

GAO

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

March 2000

IMPLEMENTATION OF HIPAA

Progress Slow in Enforcing Federal Standards in Nonconforming States



G A O

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

Health, Education, and
Human Services Division

B-284986

March 31, 2000

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

Dear Mr. Chairman:

About 160 million Americans younger than 65 rely on the private employer-sponsored or individual health insurance markets for health coverage. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established minimum federal standards regarding access to and the portability and renewability of private health insurance, including provisions that assist individuals who change or lose their jobs in maintaining health coverage. These standards apply to nearly all health coverage available in all states. Subsequently, the Congress enacted additional minimum standards that, within certain limits, require dollar limits for mental health services to be no more restrictive than those for medical and surgical services, establish minimums for the length of allowed postnatal hospital stays, and provide for coverage for reconstructive surgery following mastectomies. The Congress continues to consider and debate additional private health insurance standards as part of patient protection legislation.

Recognizing that states have traditionally regulated health insurance carriers while the federal government has authority for employer-sponsored benefit plans, HIPAA divided oversight and enforcement authority among state insurance regulators and three federal agencies—the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury. State insurance regulators assume primary regulatory authority over carriers (including traditional insurers and managed care organizations) in states that have laws comparable to or more comprehensive than the federal health insurance standards or that otherwise enforce the federal standards. In states that fail to enact or enforce standards for carriers that conform to the federal law, HHS—through the Health Care Financing Administration (HCFA)—is required to enforce the standards. HHS is also responsible for enforcing

these federal standards for state and local government plans, which HIPAA refers to as nonfederal government plans. However, these government plans that are self-funded are statutorily allowed to elect an exemption from most of the federal standards. HIPAA expanded Labor's oversight responsibilities for employer-sponsored health coverage and provided Treasury with authority to impose an excise tax on noncompliant group health plans.¹

We have previously reported that HCFA has taken a cautious approach by assuming a minimal role in enforcing HIPAA in states that do not conform to all provisions of the federal law, in part because regulating private health insurance plans was a new and initially unanticipated responsibility.² HCFA previously attributed its limited enforcement activities to several factors, such as uncertainty surrounding its regulatory authority and insufficient staff resources. To obtain information for considering how best to enforce any future federal health insurance standards, you asked us to assess the current status of HCFA's enforcement of HIPAA. Specifically, we examined (1) HCFA's progress in enforcing HIPAA and related laws in states lacking conforming statutes, (2) HCFA's role in enforcing HIPAA for state and local government health plans, and (3) the status of pending federal regulations regarding HIPAA's nondiscrimination provisions that restrict health plans from excluding employees, or varying benefits, premiums, or employer contributions, on the basis of health status. To address these objectives, we interviewed headquarters and regional representatives of HCFA, officials from Labor and Treasury, and insurance regulators in several states. We conducted our work in March 2000 in accordance with generally accepted government auditing standards.

Results in Brief

HCFA has overcome some barriers it had previously identified as contributing to its minimalist approach to enforcing HIPAA and the related laws, including clarifying its regulatory authority and having sufficient staff

¹The federal government is solely responsible for enforcing HIPAA for self-insured private employer group plans, which represent about 40 percent of all group coverage and are exempt from state insurance laws under the Employee Retirement Income Security Act of 1974.

²See *Private Health Insurance: HCFA Cautious in Enforcing Federal HIPAA Standards in States Lacking Conforming Laws* (GAO/HEHS-98-217R, July 22, 1998) and *Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards* (GAO/HEHS-99-100, May 12, 1999).

resources for HIPAA oversight and enforcement. However, nearly 4 years after HIPAA's enactment, HCFA continues to be in the early stages of fully identifying where federal enforcement will be required. To varying degrees, HCFA has assumed regulatory activities, such as reviewing carrier policies and marketing practices, in the three states that had voluntarily notified HCFA of their failure to enforce HIPAA. Beyond these activities, HCFA has identified more than 20 states where it questions whether they have conforming laws, but it is still in the process of determining whether these states are enforcing the standards through other regulatory means or whether other states' laws are fully in conformance with the federal standards. Agency officials did not provide explicit time periods for completing these reviews, and until they are complete, HCFA is largely reacting to consumers' complaints as a means of fulfilling its statutory mandate.

Although nearly 600 self-funded state and local government plans have opted out of at least one of the federal standards, HCFA has yet to fully determine its enforcement responsibilities among the remaining nonfederal government plans and is instead relying on complaints from enrollees to identify compliance problems. Finally, the final regulations regarding HIPAA's nondiscrimination provisions remain pending and are currently under review by HCFA, Labor, and Treasury. Anticipated issuance is sometime in the summer of 2000. This report makes recommendations aimed at improving HCFA's enforcement efforts.

