

ISSUE BRIEF

HIPAA as a Regulatory Model: Early Experiences and Future Prospects

Monday, April 5, 1999
Washington, DC

A discussion featuring

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HIPAA as a Regulatory Model

After a brief hiatus afforded by the fall elections and the trial of President Clinton, the 106th Congress has reengaged debate over enhancing consumer protections in the health system, with various factions taking positions similar to those they held at the end of the last session. While legislators position themselves for possible compromise along a number of substantive issues, the Department of Labor (DOL) has issued proposed regulations that for the first time spell out in considerable detail how private-sector employee health plans must process benefit disputes.

The basic task before policymakers is deciding how to close some of the wider gaps in consumer protection without imposing excessive costs or onerous regulatory requirements. Deliberation over the substance of various consumer protection proposals will be accompanied by parallel discussions over how broadly such standards might apply across the population as well as which level of government will have primary responsibility for setting consumer protection standards and enforcing them. The leading congressional proposals take markedly different approaches to how various arms of the federal government and states could determine and enforce consumer protections, while the proposed DOL claims processing regulations also raise potential jurisdictional conflicts that Congress may have to resolve.

This Forum session and a subsequent one will examine some of the key issues that have arisen in the debate over bolstering consumer protections, with particular emphasis on the regulatory model presented by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In essence, HIPAA was designed to help people in employer-sponsored health plans (and the plans themselves) gain access to health insurance, regardless of health status, and to keep it once they changed jobs or found themselves unemployed and having to buy insurance as individuals. By amending three federal laws and inviting states to enforce many of its provisions, HIPAA attempts to apply uniform minimum consumer protections across most employment-based group health plans in the country. (For a summary of HIPAA's main provisions, see Appendix A.)

Participants at this Forum session will explore early regulatory experiences under HIPAA including the

capacity of state and federal agencies to enforce its provisions. Both this meeting and the one yet to be announced (featuring congressional staff and selected experts as panelists) will address how the HIPAA model might or might not be useful in regulating various aspects of consumer protection, such as enforcing fair claims processing, resolving disputes over benefits, providing consumer information, ensuring plan content and solvency, making sure that managed care plans operate fairly, and enforcing market conduct standards.

ORIGINS OF HIPAA

Viewed one way, HIPAA was a fairly straightforward expansion of federal standards governing employee health benefit plans. Viewed another, HIPAA represented a compromise in which states lost some turf but benefited from Congress's bringing self-insured, private-sector employee health plans outside their regulatory reach under regulations similar to those for state-regulated insured plans, at least in a few substantive areas. In order to set federal minimum standards, Congress ratcheted back state autonomy over regulating health insurance; in return, it applied new standards to self-insured group plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) as well as other group health plans.

ISSUE BRIEF/No. 735

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A Federal/State Compromise

Under current law, the federal and state governments split responsibility for regulating employee health plans and health insurance in a variety of ways. ERISA, which governs private-sector employee health plans providing coverage for about 125 million Americans, creates an uneven playing field in several regulatory arenas.¹ Because ERISA preempts the application of state laws to private-sector employee benefits plans but allows states to regulate insurance, states generally can regulate the health benefits of people in fully insured plans (about 60 percent of ERISA plan participants) but not in self-insured plans (about 40 percent).²

For some matters, state law is entirely preempted across all ERISA plans, including those that are fully insured; for example, the Supreme Court has ruled that ERISA plan participants do not have access to state law remedies because ERISA's legal remedies were intended to be their exclusive means of resolving benefit disputes in court.³ States, however, generally can regulate solvency, benefit content, and many other features of insured products sold to ERISA-governed plans. In part because the extent of state jurisdiction is very dependent on court decisions, there are many gray areas. For example, in some federal circuits it is unclear whether and to what degree states can apply consumer protections to ERISA plan participants enrolled in HMOs (which some courts have declared are not in the business of insurance). It is also unclear whether external review requirements, which have been enacted by many states and are under consideration in many more, would be preempted for both self-insured and fully insured ERISA plans.

HIPAA'S APPROACH

A collection of measures designed to increase access to health coverage primarily for people in group, employment-based health plans or people leaving them, HIPAA was enacted by a Congress with Republicans in control of both houses for the first time in more than four decades. A far more modest approach to health insurance reform than the Clinton administration's failed effort to enact universal coverage, the bill garnered strong bipartisan support after a series of bitter policy disputes between the Congress and the administration.

Aware of the regulatory divide created by ERISA preemption, the principal architects of HIPAA, Sens. Nancy Kassebaum (R-Kan.) and Edward Kennedy (D-Mass.), created a complex regulatory structure in order

to bar discrimination based on health status and limit how plans may apply preexisting condition exclusions to new plan members across all ERISA plans, both insured and self-insured, as well as other types of group health plans.

To apply these core provisions across a broad part of the American population, HIPAA amended ERISA, the Internal Revenue Code (IRC), and the Public Health Service Act, directing three federal departments to coordinate efforts to enforce the provisions. As depicted on Figure 1, these "shared" provisions set down uniform consumer protections standards for people in group health plans falling under ERISA (private-sector plans organized by employers or unions for employees); for group health plans as defined by the IRC (generally speaking, ERISA plans plus church plans); and for insurers under contract with group health plans, including government and church plans.

