Early Experience With ‘New Federalism’ In Health Insurance Regulation

HIPAA, the 1996 federal health insurance reform law, changed the way states can regulate health plans; its implementation remains a work in progress.

by Karen Pollitz, Nicole Tapay, Elizabeth Hadley, and Jalena Specht

PROLOGUE: The insurance reform provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 created new minimum portability and enrollment protections for consumers. At the same time, the law changed the way health plans are regulated by the states and the federal government. However, HIPAA did not disturb existing market and regulatory divisions or address premium costs. Now, four years after the law’s passage, employers and consumers are still routinely troubled by access to affordable health insurance. Policymakers wonder if the lessons learned from HIPAA’s implementation will be useful in developing future insurance legislation, such as for managed care consumer protections.

This paper is among the first to examine the impact of HIPAA’s incremental reforms and how its national policy affects multiple insurance markets and regulatory jurisdictions. It finds that HIPAA resulted in major achievements and can be a base for future reforms. However, the law’s provisions had gaps and also led to some unintended consequences.

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ABSTRACT: The authors monitored the implementation of the Health Insurance Portability and Accountability Act (HIPAA) from 1997 to 1999. Regulators in all states and relevant federal agencies were interviewed and applicable laws and regulations studied. The authors found that HIPAA changed legal protections for consumers’ health coverage in several ways. They examine how the process of regulating such coverage was affected at the state and federal levels and under an emerging partnership of the two. Despite some early implementation challenges, HIPAA’s successes have been significant, although limited by the law’s incremental nature.

With the passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, a new era of federal/state partnership began in the regulation of health insurance and improved access to coverage for persons with preexisting health conditions. Prior to HIPAA’s passage, the federal government had largely avoided the direct regulation of private health insurance and instead, through the McCarran-Ferguson Act of more than a half-century ago, deferred to the states in this area. The notable exception to this federal policy was the Employee Retirement Income Security Act (ERISA) of 1974, which exempted self-funded employer health plans from state insurance regulation. (Today such plans cover approximately one-third of all privately insured Americans.) HIPAA created certain minimum protections for consumers in federally and state-regulated health plans, including self-funded employer plans, while maintaining states’ ability to enforce their laws that exceed federal protections. In so doing, it changed both the content of people’s protection and the way health coverage is regulated.

Before HIPAA, health care consumers had dramatically different rights, depending on where they lived or worked and the type of coverage they had or sought. States had been active in legislating insurance reforms, including those to facilitate coverage for persons with preexisting conditions. These laws varied across states as well as across markets within states. ERISA, by contrast, included no such protections for enrollees in self-funded employer health plans.

HIPAA represents incremental reform. It established a national floor of protection designed to improve access to health insurance for certain consumers by responding to certain specific barriers. The key problem addressed by HIPAA was “job lock,” which left some workers hesitant to leave their jobs (and hence their employer-based coverage) because they might incur a new preexisting condition exclusion period. HIPAA limited the scope and length of these exclusions in group health plans and, for persons who maintain coverage, limited their repeated imposition. It also prohibited conditioning a person’s eligibility for group health benefits on health
status—a protection known as nondiscrimination. Further, it required insurers to guarantee the issue of all small-group health plans to small employers. HIPAA also required all health insurance, group and individual, to be guaranteed renewable. Finally, HIPAA guaranteed access to individual health coverage for “federally eligible” persons who lose group health coverage, have at least eighteen months of prior continuous coverage, and meet other criteria.

By creating this federal floor, HIPAA also changed the way health plans are regulated by states and the federal government. Their relative roles depend on a combination of implementation decisions at state and federal levels. Congress gave states the opportunity to adopt and enforce HIPAA reforms as they apply to insurance carriers. Federal enforcement is triggered only when states fail to substantially enforce HIPAA. More-protective state reforms (for example, shorter maximum preexisting condition exclusion periods) and state laws beyond HIPAA’s scope (for example, rating rules) are not preempted if they do not prevent the application of HIPAA.

