

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY



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Date: 5/10/99

From: Stephen Finan

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DT: May 7, 1999 # of pages, including cover: ||

TO: Steve Finan, ASPE 202/401-7321
Judith Heimlich, DOL 202/219-5333

FR: Danielle Noll

RE: Appendices, Tables, and Figures for HIPAA Report

Attached are Appendices I, IV, and V and Tables 5, 6, and 8. I have also attached a new Figure 2. This should accompany the copy of the report and other tables and appendices you received via e-mail. Please contact me at the number above with any questions.

Danielle

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

LIST OF APPENDICES

- attached* - Appendix I - President's Directive of July 7, 1998
- Appendix II - Accomplishments
- Appendix III - Policy Issues
- attached* { Appendix IV - Results of Phone Survey Conducted by Missouri Department of Insurance
- Appendix V - Results of Survey Conducted by Colorado Division of Insurance

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DATE AND TIME

BY FAX

Appendix I - President's Executive Order

THE WHITE HOUSE

WASHINGTON

58 JUL -8 PM 3:22

July 7, 1998

OFFICE OF PERSONNEL
MANAGEMENT

MEMORANDUM FOR THE SECRETARY OF LABOR
THE SECRETARY OF HEALTH AND HUMAN SERVICES
THE DIRECTOR OF THE OFFICE OF PERSONNEL
MANAGEMENT

SUBJECT: Ensuring Compliance with the Health Insurance
Portability and Accountability Act of 1996

Earlier this year, my Administration received a number of troubling reports that health insurers were circumventing insurance protections under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by giving financial incentives to agents to avoid enrolling Americans with pre-existing conditions. In addition, we learned that some agents were delaying the processing of applications submitted by qualified individuals in order to ensure that the applicant had a sufficient break in coverage to lose eligibility for HIPAA protections. Such actions clearly were and are inconsistent with the letter and spirit of HIPAA.

In February, I directed the Department of Health and Human Services (HHS) to take appropriate actions to encourage health insurers and their agents to stop all such harmful practices. The Health Care Financing Administration (HCFA) responded by immediately releasing a strong guidance bulletin on March 18 to every insurance commissioner in the Nation, advising them of our strong commitment to ensure compliance with HIPAA.

Today, I am taking additional actions to ensure that health plans comply with this law. I direct the Office of Personnel Management (OPM) to use its contractual relationship with health plans to improve HIPAA compliance. The OPM oversees the Federal Employees Health Benefit Program (FEHBP), the Nation's largest employer-sponsored health benefits program with 9 million enrollees and 350 participating health plans.

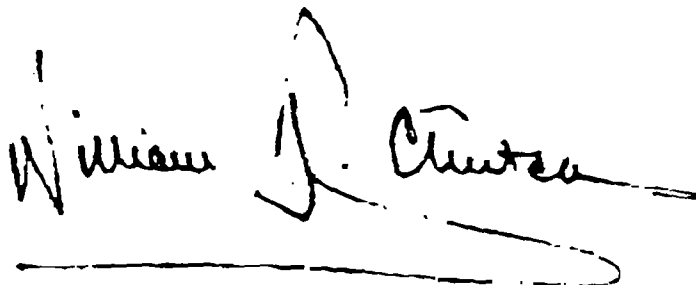
2

Specifically, I direct the OPM to take all appropriate action -- up to and including termination of a participating health plan from the FEHBP -- if the OPM determines, consistent with HIPAA and implementing regulations, that a plan is engaging in insurance practices that are inconsistent with the letter and spirit of HIPAA. In order to be eligible to participate in the FEHBP, carriers subject to HIPAA will have to certify to the OPM that they are providing access to health insurance in compliance with HIPAA. Such action by the OPM will provide another enforcement tool to the Federal Government without in any way altering or hindering any other enforcement action by the HCFA or State insurance commissioners.

To help ensure that the OPM can take these important enforcement actions, I direct the HCFA to immediately send to the OPM reports of violations by insurers or their representatives that preclude or inhibit access to the insurance protections provided under HIPAA. Any such referral to the OPM would not alter the responsibility of States or the HCFA to utilize any and all enforcement tools at their disposal to ensure HIPAA compliance.

Finally, I direct that the HHS and the Department of Labor report to me, through the Vice President, within 6 months on the successes and shortcomings of HIPAA. This report should be produced after consultation with the States and the National Association of Insurance Commissioners and should include specific legislative or regulatory recommendations to further strengthen this law.

My Administration has zero tolerance for any actions that hinder vulnerable Americans from accessing insurance, consistent with HIPAA's protections. This directive is intended to ensure that health plans come into compliance with this important statute so that Americans are assured these insurance protections.



07-09-98-0018

Appendix IV - Results of Phone Survey Conducted by Missouri Department of Insurance in May 1998.

MONTHLY RATE COMPARISON FOR HIPAA ELIGIBLE IN MISSOURI			
COMPANY	AGE 20 MALE	AGE 40 FEMALE	AGE 60 MALE
[REDACTED] pos/ 70/30 \$1000/2000	low/ \$83.22 high/ \$249.66 300%	low/ \$171.96 high/ \$515.88 300%	low/ \$337.21 high/ \$1011.63 300%
[REDACTED] hmo coverage variable co-pay no ded. St. Louis County	low/ \$69.00 high/ \$ 146.00 211%	low/ \$141.00 high/ \$303.00 214%	low/ \$277.00 high/ \$ 593.00 214%
[REDACTED] ppo \$1,000ded 80/20 Clay & Jackson Co.	low/ \$28.00 high/ \$167.00 596%	low/ \$96.00 high/ \$548.00 570%	low/ \$ 164.00 high/ \$ 928.00 565%
[REDACTED] ppo \$1500 ded 80/20	low/ \$67.55* high/ \$135.10 200% *approximate	low/ \$127.05* high/ \$254.11 200% *approximate	low/ \$262.96* high/ \$525.92 200% *approximate
[REDACTED] \$1500 ded, 50% co- pay to \$5,000 max.	low/ \$53.28 high/ \$266.40 500% (this is an age 29 M)	low/ \$109.97 high/ \$549.85 500% (this is an age 39 F)	low/ \$229.93 high/ \$1,149.67 500% (this is an age 59 M)
[REDACTED] \$1,000 ded. 50% co- pay to \$2,500 max.	low/ \$60.40 high/ \$224.04 370%	low/ \$142.97 high/ \$531.39 372%	low/ \$285.95 high/ \$1049.82 367%

ave 198.03

\$450.37

\$876.34

All of the information included in this chart was collected informally by phone from the carriers and cannot be guaranteed for accuracy.

(average of 3) 508.25

TOTAL = 1,000

Appendix V - Results of Survey Conducted by Colorado Division of Insurance in August 1997

**Results of December 1997 Survey of Market Shares and Rates
in the Colorado Individual Health Insurance Market**

as of January 8, 1998

Company	Total Covered Lives, All Individual Plans (12/1/97)	Total Covered "Eligible Individuals" ¹ (12/1/97)	Eligible Individual as Percent of Total Covered Lives	Percent of Best New Business Rate Premium for "Eligible Individuals" with Pre-Existing Conditions
A	2,475	27	1%	175%
B	23,266	0	0%	200%
C	46	0	0%	200%
D	365	0	0%	376%
E	1,804	2	0.1%	293%
F	1,297	0	0%	493% ²
G	181	Unknown	?	190%
H	635	0	0%	100% ³
I	901	0	0%	300%
J	31,918	84	0.3%	100%-now 150%-Feb '98
K	4,083	0	0%	125%
L	393	0	0%	300%
M	843	0	0%	144%
N	32,411	4 ⁴	0.01%	165%
O	167	0	0%	2000% ⁵
P	840	0	0%	145%
Q	12,458	1	0.008%	300%
R	550	0	0%	100%
S	5,052	2	0.04%	200%
T	6,226	0	0%	300%
U	1,142	Unknown ⁶	?	300%
V	10,940	1	0.009%	200%
W	2,141	0	0%	300%-Stage I cancer 400%-Stage II 700%-Stage III 800%-Stage IV ⁷
X	5,661	1	0.002%	150%
Y	91	0	0%	2000% ⁸
Z	No lives yet.			
AA	2,339	2	.009%	150%
BB	1,886	1	.005%	150%
CC	No lives yet			
DD	623	0	0%	150%
EE	916	0	0%	168%
TOTAL	152,357	125	0.08%	Average = 335% Median = 200%

¹ Federally defined "eligible individuals" are those individuals: 1) who have at least 18 months of creditable coverage; 2) whose most recent coverage was under a group plan; 3) who are not eligible for coverage under another group plan and have no other coverage; 5) whose prior coverage was not terminated due to nonpayment of premiums or fraud; and 6) who exhausted coverage if it was offered. Such individuals must be guaranteed issued individual coverage without pre-ex or any other exclusions.

² This company reported it would charge \$789 per month (\$9,568 per year) for an eligible individual with active breast cancer.

³ Best new business rate for this plan is very high (about 200% of competitors' best new business rates).

⁴ Only includes "eligible individuals" who did not pass medical underwriting.

⁵ Company reported it would charge \$1,708/mo (\$20,496/yr) for an eligible individual with an "average" case of breast cancer.

⁶ Number of eligible individuals in Colorado is unknown. Total of 9 nationwide.

⁷ Company reported it would charge \$1,576 per month (\$18,912 per year) for an eligible individual with Stage IV breast cancer.

⁸ Company reported it would charge \$1,708/mo (\$20,496/yr) for an eligible individual with an "average" case of breast cancer.

HIPAA REPORT TO THE PRESIDENT, DRAFT, 5/6/99
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attached [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

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

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Figure 1 - Criteria for State Alternative Mechanism

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

Table 21
Sample Rate-Ups for Selected Risk Factors and Rated-Up Premiums

State	Plan type	Rate-ups for selected risk factors			Maximum rate-up for health status	Standard premium plus maximum rate-up for health status					
		Overweight	Smoker	Hypertension		Age 25 M/F		Age 45 M/F		Age 60 M/F	
CA	Comm	Deny ^a			75%	\$112		\$211		\$373	
CA	BCBS	20-50% or deny		20% or deny	50% ^b	\$81		\$164		\$303	
IA	Comm	20-100%		25%-100%	100%	\$142	\$173	\$243	\$290	\$482	\$402
IA	Comm	20-80%	20-40% ^c	20% or deny	100%	\$122	\$145	\$214	\$253	\$452	\$398
MT	Comm	5-50% or deny	10%	20-60% or deny	200%	\$231		\$381		\$597	

Source: Alpha Center analysis of sample insurers' underwriting guidelines, 1997.

^aInsurer denies if applicant's weight is 15 percent in excess of insurer standard.

^bApplicant may be ineligible for most plans but offered a plan with a higher out-of-pocket annual maximum (\$5000 vs \$2000) and/or lifetime benefit maximum (\$2 million vs \$5 million) than the standard plans at a rate approximately 75% higher than a standard plan with comparable benefits.

^cSmokers over age 40 are rated up 40 percent.

Table 6

FROM UNITED STATES GENERAL ACCOUNTING OFFICE, "Private Health Insurance:
Millions Relying on Individual Market Face Cost and Coverage Trade-Offs,"
Nov. 1996

Chapter 4
High Premiums and Individual Health Status
May Affect Access to the Private Insurance
Market

experienced a broad range of specifically identified symptoms, conditions, and disorders. Applicants must also indicate whether they have any pending treatments or surgery, are taking any prescription medication, or have ever been refused or canceled from another health or life insurance policy. On the basis of these responses, carriers may request additional information—typically medical records—or require an applicant to undergo a physical examination. Some carriers require physical examinations regardless of applicants' responses to their questionnaires.

The information obtained through this process is used by carriers to determine whether to charge a higher than standard premium rate, exclude from coverage a body part or an existing health condition,¹⁵ or deny the applicant coverage altogether. The criteria used to make these determinations vary among carriers and are considered proprietary. Certain conditions are commonly treated by carriers in the same manner, however. Table 4.2 lists examples of some carriers' treatment of certain health conditions in states that do not prohibit medical underwriting.

Table 4.2: Examples of Health Conditions for Which Certain Carriers May Decline Coverage, Exclude a Condition From Coverage, or Require a Higher Premium

Decline coverage	Offer coverage but exclude condition	Offer coverage but at higher premium
HIV/AIDS	Asthma	Attention deficit disorder [*]
Rheumatoid arthritis	Cleft palate	Anemia
Parkinson's disease	Glaucoma	25% to 40% overweight
Diabetes	Ulcers	Hypertension (controlled)
Down's syndrome	Varicose veins	Arteriosclerosis (mild)

The carriers we visited generally accepted the majority of applicants for coverage at the standard premium rate. Where state mandates did not exist, however, these carriers denied coverage to a significant minority of applicants. Denial rates ranged from zero for carriers in states such as New Jersey, New York, and Vermont where the law guarantees coverage, to about 33 percent, with carriers in those states that do not prohibit medical underwriting typically denying coverage to about 18 percent of all applicants. Individuals with acquired immunodeficiency syndrome (AIDS) or other serious conditions, such as heart disease and leukemia, are virtually always denied coverage. We also found examples in which individuals with less severe conditions, such as attention deficit disorder and chronic back pain, could also be denied coverage by some of the carriers. Furthermore, at least two HMOs we visited almost always deny

^{*} This exclusion is separate from the 6- or 12-month preexisting condition exclusion period carriers typically impose upon all new applicants.

**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.

**Comparison of Lowest Available IHCP Monthly Premiums and Average
Employer-Group Monthly Premiums in the Northeast US, by Type of Policy, 1996-1998**

IHCP Lowest Individual and Family Premiums, Q4 1995-1997

Plan Type/ Deductibles	Individual			Family		
	Q4 95	Q4 96	Q4 97	Q4 95	Q4 96	Q4 97
HMO	\$185.34	\$195.10	\$195.40	\$546.74	\$573.60	\$591.76
PLAN B- \$1,000	90.00	121.48	130.00	212.00	279.50	359.00
PLAN B- \$ 500	149.00	196.00	196.00	348.00	494.00	549.00
PLAN C- \$2,500	NA	NA	119.00	NA	NA	325.00
PLAN C- \$1,000	118.00	146.20	160.00	285.00	353.68	444.00
PLAN C- \$500	193.30	242.00	NA	523.79	681.00	NA
PLAN D- \$1,000	147.00	194.00	194.00	370.00	522.45	538.00
PLAN D- \$500	217.94	294.00	294.00	581.67	830.00	830.00
PLAN E- \$1,000	185.64	238.00	238.00	502.66	660.00	660.00
PLAN E- \$500	255.75	363.00	363.00	669.87	1,026.00	1,026.00

In q4 1997, the deductibles offered for Plan C are \$1,000 and \$2,500.

**KPMG Survey of Employer-Sponsored Health Benefits: Average Monthly
Premiums in the Northeast US by Plan Type**

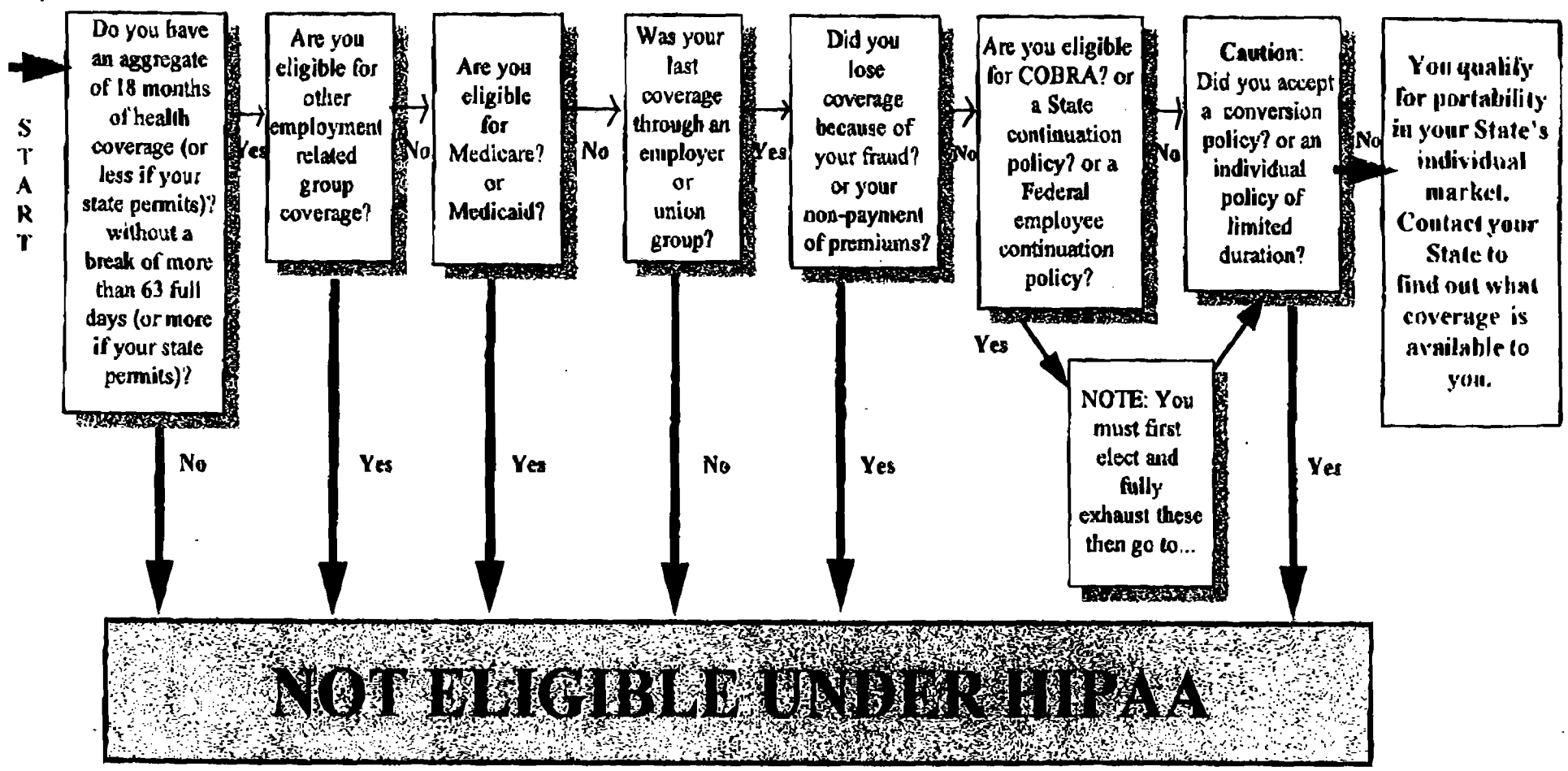
Plan Type	Individual			Family		
	1996	1997	1998	1996	1997	1998
HMO	\$163.00	\$162.00	\$177.00	\$445.00	\$465.00	\$485.00
PPO	175.00	182.00	189.00	477.00	489.00	527.00
POS	182.00	175.00	177.00	490.00	495.00	493.00
Indemnity	197.00	234.00	222.00	518.00	631.00	577.00

003/012
JENNINGS
HHS ASPE/HP
202 401 7321
05/10/99 10:25

Draft Interviewer's Guide

**GUARANTEED RIGHT TO PURCHASE
INDIVIDUAL COVERAGE UNDER HIPAA**

5-06-1999 7:40PM
FROM INS REFORM TASK FORCE 410 786 8001
P. 11



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

**REPORT TO THE PRESIDENT AND VICE PRESIDENT
OF THE UNITED STATES**

**SUCSESSES AND SHORTCOMINGS OF THE HEALTH INSURANCE
PORTABILITY AND ACCOUNTABILITY ACT OF 1996**

U.S. DEPARTMENT OF LABOR
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
MAY 1999

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INTRODUCTION

*exec
summ*

Last year, this Administration received reports that certain health insurers were acting in a manner inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The reports indicated that certain health insurers were giving financial incentives to discourage agents from enrolling individuals with preexisting conditions. In addition, some health insurance issuers reportedly were delaying the processing of applications, attempting to create significant breaks in coverage and thereby making qualified individuals ineligible for HIPAA's protections. By directive of July 7, 1998, President Clinton acted to ensure that health insurance issuers comply with HIPAA. He directed the Secretary of Labor and the Secretary of HHS to report to him, through the Vice President, on the successes and shortcomings of HIPAA, including legislative or regulatory recommendations to strengthen this important law. This report sets forth the respective responses of the Secretary of Labor and the Secretary of HHS to that directive.¹

HIPAA represents a significant change in our nation's approach to health care. It establishes, for the first time, minimum Federal standards for group health plans and for health insurance issuers in the large group, small group and individual insurance markets. HIPAA generally establishes portability, renewability and nondiscrimination requirements for most group health plans and for health insurance issuers offering insurance to group health plans. It guarantees the availability of health insurance in the small group market and for certain individuals with prior group coverage, and also guarantees the renewability of individual health insurance coverage. Intended to improve access to health coverage and the ability to continue it from when moving from job to job, HIPAA was passed by Congress with overwhelming bipartisan support.

