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September 2, 1997

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

Subject: The Health Insurance Portability and Accountability Act of 1996: Early Implementation Concerns

Dear Mr. Chairman:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides for, among other things, improved portability and continuity of health insurance coverage in private insurance markets and among employer-sponsored group health plans. At your request, we have been monitoring implementation of these health coverage-related provisions to identify any emerging problems. Many provisions of the act are already in force, while others will soon become effective. Carriers, employers, and state and federal regulators continue to develop approaches and mechanisms to implement the act.

Your Committee is considering holding a hearing on HIPAA implementation in the fall to determine whether any emerging issues warrant considering changes to the regulations or legislation. The Committee also wants to know the extent to which market participants may be generating unintended consequences in response to the act. For this reason, you asked for preliminary information on emerging HIPAA implementation issues to frame such a discussion among market participants.

The issues we identified reflect potential problems perceived by market participants during the early stages of our field work performed between May and July 1997. We did not try to validate specific issues raised or determine the extent to which these problems actually exist. Discussions with federal agencies, state regulators, carriers, trade associations, and other affected parties identified the following issues as the most prominent or those with unintended consequences. (See the enclosure for more detail on each of these issues.)

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Some issues primarily affect consumers:

- Health plan marketing practices and segregated risk pools may negatively affect access and premiums for people eligible for group to individual portability under HIPAA (HIPAA eligibles).

- Guarantee renewal requirements for some individuals may have negative consequences for consumers and carriers/health plans.

- Some consumers may make poor choices on the basis of misconceptions about HIPAA.

Other issues primarily affect carriers/health plans:

- Required certificates of creditable coverage may generate an administrative burden and may be unnecessary in most cases.

- Full credit for high deductible and less comprehensive plans may result in adverse selection.

Still other issues primarily affect federal or state regulators:

- Questions remain about the ultimate regulatory roles of federal and state agencies.

- Although all state alternative mechanism plans have been submitted and found acceptable, concerns about funding and access remain.

As implementation continues to unfold, we expect to identify more issues, and some current issues may cease to be of concern. At the Committee's initial implementation hearings last February, much discussion involved the timing of specific provisions and concerns about whether the Health Care Financing Administration, Department of Labor, and the Treasury Department would be able to issue the initial regulations in a timely fashion. They ultimately did so. Now the focus has shifted to clarifying and interpreting specific requirements in the regulations. In the near future, different issues may emerge as state legislatures continue to modify state laws to comply with HIPAA and as insurers and consumers more fully confront the effects of the act on health insurance markets.

We will restrict distribution of this correspondence for 30 days unless you request that we release it sooner. After that time, copies will be made available on request.

This information was developed under the guidance of Michael Gutowski, Assistant Director. Other major contributors include Randy DiRosa and Betty Kirksey. Please call me on (202) 512-4561 or Mr. Gutowski on (202) 512-7128 if you have any questions or comments on this letter or its enclosure.

Sincerely yours,

William J. Scanlon

William J. Scanlon
Director, Health Financing and
System Issues

Enclosure

EARLY IMPLEMENTATION ISSUES

Although HIPAA implementation is still in its early stages, several issues have raised concern. Some issues involve consumers' making important insurance decisions on the basis of misconceptions about the access protections available under HIPAA. Other issues relate to carriers' or health plans' responses based on differing interpretations of state or federal regulations. Still other implementation issues relate to possible unintended consequences of the federal HIPAA regulations as written. On the basis of our preliminary work, we identified the following frequently cited early implementation issues as they relate to consumers, carriers/health plans, and regulators.

ISSUES THAT PRIMARILY AFFECT CONSUMERS

Carrier Marketing Practices and Segregated Risk Pools May Negatively Affect Access to and Cost of Coverage

Early evidence suggests that some HIPAA eligibles transitioning from group to individual coverage may have difficulty getting access to products with portability rights. Others may pay substantially more than the standard rate for portability products. Moreover, certain carrier pricing strategies could result in even higher premiums for portability products in the future. The higher cost may be the result of carriers' attempts to segregate HIPAA eligibles from other market enrollees and prevent cross-subsidization of premium rates.

