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Report to the Chairman, Committee on Health, Education, Labor, and Pensions, U.S. Senate

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PRIVATE HEALTH INSURANCE

Progress and Challenges in Implementing 1996 Federal Standards

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The Honorable James M. Jeffords
Chairman, Committee on Health,
Education, Labor, and Pensions
United States Senate

Dear Mr. Chairman:

By setting minimum federal standards for certain aspects of private health insurance held by over 160 million Americans, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established important new federal responsibilities. HIPAA instituted minimum standards of protection to improve access to health insurance for people obtaining coverage through employment as well as for those purchasing it as individuals. For example, HIPAA limits the time that preexisting conditions may be excluded from coverage for many people changing jobs (portability) and guarantees access to coverage for certain individuals losing group coverage (group-to-individual portability). Since the enactment of HIPAA, the Congress has enacted additional federal health insurance requirements, including minimum standards affecting mental health, maternity and newborn, and reconstruction after mastectomy benefits.

Last year, we reported that the initial months of HIPAA implementation had posed some challenges for consumers, insurers, and regulators.[1] We noted that

- eligible consumers attempting to exercise their new rights to guaranteed access to individual insurance were hindered in some cases by insurance carrier practices and pricing as well as by their own misunderstanding of the law;
- issuers of health coverage, including employers and insurance carriers, were concerned about administrative burdens and unanticipated consequences of the law, as well as the potential for consumer abuse of certain protections;
- federal regulators faced a greater-than-expected role under HIPAA; and
- state regulators sought additional guidance in interpreting the regulations.

[1]See Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators (GAO/HEHS-98-67, Feb. 25, 1998), Implementation of HIPAA: State-Designed Mechanisms for Group-to-Individual Portability (GAO/HEHS-98-161R, May 20, 1998), and Private Health Insurance: HCFA Cautious in Enforcing Federal HIPAA Standards in States Lacking Conforming Laws (GAO/HEHS-98-217R, July 22, 1998).

Since additional HIPAA provisions have come into effect over the last year and consumers, insurers, employers, and regulators have had an additional year to adapt to these requirements, you asked us to provide an update on the implementation status of HIPAA provisions in the group insurance market;[2] the price of coverage for certain individuals losing group coverage; the extent of consumer understanding of HIPAA as well as federal, state, and private efforts undertaken to educate consumers about the law's protections; and federal efforts undertaken to ensure HIPAA compliance.

To provide this information, we visited five states and interviewed regulators, carriers, employers, agents, trade organizations, and benefit consulting firms. In collaboration with the National Association of Health Underwriters (NAHU), we surveyed agents to obtain premium quotes in states that are using HIPAA's standards to guarantee eligible individuals access to individual market coverage and compared these quotes with premium data from states using an alternative method to do so. We conducted our work between September 1998 and April 1999 in accordance with generally accepted government auditing standards. Appendix I provides more details about our scope and methodology.

Results in Brief

Implementation of HIPAA's insurance standards in the group market has proceeded relatively smoothly—particularly among larger group plans—although carriers and employers continue to express some concerns about certain administrative and interpretive aspects of HIPAA. This ease of transition has occurred partly because many of these group plans had already provided key HIPAA protections before the law was enacted, such as limits on coverage exclusions for preexisting health conditions. However, concerns exist about the extent to which some smaller employers are performing certain required tasks, such as issuing certificates of creditable coverage. With respect to HIPAA's requirement that carriers guarantee access to coverage for certain small employers, early evidence suggests experiences vary considerably among states, largely depending on the extent of state-level reforms that preceded HIPAA.

[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). Individuals without group coverage may obtain coverage by purchasing a policy directly from a carrier 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).

HIPAA's group-to-individual portability provision ensures that certain consumers who lose group coverage are guaranteed access to at least two individual market insurance products. However, like others in poor health, the so-called "HIPAA-eligible" individuals who have certain health conditions often pay a higher-than-standard premium for individual coverage, although the amount of the premium increase varies considerably. All but 3 of the 41 carriers we surveyed in states using HIPAA standards would charge a HIPAA-eligible with a specified health condition a higher-than-standard rate, and nearly half of these would charge 300 to 464 percent of the standard rate. The average premium for individual coverage for HIPAA-eligibles with a specified health condition that would be charged by the 41 carriers was $381 per month. In contrast, the 22 states that use a high-risk pool as an alternative to the federal portability standards limit premiums to 200 percent or less of the standard rate, or an average subsidized rate of $221 per month. The exact number of individuals who rely on HIPAA's group-to-individual portability provision to obtain coverage is difficult to determine but appears small according to carrier estimates and risk-pool enrollment figures.

Consumers' understanding of HIPAA remains limited, and many are largely unfamiliar with the law. Among those who have heard of HIPAA, many believe it provides broader access and protections than it does or are unclear about specific provisions. Thus, federal agencies and others have targeted educational efforts to specific populations in an attempt to reach those most likely to benefit from HIPAA. For example, some Health Care Financing Administration (HCFA) regional offices are coordinating with state unemployment agencies to ensure that individuals who are changing jobs know that, if they previously had group coverage, subsequent employers generally cannot exclude preexisting conditions from coverage. Moreover, HIPAA requires that those losing health coverage receive a certificate that documents the length of prior coverage. Certificates that clearly explain HIPAA's protections and restrictions would provide consumers with the information they need to exercise their portability rights.

HIPAA established a complex regulatory framework in which oversight and enforcement of the law are shared among multiple federal agencies and state regulators. While the law expanded the Department of Labor's existing oversight responsibilities for employer-sponsored health coverage, it created a new regulatory role for HCFA. HCFA's enforcement efforts, however, have been limited and have focused primarily on the states known not to have adopted statutes or regulations that fully meet

the HIPAA standard. HCFA officials attribute their limited involvement to a lack of enforcement regulations and insufficient resources.

This report contains recommendations aimed at better informing consumers of their HIPAA rights and improving HCFA's enforcement efforts.

Background

Title I of HIPAA established standards for health coverage access, portability, and renewability that apply to employer-sponsored plans in the group market and, to a more limited extent, to the individual market.[3] Group market provisions include

- limitations on preexisting condition exclusion periods;
- a requirement that previous coverage be credited to reduce or eliminate a new employee's preexisting condition exclusion period;
- restrictions against excluding an employee from the health plan on the basis of his or her health status; and
- special enrollment opportunities for certain employees, such as those who did not enroll because they were previously covered under a spouse's health plan.

With limited exceptions, carriers must renew all group coverage at the employer's request, regardless of the health status or historic health costs of the employee members. HIPAA also requires carriers in the small group market to guarantee coverage to all small employers (defined as those with 2 to 50 employees) that apply.

In the individual market, HIPAA guarantees that eligible individuals[4] losing group coverage have access to at least two individual market insurance products. This provision is referred to as group-to-individual portability. States may comply with this provision using either the federal rules—which require individual market carriers to guarantee access to certain insurance policies to eligible individuals—or an "alternative mechanism." Under an alternative mechanism, states may, within broad federal parameters, design other approaches to provide eligible individuals

[3]Some HIPAA standards also apply to certain federal, state, and local government insurance programs, such as Medicaid, state employee health plans, multiple-employer welfare arrangements, church plans, and bona fide associations.

[4]An eligible individual is one who has had at least 18 months of creditable coverage with no break of more than 63 consecutive days; has exhausted any Consolidated Omnibus Budget Reconciliation Act or other continuation coverage available under a similar state program; is not eligible for any other group coverage, Medicare, or Medicaid; and did not lose group coverage because of nonpayment of premiums by the individual or fraud.

with a choice of coverage. Twelve states are operating under the federal rules, and 38 are using an alternative mechanism. Of the latter, 22 are using a high-risk pool to provide coverage to these eligible individuals.[5] A high-risk pool is a state entity that offers comprehensive health insurance to individuals with preexisting health conditions who are otherwise unable to obtain coverage in the individual market or who may be able to obtain coverage only at a cost-prohibitive rate. (App. II contains a summary of HIPAA access, portability, and renewability standards by market segment.)

HIPAA was signed into law on August 21, 1996, and by the end of June 1998, all substantive provisions were effective for almost all plans. HIPAA regulations were issued on an interim final basis, and federal agencies issued most of the implementing regulations on April 8, 1997. Enhancements and clarifications to the regulations followed and will continue in 1999. Officials expect to finalize HIPAA regulations in 2000. Finally, after HIPAA was enacted, three additional federal laws—the Mental Health Parity Act (MHPA), the Newborns' and Mothers' Health Protection Act, and the Women's Health and Cancer Rights Act (WHCRA)—imposed federal standards on private insurance coverage of mental health, maternity and newborn, and reconstruction after mastectomy benefits.[6]

Carrier and employer officials we interviewed expressed concerns about the lead time given them to comply with HIPAA and subsequent federal insurance reforms. The adoption of the new standards requires issuers to perform various tasks, including educating staff, issuing notices to enrollees, revising premium prices and marketing materials, and retooling information systems. Carrier officials consistently said that such changes require at least 6 months' lead time or, preferably, 1 full year. Regulations implementing HIPAA were issued less than 2 months before certain provisions became effective, although carriers and employers have generally overcome the early start-up hurdles. Neither the MHPA nor the WHCRA had statutory provisions that provided for lead times of 6 months or more. Although the MHPA was signed into law in September 1996, its implementing regulations were not issued until December 22, 1997—only 9 days before some group plans became subject to the law. Similarly, while the WHCRA was signed into law on October 21, 1998, issuers were required to begin issuing notices to enrollees less than 3 months later, by January 1, 1999. Federal agencies, recognizing the short lead time, provided for a

[5]For more details on alternative mechanism approaches adopted by these 38 states, see GAO/HEHS-98-161R, May 20, 1998.