Background

HIPAA includes minimum standards that seek to improve the access, portability, and renewability of health insurance coverage in employer-sponsored group and individual insurance markets. Among other standards, HIPAA

- requires carriers to offer coverage to all small employers (defined as those with 2 to 50 employees) that apply (guaranteed issue),
- restricts excluding an employee from health plans, or varying benefits, premiums, or employer contributions, on the basis of health status (nondiscrimination),

- requires carriers to offer individual market coverage to eligible individuals losing group coverage (group-to-individual portability),³ and
- requires all health coverage to be renewable upon expiration of the policy (guaranteed renewal).

The Congress also enacted a number of additional federal standards—the Mental Health Parity Act of 1996, the Newborns’ and Mothers’ Health Protection Act of 1996, and the Women’s Health and Cancer Rights Act of 1998—that address private insurance coverage of mental health, maternity and newborn, and post-mastectomy reconstructive surgical benefits.⁴ In general, these standards require that

- plans cannot impose annual and lifetime dollar limits that are more restrictive for mental health benefits than for medical and surgical benefits,⁵
- plans cannot restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section, and
- plans that provide mastectomy coverage must also provide coverage for reconstructive surgery.

³An eligible individual has had at least 18 months of creditable coverage with no break of more than 63 consecutive days; has exhausted any federal or state mandated continuation coverage; 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.

⁴The Mental Health Parity Act applies only to groups with more than 50 employees while the Newborns’ and Mothers’ Health Protection Act and Women’s Health and Cancer Rights Act apply to the individual and all group markets.

⁵In a forthcoming report, we will examine the implementation of the Mental Health Parity Act, including how employers have changed other mental health benefit design features in response to the required parity in dollar limits.

The responsibility for ensuring that consumers receive these protections is shared by multiple federal agencies and the states. HIPAA expanded Labor's oversight responsibilities for employer-sponsored health coverage and provided Treasury with authority to impose an excise tax on noncompliant employer-sponsored health plans. In states that have standards that conform to or exceed these federal standards or that otherwise enforce the federal standards, state insurance regulators have primary enforcement authority for insurance carriers. HCFA is responsible for directly enforcing HIPAA and related standards for carriers in states that do not. In this role, HCFA must assume many of the responsibilities undertaken by state insurance regulators, such as responding to consumers' inquiries and complaints, reviewing carriers' policy forms and practices, and imposing civil penalties on noncomplying carriers.⁶ HIPAA provides for the imposition of a civil monetary penalty of up to \$100 per day per violation for each individual affected by a carrier's failure to comply.

We previously reported that HCFA was cautious in enforcing the federal standards and had undertaken limited enforcement action in the three states—California, Missouri, and Rhode Island—known to have not adopted statutes or regulations that fully meet the HIPAA standards. HCFA's enforcement activities ranged from responding to consumers' inquiries and complaints in all three states to initiating the review of carriers' policies in Missouri to ensure compliance. In our July 1998 report, we found that HCFA had not undertaken any comprehensive efforts to review the insurance laws of the remaining states to determine compliance with HIPAA or the related laws. The agency attributed its limited regulatory efforts to uncertainty surrounding the manner in which it could exercise its enforcement authority and insufficient staff resources—particularly those with experience regulating private health insurance.

⁶A health insurance policy is the legal document or contract issued by an issuer to a group plan sponsor or an individual that contains the conditions and terms of the insurance.

HCFA Is Proceeding Slowly in Using Its Enforcement Authority in States That Do Not Conform to HIPAA and Related Laws

HCFA has addressed some factors it previously identified as contributing to its limited enforcement efforts, such as clarifying its regulatory authority and having sufficient staff resources dedicated to HIPAA oversight and enforcement. However, HCFA has assumed direct regulatory functions, such as policy reviews, in only the three states that voluntarily notified HCFA of their failure to pass HIPAA-conforming legislation more than 2 years ago. HCFA continues to be in the early stages of identifying the full scope of its enforcement responsibilities in other states. For example, although HCFA has reasonable questions about whether conforming laws exist in more than 20 states for one or more of the federal standards, it is still in the process of determining whether these states are enforcing the laws through other regulatory means and whether other states' laws are fully in conformance with the federal laws.