Some Carriers' Marketing Practices May Hinder Access to Portability Products

Some carriers' practices may discourage HIPAA eligibles from enrolling in portability products. In states we visited, consumers have complained to insurance regulators that they were not told about carriers' portability products or were told carriers did not have such a product. In addition, some carriers have refused to pay commissions to insurance agents who have referred HIPAA eligibles to certain plans. Because consumers often use insurance agents to access the individual insurance market, an economic incentive to steer individuals away from portability products could have a significant impact. At least one state intends to challenge this practice under state fair marketing practice laws. Finally, carriers have also designed benefit literature that may discourage individuals from applying for the portability product. For example, one large national carrier provides consumers a one-page summary of its

HIPAA portability product that prominently features its benefit limitations and higher cost.

Higher Premiums Emerging for Portability Products

Premiums for some portability products may be substantially higher than for standard products. Of the five different carriers whose rates we reviewed, only one charged the standard rate to HIPAA eligibles. The remainder charged or anticipated charging 29, 40, 85, and 125 percent above the standard rate. To establish these rates, some carriers assumed that the claims experience of HIPAA eligibles would be similar to that of individuals enrolled in Comprehensive Omnibus Budget Reconciliation Act (COBRA) and other conversion products. One carrier based its portability product premiums on the claims experience of state high-risk insurance pools. In addition, these are standard rates that apply to generally healthy individuals. Except in the minority of states that do not permit carriers to medically underwrite in the individual market, carriers may charge higher premiums to individuals because they are unhealthy.

In addition to the initially higher rates, the way many carriers will determine future premium rates for portability products may lead to more rate increases. Some prominent individual market carriers place HIPAA eligibles into separate rating pools, where the expected higher claims costs could result in higher premiums. Moreover, some carriers permit HIPAA eligibles to apply for both the portability product and a lower cost standard product. If individuals are healthy enough to pass medical underwriting, they become eligible for and are thus likely to enroll in the standard product. If unhealthy, they are enrolled in the portability product. As one carrier official told us, this practice could result in an increasing spiral of poorer risks and higher premiums for the portability products.

Carrier officials told us that segregating HIPAA eligibles and charging higher premiums is necessary to prevent the remainder of the individual market from subsidizing HIPAA eligibles, resulting in premium increases. Regarding permitting healthy HIPAA eligibles to enroll in standard products, a carrier official suggested that denying them the opportunity to enroll in a less expensive product would be unfair. HIPAA never intended to address insurance costs, thus carriers must rate portability products fairly for all enrollees.

Insurance regulators point out that federal HIPAA regulations do not explicitly prohibit these rating practices in all instances. If a carrier chooses to offer HIPAA eligibles all of its individual market products or its two most popular products under the federal fallback approach, regulations do not explicitly require a risk-spreading mechanism to subsidize the rates. Under the third federal fallback option, carriers may create new portability products but must include a risk-spreading mechanism or financial subsidization. Regulators suggest, however, that the lack of specificity on what constitutes an acceptable risk-spreading mechanism will hamper state efforts to enforce this requirement.

Guarantee Renewal Requirements May Have Negative Consequences for Consumers and Carriers/Health Plans

HIPAA regulations explicitly state the circumstances under which an individual's health coverage may not be renewed or canceled. The permissible circumstances include nonpayment of premiums and fraud. The omission of certain other permissible circumstances, however, may have negative consequences for consumers and carriers in the individual market. Three such circumstances include individuals attaining Medicare eligibility age, failing to meet age or income thresholds of certain targeted population insurance products, or physically or verbally abusing health care providers.