[6]See app. II for a description of these laws.

period during which no MHPA enforcement action would be taken against issuers making a good-faith effort to comply.

Responsibility for enforcing HIPAA standards is divided among three federal agencies and the states. The Department of Labor is responsible for ensuring that employer-sponsored group health plans comply with HIPAA—an extension of Labor's current regulatory role under the Employee Retirement Income Security Act of 1974 (ERISA).[7] In states that do not adopt and enforce statutes or regulations that meet or exceed the HIPAA standards, the Department of Health and Human Services—through HCFA—is responsible for directly enforcing HIPAA standards for carriers in the group and individual markets. The Department of the Treasury enforces HIPAA requirements for group health plans by imposing an excise tax under the Internal Revenue Code as a penalty for noncompliance with the HIPAA standards. In states that have standards that conform to HIPAA, state insurance regulators have primary enforcement authority over insurance carriers.

HIPAA Group Market Provisions Have Been Smoothly Adopted Overall, but Questions Remain About Small Employer Compliance

Notwithstanding early start-up challenges, the adoption of HIPAA's group market access and portability provisions has proceeded relatively well—particularly for larger group plans. Noncompliance with these standards may be more common among smaller group plans. With respect to guaranteed coverage for small employers, quantitative evidence about the effects of the provision does not yet exist, but early evidence suggests that experiences vary considerably among states, in large part on the basis of the extent of pre-HIPAA state reforms.

Overall, Adoption of Access and Portability Provisions by Larger Group Plans Has Proceeded Smoothly

Larger employer plans appear to have adopted HIPAA access and portability provisions relatively easily. The Director of the Department of Labor's health care task force said the Department has uncovered no systemic problems in the group market related specifically to HIPAA. A senior Labor field official told us that large employers and insurance companies are generally informed about HIPAA and make good-faith efforts to comply, although questions of interpretation still arise. The field office had no formal investigations related to HIPAA pending at the time of our visit in December 1998. Similarly, large employers and health benefit consultants

[7]ERISA allows employers to offer uniform national health benefits by preempting states from directly regulating employer benefit plans. As a result, states are unable to directly regulate self-funded plans, but can regulate health insurers. Under ERISA, Labor is responsible for assuring that employer-sponsored group health plans meet certain fiduciary, reporting and disclosure requirements related to the provision of health benefits.

we interviewed reported few ongoing problems in adopting HIPAA portability standards.

Many carriers and large employers we interviewed said that their health plans tended to require few changes to comply with HIPAA. This was probably the case because many large employer plans had already incorporated portability protections similar to those of HIPAA. For example, many large employers had not excluded preexisting conditions from coverage before HIPAA became law. Many more have since dropped preexisting condition exclusion periods, partly because of the increased complexity of administering them under HIPAA. Table 1 shows that less than half of all group plans offered by employers with more than 200 employees continue to include preexisting condition exclusion periods.[8] Further, a large midwestern telecommunications company official told us that before HIPAA, the company's health plans (1) did not exclude preexisting conditions from coverage, (2) did not exclude individuals from the plan because of health status, and (3) provided later enrollment opportunities for those initially declining coverage. Thus, few changes were necessary.

Table 1: Percentage of Mid-Size and Large Group Plans Using Preexisting Condition Exclusion Periods, 1996 and 1998

Plan type	1996	1998
Fee-for-service	62%	38%
Preferred provider organization	70	47
Point-of-service plan	49	23

Source: KPMG Peat Marwick, LLP, Health Benefits Surveys in 1996 and 1998.

Questions Exist About the Extent of Compliance Among Small Employer Plans

The degree of compliance with HIPAA portability provisions among small employer group plans has not been measured, but health insurance agents and regulators suspect noncompliance to be more common among these plans than among medium and large group plans. Whereas medium and large employers rely on carriers, third-party administrators, or a health benefits professional staff to implement HIPAA requirements, small employers may have fewer resources and may rely largely on carriers and agents to learn about changes in health benefits required by law. Further, observations made by health insurance agents and others suggest that

[8]While the use of preexisting condition exclusion periods has decreased, the length of waiting periods for health coverage eligibility has increased. KPMG Peat Marwick, LLP, reports that the average number of days that must elapse before a new employee is eligible for coverage has increased from 39 in 1997 to 57 in 1998. Some attribute this indirectly to HIPAA, suggesting that some employers may be replacing the preexisting condition exclusion period with a longer waiting period.

some small employers either misunderstand the HIPAA requirements or are entirely unaware of them. In addition, several of the agents we surveyed volunteered that many of their colleagues do not understand HIPAA. An official of a small employer whom we interviewed in California told us an anecdote that illustrates this point. The individual responsible for human resource issues at this company with about 80 employees relied exclusively on the company's insurance agent to learn about HIPAA's certificate issuance requirement. The agent told the human resources staff person that certificates need be issued only upon the request of the employee; this is contrary to the law, which requires that certificates be issued automatically to anyone losing coverage. The discrepancy became apparent only as a result of our visit. Moreover, an agent in Florida indicated that perhaps 25 percent of her clients, most commonly the smaller employers, are not in compliance with one or more HIPAA provisions and are not making an effort to comply.

Department of Labor officials also expressed concern about compliance among smaller employers. One field office official said that smaller employers know far less than larger employers about HIPAA and are more likely to be in violation of it. This field official is particularly concerned about small employers that self-fund their health plans and do not use the services of a third-party administrator. While this arrangement is not common, such employers have virtually no contact with health benefits professionals and, according to Labor officials, are very likely to be uninformed. Officials from another Labor field office noted that the Department's experience in overseeing employer pension plans suggests that smaller employers are more likely to be in violation of requirements than larger employers.

New Guarantees of Coverage for Small Employers Have Affected States Differently

The extent to which HIPAA's guaranteed issue provision affects market access for small employers in a given state is largely dependent on the extent of state reforms preceding HIPAA. Most states had already passed laws requiring carriers in the small group market to guarantee access to at least one health insurance plan for any small employer that applied. While most of these state laws were more limited than HIPAA, a substantial minority were equally or more stringent.

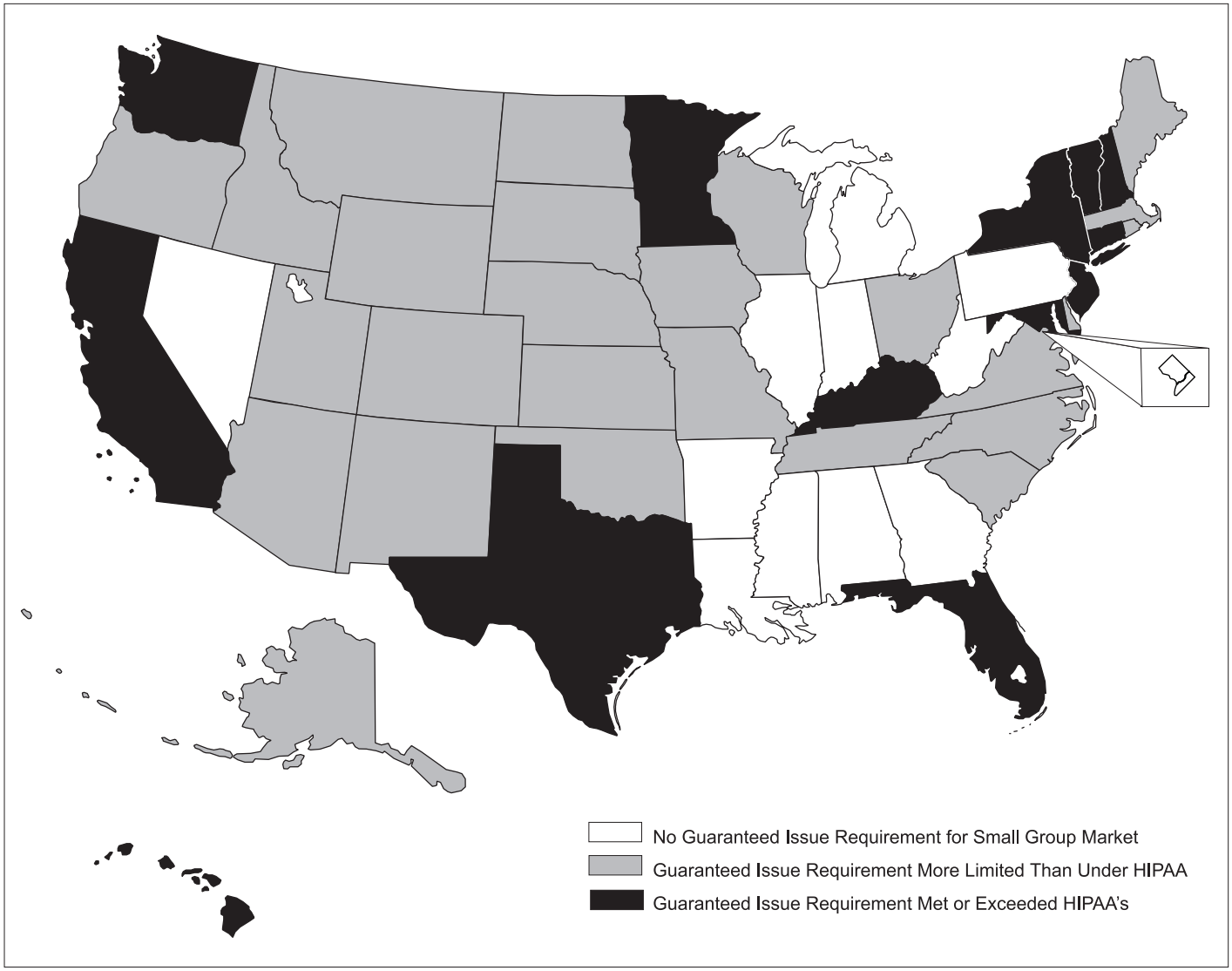
- In 13 states, reforms that preceded HIPAA required all products in the small group market to be guaranteed to be accessible to all small employers, just as HIPAA now does. Moreover, these states defined a small employer at

least as inclusively as HIPAA. Therefore, HIPAA imposed virtually no changes in the way small group coverage is sold in these states.