*exec
summ*

Millions of American workers, retirees and their dependents stand to benefit from the rights HIPAA created. Presently, 158 million individuals purchase health insurance coverage through their job or on their own. Of this population, 125 million have coverage through private sector employment-based health plans within the jurisdiction of the Department of Labor. Within the jurisdiction of the Department of Health and Human Services, 23 million individuals have coverage through group health plans sponsored by a State or local government and nearly 11 million purchase coverage in the individual market.

Part One of this report represents the Department of Labor's experience with HIPAA and group health plans and Part Two sets forth the Department of Health and Human Services' experience with HIPAA in the group and individual health insurance market. Each Department

¹A copy of the President's directive can be found in Appendix I.

recommends changes to HIPAA based upon its experience and they concur in each others' recommendations.

The organization of the report into two parts reflects HIPAA's structure. HIPAA, among other things, amended the Employee Retirement Income Security Act of 1974 (ERISA), which is administered by the Department of Labor (DOL), and the Public Health Service Act (PHS Act), which is administered by the Department of Health and Human Services (HHS).² ERISA, as amended by HIPAA, governs most private sector employment-based group health plans, regardless of the plan's size or whether the plan is insured or self-insured. Most of the problems experienced by group health plans after HIPAA concern the difficulties of small employers in obtaining or keeping group health insurance. Under HIPAA, DOL has regulatory authority over health insurance issuers, but not enforcement authority. Accordingly, Part One of this report addresses the Department of Labor's experience with group health plans and not issuers. Based on that experience, large insured and self-insured group health plans generally appear to have had little difficulty in complying with HIPAA's requirements.

As described in Part Two of this report, HHS's responsibilities and experience with HIPAA are quite different. Although implementation of HIPAA's provisions in the group health insurance market has been fairly successful, the individual health insurance market has been more problematic. In addition, HIPAA enforcement presents another significant challenge because the law's complex structure requires the involvement of not only individual State governments, but three separate Federal departments. In order to negotiate this structure, consumers need accessible, comprehensive, and comprehensible information. Although HHS has developed a consumer education campaign, this campaign must be further expanded to ensure that individuals are aware of their rights under HIPAA.

² HIPAA also amended the Internal Revenue Code, which is administered by the Department of the Treasury, but the President's directive did not ask the Treasury to report on HIPAA.

PART ONE ³

REPORT OF THE DEPARTMENT OF LABOR TO THE PRESIDENT AND VICE PRESIDENT OF THE UNITED STATES

Part One of this report describes the impact of HIPAA on group health plans in light of the Department of Labor's experience after HIPAA's enactment in 1996. The Department of Labor administers and enforces ERISA, the federal law that governs most private employment-based pension and health plans. HIPAA amended ERISA by applying portability, renewability and nondiscrimination requirements to group health plans and issuers of health insurance offered to group health plans. This Part describes ERISA's original scope, HIPAA's expansion of ERISA with respect to group health plans, the accomplishments of three federal agencies in implementing and publicizing HIPAA's requirements, and the Department of Labor's recommendations for strengthening HIPAA's protections.

Specifically, Section I of this Part describes the history and structure of ERISA, developments in the group health care marketplace, and the differing experiences of large and small group health plans, insured and self-insured, before HIPAA.

Section II provides an overview of HIPAA's provisions and the enforcement structure that HIPAA created, with overlapping jurisdiction among the Department of Labor, the Department of Health and Human Services and the Department of the Treasury.

Section III describes the ongoing coordination and implementation efforts taking place between the Department of Labor and the Departments of HHS and the Treasury with regard to HIPAA's group market provisions. As discussed in more detail within the body of the report, coordinated implementation of HIPAA's group market provisions is essential because HIPAA created concurrent jurisdiction and shared regulatory responsibility for the three Departments with regard to these provisions.

Section IV of the report details our continuing effort to develop outreach programs and compliance materials designed to educate plan sponsors, participants and beneficiaries, plan administrators and health insurance issuers on their new rights and responsibilities under HIPAA.

³ THIS DRAFT IS FOR INTERNAL REVIEW ONLY AND REPRESENTS A STAFF LEVEL RESPONSE TO THE REQUEST OF THE PRESIDENT. THIS DOCUMENT HAS NOT BEEN CLEARED THROUGH PWBA OR THE DEPARTMENT OF LABOR AND NO DECISION HAS BEEN MADE CONCERNING INCORPORATION OF THIS DOCUMENT INTO THE LARGER HHS RESPONSE.

Section V of the report describes the strengths and weaknesses in HIPAA's group health plan provisions that have come to the Department of Labor's attention through our implementation and outreach efforts.

Sections VI and VII outline specific regulatory initiatives that the Department of Labor is currently working on to bolster HIPAA's protections, and notes specific areas where additional legislation may be necessary to reinforce the important group market protections that HIPAA already provides or to address the shortcomings that have been identified in these provisions.

I. ERISA AND GROUP HEALTH PLANS BEFORE HIPAA

ERISA was enacted in 1974 to establish uniform national standards to protect the health and pension benefits that employers and joint trustees plans voluntarily provide for their workers. ERISA established federal standards for the disclosure of information to plan participants and beneficiaries, reporting of information to the federal government, and fiduciary responsibilities concerning the management of employee pension and health plans. While these provisions applied to all employee benefit plans, ERISA's early focus was on pension plan reform. Thus, ERISA also created significant substantive provisions that applied only to pension plans, concerning participation, benefit accrual, vesting, funding, and establishment of the Pension Benefit Guaranty Corporation.

Group health plans were only added to ERISA shortly before its enactment, and until the mid 1980's, ERISA contained no provisions governing the content of employee group health plans. Employers were largely free to determine plan design, including terms governing eligibility, coverage, exclusions and claims procedures. In 1985, Congress enacted the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which amended ERISA to require group health plans to continue coverage in certain circumstances. The COBRA provisions were the first substantive requirements that ERISA imposed on covered plans concerning health benefits.

Since the enactment of ERISA, the most fundamental change in the employee benefits field has taken place in the health care area. Initially, most group health plans paid for benefits by purchasing indemnity group health insurance. Later, the rising cost of health insurance led some employers to shift to a greater reliance on self-insurance. More recently, the increased popularity of managed care has stabilized rising health care costs, leading more employers to provide group health coverage by contracting with HMOs and other managed care organizations.

These developments in group health plans have resulted, in part, from the interplay of ERISA's structure and the health care marketplace. Group health plans governed by ERISA are established by private sector employers (or unions) voluntarily. ERISA does not require an employer or union to offer a group health plan. In addition, ERISA covers both insured and self-insured group health plans, without distinction as to the size of the employee group.⁴ An insured plan provides health benefits through the purchase of insurance or by contracting with an HMO or other managed care organization to provide medical care. A self-insured plan pays for benefits out of the sponsoring employer's (or union's) general assets. Under ERISA's preemption provisions, states retain authority to regulate group health insurance and managed care organizations, but states may not directly regulate insured or self-insured group health plans.

⁴ ERISA does not cover individual insurance or group plans that are not employment based.

Accordingly, plans that do not buy insurance are not subject to state insurance laws and, thus, are not subject to state regulation of such matters as mandated benefits, rates and solvency requirements. Plans that buy insurance, however, buy a state-regulated product and, as a practical matter, are indirectly affected by state insurance requirements.

The decision to provide health benefits through the purchase of insurance or by self-funding, like the initial decision to establish a group health plan, is entirely up to the employer (or union) that sponsors the plan. An important factor in that funding choice is the affordability and availability of insurance in the group market for the employer's size. Large employers generally have found it easier than small employers to obtain affordable health insurance, because spreading the risk of loss over a large employee group is less costly to insurance companies.

Another important factor affecting a group health plan's decision to insure or self-insure is state insurance law. To make health insurance more available to employers, states began to formulate approaches to address the cost, access, portability, quality and delivery of health insurance and medical care, especially in the small group insurance market. The reform efforts of individual states [described in HHS Part II at ____] varied greatly, leading to a diverse and uneven framework of statutory and regulatory health coverage standards. Group health plans that operated in different states and bought group health insurance or managed care services were indirectly subject to this patchwork of regulation.

Employers that did not want to provide the mandated benefits contained in state-approved insurance policies, could not afford the insurance policies available to them or wished to provide uniform benefits across state lines, often chose to self-insure. Self-insurance was financially viable for large employers because of their greater assets and, as with insurance, because the risk of loss could be spread over more employees. Few small employers could afford to self-insure, however, because a single high cost claim could mean financial ruin. Some small employers chose to self-insure and purchase stop-loss insurance to cover large losses above a certain percentage of claims or dollar amount. Some small employers decided they simply could not afford to offer their employees group health insurance. And other small employers bought employee group health coverage from multiple employer welfare arrangements (MEWAs).

A MEWA is an arrangement formed to provide health care coverage to the employees of two or more employers. Many MEWAs were created to take advantage of the difficulties small employers had in obtaining group health coverage for their employees. These MEWAs offered health coverage at a lower cost than insurance companies by falsely claiming to be ERISA plans that are exempt from state insurance regulation. Because these MEWAs did not satisfy state insurance requirements for reserves and solvency, many of them collected contributions from employers and employees for group health coverage and then went bankrupt, leaving the employees with large medical expenses to pay out of pocket.

II. HIPAA's PROVISIONS AMENDING ERISA

HIPAA amended portions of ERISA's disclosure provisions and modified the continuation health coverage requirements added to ERISA by COBRA. HIPAA also added a new Part 7 to ERISA, which for the first time established minimum federal requirements concerning portability, renewability, and nondiscrimination for group health plans and health insurance issuers. Under HIPAA, the United States Department of Labor, through the Pension and Welfare Benefits Administration, retains general authority to promulgate regulations and enforce HIPAA with respect to group health plans governed by ERISA. Although health insurance issuers are subject to Part 7 of ERISA, HIPAA permits only participants in the plan and their dependents to bring an enforcement action against them.

More particularly, HIPAA amended ERISA with respect to group health plans in the following respects:

- ◆ By expanding ERISA's disclosure provisions to require that group health plans amend their summary plan descriptions and summaries of material modifications:
 - * A group health plan must notify participants and their dependents of "material reductions" in covered health services and benefits within 60 days of the change in the plan. Before HIPAA, group health plans could give notice of such changes as late as 210 days after the end of the plan year in which a change was adopted.
 - * A group health plan must disclose to participants and beneficiaries information about the role of insurance companies with respect to their group health plan, including information about the name and address of the insurance issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer, and the nature of any administrative services the issuer provides, such as payment of claims. Before HIPAA, this information was not required to be provided in group health plan disclosure documents and participants and beneficiaries were often unaware of what role, if any, insurance companies played in their health plans.
 - * A group health plan must inform participants and their dependents which Department of Labor office they can contact for assistance or information about their rights under ERISA and HIPAA. Before HIPAA, this information was not required to be included in group health plan disclosure documents.
- ◆ By modifying COBRA so that certain disabled individuals can obtain extended continuation coverage for 29 months if they are determined to be disabled under the Social Security Act within 60 days after the COBRA qualifying event. Before HIPAA,

the disability extension was available only if the person was determined to be disabled under the Social Security as of the date of the COBRA qualifying event.

- ◆ By limiting exclusions for preexisting conditions for the first time at the federal level, in the following significant ways:
 - * A preexisting condition exclusion period may be applied only to a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period before the individual's enrollment date.
 - * A preexisting condition exclusion period may last a maximum of 12 months (18 months for late enrollees), and must run concurrently with a plan's waiting period, if any.
 - * A preexisting condition exclusion generally must be reduced by the number of days an individual has prior creditable health coverage, that is, coverage that was not interrupted by a break in coverage of 63 consecutive days or more.
 - * A preexisting condition exclusion may not be applied to pregnancy; to genetic information which has not resulted in a diagnosis; or to newborns, adopted children under age 18, or children under age 18 who are placed for adoption, as long as the child obtains creditable coverage within 30 days of birth, adoption or placement.
 - * Plan administrators or group health insurance issuers must provide individuals and their dependents with certificates of creditable coverage, automatically when coverage terminates or upon request, which reflects the person's prior creditable coverage so that any preexisting condition exclusion period that might apply to the person under a future group health plan can be properly reduced.
- ◆ By providing special enrollment rights under certain conditions to individuals who lose prior health coverage or who gain or become a dependent through marriage, birth, adoption or placement for adoption. Special enrollment affords qualifying individuals the right to enroll in a group health plan for 30 days after a triggering event, regardless of the plan's regular enrollment date, and limits the application of preexisting condition exclusions for special enrollees to 12 months maximum.
- ◆ By prohibiting discrimination against participants and their dependents with respect to initial eligibility, continued eligibility, and individual premium or contribution amounts, based on any health factor. Health factors include current medical condition, medical history, claims history, genetic information, disability and evidence of insurability.

- ◆ By prohibiting a multi employer plan or a MEWA from denying an employer whose employees are covered under such a plan continued access to the same or different coverage under the terms of the plan, except for five specific reasons.
- ◆ By requiring certain MEWAs that provide health coverage to report annually to the Department of Labor to determine whether they are carrying out HIPAA's portability, renewability and nondiscrimination provisions.

In addition to amending ERISA, HIPAA created parallel provisions affecting group health plans and health insurance issuers by amending the Internal Revenue Code, which is administered by the Department of the Treasury through the Internal Revenue Service, and the Public Health Service Act, which is administered by the Department of Health and Human Services (HHS) through the Health Care Financing Administration. The Treasury has authority over group health plans (including church plans) and enforces HIPAA's requirements by imposition of an excise tax on sponsoring employers.⁵ HHS has authority over nonfederal governmental plans and health insurance issuers in the group and individual markets. If a State fails to substantially enforce HIPAA's group or individual insurance provisions or asks HHS to enforce them, HHS enforces the requirements by imposing a civil monetary penalty on noncompliant issuers in that State. HIPAA conferred shared jurisdiction on the Departments of Labor, HHS and the Treasury over the provisions governing group health plans and group health insurance issuers and required the agencies to coordinate their guidance in these areas of parallel responsibility. These efforts are discussed in the following two sections.

III. IMPLEMENTATION OF HIPAA's PORTABILITY PROVISIONS

The HIPAA portability provisions establish minimum federal requirements relating to portability, access, and renewability of group health plans and group health insurance coverage. The provisions that relate to employment-based group health coverage are set forth in ERISA, the Internal Revenue Code, and the Public Health Service Act, and are referred to as the "shared group market" provisions.⁶ HIPAA required the Secretaries of the three Departments to first issue regulations to carry out the portability provisions by April of 1997. In setting this time frame, Congress wanted to ensure that the protections established by HIPAA were in place as soon as possible, and the three Departments worked diligently and successfully to ensure the

⁵ The President's directive of July 7, 1998 did not require the Secretary of the Treasury to report on its experience with HIPAA. **[TO BE INSERTED: EXPLANATION OF TREASURY'S ROLE AND JURISDICTION UNDER HIPAA]**

⁶ While some of the group market provisions are within the jurisdiction of the individual agencies, the majority of these provisions are within the jurisdiction of all three agencies.

necessary rules were completed in a timely fashion.

The Departments' overarching goal in this process was to implement HIPAA's provisions in a manner that provides workers and their families with meaningful protections, while remaining sensitive to the burdens on employers and others. The Departments also worked hard to ensure that the rules implementing the "shared" provisions were consistent, regardless of agency jurisdictions. As discussed below, we believe that the Departments accomplished these goals with the timely issuance of the initial set of compliance guidance under HIPAA's shared group market provisions.

Coordination and Implementation Efforts of the Departments

Recognizing that HIPAA is a comprehensive statute and that there was a need for guidance in the short term, the Departments undertook a series of initiatives to give such guidance. For example, HIPAA made changes to the COBRA rules and required employers to notify participants of those changes by November 1, 1996. Given the short time period within which employers had to send the notice, the Departments knew employers would appreciate timely guidance on these new requirements. Accordingly, we issued a technical bulletin on October 15, 1996, which not only described the changes made by HIPAA but also gave a model notice that employers could use to satisfy their responsibilities.

In December of 1996, prior to the issuance of interim rules, the Department of Labor, in conjunction with the Department of Health and Human Services and the Department of the Treasury, published in the Federal Register a public solicitation of comments on the HIPAA portability provisions. In developing the interim rules, the Departments carefully considered the comments received from employees, dependents, and others seeking health coverage, as well as employers, plan administrators, and health insurance issuers. In particular, the comments supporting preparation of a model certificate of prior creditable coverage proved very helpful in encouraging the Departments to design a model that significantly reduces the potential burdens on plans and health insurance issuers, while making the certification process more effective for employees and their dependents.

