United States General Accounting Office

GAO

Report to the Chairman, Committee on Labor and Human Resources, U.S. Senate

February 1998

HEALTH INSURANCE STANDARDS

New Federal Law Creates Challenges for Consumers, Insurers, Regulators

GAO/HEHS-98-67

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-278643

February 25, 1998

The Honorable James M. Jeffords
Chairman, Committee on Labor
and Human Resources
United States Senate

Dear Mr. Chairman:

Over two-thirds of Americans under 65 years old—some 160 million people—rely on the private group or individual health insurance markets for their health coverage. During the past decade, most states have passed laws designed to improve the access, portability, and renewability of private insurance coverage. However, the extent and scope of these reforms vary, and gaps in protections remain within and among states. Furthermore, self-funded employer group plans, which cover about 40 percent of all employees enrolled in a group health plan, are beyond the purview of state regulation and thus exempt from these reforms.

To provide minimum standards of protection for coverage sold in all states and insurance markets, the Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which the president signed on August 21, 1996. HIPAA is considered by some to be the most significant federal health insurance legislation in over a decade. It sets standards for access, portability, and renewability that apply to group coverage—both fully insured and self-funded—as well as to individual coverage. Federal regulatory jurisdiction for the law is shared among three agencies.

Because of the scope and complexity of this law, its implementation has been a complicated undertaking, and various concerns and challenges emerged during the first year. To assist your Committee in its oversight of the implementation process and in its consideration of possible technical amendments to the statute, you asked us to monitor the implementation process and keep your Committee informed of these concerns and challenges as they arise.[1] As requested, we reviewed the implementation of HIPAA, concentrating on issues affecting

- consumers;
- issuers of health coverage, including employers and insurance carriers;

[1]We issued a preliminary product, The Health Insurance Portability and Accountability Act of 1996: Early Implementation Concerns (GAO/HEHS-97-200R), on Sept. 2, 1997.

- state insurance regulators; and
- federal regulators.

In addition, we reviewed efforts undertaken by federal agencies to address some of the concerns and challenges that have arisen.

To address these objectives, we reviewed the statute and regulations, and interviewed representatives of the Departments of Health and Human Services (HHS) and Labor. With these officials, we discussed the federal interagency process to develop regulations and the measures agencies have taken to ensure compliance. We visited Arizona, Colorado, Michigan, and Missouri and met with representatives of insurance departments, health carriers, employers, and consumer organizations. We also interviewed representatives of several national organizations, including the National Association of Insurance Commissioners (NAIC), the Health Insurance Association of America, the American Association of Health Plans, and the Blue Cross Blue Shield Association.

We conducted our work between May and December 1997 in accordance with generally accepted government auditing standards. While we did not verify in detail all data obtained from carriers, HHS, and NAIC, we did review the consistency of the data with our own interview results and the views of experts in the field, cross-checked some data, and concluded that using the data was reasonable for our purposes.

Results in Brief

Although HIPAA provides people losing group coverage the right to guaranteed access to coverage in the individual market regardless of health status, consumers attempting to exercise their right have been hindered by carrier practices and pricing and by their own misunderstanding of this complex law. Among the 13 states where this provision first took effect, many consumers who had lost group coverage experienced difficulty obtaining individual market coverage with guaranteed access rights, or they paid significantly higher rates for such coverage. Some carriers have discouraged individuals from applying for the coverage or charged them rates 140 to 600 percent of the standard premium. Carriers charge higher rates because they believe individuals who attempt to exercise HIPAA's individual market access guarantee will, on average, be in poorer health than others in the individual market. In addition, many consumers do not realize that the access guarantee applies only to those leaving group coverage who meet other eligibility criteria. For example, individuals must have previously had at least 18 months of

coverage, exhausted any residual employer coverage available, and applied for individual coverage within 63 days of group coverage termination. Consumers who misunderstand these restrictions are at risk of losing their right to coverage.

Issuers of health coverage believe certain HIPAA regulatory provisions result in (1) an excessive administrative burden, (2) unanticipated consequences, and (3) the potential for consumer abuse. Although issuers appear to be generally complying with the requirement to provide a certificate of coverage to all individuals terminating coverage, some issuers continue to suggest that the process is burdensome and costly and that many of these certificates may not be needed. These issuers, as well as many state regulators, believe that issuing the certificates only to consumers who request them would serve the purpose of the law for less cost. Also, issuers fear that HIPAA's guaranteed renewal provision may create several unanticipated consequences for those eligible for Medicare or holding policies designed for certain targeted populations. For example, HIPAA does not permit issuers to cancel coverage of individuals once they become eligible for Medicare. Consequently, some individuals could pay more for redundant coverage. Likewise, for individuals enrolled in subsidized insurance programs for low-income persons, HIPAA may require that such coverage be renewed after these individuals' income exceeds program eligibility limits. Finally, certain protections for group plan enrollees may create the opportunity for consumer abuse. HIPAA's establishment of special enrollment periods may give employees an incentive to forgo coverage until they become ill, and guarantees of credit for prior coverage in the group market could provide enrollees an incentive to switch from low-cost, high-deductible coverage to low-deductible ("first-dollar") coverage when medical care becomes necessary. Some issuers fear that the overall cost of coverage could increase if such abuses became widespread.

State insurance regulators have encountered difficulties in their attempts to implement and enforce HIPAA provisions where they found federal guidance to lack sufficient clarity or detail. For example, regulators say unclear risk-spreading requirements contribute to the high costs faced by certain eligible individuals attempting to exercise their right to guaranteed access in the individual market. Lacking sufficient detail, for example, was guidance to implement nondiscrimination and late enrollee requirements in the group market.

Federal regulators face an unexpectedly large regulatory role under HIPAA that could strain HHS' resources and impair its oversight effectiveness. In five states that reported they had not passed legislation to implement HIPAA provisions by the end of 1997, HHS, as required, has begun performing functions similar to a state insurance regulator, such as approving insurance products and responding to consumer complaints. In addition, HHS may be required to play a regulatory role in some of the other states, the District of Columbia, and the U.S. territories that have yet to pass legislation to implement certain HIPAA provisions. Consequently, the full extent of HHS' regulatory role under HIPAA is not yet known.

Partly in response to health insurance issuers' and state regulators' concerns, federal agencies issued further regulatory guidance on December 29, 1997, intended to clarify current HIPAA regulations such as those related to nondiscrimination and late enrollment in group health plans. Agencies expect to continue supplementing and clarifying the interim regulations in other areas where problems may arise. To address its resource constraints, HHS has reprogrammed resources and requested additional resources as part of its fiscal year 1999 appropriations.

Background

Title I of HIPAA contains standards for health insurance access, portability, and renewability, which apply to group (both self-funded and fully insured) and individual insurance market coverage.[2] While some of the standards, such as guaranteed renewal of insurance coverage, apply equally to coverage offered in all markets, other standards do not. For example, HIPAA requires all products carriers offer in the small group market to be sold to any small employer that applies, but it does not extend the same requirement to the large group or individual markets.[3] Similarly, HIPAA requires that certain individuals leaving group coverage be guaranteed access to coverage in the individual market—"group to individual guaranteed access." However, no similar guarantees of access exist for people in the individual market who have coverage today but

[2]An employer may provide group coverage to its employees either by purchasing a group policy from an insurance carrier (fully insured coverage) or by funding its own health plan (self-funded coverage). For more information on fully insured and self-funded group coverage, see The Employee Retirement Income Security Act of 1974: Issues, Trends, and Challenges for Employer-Sponsored Health Plans (GAO/HEHS-95-167, June 21, 1995) and Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases (GAO/HEHS-97-35, Feb. 24, 1997). Individuals without group coverage may obtain coverage by purchasing a policy directly from carriers in the individual insurance market. For more information on the individual insurance market, see Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Tradeoffs (GAO/HEHS-97-8, Nov. 25, 1996).

[3]HIPAA defines the "small group" market generally as insurance sold to employers with 2 to 50 employees.

might lose it in the future. (App. I contains a summary of HIPAA access, portability, and renewability standards by market segment.)

Three federal agencies—Labor, HHS, and the Treasury—are required to jointly develop and issue implementing regulations for HIPAA. Each agency has somewhat different responsibilities for ensuring compliance. Labor is responsible for ensuring that group health plans comply with HIPAA standards. This is an extension of its current regulatory role under the Employee Retirement Income Security Act of 1974 (ERISA). Treasury also enforces HIPAA requirements on group health plans, but does so by imposing an excise tax under the Internal Revenue Code. HHS is responsible for enforcing HIPAA provisions with respect to insurance carriers in the group and individual markets in states that do not already have similar protections in place and do not pass appropriate laws and substantially enforce them.[4] This represents an essentially new role for that agency.[5]

The implementation of HIPAA is ongoing, in part, because the implementing regulations were on an interim final basis. Therefore, further guidance needed to finalize the regulations has not yet been issued.[6] In addition, specific HIPAA provisions have varying effective dates. Although most of the provisions became effective on July 1, 1997, group-to-individual guaranteed access standards in 36 states and the District of Columbia were allowed to take effect as late as January 1, 1998. Finally, although all provisions are now in effect, individual group plans do not become subject to the law until the start of their plan year beginning on or after July 1, 1997. For some collectively bargained plans, this may not be until 1999 or later.

During the first year of implementation, federal agencies, the states, and issuers have taken various actions in response to HIPAA. The federal agencies issued interim final regulations by the April 1, 1997, statutory deadline. Many considered this task to be a significant undertaking, and states and the insurance industry were generally pleased with the open

[4]HHS is also responsible for enforcing group market provisions of HIPAA for certain nonfederal government health plans.