- In 26 states, existing reforms included small group market guaranteed issue provisions that were more limited than the HIPAA provisions. Often, state reforms defined small employers as having 3 to 25 employees, as opposed to HIPAA's 2 to 50 employees. These states also imposed the guaranteed issue provision on fewer health plans. Thus, in these states, HIPAA's impact was to modify, to varying degrees, the existing regulations.
- In 11 states and the District of Columbia, a guaranteed issue provision applicable to all carriers did not exist in the small group market. Here HIPAA imposed significant changes on the regulation of the small group market.

Figure 1 shows the requirements of the 50 states and the District of Columbia for small group guaranteed issue coverage before HIPAA.

Figure 1: Summary of State Small Group Guaranteed Issue Requirements Predating HIPAA



Notes: Michigan requires its BlueCross BlueShield plan to guarantee coverage to groups of one or more. Hawaii is the only state with mandated employer-sponsored health insurance. Virtually all employed individuals in Hawaii are guaranteed access to health insurance through their employer.

The effects of HIPAA's small group market guaranteed issue provision on cost and access to coverage have not been evaluated, and, among the

health insurance agents we surveyed, observations on its effects varied widely. Asked a general question about the effects of the provision, 46 percent of the agents we surveyed in states where existing guaranteed issue reforms were more limited than HIPAA's said that access had improved: for example, the choices of products available to small employers had increased. Agents also noted that, because every small employer has access to every small group product on the market, employers are better able to compare carriers' products and rates. Conversely, 44 percent of the agents said that HIPAA had not improved access for small groups.[9] Many agents observed that while access is now guaranteed to groups that were previously excluded from coverage—high-risk groups—these groups may be unable to afford the available coverage.

Carrier representatives we interviewed generally corroborated agent observations concerning increased comparison shopping by agents among all carrier products and high premiums for high-risk groups. Several carrier representatives said that small group market premiums have risen overall, but these representatives could not determine what proportion of the increase might be attributable to HIPAA's guaranteed issue provision. Several carrier officials also pointed out that the guaranteed issue requirement limits carriers' flexibility in designing benefit plans. Because every plan offered must be available to every small employer group, these carriers have reduced the number of plans they offer and are less able to customize plans to specific groups. Further, one carrier was concerned that very small employer groups might change health plans to obtain certain benefits, such as maternity coverage, when one or more individuals in the group needed that coverage. Another carrier cited concerns that very small groups tend to obtain coverage only when it becomes apparent that it will be needed.

HIPAA Has Improved Access, but Not Price, for Certain Individuals Losing Group Coverage

HIPAA's group-to-individual portability provision ensures that people who are losing group coverage are guaranteed access to at least two individual market products, although these individuals, if in poor health, will probably pay more than the standard rate. The amount of the premium increase varies considerably. Our survey showed that in states using the federal rules, an individual in poor health would usually pay a premium greater than 200 percent of the standard rate, while in states using a high-risk pool, the increase was never greater than 200 percent of the

[9]The total of these percentages does not equal 100 because a number of agents we surveyed did not know if HIPAA had affected small groups' access to health insurance in their respective states.

standard rate. The exact number of individuals relying on this portability right to obtain coverage is difficult to quantify but appears small.

HIPAA-Eligibles With Health Problems Generally Pay Higher-Than-Standard Premiums

HIPAA does not limit the premium price carriers may charge eligible individuals for coverage. Thus, premiums charged to individuals eligible for coverage under HIPAA, especially those in poor health, are often substantially higher than carriers' standard rates—the rates healthy individuals pay. The extent of the increase in the premium rate is largely dependent upon whether a state restricts the amount carriers can vary premium rates and on the state's approach to complying with HIPAA's group-to-individual portability provision. Our premium survey of selected carriers in states using federal rules to guarantee group-to-individual portability under HIPAA[10] showed that a particular individual eligible for HIPAA, with a preexisting condition,[11] would be charged between 100 and 464 percent of the standard rate for a commonly sold product. In terms of monthly premiums, the rates quoted ranged from as low as $149 for a health maintenance organization (HMO) product in California to $951 for a preferred provider organization (PPO) product with a $500 deductible in the District of Columbia. As table 2 shows, the premium quotes provided by almost half of the carriers for this individual were 300 percent or more of their standard rates.

Table 2: Comparison of Selected Carriers' Standard Monthly Premiums With Carriers' Monthly Premiums for a HIPAA-Eligible With a Specified Health Condition

State	Insurer number	Plan type/ deductible level	Standard monthly premium	Monthly premium for HIPAA-eligible	Increased premium as percentage of standard premium
Arizona	1	PPO/$500	$104	$416	400
	2	PPO/500	102	306	300
	3	PPO/500	125	501	401
	4	PPO/500	133	266	200
	5	PPO/500	94	187	199
California[a]	6	PPO/2,000	127	395	311
	7	PPO/1,000	192	494	257

(continued)

[10]Although Hawaii also uses the federal rules, we were unable to obtain premium quotes from agents in the state. In addition, other states and the District of Columbia are using an alternative mechanism that essentially incorporates the federal rules. For this reason, we included Virginia and the District of Columbia in the premium survey. We included Michigan in the survey because before Mar. 1999, at which time it passed conforming legislation, it was using the federal rules to guarantee HIPAA's group-to-individual portability.

[11]A 43-year-old, nonsmoking male with juvenile-onset diabetes.

State	Insurer number	Plan type/ deductible level	Standard monthly premium	Monthly premium for HIPAA-eligible	Increased premium as percentage of standard premium
	8	PPO/1,000	121	452	374
	9	HMO/0	153	268	175
	10	POS[b]/0	181	317	175
	11	HMO/0	149	149	100
	12	HMO/0	241	590	245
Colorado[a]	13	PPO/500	96	288	300
	14	PPO/500	142	426[c]	300
	15	PPO/500	129	387[c]	300
	16	HMO/0	141	170	121
	17	PPO/500	137	411	300
Delaware	18	PPO/500	212	636	300
	19	Indemnity/1,000	132	396	300
District of Columbia	20	PPO/500	317	951	300
Maryland	21	Indemnity/400	130	166	128
Massachusetts	22	HMO/0	288	288	100
	23	PPO/250	332	332	100
Michigan	24	PPO/500	90	180	200
	25	PPO/500	223	669	300
Missouri[a]	26	PPO/300	174	374	215
	27	HMO/0	107	231	216
	28	HMO/0	108	216	200
	29	PPO/250	184	202	110
North Carolina	30	PPO/500	114	228	200
	31	PPO/500	127	247	194
	32	Indemnity/500	147	287	195
Rhode Island	33	Indemnity/500	269	807	300
Tennessee[d]	34	Indemnity/500	171	323	189
	35	PPO/500	148	443	299
	36	PPO/500	134	402	300
	37	PPO/500	207	621	300
Virginia	38	Indemnity/300	128	227	177
	39	PPO/300	104	473	455
	40	PPO/750	100	464	464
West Virginia	41	PPO/500	143	429	300

(Table notes on next page)

Note: Carriers provided premium quotes based on the information provided by the insurance agents. Acceptance in the plan and actual premiums would be contingent upon verification of this information.

[a]Certain individuals in poor health may also obtain coverage through a state high-risk pool or other program, although a waiting period or preexisting condition exclusion period may be imposed.

[b]Point-of-service plan.

[c]Premium for HIPAA-eligible in poor health estimated by NAHU.

[d]Tennessee residents in poor health may also obtain coverage through the TENNCARE program.

Source: GAO analysis of NAHU survey data.

As the table demonstrates, carriers in these states almost always charge an individual in poor health who is eligible for coverage under HIPAA a higher-than-standard monthly premium, which is similar to what unhealthy people without HIPAA portability rights experience if accepted for individual coverage in states without premium rate restrictions. Before HIPAA, however, many unhealthy people in these states could have been rejected outright for any type of individual private health insurance or could have faced an exclusion for their preexisting condition.

In the 22 states using a high-risk pool as an alternative mechanism,[12] individuals in poor health who are HIPAA-eligible also pay a higher premium, although the amount of the increase is generally less than in the states using federal rules, because the risk-pool coverage is subsidized. All 22 states using their high-risk pool as an alternative mechanism impose a premium cap for coverage in the pool of 200 percent of the standard rate or less, and about half cap premiums at 150 percent of the standard rate or less. The actual cost of covering these individuals is subsidized, most commonly by assessments on carriers. In several of these states, this assessment is offset against state premium or income taxes. As table 3 indicates, monthly premiums for the same individual discussed above for the most commonly sold product in each state ranged from $107 for a $1,000 deductible, fee-for-service plan in Minnesota to $336 for a $1,000 deductible, PPO plan in Louisiana.[13] These premiums in about half of the 22 states were below $200 and between $200 and $336 in the other half.

[12]States using their high-risk pool as an alternative mechanism cannot subject individuals eligible for coverage under HIPAA to enrollment waiting periods or preexisting condition exclusion periods.

[13]In seven states that vary premium rates for geographic location, we used the rate charged in an urban area. Monthly premiums in the rural areas of these states were between $5 and $96 less.