The impact of HIPAA—on both the content of consumer protections and the way in which health coverage is regulated—was mixed and in many respects remains a work in progress. Even so, a review of early experiences under this law suggests some lessons for those who would pursue further incremental reforms.

This paper reports on the initial years of HIPAA implementation. It examines how the content of this law affected its implementation. It also studies the approach of guaranteeing protections nationwide through federal and state law (and a partnership of these two levels of government) and how this “federalism” approach affected the implementation experience. In researching this paper, we conducted extensive interviews with insurance regulators in every state and analyzed relevant state laws and regulations. In addition, we interviewed regulators in several states again in depth regarding their experience implementing this law and working with federal agencies. Finally, we interviewed senior staff from federal agencies regarding their implementation responsibilities and experiences. Information gathered in this way became the basis for our findings and the lessons we draw.

**Lesson 1: Group-Coverage Protections Improved**

In 1995 the U.S. General Accounting Office (GAO) estimated that HIPAA would help as many as twenty-five million persons to maintain continuous coverage in employer-group health plans. No study has yet been undertaken to verify this estimate. However, it appears plausible, given the changes that HIPAA prompted in the regulation of group coverage.
The standards HIPAA added to ERISA established substantial legal protections for the first time for the forty-eight million Americans participating in self-funded employer health plans. HIPAA's legal protections also were new for most persons covered under large-group insured health plans, on which states generally imposed few standards prior to HIPAA.

For state-regulated small-group health plans, HIPAA's floor built on an extensive patchwork of existing laws. Prior to HIPAA all but one state and the District of Columbia had adopted at least some small-group protections. However, HIPAA made these state protections more uniform and, in most states, broader. For example, HIPAA's all-products guaranteed issue for small groups constituted an expansion in all but fourteen states. Of the forty-one states with small-group guaranteed issue prior to HIPAA, most required access to only certain policies—usually a “standard” and a “basic” plan. Insurers in these states could medically underwrite other small-group products; consequently, standard and basic plans were more likely to cover groups that could not pass underwriting and therefore tended to be more costly. HIPAA's all-products guaranteed issue sought to prevent carriers from channeling higher-risk groups toward these more expensive plans, thereby giving all small groups access to a broader choice of products.

HIPAA also expanded the definition of small group in many states. Previously, eighteen states with small-group reforms did not apply them to groups as large as fifty, and thirteen states did not apply them to groups as small as two.

With respect to group portability, only nineteen states credited enrollees for as many types of prior coverage as HIPAA requires. Most states permitted carriers greater discretion in defining and excluding coverage for preexisting conditions. Specifically, thirty-eight states either had no statutory definition of preexisting condition or used a “prudent layperson” standard that let insurers exclude coverage for a condition that had not been previously diagnosed if they determined that the enrollee should have sought care for symptoms. HIPAA replaced this subjective standard with an objective test based on whether medical advice, diagnosis, or care had been recommended or received. It also prohibited group plans from treating pregnancy or genetic information as a preexisting condition.

The absence of rating reforms in HIPAA might have diluted the impact of its access, renewal, and portability standards in the small-group market, if carriers had been free to use deterrent pricing to discourage certain groups from buying coverage. However, HIPAA let stand state authority to regulate health insurance rating practices, and forty-nine states had some small-group rating limits in
place when the federal law was enacted. Most maintained these rating protections, and a few expanded them when they broadened other access reforms to meet federal standards. However, three states rolled back small-group rating reforms specifically in response to HIPAA’s expanded guaranteed-issue rights. Seven more elected to retain rating forms only for groups they defined as small prior to HIPAA.

In summary, HIPAA expanded and made more consistent states’ small-group market reforms and applied similar protections for the first time to enrollees of large and self-funded group health plans. As a result, more than 120 million Americans with private employer coverage are now less likely to have that access interrupted because of their health status, no matter where they live or their employer’s size or insurance arrangement (Exhibit 1).