Consistent with Congress's intent to promulgate timely regulations, the Departments issued interim rules implementing HIPAA's portability provisions on April 1, 1997. In general, the interim rules have been well received by the regulated community. Public comments and press coverage on the rules acknowledge the substantial efforts made by the agencies to limit the potential burdens of the rules' certification and notice requirements, while maintaining adequate protections for health care consumers through greater access, portability and renewability of health care coverage. The interim rules achieve the Departments' primary goal of ensuring that the protections that Congress gave workers and their families under HIPAA remain intact. The rules allow individuals to obtain certificates of creditable coverage before they leave their job and for up to 24 months after coverage ceases. In addition, the rules enable individuals to

demonstrate their creditable coverage if their former plan or health insurance issuer fails to provide certification when it is required.

Additionally, the rules ensure that individuals are notified of the maximum length of any preexisting exclusion period imposed by their new group health plan. The rules also ensure that an individual is notified of any preexisting condition exclusion period, after taking into account the individual's prior creditable coverage. For individuals who decline plan coverage when they are first eligible to enroll in the plan, the rules require that the plan or health insurance issuer provide a description of special enrollment rights so that the individual will know that he or she can enroll later (without an extended preexisting condition exclusion period) if the individual loses other coverage, or acquires or becomes a spouse or dependent through marriage, birth, adoption or placement for adoption.

The interim rules also fulfill the Departments' commitment to reducing HIPAA's burdens on the regulated community. For example, the rules help minimize the administrative burdens for employers and plan sponsors associated with the certification of creditable coverage requirements in several ways, including transitional relief for obtaining dependent information and the reduction of unnecessary duplication of certificates. In addition, the rules allow paperless, telephone transmission of information if all parties agree. Each of these innovations serves to reduce the final cost of compliance, making it easier for regulated entities to implement HIPAA's requirements.

Additional Guidance Addressing HIPAA's Group Market Provisions

On December 29, 1997 the Departments published two notices clarifying the interim rules issued under HIPAA. These two notices provided important guidance on two of the most frequently asked questions about HIPAA since the issuance of the April 1, 1997 HIPAA regulations. The first question was how the new law should apply to individuals who were kept out of group health plans before the effective date of the law due to a discriminatory provision or practice. The notice responding to this concern addresses the group portability rules with respect to employees (or their dependents) who, until the effective date of HIPAA's nondiscrimination provisions, were denied coverage by a group health plan or a group health insurer because of factors including their health status, medical condition, disability, genetic information or evidence of insurability. The Departments clarified that these individuals cannot be prevented from enrolling in the plan after HIPAA becomes effective (even if the plan does not otherwise offer open enrollment seasons) and cannot be treated as late enrollees for purposes of applying a preexisting condition exclusion period.

The second notice addressed whether, and under what circumstances, certifications of prior creditable coverage must be issued for individuals who are covered under flexible spending accounts. The notice responding to this concern clarifies that it is appropriate to treat benefits under certain flexible spending arrangements (FSAs) as excepted benefits, rather than as

creditable coverage, for purposes of the HIPAA portability rules. If the benefits under the FSA are excepted benefits, the coverage will not be creditable coverage and the FSA is not required to issue certificates for the coverage.

In addition to the two notices, the Department worked closely with the Department of the Treasury in developing an IRS notice, published on February 2, 1998, containing questions and answers on the coordination of COBRA and HIPAA. The publication identifies issues individuals should consider, in light of these changes, in deciding whether to elect COBRA continuation coverage. For example, the notice explains that COBRA coverage can help individuals avoid a significant break in coverage (generally, a break of 63 days or more) and that such coverage can count toward reducing any preexisting condition exclusion period under a group health plan.

IV. THE DEPARTMENT'S COMPLIANCE AND OUTREACH EFFORTS

In addition to having the responsibility for issuing new guidance in the form of regulations to implement the provisions of HIPAA, the Department of Labor has also undertaken the task of educating plan sponsors, participants and beneficiaries, plan administrators and health insurance issuers about their new rights and responsibilities under HIPAA. To meet this challenge, the Department has developed a comprehensive set of compliance materials that are available to the public free of charge and undertaken an extensive public outreach program providing in-depth seminars in every region of the country. We have also distributed these materials to the National Association of Insurance Commissioners (NAIC) and individual State Insurance Commissioner's offices for use in their training seminars.

In addition, the Department has coordinated at the federal level with the Departments of Health and Human Services and the Treasury and worked in close coordination with the NAIC and individual State Insurance Commissioner's offices to establish interactive websites making educational materials and other information on State and Federal protections in the health care area available to consumers, employers and other interested parties. The Department has also established coordination and referral systems at the federal level with HHS and the Department of the Treasury, as well as at the State level with the NAIC and individual State Insurance Commissioner's offices, to coordinate investigations of alleged practices by health insurance issuers and to ensure that workers and their families are not unjustly denied any protections provided under HIPAA.

Compliance materials

In April 1997, the month that the interim regulations were issued, the Department of Labor published a reference booklet, entitled "Questions and Answers: Recent Changes in Health Care Law," to help employees and employers understand their rights and obligations under HIPAA. The booklet provides an overview of the new health care provisions and answers to the

most commonly asked questions. The Department has revised the booklet continuously as additional guidance is promulgated.

In the Fall of 1997, the Department set up additional telephone lines to field questions from participants and plan administrators seeking information on the effect of the new laws. Through the end of the first quarter of fiscal year 1998, our customer service staff responded to approximately [update] calls regarding HIPAA. The public also may receive our Q&A booklet free of charge by calling the Department's Publications Hotline toll-free at 1-800-998-7542 and, to date, we have distributed nearly [update] booklets to the public. In addition, nearly [update] people have accessed the Departments web site at <http://www.dol.gov/dol/pwba> seeking information on HIPAA. Our Q&A booklet, as well as copies of all our regulations, notices, and press releases are available on our website.

Educational Seminars

Following the publication of the interim rules under HIPAA, the Department presented half-day seminars to plan administrators and health care consumers in [update] different cities across the country. In addition, the Department has conducted more than [update] other presentations in different cities to employer and health plan groups and to representatives of state and local governments on the new health reforms. Several of these presentations were simulcast nationwide. We have also provided continuous public service announcements to the media to alert individuals about the effects of the new laws. These announcements have reached over 20 million American workers and their families.

Coordination with the NAIC and State Insurance Regulators

The Department is coordinating with the NAIC and State insurance regulators on several fronts. Recently, we created a hyper-link between our website and the website of the NAIC to facilitate access by participants and plan sponsors to information about both federal and State health care reforms. We also developed a pamphlet specific to each region entitled "Where to Go for Information" which identifies names, addresses and phone numbers of individuals at the State and Federal level whom individuals can contact regarding specific issues arising under HIPAA.

In addition, our Q&A booklet, as well as an outline used for Department training, has been made available to the NAIC, and we have compiled a list of HIPAA contact people in all the State insurance departments and distributed this list to our customer service teams and investigators in our national office and fifteen field offices to further our compliance efforts. We have also compiled a list of HIPAA contacts in the Department and distributed it to the NAIC's membership and have coordinated directly with several State insurance regulators to provide training materials and technical assistance in interpreting federal law.

Future Outreach Initiatives

In the next 12 months, we intend to continue the outreach initiatives described above and to expand these efforts to reach more consumers, plan administrators and health insurance issuers. For example, we have begun work on a health information section that will be added to the Department's "e-laws" system. E-laws is an interactive computer system accessible through the Department's website. When the health benefits system is complete, it will, among other things, allow individuals to choose among typical life or work events that affect health benefits, such as getting married or losing a job, and work their way through a decision tree to obtain important information about health care options for themselves and their families. We also intend to continue our public service announcements, speaking engagements, and other customer service efforts. Moreover, we look forward to continuing our work with the NAIC and state insurance regulators to help educate the regulated community and protect consumers' rights.

As we go forward in implementing the provisions of HIPAA, as well as other recently enacted health care reforms, the Department will continue to coordinate and maintain a close dialogue with all relevant parties in order to anticipate and effectively address issues surrounding the implementation of this important and historic legislation.

V. THE DEPARTMENT'S EXPERIENCE WITH GROUP HEALTH PLANS AFTER HIPAA

The United States Department of Labor, through the Pension and Welfare Benefits Administration, is responsible for the administration and enforcement of Title I of ERISA. ERISA governs approximately 2.6 million private employer and union sponsored group health plans covering approximately 122 million American workers, retirees and dependents. Seventy-five percent of the entire workforce and 64 percent of the non-elderly population receive health coverage through employment-based plans. Payments by ERISA plans for benefits and other expenses constitute one dollar of every four spent on health care.

The majority of group health plans became subject to HIPAA on January 1, 1998. At this time, we have not identified prevalent or systemic problems relating to implementation of HIPAA's provisions affecting group health plans that self-insure. Instead, we are finding what we believe are the normal implementation issues that follow enactment of major legislation — not unlike what we experienced with COBRA. The problems of group health plans that are insured, and of individuals seeking insurance, relate to the availability and affordability of group health insurance in particular insurance markets which, under HIPAA are the domain of HHS. We recognize that HHS' experience in the small group and individual insurance markets [as detailed in HHS Part II at ____] is different from our experience with self-insured group health plans, and we share HHS' concerns about not having adequate resources to implement the law.

The Department of Labor's experience to date with HIPAA's group health plan provisions has been generally favorable. Both the States and the regulated public are pleased with the open and inclusive nature of the Departments' regulatory process. In addition, we are finding that

through education and outreach, plans and consumers are cooperating in fulfilling their responsibilities and in realizing their rights under the law. We are not finding widespread or significant abuses among the self-insured group health plans. The majority of the inquiries we currently receive pertain to general questions about how the law works and what are the specific rights and responsibilities of both workers and employers. As described above, in anticipation of these questions, the Department has undertaken an extensive educational outreach program and initiated coordination efforts at the federal level with HHS and the Treasury, and at the State level with the NAIC and individual State Insurance Commissioner's offices, to help facilitate compliance and ensure that individuals receive the protections afforded by HIPAA.

The problems that we have identified with self-insured group health plans appear marginal in scope. However, it is our belief that the new protections put in place by HIPAA have not yet been adequately tested. This observation is based on two factors. First, after the enactment of COBRA in 1985, it took several years for individuals to become fully aware of their new rights and to begin to exercise them. Second, it is our belief that the effectiveness of HIPAA's portability protections may not be fully tested until the labor force experiences another fluctuation of downsizing and subsequent rehiring in the labor market.

We intend to continue to bolster HIPAA's protections and address specific shortcomings, to the extent possible, through future regulatory guidance and clarifications similar to the two notices published by the Departments on December 29, 1997. This guidance will further strengthen HIPAA's protections. However, not all of the issues can be addressed through the promulgation of regulatory guidance. In some instances, additional legislation will be necessary to enhance the protections set forth under HIPAA. Specific recommendations on these items, as well as issues that will be addressed by the Department through future regulatory guidance, are discussed below.

VI. REGULATORY INITIATIVES TO BOLSTER HIPAA's PROTECTIONS

While the accomplishment of the Departments in issuing the interim rules is substantial, the Departments intend to promulgate additional guidance and clarifications under HIPAA's existing provisions on issues not addressed by prior compliance materials and to finalize the interim rules on HIPAA's portability provisions. In addition, the Departments have completed a Memorandum of Understanding that formalizes their cooperative working relationship and the allocation of enforcement responsibilities. The following is a list of initiatives that are currently being undertaken by the Department to further bolster the protections put in place with the enactment of HIPAA.

- ◆ **HIPAA's Nondiscrimination Provisions:** Under section 702 of ERISA (and the corresponding provisions of the Internal Revenue Code and the Public Health Service Act) a plan or health insurance issuer may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a

health status-related factor. In addition, a plan or health insurance issuer may not require any individual (as a condition of enrollment or continued enrollment) to pay a premium or contribution that is greater than that for a similarly situated individual enrolled in the plan, based on a health status-related factor. The Departments are nearing completion on additional guidance on HIPAA's nondiscrimination provisions. The April, 1997 interim rules outlined the statute's nondiscrimination provisions and provided guidance in certain areas. We also expressly invited comments on how best to implement these important and complex provisions. Numerous comments were received in response to this request, and the Departments are reviewing them carefully in the development of further guidance. We intend to promulgate additional compliance related guidance regarding the nondiscrimination provisions before the end of this year.

- ◆ **Reporting by Multiple Employer Welfare Arrangements:** Section 101(g) of ERISA, as amended by HIPAA, provides that the Secretary of Labor may prescribe reporting requirements for multiple employer welfare arrangements (MEWAs) that provide benefits consisting of medical care but which are not group health plans within the meaning of Title I of ERISA. The reporting requirements of section 101(g) of ERISA are intended to help determine the extent to which the requirements of Part 7 of Subtitle B of Title I of ERISA are being carried out in connection with the provision of medical care by such MEWAs. The Department of Labor intends to promulgate interim final regulations regarding these provisions before the end of this year.
- ◆ **Guaranteed Renewability in Multi-Employer Plans and MEWAs:** The requirements relating to guaranteed renewability in multi-employer plans and multiple employer welfare arrangements are set forth in section 703 of ERISA and section 9803 of the Internal Revenue Code (but not in the Public Health Service Act). These provisions state that a group health plan that is a multi-employer plan or that is a MEA may not deny an employer whose employees are covered under such a plan continued access to the same or different coverage under the terms of such plan, other than for certain specified reasons.
- ◆ **Notice Requirements under COBRA:**

[TO BE COMPLETED]

- ◆ **Finalization of the Interim Rules on HIPAA's Portability Provisions:** We are continuing to work on numerous projects relating to the interim rules published on April 8, 1997. As previously mentioned, these rules govern access, portability and renewability requirements for group health plans and issuers of health insurance coverage offered in connection with a group health plan. With respect to the nine interim rules that were promulgated we are currently reviewing comments received in order to finalize the HIPAA interim portability regulations. In this regard, statutory limitations under the

Internal Revenue Code on the period for which the interim rules remain effective require the Departments to develop in FY 99, and issue in FY 2000, final rules under HIPAA to replace the comprehensive set of interim guidance issued by the Departments.

- ◆ **Memorandum of Understanding:** HIPAA also requires the Departments to execute a Memorandum of Understanding (MOU). We have completed drafting a formal MOU that is currently being circulated for clearance through the Departments. Since the passage of HIPAA, the Departments have maintained a close dialogue on implementation and enforcement issues with regard to state implementation in the shared group market. Moreover, the Departments have continued their collaboration on regulations by drafting guidance on the Mental Health Parity Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996 and, presently, the Women's Health and Cancer Rights Act. The MOU formalizes this cooperative working relationship, identifies the most critical implementation and enforcement issues and devises a rational division of responsibilities among the Departments.

VII. STATUTORY MODIFICATIONS TO BOLSTER HIPAA'S PROTECTIONS

While HIPAA significantly enhanced the availability of group health coverage for individuals who change jobs or seek to renew their existing coverage, the Department of Labor believes, based on its experience with the statute, that certain amendments to HIPAA may be needed to adequately protect the health care coverage portability that Congress envisioned would be available for American workers and their families as a result of the statute. We believe that the Departments cannot, consistent with HIPAA's current provisions, implement the suggestions described below through the issuance of regulations or other interpretive guidance. Therefore, additional legislation would be necessary to implement the following recommendations. Except for our suggestion for strengthening ERISA's disclosure provisions, which can be accomplished by amendment solely to ERISA, these statutory recommendations would require changes to the Internal Revenue Code and the Public Health Service Act, as well as to ERISA.

- ◆ **Expand HIPAA's Break in Coverage Rule:** Under HIPAA, a group health plan (and a health insurance issuer) that imposes a preexisting condition exclusion must reduce each individual's exclusion period by the number of days of the individual's prior creditable health care coverage. However, days of creditable coverage that occur before a "significant break in coverage" need not be counted towards reducing a preexisting condition exclusion period. HIPAA currently defines a significant break in coverage as a period of 63 consecutive days during which an individual lacks any creditable health coverage as defined under the statute. Because health care coverage that precedes a significant break in coverage is not counted in reducing a preexisting condition exclusion period, it is important for an individual with a preexisting condition who loses coverage to secure new coverage before a significant break in coverage occurs.

An individual may demonstrate creditable coverage to a prospective group health plan or health insurance issuer by presenting a "certificate of creditable coverage" obtained from the prior plan or health insurance issuer. HIPAA presently requires plans and health insurance issuers to provide the certificate automatically upon loss of coverage but generally permits them up to 44 days after coverage ends to do so. By the time an individual receives that certificate (presumably 45 to 50 days after coverage terminated), there may be little opportunity to make an informed choice about a new plan or policy and still avoid a significant break in coverage. For example, if a certificate is mailed on the 44th day after coverage ceases, and is received by the participant three days later, instead of having two months to make a decision concerning health care coverage, the individual has only about two weeks.

We believe Congress intended individuals to have enough time to make informed decisions about their health coverage. HIPAA and the interim regulations tie the mailing of the certificates to the time period allowed for mailings under COBRA (generally up to 44 days) to help reduce administrative burdens on group health plans. However, COBRA allows individuals 60 days after the notice has been sent to make an election for continuation health coverage.

- * **Recommendation:** To promote uniformity of these rules, to keep administrative burdens on plans to a minimum, and to afford individuals adequate time to make important health care decisions, the Department recommends that HIPAA's significant break in coverage rule be amended to expand the length of time an individual may be without coverage without forfeiting the right to apply prior creditable coverage to reduce a preexisting condition exclusion period. Specifically, the Department recommends that the statutory definition of a significant break in coverage be changed from a period of 63 days to a period of 93 days. Currently, several States have break in coverage rules of 90 days or more.

- ◆ **Strengthen ERISA's Disclosure Provisions:** ERISA generally requires employee benefit plans to disclose material changes in plan benefits within 210 days after the end of the plan year in which the change is adopted. HIPAA shortened the period for disclosure if the change is a material reduction in covered services or benefits under a group health plan. Under HIPAA, a group health plan generally is required to furnish individuals with a summary description of material reductions in services or benefits within 60 days after the change is adopted.

While HIPAA requires group health plans to give notice of these material reductions in health benefits more quickly than under prior law, individuals are still not required to be notified of reductions in their health care coverage for up to 2 months **after** a material reduction in covered services or benefits is adopted. As a result, participants and

beneficiaries may incur substantial health care costs for services without knowing that their health plan no longer provides the coverage they thought they had. This current retroactive notification system has led to great hardship for many individuals. In addition, the current lag time severely restricts the ability of participants and beneficiaries to make informed health care decisions. As a consequence, until group health plans are required to notify individuals of such material reductions **before** such reductions take effect, workers and their families will continue to be exposed to significant financial risk for uncovered medical services that they reasonably thought were covered under their group health plan.

- * **Recommendation:** To help individuals avoid incurring substantial and unnecessary out-of-pocket health care costs, the Department recommends that group health plans be required to give notice to individuals before a plan is changed. Specifically, the Department recommends that group health plans be required to give individuals a summary description of material reductions in services or benefits **60 days before** the date the material reduction in covered services or benefits takes effect, rather than 60 days after such a change occurs.

