanism--

- * Provides a choice of health insurance coverage to all eligible individuals;
- * Does not impose preexisting condition exclusions and affiliation periods for coverage of an eligible individual;
- * Includes at least one policy form of coverage that is comparable to either a) comparable coverage offered in the individual market in the State; b) a standard option of coverage available under the group or individual health insurance laws of the State; and

Implements one of the following provisions related to risk:

- * Either of two NAIC Model Acts - The Small Employer and Individual Health Insurance Availability Model Act; or the Individual Health Insurance Portability Model Act as adopted on June 3, 1996; both Models must be revised in State regulations to meet all the requirements of 45 CFR Parts 144 and 148.
- * A qualified high risk pool that provides coverage to eligible individuals without a preexisting condition exclusion or affiliation period; and provides the premium rates and covered benefits for the coverage consistent with standards included in the NAIC Model Health Plan for Uninsurable Individuals Act in effect on August 21, 1996 and revised in State regulations to meet all the requirements of 45 CFR Parts 144 and 148; or
- * Any other mechanism that provides for risk adjustment, risk spreading, or a risk-spreading mechanism or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating individuals; or a mechanism that provides a choice for each eligible individual of all individual health insurance coverage otherwise available.

TABLE 1
STATES' SMALL GROUP HEALTH INSURANCE MARKET REFORMS PRIOR TO HIPAA¹

Provision	States With Provision	States Without Any Provision
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¹The data presented in this chart is based on information provided as a supplement to "Baseline Information for Evaluating the Implementation of the Health Insurance Portability and Accountability Act of 1996: Final Report," for the RAND Corporation by Stephen H. Long and M. Susan Marquis, et al. October 1998. This information includes State legislation as of 1996.

²Kentucky and New Jersey allow only standard products to be sold in the small group insurance market and these products must be guaranteed issue. Hawaii, Michigan, and Pennsylvania require their Blue Cross Blue Shield plans to guarantee issue at least one product.

Table 1, States' Small Group Health Insurance Market Reforms Prior to HIPAA, continued

Guaranteed Issue of Health Insurance Products Sold to Small Groups ²	All products: CA, FL, KY, ME, MD, MA, MN, NH, NJ, NY, OR, TX, VT, WA (14) Only standard products are guaranteed issue: AK, AZ, CO, CT, DE, ID, IA, KS, MS, MO, MT, NE, NC, ND, OH, OK, RI, SC, SD, TN, UT, VA, WI, WY (24)	AL, AR, DC, GA, IL, IN, LA, NV, NM, WV (10)
Small Group Defined as Employers with between 2 and 50 employees ³	AK, IA, KY, MD, NM, OH, OK, SC, SD, WY (10) Group Defined as Employers With Between 1 and 50 Employees: CO, CT, DE, FL, GA, MA, RI, UT, WA (9)	No Provision: AL, DC, HI, MI, PA (5) Group Defined More Narrowly: AZ, AR, CA, ID, IL, IN, KS, LA, ME, MN, MS, MO, MT, NE, NV, NJ, NY, NC, ND, OR, TN, TX, VT, VA, WI (25)
Guaranteed Renewal of All Health Insurance Products Sold to Small Groups ⁴	AK, AZ, AR, CA, CO, CT, DE, FL, GA, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY (46)	AL, DC, PA (3)
Preexisting Condition Exclusion Period Limited to 12 months or Less ⁵	AK, AZ, CA, CO, CT, DE, FL, GA, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MN, MS, MO, MT, NE, NV, NJ, NY, NH, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WV, WA, WI, WY (46)	AL, AR, DC, HI, MI (5)

²Kentucky and New Jersey allow only standard products to be sold in the small group insurance market and these products must be guaranteed issue. Hawaii, Michigan, and Pennsylvania require their Blue Cross Blue Shield plans to guarantee issue at least one product.

³New Hampshire defines its small group insurance market to include employers with between one and 100 employees; West Virginia defined its small group insurance market to include employers with between two and 60 employees. After HIPAA was enacted, West Virginia changed its law to match the HIPAA standard of groups of employers with between two and 50 employees.

⁴Hawaii and Michigan require their Blue Cross Blue Shield plans to guarantee renew their products.

⁵Maryland and New Jersey do not allow pre-existing condition exclusion limitations and consequently, have requirements regarding the "look-back period."

Table 1, States' Small Group Health Insurance Market Reforms Prior to HIPAA, continued

Provision	States With Provision	States Without Any Provision
Look-back Period Limited to Six Months or Less	AK, CA, CO, CT, DE, FL, ID, IA, KS, MA, MN, MO, NH, NE, NM, NV, NY, ND, OH, OK, OR, PA, RI, SC, SD, TX, UT, WA, WI, WY (31)	No Provisions: AL, AR, DC, GA, HI, MI (6) Look-Back Period Exceeds Six Months: AZ, IL, IN, KY, LA, ME, MS, MT, NC, SC, TN, VT, VA, WV (14)
Credit for Prior Coverage ⁶	AK, AZ, CA, CO, CT, DE, FL, GA, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MN, MO, MT, NE, NM, NV, NH, NJ, NY, NC, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY (44)	AL, AR, DC, MI, MS, PA (6)
Pre-existing Condition for Pregnancy Prohibited	MD, OR, WA (3)	AL, AK, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, PA, RI, SC, SD, TN, TX, UT, VT, VA, WV, WI, WY (48)
Some Discrimination Prohibited	AK, AZ, CA, CO, CT, DE, FL, ID, IL, IN, IA, KS, KY, ME, MD, MA, MN, MO, MT, NE, NV, NH, NJ, NY, NC, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WY (40)	AL, AR, DC, GA, HI, LA, MI, MS, NM, PA, WV (11)

⁶State laws vary considerably in this area; some States only credited coverage for a particular service, or if the individual had already satisfied a similar pre-existing condition exclusion. Hawaii does not allow pre-existing condition exclusions.