Table 3: Monthly Premium for a HIPAA-Eligible With Juvenile-Onset Diabetes in Urban Areas of States Using a High-Risk Pool as an Alternative Mechanism

State	Monthly premium
Alabama	$215
Alaska	292
Arkansas	168
Connecticut	255
Illinois	283
Indiana	200
Iowa	270
Kansas	239
Louisiana	336
Minnesota	107
Mississippi	239
Montana	179
Nebraska	124
New Mexico	236
North Dakota	227
Oklahoma	228
Oregon	182
South Carolina	249
Texas	198
Utah	254
Wisconsin	200
Wyoming	190

Few People Rely on HIPAA's Group-to-Individual Portability Provision

The number of people that rely on HIPAA's group-to-individual portability provision to obtain coverage is difficult to quantify, particularly in states using the federal rules and states using an alternative mechanism other than a high-risk pool. In these states, carriers and state entities have not undertaken a systematic effort to count these individuals. However, in states using the federal rules, each of three national carriers estimated it had HIPAA enrollment of fewer than 200 individuals.

In contrast, most states that use a high-risk pool as an alternative mechanism are able to separately track the enrollment of people eligible for coverage under HIPAA. Enrollment data suggest that the number of individuals relying on their HIPAA portability rights in these states is also relatively low. In 20 states that track HIPAA enrollment, approximately 6,500 HIPAA-eligibles are enrolled in the risk pools—or about 10 percent of the

total risk-pool enrollment of over 63,000. Further, high-risk-pool enrollment reaches 1,000 HIPAA-eligibles in only two states.

Limited Consumer Awareness and Understanding of HIPAA May Constrain Benefit to Consumers

Consumer awareness and understanding of HIPAA remain limited, and those who have heard of the law often believe it provides broader access and protections than it does. Consumers who are unfamiliar with HIPAA may not receive the law's protections or may make poor choices. Consequently, federal agencies and other entities have undertaken educational efforts that target specific populations—such as those changing jobs or losing group coverage—in an attempt to reach those who are most likely to benefit from HIPAA's protections.

Consumers Lack a Clear Understanding of HIPAA

In February 1998, we reported that many consumers misunderstood HIPAA and believed that the federal law provided broader access and protections than it actually does.[14] Over 1 year later, most consumers are still largely unfamiliar with the law, according to agents, carriers, and state regulators. Sixty-five percent of the agents we surveyed indicated that their clients do not understand HIPAA and often approach the agents with questions. Similarly, several carriers and a third-party administrator we interviewed agreed that consumers know little about the law. For example, insurance regulators from two states told us that although consumers may have a vague understanding that HIPAA provides certain health care rights, most consumers are still unaware of specific HIPAA provisions.

Consumers often misunderstand (1) the restrictions HIPAA imposes on former group enrollees' guarantee of access to individual market coverage and (2) HIPAA's definition of portability. First, for a former group enrollee to be eligible for individual market coverage under HIPAA, the individual must

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

[14]GAO/HEHS-98-67, Feb. 25, 1998.

Consumers continue to misunderstand these restrictions, according to agents and carrier officials. For example, one of the agents we surveyed said that out of 10 applications he received for individual coverage from former group enrollees, only 3 qualified for a HIPAA-guaranteed access product. The remaining seven were ineligible for such reasons as failing to select or exhaust COBRA or having a lapse in coverage of more than 63 days. Similarly, data provided by a large carrier suggest that over a quarter of all applicants for HIPAA portability coverage in 1998—61 of 231—were denied because they did not meet one or more of these eligibility criteria.

Second, consumers commonly misunderstand the scope of HIPAA's protections and its definition of portability. According to agents we surveyed, a number of consumers mistakenly believe that HIPAA guarantees access to individual insurance coverage for everyone, including those previously uninsured. Others believe HIPAA eliminates the use of preexisting condition exclusion periods altogether. Still others believe that portability allows them to carry their current health benefits with them when they change or lose jobs, according to regulators. In reality, portability under HIPAA is much more limited and simply means that once an individual has health coverage, time spent under that coverage may be used to reduce or eliminate any preexisting condition exclusion imposed by a subsequent employer's health plan.

Uninformed Individuals Who Lose Group Coverage or Change Jobs Risk Losing Certain Protections

Consumers and small employers may not receive HIPAA protections if they do not know they exist and may make poor choices based on ignorance. Although HIPAA may affect relatively few people at any given point, a clear understanding of their rights is imperative for eligible individuals. The following scenarios describe hypothetical cases in which consumers who qualified for HIPAA protections were not aware of their rights and were unable to take advantage of the law's protections.

Scenario One: Group-to-Individual Portability

Employee A has chronic asthma and decided to quit her job to become self-employed. Although she received a certificate of creditable coverage and a notice from her prior employer's health plan administrator explaining her COBRA continuation-of-coverage rights, she declined COBRA because she perceived it to be expensive and she had heard that HIPAA provided a guarantee of access to coverage in the individual market. Several months later, she approached an agent to obtain coverage. She learned that because she had not elected COBRA and more than 63 days had elapsed since her group coverage expired, she was ineligible for a HIPAA

group-to-individual portability product. The agent told her that consequently, most carriers would reject her application for coverage because of her health condition. Moreover, if she obtained coverage, carriers would exclude coverage for her preexisting condition for 1 year.

Scenario Two: Group-to-Group Portability

Employee B has chronic back problems and had been continuously insured through his company's health plan for the past 5 years. During his first 12 months of coverage, all expenses associated with treating his costly back condition were excluded. Employee B changed jobs but never received a certificate of creditable coverage and was not otherwise aware of HIPAA's portability rights. Without this certificate, which would have documented Employee B's previous coverage, the new employer applied a preexisting condition exclusion to Employee B, not covering any costs associated with treating his back condition for another full year. Therefore, Employee B incurred an additional year of medical costs for a health condition for which he had previously fulfilled the maximum allowable waiting period.

Despite Multiple Efforts, Uncertainty Remains About How Best to Educate Consumers About HIPAA

Recognizing that many consumers do not understand their rights under HIPAA, employers, federal agencies, and others have undertaken, to varying degrees, efforts to inform consumers about their rights under HIPAA. Although several employers question the value of extensive education efforts, most have external and internal resources available to respond to consumer inquiries. In addition, federal, state, and other entities are attempting to better target consumer education efforts to individuals who are experiencing a transition in employment so these individuals have access to relevant information when they need it.

Employers Question the Need for Widespread Educational Efforts

The extent of employer educational efforts varies, depending largely on the size of the employer and the resources available. Officials of several multistate employers said that their health plans already included many of HIPAA's protections, and an official from one of these employers said that efforts to provide employees with information specific to HIPAA would only generate confusion. Consequently, in some cases, employers have simply amended their summary plan descriptions to include HIPAA protections and refer employees to this document when they have questions about their coverage. An official from one employer believes more extensive educational efforts are not an efficient use of resources, since HIPAA only affects employees in transition. Some employers noted that their human resources personnel can answer employee questions or conduct

interviews with exiting employees, at which time they can explain HIPAA and other federal laws. Some officials emphasized that just as it took several years for consumers to become familiar with COBRA protections, it will take some time for employees to understand their rights under HIPAA.

Smaller employers tend to rely on their carriers or their agents to resolve questions and to educate them about changes in federal law. Carriers we interviewed have amended their contracts to comply with the law and have customer service representatives available to answer questions. Further, many carriers have issued notices and educational materials to clarify areas of confusion and to explain HIPAA's requirements to plan enrollees.

Federal, State, and Other Efforts That Target HIPAA-Eligibles Are Under Way

Officials at both the Department of Labor and HCFA said that they are attempting to better target consumer education efforts to individuals who are experiencing a transition in employment so that these individuals will have access to relevant information when they need it. For example, the Worker Adjustment and Retraining Notification Act, among other things, requires any employer who intends to order a plant closing or mass layoff to notify state dislocated worker units. Labor has encouraged its regional offices to participate in state dislocated worker programs, allowing Department officials to provide educational materials directly to those individuals in transition. Labor's regional offices are also encouraged to meet with state insurance departments to discuss HIPAA and other federal laws. Through its education outreach program, Labor has conducted presentations about the law to employers and health associations.

Although HCFA does not yet have a coordinated outreach program, the two regional offices we visited plan to coordinate with state programs by distributing HIPAA informational materials at selected sites, such as unemployment, Social Security, and Railroad Retirement Board offices, where people in employment transition often go. Finally, both agencies have Internet sites that contain HIPAA information,[15] have customer service representatives to answer questions, and make educational publications available.

States have also undertaken a variety of efforts to better educate consumers about HIPAA, although the extent of these efforts varies among states. At least 20 states have developed consumer information materials

[15]See the Department of Labor's HIPAA information at http://www.dol.gov/dol/pwba/public/health.htm; see HCFA's HIPAA information at http://www.hcfa.gov/hipaa/hipaahm.htm.

that address HIPAA provisions. For example, insurance department officials in Montana have conducted training seminars for agents, large employers, and provider groups, and Oklahoma has incorporated HIPAA information in its continuing education requirement for agents. In addition, a number of states that use their high-risk pool as an alternative mechanism, such as Illinois, have undertaken educational efforts to inform the public about the availability of coverage through the pool. Also, two of the states we visited require carriers to notify consumers whom they decline to cover about the availability of coverage through the pool. In contrast, regulators in California do not believe they have an obligation to inform consumers about changes in federal law, and they emphasized that their primary mission is to regulate insurers. Finally, all of the states we visited have customer service personnel who are available to answer consumer inquiries related to HIPAA or to refer these questions to the appropriate federal authorities.