**Lesson 2: Access To Individual Coverage Not Improved**

In the individual market, by contrast, HIPAA added fewer protections to existing law. Initial estimates of the number of persons it would help ranged from 136,000 to three million. Again, while no study has verified these estimates, HIPAA’s projected impact on individual coverage may have been overestimated, because in all but a handful of states, federally eligible persons (and other individual-market participants) have roughly the same access to coverage following HIPAA’s enactment as they did prior to it.

To guarantee access to coverage for federally eligible persons,

### EXHIBIT 1
**Selected State Small-Group Market Reforms, 1996**

<table>
<thead>
<tr>
<th>Provision</th>
<th>Number of states</th>
</tr>
</thead>
<tbody>
<tr>
<td>States with some small-group market reforms</td>
<td>49</td>
</tr>
<tr>
<td>Small-group definition</td>
<td></td>
</tr>
<tr>
<td>Includes groups of 2</td>
<td>33</td>
</tr>
<tr>
<td>Includes groups of 50</td>
<td>27</td>
</tr>
<tr>
<td>Guaranteed issue of all products</td>
<td>14</td>
</tr>
<tr>
<td>Guaranteed renewability</td>
<td>48</td>
</tr>
<tr>
<td>Limits on preexisting condition exclusion periods</td>
<td></td>
</tr>
<tr>
<td>Maximum exclusion period of 12 months or less</td>
<td>46</td>
</tr>
<tr>
<td>Maximum look back of 6 months or less</td>
<td>31</td>
</tr>
<tr>
<td>HIPAA-like definition of preexisting condition</td>
<td>13</td>
</tr>
<tr>
<td>Creditable coverage defined similarly to HIPAA</td>
<td>19</td>
</tr>
<tr>
<td>Small-group rating limits (some or all products)</td>
<td></td>
</tr>
<tr>
<td>Community rating or modified community rating</td>
<td>15</td>
</tr>
<tr>
<td>Rating bands</td>
<td>34</td>
</tr>
</tbody>
</table>

**SOURCES:** Institute for Health Policy Solutions; and Georgetown University.

**NOTE:** Prior to passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
states had the choice of adopting either the federal fallback provisions or an acceptable alternative mechanism. HIPAA’s federal fallback provisions are in place in twelve states and the District of Columbia. These provisions require carriers to sell all products with guaranteed issue to federally eligible persons (although HIPAA permits carriers to choose to make only two guaranteed-issue products available to such persons) with no preexisting condition exclusion period. In twelve of these states this standard constituted a new right of guaranteed access to private coverage. However, because rating limits were not part of this right, carriers can charge premiums many times higher than standard rates (and some have done so: Colorado regulators documented rates ranging as high as 2,000 percent of the standard rate). These very high rates have effectively neutralized the new access guarantees. Regulators in these states do not know how many residents have obtained coverage because they are federally eligible, but they suspect that the numbers are quite small.

Instead of the federal fallback standard, states may adopt an acceptable alternative mechanism to provide group-to-individual portability for federally eligible persons. This mechanism must guarantee a choice of at least two plans, at least one of which must cover comprehensive benefits comparable to other policies typically sold in the individual market. It also must provide for some form of risk spreading or subsidy. If a state uses its high-risk pool in its alternative mechanism, it must meet National Association of Insurance Commissioners (NAIC) standards for minimum benefits and maximum premium rates.

In contrast with the federal fallback states, all but one of the thirty-eight alternative-mechanism states limit the premiums charged for coverage that is guaranteed available to federally eligible persons. For the most part, however, the access and rating guarantees in these states are very similar to what existed prior to HIPAA. For example, the six states that have guaranteed issue of all products at community rates for all residents, regardless of prior insurance status, did so prior to HIPAA. Five states that have guaranteed issue only as a portability right (only for residents with prior coverage) also did so prior to HIPAA. Two states guarantee access for federally eligible residents through Blue Cross Blue Shield plans, but this guarantee was also largely in place for all residents prior to HIPAA. Of the twenty-two states using high-risk pools in their alternative mechanisms, twenty already had these pools prior to HIPAA. In most of these, federally eligible enrollees in the high-risk pool probably would have qualified as uninsurable without HIPAA.