TABLE 2
HIPAA DATA COLLECTION EFFORTS BY STATES¹

States That Collect Data	Legislation Enacted Pre-HIPAA Individual Market	Legislation Enacted Pre-HIPAA Group Market	Number of Covered Lives in the Individual Market	Number of Covered Lives in the Group Market
Colorado	High Risk Pool effective 4/91	Guaranteed Issue (Standard Products) 1/95	Not available	'96=496,057 '97=507,322 2.3% increase (1-50 ee) Total Plans '96=57,654 '97=61,537 ('98 na)
Connecticut	High Risk Pool effective 1976	Guaranteed Issue (Standard Products) 7/90	Not available	'96=289,073 '97=231,738 (1-50 ee) 20% decrease ('98 data is not available)
Florida	High Risk Pool effective 10/83	Guaranteed Issue (All Products) 4/94	'97=528,290 ('98 na) (note: individual reform prior to HIPAA)	'96=1,452,172 '97=1,804,018 24% increase ('98 na)
Kentucky	Guaranteed Issue 7/96	Guaranteed Issue (Only Standard Products offered and Issued) 7/95	'96 data only - 122,738	'96 data only - 231,259
Maryland	Guaranteed Issue (At least 1 plan required for GI basis) (date na)	Guaranteed Issue (All Products) 7/94	'96=367,362 '97=496,534 35% increase ('98 na)	'96=479,264 '97=488,072 1.8% increase ('98 na)

¹This information is based upon a survey of States conducted in February 1999. States were asked to provide the number of covered lives in both the group and individual market if such information is routinely collected. States were also asked to provide any additional information (e.g, reports, studies) regarding the impact of HIPAA in that particular State.

States That Collect Data	Legislation Enacted Pre-HIPAA in the Individual Market	Legislation Enacted Pre-HIPAA in the Group Market	Number of Covered Lives in the Individual Market	Number of Covered Lives in the Group Market
Massachusetts	Guaranteed Issue 8/96	Guaranteed Issue (All Products) 1/92	'97=6,198 '98=18,136 293% increase²	'96=679,128 '97=689,471 1.5% increase ('98 na)
Michigan	Guaranteed Issue (At least 1 plan required for GI basis) 1956	Guaranteed Issue (Applicable to BCBS) 1956	Not Available	'96=1,010,678 '97=1,071,103 5.9% increase ('98 na)
Missouri	High Risk Pool effective 11/91	Guaranteed Issue (Standard Products) 7/94	'96=231,503 '97=207,827 10.2% decrease ('98 na)	'96=226,744 '97=199,712 11.9% decrease ('98 na)
New Hampshire	Guaranteed Issue (All Products) 1/95	Guaranteed Issue (All Products)	'94=33,670 '97=19,730 41.4% decrease ('98 na)	'94=122,436 '97=160,675 31.2% increase ('98 na)
New Jersey	Guaranteed Issue (Standard Products) 11/92	Guaranteed Issue (Only Standard Products offered and issued) 1/94	'93=156,565 ³ '96=182,588 '98=135,787 13.3% decrease overall	'94=694,312 '96=816,716 '98=867,620 25% increase overall

²These figures are based on the State's non-group membership. The large increase may reflect movement from individual health insurance policies to non-group policies. Under Massachusetts State law, health insurance issuers are required to close their individual policies and sell policies in the "non-group" market within three years of the law's enactment. Thus, the large increase in the number of covered lives may reflect individual's movement from their old individual policies to new non-group policies.

³These figures--and those for the group health insurance market--are the first available numbers following implementation of New Jersey's reforms.

Table 2, HIPAA Data Collection Efforts by States, continued

New York	Guaranteed Issue (All Products) 4/93	Guaranteed Issue (All Products) 4/93	'93=369,000 ⁴ '96=224,000 '97=228,000 1.8% increase '96-'97 38% decrease '93-97 ('98 na)	'93=913,000 '96=927,000 '97=974,000 6.7% increase overall ('98 na)
States That Collect Data	Legislation Enacted Pre-HIPAA in the Individual Market	Legislation Enacted Pre-HIPAA in the Group Market	Number of Covered Lives in the Individual Market	Number of Covered Lives in the Group Market
North Carolina	No provisions Pre-HIPAA	Guaranteed Issue (Standard Products) 8/92	Not available	'96=638,663 '97=526,512 17.6% decrease ('98 na)
North Dakota	High Risk Pool effective 1982	Guaranteed Issue (Standard Products) 8/93	'96=58,599 '97=57,518 1.8% decrease ('98 na)	'96=44,615 '97=51,580 15.6% increase ('98 na)
South Dakota	Guaranteed Issue (Standard Products) 3/96	Guaranteed Issue (Standard Products) 7/96	Numbers are not available, but '98 state survey estimated that .1% - .5% of South Dakotans are uninsurable, a decrease from a range of .2% - .7% in '97. (Survey of 6,228 individuals.)	1/94=105,965 7/95=84,522 1/96=119,653 7/96=119,269 '97=134,467 26.8% increase overall
Texas	No provisions Pre-HIPAA	Guaranteed Issue (All Products) 1/96	'96=1 million '97=.9 million (approx. numbers based on annual CPS survey by Census Bureau) '98 na	'96=917,368 '97=978,966 6.7 % increase ('98 na)

⁴These figures--and those for the group health insurance market--are the first available numbers following implementation of New York's.