By amending ERISA and the IRC to set standards for group health plans, HIPAA utilized a regulatory model that Congress had established under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to require plan sponsors to offer people leaving certain group health plans the option of maintaining group health coverage at their own expense.⁴ In a sense, amending the Public Health Service Act to apply the same standards to insurers and some public-sector group health plans built on the COBRA model, adding new layers of complexity and creating new regulatory roles and responsibilities for the Department of Health and Human Services (DHHS) and the states. Although HIPAA lays down federal minimum standards, its designers intended for enforcement to occur at the state level as much as possible.

It has been estimated that HIPAA's core portability requirements help ensure that millions of people changing jobs are able to maintain their health coverage. The GAO estimated that in 1993 more than 20 million people changed jobs.⁵ About 12 million of these workers (along with seven million dependents) had employer-sponsored health coverage. According to some observers, while HIPAA's core requirements are helpful to some people, even in a time of very high employment, the value of the law will not be entirely evident until the nation enters a period of high unemployment, when many people find themselves between jobs and attempting to maintain access to health coverage.

Having established this regulatory structure with HIPAA, Congress subsequently utilized it when adding three mandates, inserted in appropriations bills enacted

Figure 1
HIPAA's Applicability to Populations in Various Types of Health Plans

	Do HIPAA Protections Apply?	
	Insured <i>(Rules apply to insurers through Public Health Service Act)</i>	Self-Insured <i>(Rules apply through sponsors)</i>
GROUP, EMPLOYMENT-BASED/PRIVATE SECTOR		
Most plans sponsored by private-sector employers and unions <i>(HIPAA standards apply by amending ERISA and Internal Revenue Code)</i>	YES ^a <i>(About 75 million people fall into this category)</i>	YES ^b <i>(About 50 million people fall into this category)</i>
Church-sponsored plans <i>(HIPAA standards apply by amending Internal Revenue Code)</i>	YES ^c	YES ^d <i>(But some church plans excepted)</i>
GROUP, EMPLOYMENT-BASED/PUBLIC SECTOR		
State and local government-sponsored plans <i>(HIPAA standards apply by amending Public Health Service Act)</i>	YES ^e	NOT BINDING <i>(Employers can opt not to comply)</i>
Federal employee plan <i>(Excepted from HIPAA standards)</i>	NO <i>(Standards apply by executive order, not under statute)</i>	NO <i>(Standards apply by executive order, not under statute)</i>
INDIVIDUALLY PURCHASED		
Individuals	YES ^e <i>(But most of HIPAA's provisions do not apply here)</i>	NOT APPLICABLE <i>(These people are uninsured)</i>
OTHER GOVERNMENT		
Medicare, Medicaid	? <i>(Under study by DHHS)</i>	? <i>(Under study by DHHS)</i>

^a Enforcement by HCFA/states, IRS, and/or DOL

^b Enforcement by IRS and/or DOL

^c Enforcement by HCFA/states and/or IRS

^d Enforcement by IRS

^e Enforcement by HCFA/states

in 1996 and 1998; these provisions mandate coverage requirements for minimum hospital stays in connection with childbirth, parity in the application of certain limits to mental health coverage, and coverage standards for reconstructive surgery following mastectomy.

Gaps

There are gaps in the reach of HIPAA's core requirements (its antidiscrimination rules and limits on preexisting condition exclusions). Self-insured state and local government employee health plans are allowed to opt out of HIPAA's requirements, and many have done so. (In Texas, for example, more than 150 state, county, and local entities have opted out.⁶) Federal government plans, including the Federal Employees Health Benefits program (FEHB), and state-sponsored health plans that are not employment-based, are all exempt from HIPAA's primary statutory requirements (although these programs must help establish proof of continuous coverage so that people may exercise rights under HIPAA). FEHB conforms with HIPAA's core standards under executive order, according to plan administrators. Whether managed care plans contracting with Medicare and Medicaid are exempt from HIPAA's requirements and the subsequent mandates is under review by DHHS.

The year after HIPAA's passage, church plans successfully lobbied Congress to exempt some of them from HIPAA's ban on discrimination based on health status. The Balanced Budget Act of 1997 amended the IRC to lift this requirement for church plans with regard to "both any employee of an employer with 10 or less employees . . . and any self-employed individual" or "any individual who enrolls after the first 90 days of eligibility under the plan."⁷ Depending on how health plans are structured, it is possible for a plan offered by a church-operated hospital, school, or other type or organization to be defined as a church plan, according to a Treasury Department official.

HIPAA's core standards also do not apply to insurers selling nongroup products and to very small group health plans (those with fewer than two participants who are current employees.) This definition of "small," however, allows group health plans composed only of retirees to be excluded from the requirements.

Jurisdictional Overlaps

HIPAA requires three federal departments to interpret its core provisions similarly. To do this, the departments promulgate regulations jointly. Staff meet regu-

larly to coordinate implementation efforts, share information, and discuss issues that have arisen. According to federal officials, although this level of coordination among three departments creates difficulties, implementation of regulations pertaining to group health plans has proceeded well.

HIPAA's enforcement scheme involves a great deal of overlapping jurisdiction, especially with regard to insured, private-sector employee health plans falling under ERISA. For example, an employee of a private-sector firm excluded from an insured group health plan by virtue of health status could conceivably call the Labor Department or the Internal Revenue Service (IRS) or either a state agency or DHHS' Health Care Financing Administration (HCFA) in order to enforce his or her rights under HIPAA (see Figure 1). Roughly half of those protected under HIPAA's core provisions (about 75 million people) fall in this category. In some instances, when two federal departments and their respective regional offices have been simultaneously involved in responding to a complaint, coordination has been difficult, according to a HCFA official.