HCFA Has Addressed Some Earlier Barriers to Its Enforcement

Previously, HCFA officials attributed their limited efforts primarily to uncertainty surrounding their enforcement authority and insufficient staff capacity. Uncertainty surrounding HCFA's regulatory authority was largely removed with the agency's publication of enforcement regulations in August 1999. These regulations authorize HCFA to undertake more proactive enforcement activities in states. The regulations also clarified the applicability of the Paperwork Reduction Act of 1995 on the agency's enforcement efforts. Previously, some HCFA officials raised concerns that the act would require the agency to obtain approval from the Office of Management and Budget (OMB) before requiring carriers to submit policies for review. According to agency officials, the regulations clarify that HCFA's efforts to collect information and documents from carriers in the event of a complaint or any number of other triggering events are not subject to the Paperwork Reduction Act.⁷

⁷The Paperwork Reduction Act established standards for how most federal agencies may collect, maintain, and use collected information and sets governmentwide goals for reducing paperwork. It requires federal agencies to evaluate the need for information as well as identify any burdens that responding to agency requests may impose on respondents. It also sets a process for approving any collection of information, defined as collections from ten or more persons. With regard to implementing the federal insurance standards, HCFA would need to obtain approval from OMB before requiring carriers to submit policies for review. Although the act could still apply to the agency's monitoring efforts (for example, proactive policy reviews), it does not restrict HCFA's enforcement efforts in response to consumers' complaints and a number of other activities.

In addition, HCFA officials now believe that the agency has sufficient staff to handle their HIPAA enforcement responsibilities, even though the number of full-time-equivalent (FTE) staff dedicated to HIPAA activities has declined from 39 in July 1998 to about 31.5.⁸ Previously, the agency was concerned that it would not have the resources to move ahead with the full range of enforcement activities. The Congress did not initially provide additional resources for HCFA to implement the provisions of the law. Thus, HCFA originally reassigned a relatively small number of staff to address direct enforcement issues. When the scope of its enforcement activities became clearer, HCFA received a supplemental appropriation of \$2.2 million in May 1998 that allowed it to hire and train additional staff. Although its satisfaction with current staffing levels is attributable to more certainty about the extent of its involvement and a better understanding of its insurance regulatory functions, it is still in the process of determining state conformance with all the federal standards, and it is possible that the agency's staffing needs could change. Further, the number of inquiries and complaints that HCFA receives from nondirect enforcement states has decreased, resulting in a need for fewer staff resources for this duty.

Table 1: HCFA FTE HIPAA Enforcement Staff, July 1998 and March 2000

HCFA office location ^a	July 1998	March 2000
Central office	17	18
Boston	3	3
Chicago ^b	5	1
Kansas City	6	3.5
San Francisco	8	6
Total	39	31.5

Note: Actual rather than authorized FTEs. FTEs in our July 1998 report include the additional hiring resulting from the May 1998 supplemental appropriations HCFA received for HIPAA enforcement.

^aRegional offices specifically allocated FTEs for HIPAA enforcement. Regional offices not listed have persons available to work on HIPAA functions, if required, but represent less than 1 FTE.

^bThe anticipated need for HCFA staff dedicated to HIPAA enforcement was reduced after Michigan enacted an acceptable alternative mechanism in 1999, according to an agency official.

Source: HCFA.

⁸HCFA officials emphasized that they feel they have sufficient staff, provided funding for the agency's external contracts with private firms to perform market conduct examinations and actuarial analyses continues.

HCFA Has Assumed a Limited Insurance Regulatory Role in Three States

Although HCFA has made progress in its enforcement efforts since our previous reports, when its enforcement consisted largely of responding to consumers' inquiries and complaints, progress remains slow and varies among the three HCFA regions that have direct enforcement responsibilities. HCFA has assumed enforcement responsibilities for certain HIPAA provisions in California, Missouri, and Rhode Island—the three states that voluntarily notified the agency of their nonconforming status more than 2 years ago.⁹ The extent of the agency's enforcement responsibilities in these states varies, however, depending on whether a state had laws that conformed to at least some of the standards HIPAA mandated. For example, with the exception of group-to-individual portability, California law conforms to or exceeds virtually all HIPAA's provisions. In contrast, HCFA's involvement is greater in Missouri and Rhode Island, which lack conforming legislation for a number of HIPAA provisions in both the individual and small group markets.

HCFA continues to receive inquiries and complaints from the public, although the overall number has decreased. In April 1999, HCFA developed a tracking system to collect consistent data from across all regions. Through this tracking system, the agency plans to capture information such as the source of and reasons for inquiries and complaints and their disposition. The documented number of inquiries and complaints, however, has decreased considerably. From April 1999 through February 2000, the agency documented a total of about 1,000 inquiries and complaints about HIPAA or one of the related laws—a significant decrease from the combined 1,700 inquiries and complaints the San Francisco regional office alone received in the first 4 months of 1998.¹⁰ Of the more recent total, 97 were classified as complaints, two-thirds of which dealt with issues related to the individual market. The most common complaint involved allegations that carriers did not guarantee issue products to individuals eligible for HIPAA.