⁵These figures are the first available following Vermont's small group and individual health insurance market reforms. The figures for the small group health insurance market are based on the State's non-association membership only.

Table 2, HIPAA Data Collection Efforts by States, continued

Vermont	Guaranteed Issue (All Products) 7/93	Guaranteed Issue (All Products) 7/92	'94=31,257 ⁵ '96=26,680 '97=26,099 16.5% decrease overall	'92=46,644 '96=46,547 '97=42,399 9.1% decrease overall
Washington	High Risk Pool effective 7/88 Guaranteed Issue 1/96	Guaranteed Issue (All Products) 1/96	'96=360,829 '97=319,493 11.5% decrease ('98 na)	'96=578,407 '97=481,175 16.8% decrease ('98 na)
Wisconsin	No provisions Pre-HIPAA	Guaranteed Issue (Standard Products) 2/94	'96=352,811 '98=226,432 35.8% decrease	'96=1,970,669 '98=1,992,792 1.1% increase
STATES THAT DO NOT COLLECT DATA		AL, AZ, CA, DE, DC, GA, HI, IL, IA, KS, ME, MN, MT, NE, NM, NV, OH, TN, UT, VA, WV, WY (22)		
STATES THAT DID NOT RESPOND		AK, AR, ID, IN, LA, MS, OK, OR, PA, RI, SC (11)		

⁵These figures are the first available following Vermont's small group and individual health insurance market reforms. The figures for the small group health insurance market are based on the State's non-association membership only.

TABLE 4
CHARACTERISTICS OF ACCEPTABLE
ALTERNATIVE MECHANISM SUBMISSIONS

STATE	MECHANISM	EFFECTIVE DATE	PROCESS
Alabama	High-risk pool	1/1/98	Legislation provides for new high-risk pool
Alaska	High-risk pool	1/1/98	Building on existing law
Arkansas	High-risk pool	7/1/97	Modifies risk pool in existence since 1995
California**	Other Mechanism (Modeled on §2741)	1/1/98	Building on existing law
Connecticut	High-risk pool	7/1/97	Expanding on risk-pool in existence for 22 years
District of Columbia	Other Mechanism (modeled on §2741)	1/1/98	New law
Florida	Other Mechanism (combination of mandatory group conversion options or, at least, two most popular policy forms)	1/1/98	Building on existing law
Georgia	Other Mechanism (combination of mandatory group conversion with a guaranteed issue mechanism)	1/1/98	Building on existing law
Idaho	Other Mechanism (provides for risk spreading or risk adjustment)	7/1/97	Building on existing law
Illinois	High-risk pool	7/1/97	Expanding on risk pool in existence for 8 years

Table 4, Characteristics of Acceptable Alternative Mechanisms, continued

Indiana	High-risk pool	1/1/98	New Legislation to modify the existing risk pool
Iowa	High-risk pool	7/1/97	Building on risk-pool in existence since 1986
Kansas	High-risk pool and/or risk adjustment	7/1/97	New Legislation to modify the existing risk pool
Kentucky	Other Mechanism (provides choice of coverage in the individual market)	4/10/98	Building on existing law
Louisiana	High-risk pool	1/1/98	Expanding on risk-pool in existence for 7 years
Maine	Other Mechanism (provides choice of coverage in the individual market)	1/1/98	Building on existing law
Massachusetts**	Other Mechanism (provides for risk spreading)	1/1/98	Building on existing law
Michigan	Other Mechanism	3/7/99*	Building on existing law
Minnesota	High-risk pool	1/1/98	Expanding on risk pool operational since 1977
Mississippi	High-risk pool	7/1/97	Expanding on risk pool in existence since 1991
Montana	High-risk pool	5/8/97	Expanded on risk pool that was operational since 1991
Nebraska	High-risk pool	7/1/97	Expanding on risk-pool in existence for 22 years
Nevada	NAIC/Small employer and individual health	insurance availability model act	7/16/97

Table 4, Characteristics of Acceptable Alternative Mechanisms, continued

Building on Existing law	New Hampshire	Other Mechanism (modeled on §2741)	1/1/98
Building on existing law	New Jersey	Combination of guarantee issue on all products in the individual market with risk adjustment/risk spreading	1/1/98
Building on existing law	New Mexico	Combination of high-risk pool and an Other Mechanism (provides for risk spreading and risk adjustment)	4/11/98
Builds on existing risk pool	New York	Other Mechanism (Provides choice of coverage in the individual market)	7/1/97
Building on existing law	North Dakota	High-risk pool	7/1/97
Expanding on existing risk pool	Ohio	Other Mechanism (Combination of open enrollment, guaranteed issue and mandatory conversion from group to individual with health reinsurance program)	7/1/97
Building on existing law	Oklahoma	High-risk pool	5/12/97
Modification to existing risk pool	Oregon	High-risk pool	1/1/98
Modification to existing risk pool	Pennsylvania	Other Mechanism (provides for risk-spreading)	

Table 4, Characteristics of Acceptable Alternative Mechanisms, continued

1/1/98	Building on existing law	South Carolina	High-risk pool
3/31/97	Modification to existing risk pool	South Dakota	Other Mechanism (provides for risk-spreading)
7/1/97	Building on existing law	Texas	High-risk pool
7/1/97 (Risk pool must begin providing benefits NLT 1/1/98)	Builds on existing risk pool (risk pool created in 1989 but not funded until 7/1/97)	Utah	Combination of high-risk pool and Other Mechanism (modeled on §2741)
5/1/97	Building on existing law	Vermont	Other Mechanism (choice of all individual health coverage otherwise available)
1/1/98	Amendment to existing law	Virginia	Other Mechanism (modeled on §2741)
1/1/98	Building on existing law	Washington	Other Mechanism
5/8/95	Relies on existing law	Wisconsin	High-risk pool
1/1/98	Expanding on risk-pool in existence for 18 years	Wyoming	High-risk pool
1/1/98	New legislation to modify the existing risk pool		

* Legislation to implement Michigan's Alternative Mechanism was enacted on March 9, 1999 and became effective immediately.