Notwithstanding the jurisdictional overlaps posed by HIPAA, one state insurance regulator said that it has served a purpose by applying to self-insured ERISA plans standards similar to those for insured plans. State insurance regulators estimate that up to 30 percent of the health-related complaints they receive come from people in self-insured, private-sector employee health plans outside their jurisdiction.

So far, the three federal departments have not attempted to divide responsibility among them where jurisdiction is overlapping. Where consumers might want to go for help in enforcing portability rights may depend in part on the enforcement tools HIPAA provides. For example, in some instances DOL may sue the sponsors of group health plans to compel them adhere to HIPAA's requirements,⁸ but it cannot impose fines for this purpose. The IRS, however, can levy an excise tax on group health plans failing to comply. If portability rights are being denied by an insurer or managed care company covering people in a group health plan, states can enforce HIPAA's requirements having to do with insurers. DOL cannot take action against an insurer or managed care company to enforce HIPAA. If states do not enforce HIPAA's requirements, DHHS may assert federal authority to enforce the requirements against insurers and can impose sanctions, including civil monetary penalties of up to \$100 a day. If an insurer persists in not conforming, although DOL cannot enforce HIPAA's provisions by taking action

against the insurer, it can take action against the plan sponsor to enforce the law; furthermore, it could also refer the case to the IRS, which has the ability to levy the excise tax, according to DOL officials interviewed. So far, neither of the federal agencies has fined, taxed, or sued a group health plan or insurer to enforce HIPAA. Group plan participants and beneficiaries also may enforce their rights by suing under state law or ERISA, which allows them to win “equitable relief” (the benefits due them) in court but not damage awards.

Regulating Group Health Plans

More than half of the hundreds of thousands of inquiries (including complaints) DOL received last year pertained to health coverage issues. The largest category of health inquiries concerned how to keep continuation coverage under COBRA. Many people also expressed an interest in how to maintain their access to coverage under HIPAA. In almost all instances in which group health plan sponsors have been in violation of HIPAA, simply notifying them of the new requirements has sufficed to bring them into compliance; of the more than 150 cases referred to DOL’s HIPAA implementation team in fiscal year 1998, only two or three had to be referred to field offices for further investigation, according to DOL officials.

During the past four years, DOL’s Pension and Welfare Benefits Administration (PWBA) has added considerable staff to respond to benefit inquiries concerning pensions and other benefits, including health coverage. Four years ago, the agency had only 12 benefit advisors, all located in Washington, and did not have its current capacity to investigate individual health benefit complaints. PWBA now has 58 benefit advisors, 3 to 4 of whom are assigned to each of the department’s 15 regional and district offices, and is authorized to hire another 20. Representing a significant change in PWBA administrative practice (PWBA officials called it an improvement in “customer service”), the benefit advisors now regularly investigate individual disputes over health coverage and try to resolve them.

If talking with the plan sponsors does not resolve a coverage dispute or other issue, DOL may advise participants of their legal options or refer them to legal aid organizations, where available. The department’s authority to go to court on behalf of individuals is ambiguous. The department usually will not sue a plan unless what is at issue (a benefit denial or violation of HIPAA, for example) impacts the plan’s entire membership. ERISA permits individuals themselves to sue their plans for equitable relief.

PWBA officials interviewed said that they are in the early stages of implementing HIPAA (focusing primarily on developing regulations and educating people about the law) and that they are developing a long-term capacity to enforce consumer protections for participants and beneficiaries in group health plans.

Regulating Insurers

As noted above, HIPAA prevents both group health plans and health insurers selling products to those plans from refusing to cover individual members or charging them higher prices based on health status. In addition, health insurance issuers (state-regulated insurers and managed care plans) are required to renew coverage for group health plans and are required to make all products available to small group health plans (covering 2 to 50 employees) if they sell in that market segment.⁹

HIPAA also imposes standards for insurers selling to individuals. These standards are primarily directed at helping people coming out of group plans maintain access to coverage. Unless a state implements an “acceptable alternative mechanism,” such as a high-risk pool, insurers in the individual market must guarantee issue certain products and apply no preexisting condition exclusions to “federally eligible individuals.” These are people who have had at least 18 months of continuous coverage, most recently in a group health plan, and who have exhausted any available continuation coverage under COBRA or similar state laws as well as other coverage options. (To be eligible, their previous coverage also must not have been canceled for nonpayment of premium or for fraud.) Health insurers serving the individual market also must renew policies, not only for the federally eligible people just described, but marketwide. As discussed in greater detail later, HIPAA does not restrict what insurers may charge.

Varying Levels of Preemption

In applying standards to insurers, HIPAA is an amalgamation of several models of federalism, defined here as the division of responsibility for determining and enforcing policy between the federal government and the states. Nothing in HIPAA modifies the strong federal preemption expressed in ERISA’s Section 514, which prevents states from regulating self-insured group health plans. In general, HIPAA’s standard of federal preemption for its substantive provisions regarding accessibility, portability, and renewability is far narrower; HIPAA establishes a federal policy floor upon which states may add requirements for insurers serving group health plans, as long as state laws do not

weaken the federal standards. Federal preemption under HIPAA, however, is more potent for the statutory requirements limiting the application of preexisting conditions exclusions by insurers serving group health plans. In this area, state laws may not differ from federal requirements, except as specifically permitted under HIPAA.