Other entities are also conducting an assortment of educational efforts. Employee benefits consulting firms have assembled educational materials on HIPAA and have sponsored training seminars for employers. Also, Georgetown University's Institute for Health Care Research and Policy has prepared a consumer guide for each state that explains the protections available to individual consumers and small businesses under HIPAA and state insurance laws.[16]

Certificates of Creditable Coverage Could Be Used to Educate Consumers About Their HIPAA Rights

As noted above, HIPAA requires carriers and employers to issue a certificate of creditable coverage that documents the length of prior coverage to all individuals losing health coverage. To help issuers comply with this requirement, federal agencies developed a model certificate that was published in the Federal Register and is available electronically on HCFA and Labor's Internet sites. Several issuers we interviewed have essentially adopted the model certificate, which, in part, requires information about (1) the date coverage began, or a statement that an individual has at least 18 months of creditable coverage, and (2) the date coverage ended, or whether coverage is continuing, such as through COBRA. (The model certificate is included as app. V.)

As an educational tool, however, the model certificate has limitations. First, it does not explicitly inform consumers that they may have a group-to-individual portability right, nor does it highlight any of the

[16]The consumer guides are available on Georgetown University's Internet site, http://www.georgetown.edu/research/ihcrp/hipaa (cited Mar. 23, 1999). A consumer guide is not yet available for Massachusetts.

restrictions placed on this right. Second, the certificate does not explicitly inform consumers changing jobs that they may not have to fulfill another preexisting condition period under their subsequent employer's health plan. Consequently, consumers who receive certificates may not understand their purpose and may discard them, never realizing their connection to HIPAA's access and portability rights. The experiences of employers and carriers seem to indicate that this is indeed the case: according to employer and carrier estimates, few enrollees have a certificate at the time they apply for coverage either because they discarded the certificate provided by a prior employer or carrier or never received one.

Carriers and employers continue to question the value of certificates for proving creditable coverage. They point out that since most enrollees do not have a certificate, the law requires carriers and employers to otherwise verify prior coverage, as was generally the practice in states with portability laws predating HIPAA. Moreover, carriers and employers assert that since most employer plans no longer include preexisting condition exclusion clauses, most of the certificates issued are not needed. Finally, employers and carriers indicated that the cost and administrative resources needed to issue a certificate to every departing enrollee pose a significant burden. Carriers and employers would prefer to issue certificates on demand—that is, to only those who request them.

Nevertheless, HIPAA currently requires that certificates be issued to all individuals losing health coverage. Individuals who clearly understand their rights under the law are better able to make use of its protections. Regulatory authorities we interviewed agreed that certificates that clearly delineate a consumer's rights, and the restrictions placed on these rights, could serve as an important educational tool and increase the likelihood that consumers in transition have the information they need to take advantage of their HIPAA rights.

HIPAA Established New Federal Regulatory Responsibilities

HIPAA established a complex regulatory framework in which oversight and enforcement of the law are shared among multiple federal agencies and state regulators. While the law essentially expanded Labor's existing oversight responsibilities under ERISA, it created a new regulatory role for HCFA. Thus far, HCFA's enforcement efforts have been limited.

HIPAA Expanded Labor's Oversight Responsibilities Under ERISA

Under ERISA, Labor is responsible for ensuring that employer-sponsored group health plans meet certain fiduciary, reporting, and disclosure requirements related to the provision of health benefits. Labor's approach to identifying noncompliance among ERISA plans has been largely complaint-driven, and investigative and enforcement efforts tend to focus on firms from which patterns of employee complaints are received. HIPAA significantly expanded the complexity of Labor's health plan oversight role: Labor is now also charged with ensuring that employer plans comply with access and portability standards.

While its role in overseeing ERISA plans has expanded, Labor continues to rely on consumer complaints to identify noncompliance. However, recognizing the increased complexity of its role brought about by HIPAA and other federal insurance laws, Labor has attempted to enhance its customer service function and undertake other oversight improvements, as discussed below.

Expanding and Decentralizing Customer Service Staff

Before 1996, Labor's customer service function was centralized in Washington, D.C. The Department has decentralized customer service staff to its field offices in an effort to be more responsive to employers and employees. In addition, Labor has increased the number of staff dedicated to this purpose. In 1998, Labor added about 9 customer service staff-years to its 1997 levels and will add up to 23 additional staff-years during 1999. (App. III describes the resources Labor estimates it has used in the implementation of HIPAA.)

Better Educating Customer Service Staff

The customer service staff position has evolved from an administrative/clerical position to that of a paraprofessional or professional. Labor's eventual goal is to have all customer service positions filled by college-educated professionals.

Improving Tracking of HIPAA Questions/Complaints

The national question/complaint tracking system has been enhanced to better capture information related specifically to HIPAA. Whereas all HIPAA-related questions and complaints were captured under a single category before October 1998, they are now differentiated into separate categories relating to their specific nature.

Including HIPAA Compliance Reviews During Employer Investigations

Labor is developing a series of HIPAA compliance review steps to be added to guidelines it uses in investigating employers. These review steps will be followed regardless of the reason for the investigation.

HIPAA Created a Broad New Regulatory Role for HCFA, but Agency Efforts Have Been Limited

Whereas Labor was able to build upon an existing regulatory role, HIPAA created broad new regulatory responsibilities for HCFA. In states that do not adopt and enforce statutes or regulations that meet or exceed HIPAA standards, HCFA is responsible for directly enforcing them. To do this, HCFA has had to assume responsibilities typically undertaken by state insurance regulators, such as providing guidance to carriers, reviewing carrier policy forms, and monitoring carrier marketing practices. To date, HCFA's regulatory and enforcement activities have been limited primarily to the five states known not to have passed statutes or regulations that fully conform to HIPAA: California, Massachusetts, Michigan, Missouri, and Rhode Island.[17] Further, the extent of HCFA's efforts within four of the five states remains limited, still consisting largely of responding to consumer queries and complaints. Also, HCFA has yet to comprehensively evaluate the extent to which the other 45 states conform to HIPAA.

We reported in July 1998 that the extent of HCFA's efforts in the direct enforcement states varied.[18] For example, in California, Missouri, and Rhode Island, HCFA developed guidance that delineated state and federal regulatory responsibilities; HCFA also held informational meetings with carriers in Missouri and Rhode Island. Further, while HCFA had begun to review carriers' policies sold in Missouri to ensure compliance, it had not initiated any regulatory activities beyond responding to consumer inquiries and complaints in Massachusetts and Michigan. Since that report, the extent of HCFA's enforcement efforts has not dramatically changed; however, HCFA has awarded three external contracts to assist in enforcement tasks, and regional officials have held informational meetings in California.[19] Enforcement efforts in the direct enforcement states remain largely complaint driven except for policy reviews in Missouri where carriers voluntarily submit policies for review.

Further, HCFA has not determined the extent to which the remaining states have passed conforming legislation, and regional officials said they are just beginning to determine how they can identify any gaps in state laws and what their role should ultimately be in states in which gaps are identified. Although evidence suggests that most of these states have standards in place that meet or exceed HIPAA requirements, isolated gaps are likely to remain. For example, several officials noted that many states have not

[17]Michigan passed conforming legislation for its individual market in Mar. 1999.

[18]See GAO/HEHS-98-217R, July 22, 1998.

[19]HCFA devoted $1.7 million of its $2.2 million FY 98 supplemental budget allocation to contracts that assist the agency in its enforcement efforts. The three major contracts address HIPAA enforcement options ($98,200); actuarial support ($615,228); and market conduct ($685,650).

adopted the certificate of creditable coverage issuance requirement or a definition of a small group that is consistent with HIPAA's.

HCFA's Enforcement Efforts Have Been Slowed by Issues Surrounding Its Regulatory Authority

HCFA officials acknowledge that the agency has thus far pursued a minimalist approach to regulating under HIPAA and largely attribute their limited efforts to a lack of enforcement regulations and insufficient staff capacity.[20]

While HIPAA provides for a civil monetary penalty for noncomplying carriers, the statute is largely silent about the standards and processes by which HCFA will carry out its regulatory role in states. According to agency officials, the enforcement regulations will clearly delineate these standards and processes to the regulated community, thereby enhancing HCFA's ability to carry out necessary enforcement actions. Although officials had anticipated publishing the regulations by late 1998, they remain unpublished.

HCFA officials also attribute their limited efforts to insufficient staff capacity. When HIPAA was originally passed, the Congress did not provide any additional resources for HCFA to implement the provisions of the law. Thus, the agency initially reassigned staff from other functions to assist in HIPAA's implementation. HCFA did receive a supplemental appropriation of $2.2 million in May 1998. Although these funds allowed the agency to hire and train 22 additional regional staff, including some who have specialized expertise in health insurance, they were not sufficient to allow the agency to move forward with the "full range of HIPAA enforcement activities," according to the HCFA Administrator. Given the current level of resources, HCFA intends to focus on (1) completing the enforcement regulations and (2) conducting direct enforcement responsibilities in the states that have not passed conforming legislation. According to agency officials, HCFA has not begun to review the insurance laws of the remaining states to determine compliance with HIPAA. (App. IV describes the resources HCFA estimates it has used in the implementation of HIPAA.)

Conclusions

Since our February 1998 report, progress has continued in implementing HIPAA. The law's provisions, which were intended to improve consumers' access to private health insurance, are now applicable to nearly all group and individual private health plans. Consequently, minimum standards of

[20]The Paperwork Reduction Act also constrained HCFA's ability to carry out certain oversight functions.

protection now apply to group (both fully insured and self-funded) and individual insurance coverage sold in all states. As a result of these new federal standards

- many consumers face fewer preexisting condition exclusions,
- enrollees should be able to more easily renew their health plans,
- employees may not be excluded from group health plans on the basis of their health status,
- small employers must have guaranteed access to all coverage sold in the small group market, and
- high-risk individuals losing group coverage may have better access to either individual health insurance or a subsidized high-risk pool.

Nonetheless, some concerns persist. High-risk individuals and some small groups may continue to face high premiums for guaranteed coverage because HIPAA does not constrain carriers' rating practices beyond existing state laws. Partly because of this, relatively few eligible high-risk individuals who lost group coverage appear to have purchased HIPAA-guaranteed individual insurance.