[5]HIPAA provisions applicable to group health plans are under a new part 7 of subtitle B of title I of ERISA; a new title XXVII, part A, of the Public Health Service Act; and a new subtitle K of the Internal Revenue Code. HIPAA provisions applicable to individual market health insurance are in the Public Health Service Act, sections 2741 through 2763 and 2791.

[6]Normal federal rulemaking procedures require agencies to publish a Notice of Proposed Rulemaking in the Federal Register and provide for a comment period before issuing regulations. Under the interim final approach, agencies issue regulations prior to a notice and comment period.

and inclusive nature of the process. More regulations and guidance are expected to be issued in 1998. The agencies also conducted various educational outreach activities. For example, Labor sponsored a series of informational seminars for employers held in several large cities, created informational literature, and provided guidance on its Web page. HHS consulted with state insurance regulators at quarterly meetings of NAIC, held informational meetings for insurance industry representatives in at least two states where it will play an enforcement role, and also maintains a Web page containing information on HIPAA. Also during the first year, state legislatures have enacted laws to enforce HIPAA provisions locally, and state insurance regulators have written regulations and prepared to enforce HIPAA provisions. Issuers of health coverage have modified products and practices to comply with HIPAA.

HIPAA Guarantees Access to Coverage for Individuals Leaving Group Plans, but Consumer Ability to Obtain This Coverage Is Compromised

To ensure that individuals losing group coverage have guaranteed access—regardless of health status—to individual market coverage, HIPAA provides states with two different approaches. The first, which HIPAA specifies and which has become known as the "federal fallback" approach, requires all issuers who operate in the individual market to offer eligible individuals at least two health plans. (This approach became effective on July 1, 1997.) The second approach, the so-called "alternative mechanism," grants states considerable latitude to use high-risk pools and other means to ensure guaranteed access. (HIPAA requires states that adopt this approach to have it implemented no later than Jan. 1, 1998.[7]) Among the 13 states that are using the federal fallback approach, carrier marketing activities and high premium prices may limit consumers' ability to take advantage of this guarantee. Some carriers initially attempted to discourage consumers from applying for products with guaranteed access rights, and some are charging premiums 140 to 600 percent of the standard rate. In addition, widespread consumer misunderstanding of HIPAA guarantees of individual market coverage and the restrictions placed on those guarantees has also contributed to access problems.

States Use Federal Fallback Approach or an Alternative Mechanism to Guarantee Access

Under HIPAA, guaranteed access to coverage is restricted to eligible individuals who, among other criteria, had at least 18 months of coverage without a break of more than 63 days and with the most recent coverage obtained under a group health plan. Recognizing the controversial nature of this requirement and that many states had already passed reforms that could be modified to meet or exceed these requirements, HIPAA gave states

[7]Nineteen states began implementing an alternative mechanism before January 1, 1998.

the flexibility to implement this provision by using either the federal fallback or the alternative mechanism approach.

Under the federal fallback approach, carriers have three options for offering eligible individuals guaranteed access to coverage. A carrier may offer (1) all of its individual market plans, (2) only its two most popular plans, or (3) two representative plans—a lower-level and a higher-level coverage option—which are explicitly subject to some mechanism for risk spreading or financial subsidization.[8] Thirteen states use the federal fallback approach.

In the 36 states and the District of Columbia that use an alternative mechanism, which was to become effective no later than January 1, 1998, the law allows a wide range of approaches as long as certain minimum requirements are met.[9] For example, an eligible individual must have a choice between at least two different coverage options. Twenty-two of these states chose a state high-risk insurance pool to provide group-to-individual guaranteed access rights. Appendix II summarizes the different options states have chosen to provide group-to-individual guaranteed access rights.

Carrier Marketing of HIPAA Guaranteed Access Products May Have Discouraged Individuals From Applying

Some initial carrier marketing practices may have discouraged HIPAA eligibles from enrolling in products with guaranteed access rights. After the federal fallback provisions took effect on July 1, 1997, many consumers complained to state insurance regulators that carriers did not disclose the fact that a product with HIPAA guaranteed access rights existed or, when the consumers specifically requested one, they were told that the carrier did not have such a product available. One state regulator we visited said that some carriers told consumers HIPAA products were not available because the state had not yet approved them. However, the regulator had notified all carriers that such products were to be issued starting July 1, 1997, regardless of whether the state had yet approved them.

Soon after July 1, some carriers had also refused to pay commissions to insurance agents who referred HIPAA eligibles. In two of the three federal

[8]Under a risk-spreading requirement, a health insurance carrier must aggregate the health care costs incurred by one group of enrollees with the costs incurred by a larger group of enrollees for purposes of establishing premium rates. Therefore, if the smaller group incurred higher costs than the larger group, its premiums under risk spreading would be lower than they otherwise would have been.

[9]Because the Kentucky legislature was not in session during 1997, that state has until July 1, 1998, to implement group-to-individual guaranteed access.

fallback states we visited, insurance regulators told us that some carriers were advising agents against referring HIPAA-eligible applicants, or paying reduced or no commissions. Because consumers often use insurance agents to access the individual insurance market, an economic incentive to steer individuals away from guaranteed access products could significantly reduce consumer access to them. Several states have challenged this practice under state fair marketing practice laws. HHS officials looked into reports of such practices and learned of about 10 carriers that had reduced or eliminated agent commissions for HIPAA eligibles. Responding to pressure from state insurance regulators, two of these carriers have resumed paying commissions, and the other eight, according to the officials, appear to be wavering. Since finding these initial 10, HHS officials have not heard of other carriers refusing to pay agent commissions.

Carrier Pricing of HIPAA Guaranteed Access Products Can Result in Substantially Higher Rates

Premiums for products with guaranteed access rights may be substantially higher than standard rates. In several of the 13 federal fallback states, anecdotal reports from insurance regulators and agents suggest that rates range from 140 to 600 percent of the standard rate. Rates charged by several individual market carriers in the three federal fallback states we visited ranged from 140 to 400 percent of the standard rate, as indicated in table 1. Carriers charge higher rates, in part, because they believe HIPAA-eligible individuals will, on average, be in poorer health and hence would likely have higher medical costs. In addition, carriers that do not charge higher premiums to HIPAA eligibles could be subject to adverse selection. That is, once a carrier's low rate for eligible individuals became known, agents would likely refer unhealthy HIPAA eligibles to that carrier.

We also found that these carriers typically evaluate the health status of applicants and offer healthy individuals access to their standard products. Although these products may include a preexisting condition exclusion period, they may cost considerably less than the HIPAA product and therefore are likely to draw healthy individuals away from HIPAA products. Unhealthy HIPAA-eligible individuals may have access to only the guaranteed access product, and some of them may be charged an even higher premium on the basis of their health status.

Table 1: Premiums as a Percentage of Standard Rate Charged for Selected Guaranteed Access Products in Arizona, Colorado, and Missouri

Carrier	Premium as a percentage of standard rate
A	140
B	150
C	185
D	200
E	200
F	225
G	300
H	300
I	400

Carriers permit or even encourage healthy HIPAA-eligible individuals to enroll in standard plans. According to one carrier official, denying these individuals the opportunity to enroll in a less expensive product for which they are eligible would be contrary to the consumers' best interests. Moreover, the practice of encouraging healthy HIPAA-eligible individuals to enroll in standard products may lead to further rate increases for HIPAA guaranteed access products in the future. According to an official from one large insurance carrier, a spiral might ensue as higher premiums induce the better health risks to disenroll from HIPAA products, leaving a pool of poorer risks and spurring insurers to further raise premiums.

Finally, HIPAA regulations explicitly impose a risk-spreading requirement under only one of the three options carriers have to provide coverage to HIPAA-eligible individuals. If carriers choose to develop two new products to be offered to eligible individuals, they must include some method of risk spreading or a financial subsidization mechanism. Under the other two options, the regulations are silent about rates. In fact, the preamble to the regulations expressly acknowledges that HIPAA does not place limits on the premiums insurers may charge. This, some state regulators contend, permits issuers to charge substantially higher rates for products with guaranteed access in the federal fallback states.

Widespread Consumer Misunderstanding of HIPAA Group-to-Individual Guaranteed Access Rights May Foster Dissatisfaction and Diminish Access

HIPAA's group-to-individual guaranteed access rights are limited to eligible individuals and are subject to several other restrictions. Consumers who do not understand these rights may be disappointed or even be at risk of losing their group-to-individual portability rights.

HIPAA Individual Market Coverage Guarantees Are More Limited Than Many Consumers Believe

Some consumers believe HIPAA provides broader access and protections than it actually does. After HIPAA was enacted, insurance regulators in several states received numerous calls from individuals, including the uninsured, who misunderstood their rights and expected to have guaranteed access to insurance coverage. One state reported receiving consumer calls at the rate of 120 to 150 a month beginning shortly before most HIPAA provisions became effective on July 1, 1997. About 90 percent of these calls related to the group-to-individual guaranteed access provision, about half of which were complaints about the lack of access to coverage in the individual market. Similarly, an official from one large national insurer told us that many consumers believe the law covers them when it actually does not. One insurance agent suggested that perhaps only 10 percent or fewer of all individuals actually know that HIPAA exists, much less fully understand the protections it offers. Some regulators and others contend that the press has poorly served the public by not accurately portraying the consumer protections provided under HIPAA. They believe that the media reporting of the rhetoric surrounding the passage of HIPAA may have contributed to misunderstanding among consumers.

Consumers Who Misunderstand Restrictions May Lose Their Individual Coverage Guarantee

HIPAA imposes several restrictions on former group enrollees' guarantee of access to individual market coverage. Among other restrictions, eligible individuals must

- have had at least 18 months of creditable coverage (the most recent of which must have been group coverage) with no break of more than 63 consecutive days;
- have exhausted any COBRA[10] or other continuation coverage available;
- not be eligible for any other group coverage, or Medicare or Medicaid; and
- not have lost group coverage because of nonpayment of premiums or fraud.