**Legislation necessary to implement Alternative Mechanism has not passed legislature.

Updated 4/99

TABLE 3
STATES' INDIVIDUAL HEALTH INSURANCE MARKET REFORMS PRIOR TO HIPAA¹

Provision	States With Provision	States Without Any Provision
Guaranteed Issue of at Least One Health Insurance Product ²	ID, IA, KY, ME, MA, ³ MD, MI, NH, NJ, NY, OH, PA, RI, SD, VT, VA, WA (17) (MD, MI, PA, RI, and VA require the Blue Cross/Blue Shield carrier to guarantee issue at least one product.)	No Provision: AL, AK, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, KS, LA, MN, MS, MO, MT, NE, NV, NM, NC, ND, OK, OR, SC, TN, TX, UT, WV, WI, WY (34)
Guaranteed Renewal of All Health Insurance Products Sold in the Individual Market	CO, FL, GA, ID, IA, KY, ME, MA, MI, MN, NH, NJ, NY, ND, OH, OR, SD, UT, VT, VA, WA, WY (22) (MI requires Blue Cross/BlueShield to guarantee renew its individual market products.)	No Provision: AL, AK, AZ, AR, CA, CT, DE, DC, HI, IL, IN, KS, LA, MD, MS, MO, MT, NE, NV, NM, NC, OK, PA, RI, SC, TN, TX, WV, WI (29)
Preexisting Condition Exclusion Period Limited to 12 months or less	CA, CO, CT, ID, IA, KY, LA, MD, ME, MA, MN, NH, NJ, NM, NY, ND, OH, OR, SC, SD, TX, UT, VT, VA, WA, WY (26) (RI does not allow pre-existing condition exclusion periods) (1)	No Provisions: AL, AK, AZ, AR, DE, DC, GA, HI, IL, KS, MI, MS, MO, MT, NE, NV, NC, OK, PA, TN, WV, WI (22) (FL limited the exclusion period to 24 months; IN limited the exclusion to 18 months.) (2)
Look-back Period Limited to Six Months or less	ID, MA, MN, NH, NJ, NM, NY, ND, OH, OR, UT, WA, WY (13) (RI does not allow pre-existing condition exclusion periods)	No Provision: AL, AK, AZ, AR, DE, DC, GA, HI, IL, KS, MD, MI, MS, MO, MT, NE, NV, NC, OK, TN, WV, WI (22) Look-Back Period Exceeds Six Months: CA, CO, CT, FL, IN, IA, KY, LA, ME, PA, SC, SD, TX, VT, VA (15)

¹The data presented in this table is based upon information provided as a supplement to "Baseline Information for Evaluating the Implementation of the Health Insurance Portability and Accountability Act of 1996: Final Report," for the RAND Corporation by Stephen H. Long and M. Susan Marquis, et al., October 1998. This information includes State legislation as of the end of 1996. The Institute for Health Care Research and Policy at the Georgetown University Medical Center also provided information that is reflected in this table.

²Kentucky, Massachusetts, and New Jersey require only standard products to be sold in the small group insurance market and these products must be guaranteed issue.

³Massachusetts requires guaranteed issue only for those individuals with prior health insurance coverage.

Table 3, States' Individual Health Insurance Market Reforms, continued

Provision	States With Provision	States Without Any Provision
Credit for Prior Coverage ⁴	CA, CO, CT, FL, ID, IN, IA, KY, LA, ME, MA, MN, NE, NH, NJ, NM, NY, ND, OH, OR, RI, SD, UT, VT, VA, WA, WY (27)	No Provision: AL, AK, AZ, AR, DE, DC, GA, HI, IL, KS, MD, MI, MS, MO, NE, NV, NC, OK, PA, SC, TN, TX, WV, WI (24)
Lapse in Coverage of 63 Days or More Allowed	CO, ME, ND, UT, WA, WY (6)	No Provision: AL, AK, AZ, AR, DE, DC, GA, HI, IL, KS, MD, MI, MS, MO, NE, NV, NH, NC, OK, PA, RI, SC, TN, TX, VT, WV, WI (27) Lapse in Coverage of Less Than 63 Days Allowed: CA, CT, FL, ID, IN, IA, KY, LA, MA, MN, MT, NJ, NM, NY, OH, OR, SD, VA (18)
Premium Rates May Not Be Based on Health Status	ID, KY, ME, MA, NH, NJ, NM, NY, ND, OR, UT, VT, WA (13) Some Variation Based on Health Status Allowed: IA, LA, MN, SD, (4) (MD, MI, PA, and RI require Blue Cross/Blue Shield carriers to apply pure community rating) (4)	No Provision: AL, AK, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, KS, MS, MO, MT, NE, NV, NC, OH, OK, SC, TN, TX, VA, WI, WV, WY (30)

⁴State laws vary considerably in this area; some States only credited coverage for a particular service, or if the individual had already satisfied a similar pre-existing condition exclusion.