- ◆ **Require individual notice before terminating group health insurance policies.** Presently, many employers offer group health coverage through fully-insured group health plans. In a fully-insured plan, the employer provides coverage by purchasing a group health insurance policy that provides reimbursement for medical costs that individuals incur. As a result, the employer is often responsible for paying the premiums directly to the health insurance issuer.

The law currently does not require health insurance issuers to notify participants if the issuer terminates, or intends to terminate, a group health insurance policy because the employer stopped paying premiums. Moreover, health insurance issuers sometimes permit months to pass before terminating a group health plan policy for nonpayment but then make the termination retroactive to the date of nonpayment. In such situations, individuals often incur large medical costs for which they are responsible even though they could not know that coverage was terminated because the employer failed to pay the premiums to the health insurance issuer. In addition, retroactive cancellation can cause individuals to have a significant break in coverage, thereby forfeiting their HIPAA rights, in situations where they did not know they were without coverage. These inequities often occur even where individuals paid their share of the premiums, usually through wage

⁷ This change is needed, in addition to the prior recommendation to strengthen HIPAA's disclosure provisions by requiring advance notification by a group health plan, so that health insurance issuers separately may be required to notify individuals prior to terminating health care coverage for participants and beneficiaries.

withholding, and the employer failed to forward the payments to the health insurance issuer.⁷

- * **Recommendations:** To protect individuals in fully-insured group health plans from incurring medical expenses that they will have to pay for out of pocket because the employer failed to make premium payments, as well as ensuring that these individuals do not inadvertently incur a significant break in coverage, the Department makes four recommendations. First, the Department recommends that ERISA be amended to add a new section requiring health insurance issuers to provide written notice to individuals in a fully-insured group health plan not later than **30 days before** the date the group policy terminates or lapses due to the employer's failure to pay to the health insurance issuer the premiums necessary to maintain coverage. The notice should include the date that coverage will end. Second, the law should expressly prohibit health insurance issuers from terminating policies retroactively by requiring that coverage cannot be terminated until at least **30 days after** the required notice is provided.

Third, when health insurance issuers terminate or let lapse a group health insurance policy for nonpayment of premiums, the law should require health insurance issuers to offer individuals (for a period of 180 days beginning on the termination or lapse date) the option of converting to an individual health policy. Finally, the law should require group health plans and health insurance issuers to provide notice of these new requirements to plan participants and beneficiaries.

- ◆ **Expand HIPAA's Special Enrollment Rights in Two Respects.** In general, HIPAA requires group health plans and group health insurance issuers to permit certain individuals who are otherwise eligible for coverage under the plan to specially enroll in the plan, regardless of the plan's or health insurance issuer's regular enrollment periods, upon certain special enrollment "triggers." The first trigger occurs when an individual who declined the employer's coverage because he or she had other coverage loses the other coverage. The second trigger occurs when an individual acquires or becomes a spouse or new dependent after a marriage, birth, adoption, or placement for adoption ("life events"). HIPAA requires plans and health insurance issuers to permit special enrollment in the plan if enrollment is requested within 30 days of the triggering event.

(1) **Allow special enrollment opportunities for siblings of new dependents.** As

⁷ This change is needed, in addition to the prior recommendation to strengthen HIPAA's disclosure provisions by requiring advance notification by a group health plan, so that health insurance issuers separately may be required to notify individuals prior to terminating health care coverage for participants and beneficiaries.

currently drafted, special enrollment under HIPAA's second trigger may lead to unintended and harsh results. For example, consider a family comprised of a mother, father, and son. The mother then gives birth to a daughter. The mother is entitled to a special enrollment because she acquired a new dependent. The same is true for the father. In addition, the new baby girl is entitled to a special enrollment because she became a new dependent. However, under HIPAA's current statutory provisions, the son neither acquired a new dependent nor became a new dependent. Therefore, he is not entitled to a special enrollment opportunity in the plan. Even if his family pays the family premium, he has no special enrollment right. We do not believe this result is what Congress intended in drafting the special enrollment provisions under HIPAA.

- * **Recommendation:** To help families acquire family coverage for all of their dependents, the Department recommends expanding the special enrollment period triggers so that entire families can enroll upon "life events." Specifically, the Department recommends that the law be amended to permit special enrollment of all dependents of an individual upon any "life event" delineated in HIPAA's special enrollment provisions.

(2) Extend the length of special enrollment period. HIPAA requires plans and health insurance issuers to permit special enrollment only if enrollment is requested within 30 days of the triggering event. However, the 30-day window may be too short a time frame for many individuals. For example, in the case of a special enrollment triggered by loss of other coverage, under current law, employees often do not know for some time that their coverage has been terminated. Currently, the law does not require health insurance issuers to notify participants that an employer has stopped paying group premiums⁸. In addition, for individuals on COBRA continuation coverage, no notice of the termination of COBRA coverage is required. Moreover, in the case of special enrollment triggered by a "life event" such as marriage, securing health coverage within 30 days easily can be overlooked.

Missing a special enrollment period may have serious consequences for employees and their dependents. For example, not all plans offer late enrollment periods and even if they do, individuals may have incurred a 63-day break in coverage by the time the late enrollment would be effective. In such a situation, an individual with a preexisting condition suffers a double disadvantage -- he or she may be subject to a longer, 18-month, preexisting condition exclusion period for being a late enrollee, and he or she

⁸ Even if our earlier recommendation regarding notification of material reductions is changed from its current retroactive status to prospective notification, we believe additional time and flexibility is warranted in these circumstances.

may lose all prior creditable coverage that could have reduced the preexisting condition exclusion period because of the 63-day break in coverage.

- * **Recommendation:** To help individuals avail themselves of special enrollment periods, the Department recommends expanding the special enrollment period so that individuals have more time to request such enrollment. Specifically, the Department recommends amending the law to allow special enrollment within 90 days of a loss of other coverage or other "life event."

- ◆ **Further Modify COBRA's Disability Extension Provisions:** An individual ordinarily is entitled to COBRA continuation coverage for 18 months from the date of a termination of employment, but certain disabled individuals are entitled to a longer coverage period. Before HIPAA's enactment, an individual was entitled to COBRA continuation coverage for a total of 29 months from the date of a "qualifying event" (e.g., the date of the termination of employment) if the individual was determined to be disabled under the Social Security Act **on the date** of the qualifying event. This additional continuation coverage period was enacted in order to provide these disabled individuals with the additional health coverage needed until they became eligible for Medicare. However, an individual was entitled to the 11-month disability extension only if the individual notified the plan administrator within 60 days of a disability determination from the Social Security Administration (SSA) and before the end of the original 18-month period.

HIPAA modified the COBRA disability rule so that an individual is entitled to 29 months of COBRA coverage if the person is determined under the Social Security Act to have been disabled at any time **within the first 60 days** after the COBRA qualifying event. Although this change made it easier for individuals to become eligible for the additional 11 months of disability coverage under COBRA, it left unchanged both the requirement that qualified individuals must give notice to the plan administrator within 60 days of the SSA disability determination and the length of the disability extension. These two rules have created difficulty for individuals for two reasons. First, many people are unaware of the notification requirement. Second, a gap may be created at the end of coverage because the 29-month time period was not extended to correspond with the 60-day extension provided at the beginning of the COBRA period.

(1) Improve Notification Provisions to Help Disabled Individuals Take Advantage of COBRA's Disability Extension. In many cases this 60-day notification requirement is a trap for the unwary, particularly since the determination letter from the SSA does not alert individuals to the requirement that they provide notice of the determination to their group health plan administrator within 60 days of the date of the determination letter. Many individuals, especially at the beginning of their initial 18 months of COBRA continuation coverage, have no idea that they must promptly notify their plan administrator in order to obtain the additional 11 months of disability-based COBRA

coverage. As a result, once their initial 18 months of COBRA coverage expires, disabled individuals who missed the 60-day deadline may be without health care coverage until they become eligible for Medicare months later. We do not believe Congress intended this result.

* **Recommendations:** To help ensure that disabled individuals, who would otherwise qualify for the 11-month disability extension under COBRA, are not adversely affected by COBRA's current 60-day notification requirement, we recommend the following two changes. First, we believe COBRA should be modified to allow a qualified individual to notify the plan administrator of a disability determination by the SSA **at any point** during the initial 18-month COBRA continuation coverage period. Specifically, the Department recommends changing the COBRA provision which requires such notice to be given to the plan administrator within 60 days after the date of the disability determination to instead require that such notice be given before the end of the 18-month COBRA continuation period.

Second, we believe the Social Security Administration should include a **prominent** statement in its determination letter explaining to qualified individuals who may be on COBRA that in order to qualify for the 11-month disability extension under COBRA, they must notify their plan administrator of SSA's disability determination before the expiration of the initial 18-month COBRA continuation coverage period. Moreover, a similar change should be made to COBRA so as to require that any notice that a plan administrator is required to give a qualified person regarding the individual's COBRA rights shall include a prominent statement that, to obtain the 11-month disability extension, the individual must notify the administrator within the initial 18-month continuation period of SSA's disability determination.⁹

(2) Further Expand the Disability Extension for Certain Individuals. The HIPAA modifications to COBRA were intended to expand the number of disabled individuals eligible for the 11-month disability extension. However, without a parallel change to the length of the COBRA disability extension, the modification may lead to unintended results.

⁹ As noted in Section VI of this report, one of the regulatory initiatives that the Department is undertaking to bolster HIPAA's protections pertains to providing additional guidance on COBRA notification requirements. We are currently analyzing whether this recommendation can be incorporated as part of the Department's regulatory initiative.

Prior to HIPAA, the disability extension was designed to provide disabled individuals access to health coverage until they become entitled to Medicare disability benefits (typically 29 months from the date of determination of disability). A plan administrator is generally allowed to terminate COBRA continuation coverage once an individual who has elected COBRA continuation coverage becomes entitled to Medicare. Under these provisions, individuals who were qualified to receive 18 months of coverage were required to be determined disabled on the date of the qualifying event to receive the 11-month disability extension. This extension gave individuals 29 months of continuous COBRA coverage which was the amount of coverage needed for the individual to have uninterrupted health coverage until Medicare benefits became available.

HIPAA's modifications to the COBRA provisions changed these requirements and expanded the universe of individuals eligible for the disability extension under COBRA. These changes provided that individuals may qualify for the 11-month disability extension if they are determined to be disabled within 60 days after the COBRA qualifying event. As a result, without a parallel 60-day increase in the disability extension period, an unintended coverage gap is created for certain disabled individuals.

To illustrate this point, consider the following example: An individual experiences a qualifying event. The individual subsequently is determined to be disabled by SSA as of the 45th day following the qualifying event. Assuming the individual complies with COBRA's notification provisions, the individual is entitled to the 11-month disability extension for a total of 29 months of COBRA coverage. However, COBRA continuation coverage, including the disability extension period, starts at the time of the qualifying event rather than at the time the individual is determined to be disabled. As mentioned, Medicare is not available until the individual has been disabled under the Social Security Act for 29 months. As a consequence, at the end of the individual's 29-month COBRA coverage period, the individual remains 45 days short of Medicare eligibility (because the individual's 29 month COBRA continuation coverage period begins at the time of the qualifying event while the individual's 29-month SSA period begins as of the date the individual became disabled, which is 45 days later).

- * **Recommendation.** To provide individuals access to continuous COBRA coverage until Medicare disability benefits are available, the Department recommends extending the 11-month disability extension for individuals who become disabled within 60 days of the qualifying event to provide access to the health coverage they need until they become eligible for Medicare disability benefits. Specifically, the Department recommends that COBRA continuation

coverage for individual's who meet the disability extension requirements begin at the qualifying event and extend to the end of the 29th month following the date the individual is determined to be disabled by SSA. This change will help ensure that individuals who receive their disability determination within the first 60 days of COBRA eligibility are afforded adequate coverage until they qualify for Medicare.

VIII. CONCLUSION

[TO BE ADDED]

PART TWO

REPORT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO THE PRESIDENT AND VICE PRESIDENT OF THE UNITED STATES

The purpose of this report is to describe HIPAA's successes and shortcomings as required by the July 7, 1998 Presidential Directive entitled, "Ensuring Compliance with the Health Insurance Portability and Accountability Act of 1996." In contrast to the report by the Department of Labor, this report by the Department of Health and Human Services focuses on HIPAA implementation in the group and individual health insurance markets. This report is divided into seven sections.

Section I describes the background and history of the group health insurance market, including States' efforts to reform this market. This section also describes HIPAA's successes and shortcomings with respect to the group health insurance market. For the most part, HIPAA has been successful in establishing a Federal minimum standard that builds upon States' current reform efforts in the group health insurance market. No major recommendations for this area are made, but several secondary policy issues have arisen during HIPAA's implementation. These issues, and recommendations for resolving these issues, are further discussed in Appendix III.

Section II is similarly structured, with a brief history and background of the individual health insurance market and States' efforts to reform this market. This section also describes HIPAA's shortcomings in the individual market. Section III describes a number of the lessons learned from States' recent efforts to reform the individual health insurance market and provides recommendations for Federal reforms that would help to address the lack of affordable coverage in this market.

Section IV of the report describes the complexity of HIPAA's structure and the need for a coordinated consumer outreach campaign to inform individuals of their rights under HIPAA. The report also recommends that the Administration, through the Health Care Financing Administration (HCFA), establish a new council of Federal and State regulatory officials to discuss issues related to HIPAA implementation and share information about emerging trends in States' approaches to health insurance reform. This council would also serve as a forum for discussing ways to improve monitoring at the State and Federal levels of HIPAA implementation and States' health care reform efforts, through new data collection efforts. It would also provide a forum to share and learn new ways to better educate consumers about their rights under HIPAA. These and other recommendations are briefly summarized in Section V.

I. THE GROUP HEALTH INSURANCE MARKET

A. Background and History

In 1945, Congress enacted the McCarran-Ferguson Act, which essentially declared that the regulation of insurance is left exclusively to the States, unless there is a clear Federal preemption.¹⁰ ERISA preempts State laws that “relate to” private-sector employee benefits, but saves from preemption State laws that regulate insurance. In effect, as a result of the McCarran-Ferguson Act and ERISA, States do not directly regulate employer-sponsored plans, whether insured or self-insured, but States do regulate the business of insurance, including solvency, benefit and coverage requirements, marketing and premium rates.

At the time of ERISA’s enactment, the health plan world was much simpler than today. Self-insured plans were relatively few and almost exclusively run by very large companies. Commercial insurance consisted almost entirely of indemnity products and that market was heavily dominated by Blue Cross/Blue Shield and a few other large insurance companies. Managed care was still in a nascent stage in most parts of the country. Since 1974, the universe of health plans has changed dramatically. Beginning in the mid-1970s, inflation in general and medical inflation began to increase sharply, reaching double digits by the early 1980s. In an attempt to limit cost increases, employers became much more active in purchasing and overseeing health care delivery, and insurers, particularly in the small group and individual health insurance markets, became more numerous and much more sophisticated about designing, pricing, and marketing products. Moreover, insurers began to develop Health Maintenance Organizations (HMOs) and other delivery arrangements designed to control costs and improve quality. These arrangements also affected the manner in which individuals actually received care.

The result of the rapid changes in the insurance market was often to reduce the value of insurance as a product. Some insurers had developed so many ways of limiting their exposure to claims that the “insurance” was of little real value to many potential purchasers. Tight underwriting--i.e., declining to insure all but the healthiest individuals--preexisting condition restrictions, experience rating and other practices often meant that people could not get or maintain coverage if they incurred, or appeared likely to incur, significant claims. In fact, it was not uncommon for some insurers to drop beneficiaries once they made significant claims. These practices were not universal, but they became sufficiently widespread that the insurers that did

¹⁰Section 2(a) of the McCarran-Ferguson Act (15 U.S.C.) provides that “[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.” The law further states at section 2(b) that “[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance...”

engage in these practices were able to siphon the relatively healthy population and leave the rest of the market unstable. The insurers that were not engaged in these detrimental insurance practices were left with high premiums and a smaller and relatively sicker insurance pool.

By the late 1980s, insurance markets had become sufficiently unstable that many States moved to reform their markets. By 1996, just prior to HIPAA's enactment, 49 States had enacted one or more reforms in the small group insurance market, which had been the market where the detrimental practices had been most widespread.¹¹ The reforms included rating restrictions, guaranteed issue, guaranteed renewal, and limits on preexisting condition restrictions. These were generally based on model statutes developed by the National Association of Insurance Commissioners (NAIC).

B. Detailed Summary of HIPAA's Group Insurance Market Provisions

HIPAA establishes a Federal floor of minimum standards that builds upon the reforms enacted by States in the past decade, including guaranteed availability and renewability of health insurance coverage for small employer groups. These standards include:

- * **Guaranteed Access/Availability** - Health insurance issuers that offer coverage in the small group health insurance market must make all of those products available and issue coverage to any small employer that applies, regardless of the employer group's claims history or the health status of enrollees. HIPAA expands the definition of small employer that was in place in many States. All States must include all firms with between two and 50 employees in the "small group" market, and States can broaden this definition to include groups of one if they so choose. Guaranteed availability does not apply to the large group market, i.e., insurance sold to employer plans with more than 50 employees.
- * **Guaranteed Renewability** - HIPAA requires that all health insurance policies be renewed at the option of the plan sponsor, regardless of health status or claims experience of any individual enrolled in the plan, with limited exceptions. Those exceptions are 1) cases of fraud; 2) failure to pay premiums; 3) movement of all enrollees out of an issuer's service area; 4) termination of membership in a bona fide association; 5) withdrawal of a particular product by the insurance carrier or of all of the carrier's products from the market; and 6) violation of an issuer's participation or contribution rate rules.

¹¹Stephen H. Long and M. Susan Marquis with Ellen R. Harrison, Peter D. Jacobson, and Jennifer S. Sloan, "Baseline Information for Evaluating the Implementation of the Health Insurance Portability and Accountability Act of 1996: Final Report," The RAND Corporation, Prepared for the Health Care Financing Administration, October 1998. Table 1 shows these reforms on a State-by-State basis.