Enforcement a State Option

Although they built a federal policy floor, most of those who designed HIPAA assumed that enforcement of insurance provisions would take place primarily at the state level. States have the option of enforcing HIPAA's access, portability, and renewability standards applying to insurers in the group and individual markets.¹⁰ If states do not pass laws that substantially enforce these standards, however, DHHS must do the enforcing itself, thereby assuming a new regulatory role. When HIPAA was enacted, it was generally believed in Congress and the administration that all the states would opt to enforce these standards and not allow federal officials to enforce regulations in the insurance markets, a traditional state domain guarded by the National Association of Insurance Commissioners (NAIC). (The McCarran-Ferguson Act of 1945 reinforced states' role as primary insurance regulators by stating that no federal law should be interpreted as overriding state insurance regulation unless it does so explicitly, while exempting the business of insurance from federal antitrust regulation to the extent it is regulated by the states.)

HCFA's New Role

HCFA faces the prospect of enforcing of HIPAA's provisions in five states—Missouri, California, Rhode Island, Massachusetts, and Michigan—where legislatures for a variety of reasons have failed to enact laws to conform with all or some of HIPAA's requirements. In the long run, HCFA's regulatory role may widen because HIPAA also requires the federal agency to enforce in states that have conforming laws but that fail to sufficiently enforce them. So far, HCFA has not studied the laws of the 45 states that have made an effort to pass conforming legislation to ensure that they do so. HCFA, also, may not be aware of lapses in enforcement by state agencies, in part because it lacks a mechanism to monitor enforcement activity and must depend in large part on state regulators to report what types of consumer complaints are being received and how they are being resolved. HCFA's regulatory role also may grow if Congress continues to use the HIPAA

model or build on it to set federal floors in other substantive areas.

As noted above, in order to ensure that certain former members of group health plans have access to individual coverage, regardless of health status, HIPAA presents states with a series of policy choices. First, a state must choose between the "federal fallback" approach, which requires all issuers in the individual market to offer eligible individuals at least two health plans, or an "alternative mechanism," which can be a high-risk pool or other means of providing guaranteed access to coverage for this population. If states fail to act, then HCFA must enforce the federal fallback approach.

Under the federal fallback approach, used in about one-quarter of the states, insurers have three options for selling policies to eligible individuals. An issuer may offer (a) all of its individual market plans, (b) only its two most popular plans, or (c) two representative plans—offering higher and lower coverage levels—that are explicitly subject to a mechanism for spreading risk or financial subsidization.¹¹ One year ago, the GAO reported that several problems had cropped up in the states using the "federal fallback" approach, including carrier marketing and pricing practices that restricted consumers' ability to purchase. The GAO reported that insurers were charging premiums ranging from 140 percent to 600 percent of the standard rate to federally eligible people. At the time, the GAO also reported that 36 states and the District of Columbia had opted to use an alternative mechanism. Twenty-two of these states had chosen a high-risk pool as a way to provide access to this group of people.

HCFA's Office of Insurance Standards has announced that it will enforce HIPAA provisions in three of the five states that have not enacted laws conforming to HIPAA. In Rhode Island and Missouri, HCFA is responsible for enforcing all requirements applying to health insurers under the law, while in California the federal agency must enforce only the provisions guaranteeing access to individual coverage for federally eligible people. California passed legislation enabling the state to enforce the other HIPAA provisions affecting its insurance market. HCFA officials are in the process of determining whether the agency will have to enforce HIPAA in Massachusetts and Michigan and, if so, to what degree.

In Missouri, the first state in which HCFA began enforcing HIPAA, a Democratic governor facing a potential battle over various aspects of insurance reform decided not to pursue legislation enabling the state to

enforce the law because he thought consumers would be better off under federal enforcement than under reforms the legislature would likely pass. After some opposition arose in both Rhode Island's executive and legislative bodies, enabling legislation also failed to pass there. Among the factors cited by a state regulator who helped draft the legislation were a general lack of interest in reform, a historic aversion to regulation, and a feeling by some that this was an unfunded federal mandate. Massachusetts had enacted insurance reforms that technically do not conform with HIPAA just before the federal law passed and insurance regulators there began taking steps to implement an alternative mechanism (guaranteed issue of one standard plan). A stalemate in the state legislature, however, has left state regulators in the position of operating with an alternative mechanism, while the federal regulators must decide whether and how to enforce the federal fallback rules. State regulators on occasion have enforced some of HIPAA's requirements in the absence of state legislation to address HIPAA. The issue of how to enforce HIPAA in Massachusetts remains unsettled.

Officials in HCFA's Kansas City and San Francisco regional offices said that, in effect, they are trying to function as insurance regulators. To accommodate this new role, the Kansas City office has hired staff from three state insurance departments. The San Francisco office has assembled an eight-member HIPAA enforcement unit, including an attorney, to enforce individual market requirements in California and potentially assist with HIPAA-related issues that might arise in other western states. The Boston office also has added staff.