TABLE 7 - HIGH-RISK POOLS USED AS AN ALTERNATIVE MECHANISM¹

State	Enrollment pre-HIPAA ²	Current Enrollment	HIPAA Eligibles	Funding ³	Premium Cap
Alabama ⁴	N/A	978	978	Assessmnt/offset	200%
Alaska	179	198 (1997)	5-7‡	Assessment	200%
Arkansas	401 (1996)	588 (1997)	N/A	Assessment	150%
Connecticut	1,149	1,459	244	Assessment	150%
Illinois	4,805	6,580	1,570	Direct approp.	125-150%
Indiana	4,483	3,950	81	Assessmnt/offset	150%
Iowa	1,099	482 (1997)	N/A	Assessmnt/offset	150%
Kansas	619	1,113	184	Assessmnt/offset	N/A
Louisiana	532	747	48	See note	200% max
Minnesota ⁵	30,470	25,125	10	Assessment	125% (wgt'd avg)
Mississippi	835	1,765	183	See note	175% max
Montana	321	1,164	473	Assessmnt/offset	150% avg
Nebraska	3,366	4,214	N/A	Assessmnt/offset	135%
New Mexico	858	792 (1997)	N/A	Assessmnt/offset	150%
N. Dakota	1,334	1,346	7	Assessmnt/offset	135% max
Oklahoma	119 (1996)	783	N/A	Assessmnt/offset	125% avg.
Oregon	4,235	4,199	381	Assessment	125%
S. Carolina	1,078	1,031	324	Assessmnt/offset	200%
Texas	N/A	2,658	950	Assessment	150/200
Utah	710	1,111	200	Direct approp.	N/A
Wisconsin	9,512	7,066	640	Assessment	200%
Wyoming	279	452	3	Assessmnt/offset	150% max
TOTALS	66,384	67,801	6,281-3	N/A	N/A

1. This table includes only information regarding those high-risk pools used by States as their acceptable alternative mechanism. Three Federal Fallback States--California, Colorado, and Missouri have high-risk pools, but are not using these as their alternative mechanism. (Source: Communicating for Agriculture, *Comprehensive Health Insurance for High-Risk Individuals*. 1998.)

2. Except where noted, total enrollment prior to HIPAA is as of 1995. Total current enrollment is as of December 31, 1998 and based on a survey conducted by Communicating for Agriculture in January 1999.

3. States generally fund high-risk pools through an assessment on association members or allocations from State funds, often offset by a premium tax credit, as noted above. Illinois' risk pool is funded by general revenue, but its separate HIPAA pool is funded by an assessment on all health insurers. Louisiana funds its risk pool through general revenue and a service charge on hospital admissions and outpatient procedures. Its HIPAA pool is funded by assessments on HMOs and insurance carriers. Mississippi has a fixed dollar amount assessment on every insurer in the State.

4. Alabama's high-risk pool is only for HIPAA eligibles.

5. Minnesota also receives some of the surcharge funds from health care providers for its low-income subsidy program.

TABLE 9
STATES' SMALL GROUP HEALTH INSURANCE MARKET PROVISIONS AFTER HIPAA¹

Provision	States With Provision	States Without Any Provision
Guaranteed Issue of Health Insurance Products Sold to Small Groups	AL, AK, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MN, MS, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY (49)	No Provision: MI, OK (2)
Small Group Defined as Employers with between two and 50 employees ²	AL, AK, AZ, AR, CA, DC, GA, ID, IL, IA, KS, KY, LA, MN, MS, MT, NE, NV, NJ, NM, NY, ND, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, WV, WI, WY (34) Defined as between one and 50 employees: CO, CT, DE, FL, HI, ME, MD, MA, NH, NC, RI, VT, WA (13)	No Provision: MI, MO (2)
Guaranteed Renewal of All Health Insurance Products Sold to Small Groups	All States and the District of Columbia (51)	None
Pre-existing Condition Exclusion Period Limited to 12 months or Less	AL, AK, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NJ, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY (51)	None
Look-back Period Limited to Six Months or Less	AL, AK, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NJ, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY (51)	None

¹The data presented in this chart is based on information provided as a supplement to "Baseline Information for Evaluating the Implementation of the Health Insurance Portability and Accountability Act of 1996: Final Report," for Rand by Stephen H. Long and M. Susan Marquis, et al., October 1998. Supplemental information was provided by the Institute for Health Care Research and Policy at the Georgetown University Medical Center. HHS staff are currently confirming the status of States' compliance with the group market provisions.

²New Hampshire defines its small group health insurance market as employers with between one and 100 employees.

To: Chris Jennings

From: Jay Angoff

Re: Four recommendations from the Report to the President on HIPAA, and the evidence in the report supporting those recommendations

May 4, 1999

This memorandum sets out four significant recommendations that could be made based on the evidence contained in the Report to the President, describes the evidence in the report that supports those recommendations, explains the arguments the industry and other opponents could make in opposition to those recommendations, and suggests our response to those recommendations. The first three recommendations are now in the report. The fourth recommendation is not in the report; the evidence supporting it is.

I. Recommendation 1: Limit rates to HIPAA eligibles.

Insurers have been charging very high rates to HIPAA eligibles. The latest GAO report on HIPAA implementation, which is to go to Senator Jeffords May 5, finds that insurers typically charged HIPAA eligibles at least 300% of standard; our report finds that rates were even higher, and in several cases much higher. In addition, due to both earlier GAO reports and testimony from the states before Congress, both the general and trade press have written about the high rates--up to 500 or 600% of standard--that insurers have been charging HIPAA eligibles. In short, it is very difficult to dispute the fact that rates charged to HIPAA eligibles have been very high.

Accordingly, the report as currently drafted recommends that HIPAA be amended to limit the rates charged to HIPAA eligibles to 150% of standard. It does not recommend limiting insurers' ability to rate by age or sex; since insurers typically charge older people about four times as much as younger people, under this proposal older HIPAA eligibles would pay about 600% (4 X 150%) of what young, healthy people pay in the private market. The 150% figure is the same figure used in the bill introduced last year by Senator Kennedy to limit rates under HIPAA; it is also the limit that exists in about five state high-risk pools. Importantly, it is a much more modest limitation than exists in several states, including New Jersey, Vermont, and New York, which have pure or near-pure community rating laws: they require insurers to charge the same rate, or about the same rate, to anyone that applies, regardless of health status, sex or age.