In addition to continuing to respond to consumers' questions and complaints, the regional offices with direct enforcement responsibilities

⁹State officials provided some reasons why conforming legislation was never passed: political differences between the legislature and the administration, industry lobbying efforts, and concerns that HIPAA was an unfunded federal mandate.

¹⁰One HCFA official attributes this decrease to the strong economy because the law is particularly relevant to individuals who lose their jobs or employer-sponsored health insurance.

are in various stages of reviewing carrier policies for compliance with HIPAA. HCFA's Kansas City regional office has undertaken the most extensive enforcement activities for Missouri, where it began reviewing policies in 1998. Regional officials said they have now reviewed policies representing 88 percent of the state's small group market and virtually all the individual and health maintenance organization markets. Similarly, officials in HCFA's Boston and San Francisco offices told us they are also reviewing policies, although they did not begin their reviews until 1999.¹¹ In these reviews, HCFA officials have found instances of preexisting condition exclusions imposed illegally on enrollees and carriers that delayed guaranteeing coverage to individuals eligible for HIPAA.

Through an external contractor, HCFA also began on-site market conduct examinations at selected carriers in Missouri in June 1999 and in California in January 2000. HCFA informed us that it is initiating a similar study of one carrier in Rhode Island. In a market conduct examination, HCFA monitors carriers' business practices for compliance with HIPAA standards. HCFA typically selected carriers on the basis of their market share, complaints received, or the results of the policy review. HCFA identified several potential HIPAA violations in Missouri through these market reviews, including a carrier that excluded information about HIPAA in its Internet-based advertising and a carrier that eliminated its maternity benefit for individuals eligible for HIPAA.

HIPAA also provides for the imposition of a civil monetary penalty on noncomplying carriers, and the final enforcement regulations include detailed standards to follow in imposing penalties. Officials in two of the regional offices told us they have begun notifying a few carriers of the potential for pursuing civil monetary penalties. In addition, in lieu of civil monetary penalties, officials at one of these offices said they are in the process of negotiating settlements with two carriers that agreed to pay consumers for claims that were wrongly denied in the amount of about \$113,000.

¹¹According to HCFA regional officials, the regions also varied in selecting carriers' policies to review. Whereas the Kansas City office asked the nine largest Missouri carriers to submit product literature for their health plans, the San Francisco office selected carriers representing about 90 percent of California's individual market, based on complaints it had received. The Boston office is reviewing the policies of four carriers, which represent about 90 percent of Rhode Island's individual and small group markets.

HCFA has given its regional offices considerable discretion in how they can enforce HIPAA. For example, HCFA's central office has not provided regions with specific guidance in terms of criteria and time periods for performing policy reviews or market conduct examinations. HCFA attributes the varying extent of enforcement activities among regions to its efforts to work collaboratively with states and not pursue an approach that could disrupt a market that states had traditionally regulated. Further, the statute and regulations were written in a way such that states would be provided every possible opportunity to conform their regulatory authority to the federal laws.

We previously reported that Massachusetts and Michigan were known not to have conforming HIPAA legislation and therefore could require HCFA to pursue a determination of whether federal enforcement would be required. While Michigan passed legislation implementing an acceptable alternative mechanism in March 1999, HCFA officials acknowledged that Massachusetts is still not fully in conformance with HIPAA. However, HCFA has not begun to assume enforcement responsibilities in the state. Instead, because the state enacted insurance reforms immediately before HIPAA, including provisions that in some areas, according to HCFA officials, exceed HIPAA's requirements, HCFA has continued to work on bringing the state into conformance without undermining state provisions that afford consumers more extensive protections than HIPAA requires. Officials from HCFA and the Massachusetts' insurance department currently meet every 2 weeks to discuss issues related to HIPAA.

HCFA Is Still in the Process of Determining Its Role in Other States

HCFA is currently in the process of identifying the scope of its enforcement responsibilities by conducting legislative analyses to determine states' conformance with each of the federal standards. HCFA officials said they began a state-by-state comparison of existing state laws with HIPAA provisions in April 1999. HCFA has nearly completed this review and is in the process of clearing outstanding issues with a small number of states. The agency also assessed states' conformance with the Mental Health Parity Act and the Women's Health and Cancer Rights Act, while it relied largely on Labor's analysis of state laws to determine conformance with the Newborns' and Mothers' Health Protection Act. Through these analyses, the agency placed states in one of three categories: (1) those that appear to have acceptable laws, (2) those with questionable laws, and (3) those that appear not to have applicable laws. HCFA identified at least 21 states that appeared not to have any laws conforming to one or more of the federal standards.¹² (See table 2.)