[10]Consolidated Omnibus Budget Reconciliation Act of 1985.

In addition to these restrictions, consumers need to be aware of other factors in order to exercise their rights. For example, in states that used the federal fallback approach, eligible individuals needed to be aware that the provision became effective on July 1, 1997, and that coverage must be offered by all carriers in the state that operate in the individual insurance market. In states that chose an alternative mechanism, eligible individuals needed to know that the provision had until January 1, 1998, to take effect and also needed to be aware of which method the state chose to provide guaranteed access to coverage in order to exercise their group-to-individual guaranteed access right.

Consumer misunderstanding of these restrictions can hamper or limit access to products for eligible individuals. For example, individuals who are unaware of the 63-day limit on coverage interruptions may wait until medical care is necessary before applying for coverage, only to find that coverage is unavailable, according to one regulator. A regulator told us that individuals coming from group coverage have waited beyond 63 days to apply for individual coverage and thus have lost their portability rights. Another insurance regulator said that some consumers lost their guarantee to individual coverage because they left group coverage before January 1, 1998, believing HIPAA guaranteed access rights to be in place. However, because the state chose an alternative mechanism, protections did not exist until January 1, and insurance department officials in the state were in the unfortunate position of telling consumers that they had no guaranteed access rights.

Consumer Education Needed

Some state regulators and consumer advocates support the need for more consumer education. HHS also recognizes that the lack of consumer education is a significant problem. A well-informed consumer is better able to take advantage of the protections HIPAA offers, according to the officials. The agency is more convinced than ever that education outreach and assistance are the keys to improving group-to-individual portability under HIPAA. However, because of resource constraints, the agency is unable to put much effort into consumer education. HHS officials told us the agency is attempting to expand the information available on a toll-free telephone number to include HIPAA particulars, is expanding its Web site to include more HIPAA information, and is in the very early stages of developing an education pilot program in two regions.

Issuers of Health Coverage Concerned About HIPAA's Administrative Burden and Possible Unintended Consequences

Issuers of health coverage have several concerns about the unintended consequences of certain HIPAA requirements. An ongoing concern has been the administrative burden and cost associated with the requirement to issue certificates of creditable coverage to all enrollees who terminate coverage. While issuers generally have complied with this requirement, some suggest that a more limited requirement, such as issuing the certificates only to consumers who request them, would serve the same purpose for less cost. Issuers are also concerned that HIPAA's guaranteed renewal requirement may have negative consequences for certain populations, including individuals eligible for Medicare. Finally, issuers are concerned that certain HIPAA provisions create opportunities for individuals to abuse protections afforded to group coverage enrollees.

Issuers Comply, but Still Cite Requirement to Provide Certificates as Burdensome and Largely Unnecessary to Prove Prior Coverage

HIPAA requires issuers of health coverage to provide certificates of creditable coverage to enrollees whose coverage terminates. The certificates are intended to document an individual's period of coverage so that a subsequent health issuer can credit this time against the preexisting condition exclusion period of the new coverage. Early indications suggest that issuers generally appear to be complying with this requirement. Moreover, none of the health carrier officials with whom we met were unable to issue the certificates once systems were put into place to generate them. Likewise, state insurance regulators we visited had received few complaints from consumers who were unable to obtain a certificate of coverage, and they therefore do not consider issuer compliance with the certification requirement a significant concern.

Nevertheless, as we reported in our September 2, 1997, correspondence,[11] concerns about HIPAA's certification requirement remain:

- Some issuers suggest that information needed for certificates can be difficult to obtain. For example, certificates must include information on each dependent covered under the policy, such as the date they were first covered and how long the coverage was in effect. Since changes in the number or status of dependents in a family—as a result of events such as births, deaths, and marriages—are fairly common in a large group plan, issuers may have a difficult time keeping abreast of all these changes. They believe that maintaining and updating records could be time-consuming and expensive. To address such concerns, federal agencies provided issuers a transition period ending June 30, 1998, during which certain dependent information need not be included in certificates.

[11]GAO/HEHS-97-200R.

Issuers are also provided additional time to issue a certificate when a dependent's cessation of coverage is not known to the issuer.

- Some regulators have also raised concerns that the certification requirement will create an added administrative burden for state Medicaid agencies. Medicaid recipients tend to enroll and disenroll in the Medicaid program frequently as their income and employment status change. This volatility in enrollment will increase the volume of certificates issued by the Medicaid program. In addition, Medicaid agencies have had a difficult time maintaining accurate addresses for recipients and expect a large volume of certificates to be undeliverable, according to NAIC. In the preamble to the interim final regulations, federal agencies requested comments on how the certification process might be adapted to the special circumstances of Medicaid agencies and other entities.
- Finally, issuers contend that certificates may not be necessary to prove creditable coverage in all cases and that issuance on demand would serve the same purpose at a lower cost. In fact, the Blue Cross Blue Shield Association estimates that consumers ultimately will not use as many as 90 percent of all certificates issued to prove creditable coverage. For example, several issuers, as well as a state regulator, pointed out that portability reforms passed by most states have worked well without a similar certification requirement. Where proof of prior coverage was needed, issuers asked for documentation of prior coverage from the applicant and, if unavailable, simply called the prior issuer to confirm that coverage. Also, many group health policies do not contain clauses with preexisting condition exclusions and therefore do not need certificates from incoming enrollees.

Guaranteed Renewal Requirements May Have Negative Consequences

HIPAA regulations explicitly state the circumstances under which an individual's health coverage may not be renewed or may be canceled, such as for nonpayment of premiums or fraud. Issuers are concerned that the omission of other circumstances, such as the attainment of Medicare eligibility age and ceasing to meet eligibility criteria for targeted population insurance programs, may affect both issuers and consumers adversely.

Commonly cited as problematic is the renewal of comprehensive coverage for individual market enrollees who become eligible for Medicare. When individuals reach the age of Medicare eligibility, issuers have typically terminated individuals' comprehensive coverage and offered Medicare supplemental coverage instead. HIPAA's requirement to automatically renew this comprehensive coverage may have a number of drawbacks.

First, individuals risk losing their 6-month open enrollment window for Medicare supplemental coverage. If individuals choose to retain comprehensive coverage rather than obtain Medicare supplemental coverage, they may permanently lose their right to enroll in a supplemental policy without preexisting condition exclusions in the future. This could have a significant impact on some consumers, since individual market coverage is often more expensive than Medicare supplemental coverage. In addition, many states do not permit issuers to coordinate their coverage with that provided by Medicare. Thus, some consumers may pay for duplicate coverage. Finally, NAIC is concerned that renewing coverage for Medicare eligibles could have a deleterious effect on the individual insurance market. Premiums for all individuals could increase if large numbers of older and less healthy individuals remain in that market. Because of these consequences, several state insurance regulators require issuers to notify enrollees of the implications of renewing their coverage once they become eligible for Medicare.

HIPAA's guaranteed renewal requirements may also preclude issuers from canceling the coverage of individuals enrolled in insurance programs targeted for low-income populations once these individuals exceed eligibility criteria. Since carriers might be prohibited from canceling coverage once an enrollee's income exceeds the eligibility threshold, a program's limited slots could be filled by otherwise ineligible individuals. Similarly, under children-only insurance products, issuers could be required to renew coverage for those who have reached adulthood. Several issuers and their representative organizations have expressed concern about such implications of the guaranteed renewal requirement and have asked the federal agencies to revise regulations to provide appropriate exceptions.

Issuers Concerned That HIPAA Creates Opportunities for Individuals to Abuse Certain Consumer Protections

Issuers cite two provisions in HIPAA that consumers could potentially abuse. First, HIPAA requires group health plans to give new enrollees or enrollees switching plans during an open enrollment period full credit for a broad range of prior health coverage, regardless of the deductible level of that coverage. Since the law does not recognize differences in the deductible levels, issuers and regulators are concerned that where given a choice of health coverage options, individuals may enroll in inexpensive, high-deductible plans that may have limited benefits while healthy and then switch to plans with comprehensive, first-dollar coverage when they become ill. Likewise, a small employer could move all its employees from a high- to a low-deductible plan once a single employee becomes ill.

Second, issuers are concerned that certain enrollment rights under HIPAA create the opportunity for abuse. Under certain circumstances, HIPAA permits an individual who initially declines coverage under the employer's group plan to later obtain coverage under the plan without waiting for the specified open enrollment period or being penalized as a late enrollee. The circumstances under which this special enrollment period is allowed include the loss of other health coverage as well as family changes that affect the status of dependents, such as marriage, birth, and adoption. Issuers suggest that since individuals essentially control some of the circumstances that create these special enrollment periods, some may forgo coverage until medical care is needed and then create the circumstances that trigger an open enrollment period. For example, an unmarried couple could avoid the expense of health coverage, knowing they could obtain access to their employers' group coverage if necessary later by marrying. Citing a related example, a Health Insurance Association of America official noted that individuals could also misuse HIPAA's prohibition against including pregnancy as a preexisting condition. For example, nothing would prevent an employee from avoiding the expense of health coverage until medical care for pregnancy became necessary. The employee need merely enroll as a late enrollee to immediately obtain full coverage for maternity benefits.

State Insurance Regulators Cite Lack of Sufficient Clarity or Detail in Some HIPAA Regulations as Hindering Implementation Efforts

State regulators have encountered difficulties implementing HIPAA provisions in instances where federal regulations lacked sufficient clarity or detail. Where federal regulations have been viewed as unclear, the resulting confusion has affected state regulators and issuers in carrying out their roles under HIPAA. Federal agency officials suggest that statutory deadlines, competing demands, and their desire to provide states the flexibility to implement the regulations in a manner best suited to each state may have contributed to the perceived lack of clarity.