- * Limitations on preexisting condition exclusion period - HIPAA limits the period during which a health insurance issuer may deny, exclude, or limit an enrollee's benefits based on a preexisting condition to 12 months following the enrollment date (18 months for late enrollees). It requires that the period be further reduced by the amount of prior "creditable coverage" that the individual has. For example, a person with 12 months of prior creditable coverage would have no preexisting condition exclusions in a new plan if he obtains coverage within 63 days. Most types of health coverage can count as creditable coverage. HIPAA further limits a preexisting condition exclusion to a condition for which medical advice, diagnosis, care or treatment was received or recommended during the six months preceding the date of coverage or the first day of the waiting period for coverage. HIPAA also prohibits the frequent industry practice of treating pregnancy as a preexisting condition and prohibits health insurance issuers from imposing a preexisting condition exclusion on newborn or adopted children in most cases. HIPAA also prohibits genetic information from being treated as a preexisting condition in the absence of a diagnosis.
- * Certificates of Creditable Coverage - HIPAA requires issuers of health insurance coverage to automatically provide certificates of creditable coverage to individuals whose coverage terminates and also at an individual's request.¹² The certificates must document the period during which the enrollee was covered so that the individual can use it as evidence to provide to a subsequent issuer, who must then credit this time against its preexisting condition exclusion period. A certificate issued upon request must include coverage for the prior 24 months.
- * Special Enrollment Periods - Individuals who do not enroll for coverage in a group health plan during their initial enrollment opportunity may be eligible for a special enrollment period later if they originally declined to enroll because they had other coverage, such as COBRA or as a dependent under a spouse's coverage, and later lost that coverage. In addition, if an enrollee has a new dependent due to the birth, adoption, or placement for adoption of a child or through marriage, the enrollee and new dependents may become eligible for coverage during a special enrollment period.
- * Nondiscrimination -- Health insurance issuers may not establishing rules for eligibility (including continued eligibility) of an individual to enroll for coverage in a group health

¹²Prior coverage must have been consecutive with no lapse in coverage of more than 62 days to be creditable. For example, an individual who was covered for 6 months and then changes employers may be eligible to have the subsequent employer plan's 12-month preexisting condition exclusion period reduced by 6 months. Time spent in a prior health plan's waiting period may not count as part of a break in coverage.

plan based on health status or medical history. Similarly, issuers may not require any individual to pay a premium or contribution that is greater than that for a similarly-situated individuals based on health status or medical history.

C. HIPAA's Successes in the Group Health Insurance Market

HIPAA can claim a number of successes in the small group health insurance market. First, HIPAA mandates guaranteed issue of all products in the small group insurance market throughout the country. This is a major advance, since although 38 States had some form of guaranteed issue legislation for small employer groups at the time HIPAA was enacted, only 14 of these States required insurers to guarantee issue all their products to small groups.¹³ Furthermore, 20 of the 38 States with some form of guaranteed issue legislation defined the small group more narrowly than 2 to 50--for example, from 3 to 25 employees, or 3 to 35 employees. Since HIPAA's enactment, all States require guaranteed issue of all products in the small insurance group market.¹⁴ In most States, these laws apply to employer groups with between 2 and 50 employees.¹⁵

A second major success of HIPAA is that it standardizes limits on preexisting condition exclusion clauses. Using this clause, an insurer can exclude payment for services related to a preexisting medical condition, which may include a wide range of chronic conditions--from high blood pressure, diabetes, or asthma to cancer or kidney failure--for a defined period of time, usually at least 12 months. Prior to HIPAA, 46 States limited the preexisting condition exclusion period to 12 months or less.¹⁶ HIPAA extends this limit to all 50 States and the District of Columbia by limiting the maximum length of the preexisting condition exclusion period to 12 months and further requires that this period be reduced by prior creditable coverage.¹⁷ In addition, HIPAA allows States to limit the preexisting condition exclusion period to less than 12 months.

In establishing a preexisting condition exclusion, insurers could typically treat as “

¹³Two of these 14 States--Kentucky and New Jersey--had standard benefit packages that were the only products that could be issued in the small group market. Another three States--Hawaii, Michigan, and Pennsylvania--required their Blue Cross/Blue Shield carriers to guarantee issue all products. For more information, see Table 1. (Source: Stephen H. Long and M. Susan Marquis, op. cit.)

¹⁴This information needs to be confirmed. HHS staff are currently in the process of assessing States' compliance with the HIPAA provisions.

¹⁵Several States define the small group health insurance market to include employers with between one and 50 employees; New Hampshire defines this market to include employers with between one and 100 employees. For more information, see Table 1.

¹⁶See Table 1 for a more specific information on States' health insurance reforms in the small group health insurance market prior to HIPAA.

¹⁷The current status of States' compliance must be confirmed by HHS staff.

preexisting" any condition for which medical treatment or diagnosis was received or recommended as far back as 12 months prior to the individual's enrollment in the plan. This period is generally known as the "look-back period." Prior to HIPAA, 31 States limited the "look-back period" to six months or less. HIPAA extends the six-month limit standard to the other 19 States and the District of Columbia.¹⁸ In addition, prior to HIPAA, 37 States used the broader "prudent layperson standard" (i.e., any condition for which a prudent person would have sought medical treatment) to determine whether a condition qualified as a preexisting condition.¹⁹ HIPAA narrows the definition of a preexisting definition to include only those conditions for which medical treatment or diagnosis was actually received or recommended.

Under traditional insurance industry rating practices, insurers typically gave employer groups relatively low first-year rates along with a preexisting condition exclusion clause. Insurers then raised their rates significantly once the period of the preexisting condition exclusion clause had run, leaving the employer with the choice of excluding any sick people from the group in order to get a lower rate from the incumbent insurer, or changing to a new insurer at a lower rate, but with a new preexisting condition clause. In either event, the sick people in the group are left without coverage. Furthermore, self-insured plans sometimes had long preexisting condition exclusion periods or even lifetime exclusion periods. HIPAA changes this practice by providing that an individual need only fulfill a preexisting condition exclusion period once as long as he maintains continuous health insurance coverage without incurring a break in such coverage of more than 62 days.

A third success of HIPAA is that it prohibits health insurance issuers from excluding individuals in the group from coverage based upon the individual's health status or medical history. Similarly, premiums charged and contributions to the plan may not vary within a similarly-situated group of plan enrollees on the basis of health status or medical history. Although this provision will likely benefit a small segment of the population, this is nonetheless an important Federal floor of protections for these sick individuals.²⁰

Measuring the effects of these new HIPAA provisions is difficult because of the incremental nature of the law and the variation permitted among the States. Most States had previously enacted some reforms similar to HIPAA's, particularly in the small group health insurance market; therefore the effects of HIPAA may be relatively small and hard to measure

¹⁸The Report by Stephen H. Long and M. Susan Marquis for the RAND Corporation (op. cit.), indicates that a few States fail to limit the "look-back" period to six months. However, HHS staff are currently confirming the status of States' compliance with the HIPAA provisions.

¹⁹Ibid.

²⁰Stephen H. Long and M. Susan Marquis, op. cit.

empirically. Nevertheless, some data on the small group health insurance market is available. In a recent informal survey of all 50 States and the District of Columbia, for example, 18 reported some information regarding the number of covered lives for either the individual or group markets; this information is set out in Table 2. On the other hand, 22 States reported that data on covered lives was not available, and the remaining 11 States did not respond.²¹ In addition, although the nation has now experienced more than seven years of economic growth and a rise in real wages, the total number of uninsured has increased and the number of people covered by employer-sponsored plans has declined. Analytically separating the effects of HIPAA from the effects of economic and other factors is not possible at this time.

C. HIPAA's Shortcomings in the Group Health Insurance Market

In general, HIPAA represents a significant step forward for market reforms in the group health insurance market. However, several specific issues have arisen during the implementation and enforcement processes that need to be addressed. These are briefly discussed below; additional information is provided in the specified appendix.

1. HIPAA Does Not Address Premium Rates

Although HIPAA guarantees access in the small group health insurance market, it does not regulate premium rates. There have been reports of health insurance issuers offering coverage at rates well in excess of the general industry maximum in place before HIPAA of 200 percent of standard risk. However, these problems do not appear to be as common or widespread relative to the individual health insurance market. This may be due to the fact that most 49 States and the District of Columbia had some kind of restriction on rates in this market prior to HIPAA.²² These laws ranged from the simple pure or near-pure community rating laws of New Jersey, New York, and Vermont--which required an insurers to charge the same rate, or about the same rate, to all small groups regardless of health status--to laws setting up complicated formulas that continued to allow the use of health status--to laws setting up complicated formulas that continued to allow the use of health status, age, sex, industry and other factors in setting rates, but sought to limit both the manner in which these variables can be used and the extent to which rates between different small groups can vary.

In contrast, HIPAA does not limit rates. HHS issued a bulletin in March 1998 describing rating and other issuer practices that may violate HIPAA's guaranteed availability provisions.

²¹For a State-by-State listing of the data collected, see Table 2.

²²Alabama does not have rate restrictions in the small group health insurance market. (Source: Report by Stephen H. Long and M. Susan Marquis for the RAND Corporation and additional information from the Georgetown University Medical Center's Institute for Health Care Research and Policy.)

HHS is not recommending any statutory change at this time, but continues to monitor the problem.

2. Access Is Still Limited

Although HIPAA provides guaranteed access to all products in the small group health insurance market, more could be done to facilitate coverage for small firms. More than a quarter of private sector workers in firms with 50 or fewer employees lack health insurance--significantly more than the national average of approximately 17 percent of workers. This deficiency in insurance coverage occurs, in part, because the costs of setting up and operating health plans in the current small business insurance market are higher than those for large employers. In addition, insurance companies may require a minimum number of covered employees to be able to provide insurance to a group. This makes it difficult for small employers to offer multiple health plans to their employees. Only a very small fraction of the small businesses that offer health insurance benefits provide workers with a choice of health plans.²³

The original HIPAA legislation included provisions that would encourage the growth of purchasing cooperatives. Although these provisions were later removed during the legislative process, experience since then suggests that such cooperatives have merit. A few health benefit purchasing coalitions have been established to help pool employer workforces, negotiate lower prices and better benefit packages with insurers, provide comparative information about available health plans to participating employees, and, in some cases, administer premium payments made by employers and their workers. Such coalitions provide an opportunity for small employers to purchase health insurance for their workers at reduced cost and to offer a greater choice of health plans than is currently available to employees of small businesses.

3. Flaws in the Law Limit Access Intended

HHS has reason to address four small but not unimportant policy problems in the group health insurance market that have become apparent during implementation. A fuller discussion is included in Appendix III, but the Department's recommendations are listed below.

Recommendations

1. Encourage Growth of Purchasing Cooperatives

²³In firms with 3 to 9 employees, only 6 percent offer a choice of plans; in firms with 10-24 employees, 12 percent offer a choice; and in firms with 25-49, 16 percent offer a choice. Source: "Health Benefits of Small Employers in 1998," prepared by KPMG Peat Marwick for the Henry J. Kaiser Family Foundation, February, 1999.

The President's Fiscal Year 2000 budget contains two proposals to encourage more purchasing cooperatives and to increase coverage in small firms that previously had not provided insurance. Specifically, a special rule would be established to facilitate the ability of private charitable foundations to make grants to cover the start-up and initial operating expenses of purchasing cooperatives. In addition, a temporary tax credit would be provided to firms with 2 to 50 employees which purchase insurance through a qualified health benefit purchasing cooperative. The firms could not have offered insurance in 1997 or 1998. The credit would equal ten percent of employer contributions to employer health plans, up to \$200 for a single plan and \$500 for a family plan.

2. Extend Guaranteed Availability to Large Employer Groups

HIPAA should be amended to extend the guaranteed access requirements to employer groups with more than 50 employees.

3. Address Other Policy Issues

Four smaller but not unimportant policy problems in the group health insurance market have become apparent during implementation. These issues are further discussed in Appendix III, but the recommendations are:

- * Although the law requires guaranteed access to small groups, it does not require issuers that sell to associations to provide guaranteed access. To avoid "cherry picking" of healthier groups through associations, issuers in the group or individual market should have to guarantee access to all bona fide associations.
- * Require group health plans and health insurance issuers to provide a 30-day annual open enrollment period for those individuals who previously declined coverage.
- * The law provides a special enrollment period in group health plans for individuals who have lost coverage under another group or individual plan, but it does not provide this opportunity for people who have lost Medicaid. The law should be amended to provide a 30-day special enrollment period under a group plan for individuals whose Medicaid coverage terminates, regardless of whether the coverage was fee-for-service or managed care.
- * Under current law, a person who has lost group coverage has 62 days to exercise their guaranteed access to the individual market, but the Department has learned of cases where individuals have not learned of their loss of group coverage until well after the coverage was terminated, leaving them little time to find new coverage. The law should be amended to begin the time period to request special enrollment into another group health plan or to apply for an individual policy as a HIPAA eligible on the day

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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.

II. THE INDIVIDUAL HEALTH INSURANCE MARKET

A. Background and History

Although the individual health insurance market has traditionally represented only a small percentage of the total insured population, it is nonetheless an important component of the nation's overall health insurance system. An estimated 10.8 million people under age 65 receive primary coverage annually through this market; this number rises to nearly 16 million counting people with more than one source of coverage.²⁴ The size of the market varies widely among States, from 13 to 15 percent of the non-elderly population in North Dakota, South Dakota, and Nebraska to less than five percent in Massachusetts, Michigan, New Mexico, and Ohio.²⁵ Furthermore, the data suggest that turnover is relatively high.

The individual market is important to fulfilling HIPAA's goals of increased continuity of coverage and improved access, and therefore of concern to Federal policy makers. Employer-sponsored coverage has been slowly but steadily declining in recent years. Although a number of factors appear to be contributing to this decline, one of them appears to be changing work patterns and employment relationships that preclude eligibility for employer-sponsored group plans. Furthermore, some, including Members of Congress, are suggesting that tax credits or other incentives should be developed to increase coverage and reduce the number of uninsured. Such a strategy, however, would appear to have limited potential without reforms that ensure access regardless of health status, reasonable premium rate restrictions, subsidies for lower-income individuals, portability and some form of risk-sharing among insurers.

The individual health insurance market has traditionally been considered more volatile than the group health insurance market, and premiums in the individual health insurance market are generally higher relative to those in the group health insurance market. Insurance in the individual market has higher administrative costs, is usually underwritten, has fewer tax advantages for most enrollees²⁶ and is less likely to offer managed care options. The cost of underwriting and marketing to individuals is generally in the range of 30 to 35 percent of the premium paid, which is considerably higher than the 12 to 15 percent for group health plans and

²⁴Source: Current Population Survey, March 1998. Four million individuals with employer-sponsored coverage indicated that they also have individual health insurance coverage.

²⁵Chollet, Deborah and Adele Kirk. "Understanding Health Insurance Markets: Structure, Practices, and Products in Ten States." March 1998. The Kaiser Family Foundation.

²⁶Current tax law provides a deduction for the self-employed of 60 percent in 1999; 70 percent in 2002; and 100 percent in 2003. People with individual insurance who are not self-employed do not get a deduction for health insurance; however, they can deduct any medical expenses over 7.5 percent of income and the premiums for health insurance count toward this amount.

less than 10 percent for the largest group health insurance. Moreover, group health plans, especially larger groups, are more likely to include a broader range of health risks than individual policies because the overall premium is lower and tax advantages and employer contributions make the cost of group plans appear lower to the individual. This encourages individuals with lower health care risks to join. The group health plans are thus able to spread risks and costs more broadly than individual policies.

Although States have been slower to implement broader reforms in the individual health insurance market than in the small group health insurance market, change is occurring. Between 1990 and 1996, 26 States enacted some kind of reform in the individual market, including rating restrictions, guaranteed access, guaranteed renewal, limits on preexisting condition restrictions, and minimum loss ratios.²⁷ Specifically, 13 States require all insurers in the individual market to guarantee issue at least one or more products to either all applicants or those who meet specific qualifications, e.g., were continuously covered for the past 12 months. Four of these States--New York, New Jersey, Vermont, and Washington--require guaranteed issue of all products. Eighteen States have passed legislation limiting variation in premium rates or prohibiting the use of certain factors, such as health status, claims experience, age, or gender, in setting rates. Twenty-two States limit preexisting condition exclusions, either by limiting the "look-back" period or waiting period, or both.²⁸ Many States limit each period to 12 months; however, insurers may use "riders" that exclude coverage for specified conditions. A few States have added other reforms, such as mandatory or voluntary reinsurance or minimum loss ratios.

B. HIPAA's Individual Insurance Market Provisions

HIPAA establishes two minimum standards in the individual health insurance market: it requires health insurance carriers to renew health insurance coverage and guarantees coverage to certain individuals who have lost group coverage. However, HIPAA allows States flexibility to design their own alternative mechanisms to guarantee health insurance coverage in the individual health insurance market for "eligible individuals."

In order to be eligible for this guaranteed access to the individual market, a person must meet the following five criteria:

²⁷Chollet, Deborah and Adele Kirk. "Understanding Health Insurance Markets: Structure, Practices, and Products in Ten States." Kaiser Family Foundation. March 1998. Additional information about States' reforms in the individual health insurance market is provided in Table 3.

²⁸Insurers may exclude payment for services related to a preexisting condition for a defined period of time, usually at least 12 months. In addition, insurers may consider any condition for which medical treatment or diagnosis was received or recommended as far back as 12 months prior to the individual's enrollment in the plan. This period is generally known as the "look-back period."

- * have at least 18 months of prior continuous coverage,²⁹ the most recent of which must have been through a group health plan;
- * have elected and exhausted continuation coverage under COBRA or State mini-COBRA coverage, if such coverage is offered;
- * not be eligible for coverage through another group health plan, Medicare, or Medicaid;
- * not have any other health insurance coverage; and
- * not have had his/her most recent coverage terminated because of nonpayment of premiums or fraud.

States must ensure that these eligible individuals (also called “HIPAA eligibles”) are guaranteed issue a choice of coverage. They may do so either by enacting the Federal provisions into their own State law or by establishing one of several “acceptable alternative mechanisms” specifically authorized by HIPAA. In those States that choose to enact the Federal minimum standard into State law, issuers are required to guarantee issue to eligible individuals either all their policies, their two most popular policies, or two so-called “representative” policies, which must be designed for, made generally available to, and be actively marketed to and enroll, both HIPAA eligibles and other individuals.

States that do not enact the Federal minimum standard into State law must establish an “acceptable alternative mechanism.”³⁰ Generally, the alternative mechanism must offer eligible individuals a choice of at least two policy forms of coverage comparable to that offered in the State’s individual market or a standard option of coverage available under the group or individual market laws of the State.³¹ Eligible individuals may not be subject to a preexisting condition exclusion. The mechanism must also provide for the spreading of risk through one of the following: 1) a qualified high-risk pool that provides coverage to eligible individuals without a preexisting condition exclusion; 2) either of two NAIC Model Acts;³² or 3) any other mechanism

²⁹There may not be a lapse in coverage of more than 62 days.

³⁰See Figure 1 for specific criteria for States’ alternative mechanisms.

³¹A complete list of each State’s alternative mechanisms is provided in Table 4.

³²States may implement 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. The NAIC Model Availability Act would require carriers to guarantee issue all their policies to all individuals--not just HIPAA eligibles--and would prohibit carriers from using health status in setting rates. It would allow carriers to use age and sex in setting rates, but the highest rate an insurer charged an individual could be no more than four times the rate it charged any other individual. The NAIC Model Portability Act would allow people with prior coverage to obtain insurance in the private market after spending a year in a high-risk pool. It would limit rates, but less significantly than the Model Availability Act. While prior to HIPAA several states adopted laws similar to the Model Availability Act and at least one state adopted a law based on the Model Portability Act, no state adopted either law after HIPAA was enacted.

that provides for risk adjustment, risk spreading, or a mechanism that provides a choice for each eligible individual of all individual health insurance coverage otherwise available.

In all States, issuers must also guarantee renewal of all health insurance coverage provided in the individual health insurance market at the option of the individual.