One regional official said that enforcing HIPAA has been a new experience for HCFA in more than one sense. For one thing, the federal agency is regulating insurance coverage that it is not also buying; secondly, it is attempting to regulate an industry already heavily regulated at the state level. Another regional official noted that HCFA regulators were used to using "large hammers" in other areas of activity but were discovering that state insurance departments in practice use less dramatic interventions to enforce rules.

Both the Kansas City and San Francisco offices have been responding to complaints and have begun reviewing policies offered by insurers in the individual market. According to an official in HCFA's central office, enforcement tools available to the federal agency include "market conduct surveys," which involve monitoring insurers' practices in response to complaints, and "policy form reviews," which involve periodic examination of insurance policy forms and other documentation. If

violations are discovered, HCFA may impose civil monetary penalties of up to \$100 a day per violation or refer a case to the Office of Personnel Management, which may attempt to influence insurers with whom it contracts to provide coverage for federal employees to comply with the HIPAA requirements. HCFA is in the early stages of developing an enforcement strategy and has yet to levy any such fines. In fact, DHHS has yet to do a complete analysis of the degree to which any state's insurance laws, including the five nonconforming states, fail to match HIPAA's requirements.

Issues Raised

While HCFA's ability to enforce HIPAA remains an open question, most of the consumer complaints received by state and federal regulators have more to do with HIPAA's substance, particularly with regard to the group-to-individual market mandate.¹² Among the most prevalent consumer issues concerning the group-to-individual mandate are the following:

- Very few people are eligible.
- The cost of coverage in many states is very high.
- Not many people know about their rights under HIPAA.
- Carriers sometimes create barriers to purchasing by processing applications too slowly, taking applications only on certain days of the month, or steering HIPAA eligibles toward standard individual coverage where medical underwriting may take place.

To be eligible for post-group coverage in the individual market without medical underwriting under HIPAA, a person must pass through several hoops. Besides having no break in coverage longer than 63 days since being in a group health plan, the most formidable barrier is exhausting continuation rights under COBRA, which means paying premiums for 18 or more months at 102 percent of group rates. Many people cannot afford to stay on COBRA for that long, particularly if they are unemployed. Those that do persevere tend to be sicker than average, thereby causing insurers to charge them more than the standard rate (unless state law imposes rating restrictions such as community rating). In response to a question about the price of coverage in California for HIPAA eligibles, a HCFA regulator commented that from the consumer's point of view: "It's 'sticker shock' all along the way." Price shocks occur as a person moves from paying only the employee's contribution toward group coverage to paying a little more than the group rate under COBRA,

and, finally, in California at least, to paying 250 to 300 percent of the standard rate for individual health insurance. Compounding the shock is the fact that the standard rate for individually purchased health insurance is usually significantly higher than the cost of comparable coverage at a group rate.

Although HIPAA set a federal floor intended to guarantee federally eligible people access to insurance, the number of policy options available to states and insurers to accomplish this goal, coupled with virtually no federal rules concerning what insurers may charge for such coverage, means that the federal “floor” can be experienced at a wide variety of levels by consumers in different states. For example, in states that require community rating in the individual market, such as New Jersey and Vermont, HIPAA eligibles like anyone else have access to insurance at an average price; assuming that these people are sicker than average, their insurance would be subsidized by younger, healthier individuals. In states offering access to HIPAA eligibles through high-risk pools, the law caps their premiums at 200 percent of the standard rate. Arkansas’ HIPAA eligibles have access to coverage through a state high-risk pool at about 115 percent of the “new business” rate in the marketplace (with a rate increase possibly on tap), while premiums in Minnesota’s and South Carolina’s high-risk pools were set at 125 percent and 200 percent of the standard rate, respectively.

Rates in several federal fallback states tend to be higher still. For example, North Carolina regulators surveyed insurance carriers and found that 24 offered HIPAA eligibles insurance on a guaranteed availability basis (five insurers chose to offer the representative plans with options for higher or lower levels of coverage and 18 opted to offer their two policies with the largest premium volume). On average, these policies were priced at about 300 percent of the standard rate, a level that one state insurance regulator said was probably not merited by the health status of the HIPAA eligibles but rather caused by insurers’ fear of taking on too much risk. Rates in Colorado ranged from 200 percent to 300 percent of standard, prompting one regulator there to comment that, without rate controls, guaranteed issue in the individual market “is largely a joke.” Insurance officials in several other states agreed, observing that high prices make coverage unaffordable for most people. HCFA’s regional office in Kansas City noted that rates for HIPAA eligibles in Missouri were reported to be up to 600 to 700 percent of the standard rate and a state legislator interviewed said that the upper limit might be even higher.

An insurance regulator in Delaware said that the state opted to enforce HIPAA as a federal fallback state for several reasons, including time constraints and the fact that it had not enacted individual market reforms before HIPAA. Developing an alternative mechanism at the last minute did not seem worth it for the fewer than 100 people that state officials estimated would be eligible for group-to-individual coverage.

With a few exceptions, state officials reported many fewer problems with implementation of the group market requirements under HIPAA, which were based on NAIC model laws that many had already enacted. Before HIPAA, most states, but not all, had enacted small-group insurance reforms, such as guaranteed issue and guaranteed renewability. (For example, 24 states did not guarantee issue products to small groups or did not have guaranteed issue legislation encompassing all groups from 2 to 50.¹³) The biggest headache reported by most was having to sift through hundreds of pages of insurance law to make sure they were in technical compliance with the federal statute.