Consumers' lack of awareness or understanding of HIPAA can in some cases impede their ability to exercise the rights afforded by the law. Federal agencies and others are attempting to target education efforts at consumers in employment transition, but such efforts could take years, as was the case with educating consumers about COBRA. One potentially effective education tool is the certificates of creditable coverage that the law requires be issued to every enrollee who loses insurance coverage. The certificates' value as an educational tool, however, is diminished because model guidance on these certificates does not explicitly and comprehensively outline the protections provided by HIPAA.

Finally, both HCFA and Labor have become better equipped over the last year to oversee compliance with HIPAA. Nonetheless, both agencies recognize that further efforts are needed, including targeting consumer education efforts; proactively ensuring employers' compliance; and, for HCFA, ensuring that all states' insurance regulations fully conform with the federal standards. Moreover, HCFA recognizes that its ability to fully perform its new regulatory role will be enhanced when enforcement regulations are issued. Until HCFA issues these regulations, its efforts to guarantee consumers in all states the protections to which they are entitled under HIPAA may be hindered.

Recommendations to the Administrator of the Health Care Financing Administration and the Secretary of Labor

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

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

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

Agency Comments and Our Response

HCFA and the Department of Labor commented on a draft of this report and generally agreed with our findings and recommendations. Both HCFA and Labor highlighted recent initiatives to increase outreach and oversight related to HIPAA. For example, the Director of Labor's Health Care Task Force, Pension and Welfare Benefits Administration, noted that additional outreach efforts have been initiated through partnerships with consumer, labor, and business organizations and that additional materials have been developed to support the agency's consumer service staff and investigators.

For its part, HCFA noted that it has recently hired a new director with expertise in insurance regulation to oversee HIPAA enforcement, submitted the agency's enforcement regulation for review by the Office of Management and Budget, and expanded the agency's review of insurers' policy forms. HCFA also noted that it has begun to review states' conformance with HIPAA's provisions and intends to initiate market conduct exams.

In addition, HCFA commented that our report should have emphasized some of the agency's efforts since February 1998, such as obtaining additional funding and staff resources. We addressed HCFA's fiscal year

1998 supplemental appropriation and the agency's hiring of additional regional staff in our July 1998 report, as well as on pages 23 and 24 of this report.

Both agencies also provided technical comments, which we have incorporated as appropriate. Appendix VI contains the comment letter from HCFA.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Honorable Nancy-Ann Min DeParle, Administrator of the Health Care Financing Administration; the Honorable Alexis M. Herman, Secretary of Labor; and other interested congressional committees and members and agency officials. We will also make copies available to others upon request.

The information presented in this report was developed by Susan Anthony, Randy DiRosa, Mary Freeman, and Betty Kirksey under the direction of John Dicken. Please call me at (202) 512-7114 if you have any questions about the information provided in this report.

Sincerely yours,

William J. Scanlon
Director, Health Financing
and Public Health Issues

Contents

Abbreviations

COBRA	Consolidated Omnibus Budget Reconciliation Act
ERISA	Employee Retirement Income Security Act of 1974
HCFA	Health Care Financing Administration
HIPAA	Health Insurance Portability and Accountability Act of 1966
HMO	health maintenance organization
MHPA	Mental Health Parity Act
NAHU	National Association of Health Underwriters
POS	point-of-service plan
PPO	preferred provider organization
WHCRA	Women's Health and Cancer Rights Act

Scope and Methodology

Site Visits

To address our objectives, we visited five states—California, Florida, Illinois, Montana, and Oklahoma—and interviewed regulators, carriers, agents, and employers. We selected these states on the basis of their geographic dispersion and approach to implementing the group-to-individual portability provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). With officials in these states, we discussed a multitude of issues, including each state's implementation of HIPAA provisions, monitoring and enforcement efforts, educational efforts, and challenges faced in implementing the various provisions of the law.

Agent Survey and Premium Rate Collection

We collaborated with the National Association of Health Underwriters to survey agents in 13 states and the District of Columbia that are using the federal rules (or a similar approach) to guarantee eligible individuals group-to-individual portability under HIPAA. In these states, agents obtained premium rate quotes from selected carriers for a commonly sold product for a specified high-risk individual losing group coverage and for a demographically similar, but healthy, individual. In addition, the survey queried agents about consumers' knowledge of the law and their experiences. We also selected eight states not using the federal rules and surveyed an additional 40 agents to obtain comparable information about consumers' and agents' experiences. For states using a high-risk pool to guarantee access for those losing group coverage, we reviewed published enrollment and premium data and interviewed representatives of each state's risk pool.

Other Interviews

In addition, we interviewed officials at the Health Care Financing Administration (HCFA) and the Department of Labor to discuss monitoring and enforcement issues and educational efforts undertaken to inform consumers about the law. We also interviewed individuals at national organizations, including the National Association of Insurance Commissioners, the Health Insurance Association of America, the BlueCross BlueShield Association, and the Council for Affordable Health Insurance. In addition, we hosted forums, at which over 25 national insurance carriers discussed their experiences with HIPAA and challenges they faced in its implementation. Finally, we interviewed representatives of research organizations, such as Georgetown University's Institute for Health Care Research and Policy, and reviewed available literature.

HIPAA Access, Portability, and Renewability Standards

To achieve its goals of improving access to and portability and renewability of private health insurance, HIPAA set forth standards that variously apply to the individual small group (2 to 50 employees) and large group (more than 50 employees) markets of all states. Most HIPAA standards became effective on July 1, 1997. However, group plans do not become subject to the applicable standards until their first plan year beginning on or after July 1, 1997. HIPAA's health coverage access, portability, nondiscrimination, and renewability standards are summarized in table I.1.

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

	Individual	Small group employer (2 to 50 employees)	Large group employer (over 50 employees)
Certificate of creditable coverage	Yes	Yes	Yes
Guaranteed access/availability	Only for eligible individuals leaving group coverage	Yes	No
Guaranteed renewability	Yes	Yes	Yes
Limitations on preexisting condition exclusion periods	No[a]	Yes	Yes
Nondiscrimination	[b]	Yes	Yes
Portability	No	Yes	Yes
Special enrollment periods	[b]	Yes	Yes

Note: Some of these standards also apply to certain federal, state, and local government insurance programs, such as Medicaid, state employee health plans, multiple-employer welfare arrangements, church plans, and bona fide associations.

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

[b]Applicable to group plans only.

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 had 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.[21] Depending on the option states choose to implement this requirement, coverage may be provided by carriers, through state high-risk insurance pool programs, or in other ways.

Guaranteed Renewability

HIPAA requires that all health plan policies be renewed regardless of the health status or claims experience of plan participants, with limited exceptions. Exceptions include cases of fraud, enrollee failure to pay premiums, enrollee movement out of a plan service area, and the withdrawal of an issuer from the market.[22]

Limitations on Preexisting Condition Exclusion Periods

Group plan issuers generally 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.

[21]An eligible individual is one who has had at least 18 months of creditable coverage with no break of more than 63 consecutive days; has exhausted any Consolidated Omnibus Budget Reconciliation Act or other continuation coverage available under a similar state program; is not eligible for any other group coverage, Medicare, or Medicaid; and did not lose group coverage because of nonpayment of premiums by the individual or fraud.

[22]We reported in GAO/HEHS-98-67, Feb. 25, 1998, that carriers were concerned about the effect of this provision on individuals who become eligible for Medicare. Carriers continue to express these concerns. Before HIPAA, when an enrollee reached the age of Medicare eligibility, issuers typically terminated comprehensive coverage and offered Medicare supplemental coverage instead. HIPAA's requirement to renew the comprehensive coverage may have drawbacks. For example, individuals who retain comprehensive coverage rather than obtain Medicare supplemental coverage may permanently lose their right to enroll in a supplemental policy without preexisting condition exclusions. Carriers told us that although Medicare beneficiaries have generally not retained their comprehensive coverage, carriers have had to create new rate bands for those that have. One carrier said the high rates charged to this over-65 age band discourage renewal. Some carriers send notices to enrollees describing the implications of their choices and advising that they enroll in Medicare supplemental coverage, yet enrollees are often skeptical of carrier advice.

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 contributions to the plan may not vary for similarly situated group plan enrollees 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 the group issuer's 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 has been covered for 6 months and changes employers may be eligible to have the subsequent employer's plan's 12-month waiting period for preexisting conditions reduced by 6 months. Time spent in a prior health plan's waiting period may not count as part of a break in coverage.

Special Enrollment Periods

Individuals who do not enroll for coverage 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 under the Consolidated Omnibus Budget Reconciliation Act (COBRA), or if they were covered as a dependent under a spouse's coverage and later lost that coverage. In addition, if an enrollee has a new dependent because of marriage or the birth or adoption of a child, 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 expansions of COBRA coverage rights, new disclosure requirements for Employee Retirement Income Security Act plans, and new requirements for uniform enrollee and claims information, to be phased in through 1999. Tax law changes authorize federally tax-advantaged medical savings accounts for small employer and self-employed plans.

Other Federal Insurance Standards Passed After HIPAA

For employers with 50 or more employees that provide mental health benefits, the Mental Health Parity Act requires that the annual and lifetime dollar maximums for mental health be the same as dollar maximums for medical/surgical benefits. The law does not establish a separate lifetime dollar maximum for mental health services. If medical/surgical benefits do

not have annual or lifetime dollar maximums, mental health benefits cannot have lifetime maximums. Plans may continue to otherwise set the terms and conditions of mental health coverage, such as by imposing an annual limit on the number of inpatient days, the number of visits, or the percentage of cost-sharing for services. Group plans that can demonstrate that compliance will result in a cost increase of 1 percent or more may be exempt from the law.