Although HIPAA did not dramatically expand access to high-risk
pools, it did other things to strengthen coverage in more than half of them. To conform to new federal minimum standards, thirteen state pools were amended to increase lifetime maximum benefits, reduce premiums to 200 percent of standard rates, and/or exempt federally eligible persons from enrollment caps or other waiting periods.\textsuperscript{16} In addition, although not required to by federal law, one state’s high-risk pool dropped its exclusion of coverage for acquired immunodeficiency syndrome (AIDS)–related care.

Guaranteed renewability was another new requirement in twenty-nine states’ individual markets because of HIPAA. However, this protection also may be limited in states without rating reforms. When carriers can raise premiums for enrollees who become ill or otherwise sort people into plans priced by enrollees’ claims experience, coverage that is guaranteed renewable can nonetheless be rendered unaffordable.\textsuperscript{17}

With a few notable exceptions, the national floor of protections set by HIPAA for the individual market turned out to be a sub-basement. The incremental protection it provided was too small to be very meaningful. Congress gave states flexibility to provide alternative relief. But the standard was so flexible that states were generally not required to build on or improve existing individual-market reforms; instead, states could retain them with only minor changes. Of those that did enact new access reforms, only a few adopted rating reforms to make access affordable.

\textbf{Lesson 3: Difficulty In Imposing National Standards On Multiple Insurance Markets}

When Congress created a common floor of portability and enrollment protections for health insurance consumers, it also sought to leave undisturbed the existing division of market boundaries and regulatory authority over them. In several respects, the overlay of national, though incremental, standards on varied market divisions created problems at the “cliffs”—the points at which change in consumers’ group size, location, or other characteristics can vastly change their legal protections.

For example, the definition of \textit{employee}, for purposes of determining group size, is different under HIPAA than under many state laws. HIPAA counts full- and part-time employees, while many states only count full-time employees. States can keep their old
definitions as long as they do not undercut federal protections. Consider this explanation of how an employer with both full- and part-time employees may now be treated under federal and state law:

For purposes of [HIPAA], an employer with 10 part-time employees is entitled to guaranteed availability of coverage because it has two or more employees. If, however, State law provides for counting only “full-time” employees, this employer would be considered to have no employees, and, having fewer than two employees, it would be denied [HIPAA] protections. Under these circumstances, the State law would prevent the application of the [HIPAA] requirement, and would be preempted.

If an employer in the same State had 45 full-time employees, and 20 part-time employees, it would meet the definition of a “large” employer under [HIPAA], but would be a “small” employer under State law. Since the employer would still qualify for guaranteed availability in the small group market, the State law would not prevent the application of the guaranteed availability provision. However, since large employers (defined by [HIPAA] as having more than 50 employees) are entitled to protections under the [Mental Health Parity Act (MHPA)], the State law does prevent the applicability of the MHPA under these facts, and would be preempted with respect to MHPA. In theory, the State could adopt two different definitions of an employee, one that would apply for purposes of MHPA, and another that would apply for purposes of guaranteed availability.

As this example indicates, cliffs can be confusing. Some federal protections apply only to small groups, others only to large groups, and now the overlay of federal and state rules means that some groups can be both small and large.

The imposition of national policy on multiple insurance markets also can produce uneven effects across states. For example, New Jersey reformed its small-group and individual markets prior to HIPAA. One goal in drawing these market boundaries was to ensure that the individual market would have enough participants to support the requirements of guaranteed issue and community rating. Self-employed persons in New Jersey must buy coverage in this market, not the small-group market, unless they clearly qualify as small employers or members of another group. With the passage of HIPAA, New Jersey sought federal guidance on whether a new sole proprietor who has never had an employee but who reasonably expects to hire one is guaranteed access to the small-group market under HIPAA. A federal decision to allow such employers into the small-group market could weaken New Jersey’s individual market. However, that decision would help self-employed persons in many other states that have guaranteed issue and rating protections in the small-group but not the individual market. Imposing uniform federal regulatory standards on diverse jurisdictions and markets may have the perverse effect of helping consumers in some states and harming them in others.