An insurance regulator in Arkansas, which did not require guaranteed issue of products in the small-group market before HIPAA, said that, while HIPAA portability and renewability requirements generally have been successful, guaranteed issue was a “big mistake,” helping to cause recent rate increases of more than 20 percent in that market segment. A regulator in Colorado reported some very small groups (of one to five people) had been “gaming” the guaranteed issue requirement by initially purchasing relatively cheap high-deductible coverage when members were healthy and later switching to plans offering first-dollar coverage once someone came down with a costly medical condition.

Federal regulators covering Missouri said that so far they have been focusing most of their energies on enforcing in the individual market but did mention that the most frequent complaint about the group market was that many state and local plans had opted out of HIPAA’s core requirements. One state regulator mentioned that guaranteed renewability could cause problems by foreclosing individual-market insurers’ ability to automatically cancel policies at age 65 when most people become eligible for Medicare. In theory, she said, carriers could continue to cover such people as a separate block of business, thereby undermining the laws that standardize Medigap policies and possibly causing Medicare beneficiaries to lose their window of opportunity to purchase community-rated Medigap coverage.

HIPAA AS A MODEL

As federal and state regulators work to establish HIPAA's complex regulatory structure, several bills before Congress would build on it. The Democrats' Patient Bill of Rights (S. 6/H.R. 358) would do so most dramatically by adding more than 25 new requirements, many of which are designed to regulate managed care practices. For example, the bill would set standards for access to emergency care, coverage options that may be offered, choice of providers, access to specialty care, continuity of care, coverage for individuals participating in clinical trials, access to prescription drugs, adequacy of provider networks, nondiscrimination in delivery of services, internal quality assurance programs, collection of standardized data, the process of provider selection, drug utilization review programs, patient information, protection of patient confidentiality, grievance processes, internal and external appeals of adverse determinations, and prohibition on interference with certain medical communications. The Democrats' bill reaches more people than HIPAA's core provisions through amendments that would extend most of its provisions to state and local government plans (not letting them opt out) and to insurers selling to individuals.

The Senate Republicans' "Patients' Bill of Rights Plus Act" (S. 300), takes a much more targeted approach to regulation of health benefits and insurance than the Democrats' bill with regard to both substance and breadth of the population covered. Introduced by Senate Majority Leader Trent Lott (R-Miss.), the bill would establish several new standards applying to self-insured ERISA health plans only, including rules about access to emergency medical care; coverage options that can be offered; access to obstetric, gynecological, or pediatric care; continuity of care; and protection of communications between providers and patients. These standards would apply only to ERISA plans that are "not fully insured." Therefore, if S. 300 were enacted, the Labor Department might find itself regulating aspects of the health system (much like HCFA is regulating aspects of the insurance system under HIPAA). The Senate Republican bill would establish new information and appeals standards to all ERISA plans but does not amend the Public Health Service Act to apply these standards to insurers and state and local government group health plans. S. 300, however, does build on and extend the HIPAA model with regard to barring the use of genetic information by group health plans and insurers. This is done by adding to nondiscrimination requirements already in place for group health plans and group insurers and by applying requirements (forbidding use of genetic information to

determine eligibility to enroll or as a basis for setting premiums) to insurers in the individual market.

The House Republicans' patient protection legislation, reintroduced as H.R. 448 on February 2 by Rep. Michael Bilirakis (R-Fla.), uses the HIPAA framework more extensively than the Senate Republican bill, but far less so than the Democrats'. The House bill would use this framework to apply standards concerning access to unrestricted medical advice; emergency medical care; obstetric, gynecological, and pediatric care; and information regarding plan coverage, managed care procedures, health care providers, and quality of medical care by amending ERISA, the IRC, and the Public Health Service Act. The House Republicans' bill would require closed-panel HMOs to offer a point-of-service option to group health plans through amendments to the Public Health Service Act, but does not amend ERISA or the IRC to require group health plan sponsors to offer such coverage. (If sponsors declined to purchase coverage with a point-of-service option, the closed-panel HMO would be required to offer such coverage to individual participants to supplement their group coverage.) The bill includes a number of other measures that would have major effects on state insurance regulation, including some designed to expand small businesses' access to coverage through association plans and "HealthMarts."

States' Willingness to Play

As noted above, a critical element of HIPAA's enforcement strategy is states' willingness to enforce minimum standards established by the federal government for insurance markets that states have traditionally regulated. While 10 percent of the states have declined to do so with regard to HIPAA access and portability requirements, more may be likely to refrain from "playing ball" with regard to enforcing managed care regulation. Managed care standards, such as rules determining the adequacy of provider networks, may be harder to define and may be more localized due to variation in health care markets, some insurance regulators have noted. However, others note that many states have enacted more stringent consumer protections, and a federal floor that did not preempt such standards might not be too difficult to implement.

Recent tensions arising from federal preemption of states' traditional activity in regulating insurance indicate that fewer states might choose to enforce federal standards, especially if those standards are at odds with state regulatory practices. The more the HIPAA model is used to impose standards that are not popular with the states, the more enforcement activity will have to occur at the federal level.