Under the Newborns' and Mothers' Health Protection Act, group health plans may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child following a normal vaginal delivery to less than 48 hours, restrict benefits for any hospital stay for a cesarean section to less than 96 hours, or require that a provider obtain authorization from the plan for prescribing any length of stay required. The minimum stays do not apply if the decision to discharge the mother or newborn is made by the mother and her doctor.

The Women's Health and Cancer Rights Act contains protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. Under the act, reconstructive benefits must include coverage for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications at all stages of treatment related to a mastectomy. Benefits under the act may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage.

Department of Labor Resources Used to Implement HIPAA

U.S. Department of Labor

Pension and Welfare Benefits Administration
Washington, D.C. 20210

Randy M. DiRosa
Health, Education, and Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Randy:

This is in response to your request of January 11, 1999, for a summary of resources spent by the Department of Labor's Pension and Welfare Benefits Administration (PWBA) on activities related to implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In order to best respond to your request, we have enclosed charts organized by fiscal year that delineate FTE received as part of the agency's FY1998 and FY 1999 appropriation as well as the dollar amounts spent in FY 1997, FY 1998, and estimated to be spent in FY 1999 on HIPAA-related activities. Although I believe the enclosed charts are self-explanatory, the following clarification with regard to some of the enclosed data may be of assistance to you.

As we have discussed in prior conversations, it is difficult to precisely identify PWBA's HIPAA-related expenditures. This difficulty exists for several reasons. For example, the agency has not hired full-time customer service and enforcement staff devoted exclusively to HIPAA. Instead, all of our staff are trained to deal with both pension and health-related issues. This structure applies to agency staff, whether they are responsible for preparing press releases or other public affairs materials, conducting investigations, or providing technical assistance to employers and participants and beneficiaries.

It is our belief that this structure is the most efficient use of resources for the agency and best serves the needs of our customers. For example, we feel customer service staff must be able to respond to all benefit-related questions without having to refer the caller to yet another staff person. In addition, our investigators are trained to conduct full-scale, on-site investigations of both pension and health plans. Although we have found that this structure best suits the agency's needs, it makes it difficult to extrapolate precise data on HIPAA-related expenditures. This difficulty, as I mentioned previously, is also due to the fact that until recently the agency tracked "health" related inquiries generally without specifically identifying HIPAA-related inquiries.

With regard to the FY 1997 data, we used approximately 66 FTE during this period. However, these resources came from PWBA's operational base since we did not receive any new funding for HIPAA implementation during FY 1997 and statutory deadlines required the dedication of significant agency resources to complete the HIPAA-related regulatory guidance as well as to provide HIPAA-related customer service and outreach activities during this period .

Working for America's Workforce

Finally, it should be noted that PWBA faces a continuing challenge in dealing with the problem of staff attrition since our investigators, pension and health law specialists, and other professional staff develop very marketable skills that are attractive to private sector employers. As a result, we are constantly working to recruit and train new staff. Moreover, our hiring efforts in FY 1999 have been somewhat delayed due to the continuing resolution and the resulting uncertainty surrounding the scope of the agency's budget for FY 1999.

I hope that the enclosed information is helpful to you in your preparation of your report on HIPAA implementation. As always, let me know if you have any additional questions or comments.

Sincerely,

Daniel J. Maguire /1ST

Daniel J. Maguire
Director, PWBA Health Care Task Force

Enclosures

HIPAA-RELATED RESOURCES EXPENDED BY PWBA
FY 1997, FY 1998, FY 1999

FY 1997 (no additional resources received by PWBA)

46.69 FTE/$2,670,778 used in the Field handling health inquiries, conducting health outreach programs and preparing, attending and/or conducting HIPAA-related training for PWBA staff.

19.56 FTE/$1,561,469 used in the National Office for developing HIPAA regulations, providing health-related assistance to participants, plan officials, etc., developing HIPAA training programs for PWBA staff, and conducting HIPAA-related outreach, and public affairs events led by the Secretary of Labor.

Approximately $1,341,000 was spent on non-personnel costs:
$200,000 for research;
$88,000 for participant education and outreach including printing, radio Public Service Announcements, and newspaper columns;
$50,000 for labor and postage associated with requests for HIPAA information made to our toll-free publications hotline;
$1,003,000 for rental payments to GSA, telephone, travel, equipment, supplies, and other administrative costs (for Field and National Office staff).

FY 1998 (50 FTE assigned to the Field for customer service, educational outreach, and enforcement; 7 FTE assigned to the National Office for customer service)

56 FTE/$3,181,830 used in the Field handling health inquiries, conducting health outreach programs and preparing, attending and/or conducting HIPAA-related training for PWBA staff.

17.54 FTE/$1,337,472 used in the National Office for developing HIPAA regulations, providing health-related assistance to participants, plan officials, etc., developing HIPAA training programs for PWBA staff, and conducting outreach and public affairs events related to HIPAA.

Approximately $1,536,000 was spent on non-personnel costs:
$175,000 for research;
$11,400 for participant education and outreach including printing, newspaper columns, and public affairs events;
$59,000 for labor and postage associated with requests for HIPAA information made to our toll-free publications hotline;
$1,290,000 for rental payments to GSA, telephone, travel, equipment, supplies, and other administrative costs (for Field and National Office staff).

FY 1999 (23 FTE assigned to the Field for customer service and educational outreach; in the National Office, 7 FTE distributed for customer service and 20 FTE for HIPAA compliance assistance, guidance, interpretations and coordination activities)

54.1 FTE/$2,804,551 estimated to be used in the Field handling health inquiries, conducting outreach programs and preparing, attending and/or conducting HIPAA-related training for PWBA staff.

28.2 FTE/$1,981,416 estimated in the National Office for developing HIPAA regulations, providing HIPAA assistance to participants, plan officials, etc., developing HIPAA training programs for PWBA staff, and conducting outreach and public affairs events related to HIPAA.

Approximately $1,684,000 is estimated to be spent on non-personnel costs:
$300,000 for research;
$50,000 for participant education and outreach including printing, Public Service Announcements, and public affairs events;
$36,000 for labor and postage associated with requests for HIPAA information made to our toll-free publications hotline;
$1,298,000 for rental payments to GSA, telephone, travel, equipment, supplies, and other administrative costs (for Field and National Office staff).

RESOURCES PROVIDED by CONGRESS

	FY 1997	FY 1998	FY 1999
Field Offices	No additional resources were allocated by Congress for HIPAA-related activities. Resources for HIPAA-related activities were used from PWBA's operational base.	50 FTE were allocated to the Field for customer service, educational outreach, and enforcement.	23 FTE were allocated to the Field for customer service and educational outreach.
National Office	No additional resources were allocated by Congress for HIPAA-related activities. Resources for HIPAA-related activities were used from PWBA's operational base.	7 FTE were allocated to the National Office for customer service.	7 FTE were allocated for customer service and 20 FTE for HIPAA compliance assistance, guidance, interpretations and coordination activities.

FTE RESOURCES USED

	FY 1997	FY 1998	FY 1999
Field Offices	46.7 FTE $2,670,778 were used in the Field handling health inquiries, conducting health outreach programs and preparing, attending and/or conducting HIPAA-related training for PWBA staff. In addition, approximately 51 FTE were devoted to health investigations related to MEWAs, Blue Cross/Blue Shield, etc.	56 FTE/$3,181,830 were used in the Field handling health inquiries, conducting health outreach programs and preparing, attending and/or conducting HIPAA-related training for PWBA staff. In addition, approximately 41 FTE were devoted to health investigations related to MEWAs, Blue Cross/Blue Shield, etc.	We are currently in the process of filling the 23 FTE assigned to the Field for customer service and educational outreach. In addition, in the first quarter of FY 1999 approximately 19 FTE were devoted to health care investigations related to MEWAs, Blue Cross/Blue Shield, etc.
National Office	19.6 FTE $1,561,469 were used in the National Office for developing HIPAA regulations, providing health-related assistance to participants, plan officials, etc., developing HIPAA training programs for PWBA staff, and conducting HIPAA-related outreach and public affairs events led by the Secretary of Labor.	17.5 FTE $1,337,472 were used in the National Office for developing HIPAA regulations, providing health-related assistance to participants, plan officials, etc., developing HIPAA training programs for PWBA staff, and conducting outreach and public affairs events related to HIPAA.	We are currently in the process of filling the 7 FTE distributed for customer service and 20 FTE for HIPAA compliance assistance, guidance, interpretations and coordination activities.

NON-FTE RESOURCES USED

FY 1997	FY 1998	FY 1999
Approximately $1,341,000 was spent on non-personnel costs:	Approximately $1,536,000 was spent on non-personnel costs:	Approximately $1,684,000 is estimated to be spent on non-personnel costs:
♦ $200,000 for research;	♦ $175,000 for research;	♦ $300,000 for research;
♦ $88,000 for participant education and outreach including printing, radio Public Service Announcements, and newspaper columns;	♦ $11,400 for participant education and outreach including printing, newspaper columns, and public affairs events;	♦ $50,000 for participant education and outreach including printing, Public Service Announcements, and public affairs events;
♦ $50,000 for labor and postage associated with requests for HIPAA information made to our toll-free publications hotline;	♦ $59,000 for labor and postage associated with requests for HIPAA information made to our toll-free publications hotline;	♦ $36,000 for labor and postage associated with requests for HIPAA information made to our toll-free publications hotline;
♦ $1,003,000 for rental payments to GSA, telephone, travel, equipment, supplies, and other administrative costs (for Field and National Office staff).	♦ $1,290,000 for rental payments to GSA, telephone, travel, equipment, supplies, and other administrative costs (for Field and National Office staff).	♦ $1,298,000 for rental payments to GSA, telephone, travel, equipment, supplies, and other administrative costs (for Field and National Office staff).