The division of regulatory authority among fifty states and the federal government—each applying different rules to different mar-
kets—has complicated the resolution of these and other difficult boundary questions. If future federal reforms continue to leave existing market and regulatory divisions undisturbed, Congress should consider the resulting confusion, bureaucracy, and uneven consumer protections.

An exception to this observation occurs where federal law greatly raises protections across the board. As noted earlier, when HIPAA applied comparable standards for preexisting conditions and creditable coverage to state-regulated and ERISA plans, it leveled the cliff between these kinds of plans. Consumers with preexisting conditions will be treated more similarly by all group plans as a result.

**Lesson 4: Federal Enforcement Capacity Required**

The Health Care Financing Administration (HCFA) is the federal agency responsible for implementing HIPAA in private insurance markets. HCFA responsibilities included review of states’ alternative mechanisms and direct enforcement of HIPAA in states that fail to do so. Congress (and most other observers at the time) assumed that states would choose to institute HIPAA’s reforms and therefore initially allocated scant resources to HCFA for federal implementation. Experience has since shown that the federal government needs permanent resources devoted to ongoing monitoring of state enforcement, as well as supplemental resources to intervene as necessary to enforce HIPAA at certain times in certain states.

By fall 1997 three states had failed to enact at least some HIPAA protections. With these defaults, resources initially allocated to HCFA to implement HIPAA quickly proved inadequate. In May 1997 Missouri was the first state to notify HCFA that it would not implement HIPAA’s protections in either the group or the individual market. However, because the Missouri Department of Insurance (MDI) offered extensive assistance, HCFA was able to assume its regulatory role, despite the federal agency’s minimal resources and experience. The MDI helped to train HCFA staff, shared carrier policy filings with HCFA, agreed to continue accepting consumers’ inquiries and complaints relating to HIPAA, and provided other assistance. By July 1997 Missouri residents had HIPAA protections and a federal enforcement structure in place that operated much like state regulation.

In August 1997 Rhode Island notified HCFA of its legislature’s failure to enact implementing legislation. Again, because of the cooperation of the state’s Insurance Division, HCFA established a direct regulatory presence in Rhode Island in a short period of time and with minimal resources.

However, when California’s legislature adjourned in September
1997, having enacted HIPAA group (but not individual) market reforms, HCFA’s resources were severely strained. It had to assume direct responsibility for HIPAA enforcement in California’s individual market of 1.3 million participants. It also had to coordinate with two state agencies—the Department of Insurance (which regulates insurance carriers) and the Department of Corporations (which regulates managed care plans). Without funds or staff dedicated to these tasks, HCFA took more than a year to establish a regulatory framework in California.

HCFA’s early experience with HIPAA implementation demonstrated that Congress, in enacting a federal law, should anticipate the possibility of a direct federal role. Default by California, in particular, proved that in the absence of careful planning, the federal government is ill prepared to undertake direct enforcement activities in a large state. Budgeting resources for enforcement as needed is not practical, especially if the need may be temporary. At a minimum, backup federal enforcement capacity is essential.

**Lesson 5: Federal Oversight Is Incomplete**

Responsibility for HIPAA is shared among three departments—Health and Human Services, Labor, and Treasury—each with its lead enforcement agency—respectively, HCFA, the Pension and Welfare Benefits Administration (PWBA), and the Internal Revenue Service (IRS). During the first three years of implementation, federal oversight relating to HIPAA compliance was insufficient at every level and in every agency. Agencies lacked basic data necessary to monitor or evaluate HIPAA compliance, although some are beginning to gather it.