Some Regulators Call for More Clarity and Guidance in Certain HIPAA Regulations

The unclear or ambiguous nature of some of HIPAA's implementing regulations have presented several challenges to state regulators. Specifically, some regulators are concerned that the lack of clarity may result in varying interpretations and confusion among the multiple entities involved in implementation. For example, Colorado insurance regulators surveyed carriers in that state to determine how they interpreted regulations pertaining to group-to-individual guaranteed access. The

survey results indicated that issuers had a difficult time interpreting the regulations and were applying the regulations differently.

Such regulatory ambiguities can have critical consequences for consumers and have created some situations in which the intent of the statute may have been thwarted, according to NAIC. For example, as discussed earlier, partly because of the inconsistency in the risk-spreading requirement for products available to HIPAA-eligible individuals in the individual markets of federal fallback states, rates for these products in some states range from 140 to 600 percent of standard rates. As a result, many regulators believe this outcome raises a question about whether those leaving group coverage are provided with meaningful access under HIPAA to coverage in the individual insurance market.

The following are examples of other regulatory provisions for which state insurance regulators have sought further federal guidance or clarification.

- Plan design as preexisting condition exclusion period. One of HIPAA's key goals is to provide portability of coverage to those who change jobs or lose group coverage. To achieve this objective, the regulations limit the extent to which issuers can exclude preexisting conditions from coverage. However, the regulations do not contain guidance about whether an issuer may structure the benefits of a plan in a way that effectively excludes certain preexisting conditions. For example, according to NAIC, some health plans have established waiting periods of up to a year during which certain conditions or procedures, such as organ transplants, are excluded from all enrollees' coverage. Requiring such waiting periods effectively excludes such preexisting conditions from coverage and, according to regulators, is contrary to the statutory intent to provide portability of coverage.
- Treatment of late enrollees. State regulators believe HIPAA is unclear about whether late enrollees are eligible for coverage. Although the regulations explicitly define "late enrollees" as individuals who enroll for group coverage any time after the date on which they were initially eligible (or subsequently eligible under a special enrollment period), the preamble to the regulations indicates that issuers are not required to accept late enrollees. Regulators believe that certain distinctions, such as an 18-month preexisting waiting period for late enrollees versus 12 months for on-time enrollees, would not have been made if late enrollees were not intended to be covered. Accordingly, NAIC has asked that HHS interpret the statute to explicitly require the acceptance of late enrollees.

- Market withdrawal as exception to guaranteed renewability. Regulators believe that the HIPAA provision that allows issuers who cease offering coverage throughout the individual and group markets to not renew the coverage of an individual or a group creates uncertainties that may affect their ability to regulate insurance. Regulators believe the interim regulations leave three key questions unanswered. First, must an issuer who withdraws from the market also not renew existing coverage, or does it have the discretion to maintain existing coverage but not write new coverage? Second, must the issuer also cease to issue all other types of health policies, such as limited-benefit or specified-disease policies? And finally, must the issuer terminate all coverage at once, or can it terminate each policy on its respective anniversary date?
- Nondiscrimination provisions in group plans. HIPAA regulations prohibit group plan issuers from excluding an individual of the group from coverage or charging a higher premium because of an individual's health status or medical history. In the preamble to the nondiscrimination regulations, federal agencies sought input on this requirement from regulators and issuers and indicated that further guidance would be forthcoming. Until further guidance is issued, regulators have several questions concerning how this requirement is applied, such as to what extent the statute permits an issuer to limit benefits on the basis of the source of a person's injury and whether issuers may vary benefits for different groups of employees.

Federal Officials Cite Tight Statutory Deadlines and States' Desire for Flexibility to Help Explain Perceived Lack of Clarity or Detail in Some Regulatory Guidance

Federal agency officials point to several factors that contributed to the perceived lack of clarity or sufficient detail in some HIPAA regulations. First, the agencies were required to issue a number of complex regulations within a relatively short period of time. The statute, signed into law on August 21, 1996, required that implementing regulations be issued within fewer than 8 months, on April 1, 1997. Implicitly recognizing this challenge, the Congress provided for the issuance of regulations on an interim final basis.[12] This time-saving measure helped the agencies to issue a large volume of complex regulations within the statutory deadline, while also providing the opportunity to add more details or further clarify the regulations based on comments later received from industry and states. Therefore, some regulatory details necessarily had to be deferred until a later date.

[12]Normal federal rulemaking procedures require agencies to publish a Notice of Proposed Rulemaking in the Federal Register and provide for a comment period before issuing regulations. Under the interim final approach, agencies issue regulations before a notice and comment period.

Furthermore, agency officials point out that in developing the regulations, they sought to balance states' need for clear and explicit regulations with the flexibility to meet HIPAA goals in a manner best suited to each state. For example, under group-to-individual guaranteed access requirements, states were given several options for achieving compliance. While the multiple options may have contributed to confusion in some instances, the controversial nature of the requirement suggested to agency officials that a flexible approach was in the best interests of states. Officials said that many state officials requested that minimal detail be included in the federal regulations. In particular, with respect to risk spreading for guaranteed access products in the individual market, HHS officials said they attempted to meet with federal fallback states to discuss appropriate regulations. However, the states were hesitant to participate in such meetings until after the July 1, 1997, effective date passed and they were confronted with greater than expected operational problems. Officials further noted that HIPAA does not preclude states adopting their own risk-spreading requirements. Finally, some of the regulatory ambiguities derive from ambiguities existing in the statute itself. For example, regulations concerning late enrollees closely track the language from the statute.

To ease the burden on state regulators and issuers, HIPAA regulations provided an overall good faith compliance period, which ended on January 1, 1998. Until that time, federal officials agreed to take no compliance action against any issuer who attempted to comply with HIPAA. In addition, a good faith compliance period continues to apply to the nondiscrimination provisions until further guidance is issued, and additional leeway is given in the form of phase-ins for certain other provisions.

Unexpectedly Large Role for Federal Regulators May Strain Resources, Hamper Oversight

States have the option of enforcing HIPAA's access, portability, and renewability standards as they apply to fully insured group and individual health coverage. In states that do not pass laws to substantially enforce these federal standards, HHS must perform the enforcement function. According to HHS officials, the agency as well as the Congress and others assumed HHS would generally not have to perform this role, believing instead that states would not relinquish regulatory authority to the federal government. However, several states reported that they did not pass legislation implementing key provisions of HIPAA, thus requiring HHS to actively regulate insurance plans in these states. Preliminary information suggests that a number of additional states may not enact one or more

HIPAA provisions, potentially requiring HHS to also play a limited regulatory role in these states. HHS resources are currently strained by its new regulatory role in the five states where enforcement is under way, according to officials, and concern exists about the implications of the possible expansion of this role to additional states.

HHS Given New Health Insurance Regulatory Role If States Decline to Implement and Enforce HIPAA Standards

Unlike Labor and the Treasury, HHS was given a new regulatory role under HIPAA. The agency must enforce HIPAA provisions for fully insured group and individual market plans in states that do not enact the standards in state laws and substantially enforce them. In these states, HHS must take on functions typically reserved for state insurance regulators. The agency must

- provide guidance to help issuers in modifying their products and practices to comply with HIPAA requirements,
- obtain and review issuers' product literature and policy forms,
- monitor issuer marketing practices,
- respond to consumer complaints and encourage issuers to take corrective actions where noncompliance is determined, and
- impose civil monetary penalties on issuers who fail to initiate corrective actions.

Although the role of an insurance regulator represents a significant new responsibility for HHS, neither the Congress nor HHS anticipated the agency would actually be required to perform this role to any great extent. Many federal authorities assumed that the vast majority of states would choose to pass laws to enforce HIPAA provisions rather than relinquish regulatory authority to the federal government.

Gaps Remain in State Laws Needed to Enforce HIPAA Standards

As of December 1997, HHS was preparing to enforce HIPAA standards in five states that reported federal enforcement would be necessary. These five states—California, Massachusetts, Michigan, Missouri, and Rhode Island—did not pass laws to implement the group-to-individual guaranteed access provision, among others, according to an NAIC survey and HHS officials. HHS has also been working with insurance regulators from U.S. territories to determine whether federal enforcement is necessary there.

HHS will next turn its attention to the remaining states. According to agency officials, because states were not required to report their plans for enforcing most HIPAA standards, HHS has had to rely on information

provided voluntarily by states, surveys performed by others, and anecdotal reports to determine the status of state legislative activity. Resources permitting, HHS may survey each state during 1998 and make a comprehensive determination of the status of HIPAA legislation and enforcement. Nevertheless, preliminary data from an October 1997 NAIC survey indicate that while most states have made progress in enacting statutes implementing key HIPAA provisions, many gaps remain. For example, as indicated in table 2, in the individual market, eight states had not passed laws to implement guaranteed renewal. In the group markets, two states had not passed laws to implement small-group guaranteed access, and four states had not passed laws to implement guaranteed renewal and limits on preexisting condition exclusion periods in the large-group markets. In addition, these preliminary data do not include HIPAA's certificate issuance requirement, and anecdotal evidence suggests that many states have not incorporated this requirement into state statutes. While states continue to pass legislation to close some of these gaps, the possibility remains that not all provisions in all market segments will be addressed, necessitating an expansion of HHS' enforcement role.

Table 2: Gaps in State Laws to Implement Selected HIPAA Standards, as of October 31, 1997

	HIPAA standard to be adopted by states				
Market segment	**Guaranteed access/ availability**	**Guaranteed renewal**	**Preexisting condition exclusion periods limits**	**Credit for prior coverage**	**HIPAA definition of "small-group" employer**
Individual	1	8	Not applicable	Not applicable	Not applicable
Small group	2	1	1	1	17
Large group	Not applicable	4	4	4	Not applicable

Note: Excludes gaps in the five states in which HHS has begun enforcement activities.