C. HIPAA's Successes in the Individual Health Insurance Market

Most States are now in compliance with HIPAA's individual market provisions. All but two States--Missouri and Rhode Island--have enacted State laws guaranteeing renewal in the individual market; prior to HIPAA, only 15 States had required guaranteed renewal.³³ In Missouri and Rhode Island, Federal law now guarantees renewal. All but four States--California, Massachusetts, Missouri and Rhode Island--have enacted a provision in law guaranteeing issue to HIPAA eligibles of at least two health insurance products by either private insurers or a State high-risk pool. HHS is enforcing HIPAA's guaranteed availability provisions in California, Missouri, and Rhode Island; it may enforce certain HIPAA provisions in Massachusetts depending upon the outcome of discussions with Massachusetts officials.³⁴ The other States' mechanisms for guaranteeing health insurance coverage in the individual market vary widely.³⁵ The consequences of this variance are discussed in Section IV--Structural Issues.

The establishment for the first time of some minimum standard requiring comprehensive coverage to be made available to HIPAA eligibles regardless of health status is an important policy change. This step is particularly significant because some insurers had previously declined to provide coverage to individuals with certain health conditions at any price or had permanently excluded coverage of certain conditions. According to a recent study by the Kaiser Foundation, insurers have traditionally refused to insure people with such conditions as arthritis and angina, while excluding coverage for many other conditions, including endometriosis and gallbladder disease.³⁶ Similarly, a 1996 study by the General Accounting Office (GAO), found that individuals with serious health conditions such as AIDS and heart disease are "virtually always

³³Chollet and Kirk, 1998.

³⁴Massachusetts law is in many ways more protective of consumers than are the minimum Federal standards set out in HIPAA, but is missing certain provisions required by HIPAA.

³⁵See Table 4 for a complete listing of States' alternative mechanisms. Ten States--Arizona, Colorado, Delaware, Hawaii, Maryland, Missouri, North Carolina, Rhode Island, Tennessee, and West Virginia--and five U.S. territories--American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the Virgin Island--did not submit an alternative mechanism and are assumed to have enacted the Federal provisions into their own laws. HHS is enforcing the individual health insurance market provisions in Missouri and Rhode Island. HHS staff are currently confirming the compliance of all States with the HIPAA provisions in both the group and individual health insurance markets.

³⁶See Table 5 for a list of these risk factors.

denied coverage,” while those with non-life threatening conditions such as chronic back pain and attention deficit disorder may also be denied.³⁷ In addition, carriers had also excluded benefits related to certain conditions such as a knee injury or glaucoma or chronic conditions such as asthma.

The intent of the Federal minimum standard is to assure HIPAA eligibles that coverage will be available and that it will be reasonably comprehensive. Although the States have options as to what they can require of insurers, the effect of HIPAA is that insurers--even in States permitting insurers to sell only two “representative” policies to HIPAA eligibles--must sell the same type of coverage to HIPAA eligibles that they sell to others. This is a major step forward. The significance of this policy is limited, however, by the fact that HIPAA is silent on premium rates for these individuals, a problem that is discussed below.

High risk pools are an alternative for States that do not want to guarantee access for HIPAA eligibles to the individual market. A high-risk pool is a mechanism that provides coverage to individuals who private insurers decline to insure based on their health status. It is typically administered, for a fee, by the largest carrier in the state. To the extent the premiums paid into the pool are insufficient to cover the claims it must pay out, either direct appropriations from general revenues or carrier assessments--for which they typically receive a tax credit--make up the difference. Twenty-two States have elected this option.³⁸ The success of the high-risk pool option appears to be limited, however. Some States limit benefits significantly. For example, Alaska and Illinois do not provide maternity benefits, Indiana limits transplant benefits, Alabama limits radiation and chemotherapy treatments, and numerous States have high cost-sharing or low annual benefit limits. In addition, most high-risk pools are heavily subsidized by taxpayers through either direct appropriations or tax credits to insurers. Thus, HIPAA eligibles are receiving subsidies that could be used to provide coverage to those high-risk individuals who have never had access to coverage.

D. HIPAA's Shortcomings in the Individual Health Insurance Market

In practice, the HIPAA goals in the individual health insurance market appear to fall far short of their intent. The law limits those who can get guaranteed access to the individual market to a very small number of people. Moreover, State flexibility in providing the access, either through insurance in the individual market or high-risk pools, may result in people being unable to obtain good coverage, and the lack of premium limits may make the coverage unaffordable for many. Finally, once in the individual market, people are often “locked-in” because there is

³⁷General Accounting Office, “Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs,” November 1996. See Table 6 for a list of these conditions.

³⁸One of these 22 States, New Mexico, uses its high-risk pool as part of its alternative mechanism.

generally no portability within the individual market and among high risk pools. These problems are discussed more fully below.

1. HIPAA's Guaranteed Access in the Individual Market Applies Only to a Limited Class of People

Individuals seeking coverage in the individual health insurance market must meet several criteria to be eligible for insurance under HIPAA.³⁹ First, HIPAA does not provide “individual-to-individual” portability; only those individuals leaving a group health plan to purchase an individual policy are potentially eligible for the HIPAA protections. Second, even those individuals leaving a group health plan must have had at least 18 months of prior creditable coverage, thus excluding not only those who have individual health insurance, but also those who have been covered by Medicare or Medicaid. It also excludes those who have purchased a conversion policy and those in a college plan or State high-risk pool.

Third, in order to be eligible for coverage under HIPAA, an individual must have elected and exhausted continuation coverage under COBRA if such coverage is offered. Many individuals are not aware of this requirement when COBRA is offered to them and, since individuals pay the full premium (and a bit more) for COBRA coverage, many decide not to accept COBRA continuation coverage. Finally, 38 States have “mini-COBRA” laws, which extend COBRA rights to groups with fewer than 20 employees; this further reduces the potential number of HIPAA eligibles.⁴⁰

The original estimates of the number of individuals qualifying as “eligible individuals” were very low. For example, the Congressional Budget Office estimated that 45,000 individuals would receive coverage by the end of the first year, and that the number of such individuals receiving coverage “would plateau at around 150,000” in about four years.⁴¹ Preliminary data from the States indicate that even these estimates may have been too high (see Table 2).

2. Issuers Able to Take Advantage of Lack of Consumer Awareness of HIPAA Rights

A lack of knowledge and information about HIPAA protections also limits the number of potential HIPAA eligibles. The complexity of HIPAA and its administrative structure hinder consumers’ ability to understand their protections. (This issue is discussed in greater detail in Section IV: Structural Issues.) For example, timing is particularly important, since individuals who incur a break in coverage of more than 62 days lose their status as eligible individuals under

³⁹Figure 2 illustrates the process necessary to determine whether an individual is an eligible individual.

⁴⁰Chollet and Kirk, 1998.

⁴¹Congressional Budget Office. Letter to the Honorable Bill Archer. August 1, 1996.

HIPAA. Since HIPAA's enactment, Federal and State regulators have learned of instances where issuers have taken advantage of the lack of consumer awareness of HIPAA by delaying the processing of applications, reducing agents' commissions for policies sold to HIPAA eligibles, or simply denying coverage altogether. For example:

- * Many health insurance issuers are not identifying potential HIPAA eligibles, as required by regulations published in April 1997, and as emphasized in a subsequent bulletin issued in March 1998. HCFA's regional office in San Francisco, which is enforcing the HIPAA standards in the individual market in California, reports that the failure of issuers to identify applicants as HIPAA eligibles has been and continues to be the most frequently violated HIPAA provision. In fact, of almost 2,000 inquiries received by the regional office between January 1998 and September 1998, roughly one-third were instances in which HIPAA eligibles were denied insurance, including those instances in which the issuer failed to identify applicants as HIPAA eligibles.
- * Staff in HCFA's San Francisco Regional Office report that 43 percent of the nearly 2,000 inquiries received between January and September 1998 involved consumer reports of issuers' professed lack of knowledge of HIPAA or overall poor customer service. Another 10 percent of the inquiries involved reports of unreasonable delays--sometimes 6 to 8 weeks or longer--in processing health insurance applications. The Missouri Department of Insurance also reports that there is a lack of agent education about HIPAA and similar delays in processing applications.
- * Some issuers are attempting to discourage the offering of policies to HIPAA eligible individuals in the individual market by withholding commissions from agents for sales to such individuals. In Colorado, some carriers have announced that they are paying no commissions at all on policies sold to eligible individuals or just a flat fee of \$25 per policy, which is a violation of State law and a HCFA bulletin. Although the commission issue is frequently cited by agents and brokers, who feel the most immediate and obvious impact, it can affect consumers as well, particularly if as a result of a commission-driven decision an agent or broker steers the individual to another product with less coverage or higher premiums.
- * There is some evidence that some health insurance issuers electing the so-called "representative" policy option under the Federal minimum standard are failing to offer policies to HIPAA eligibles that comply with the HIPAA provisions. Recent actuarial reviews performed by Milliman and Robertson of issuers' policy forms in Missouri--where HHS is enforcing the Federal provisions--indicate that policies offered by some issuers purporting to be "representative" policies are in fact designed for and enroll only HIPAA-eligibles.
- * HCFA staff in San Francisco have also received reports of one of the larger insurance

carriers offering interim or short-term policies to HIPAA eligibles who apply for coverage as a way to bridge the possible gap in coverage between the time an individual's COBRA coverage expires and the time the new application for coverage is approved. However, the individual does not realize, nor does the insurer inform the individual, that acceptance of such a policy renders him ineligible for the HIPAA protections. As a result, if the individual accepts the policy but the insurer later denies the individual's application for a HIPAA policy or quotes a premium that the individual finds unaffordable, the individual cannot apply for any HIPAA policies, including those offered by another carrier, because he has lost his status as an eligible individual.

- * HCFA's San Francisco regional office staff report that one issuer is attempting to use the law's exceptions for uniform modification of policies as an opportunity to eliminate two of its three individual market policies, leaving only a high deductible catastrophic policy. Then, through its subsidiary, the carrier is offering an HMO product only for its healthy enrollees, thereby effectively segregating the bad risks from the rest of the market. Technically, since the issuer is not discontinuing coverage, it is not subject to HIPAA's requirement that the carrier withdraw from the individual market for five years.

Several States have taken action, under their Unfair Trade Practices Acts or their rating authority, to combat the practice of unfairly reducing or eliminating agent commissions. Other States that have prior approval authority of rates have attacked this practice by declaring that issuers who alter commission structures to deter agents from soliciting or processing applications from HIPAA eligible individuals or groups are using an unapproved rate. Federal law currently provides no direct equivalent to these State laws. Nevertheless, these and other marketing or distribution practices may, in many instances, constitute failure on the part of issuers to offer required coverage to HIPAA-eligible individuals. Furthermore, health insurance issuers are required by Federal regulations to identify HIPAA eligibles and to adapt their internal processes and applications to screen for HIPAA eligibles.

In those States where the Federal government is enforcing the HIPAA provisions, HHS staff has acted to resolve consumer complaints and require that corrective action be taken by the issuer. For example, staff in HCFA's regional office in San Francisco investigated and resolved 239 allegations of potential HIPAA violations between January 1998 and March 1999. Staff in HCFA's regional office in Kansas City, Missouri have handled 426 inquiries and resolved 43 complaints and intervened with the issuer on behalf of the consumer in at least 30 of these cases.⁴² HCFA's central and regional office staff meet weekly to discuss complaints and issues.

⁴²The 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.

HHS's priorities since HIPAA's enactment have been on the development and promulgation of regulations to clarify the law. Now that those significant regulations have been promulgated and additional staff with insurance expertise have been hired, the Department will give increasing emphasis to working with the States to enforce the law and reduce these kind of problems. The Department will continue to work with the industry to achieve compliance, but where abusive practices come to the Department's attention, appropriate enforcement action will be taken to ensure that the HIPAA rights are available to consumers.

3. HIPAA Does Not Restrict Premium Rates Charged HIPAA Eligibles

Even if, despite all of the potential obstacles described above, an individual applies and is accepted for coverage in the individual market, the price of the policy may be more than the individual can afford, because HIPAA does not regulate rates. For example, in North Carolina a survey of insurers indicated that rates for HIPAA-eligibles were on average about 300 percent and ranged up to 600 percent of the standard rate.⁴³ In Missouri, where HHS staff are also enforcing the HIPAA provisions, results of an informal phone survey conducted by the State's Department of Insurance in May 1998 indicated that premiums for HIPAA eligibles may be cost almost 600 percent of the standard premium and vary widely--up to \$800--based on the age and gender of the individual.⁴⁴ For example, one company offered a policy cost 500 percent of standard for HIPAA eligibles, with the monthly premium as high as \$1,149 for a 59 year-old male. Another company priced a similar policy at 367 percent of standard, with a monthly premium as high as \$1,049 for a 60 year-old male.

Another survey conducted by the Missouri Department of Insurance in 1998 showed a wide range; of 46 rates quoted for policies sold to HIPAA eligibles, the average was \$279.81 per month, with the highest at \$870.33 per month. In another complaint investigated by HCFA's Kansas City Regional Office, an individual seeking individual health insurance coverage was quoted one rate upon application but when the company learned that she was a HIPAA eligible, it charged her almost twice the amount--more than \$1,000 per month. Regional Office staff have also received reports that one carrier automatically, as a standard practice, sets premiums for policies sold to HIPAA eligibles at 500 percent of its standard rate.

The Colorado Division of Insurance surveyed health insurance issuers' premium rates for HIPAA policies in 1997 and found that the average monthly premium was 335 percent of the

⁴³Polzer, Karl. "HIPAA as a Regulator Model: Early Experiences and Future Prospects." National Health Policy Forum. Issue Brief No. 735.

⁴⁴Missouri Department of Insurance. Informal phone survey results conducted in May 1998. See Appendix IV for more information regarding the survey results.

⁴⁵Colorado intends to resurvey carriers later this year. See Appendix V for the survey results.

standard premium rate, but ranged from 100 percent to 2,000 percent of standard.⁴⁵ Two companies reported that they would charge \$1,708 per month (\$20,496 per year) for an eligible individual with an “average” case of breast cancer. The findings of a General Accounting Office (GAO) study of March 1998 are consistent with these surveys.⁴⁶ In that study, the GAO suggested that premiums for HIPAA eligibles “are likely to remain high unless regulations with more explicit risk-spreading requirements are issued at the Federal or State level or States adopt other mechanisms to moderate these rates.”

4. HIPAA Relies Too Heavily on High-Risk Pools as a Substitute for Insurance

Twenty-two States use high-risk pools as their alternative mechanism for providing coverage to HIPAA eligibles. However, high-risk pools are fundamentally different from insurance in that, by definition, an individual in a high-risk pool must be a high risk and be unable to obtain coverage. Most States require applicants to have been rejected by one or more insurers before they can qualify for the high risk pool. They are generally insurers of last resort in most States and require subsidies to remain solvent.

Enrollment in high-risk pools has been and remains low. The high cost of risk pool coverage appears to be at least one barrier to participation. As discussed in a recent RAND report, enrollments appear to be inversely related to premium levels.⁴⁷ After examining all State high-risk pools in existence prior to HIPAA’s enactment, the General Accounting Office (GAO) concluded in its November 1996 report that these pools “essentially enroll an insignificant number of individuals.”⁴⁸ In fact, of the 26 high-risk pools in existence prior to HIPAA’s enactment, only seven had more than 2,000 members, and eleven had fewer than 1,000.⁴⁹ The high-risk pool insuring the most people in 1995 was Minnesota’s, with 30,470. Recent data indicate that, of those 22 States that chose to use their high-risk pool as their acceptable alternative mechanism, roughly 6,200 total HIPAA eligibles have been enrolled since the law was enacted. Numbers for individual States ranged from 1,570 in Illinois’ risk pool to seven in Alaska’s risk pool. In Alabama, which established a high-risk pool solely for HIPAA eligibles,

⁴⁵Colorado intends to resurvey carriers later this year. See Appendix V for the survey results.

⁴⁶United States General Accounting Office. “Health Insurance Standards: Implications of New Federal Law for Consumers, Insurers, Regulators.” Testimony before the Committee on Labor and Human Resources, U.S. Senate. March 19, 1998.

⁴⁷Stephen H. Long and M. Susan Marquis, op. cit.

⁴⁸United States General Accounting Office. “Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs.” November 1996, GAO/HEHS-97-8.

⁴⁹Communicating For Agriculture, “Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis,” 1998. These figures are taken from enrollment totals as of the end of 1995. For a complete chart of all State high risk pools, including the number of HIPAA eligibles in each pool, see Table 7

⁵⁰Figures are based on States’ responses to recent surveys as of 12/31/98; at least five of the 22 States with

978 individuals have been enrolled since 1997.⁵⁰

A few States have used their high-risk pool as a basis for further incremental reform. Minnesota, for example, has enrolled only ten HIPAA eligibles in its high-risk pool to date, but coverage through a high-risk pool is just one of several options for HIPAA eligibles there. For example, the State requires health insurance issuers to offer conversion policies which are capped at 90 percent of the high-risk pool rates. This slows the flow of individuals into the pool. In addition, HMOs are required to guarantee issue coverage and to offer an annual open enrollment period, with limited preexisting condition exclusion periods. Rating bands are also used to limit premium variation.

New Mexico incorporates several approaches to expanding access and stabilizing the market. First, the State requires modified community rating of individual market products and limits preexisting condition exclusion periods. Second, HIPAA eligibles can purchase coverage through the New Mexico Health Insurance Alliance, originally established for small employers. Finally, the State has a high-risk pool with a small subsidy program to reduce premiums for individuals below 200 percent of the Federal poverty level.

Iowa has also attempted to use its high-risk pool as the last option for individuals seeking to purchase coverage in the individual market. First, the State requires guaranteed issue of health insurance coverage to all individuals with 12 months of continuous coverage. Individuals who are denied coverage (those without 12 months of continuous coverage) may purchase coverage through the high-risk pool, although preexisting condition exclusions may apply. After spending one year in the pool, individuals can then obtain a standard or basic product from any insurers without an exclusion period. Although Iowa's enrollment in the risk pool is very limited--approximately 482 individuals in 1997--it enables people to move into the larger private insurance pool at reasonable rates.

HIPAA eligibles, however, are somewhat different from those who otherwise enroll in high-risk pools. Although there is currently no good data on the health status of these people, HIPAA eligibles have all had continuous health care coverage for at least 18 months. If they have health problems, they have obtained medical treatment while under their group coverage. Therefore, they do not represent the classic adverse selection problem that most concerns insurers: that is, they do not avoid treatment for medical conditions until they become fairly serious and then attempt to buy insurance and make significant claims. They have been participants in and contributors to the insurance pool; being a HIPAA eligible should provide them the right to continue in the insurance pool and choose among product at reasonable rates.

high-risk pools for HIPAA eligibles do not track HIPAA eligibles who enter the high-risk pool. Specific information about each States' risk pool can be found in Table 7.