¹²The agency is still analyzing certain states' compliance with HIPAA and has not yet formally decided whether or not it will pursue an enforcement role in additional states.

Table 2: States HCFA Identified as Not Having Any Legislation Conforming to Certain HIPAA Requirements

State	Newborns' and Mothers' Health Protection Act	Women's Health and Cancer Rights Act	Mental Health Parity Act
Alabama		X	X
Alaska		X	
Colorado		X	
Delaware		X	
District of Columbia		X	
Georgia		X	
Hawaii	X	X	
Idaho		X	X
Iowa		X	
Massachusetts		X	
Michigan	X		X
Mississippi	X	X	
Nebraska	X	X	
New Mexico		X	
New York			X
North Dakota		X	
Ohio		X	X
South Dakota		X	
Utah	X	X	X
Wisconsin	X		
Wyoming	X	X	X
Total	7	18	7

Source: HCFA.

In December 1999, HCFA sent letters to these states, indicating that it had a reasonable question about whether a state's standards substantially met the specified federal requirements. HCFA is currently in the process of determining whether these states meet the federal standards through other means, such as regulations or advisory bulletins. HCFA officials said they would accept that states meet the federal standards if such alternative means exist and have some statutory basis. HCFA officials said they have already received from several states clarifications of statutes, regulations, or advisory bulletins that demonstrate that they are enforcing these federal insurance standards. In states that do not meet these standards through other regulatory means, HCFA will begin its formal determination process in which it could ultimately assume direct enforcement responsibilities.¹³

HCFA officials said the agency would not undertake any enforcement activities in states it has identified as appearing to have acceptable laws, regulation, bulletins, or other guidance, and it assumes states are enforcing the provisions unless it has reason to believe otherwise. For states it has identified as having questionable laws for any of the federal standards, HCFA is still further reviewing state laws to determine conformance. HCFA officials did not provide a specific time period for the completion of this review. However, a HCFA official said that further review of state conformance with the Women's Health and Cancer Rights Act is awaiting clarification of the scope of the law's preemption language in future regulations.

¹³If a state does not voluntarily notify HCFA of its nonconformance, HCFA must undertake a determination process in which it establishes the state's nonconformance, thus providing the agency with the authority to become involved. This determination process is set forth in the federal regulation and provides for several iterative steps before HCFA formally assumes enforcement responsibility.

HCFA Has Not Determined Its Scope of Enforcement Responsibilities for State and Local Government Health Plans

HCFA is also responsible for enforcing federal insurance standards on state and local government plans, such as health plans for public universities and city, county, and state governments. Nonfederal government plans that are self-funded, however, are allowed by the federal laws to elect exemption from one or more requirements, provided that they comply with provisions related to certification and disclosure of creditable coverage.¹⁴ Plans must file or renew their exemptions with HCFA annually, and as of March 1, 2000, 568 plans had done so. A fully insured nonfederal government plan that buys insurance coverage from a carrier does not have this option and must comply with all HIPAA group market requirements.

Thus, in addition to states without conforming legislation, HCFA must enforce HIPAA and the related laws for state and local government plans that do not claim an exemption from one or more of the provisions. However, the agency has undertaken virtually no enforcement efforts related to these plans. For example, the agency has not determined the scope of its responsibilities because it has never identified the universe of these plans, although an official estimates their number to be in the thousands. Instead, the agency has relied on complaints to identify areas of nonconformance. An agency official said that HCFA has received a small number of complaints from participants of these plans and, in virtually all these cases, the issue was resolved through dialogue between HCFA and the plan. The official said that in one case, a participant in one of these plans contacted HCFA because his mental health claims were being denied. When HCFA investigated, it found that the plan had lower dollar limits on mental health benefits than on medical benefits, a violation of the Mental Health Parity Act.

¹⁴A plan may elect exemption from any number of the following federal requirements: limitations on preexisting condition exclusion periods, special enrollment periods, nondiscrimination, newborns' and mothers' health protection, mental health parity, and coverage for reconstructive breast surgery. Regulations require plans making this election to notify participants at enrollment and annually that they have made the election and what the effect the election has. Failure to do so invalidates the election.