The entire insurance industry is likely to oppose this recommendation, although the large and the small carriers will make different, and contradictory, arguments against it. The large carriers will argue that a limitation on rates is unfair to them. Because they are so large and because everyone knows their names, they will argue, they will get a disproportionate share of

high risks who they will only be able to charge 150% of standard, which is less than the true cost of covering HIPAA eligibles. Conversely, the small carriers will argue that a limitation on rates is unfair to them. They will argue that unlike the large carriers, who can afford to absorb several high risks because they insure so many healthy people, a small carrier can't afford to insure many--perhaps even any--high risk people, since they don't have a big enough base of healthy people among whom to spread that risk.

The large carriers and small carriers will agree, however, that any limitation on rates will force healthy people to subsidize sick people and thus will force insurers to charge their healthy insureds more.

We can meet these objections with both actuarial studies and empirical evidence. The actuarial studies come from the original Kennedy-Kassebaum debate. One, done by the Hay Group, Inc., for the Congressional Research Service, finds that if premiums in the individual market were limited to 200% of the average group premium, premiums in the individual market would increase by less than 1% in the first year and by a maximum of 3% when all HIPAA eligibles were brought into the market. Another study, by the American Academy of Actuaries, finds the likely rate increase to be between 2% and 5%.

The empirical evidence comes from the states--primarily New Jersey, Vermont, and New York--which have enacted legislation requiring insurers to charge the same or about the same rate to all individuals regardless of health status, age, or sex, and which thus limit rates to a much greater extent than would our recommendation, which continues to allow the use of age and sex. Those laws have remained in place under both Democratic and Republican administrations and legislatures, and Gov. Pataki has been quoted in The New York Times saying that New York hasn't seen the problems many other states have experienced under HIPAA because New York enacted its own law prior to HIPAA. On the other hand, while these laws have increased coverage in the individual and small group market combined, since these laws have been enacted the number of people insured in the individual market in New York and New Jersey has decreased. However, the industry's explanation for why enrollment in the individual market has gone down in these states is that young people find their rates going up and drop coverage. Because our proposal doesn't limit insurers' ability to rate by age, the industry could not credibly criticize it on this grounds.

Nevertheless, any time the government recommends meaningfully--even if modestly--limiting rates, it is in for a big fight with the industry. There is, however, one advantage in having this fight at the federal level: whenever a state seeks meaningful reform insurers may threaten to withdraw from the state, but if the federal government seeks reform insurers are unlikely to threaten to withdraw from the country.

II. Recommendation II: Establish a joint NAIC-HCFA Council

The report documents several issues that both the states and HCFA--particularly in the

states in which it directly enforces the law--must deal with. For example, the report makes it clear that we must both find ways to enable as many people as possible to gain access to insurance under HIPAA, and to prevent insurers from avoiding or evading HIPAA. The report also sets out the data that are available on the number of people insured in the individual market and the small group market and on the number of people who have been insured under HIPAA, but makes clear both that little data exists and that there is no standard method of collecting such data. A joint HCFA-NAIC council would enable the states and HCFA to better monitor the marketplace, evaluate the effectiveness of HIPAA, and ensure that people who qualify under HIPAA get the benefit of its protections. It would also serve as a forum where issues could be discussed and resolved in a timely, informal and non-bureaucratic manner.

Some insurers might oppose a joint HCFA-NAIC council on the grounds that it is simply another bureaucracy; they might seek to caricature such a council in the same manner that they caricatured the health alliances in the 1993-94 health plan. In addition, some insurance commissioners--though by no means all--might resist such a council because they view it as an intrusion by the federal government on their turf.

Our response could be that there is an increasing interdependence between the states and the federal government on insurance issues. For example, state insurance departments have traditionally played no role in either medicare or medicaid; in recent years, however, as managed care has come to both programs, state insurance departments have been licensing and examining medicare and medicaid HMO's. Conversely, while HCFA has traditionally played no role in private insurance regulation, it does have such a role under both the medigap statute and HIPAA. In the future it can only be a benefit to both the states and HCFA to have a forum at which they can work together and work out problems.

III. Recommendation 3: Establish an education campaign

The report makes clear that many people are unaware of the various hoops they must jump through to qualify for insurance under HIPAA, and that insurers are not overeager to help people qualify, or to inform people that they do qualify if they don't know they qualify. The report also makes clear that HIPAA has helped few people seeking individual coverage: for example, in the 21 states that use their high risk pools to comply with HIPAA, only 6500 HIPAA-eligible individuals have been insured. By undertaking a major campaign to inform people of what they need to do to qualify under HIPAA--and what they need to avoid in order not to lose their eligibility under HIPAA--HIPAA can have a greater impact that it has up till now.

However, a massive education campaign by itself will not fix the two fundamental weaknesses of HIPAA: its failure to limit rates and its applicability to only a limited class of individuals. In addition, making available comparative price information--whether by means of the booklets traditionally put out by state insurance departments on auto and homeowners insurance, or on the internet as HCFA is doing with medicare HMO and medigap insurance--will

probably not work in connection with HIPAA. This is because insurers in the auto, homeowners, and medicare/medigap markets want to insure people, and therefore the availability of comparative price information in those markets will force insurers to compete on price. In contrast, insurers want to avoid insuring HIPAA-eligibles, and therefore the availability of the prices charged by all insurers to HIPAA-eligibles is not likely to bring those prices down. To the contrary, a reasonable argument can be made that making available comparative price information in a market in which insurers want to avoid selling insurance will encourage each insurer to raise its prices so as to avoid selling to HIPAA-eligibles.