Most importantly, using the high-risk pools for HIPAA eligibles undermines both the purpose of the pools and the intent of HIPAA to improve access to coverage in the market. In most States, high-risk pools were established for people that were otherwise unable to obtain coverage: it provides coverage as a last resort. The high-risk pools are heavily subsidized by taxpayers through appropriations or tax credits to keep premiums at affordable levels. A number of States have set and reached the ceiling for the number of enrollees.

Recommendations

1. Limit Premium Rates for Policies Sold to HIPAA Eligibles

In States where HIPAA eligibles purchase individual health insurance coverage from health insurance carriers (i.e., not through a State high-risk pool), limit the premiums charged for policies sold to HIPAA eligibles to 150 percent of standard rate. If a State or its issuers are concerned about higher risks or too much concentration of HIPAA eligibles in a few products, they should devise a reinsurance or risk adjustment mechanism so that the cost is spread across a wider insurance base.

2. Require Guaranteed Issue of All Policies for HIPAA Eligibles in Federal Fallback States

HIPAA does not establish a true minimum Federal standard in the individual market, but instead mandates that the States enact one of several specific types of legislation relating to that market. HIPAA could be made both simpler in application and more effective in providing coverage to more individuals if it instead required that States that chose to enact the Federal provisions of HIPAA (also known as “Fallback States”), require health insurance carriers to guarantee issue all individual policies to HIPAA eligibles.

3. Require High-Risk Pools to Serve Only as a Transition for HIPAA Eligibles

Those States that have elected to use their high-risk pools as an acceptable alternative mechanism should also adopt a mechanism similar to Iowa’s model that enables HIPAA eligibles to transition out of the high-risk pool and into the private health insurance market. States should also explore other mechanisms to provide portability within the individual health insurance market.

III. STATES' COMPREHENSIVE HEALTH INSURANCE REFORM EFFORTS

Some States that have enacted comprehensive health insurance reform in the individual and small group health insurance markets have been able to achieve the goal of providing affordable health insurance coverage to individuals in poor health, regardless of their age. Some of these States' efforts have been successful, while others have not; the degree to which a particular States' reform efforts has succeeded appears to depend on several factors. Those who are interested in strengthening HIPAA may wish to consider these efforts and these factors, which are discussed further below.

Vermont

Vermont enacted guarantee issue and renewal of all products sold in the small group and individual health insurance markets in 1992 and 1993, respectively. Vermont also adopted near-pure community rating in both markets, although it exempted professional and trade associations from these rules; such associations can set their premiums based on their own experience.⁵¹ Unlike other States with guaranteed issue and nearly-pure community rating of all products, Vermont did not establish any risk adjustment or reinsurance mechanism.

Overall, the reform law appears to have enhanced insurance availability for high risk groups and individuals. For example, in 1998, a family of four without employer-sponsored coverage seeking coverage could, regardless of their health status, choose between two HMOs with annual premiums of about \$7,000 (\$583 per month) and between two indemnity insurers with rates ranging from about \$6,000 to \$9,000 per year (\$500 to \$750 per month). Prior to reform, individuals with health problems could obtain individual coverage only from Blue Cross.

An Alpha Center analysis of data from the Current Population Survey showed that individual market coverage increased from 6.9 percent in 1992, the year prior to reform taking effect, to 8.4 percent in 1997. During that time, the percentage of the insured in the individual market rose each year over the 1992 base period, with the sharpest increase occurring in the first year of reform (1993). Average premiums increased 16 percent a year for the two-year span between 1994 and 1996, but did not increase at all in 1997. With regard to coverage in the group health insurance market, this same analysis showed that during the same period (1992-1997), the percentage of employer coverage in Vermont dropped slightly, from 71.2 percent to 67.6 percent. However, the latter figure is very close to the average percent covered (68.1 percent) for the six

⁵¹Commercial indemnity insurers are permitted to vary rates +/-40 percent in the individual market for the first two years for demographic and other permissible factors, including age and gender. This variance in rates dropped to +/-20 percent thereafter. In the small group health insurance market, insurers were permitted to vary rates +/-20 percent. (Hall, Mark A. "An Evaluation of Vermont's Health Insurance Laws." Wake Forest University School of Medicine. December 1998.)

years.

Another analysis of State data (Hall 1998) showed increases in the percentage of employees offered coverage between 1993 and 1997.⁵² While the overall increase was roughly one percentage point, this figure obscures major gains noted in specific ranges of employers by size. For example, 68.3 percent of firms with 10-24 employees offered their employees coverage in 1993, compared with 76.9 percent in 1997, or a 12.5 percent increase. Similarly, 81.4 percent of firms with 25-49 employees offered their employees coverage in 1993, compared with 87.8 percent in 1997, or an 8 percent increase. Price increases for non-association products in the small group health insurance market were similar to those in the individual market. However, these increases do not present a complete picture of pricing in the market because a slight majority of sales occur through business associations that are exempt from Vermont's community rating law. Hall concludes that the exemption of associations from the community-rated requirements creates the potential for eroding or undermining the broader community-rated market.⁵³ Nevertheless, Vermont's reforms have made more coverage available for high-risk groups and individuals.

New Jersey

New Jersey implemented comprehensive individual market reform in 1992 with the creation of its Individual Health Coverage Program (IHCP). At the time, Blue Cross/Blue Shield, the insurer of last resort and the only significant insurer in the State's individual market was about to raise individual premiums substantially. The Program requires carriers writing in the individual market to guarantee issue five standard policies to any New Jersey resident without access to group health insurance. Preexisting condition exclusions are limited to one year, and may not be imposed on any individual who has had no lapse in coverage of more than 30 days.⁵⁴ Policies sold by each carrier must be community rated, and each carrier must meet a minimum loss ratio of 75 percent or refund a portion of the premium to policyholders.⁵⁵ Perhaps most importantly, the program requires all carriers to either participate in the IHCP or pay a share of any losses incurred by carriers that do not participate.

There are currently 25 carriers offering coverage in the individual market, whereas Blue

⁵²Hall, Mark A, op. cit.

⁵³Ibid.

⁵⁴This lapse is extended to 62 days for HIPAA eligibles.

⁵⁵New Jersey did not institute pure community rating in their small group health insurance market. Instead, they established a 2:1 ratio, i.e., the highest rate a carrier could charge a small group purchasing a given policy could be no more than twice as high as the lowest rate it charged to any small group purchasing that policy.

⁵⁶Source: New Jersey Individual Health Coverage Program and Small Employer Health Benefits Program.

Cross had been the only substantial individual market carrier prior to the creation of the IHCP.⁵⁶ In addition, insurance premiums dropped for the first two years following the reforms, before rising in 1995. Nevertheless, even after these increases, the lowest available premiums for the standardized products were not dramatically different from, and, in some cases, were actually lower than the average premiums for employer groups. According to a recent study of New Jersey's individual market reforms, the lowest premiums for the IHCP's HMO product are 10 to 23 percent higher than the average monthly premiums for employer-groups' HMO products and the lowest premiums for the IHCP's Plan D with a \$1,000 deductible are 7 to 29 percent lower than the employer-groups' average premiums for indemnity coverage.⁵⁷ (See Table 8 for comparison data between IHCP's lowest individual and family premiums and employer-sponsored health benefits.)

New Jersey is apparently unique in collecting data each quarter on the number of people covered in both its individual and small group insurance markets. This data demonstrates that since New Jersey's community rating and guaranteed issue laws took effect, the number of people insured in those markets has increased by well over 100,000, or by more than 10 percent. According to the New Jersey data, there were a total of 905,165 people insured in the individual and small group markets combined in the fourth quarter of 1994; there were 1,003,407 people insured in those markets in the fourth quarter of 1998. This difference of 100,000, however, understates the true effect of New Jersey's reforms, since the baseline fourth quarter of 1994, which is the first quarter for which New Jersey collected data on its small group market, included an increase of more than 50,000 in the individual market over the third quarter of 1993, which is the first quarter for which New Jersey has kept data on its individual market.

New Jersey also collects separate data on the number of people covered by pre-reform policies--those that were underwritten and demographically rated--and the community-rated, guaranteed-issue post reform policies, as well as separate data on individual market and small group policies. The number of people in the individual market, whether measured by including or excluding the relatively few people in the old, pre-reform Blue Cross policies, peaked in the fourth quarter of 1995: there were 186,130 people in the community-rated/guaranteed-issue policies, and another 28,568 people in the old Blue Cross policies.⁵⁸ These numbers compare to 159,213 in the old Blue Cross plans in third quarter 1993--the first quarter for which New Jersey kept data. Also in the fourth quarter of 1995, however, Health Access, a program that subsidized

⁵⁶Source: New Jersey Individual Health Coverage Program and Small Employer Health Benefits Program.

⁵⁷Swartz, Katherine and Deborah Garnick. "Lessons from New Jersey's creation of a Market for Individual Health Insurance." Draft paper funded by the Robert Wood Johnson Foundation. Cited with permission from the authors.

⁵⁸There was also a decrease in the number of the State's uninsured population from 1994 to 1995, although the number has risen since then.

individual health coverage, stopped accepting applications, and since that time enrollment in the individual market has fallen. Some of this decline in enrollment would appear to be attributable to the movement of family-owned businesses from the individual to the small group health insurance market.⁵⁹ In addition, in 1997, New Jersey changed its individual market law (retroactive to 1996) to make it substantially more difficult for carriers in the individual market to obtain reimbursement and, conversely, to lessen if not eliminate the amount that carriers choosing not to write in the individual market would have to pay. Nevertheless, there were still 131,128 people in the community-rated, guaranteed issue individual products in the fourth quarter of 1998.

New York

New York implemented guaranteed issue and pure community rating of all products in both its individual and small group markets in 1993. It also established a mandatory risk adjustment mechanism designed to help spread risks evenly among insurers.⁶⁰ In 1996, the law was amended to require all HMOs to offer a standardized HMO and point of service (POS) benefit option in the individual market.⁶¹ Since New York's reform law was enacted, small group market enrollment has increased by seven percent in New York, with coverage rising from 913,000 employees in 1993 to 974,000 employees in 1998. HMO enrollment more than tripled during the period, increasing from 180,000 in 1993 to 664,000 in 1998. On the other hand, enrollment in the individual market fell from a total of 369,000 "insured units" (which can be individuals or families) in 1993, to 228,000 in 1998. Nevertheless, HMO growth was strong in the individual market following reform, increasing from 32,000 in 1993 to 130,000 in 1998.⁶²

Average annualized rate increases for HMOs between 1993 and 1998 in the small group market after reform were nearly flat. In contrast, rates for indemnity carriers rose an average of 10-14 percent a year between 1993 and 1998, while Blue Cross rates increased by about seven percent a year. In a recent survey of health insurance agents in New York's small group

⁵⁹Under New Jersey law, employers with at two employees working at least 25 hours per week on average may choose to apply for coverage in the small group health insurance market. Many families have certified that both spouses are working for a family business and have obtained coverage in the small group health insurance market. (Information provided by New Jersey Individual Health Coverage Program and Small Employer Health Benefits Program.)

⁶⁰This was a component of the 1996 law; previously, New York had two risk adjustment pools, one based on demographic factors, the other based on the costs of covering four high-cost medical conditions--AIDS, premature birth, certain transplants and ventilator dependency.

⁶¹This requirement was intended to compensate for the withdrawal of Empire Blue Cross from the market; previously, HMOs could decide whether or not to sell in the individual market. (Mark A. Hall. "Evaluation of New York's Health Insurance Reform Laws." Wake Forest University School of Medicine. November 1998.)

⁶²Ibid.

insurance market, several agents said that the guaranteed issue requirements created more business for them and made doing business easier for both agents and employers, by eliminating the lengthy, paper-intensive underwriting process.⁶³ They also noted that coverage is now readily available for high-risk individuals from a number of insurers at competitive rates.

On the other hand, health insurance agents who sold individual coverage commented that insurers have reduced commissions on individual policies from 20 percent to five or ten percent. Furthermore, almost no insurer pays commissions for individual policies since all are now sold by HMOs that use direct marketing, nor do insurers actively market individual coverage. Each of these factors may have contributed to the decline in enrollment in the individual market in New York.

Washington

Washington enacted a set of individual health insurance market reforms in 1993 that included a minimum standard benefits package (with a maximum premium), community rating, guaranteed issue and renewability of coverage, and limits on preexisting condition exclusion periods. The most dramatic of these reforms were the establishment of a three-month open enrollment period when the law became effective and a three-month preexisting condition exclusion period thereafter.

Unlike the evidence from New Jersey, Vermont, and New York, where comprehensive insurance reform seems to be working, the evidence from Washington State is mixed. A study by the Washington State Insurance Commissioner in January 1999 was generally positive about Washington's reforms. For example, that study found:

- * that "Washington State's 1994 reforms successfully addressed consumers' complaints that they had been locked out of the private insurance market";
- * that "the rate of uninsured in Washington declined from 13 percent in 1996 to 11.4 percent in 1997, while the uninsured rate in the rest of the U.S. increased from 15.6 percent to 16.1 percent";
- * that the loss ratio--the percentage of the premium dollar that goes to pay medical expenses--for individual insurance was lower than that for group insurance; and

⁶³Ibid.

⁶⁴Source: "Washington State's Individual Market in Perspective," Deborah Senn, Washington State Insurance Commissioner, January 1999.

* that 22 percent of those covered by the 1994 reforms were previously uninsured.⁶⁴

The findings of a more recent study of Washington's reforms, on the other hand, lead to the conclusion that Washington's reforms have not been successful, primarily because the open enrollment period and short preexisting condition exclusion period created adverse selection. That study concluded that, in the absence of a waiting period in the first year of reform, individuals could wait until they needed coverage--particularly maternity benefits--before obtaining coverage, and that Washington's three-month preexisting condition exclusion period "effectively encourages irresponsible behavior, and to the extent it drives up rates for everyone, punishes responsible behavior."⁶⁵ One of the State's three major insurers ceased selling its individual products to new purchasers as of January 1, 1999, and two other large insurers received permission from the State's insurance commissioner to cease sales of their standard benefit package as well.⁶⁶

Kentucky

Kentucky enacted comprehensive reform in 1994, then partially repealed these reforms in 1996 and added additional requirements in 1998. The reforms in 1994 created a five-member Health Policy Board responsible for designing standard benefit packages that would be the only products sold after July 1995.⁶⁷ The law also established a purchasing alliance and implemented other reforms, including guaranteed issue of all products in both the group and non-group markets, guaranteed renewability, and modified community rating, with variations for age and geographic location permitted.

In 1996, however, the State exempted associations of employers or individuals from the modified community rating requirements, thus worsening the average health status in the pool. The law also granted insurers more freedom in setting their rates, so that an insurer could charge one individual as much as 500 percent of what it charged another individual. The law also required the State's Insurance Commissioner to hold a public hearing for any rate increase exceeding a specific percentage and prohibited insurers from submitting rate increases more often than once every 12 months. The law permitted carriers to continue to renew their pre-reform policies another 12 months, thereby postponing the switch from old, pre-reform

⁶⁴Source: "Washington State's Individual Market in Perspective," Deborah Senn, Washington State Insurance Commissioner, January 1999.

⁶⁵Kirk, Adele. "Case Studies of the Individual Insurance Market: Riding the Bull: Experience with Individual Market Reforms in Washington, Kentucky, and Massachusetts." This paper was commissioned by the Robert Wood Johnson Foundation for use at its invitational meeting, *The Evolution of the Individual Insurance Market: Now and in the Future*, held January 20, 1999. Cited with permission from the author.

⁶⁶Ibid.

⁶⁷Ibid.

policies to standard policies.

As a result of these changes, only a small proportion of the individual market was subject to the modified community rating; only those individuals in the pre-reform policies who were paying high rates due to poor health or those seeking additional benefits sought coverage in post-reform policies. In addition, as noted in a recent study of Kentucky's individual market reforms, "the association exemption provided a haven for healthy risks in the associations."⁶⁸ Thus, there was significant potential for adverse selection against the new, post-reform policies that were subject to modified community rating. Although available data do not indicate that severe adverse selection actually occurred in the individual market in 1996, nearly all insurers left the State's individual market by the end of the year. According to a 1997 survey by the State's Department of Insurance, insurers were also concerned that the requirements of rate hearings for increases exceeding a fixed amount and the prohibition of subsequent rate increases in the same 12-month period would not allow issuers to correct poor pricing decisions on a timely basis. In addition, they believed that Kentucky's any-willing-provider law prevented them from obtaining significant provider discounts to reduce medical expenses.⁶⁹ Nevertheless, the same survey also found that the average monthly premium in the individual market in Kentucky in 1996 was only \$173.⁷⁰

Lessons From States That Have Enacted Comprehensive Reforms

Comprehensive community rating and guaranteed issue laws will never work perfectly in markets without universal coverage, since older, less healthy people will generally perceive the community rate to be a better value than will younger, healthier people. The experiences of New Jersey, Vermont, New York, Kentucky, and Washington, however, suggest that certain provisions contained in community rating and guaranteed issue laws exacerbate adverse selection, while others limit it. Both the package of reforms enacted and the timing of implementation appear to be important in achieving successful reform.

For example, exemptions that permit certain groups, such as associations, to continue to decline to insure people based on health status and to charge higher rates or "rate up" based on health status are particularly harmful to community rating laws. These provisions allow the exempt group to accept healthy people and force a disproportionate number of unhealthy risks into the community-rated pool. Requiring prior approval of rate increases, or allowing increases

⁶⁸Kirk, Adele, op. cit.

⁶⁹"Number and Characteristics of the Individually Insured, Small-Group Insured, and Uninsured in Kentucky," Research Memorandum No. 474, Legislative Research Commission, March 1997, Regulatory Environment, p. 3.

⁷⁰Ibid., p. 11.

only once a year--as in Kentucky--seems also to be harmful in a guaranteed issue/community rating environment, since it encourages insurers to seek large rate increases based on a fear that they will not be able to raise their rates when needed. The elimination or near-elimination of preexisting condition exclusion clauses for those without previous coverage, as in Washington, also exacerbates adverse selection, since eliminating such clauses also eliminates any incentive for people to purchase insurance before they get sick. Finally, allowing insurers to pay high commissions for healthy risks but low or no commissions for less healthy risks also contributes to risk avoidance.

Community rating and guaranteed issue laws are likely to be more successful, therefore, if they keep the community-rated pool as large as possible by doing the following: 1) eliminating exemptions for specific groups; 2) permitting a reasonable preexisting condition exclusion clause; and 3) prohibiting insurers from varying commissions based on the health status of the group or individual. New Jersey's large increase in enrollment in its small group health insurance market--where carriers are permitted to vary their rates by +/- 33 percent of the community rate--would indicate that some rating flexibility is likely to limit adverse selection. In addition, New Jersey's experience in its individual health insurance market suggests that a "carrot-and-stick approach" may be the most effective tool for increasing enrollment and minimizing adverse selection. The State's individual health insurance market saw a dramatic increase in enrollment when insurers were given substantial incentives to write coverage in the individual market and substantial penalties for not writing in that market. After these incentives and penalties were reduced, enrollment in the individual market decreased.