Regulations on HIPAA's Nondiscrimination Provisions Have Not Yet Been Made Final

Nearly 4 years have passed since the enactment of HIPAA, and final regulations for its nondiscrimination provisions have not yet been issued. Without final regulations, issuers have had to rely on the April 1997 interim regulations, which provide for “good faith compliance”—that is, the federal agencies agree not to take action against employers who attempt in good faith to comply with the law, pending the issuance of final regulations.¹⁵ The enforcement of this provisions, and thus the development of the final regulations, is shared by HCFA, Labor, and Treasury.

Under HIPAA's nondiscrimination provisions, group plan issuers may not exclude a member within the group from coverage on the basis of the member'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. Without final regulations, however, questions remain about the meaning of statutory language that could affect health plans' design or eligibility requirements, such as the definition of bona fide wellness programs and “source of injury.”¹⁶ Until these and similar terms are more clearly defined, employers may hesitate to make certain changes to their health plans or wellness programs, according to a representative from an employer benefits consulting firm. This representative said that most employers are waiting for the final regulations before changing their health plans.

While there is not an established deadline, federal officials anticipate issuing the final regulations this summer and attribute the delay to the protracted nature of developing policy and rules when multiple federal

¹⁵The April 1997 interim regulations clarified a number of issues related to HIPAA's nondiscrimination provisions. For example, the effective regulations included a prohibition on imposing a physical examination as a condition for eligibility in a group health plan, a common feature with respect to late enrollees before HIPAA. Since the interim final rules were published in April 1997, the agencies have published two additional pieces of guidance. In December 1997, the departments issued a technical bulletin in the *Federal Register* addressing the treatment of individuals who had been discriminated against before HIPAA's effective date. In March 2000, a HCFA insurance standards bulletin addressed nonconfinement clauses.

¹⁶The proposed regulations clarify the definition of “source of injury” with regard to the extent to which HIPAA permits benefit limitations to be based on the source of an injury. For example, this would clarify whether HIPAA allows plans to exclude coverage for injuries sustained in a motorcycle accident when the rider does not have a helmet or injuries sustained in committing a felony.

agencies are involved and the complexity of the statutory provisions. However, in the past 2 years, a Labor official testified and regulatory agendas have indicated that these regulations were forthcoming, but they still have not been issued. Nonetheless, agency officials said they were not aware of significant complaints or inquiries regarding the nondiscrimination provision, and they believe that employers generally have followed good faith compliance.

Conclusions

HCFA has been responsive to several of our previous findings and recommendations by issuing enforcement regulations in August 1999, beginning to catalog the extent to which states have conforming laws meeting the federal minimum standards, and developing staff with insurance regulation expertise dedicated to overseeing HIPAA, the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act, and the Women's Health and Cancer Rights Act. While HCFA currently reports having the regulatory authority and staff resources it needs to accomplish its responsibilities, its role could further expand if it determines that it must assume insurance regulation functions in more than the three states in which it currently plays this role. HCFA is still proceeding slowly in its enforcement role and generally affords states every opportunity to demonstrate that they will assume primary enforcement responsibilities. Nearly 4 years after the Congress enacted new federal health insurance standards, HCFA still does not fully know the level of many states' conformance with these federal standards and has not developed specific time periods for completing its evaluation of states' conformance. In several states and for state and local government health plans, HCFA has largely relied on complaints to guide its enforcement efforts. HCFA has also given its regions considerable discretion in enforcing the federal standards in states lacking their own enforcement authority and has not established a consistent strategy or time periods for fulfilling these enforcement responsibilities. However, to the extent that consumers do not understand or are unaware of HIPAA and the related laws, consumers' complaints alone may be insufficient to identify problems. Further, HCFA, Labor, and Treasury have encountered repeated delays in issuing final regulations regarding HIPAA's nondiscrimination provisions.

Recommendations

We recommend that the HCFA Administrator complete the established federal process for determining whether federal enforcement will be required in additional states as quickly as possible, to include developing a

consistent strategy and time period for enforcing HIPAA and the related laws' provisions in the states that lack conforming enforcement authority.

We further recommend that HCFA, Labor, and Treasury promptly complete regulations related to HIPAA's nondiscrimination provisions.

Agency Comments

We provided a draft of this report to HCFA, Labor, and Treasury for comments. HCFA generally concurred with our findings and recommendations. HCFA listed a number of actions planned or under way to complete its assessment of state enforcement regulations and other laws as well as to assume enforcement itself where necessary. HCFA emphasized the need for a deliberative approach in establishing new federal enforcement roles for health insurance standards given the tradition of state regulation of private health insurance. HCFA also noted that since it received additional funds for oversight in May 1998, it has made progress in establishing collaborative federal-state enforcement of HIPAA and related laws. Further, HCFA noted that the laws require "substantial" rather than "absolute" compliance with the federal standards and, thus, the agency has provided states every opportunity to come into conformance. HCFA and Labor officials also noted that, while final nondiscrimination regulations have not yet been issued, they have provided some interim guidance related to this provision.