HCFA Resources Used to Implement HIPAA

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

FEB 9 1999

Mr. Randy M. DiRosa
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. DiRosa:

I am responding to your request for information concerning HCFA resources spent on HIPAA-related activities.

Prior to the fiscal year 1998 Supplemental Budget Appropriation provided in May of 1998, the Health Care Financing Administration (HCFA) reassigned staff from other divisions in order to carry out HIPAA responsibilities. At that time, there was no appropriation and the FTE and associated costs were not captured as HIPAA expenditures.

Of the $2.2 million FY98 supplemental funds, $300,000 was devoted to Salary and Benefits; $100,000 was devoted to travel, $100,000 to training and $1.7 million was devoted to contracts to assist us in our enforcement tasks. The three major contracts are the HIPAA Enforcement options contract at $98,200; the actuarial support contract at $615,228; and the market conduct contract at $685,650. We also used $290,047 of the remaining contract funds on three working conferences related to enforcement, individual market issues and training. Additionally, money was allocated for a conference in FY99 relating to the Federal fallback States.

Currently we have 18 FTEs in the HCFA central office exclusively allocated for HIPAA. As indicated in the Administrator's July 21, 1998 letter, HCFA was able to hire and train 22 additional staff in our regional offices where we expect most of the enforcement activity to occur. In some of the regional offices the new staff allocation granted as a result of the FY98 supplemental appropriation replaced the staff that were formerly redirected from other agency activities. Currently there are 22 FTEs in the regional offices who work exclusively on HIPAA activities. Additionally, there are approximately 8 staff in the regional offices who, while they do not work exclusively on HIPAA, expend some part of their time on HIPAA activities.

Approximately 24 FTEs are allocated to direct enforcement, 6 FTEs are allocated to regulation and policy development. Additionally, we estimate that 8 FTEs are allocated

Page 2 - Mr. Randy DiRosa

to consumer education and outreach, including such activities as speeches, responding to and resolving consumer inquiries, as well as responding to both written and oral inquiries from members of Congress and from States, plans and issuers. We estimate 2 FTEs are used in a support capacity.

Finally, you asked about other expenses associated with HIPAA. In FY99, we expect that HIPAA insurance reform related responsibilities will account for approximately $100,000 in travel funds, $339,000 funding for conferences, $1.3 million in contract support, and $925,000 for information technology investments-. In addition, funds for training and supplies are handled as ongoing administrative items.

Please let me know if you have any additional questions.

Sincerely,

Jay Angoff
Director
Insurance Standards

cc: Sally Richardson
Rachel Block

Model Certificate of Creditable Coverage

Note: Model certificates were issued for both group and individual health plan coverage. The language describing the HIPAA protections is essentially the same in both.

Model Certificate

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

* IMPORTANT - This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: _____
2. Name of group health plan: _____
3. Name of participant: _____
4. Identification number of participant: _____
5. Name of any dependents to whom this certificate applies:

6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____
   _____
   _____
7. For further information, call: _____
8. If the individual(s) identified in line 3 and line 5 has at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here ____ and skip lines 9 and 10.
9. Date waiting period or affiliation period (if any) began: _____
10. Date coverage began: _____
11. Date coverage ended: _____(or check if coverage is continuing as of the date of this certificate: _____).

Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

APR 26 '99

FROM: Nancy-Ann Min DeParle
Administrator, HCFA

SUBJECT: General Accounting Office (GAO) Draft Report, "Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards"

TO: William J. Scanlon, Director
Health Financing and Public Health Issues, GAO

We appreciate the opportunity to review your draft report to Congress on the implementation challenges of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its impact on the private insurance market. We agree with the report's major findings and with the conclusion that, while progress has been made since your February 1998 report, further efforts are needed. As explained in more detail in the attached comments, I believe your draft report should have discussed the substantial work that has been done since February 1998, including activities such as:

- Requesting and obtaining some, but not all, of the initial funding necessary to implement HIPAA;
- Hiring an additional 24 staff members for both our regional and central offices to aid in HIPAA enforcement. The additional staff has also been working closely with states to resolve consumer complaints, review state legislation, and monitor carrier marketing practices; and,
- Conducting a nationwide search that resulted in the hiring of a senior official who will direct our HIPAA enforcement activity. This person has extensive experience as a state regulator, most recently as director of insurance for Missouri.

We appreciate the recommendations you have made and will continue to work with the Departments of Labor and Treasury in strengthening our oversight of this important legislation.

GAO's review will continue to be helpful to us as a benchmark as we carry out our responsibilities in the future. HCFA's specific comments on the report's recommendations follow.

Enclosure

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

Overview

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

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

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

When HIPAA was enacted, few expected the Federal government to be required to directly enforce the law. However, three states--Missouri, Rhode Island, and California--have not enacted part or all of HIPAA's protections, and HCFA is therefore directly

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enforcing the law in those states. In addition, HCFA has begun the process that could result in HCFA directly enforcing certain provisions of HIPAA in two other states--Michigan and Massachusetts.

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

- **Developing Regulations.** The HIPAA enforcement regulation should be published in the near future.

- **Initiating Review of Insurers' Practices.** HCFA is preparing its first "market conduct" examination--an examination of an insurer's records to determine the extent to which its marketing practices comply with the law. The report notes that in the states in which HCFA directly enforces HIPAA, HCFA must assume the responsibilities typically undertaken by state insurance departments, including monitoring carrier marketing practices. HCFA will work with insurers who are found out of compliance to ensure that practices are changed. HCFA has the authority to impose civil monetary penalties against those that violate the law and we will use this authority where appropriate.

- **Increasing Review of Insurers' Forms.** HCFA has increased its review of insurers' policies (known in the industry as a policy "form".) The report notes that reviewing carrier policy forms is another responsibility typically undertaken by state insurance regulators that HCFA must now undertake in states in which it directly enforces the law. By reviewing forms, HCFA will strengthen its ability to make sure that insurer's are in compliance with HIPAA. We have been the most active in Missouri, where we are enforcing HIPAA in both the individual and small group market. Since enactment of HIPAA, HCFA has been working particularly closely and cooperatively with the state insurance department. Eighty-six companies (accounting for the overwhelming majority of both the individual and small group markets) have submitted a total of 120 policy forms for our review; 30 have been accepted; 17 have been withdrawn; and 73 are currently pending. In addition, HCFA's San Francisco regional office began reviewing policy forms and related marketing materials in California (where we are enforcing the individual market standards), and our Boston regional office will begin reviewing policy forms in Rhode Island in May. To the extent the report suggests that the "minimalist approach" under which HCFA merely reacts to complaints was inadequate, we agree. HCFA can not carry out direct enforcement in states

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unless it proactively reviews policy forms to determine whether they comply with HIPAA.

- **Strengthening Oversight of State Activities.** HCFA is reviewing the individual and small group market provisions of state laws to determine the extent to which they comply with HIPAA. Although HIPAA required states that intended to enact so-called "acceptable alternative mechanisms" to submit those proposals by April 1, 1997, HIPAA did not require any submissions by states enacting the individual market minimum standard, nor did it require any submissions at all regarding the small or large group markets. Nevertheless, we are analyzing the individual, small group and large group market laws of each state, as well as analyzing each state law to determine the extent to which it complies with the various amendments that have been made to the provisions originally enacted by HIPAA.

- **Creating Needed Tracking Systems.** HCFA has improved the tracking of complaints. In order to collect all appropriate characteristics of complaints and inquiries on a consistent basis among our regional offices, we developed a complaint data form that is now being used by all HCFA offices. Information that was captured on old complaints will be compiled using the new format to the extent possible. The complaint information will be invaluable to insurance regulators (HCFA, state governments, DOL) for identifying problems. HCFA will use this information and will act upon it as appropriate.

- **Developing and Implementing Education Programs.** HCFA has an organized consumer outreach program, and HCFA is targeting our educational efforts to those individuals who are changing jobs. On April 27, 1999, we are hosting a national conference for consumer advocates, representatives of state health insurance programs, state regulators and others. This conference will focus on identifying key information needed by those eligible for HIPAA protections and how to most effectively get that information to them. We are also developing training CD's, web-based materials, public service announcements, videos and audio training tapes, and a comprehensive, consumer-oriented Internet site.

- **Putting the Right Team in Place.** In January we hired a former state insurance commissioner to take charge of our HIPAA enforcement efforts. Because insurance has traditionally been regulated by the states, his expertise and experience will be invaluable to HCFA. In addition, as a result of the 1998 supplemental appropriation, we were able to hire an additional 24 FTEs (The

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report refers to 22 FTEs which was the allocation for regional staff. We also hired two FTEs in central office for a total of 24 FTEs). HCFA made a significant effort to hire people with insurance industry experience and to place the increased staffing in the regions where we had direct enforcement responsibilities. The additional staff have been working with the states in tracking and resolving consumer complaints, analyzing state legislation, preparing and initiating market conduct reviews and, in three regions, reviewing policy forms.

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

GAO Recommendation

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

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

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HCFA Comment

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

GAO Recommendation

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

HCFA Comment

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

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Related GAO Products

Private Health Insurance: HCFA Cautious in Enforcing Federal HIPAA Standards in States Lacking Conforming Laws (GAO/HEHS-98-217R, July 22, 1998).

Implementation of HIPAA: State-Designed Mechanisms for Group-to-Individual Portability (GAO/HEHS-98-161R, May 20, 1998).

Health Insurance Standards: Implications of New Federal Law for Consumers, Insurers, Regulators (GAO/T-HEHS-98-114, Mar. 19, 1998).

Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators (GAO/HEHS-98-67, Feb. 25, 1998).

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

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

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

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