If HIPAA is amended so that it limits rates, a massive education campaign might make sense. Organizations that work on behalf of individuals with diseases that typically make it difficult or impossible for them to find insurance--such as cancer, diabetes, multiple sclerosis, heart disease, etc.--are potential allies. Their involvement with and enthusiasm for HIPAA to this point has been limited because HIPAA does not limit rates.

Recommendation 4: Expand HIPAA's guaranteed issue provisions to apply to all individuals, not just HIPAA eligibles

The report makes clear that only a limited class of individuals are entitled to insurance under HIPAA--those with at least 18 months of prior coverage whose most recent coverage is in a group plan and who have had no more than a 63-day break in coverage. The restrictiveness of this definition precludes many people--including all those covered by individual rather than group insurance, as well as all those who have gone without insurance for more than 63 days--from qualifying under HIPAA. In addition, the restrictiveness of this definition makes it difficult for people to know whether they qualify under HIPAA, and encourages insurer gamesmanship--such as turning away HIPAA-eligibles unless they present themselves as HIPAA-eligibles, or offering people who qualify under HIPAA conversion or short-term policies that disqualify them under HIPAA. Finally, the restrictiveness of this definition forces the government to engage in a great deal of regulation to make sure that insurers are insuring people who do qualify, that they issue certificates of coverage, and that they otherwise comply with the statute, but results in very little additional coverage. If HIPAA were expanded to cover all individuals, regulation could be reduced and coverage increased.

Any effort to expand guaranteed issue will be opposed by the industry on the grounds that it will raise rates for everyone, as well as by the large and small carriers for the different and contradictory grounds discussed under Recommendation 1. If we do not recommend limiting rates, the argument that guaranteed issue will raise rates is without merit, since insurers will still be able to charge sick people whatever they wish--just as they do under HIPAA today. If rates are limited, as this memorandum recommends, then this argument has some merit. We can meet it with three responses. First, New Jersey, New York and Vermont have enacted legislation not only guaranteeing issue to all individuals but also limiting rates far more dramatically than our proposal would limit them, and HMO rates have not risen substantially in those states since that legislation was enacted. Rates charged by the traditional indemnity carriers have increased

substantially in those states, but this is because those carriers insured only the healthiest risks prior to the enactment of guaranteed issue. The consumer--both healthy and unhealthy--can find reasonably priced coverage from other carriers in all three states. Second, if HIPAA is expanded to cover more individuals carriers will be able to reduce their expenses associated with determining who is and who isn't eligible. These savings should counteract to some extent the increase in costs brought about by bringing new people into the insurance system. Third, if a system is set up in which insurers have no choice but to sell to the less healthy if they want to sell to the healthy, they will be forced to find ways to market to and insure as many healthy people as possible if they want to stay in business. Insurers have been very successful marketers; if the rules of the system force them to do so, they should be able to figure out how to market more successfully to young, healthy individuals.

None of these arguments, however, will reduce the intensity of the opposition by the industry and its allies to guaranteed issue combined with rate controls.

On the other hand, like the recommendation to limit rates to 150% of standard, any expansion of the class of people to which HIPAA applies would be supported by groups representing people with diseases that make it difficult or impossible for them to get insurance, as well as by the AARP.

To: Jay Angoff (HCFA)
Peter Harbage (HCFA)
Kate Kirchgraber (OMB)
Steve Finan (ASPE)
Phil Ellis (Treasury)
Dan Maguire (DOL)

From: Devorah

Re: Release of Report to the President on HIPAA

60 days before
in health plan ~~AS~~
63 days break
→ 90 days
stat ~~AS~~

Hello –

We are scheduled to meet about HIPAA and the Report to the President on Thursday, May 13th at 10 am . The conference call line is 456 6755, and the access code is 7213.

I am hoping that we can close out some of the issues that were raised at the last meeting we had, and discuss the progress we made in terms of nailing down the details of some of the announcements. Specifically, I would like to:

1. Ensure that everyone is comfortable with the proposal to limit premiums for HIPAA eligibles to 150 percent of the standard rate.

If everyone is comfortable, we should also discuss the internal process that needs to begin in order to draft this legislation and get it cleared in time for early June.

2. Discuss the proposal for the public-private partnership to ensure effective implementation of HIPAA (~~the latest incarnation of the 'regulatory board'~~).

We should discuss in more detail how the board would actually be operationalized.

I would also like to hear about the results of Jay's outreach to state insurance commissioners.

3. ~~Discuss the pros and cons of the proposed outreach campaign.~~

I would like to hear about the results of Steve and Jay's internal discussions with ASPA ^{they do not want to talk about this.} about (1) funding for a campaign, (2) how any new efforts would build on existing efforts, (3) what the core message might be, and (4) how soon we could get it off the ground.

If, for some reason, the agenda leaves out important topics or covers extraneous ones, please call me at 456 5707.

* We should also ask them about the enforcement reg *

To: Jay Angoff (HCFA)
Peter Harbage (HCFA)
Steve Finan (ASPE)
Kate Kirchgraber (OMB)
Leslie Kramerich (DOL)

From: Devorah

Re: Release of HIPAA Report to the President

Hello –

Based on the meeting that we had with HCFA and ASPE a little over a week ago, I have drafted up a summary of the potential announcements we could make as part of the submission of the HHS / DOL Report to the President on HIPAA. The summary is attached.