Regarding state and local government plans, HCFA said that it is almost impossible to identify the universe of these plans. HCFA also said that it does not believe that identifying the universe is critical to enforcing federal standards for these plans because (1) self-funded state and local government plans may elect exemption from certain HIPAA-related requirements; (2) fully insured plans are subject to state or HCFA oversight, regardless of whether they are purchased by private or government employers; and (3) HCFA continues to respond to complaints related to these government plans. Recognizing the data limitations associated with identifying these plans, we agree that this is a reasonable approach.


HCFA, Labor, and Treasury also provided technical comments that we incorporated as appropriate. Appendix I contains the comment letter from HCFA.

As we agreed with your office, unless you publicly announce this report's contents earlier, we plan no further distribution of it until 30 days after its

issue date. We will then send copies to the Honorable Nancy Ann Min DeParle, Administrator of the Health Care Financing Administration; the Honorable Alexis M. Herman, Secretary of Labor; the Honorable Lawrence H. Summers, Secretary of the Treasury; and other interested congressional committees and members and agency officials. We will also make copies available to others on request.

The information presented in this report was developed by Susan Anthony and John Dicken. Please call me at (202) 512-7114 if you have any questions.

Sincerely yours,

A handwritten signature in cursive script that reads "Kathryn G. Allen".

Kathryn G. Allen
Associate Director, Health Financing
and Public Health Issues

Comments From the Health Care Financing Administration



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington D.C. 20201 - 0001

DATE: MAR 30 2000

TO: Kathryn G. Allen
Associate Director, Health Financing and
Public Health Issues

FROM: Michael M. Hash *Michael M. Hash*
Deputy Administrator

SUBJECT: General Accounting Office (GAO) Draft Report: "Implementation of HIPAA: Progress Slow in Federal Standards in Nonconforming States"

Thank you for the opportunity to review your draft report to Congress concerning our enforcement efforts in states without laws conforming to the Health Insurance Portability and Accountability Act (HIPAA) or related Federal insurance standards.

We appreciate GAO's recognition that HCFA has overcome some barriers in implementing and enforcing HIPAA. We believe a great deal of progress has been made in our efforts.

Attached are our comments on the specific recommendations in the report. Thank you for your efforts on this issue, as well as the opportunity to review the draft report.

Attachment

Comments of the Health Care Financing Administration
on the General Accounting Office (GAO) Draft Report
“Implementation of HIPAA: Progress Slow in Enforcing
Federal Standards in Nonconforming States”

When evaluating the implementation and enforcement processes for the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it is critical to understand the full context and history of insurance oversight. While Congress did establish new national standards for private insurance in HIPAA, Congress also showed great deference to the traditional state role regarding insurance. Congress clearly wanted the federal-state relationship to be collaborative, not confrontational. The Health Care Financing Administration's (HCFA's) enforcement of HIPAA, if viewed in this context, has been very successful and provides a solid base for a long-term federal-state relationship in private insurance. In fact, the number of consumer complaints has been declining, and HCFA and the states are successfully defining their respective roles in assuring compliance with HIPAA requirements.

Since 1945, with the passage of the McCarran-Ferguson Act, the regulation and oversight of commercial health insurance has been the primary responsibility of the states. With the passage of HIPAA, however, a new and important relationship between the federal government and the states was created. The federal government has been given the role to assure certain minimum national standards in areas such as access, portability, and renewability. In enacting HIPAA, Congress respected the traditional state role in private insurance: states were given the option of enacting equal or greater protections and maintaining jurisdiction over commercial health insurance with regard to these protections.

It has taken HCFA and the states some time to deliberatively assess the best way to proceed in ensuring that the goals of the law are met. For example, HIPAA extends authority to HCFA to enforce HIPAA requirements only if the agency determines that a state has failed to “substantially enforce” them. It is important to note that Congress set a subjective standard, “failure to substantially enforce,” rather than an absolute standard of “Any failure to enforce.” This, and other language in HIPAA, clearly indicate Congressional desire for a collaborative, not confrontational, relationship between HCFA and the states.

Since the law's enactment, HCFA has been committed to maintaining the spirit of collaboration embodied in the law. In the initial stages of implementation, HCFA actively sought the advice of the states, the National Association of Insurance

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Commissioners (NAIC) and the many constituencies that might be affected. The first regulations, though extensive in scope, were well received and published in a timely manner. Subsequently, HCFA gave increased attention to developing effective oversight of state enforcement of HIPAA. The process established by HCFA is intended to be deliberate and to allow states ample opportunity to review our findings, discuss their concerns and to correct any errors.