Renewing Comprehensive Coverage for Medicare Eligibles May Have Negative Consequences

Carriers generally cancel individuals' comprehensive coverage when they become eligible for Medicare. Requiring carriers to renew this coverage may have negative implications, according to state insurance regulators and carrier representatives. First, individuals risk losing their 6-month open enrollment window for Medicare supplemental coverage. When individuals choose to retain comprehensive coverage and therefore do not enroll in a Medicare supplemental product, they risk permanently losing the opportunity to obtain guaranteed access to Medicare supplemental coverage with no pre-existing condition exclusions. This could have significant economic consequences for consumers because the comprehensive coverage may be more expensive than the Medicare supplemental coverage. Because of the consequences, several state insurance regulators require carriers to notify enrollees of the implications of their choices.

Second, carrier officials told us they will need to change all current and future individual market products to reflect the option of renewal at age 65. Contracts will need to provide for coordinating benefits with Medicare and will need to be repriced accordingly. In many states, this will require carriers to file these changes and new products with the state insurance department. Some states do not permit coordinating benefits. In these states, individuals may pay for expensive coverage that duplicates their Medicare benefits. Finally, according to the National Association of Insurance Commissioners (NAIC), renewing comprehensive coverage for those 65 and older could adversely affect the individual insurance market. Premiums for all individuals could increase as older and presumably less healthy individuals remain in that market.

Insurance Programs for Targeted Populations May Be Negatively Affected

HIPAA's guarantee renewal requirement may also preclude carriers from canceling coverage under targeted population insurance programs for individuals who exceed eligibility guidelines, according to carrier representatives. For example, under certain subsidized public and private insurance programs for low-income individuals, carriers might be precluded from canceling coverage once an enrollee's income exceeds the eligibility threshold. Consequently, programs' limited slots could be filled by otherwise ineligible individuals. Also, under children-only insurance products, carriers could be forced to renew coverage for those who have reached adulthood.

Questions Surround Whether Abusive Enrollees May Be Terminated

Finally, a state insurance regulator told us that some carriers, particularly health maintenance organizations (HMO), are concerned that the guaranteed renewal requirement does not appear to permit the nonrenewal or cancellation of coverage for those who physically or verbally abuse health care providers. One HMO official told us that such occurrences are common and that carriers typically respond by terminating coverage. Doing so now may violate HIPAA.

Some Consumers May Base Important Decisions on Misconceptions About HIPAA

Many consumers may believe HIPAA provides broader access and protections than it actually does. Many consumers have complained to state insurance regulators as a result of misunderstanding their rights under HIPAA. For example, some consumers believe they have guaranteed access to coverage in

the individual insurance market. This causes concern when an individual waits until medical care is necessary before applying for coverage only to find coverage unavailable, according to one regulator. In addition, the regulator told us, individuals coming from group coverage have waited beyond 63 days to apply for individual coverage and thus have lost their portability rights. Other consumers fail to understand that HIPAA requirements do not apply to group plans until the start of the next plan year. Therefore, an individual changing jobs and expecting portability may not get it, depending on when the new employer's plan year begins. Some regulators contend that the press has poorly served the public by not accurately reporting on consumer protections under HIPAA. Another regulator said much consumer education remains to be done.

ISSUES THAT PRIMARILY AFFECT CARRIERS/HEALTH PLANS

Issuance of Creditable Coverage Certificates May Be an Administrative Burden and Not Needed in Many Instances

The cost and administrative burden of issuing written certificates of creditable coverage for all enrollees terminating coverage was one of the first HIPAA implementation issues to raise concerns. Although early indications suggest that carriers are generally complying with the requirement, concerns remain. Moreover, carrier representatives and insurance regulators continue to suggest that consumers will ultimately not need most certificates.

Needed Certificate Data Difficult to Obtain and Certificates Costly to Issue

Some information needed to issue certificates is proving difficult for carriers to obtain. Carriers frequently cite that obtaining data on each enrollee's dependents is troublesome. Carriers and plan sponsors are not always informed of changes in dependent status within families. Carriers contend that keeping records updated could be time consuming and expensive. Although HIPAA provides carriers a transition period until July 1998 to achieve full compliance, some carriers still have concerns about their ability to meet the deadline.