Source: NAIC survey based on self-reported data from state officials.

HIPAA Implementation and Enforcement May Strain HHS Resources

The new enforcement role HHS is required to perform in California, Massachusetts, Michigan, Missouri, and Rhode Island may strain the resources of its regional offices serving those states, according to HHS officials. For example, HHS staff in the Kansas City regional office (covering Missouri) are challenged to regulate the insurance products offered by up to 500 insurers in Missouri. To carry out this function, the office asked for 11 new full-time positions but, as of December 1997, was

authorized to hire only 4. Three of the four positions have been filled through outside hires, and one was filled through an internal promotion. Two additional staff were rotated from other units to assist in HIPAA-related activities. Even fewer resources are devoted to HIPAA enforcement in the two other regions, Boston and San Francisco. Also as of December 1997, Boston had only one full-time and two part-time staff members devoted to enforcing the HIPAA compliance of hundreds of Massachusetts and Rhode Island insurers. Although the office had received authorization for two additional staff, none had yet been hired. A health insurance specialist in that office said that with such limited staffing, the office will be hard-pressed to fulfill its upcoming policy form review tasks and handle the expected surge in consumer queries in early 1998. In San Francisco, no additional staff had yet been authorized, and only one person was working full time on HIPAA issues as of December 1997. HHS was surprised by California's failure to pass group-to-individual guaranteed access, a fact that did not become known until September 1997. According to an HHS deputy director, regulation in California will be especially challenging because of the state's large size and the fragmented, complicated structure of its health insurance markets.

HHS' resources will be further strained if the enforcement role it is serving in these five states becomes permanent or expands to other states. If HHS determines that other states have not passed one or more HIPAA provisions, as preliminary data suggest, HHS will have to play a regulatory role in these additional states. Staff throughout the agency noted that HHS' current resources are insufficient to handle such a task. Officials outside HHS have also publicly expressed concern that its resources could become overtaxed. For example, in his September 1997 testimony before the House Ways and Means Committee's Subcommittee on Health, the president of the Health Insurance Association of America testified that HHS faces "regulatory overload" because of the demands placed on the agency by HIPAA and other new responsibilities under the Balanced Budget Act of 1997.[13] Also, in an October 1997 speech, the former administrator of HHS' Health Care Financing Administration said that the agency is facing a serious problem if it does not receive additional resources to cope with its expanded responsibilities under HIPAA and other recent laws.

[13]Bill Gradison, Statement of HIAA on Implementation of the Health Insurance Portability and Accountability Act, P.L. 104-191 (Washington, D.C.: Sept. 25, 1997).

Federal Actions Under Way to Address Some HIPAA Implementation Concerns

Federal officials have begun to respond to some of the concerns raised during the first year of HIPAA implementation. HHS is continuing to monitor the need for more explicit risk-spreading requirements to mitigate the high cost of guaranteed access products in the individual market under the federal fallback approach. Though HHS does not at present support changes to the certificate issuance requirement, some of the other unintended consequences and concerns that issuers and states cite may be addressed by ongoing revisions to and clarifications of the regulations. Federal agencies issued further guidance at the end of 1997 and expect to continue issuing guidance in 1998. Finally, because of the increasing pressure on its resources, HHS has asked for additional funding as part of its fiscal year 1999 budget request.

HHS Is Monitoring the Need for More Explicit Risk-Spreading Requirements for Products Offered to HIPAA-Eligible Individuals

HHS has realized that many HIPAA-eligible individuals in states using the federal fallback approach to group-to-individual guaranteed access may be unable to obtain affordable coverage and may effectively be priced out of the market. According to officials, HHS legal staff are reevaluating whether HIPAA provides the agency authority to issue regulations with more explicit risk-spreading requirements and the agency is continuing to monitor the situation.

HHS Does Not Now Support Changes to Certificate Issuance Requirement

HHS officials believe it is premature to revise the certificate issuance requirement in response to issuer concerns that issuing certificates creates an administrative burden and is unnecessary to prove creditable coverage. The officials indicated that certificates do serve another important purpose in that they notify consumers of their portability rights, regardless of whether the consumers ultimately need to use the certificate to exercise those rights. In addition, HHS officials have heard anecdotal evidence that suggests even with the certificate some consumers are having difficulty exercising their portability rights. With respect to state Medicaid agencies, officials acknowledged that they may face an increased administrative burden, but HHS and other federal agency officials were concerned that offering an exception to Medicaid agencies might encourage other groups to also seek an exception.

Ongoing Amplification and Clarification of HIPAA Regulations May Address Some Issuer and State Concerns

Federal agencies interpret HIPAA's guaranteed renewal provision to mean that individuals, upon becoming eligible for Medicare, must be given the option of maintaining their individual market coverage. HHS officials point out that some retirees with special needs, such as those dependent on expensive prescription drugs, may benefit from retaining their individual market coverage rather than buying a Medicare supplemental policy. Moreover, they disagree with the insurance industry and state regulators' contention that sufficient numbers of individuals in poor health will remain in the individual market to affect premium prices there. Finally, even if HHS supported a change to this requirement, agency legal staff are uncertain whether HHS could simply change the regulations or whether a technical amendment to the statute would be needed.

With respect to insurance products offered to targeted populations, such as children or low-income families, HHS has no immediate plans to revise HIPAA requirements. However, officials say they are considering industry comments on this issue and would not rule out the possibility in the future.

Federal officials have also acknowledged concern that certain other HIPAA provisions, such as those that give group enrollees who switch health plans full credit for a broad range of prior coverage, may create an incentive for consumers to abuse the provision. Furthermore, they acknowledged that such abuse may lead to adverse selection. In response, the federal agencies have asked for comments from issuers and regulators about how differences between high- and low-deductible plans should be treated under HIPAA. The agencies have received many comments on the issue and are continuing to examine potential changes. The agencies also issued supplemental guidance for provisions concerning nondiscrimination and late enrollment on December 29, 1997. This guidance clarifies how group health plans must treat individuals who, prior to HIPAA, had been excluded from coverage because of a health status-related factor. Further guidance and clarification in these and other areas will follow.

HHS Seeks Additional Resources

To address its resource constraints, HHS has shifted resources to HIPAA tasks from other activities. In its fiscal year 1999 budget request, HHS has also requested an additional $15.5 million to fund 65 new full-time-equivalent staff and outside contractor support for HIPAA-related enforcement activities. Its most critical unmet need, according to agency officials, relates to the direct federal enforcement of HIPAA insurance

standards in the states. Officials further noted that, even if the requested funding becomes available, it may not be adequate if direct HHS enforcement becomes necessary in additional states.

Conclusions

HIPAA provides, for the first time, nationwide minimum standards for health coverage access, portability, and renewability in all private insurance markets. Importantly, these new standards apply to both fully insured and self-funded coverage. However, implementation of the standards is complicated. It requires three federal agencies, state legislatures and insurance regulators, and issuers of health coverage to coordinate their efforts. Further complicating implementation, the issuance of federal regulations has been on an interim final basis. Moreover, different HIPAA provisions have become effective and group plans have become subject to the law on different dates. Nevertheless, implementation has moved forward. For example, federal agencies issued interim final regulations within the deadline set by HIPAA, using a process widely commended for being open and inclusive. As might be expected, however, the process has raised certain concerns and posed challenges to those charged with implementing this new law.

Some challenges are likely to recede or be addressed in the near term. What could be called "early implementation hurdles," especially those related to the clarity of federal regulations, may be resolved during 1998. Federal agencies issued supplemental guidance on December 29, 1997, and expect to provide further regulatory guidance during 1998 to states and issuers, who consider certain regulations—relating to nondiscrimination, late enrollment, and special enrollment periods—to be ambiguous. Moreover, as states and issuers gain experience in implementing HIPAA standards, the intensity of their dissatisfaction may diminish. For example, while still criticizing the cost and administrative burden of issuing certificates of creditable coverage, issuers seem able to comply. (Now that the start-up burden of putting procedures in place is largely behind them, issuers we visited seemed to find the day-to-day process of issuing these certificates to be manageable.)

Various participants involved in implementing HIPAA have pointed to several potential unintended consequences, but whether these possibilities will be realized is difficult to predict. These concerns are necessarily speculative in nature because HIPAA's insurance standards have not been in effect long enough for evidence on these potential problems to accumulate. First, for example, evidence is not yet available to determine

whether large numbers of Medicare eligibles will remain in the individual market for health insurance (and consequently push up premiums there). The same is true for whether good health risks will select high-deductible plans, leaving the sicker individuals in low-deductible plans, or whether consumers will abuse special enrollment periods to obtain coverage. Second, possible changes in the regulations or the HIPAA statute may further affect whether a concern becomes a reality. However, uncertainty over whether the changes will be made or will rectify the potential unintended consequences makes more difficult any assessment of these possibilities.

Finally, two implementation difficulties are substantive and likely to persist unless measures are taken to address them. First, among the 13 federal fallback states, some consumers are finding it difficult as a result of high premiums to obtain the group-to-individual guaranteed access coverage that HIPAA requires. This situation is likely to continue unless HHS interprets HIPAA to provide for more explicit risk-spreading requirements or states adopt explicit risk-spreading requirements of guaranteed access to coverage for HIPAA eligibles. In addition, if consumer education about HIPAA coverage guarantees in the individual market continues to be spotty or absent, consumers will likely continue to be discouraged by the limited nature of HIPAA protections. Similarly, some will probably continue to be at risk of losing those protections. Second, HHS' regulatory role could expand as the status of state efforts to adopt and implement HIPAA provisions becomes clearer in 1998. HHS' current enforcement capabilities could be inadequate to handle the additional burden unless further resources become available.