Under each potential announcement, I have a list of questions that I need help answering. I was hoping that we could have a quick, staff-level conference call this week with DOL and HHS to discuss the answers to the outstanding questions, correct any errors in the summary document that is attached, and talk about next steps in moving forward. If this is okay with everyone, I will have our office schedule the meeting. I would prefer to make this a small conference call – so it would be great if HHS could coordinate their attendance through Peter.

Also, I am hoping to get a draft of the Report to the President by 5/7 (end of this week). Please let me know if there is a problem with this.

Thanks a lot for all your help so far. Please call with questions, comments, or suggestions – I'm at 202 456 5707.

[Handwritten signature]

June 5th
June hearing

Jay reg
Steve ASPE

Federal high risk
no burden pool? vs
150%
on industry
sub by
taxpayers

What is 150%
based on?

RELEASE OF HIPAA REPORT TO THE PRESIDENT
POTENTIAL ANNOUNCEMENTS

Treas:
concerns
that
admin
doing
so
many
more
mandates
what
extent
is their
norm
in report
to have
policy
rationale

New actions to limit out-of-pocket expenditures for individuals insured under HIPAA. This proposal will limit the premium for individuals insured under HIPAA to 150 percent of the premium that would be charged to someone of comparable age and sex. HIPAA, which ensures access to health insurance for people who have lost their jobs and exhausted their COBRA coverage, was designed to ensure continuity of care for these individuals. However, because there are currently no statutory limits on the premiums they can be charged, many people are being charged exorbitant premiums for their health insurance coverage. This new proposal would prevent insurers from charging more than 150 percent of the standard rate in order to ensure that the access to and continuity of care this population was promised under HIPAA is a reality.

QUESTIONS:

surveys
CO NC
MO earlier GAO report

1. It would be great to get a summary of the studies demonstrating that people insured under HIPAA are being charged up to 500 percent of the standard rate for their coverage.
2. I would like to be able to have an example of what being charged up to 500 percent of the standard rate actually translates to in dollars.
3. I would like to be able to have a list of ^{insurers} ~~states~~ that charge more than 150 percent of the standard rate (with a column on what they do charge people).
4. I know that this number is probably not very big – but do we know how many people are actually taking advantage of the HIPAA benefit? If we don't know this number and it is impossible to get, that's fine. *high risk pool states 6,000 (21) appendix to report # people in ind small group; # 96*
5. This proposal needs legislation. I understand that Kennedy put forth this proposal last year, but has not reintroduced it, so we can't just endorse their proposal. What do we need to do to get our own legislative proposal drafted and moving through the process? *# GAO state reform*
6. Do we have any information on states with community ratings? I am interested in learning whether there is any evidence showing that community ratings has (or hasn't) affected premiums or plan participation in those states. *VT, NY, NJ → 3 states with community ratings*

Establishing a new regulatory council to ensure effective enforcement of HIPAA. This proposal would create a regulatory council with Federal and State representatives in order to ensure effective enforcement of the HIPAA legislation. The current enforcement structure, which involves three Departments and 50 State Insurance Commissioners, is often inefficient and sometimes ineffective. This new regulatory council would bring together State Insurance Commissioners and representatives of the Federal government to provide technical assistance to states and develop and meaningful partnership as they work to implement and enforce the HIPAA legislation.

change
name

not prepared to say (report talks about what we've done in an admin sense don't want to change the law.)

data
DOL, HHS, MDU → hold on pris of this

QUESTIONS

- trad hostility to Fed involvement enter in to new partnership w NAC
W/C shouldn't discount hostility
1. I think it is necessary to get much more specific about the actual responsibilities of this council. Who does it answer to? What activities will it undertake? Will it have all 50 state insurance commissioners, or just a representative sample? Since states are not enforcing the law now, what is their impetus to participate in this? Please help.
2. Before we announce this, we need to make sure that the state insurance commissioners endorse this proposal. Have we done any outreach to them? What is the best way to do this, if it has not been done yet? JAY

Launching a new public education campaign about the health insurance options available under HIPAA. HHS and DOL will build on their current efforts to provide information to consumers and launch a new public education campaign this fall to educate beneficiaries about their rights under HIPAA. This campaign will conduct direct outreach to consumers through the development of a *[please help with details on the campaign]*.

1. Will HCFA sponsor this campaign?
2. What will the campaign focus on?
3. Will we have private-public partnerships?
4. What will our information distribution mechanisms be?
5. What is the core message?
6. What is the timing? Steve

DOL launched health benefits campaign to private partners
HHS wider outreach more outlets

New administrative actions to enforce HIPAA and prevent group plans from discriminating against individuals based on their health status. HCFA will publish regulations imposing civil money penalties of \$100 per day per violation on issuers who have failed to fully implement the requirements of HIPAA. In addition, DOL, HHS, and Treasury will establish regulations detailing the protections afforded by the provision prohibiting discrimination against individuals seeking coverage under group health insurance plans based on their health status. Currently, *[definition of the problem that these regulations are fixing]*.

1. How do we know that discrimination is a problem under group health insurance plans?
2. When will the enforcement regulation be cleared by OMB?
3. When will the non-discrimination regulation be sent to OMB? When can we expect it to be cleared? Weeks

Jay

Steve

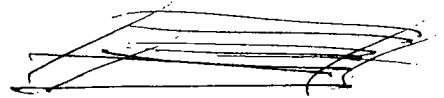
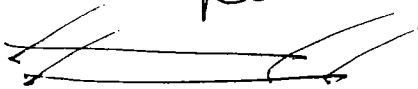
Jay

702

enforcement reg → not @ OMB
signed by NAMB → effective date
interim 60 days after publication
final.

June 6 NAIC mtg in Kansas City

health benefits education campaign →
heslie



Final Call leg.

POTUS or not

reg moving

bennie campaign.

Wed or
Th mtg
next week.