IV. STRUCTURAL ISSUES

A. Background

In addition to the “cliffs”--points where access and portability abruptly end--created by the incremental nature of HIPAA, several key structural problems in the law hinder attempts to ensure that all consumers receive the protections Congress intended. First and foremost, the Federal and State roles are inadequately defined. States are not only given the flexibility to adopt the HIPAA provisions in their own law and provide broader consumer protections, but are able also, in both the individual and group markets, to choose which provisions of the law they will adopt.

In the group health insurance market, if a State fails to enact one of the HIPAA provisions, the Federal government is expressly required to step in and enforce that provision(s). In the individual health insurance market, HIPAA requires Federal enforcement of the “requirements of this part” whenever a State fails to substantially enforce them. However, HHS does not enforce those State laws that constitute an “acceptable alternative mechanism” (as defined in 45 CFR 148.128) for enforcing guaranteed availability regulations. In addition, HIPAA does not preempt State laws that afford greater protections to HIPAA-eligible individuals without preventing the application of a HIPAA requirement. Thus, in the individual and group health insurance markets, it is possible that HHS will enforce some requirements while the State enforces others. The complexity of the situation varies from one State to another and necessitates careful consideration on a case-by-case basis.**The impact of the law on consumers may vary widely from one State to another and the resulting “patchwork” of Federal-State regulation may require consumers to negotiate a complicated maze of Federal and State oversight among three separate departments that share Federal oversight—Health and Human Services, Labor, and Treasury.

As a result of this “patchwork” of State and Federal regulations, a consumer could find that some provisions in the group or individual health insurance market are enforced by the State and some by the Federal government. In addition, States’ individual and often unique approaches to insurance reform make it difficult to clearly determine an individual’s rights in a given situation. Each of these issues is discussed further below.

B. Federal-State Relations

Although most States moved expeditiously to implement HIPAA, California, Missouri

⁷¹HHS is enforcing HIPAA’s group and individual health insurance market provisions in Missouri. In

and Rhode Island did not enact the necessary legislation, and as a consequence, HHS is now enforcing HIPAA as it applies to issuers in those States.⁷¹ Federal enforcement is also being contemplated in Massachusetts and Michigan.⁷² In these cases, the States already had in effect insurance market reforms that provided consumers with some, but not all, of the HIPAA protections.

Those States that are enforcing all of the HIPAA provisions in the small group health insurance market have jurisdiction only over health insurers in those States. The Department of Labor (DOL) has jurisdiction and enforcement authority over all plans, including those that self-insure. Consumers in self-funded employer plans may be unaware that they must contact one of the DOL regional offices, not their State Insurance Departments, for assistance with matters involving a group health plan's noncompliance with HIPAA. With regard to insured group health plans, DOL has jurisdiction over the plan, but the States, and in some cases, HHS have jurisdiction over the insurer. In addition, HHS has sole jurisdiction over non-Federal governmental plans, but those plans that are self-funded may elect to be exempt from one or more provisions of the law. The practical implication of these overlapping jurisdictions is that staff from at least three separate regulatory bodies-- DOL, HHS, and State regulators--must coordinate enforcement efforts and discuss potential noncompliance in the group health insurance market in each State.

Subsequent to HIPAA, three laws were enacted that built upon the HIPAA structure. The Mental Health Parity Act of 1996 provides for parity in the application of certain annual and lifetime dollar limits on mental health benefits with annual and lifetime dollar limits on medical/surgical benefits. The Newborns' and Mothers' Health Protection Act of 1996 provides protections for mothers and their newborn children with regard to the length of hospital stay following childbirth. The Women's Health and Cancer Rights Act of 1998 requires group health plans and health insurance issuers in both the group and individual markets that provide mastectomy benefits to also provide coverage for reconstructive surgery following a mastectomy. These laws also amended the Public Health Service Act, ERISA, and, with the exception of the Women's Health and Cancer Rights Act, the Internal Revenue Code, but the States have different options with regard to the enforcement of each of these statutes, as described below.

Rhode Island, HHS is enforcing HIPAA's group health insurance market provisions to the extent that State law does not provide equal protection in this market. HHS is also enforcing HIPAA's individual health insurance market provisions in Rhode Island. In California, HHS is enforcing HIPAA's guaranteed availability provisions in the individual health insurance market; the State is enforcing HIPAA's guaranteed renewability provisions in this market.

⁷²Massachusetts law is in many ways more protective of consumers than are the minimum Federal standards set out in HIPAA, but is missing certain provisions required by HIPAA. In March of 1999, Michigan passed legislation bringing its individual market into conformance with HIPAA, but its group health insurance law does not contain all of the provisions required by HIPAA.

The Mental Health Parity Act of 1996 applies generally to group health plans with more than 50 employees, health insurance issuers offering coverage in connection with group health plans with more than 50 employees, and to certain State and local governmental plans. States enforce the Mental Health Parity Act with respect to health insurance issuers, but are not required to enact the Federal requirements into existing State law. However, the law does not preempt any State law that requires more favorable treatment of mental health benefits under health insurance coverage offered by issuers.

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) applies to employer group health plans, health insurance coverage offered in connection with a group health plan, and individual health insurance coverage. However, the law applies only to those plans and issuers that provide benefits for a hospital stay in connection with childbirth; plans and issuers are not required to provide such benefits. If a State has a law that meets one of three criteria, then the State law, rather than the requirements of the Federal law, apply to health insurance coverage in that State.⁷³

A preliminary review of States' laws as of July 1, 1998 indicated that 39 States and the District of Columbia have laws that meet one or more of these three criteria. Three States--Delaware, Idaho, and Oregon--have adopted the Federal law into their State laws. Seven States--Hawaii, Michigan, Mississippi, Nebraska, Utah, Wisconsin, and Wyoming--do not have laws regarding the hospital length of stay in connection with childbirth. The remaining State, Vermont, has a law that does not meet any of the three specified criteria; rather, Vermont's law leaves the decision regarding the hospital length of stay to the attending provider, parents of the newborn, and the patient's health insurance company. In these eight States, the Federal government (HHS) is authorized to enforce the requirements on issuers in the group and individual health insurance markets and non-Federal governmental plans.⁷⁴

⁷³Specifically, the State law may 1) require health insurance issuers to provide at least a 48-hour (or 96-hour stay for Caesarean deliveries) hospital length of stay in connection with childbirth; 2) require health insurance coverage in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association; or 3) require that decisions regarding the appropriate hospital length of stay in connection with childbirth be left entirely to the attending provider in consultation with the mother. State laws that require the mother to consent to the decision made by the attending provider satisfy the last of these three criteria. (See 45 CFR 146.130(e).)

⁷⁴The preliminary review also indicated that the five U.S. jurisdictions--American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands--do not have laws regarding hospital length of stay in connection with childbirth. Therefore, in these territories, the Federal government is authorized to enforce the requirements of NMHPA on non-Federal governmental plans and health insurance issuers in the group and individual markets.

With regard to the Women's Health and Cancer Rights Act of 1998, the Departments of Health and Human Services and Labor are currently developing regulations and have not yet determined how States will enforce these provisions.⁷⁵

In the short term, Federal enforcement of HIPAA is a stopgap measure to ensure that consumers have the protections afforded by the law. In the long term, the complexity and confusion of the HIPAA structure needs to be addressed.

C. Establishing a New Federal-State Partnership over the Longer Term

Federal-State partnerships are not new in health care or other areas of social policy; there is a rich experience upon which to build a collaborative relationship. For example, Federal law set Medigap insurance standards that could be Federally enforced if a State fails to adopt them, but every State has adopted such standards. Therefore no Federal enforcement has been necessary. Despite seven separate amendments to the law, this structure has been in place for nearly 20 years, demonstrating that a Federal-State relationship similar to HIPAA is viable.

The Medicaid program, while distinctly different from HIPAA, provides another model of a Federal-State partnership. While HIPAA confers certain rights to help people access and retain private health insurance coverage under Medicaid, States provide medical assistance to certain low-income individuals. Medicaid offers Federal matching funds to States that elect to participate and follow certain basic Federal standards relative to eligibility and benefits. However, if a State does not adopt a program, there is no responsibility on the part of the Federal government to operate a Medicaid program in that State. Moreover, the Federal government provides substantial funding, including administrative money, to States that operate the Medicaid program. In contrast, HIPAA and the Medigap statute are not publicly-funded programs, but rather are laws governing private insurers; the Federal government provides no funding to states to administer these laws.

These two partnerships demonstrate that collaboration between the Federal and State governments is possible, especially where there is a framework for open communication.

Recommendations

1. Establish a New Federal-State Council

HCFA should build upon its current relationship with States by establishing a new

⁷⁵The Department of the Treasury is also participating in these discussions with the expectation that similar provisions will be added to the Internal Revenue Code.

council of Federal and State insurance officials to discuss issues related to private health insurance and HIPAA implementation. HCFA has already established a relationship with State Insurance Commissioners through the National Association of Insurance Commissioners (NAIC). At the NAIC's quarterly meetings, HCFA staff meet with State officials to discuss issues related to HIPAA implementation; the groundwork has thus been laid for future Federal-State collaboration. This council would build upon this Federal-State dialogue by strengthening existing and creating new relationships with State Insurance Commissioners and HCFA staff. We hope to use this forum to communicate at regular intervals in order to share information regarding States' approaches to addressing some of the problems discussed earlier in this report. This council could also discuss ways to improve efforts at the State and Federal levels to monitor HIPAA implementation and States' health care reform efforts and to share ways to better educate consumers about their rights under HIPAA.

2. Establish a Grant Program for Model Reporting Systems for the States

Establish a grant program to develop model reporting systems for the States. Most data currently collected by States are designed to facilitate their financial oversight of insurers; very little data are collected that facilitate development or assessment of policy. For example, few States can provide such basic data as the number of active insurers in various markets, their market share or the number of covered lives in their plans. If the partnership between Federal and State regulators is to be effective in the long run, it is incumbent that better data, particularly at the State level, be available. The grants would be used to assist a few States, perhaps in partnership with the NAIC, to design and implement one or more reporting systems that could then be replicated in other States.

D. The Consumer under HIPAA

In recent years, purchasers of health insurance, whether they be employers or individuals, have often been confronted with a plethora of options and arrangements. Determining "value" based on price, quality and appropriateness of coverage can be a significant challenge. HIPAA has added to the consumer confusion and complexity in health care. In the long-run, particularly if Congress continues to make incremental amendments to HIPAA, the confusion and complexity may undermine the achievement of the goals the law was intended to enhance.

The type of plan a person is enrolled in affects the extent of coverage under HIPAA and determines which level of the Federal or State government and which agency at the Federal level oversees the law. In addition, as noted above, not all States have adopted all provisions, meaning consumers may have to go to a State agency with some problems and a Federal agency with others. For example, private employer self-insured plans are not covered by State insurance law and they are only subject to ERISA under the jurisdiction of DOL. However, non-Federal governmental plans are under the sole jurisdiction of HHS under the Public Health Service (PHS) Act and those that are self-insured may elect to be exempt from almost all of the HIPAA

provisions, as approximately 615 such plans have done.⁷⁶ Furthermore, Federal employee health plans are not subject to HIPAA, although the plans are all in conformance with the requirements.⁷⁷

The Department of Labor, some States, and a few private groups have developed materials to try to explain the basic rights under the law and how they apply. However, the significant variation permitted under the law may make its application to a person's particular problem difficult to determine. People often do not know all of the information about their coverage and plan that is required to determine both their rights under the law and which State or Federal government is responsible for enforcing the law. Experience in dealing with the public has shown that it often takes considerable time just to determine where to direct a person for further assistance.

In order for people to understand their rights and for the market to operate efficiently and effectively, consumers need accessible, comprehensive, and comprehensible information. Furthermore, consumers need adequate means to enforce the law. At the State level, consumers who believe their rights have been violated generally do not have a private right of action. They generally have to file a complaint with the State insurance department, which can informally seek to resolve the matter, or if necessary, bring some kind of administrative action against the insurer. In plans that are covered by ERISA, an individual can generally bring a private right of action for certain relief in Federal District Court, which is often too expensive for relatively small violations or for those with limited financial resources. In those States in which HHS enforces HIPAA, an individual has no private right of action, and the Secretary has civil money penalty authority only, with a maximum penalty of \$100 per violation per day for each affected individual.

Recommendation

1. Expand Consumer Education and Outreach Campaigns

The Department, through the Health Care Financing Administration (HCFA) has established an organized consumer outreach program. However, this program should be further expanded to include the establishment of a toll-free call center for consumers. Information booklets that describe HIPAA's provisions should be distributed to HCFA's Regional Offices, as well as State regulators, agents and brokers in all States. Articles should be placed in local

⁷⁶Self-insured non-Federal governmental plans are still required to issue certificates of creditable coverage, as described in 45 CFR 146.115(a)(6).

⁷⁷According to the Office of Personnel Management (OPM), Federal government plans in the Federal Employees Health Benefits Program conform with HIPAA's core standards under executive order.

newspapers and other consumer publications in these States and public service announcements should be developed for local radio and television stations. HHS should also conduct training sessions for consumer advocacy groups and State regulators and continue to speak to industry groups and professional associations regarding the HIPAA provisions. The State Health Insurance Programs (SHIP) should be expanded to provide specific information about HIPAA in those States in which the Federal government is enforcing the HIPAA provisions. HHS should continue to convene conferences with advocacy groups to obtain feedback, provide training, and share information. This effort will be undertaken in conjunction with the Department of Labor to assure consistency of information and the most efficient use of resources.

V. SUMMARY OF RECOMMENDATIONS

A. The Group Health Insurance Market

1. Facilitate the Establishment of Purchasing Cooperatives

The President's Fiscal Year 2000 budget contains two proposals to encourage more purchasing cooperatives and to increase coverage in small firms that previously not provided insurance. Specifically, a special rule would be established to facilitate the ability of private charitable foundations to make grants to cover the start-up and initial operating expenses of purchasing cooperatives. In addition, a temporary tax credit would be provided to firms with two to 50 employees which purchase insurance through a qualified health benefit purchasing cooperative. The firm could not have offered insurance in 1997 or 1998. The credit would equal ten percent of employer contributions to employer health plans, up to \$200 for a single plan and \$500 for a family plan.

2. Guarantee Issue for Large Employers

HIPAA's guaranteed availability requirements do not apply to employer groups with more than 50 employees. HIPAA should be amended to extend the guaranteed access to these groups.

3. Flaws in the Law Limit Access Intended

HHS has proposed the following recommendations to address smaller but not unimportant policy problems in the group health insurance market that have become apparent during implementation. (A fuller discussion is included in Appendix III.)

- * Although the law requires guaranteed access to small groups, it does not require issuers that sell to associations to provide guaranteed access to all associations. To avoid "cherry picking" of healthier groups through associations, issuers in the group or individual market should have to guarantee access to all bona fide associations.
- * Require group health plans and health insurance issuers to provide a 30-day annual open enrollment period for those individuals who previously declined coverage.
- * HIPAA provides a special enrollment period in group plans for individuals who have lost coverage under another group or individual plan, but does not provide this opportunity for people who have lost Medicaid coverage. The law should

be amended to provide a 30-day special enrollment period under a group plan for individuals whose Medicaid coverage terminates, regardless of whether the coverage was under fee-for-service or managed care.

- * Under current law, a person who has lost group coverage has 63 days to exercise their guaranteed access to the individual market, but the Department has learned of cases where people have not learned of their loss of group coverage until well after the coverage was terminated, leaving them little time to find new coverage. The law should be amended to begin the time period to request special enrollment into another group health plan or to apply for an individual policy as a HIPAA eligible 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 payments to the issuer.

B. The Individual Health Insurance Market

1. Limit Premium Rates

In States where HIPAA eligibles purchase individual health insurance coverage from health insurance carriers (i.e., not through a State high-risk pool), limit the premiums charged for policies sold to HIPAA eligibles to 150 percent of standard rate. If a State or its issuers are concerned about higher risks or too much concentration of HIPAA eligibles in a few products, they should devise a reinsurance or risk adjustment mechanism so that the cost is spread across a wider insurance base.

2. Tighten the Federal Standard

In States that chose to enact the Federal provisions of HIPAA (also known as “Fallback States”), health insurance carriers should be required to guarantee issue all individual policies to HIPAA eligibles. This would make HIPAA both simpler in application and more effective in providing coverage to more individuals.

3. Require Guaranteed Access to Coverage for HIPAA eligibles in High-Risk Pools

States that elect to use their high-risk pools as an acceptable alternative mechanism should also adopt a mechanism similar to Iowa’s model that enables HIPAA eligibles to transition out of the high-risk pool and into the private health insurance market.

C. Structural Issues

1. Establish a New Federal-State Council

HCFA should build upon its current relationship with States by establishing a new council of Federal and State insurance officials to discuss issues related to private health insurance and HIPAA implementation. HCFA has already established a relationship with State Insurance Commissioners through the National Association of Insurance Commissioners (NAIC). At the NAIC's quarterly meetings, HCFA staff meet with State officials to discuss issues related to HIPAA implementation; the groundwork has thus been laid for future Federal-State collaboration. This council would build upon this Federal-State dialogue by strengthening existing and creating new relationships with State Insurance Commissioners and HCFA staff. This forum could be used to share information regarding States' approaches to addressing some of the problems discussed earlier in this report. This council could also discuss ways to improve efforts at the State and Federal levels to monitor HIPAA implementation and States' health care reform efforts through new data collection efforts and to share and learn new ways to better educate consumers about their rights under HIPAA.

2. Establish a Grant Program for Model Reporting Systems for the States

Establish a grant program to develop model reporting systems for the States. Most data currently collected by States are designed to facilitate their financial oversight of insurers; very little data are collected that facilitate development or assessment of policy. For example, few States can provide such basic data as the number or active insurers in various markets, their market share or the number of covered lives in their plans. If the partnership between Federal and State regulators is to be effective in the long run, it is incumbent that better data, particularly at the State level, be available. The grants would be used to assist a few States, perhaps in partnership with the NAIC, to design and implement one or more reporting systems that could then be replicated in other States.

3. Expand Consumer Education and Outreach Campaigns

The Department's current consumer outreach program should be further expanded to include the establishment of a toll-free call center for consumers. Information booklets that describe HIPAA's provisions should be distributed to HCFA's Regional Offices, as well as State regulators, agents and brokers in all States. Articles should be placed in local newspapers and other consumer publications in these States and public service announcements should be developed for local radio and television stations. HHS should also conduct training sessions for consumer advocacy groups and State regulators and continue to speak to industry groups and professional associations regarding the HIPAA provisions. The State Health Insurance Programs (SHIP) should be expanded to provide specific information about HIPAA in those States in which the Federal government is enforcing the HIPAA provisions. HHS should continue to

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convene conferences with advocacy groups to obtain feedback, provide training, and share information. This effort will be undertaken in conjunction with the Department of Labor to assure consistency of information and the most efficient use of resources.