As additional health plans become subject to the law, and as the remaining regulations and guidance are issued, new problems of implementation may emerge. Corrective actions will necessarily be ongoing. A comprehensive determination of HIPAA's impact remains years off.

Agency Comments

The Departments of Health and Human Services, Labor, and the Treasury commented on a draft of this report. In general, the agencies believed that our report did not adequately describe the obstacles they faced in issuing interim final HIPAA regulations within the statutory deadline. Labor added that our draft did not adequately discuss consumers' views, distinguish the individual market from the group market regarding implementation challenges, identify all of Labor's outreach efforts, or convey the extent to which its expanded regulatory role under HIPAA will place new demands on

agency resources. Treasury generally concurred with the HHS and Labor comments. In light of these comments, we have refined our presentation in several places as appropriate. Appendixes III, IV, and V contain the agencies' letters and for HHS and Labor, our responses.

We also furnished a draft of this report for review to the American Association of Health Plans, Blue Cross Blue Shield Association, Consumers Union, ERISA Industry Committee, Health Insurance Association of America, and NAIC. We received comments from all but the ERISA Industry Committee. In response, we clarified certain distinctions and made technical changes as appropriate.

As agreed with your office, unless you publicly release its contents earlier, we will make no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Secretaries of Health and Human Services, Labor, and the Treasury and will make copies available to others on request.

Please contact me at (202) 512-7114 or Jonathan Ratner, Senior Health Economist, at (202) 512-7107 if you or your staff have any further questions. Other GAO contacts and staff acknowledgments for this report are listed in appendix VI.

Sincerely yours,

William J. Scanlon
Director, Health Financing and
Systems Issues

Contents

Tables

Abbreviations

ERISA	Employee Retirement Income Security Act of 1974
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
HIPAA	Health Insurance Portability and Accountability Act of 1996
HHS	Department of Health and Human Services
NAIC	National Association of Insurance Commissioners

HIPAA Access, Portability, and Renewability Standards

To achieve its goals of improving the access, portability, and renewability of private health insurance, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) sets forth standards that variously apply to the individual, small-group, and large-group markets of all states. Most HIPAA standards became effective on July 1, 1997. However, the certificate-issuance standard became effective on June 1, 1997, and issuers had to provide certificates automatically to all disenrollees from that point forward as well as upon request to all disenrollees retroactive to July 1, 1996. In states that chose an alternative mechanism approach, the guaranteed access standard in the individual market (often called "group-to-individual portability") was to become effective no later than January 1, 1998. Finally, group plans do not become subject to the applicable standards until their first plan year beginning on or after July 1, 1997.

Each of HIPAA's health coverage access, portability, and renewability standards is summarized in table I.1 by applicable market segment. The subsequent text describes each standard.

Table I.1: Summary of HIPAA Access, Portability, and Renewability Standards, by Market Segment

HIPAA standard	Individual	Small group (2-50 employees)	Large group
Certificate of creditable coverage	Yes	Yes	Yes
Guaranteed access/availability	Only for some individuals leaving group coverage	Yes	No
Guaranteed renewability	Yes	Yes	Yes
Limitations on preexisting condition exclusion periods[a]	No[b]	Yes	Yes
Nondiscrimination	N/A	Yes	Yes
Credit for prior coverage (portability)	No	Yes	Yes
Special enrollment period	N/A	Yes	Yes

Notes: Some of these standards also apply to certain federal, state, and local government insurance programs such as Medicaid or state employee health plans.

N/A = not applicable.

[a]Preexisting conditions may be excluded from the coverage of a late enrollee for up to 18 months.

[b]Issuers may not impose preexisting condition exclusions upon individuals eligible for group-to-individual guaranteed access.

Certificate of Creditable Coverage

HIPAA requires issuers of health coverage to provide certificates of creditable coverage to enrollees whose coverage terminates. The certificates must document the period during which the enrollee was covered so that a subsequent health issuer can credit this time against its preexisting condition exclusion period. The certificates must also document any period during which the enrollee applied for coverage but was waiting for coverage to take effect—the waiting period—and must include information on an enrollee's dependents covered under the plan.

Guaranteed Access/Availability

In the small group market, carriers must make all plans available and issue coverage to any small employer that applies, regardless of the group's claims history or health status. Under individual market guaranteed access—often referred to as group-to-individual portability—eligible individuals must have guaranteed access to at least two different coverage options. Generally, eligible individuals are defined as those with at least 18 months of prior group coverage who meet several additional requirements.[14] Depending on the option states choose to implement this requirement, coverage may be provided by carriers or under state high-risk insurance pool programs, among others.

Guaranteed Renewability

HIPAA requires that all health plan policies be renewed regardless of health status or claims experience of plan participants, with limited exceptions. Exceptions include cases of fraud, failure to pay premiums, enrollee movement out of a plan service area, the cessation of membership in an association's health plan, and the withdrawal of an issuer from the market.

Limitations on Preexisting Condition Exclusion Period

Group plan issuers may deny, exclude, or limit an enrollee's benefits arising from a preexisting condition for no more than 12 months following the effective date of coverage. A preexisting condition is defined as a condition for which medical advice, diagnosis, care, or treatment was received or recommended during the 6 months preceding the date of coverage or the first day of the waiting period for coverage. Pregnancy may not be considered a preexisting condition, nor can preexisting conditions be imposed on newborn or adopted children, in most cases.

[14]An eligible also must have had no break in the prior coverage of more than 63 consecutive days; must have exhausted any Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or other continuation coverage available; 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.

Nondiscrimination

Group plan issuers may not exclude a member within the group from coverage on the basis of the individual's health status or medical history. Similarly, the benefits provided, premiums charged, and employer contributions made to the plan may not vary within similarly situated groups of employees on the basis of health status or medical history.

Credit for Prior Coverage (Portability)

Issuers of group coverage must credit an enrollee's period of prior coverage against its preexisting condition exclusion period. Prior coverage must have been consecutive, with no breaks of more than 63 days to be creditable. For example, an individual who was covered for 6 months who changes employers may be eligible to have the subsequent employer plan's 12-month waiting period for preexisting conditions reduced by 6 months. Time spent in a prior health plan's waiting period cannot count as part of a break in coverage.

Special Enrollment Periods

Individuals who do not enroll in a group 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. In addition, if an enrollee has a new dependent as a result of a birth or adoption or through marriage, the enrollee and dependents may become eligible for coverage during a special enrollment period.

Other Insurance-Related Provisions

HIPAA also includes certain other standards that relate to private health coverage, including limited expansion of COBRA coverage rights, new disclosure requirements for Employee Retirement Income Security Act of 1974 (ERISA) plans, and, to be phased in through 1999, new uniform claims and enrollee data reporting requirements. Changes to certain tax laws authorize federally tax-advantaged medical savings accounts for small employer and self-employed plans. Finally, although not included as part of HIPAA but closely related are new standards for mental health and maternity coverage, which became effective on January 1, 1998.

State Approaches to Group-to-Individual Market Guaranteed Access

Under HIPAA, states may choose to guarantee access to individual market coverage for eligible individuals using either the "federal fallback" or state "alternative mechanism" approach.

Federal fallback approach: Carriers must offer eligible individuals guaranteed access to coverage in one of three ways. Under this approach, HIPAA specifies that a carrier must offer either (1) all of its individual market plans, (2) only its two most popular plans, or (3) two representative plans—a lower-level and a higher-level coverage option—that are subject to some risk spreading or financial subsidization mechanism. Thirteen states are using the federal approach.

State alternative mechanism: States may design their own approach to guarantee coverage to eligible individuals as long as certain minimum requirements are met. Essentially, the approach chosen must ensure that eligible individuals have guaranteed access to coverage with a choice of at least two different coverage options. Twenty-two of the 36 states and the District of Columbia that chose an alternative mechanism are using a high-risk insurance pool to provide group-to-individual guaranteed access rights. Table II.1 shows which states chose which approach.

Table II.1: State Approaches to Group-to-Individual Guaranteed Access

		State alternative mechanism approach	
State	Federal fallback approach	High-risk pool	Other
Alabama		X	
Alaska		X	
Arizona	X		
Arkansas		X	
California	X		
Colorado	X		
Connecticut		X	
Delaware	X		
District of Columbia			X[a]
Florida			X
Georgia			X
Hawaii	X		
Idaho			X
Illinois		X	
Indiana		X	
Iowa		X	

(continued)

State	Federal fallback approach	State alternative mechanism approach	
		High-risk pool	Other
Kansas		X[b]	
Kentucky	[c]	[c]	[c]
Louisiana		X	
Maine			X
Maryland	X		
Massachusetts	X		
Michigan	X		
Minnesota		X	
Mississippi		X	
Missouri	X		
Montana		X	
Nebraska		X	
Nevada			X
New Hampshire			X[a]
New Jersey			X
New Mexico		X[b]	
New York			X
North Carolina	X		
North Dakota		X	
Ohio			X
Oklahoma		X	
Oregon		X	
Pennsylvania			X
Rhode Island	X		
South Carolina		X	
South Dakota			X
Tennessee	X		
Texas		X	
Utah		X[a,b]	
Vermont			X
Virginia			X[a]
Washington			X
West Virginia	X		
Wisconsin		X	
Wyoming		X	

(Table notes on next page)

[a]State submitted an alternative mechanism that closely resembles the federal fallback approach.

[b]High-risk pool and other mechanism.

[c]Because state legislature was not in session during 1997, HIPAA allows Kentucky until July 1, 1998, to comply.

Source: Health Care Financing Administration.