Some carriers have also had difficulty getting information on the time period between employee hire dates and the dates on which they become eligible to enroll in the health plan. Carriers have not typically gotten these waiting period data from employers in the past and are now finding some employers reluctant

or unable to provide it. In some instances, the waiting period may vary among employees and be considered part of the employee benefits packages. As such, employers may consider it confidential and prefer not to routinely share it. In other cases, it may be difficult to determine an employee's waiting period. For example, quantifying the waiting period imposed on an individual who frequently enrolls and disenrolls in a health plan coinciding with his or her changing part-time/full-time status would be difficult. Because of these problems, some carriers include a blanket statement on their certificates indicating that waiting period information may be incomplete.

In addition, carriers have concerns about their ability to issue a certificate for employees who have exhausted their COBRA coverage. Carriers must generally rely on employers for this information and are concerned it may prove difficult or impossible to issue certificates on a timely basis when employers do not provide the information in a timely manner.

Finally, carriers suggest that the certificates are costly to issue and mail to enrollees. About 1-1/2 months into the certificate issuance requirement, one large carrier had issued about 59,000 notices and 6,000 certificates costing about $48,000. Another large carrier was solicited by a benefits consulting firm to handle the certification process. The firm proposed charging the carrier $7 for each of the approximately 140,000 retroactive certificates to be issued and thereafter 19 cents per enrollee per month for ongoing certification administration. Although the carrier had the capability to administer the certification process internally, some smaller carriers and employers may not and could face similar costs.

Questions Persist About Certificate Issuance During Plan Open Enrollment Periods

Some state insurance regulators, carriers, and health plan administrators continue to question the applicability of the certificate issuance requirement when enrollees switch health plans during an open enrollment period. For example, representatives of one state employee benefits plan said they face an upcoming open enrollment period and are still uncertain about whether certificates must be issued. They said that much confusion would be created if a certificate must be issued to each enrollee who switches plans. Insurance regulators in that state expressed similar concerns. During an educational seminar for employers sponsored by the Department of Labor, questions about certificate issuance during open enrollment periods were common.

These questions persist even though federal regulations do not explicitly require certificates to be issued in these instances. The regulations require instead that issuers provide enough information to the new issuer or the plan administrator to ensure that any subsequent certificate accurately reflects the prior coverage. Officials from one large carrier, however, pointed out that they usually have no way of knowing if individuals are switching to another plan or are disenrolling altogether. They only receive notification that the individual has dropped coverage and they must therefore issue a certificate. Officials noted that these certificates are not needed, raise questions and concerns for enrollees, and cost money to issue and send.

Certificate Issuance Requirement May Create Additional Administrative Burden for State Medicaid Agencies

State and NAIC officials suggest that because of characteristics of state Medicaid programs and the Medicaid population, certificate issuance will pose an additional administrative burden for state Medicaid agencies. Some Medicaid recipients tend to enroll and disenroll in the program as income and employment status changes. Issuing certificates in each instance will increase the volume of certificates issued. Also, according to NAIC, Medicaid agencies have a difficult time maintaining accurate addresses for enrollees and would expect a large volume of certificates to be returned as undeliverable.

Certificates May Be Rarely Needed by Consumers

Carrier representatives have long contended that certificates would not be necessary to prove creditable coverage in most cases. NAIC and carrier representatives point out that small group portability reforms in place in most states have succeeded without certification requirements. Where proof of prior coverage has been needed, carriers have simply called the prior carrier or requested the enrollee to furnish documentation. In addition, many carriers do not include pre-existing condition clauses in group market products and therefore will not need certificates from incoming enrollees. Officials from one large carrier we visited told us they have dropped the clauses for most products because of the difficulty of administering them under HIPAA.