Moreover, as noted in the GAO report, HCFA has taken steps to address its responsibilities under HIPAA. We hired a solid staff, including those with direct state insurance experience, capable of handling the responsibility within our jurisdiction through a process that is sensitive, informed, and effective. As the GAO report also notes, and as discussed in detail below, the staff are now conducting market conduct and policy form reviews, issuing bulletins on key enforcement questions, and tracking complaints. The three departments (Health and Human Services, Treasury, and Labor) are planning to publish a final non-discrimination regulation during the Summer of 2000 based on comments received. The departments are reviewing the initial regulations published in April 1997 in order to finalize them and based on comments received.

In all of these efforts, HCFA is working effectively with the states to assure maximum protection for consumers within the HIPAA framework Congress created. We believe that the Department's record as a whole demonstrates a successful implementation of the new and unique federal-state relationship created by HIPAA. And, we have become more successful as we have continued to develop the infrastructure and relationships needed to implement this law. We will build on this foundation to implement any future additions to the HIPAA statute.

GAO Recommendation 1

We recommend that the HCFA Administrator complete the established federal process for determining whether federal enforcement will be required in additional states as quickly as possible, to include developing a consistent strategy and time period for enforcing HIPAA and related laws' provisions in those states lacking conforming enforcement authority.

HCFA Comment

We agree. HCFA should continue to develop the federal process for working with states. In fact, we are well underway in the process to determine whether federal enforcement will be required in additional states. However, as mentioned earlier, it is important to understand the history of insurance oversight when evaluating the progress on HIPAA.

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As discussed above, the process we have established to review states' compliance with HIPAA is deliberative and is intended to allow states every opportunity to review our findings, to discuss their concerns, and to give the state an opportunity to remedy any shortfalls. Again, Congress did not require absolute compliance. Rather, the law extends authority to HCFA to enforce HIPAA requirements only if HCFA determines that a state has failed to substantially enforce HIPAA requirements. HCFA has been working to determine what constitutes a failure to substantially enforce" --as distinguished from any failure to enforce.

In addition, although the law was enacted in August 1996, it was not until May 1998 that Congress appropriated funds to provide the additional resources needed to begin implementation. HCFA used the appropriations to launch a more comprehensive effort to implement HIPAA. In order to move forward with HIPAA implementation, HCFA has:

- **Issued** an enforcement regulation and several clarifying bulletins;
- **Hired** a solid staff, including those with direct state insurance experience, capable of handling the responsibility within its jurisdiction;
- **Increased** coordination with the states themselves (including outreach to the NAIC);
- **Completed** initial analysis of state laws with regard to provisions in the initial HIPAA legislation and begun the process of focusing on potential problems with key provisions in individual states in order to determine whether those potential problems represent a failure to "substantially enforce" such provisions;
- **Completed** the review of states' abilities to substantially enforce HIPAA related provisions since 1996. Initial letters have been sent to states where concerns were identified. We are now evaluating responses from those states;
- **Conducted**, and will continue to conduct, market conduct examinations in direct enforcement situations to review insurance procedures;
- **Established** a coordinated policy for reviewing and tracking insurance complaints; and,
- **Continued** to work closely with other government agencies to complete regulations.

We have achieved a significant level of cooperation with states, and compliance with the law, by working with states. We have done this by providing consistent guidance and technical assistance. For example, we provided extensive guidance on state Alternative Mechanisms. (HIPAA sets forth federal rules in the individual market; however, it also allows states flexibility in developing alternatives to federal rules. The acceptability of these alternatives are outlined in the law.) We have also written policy letters to individual states on a variety of issues such as the sale of individual market policies through employers; the impermissible application of a preexisting condition exclusion for

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cosmetic surgery to treat an injury sustained under a prior plan; and market abandonment rules. Finally, HCFA provides technical assistance to a significant number of states. We believe that our approach is what Congress intended and it has resulted in a better level of compliance than a more regulatory process might have achieved.

GAO Recommendation 2

We further recommend that HCFA, Labor and Treasury promptly complete regulations related to HIPAA's nondiscrimination provisions.

HCFA Comment

We agree. It is important for HCFA to follow-up on the interim final rule published in 1997 to help make sure that states and insurance carriers fully understand the complexities of the law. Since the publication of that rule, HCFA has published guidance to states in the form of a Federal Register notice, letters to individual states on specific concerns, and bulletins to insurance commissioners. HCFA will continue to work closely with the Departments of Labor and Treasury to complete the regulation during the Summer of 2000.

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