Comments From the Department of Health and Human Services

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

FEB - 9 1998

Mr. William J. Scanlon
Director, Health Financing and Systems Issues
U.S. General Accounting Office
441 G St., N.W.
Washington, D.C. 20548

Dear Mr. Scanlon:

Thank you for the opportunity to comment on the draft report by the U.S. General Accounting Office (GAO) entitled, "Health Insurance Standards: Implementing New Federal Law Creates Challenges for Consumers, Insurers, and State and Federal Regulators" (GAO/HEHS-98-67).

We are pleased to update Congress about the progress and challenges in our first year of implementing the portability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA is an historic piece of legislation, which takes important steps to help people obtain and keep health insurance. As one of the Federal agencies responsible for implementing and enforcing these insurance reform provisions, the Health Care Financing Administration (HCFA) has a number of comments about the draft report's content and presentation. Our general comments are described below and technical comments are attached.

See comment 1.

First, while we agree generally with GAO's assessment of the challenges that implementing HIPPA has posed, we believe that the Federal government is making substantial progress that could be described in a more balanced fashion. The April 1997 interim final regulations implementing the group and individual market portability provisions were published on a timely basis. Regulations implementing related HIPAA legislation (the Mental Health Parity Act of 1996) were published on December 22, 1997, which is before the January 1, 1998, statutory effective date. Additional guidance was published on December 29, 1997, concerning the relationship of HIPAA's group market rules to health flexible spending arrangements and to individuals who were denied coverage due to a health status-related factor.

See comment 2.

See comment 1.

The publication of this initial body of regulatory guidance is a major accomplishment given the size and scope of the undertaking, HIPAA's demanding implementation schedule, and the new working relationships required among HCFA, the Department of Labor, the Department of the Treasury, and the Internal Revenue Service. In addition, HIPAA is a new and complicated law for which there are few operational, legislative or

legal guideposts. Because we are often working in uncharted territory, we have been pleased to be able to issue so much detailed guidance on complex issues in so short a time. But our work is far from done. We agree with the GAO and many of its sources that difficult regulatory challenges lie ahead as we develop guidance on other HIPAA provisions. We look forward to keeping the Congress updated as we proceed.

See comment 1.

Second, we have consulted frequently, and in a very open fashion, with representatives of States, the National Association of Insurance Commissioners, the insurance industry, consumers, actuaries, and other interested parties. Their input was valuable in our deliberations and the development of the regulations. For example, many of the constituent groups suggested that HIPAA regulatory requirements should not be developed hastily or in a great level of detail. This request was accommodated in the April 1997 interim final regulations, which were designed to allow the States maximum flexibility and take into account their unique market characteristics, political situations and insurance regulatory mechanisms.

See comment 1.

Areas cited in the draft report as lacking clarity or guidance are precisely the same ones where we particularly sought public comment. We took advantage of our ability to issue interim final regulations so our rulemaking could further benefit from the views of the States, the insurance industry, and consumers. We will continue to seek guidance from a the range of constituent groups as we proceed in HIPAA's historic implementation.

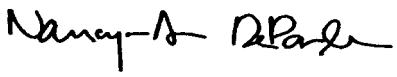
Our final concern is resources. As the draft report correctly notes, HIPAA provided no additional resources for HCFA to perform its new major regulatory and enforcement responsibilities. Our resources problem is further complicated by equally significant new responsibilities given to us in the Balanced Budget Act. So far, we have been doing the best we can by trying to redistribute already scare resources. We have redirected staff from other responsibilities to focus on the most essential tasks, such as developing regulations, reviewing State alternative mechanism proposals, and beginning enforcement activities in States that failed to enact their own HIPAA insurance reforms.

The President's fiscal year 1999 budget requests $15.5 million for HIPAA-related insurance reform activity, including 65 full-time-equivalent staff positions and funding for outside contractors to help with the very labor-intensive tasks at hand. Among our largest, currently unmet needs, is for resources to conduct direct Federal enforcement in those States that fail to implement insurance reform requirements of their own. We must also monitor and provide technical assistance to States including collection, review and analysis of laws and administrative practices, determination of compliance gaps, and identification of potential problems. If additional States default to federal enforcement, we will be hard pressed to meet the requirements of the law even with additional resources.

Page 3- William J. Scanlon

We look forward to consulting with you and your staff as we work to achieve the objectives of HIPAA over the coming months. We would be happy to answer any questions or provide additional information.

Sincerely,



Nancy-Ann Min DeParle
Administrator

Attachment

The following are GAO's comments on the Department of Health and Human Services' letter dated February 9, 1998.

GAO Comments

1. HHS commented that we did not adequately convey the many challenges it faced in issuing interim final regulations by the April 1, 1997, statutory deadline, and did not give sufficient credit to its accomplishment in doing so. Our original draft noted the federal agencies' achievements (issuing interim final regulations by the statutory deadline and being widely commended for their open and inclusive process) as well as the obstacles the agencies faced (the complexity of the law, the difficulty of balancing the need for detail in the regulations with states' desire for latitude in implementing them, and tight statutory deadlines). Nonetheless, we have refined our presentation, especially regarding these obstacles. The report elaborates on the nature of interim final rules and notes that HIPAA authorized their use. The report also now emphasizes that clarity and detail in the regulations are the more fundamental issues. For example, nondiscrimination rules were issued on time, but many of the necessary details states need to implement the rules have not yet been issued. We recognize the agencies' achievement in issuing the majority of the interim final regulations by the statutory deadline, but also underscore the work that remains to be done.

2. HHS noted that supplemental HIPAA guidance was issued on December 29, 1997. This development is now incorporated in our report.

Comments From the Department of Labor

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

U.S. Department of Labor

Assistant Secretary for
Pension and Welfare Benefits
Washington, D.C. 20210

FEB - 3 1998

Mr. William J. Scanlon
Director, Health Financing
and Systems Issues
United States General Accounting Office
Washington, DC 20548

Dear Mr. Scanlon:

Thank you for providing the Department of Labor (DOL) with the opportunity to comment on the General Accounting Office's draft report entitled "Health Insurance Standards: Implementing New Federal Law Creates Challenges for Consumers, Insurers, and State and Federal Regulators" (GAO/HEHS-98-67). For your convenience, we have enclosed a technical markup of the draft report as a supplement to our comments provided to your staff on February 2, 1998.

I would like to take this opportunity to offer a few general comments in addition to the more extensive and detailed comments we have provided you.

As you know, the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) and the Mental Health Parity Act of 1996 (MHPA) significantly expanded the DOL's regulatory, interpretative, and enforcement responsibilities under the Employee Retirement Income Security Act of 1974 (ERISA). These statutes and the regulations and interpretations promulgated by the Department's Pension and Welfare Benefits Administration (PWBA) potentially impact over 2.5 million group health plans that provide health care coverage to an estimated 125 million participants and beneficiaries and incur health benefit-related expenditures in excess of $250 billion annually.

First, as a preliminary matter, the draft report mentions that the General Accounting Office has continued to monitor the implementation process following the issuance in September of 1997 of its preliminary report on the implementation process (GAO/HEHS-97-200R). The current draft report indicates that General Accounting Office's monitoring has focused on issues relating to consumers, issuers of health coverage (including employers and health insurance carriers), and state and federal regulators. The draft report incorporates the views of state and federal regulators as well as select members of the regulated community including insurance companies. However, the draft report fails to mention the views of any consumer groups or any individual consumers. We believe that this failure to consult with the ultimate beneficiaries of these laws (the estimated 25 million people who will benefit from these laws) leads to an unbalanced reliance on the views of some insurance carriers that these provisions place an undue burden on the insurance community. We believe the draft report would benefit from including the perspective of consumer groups and individual citizens concerning the benefits and limitations of these important new health care provisions.

See comment 1.

See comment 2.

Second, in several places the draft report indicates that consumer education and outreach efforts regarding these recently enacted health care provisions appear "spotty or absent." While I cannot speak for the other responsible federal agencies, State insurance regulators, members of private industry, or consumer groups, I can tell you the DOL has devoted a significant amount of time and resources in conducting an extensive Educational Outreach Program to educate plan administrators, employers, and participants and beneficiaries on the new health care reforms.

This ongoing educational outreach effort has included providing in-depth half-day seminars in 10 cities covering every region of the country on the interim rules issued under HIPAA. In addition, PWBA has conducted more than 40 presentations to employers, employees, and various health plan associations explaining the statutory and regulatory framework of HIPAA, NMHPA, and MHPA. We have also participated in several seminars sponsored by the American Bar Association regarding compliance and implementation of these health care initiatives. These seminars were simulcast to over 70 locations nationwide.

PWBA has also published a comprehensive reference booklet, entitled "Questions and Answers: Recent Changes in Health Care Law," to help employees and employers understand their rights and obligations under the recently-enacted health care laws. We have distributed over 200,000 booklets to the public. The DOL's Q&A booklet, as well as a complete summary of HIPAA, NMHPA, and MHPA is also readily available to the public on PWBA's website on the Internet at http://www.dol.gov/dol/pwba. The public can also access the same information through the PWBA's toll-free Publications Hotline at 1-800-998-7542. In addition, we are providing public service announcements for the media (both radio and print) to alert individuals of the effects of these new health care laws. To date, our public service announcements have reached over 20 million individuals.

The DOL has also set up additional phone lines dedicated to answering health care questions from the public. We are also in the process of establishing Internet links to state insurance departments' web pages. This will enable consumers to instantly access additional information about state-based health insurance rights. I can assure you that the DOL will remain committed to providing these types of outreach and educational programs as we continue implementation of these important new health care provisions.

Third, since the passage of HIPAA the DOL, in coordination with the Departments of the Treasury and Health and Human Services, has worked diligently to issue comprehensive and timely guidance necessary to begin implementing these important new health care provisions. We requested information from the public and balanced the concerns of the regulated community to ensure that plan sponsors face as few additional costs and burdens as possible in complying with the requirements of these important new health care provisions. The draft report fails to convey the fact that the Departments, in keeping with Congress' desires that these rules be in place by April of 1997, promulgated on April 1, 1997 a comprehensive, extensive, and balanced set of guidance that was both on time and implemented over 90% of the provisions of HIPAA including provisions governing its fundamental portability, access and renewability rights.