The Labor Department's effort to strengthen the ERISA's minimum standards for handling disputed benefit claims, as well as legislative proposals spelling out internal and external review procedures, have raised the concern of many state insurance commissioners about the degree to which new federal rules might preempt state laws applying to insurers in these areas. In September 1998, the Labor Department published proposed regulations that would significantly shorten the period of time required for processing claims, provide for expedited review of urgent care claims, require plan fiduciaries to consult with independent health care professionals in appeals of any adverse benefit determination involving a medical judgment, require de novo review of appealed claims, and make other changes to long-standing ERISA claim processing regulations largely devoid of specific requirements.¹⁴ The Labor Department also supports establishing external review standards under ERISA and expanding court remedies available to consumers but does not have the authority to do so through regulations.

While the NAIC has advocated that Congress amend ERISA to provide consumer protections for self-insured plans that states can not regulate, Kansas Insurance Commissioner Kathleen Sebelius recently testified that "with respect to state-regulated insurers and health plans, we continue to believe that the states are better able to determine what works best in their marketplace."¹⁵ Warning that preemptive federal actions could leave consumers with fewer protections, Sebelius characterized the delivery of health services as a local activity shaped by geographic and demographic factors, the level of market penetration by different types of entities, the composition of the health care workforce, and consumer preferences. She argued that a single federal standard would be difficult to apply and might stifle innovation in local markets.

THE FORUM SESSION

At this meeting, state and federal regulators will share experiences and observations about early efforts to implement HIPAA. Several short presentations will be followed by a round-table discussion including others knowledgeable about HIPAA. Discussion will also address HIPAA's potential as a regulatory vehicle in light of what has been learned.

Issue Questions

Among the questions to be addressed are the following:

- What does the early experience with implementing HIPAA tell us?
 - About the law's substance?
 - About its enforcement structure?
 - About its ability to protect consumers?
- Are the three federal departments and states coordinating effectively? Is their jurisdictional overlap inefficient? Is it necessary to accomplish HIPAA's objectives?
- What do we know about the ability of federal agencies to enforce HIPAA's provisions?
- Can this model be applied to managed care regulation and other areas?
- Does the HIPAA model work better for some types of regulations than others? For example, for rules concerning (a) basic rights, (b) plan contents, and (c) operations of insurers and managed care entities?
- Is HIPAA more effective at regulating group health benefit plans than insurers and managed care companies?
- What is the likelihood that states would opt to enforce federal standards in various substantive areas? Would enforcing managed care standards, for instance, ensuring network adequacy, create a fiscal burden for states that have not already implemented such standards?
- Is HIPAA's enforcement structure too complex? Are there other options for setting a federal floor for regulating health benefits and insurance? How might HIPAA's enforcement structure be streamlined?

Speakers

Daniel J. Maguire is director of the Health Care Task Force for the Pension and Welfare Benefits Administration in the Department of Labor. His responsibilities include leading the department's participation in developing regulations with the Department of Treasury and DHHS under HIPAA, the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act, and the Women's Health and Cancer Rights Act.

Alan Tawshunsky is special counsel to the associate chief counsel (employee benefits and exempt organizations) at the IRS. In this position, he is responsible for supervising many of the chief counsel attorneys working on published guidance on employee benefits issues.

As director of insurance standards of HCFA's Center for Medicaid and State Operations, **Jay Angoff**

is responsible for developing and implementing regulations under HIPAA. He came to the position early this year after serving as director of the Missouri Department of Insurance since 1993.

Barbara Yondorf is director of policy and research for the Colorado Division of Insurance. Working with the commissioner of insurance, Ms. Yondorf is responsible for conducting major research and policy initiatives and drafting bills and regulations, particularly with respect to health insurance issues. Most recently, she has worked on small-group health reform in Colorado, health carrier grievance procedures, the design of a benefits package and employer buy-in program for the state's Child Health Benefit Plan, and a standardized health benefit plan description form.

Since 1995, **Tom Jacks** has been deputy commissioner of the North Carolina Department of Insurance Life and Health Division. From 1993 to 1995, he was legal advisor to the North Carolina Health Planning Commission. In this capacity, he was responsible for developing studies relating to insurance reform, primary care, and health care cost containment as well as advising the gubernatorial and legislative study group, which made recommendations to reform the state's health care system.

Wardell Sanders is the executive director of the New Jersey Individual Health Coverage Program and New Jersey Small Employer Health Benefits Program. These two health reform boards are state agencies charged with regulating and policing the individual and small-employer health insurance marketplaces in conjunction with the state Department of Banking and Insurance. These segments of the health insurance market cover more than one million state residents.

John Hartnedy is chief life and health actuary for the Arkansas Insurance Department. He has 35 years of insurance industry experience, including positions with a number of well-known insurers, and has worked with a variety of products offered in the insurance industry today. He began working at the Arkansas Insurance Department in 1996. In addition to serving as manager of internal analysis, he assists the department with actuarial responsibilities including review and consideration of HIPAA requirements and equity-indexed products.

ENDNOTES

1. See "Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law," Patricia

Butler and Karl Polzer, National Health Policy Forum, George Washington University, June 1996, and "Employee Health Plan Protections under ERISA," Karl Polzer and Patricia Butler, *Health Affairs*, September/October 1997.

2. To understand how to access their legal protections, employees must know whether they are in a self-insured plan (which states may not regulate) but, for several reasons, this may be difficult to determine. Neither the ERISA statute, the labor department, nor the Supreme Court has defined self-insurance explicitly. Second, firms may offer both self-insured and fully insured plans. Also, many plans use complex risk-sharing arrangements with providers that they claim do not constitute insurance. Finally, most self-insured plans purchase "stop-loss" coverage that is not considered to be health insurance, even though payoffs are contingent on the health costs of either individuals in the plan or the entire group.