To quantify the extent to which consumers might actually need the certificates to obtain coverage, three carriers cited the low number of certificates early disenrollees have requested. On the June 1, 1997, effective date for certificate issuance, HIPAA required carriers and plan administrators to provide either actual certificates or notices of certificate eligibility for all disenrollees

retroactive to October 1, 1996. Three carriers we visited sent notices instead of certificates. The notices generally informed disenrollees that they were entitled to and could obtain a certificate upon request. These carriers had very low request rates estimated at 13, 2, and 3 percent. One official said that had disenrollees actually needed the certificates to prove creditable coverage, the carrier would have had many more requests. Another carrier official suggested that many certificates that consumers requested were probably not needed but requested out of ignorance or caution. The Blue Cross Blue Shield Association, in its comments on HIPAA regulations, estimates that up to 90 percent of individuals losing coverage will not need certificates issued to prove creditable coverage.

Full Credit for High Deductible and Less Comprehensive Plans May Create Opportunities for Adverse Selection

HIPAA regulations require that a health plan give full credit for a broad range of prior coverage regardless of the deductible level of that coverage. Carriers and insurance regulators are concerned that this provides an opportunity for gaming. That is, an individual could maintain a high deductible plan while healthy and then switch to comprehensive, low deductible coverage when medical needs arise. Likewise, a small employer could switch the entire group plan from a high to a low deductible plan once an employee becomes ill. An individual could likewise switch from a plan with minimal benefits to one with more comprehensive coverage once additional coverage would be necessary. The resulting adverse selection against low deductible, comprehensive plans could result in higher rates for those plans. Moreover, carriers could limit the benefits available under low deductible plans to lessen adverse selection.

ISSUES THAT PRIMARILY AFFECT FEDERAL AND STATE REGULATORS

Allocation of Enforcement Authority Among Federal and State Agencies Not Yet Resolved

The oversight and enforcement roles of federal and state agencies have not yet been fully determined. First, state compliance with HIPAA may not be fully determined until 1998 or beyond. Although HIPAA has required states to report to HCFA on alternative mechanism plans, states are not otherwise required to report on compliance activities or status. To determine whether all states have enacted laws or regulations that comply with HIPAA, HCFA will have to review publicly available data sources and may, according to HCFA officials, have to

visit each state individually. HCFA officials said that this review could take at least 1 year.

If HCFA determines that certain HIPAA provisions have not been incorporated into state legislation or regulations or that states are not substantially enforcing these provisions, HCFA will have to enforce the provisions. Early evidence suggests that some states will not address all HIPAA requirements or will not do so in a timely manner. One of three states we visited was not likely to include all provisions of HIPAA in its statutes before 1998. A regulator there indicated that in the interim, HCFA may have to enforce those provisions. In addition, HCFA officials have heard anecdotal reports about several other states possibly not including certain HIPAA provisions in their statutes.

Finally, HCFA is expected to be the primary enforcement authority for all HIPAA provisions in at least two states and two U.S. territories. On the basis of its review of state laws, HCFA could determine that it will have the primary enforcement authority in additional states.

State Alternative Mechanism Plans Found Acceptable, but Some Concerns Remain

Thirty-nine states and the District of Columbia have notified HCFA of their intention to implement alternative mechanisms to implement HIPAA's group to individual portability requirements. These mechanisms generally must be effective as of January 1, 1998. After a preliminary review, HCFA found all states' plans acceptable but recognizes that ultimately determining compliance and effectiveness will not take place before 1998 or beyond. Meanwhile, some concern has emerged about the possible effect on those not eligible under HIPAA.

Twenty-two of the thirty-nine state alternative mechanisms will use a high-risk pool to provide group to individual portability. Past experience with state high-risk pool programs suggests that funding limitations can result in capped enrollment or waiting lists. Because federal regulations will require that HIPAA eligibles not have to wait for coverage, concerns exist that access to high-risk pools for those not eligible under HIPAA could be further reduced. HCFA officials note that should this occur, HCFA could not disapprove the alternative mechanisms. Only if a state wait listed HIPAA eligibles or otherwise declined coverage could HCFA require a state to change its alternative mechanism.

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