See comment 3.

-2-

See comment 4.

Fourth, the draft report throughout incorrectly commingles its analysis of HIPAA's group market rules and the individual insurance market reforms. Contrary to the impression given in the draft report, the overall response we have received from the regulated community regarding the group market rules, including testimony in Congressional hearings subsequent to the publication of the Departments' interim guidance, has been mostly favorable.

In this regard, the majority of responses have expressed the belief that the new laws and interim rules governing the group market provisions promulgated by the Departments are evenhanded and achieve a practical balance between providing meaningful health care protections to American workers and their families while minimizing the burdens placed on employers attempting to comply with the requirements of the new laws. The DOL will continue to monitor the implementation process in the group market and will glean more information with respect to the impact of the new laws and our interim guidance on employees and their families, as well as plans and employers as more plans become subject to the group market provisions during the first part of 1998.

See comment 5.

Fifth, the draft report also notes that two areas remain "unclear or ambiguous" after the promulgation of the Departments' April regulations, involving the treatment of late enrollees and HIPAA's nondiscrimination provisions. What the draft report fails to mention is that on December 29, 1997, the Departments, in response to requests from the regulated community and other interested parties, issued supplemental guidance that included clarification of issues surrounding the treatment of late enrollees under HIPAA as well as additional guidance concerning HIPAA's nondiscrimination provisions.

See comment 6.

Sixth, as I mentioned earlier, the passage of HIPAA, NMHPA, and MHPA have significantly expanded the DOL's responsibilities under ERISA. In this regard, the draft report seems to suggest that the DOL's oversight responsibility is limited to self-insured plans covered under ERISA. However, the DOL has oversight responsibilities with regard to all ERISA covered group health plans whether insured or self-insured. This includes monitoring over 2.5 million ERISA-covered group health plans that provide health care benefits to an estimated 125 million American workers and their families. Approximately half of these 125 million individuals receive health coverage through ERISA-covered group health plans that provide benefits through the purchase of insurance. In this regard, the draft report does not mention that, like the Department of Health and Human Services, the DOL's already limited resources are significantly impacted by States that fail to enforce their oversight authority with regard to health insurance issuers providing insurance coverage to ERISA-covered group health plans.

Finally, the Administration is working to ensure that we will be able to obtain from Congress the additional resources needed in the health care area to continue the implementation process of these important new health care initiatives. I can assure you that the DOL will make every effort to secure the needed resources to allow us to continue to efficiently implement our current health care responsibilities in a manner that is both timely and provides useful educational and outreach

programs and materials to employers, participants and beneficiaries, and other individuals affected by these new laws.

The Department of Labor appreciates the opportunity to comment on this draft report.

Sincerely,

Olena Berg
Assistant Secretary

Enclosure

-4-

The following are GAO's comments on the Department of Labor's letter dated February 3, 1998.

GAO Comments

1. Labor believed we should have included in our report the perspective of consumer groups and individual citizens to provide a better balance of the benefits and limitations of HIPAA. We disagree with this point for two reasons. First, our report does reflect consumer perspectives. In our fieldwork, we interviewed officials from certain national and local consumer organizations, such as Consumers Union and the Missouri Consumer Health Care Watch Coalition. Their members' very limited awareness of and experience with this new law tended to corroborate our findings concerning challenges in the individual market. Second, a comprehensive assessment of HIPAA's benefits and limitations lies outside our scope. Our study aimed at monitoring the actual process of implementing HIPAA, not at systematically evaluating its effects or assessing its merits from a consumer's perspective. Consequently, we focused on the activities of those implementing the law—state and federal regulators and issuers—and emphasized areas where preliminary evidence signaled emerging challenges.

2. Labor stated that our report does not describe adequately its industry and consumer outreach efforts. On the contrary, we believe the examples of Labor outreach efforts that we cite do recognize these efforts adequately. We did not provide a fuller list of Labor's efforts because our conclusion concerning the lack of consumer education bears only on the individual insurance market, where Labor has no jurisdiction. However, we have clarified that the consumer education conclusion applies to the individual—not group—insurance market.

3. Labor commented that we did not adequately convey the many challenges it faced in issuing interim final regulations by the April 1, 1997, statutory deadline, and did not give sufficient credit to its accomplishment in doing so. Our original draft noted the federal agencies' achievements (issuing interim final regulations by the statutory deadline and being widely commended for their open and inclusive process) as well as the obstacles the agencies faced (the complexity of the law, the difficulty of balancing the need for detail in the regulations with states' desire for latitude in implementing them, and tight statutory deadlines). Nonetheless, we have refined our presentation, especially regarding these obstacles. The report elaborates on the nature of interim final rules and notes that HIPAA authorized their use. The report also now emphasizes that clarity and

detail in the regulations are the more fundamental issues. For example, nondiscrimination rules were issued on time, but many of the necessary details states need to implement the rules have not yet been issued. We recognize the agencies' achievement in issuing the majority of the interim final regulations by the statutory deadline, but also underscore the work that remains to be done.

4. Labor commented that the draft report inappropriately commingles our analyses of group and individual HIPAA standards and does not recognize the relatively favorable responses it has received regarding the group market reforms. We clarified the distinction in our report between the challenges arising in the individual markets of some states and those in the employer-sponsored group markets. We devoted our resources to gathering information where preliminary evidence pointed to emerging challenges rather than where they were less apparent, resulting in a less extensive review of HIPAA implementation in the group market.

5. Labor stated that the draft report failed to mention the issuance of supplemental HIPAA guidance (concerning late enrollees and nondiscrimination provisions) on December 29, 1997. We have incorporated the new information the agencies have provided in their comments. (In early December 1997, HHS officials had estimated that it would not be issued before "early 1998.") However, since the new guidance does not address the particular aspects of the late enrollment and nondiscrimination requirements that we cite as lacking clarity, the examples remain.

6. Labor commented that the draft report suggested its enforcement responsibilities are limited to self-funded group plans and did not note that the agency, like HHS, also faces expanded enforcement responsibilities. However, as we pointed out in the report under HIPAA, only HHS faces an entirely new enforcement role—one that has become larger than anticipated. We also observed that, because of HIPAA, Labor faces an extension of its existing enforcement role under ERISA. Nonetheless, while this creates extra demands on Labor's resources, in the near term, the demands facing HHS in its new enforcement role appear to be more urgent. Regarding enforcement responsibilities, the report now refers to all, not just self-funded, group plans.

Comments From the Department of the Treasury

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220
February 6, 1998

HAND DELIVERED

Mr. William J. Scanlon
Director, Health Financing and Systems Issues
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Scanlon:

Thank you for sending to Treasury Secretary Rubin a copy of your draft report to the Chairman of the Senate Labor and Human Resources Committee entitled Health Insurance Standards: Implementing New Federal Law Creates Challenges for Consumers, Insurers, and State and Federal Regulators. The report discusses implementation issues associated with the insurance reforms relating to portability, access, and renewability of health coverage that were enacted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related legislation.

In general, HIPAA sets forth federal requirements that apply both in the employer group health plan market, including health insurance offered in connection with such plans (the "group market"), and in the remainder of the health insurance market (the "individual market"). The statute provides for overlapping jurisdiction for the Secretaries of Health and Human Services, Labor, and the Treasury on most of the group market provisions, and the three Departments have worked together in developing regulations concerning these shared provisions.

The draft report notes that, in preparing the draft, GAO interviewed representatives of the Departments of HHS and Labor. We concur in substance with the comments that the Departments of HHS and Labor have conveyed to GAO concerning the portions of the draft report that relate to the shared group market provisions, including the suggestion that the report more clearly distinguish between implementation issues in the group market and the individual market. The comments of those Departments reflect views that we have communicated to them.

Very truly yours,

J. Mark Iwry
Benefits Tax Counsel

GAO Contacts and Staff Acknowledgments

GAO Contacts

Jonathan Ratner, Project Director, (202) 512-7107
Randy DiRosa, Project Manager, (312) 220-7671

Staff Acknowledgments

The study team consisted of Randy DiRosa, who managed the project, and Betty Kirksey, Evaluator. Susan Thillman advised on report presentation, Craig Winslow provided legal review, and Elizabeth T. Morrison provided editorial review. This report was prepared initially under the direction of the late Michael Gutowski; his role was later assumed by Jonathan Ratner.

Related GAO Products

Medical Savings Accounts: Findings From Insurer Survey (GAO/HEHS-98-57, Dec. 19, 1997).

The Health Insurance Portability and Accountability Act of 1996: Early Implementation Concerns (GAO/HEHS-97-200R, Sept. 2, 1997).

Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures (GAO/HEHS-97-122, July 24, 1997).

Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases (GAO/HEHS-97-35, Feb. 24, 1997).

Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Tradeoffs (GAO/HEHS-97-8, Nov. 25, 1996).

Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance (GAO/HEHS-96-161, Aug. 19, 1996).

Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate (GAO/HEHS-96-129, June 17, 1996).

Health Insurance Portability: Reform Could Ensure Continued Coverage for Up to 25 Million Americans (GAO/HEHS-95-257, Sept. 19, 1995).

Health Insurance Regulation: National Portability Standards Would Facilitate Changing Health Plans (GAO/HEHS-95-205, July 18, 1995).

The Employee Retirement Income Security Act of 1974: Issues, Trends, and Challenges for Employer-Sponsored Health Plans (GAO/HEHS-95-167, June 21, 1995).

Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms (GAO/HEHS-95-161FS, June 12, 1995).

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