3. *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987).

4. Under COBRA, former employees and their dependents in firms with 20 or more employees are entitled to remain covered through the employee health plan for specific time periods.

5. General Accounting Office, "Health Insurance Portability: Reform Could Ensure Continued Coverage for up to 25 Million Americans," GAO/HEHS-95-257, September 1995, 7.

6. Karen Pollitz, Nicole Tapay, Lauren Polite, Jalena Curtis, "A Consumer's Guide to Getting and Keeping Health Insurance in Texas," Georgetown University Institute for Health Care Research and Policy, January 1998.

7. Internal Revenue Code, Sec. 9802(c).

8. DOL has the authority to sue a plan for equitable relief if what is at issue impacts the plan's entire membership, but its authority to go to court on behalf of individuals is ambiguous. ERISA permits individuals themselves to sue their plans for equitable relief.

9. States may elect to treat groups of one as being either in the individual or the small-group markets; about one-quarter of the states consider these to be small groups.

10. General Accounting Office (GAO), "Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators," GAO/HEHS-98-67, February 1998, 18.

11. GAO, "Health Insurance Standards," 7.

12. In preparing this article, the author interviewed insurance regulators in 11 states and two HCFA regional offices as well as in HCFA's central office, the U.S. Department of Labor, and the U.S. Department of Treasury.

13. Stephen H. Long and M. Susan Marquis with Ellen R. Harrison, Peter D. Jacobson, and Jennifer S. Sloan, "Potential Effects of HIPAA: A Review of the Literature," *Baseline Information for Evaluating the Implementation of the Health Insurance Portability and Accountability Act of 1996: Final*

Report, Part II, RAND Corporation, prepared for the Health Care Financing Administration, October 1998, 3.

14. For more background information on internal and external review, see Karl Polzer, "ERISA Health Plan Denials: Exploring Models for External Review," National Health Policy Forum Issue Brief No. 720, June 19, 1998.

15. Kathleen Sebelius, "Testimony of the Special Committee on Health Insurance of the National Association of Insurance Commissioners before the Committee on Health, Education, Labor, and Pensions of the U.S. Senate on Group Health Plan Comparative Information and Coverage Determination Standards," January 20, 1999.

Appendix A

HIPAA's Access, Portability, and Renewability Rules¹

Core Requirements Protecting Individuals

Enforced by the Internal Revenue Service and the Department of Labor for group health plans and by the states or the Department of Health and Human Services' Health Care Financing Administration for insurers covering people in group health plans.

Nondiscrimination—Individuals may not be excluded from group health plans or by insurers covering group health plans on the basis of factors related to health status. Similarly, the benefits provided, premiums charged, and employer contributions may not vary within similarly situated groups of employees based on factors related to health status.

Limitations on preexisting condition exclusion periods—Group health plans or insurers selling products to them may deny, exclude, or limit an enrollee's benefits arising from a preexisting condition for no more than 12 months following the date of enrollment. A preexisting condition is defined as condition for which medical advice, diagnosis, care, or treatment was received or recommended during the six months preceding the date of enrollment. Pregnancy may not be considered a preexisting condition.

Credit for prior coverage—Group health plans and insurers covering them must credit an enrollee's period of prior coverage against its preexisting condition exclusion period. To be creditable, prior coverage must have been consecutive, with no breaks of more than 63 days. For example, someone changing jobs who has been covered for 9 months may be eligible to have the new employer's 12-month exclusion period for preexisting conditions reduced by 9 months.

Certificate of creditable coverage—Group health plans, issuers, and other entities must provide certificates of creditable coverage to enrollees whose coverage ends. These certificates must document the period the enrollee was covered in order to credit this time against a preexisting condition exclusion period that may be imposed by the next group health plan or issuer.

Special enrollment periods—People who do not enroll 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 coverage under COBRA, or were covered as a dependent under a spouse's coverage and later lost that coverage. Also, if an enrollee has a new dependent as a result of birth or adoption or through marriage, the enrollee and dependents may become eligible for coverage during a special enrollment period.

Requirements for Insurers Covering Small Groups

Enforced by the states or HCFA.

Guaranteed issue and guaranteed renewability—Insurers must make all plans available and issue coverage to any small employer applying, regardless of the group's health status or claims history. Coverage must be renewed with standard exceptions.

Requirements for Insurers Covering Large Groups

Enforced by the states or HCFA.

Guaranteed renewability—Coverage must be renewed with standard exceptions.

Requirements for Insurers Covering Individuals

Enforced by the states or HCFA.

Guaranteed issue for certain people leaving group coverage—Eligible individuals must have guaranteed access to at least two different coverage options. These people are defined as those having at least 18 months of prior coverage, the last of which was under a group health plan, and having had no break in coverage of more than 63 consecutive days. They also must have exhausted any continuation coverage available under COBRA, must not be eligible for any other group coverage or Medicare or Medicaid, and must not have lost group coverage because of nonpayment of premiums or fraud. States may choose to implement this option either through guaranteed access to individual products or through a high-risk pool or other mechanism.

Guaranteed renewability—Coverage must be renewed across the individual health insurance market with standard exceptions.

1. Sources: Text of HIPAA statute and regulations as well as GAO's "Health Insurance Standards," cited above.