The U.S. Department of Labor (DOL) has oversight responsibility for HIPAA protections as they apply to some 124 million Americans in employer-based health plans, including those in self-funded plans that are exempt from state regulation. However, the DOL has no uniform information-filing requirements for all employer health plans, because of exemptions for certain plans covering fewer than 100 participants, and no systematic data on all of these plans to indicate what or whom they cover.19

The PWBA is gathering some information about HIPAA compliance through its field offices, whose staff has increased significantly since HIPAA in expectation of increased public inquiries and complaints.20 In fiscal year 1998 the PWBA received almost 90,000 calls from plan participants seeking help with a health plan problem. Without more general information on employer compliance, however, it is not possible to say whether these calls constitute the tip of an iceberg or the universe of compliance problems.
HCFA similarly lacks systematic data on health insurers’ compliance with HIPAA. In the first year of HIPAA implementation, most agency resources were devoted to reviewing states’ alternative mechanism submissions and drafting regulations. Today HCFA regional offices that have direct regulatory responsibilities are beginning to gather some marketwide information and track consumers’ inquiries and complaints. Some of these indicate potential compliance problems.

HCFA is actively exploring options for collecting more systematic compliance data. Gathering this information will not be easy, because many states also lack it. A strong partnership between state and federal regulators could be beneficial in generating much needed information. Data collection, in fact, was one of several key issues discussed during a 1999 field conference between HCFA staff and state health insurance regulators.

Finally, the oversight role of the IRS appears to be quite limited. IRS staff also receive direct inquiries from some consumers but do not separately log or track these cases, nor is this information systematically published in summary form.

**Lesson 6: Federal Guidance Needed For States**

To date, federal agencies have been slow in issuing guidance to state regulators and others on how to interpret and implement federal law. Federal responsiveness was cited as a problem the most widely and consistently by the state regulators we interviewed. Some of this slowness appears inevitable, at least for the time being.

So far the three-agency process has worked expeditiously to produce policy guidance only once, when it was required to do so by law. HCFA, the PWBA, and the IRS met the 1 April 1997 deadline for issuing HIPAA implementing regulations. The regulation was published in the *Federal Register* in “interim final” form to provide an opportunity for public comment and to afford the agencies more time to resolve several complicated policy issues. Future guidance on these unresolved issues was promised but has not yet materialized for the most part. Federal guidance issued since then has come only after a protracted Executive Branch clearance process. For example, regulations answering important questions about how employers and insurers can comply with federal nondiscrimination rules have yet to be issued.21

The three agencies have formed a standing work group that meets regularly to discuss policy issues. Staff hope that this process will help to speed up decision making. Agencies also have employed other avenues for issuing guidance. HCFA, for example, has published several bulletins to clarify the impact of federal rules.
Other factors have slowed responsiveness. As noted earlier, imposing national standards on multiple markets and jurisdictions is complicated. A steep learning curve also impeded initial implementation. As federal agencies gain experience in their new roles, they should operate more effectively.

Finally, complex legal and political issues have complicated HCFA’s response to two states that have not yet adopted certain HIPAA reforms. Michigan never enacted the HIPAA standard of all-products guaranteed issue in the small-group market. Massachusetts has yet to enact smaller HIPAA-conforming changes in the individual market.

These situations are complicated for several reasons. Unlike Missouri, California, and Rhode Island, neither Michigan nor Massachusetts has formally notified HCFA that it should enforce HIPAA for its residents. As a practical matter, therefore, HCFA’s role in these states has been more difficult to define. To help clarify its role, HCFA recently issued a regulation detailing procedures for enforcing HIPAA in states that do not actively enforce all of HIPAA’s reforms. Another complicating factor is HIPAA’s language, which articulates different standards for federal enforcement in the group and individual markets. In general, the law requires federal enforcement when a state fails to “substantially enforce” the provisions of HIPAA. However, the group-market standard permits a provision-by-provision evaluation of a state’s enforcement activity and authorizes HCFA to enforce any specific provision or provisions that the state does not. By contrast, the individual-market standard may require HCFA to judge whether a state, in the entirety of its policies and actions, is enforcing at least the minimum federal protections for its residents. 22 It remains to be tested whether these differences in HIPAA’s language require different responses by HCFA to these two state situations.

**Lesson 7: Need For Federal/State Partnership**

Such a partnership may yet emerge, and it is already evident in some states. Federal/state cooperation secured HIPAA’s protections for Missouri and Rhode Island residents while minimizing regulatory resources. Regulators in other states have commented on how the federal government can reinforce and strengthen states’ authority. Colorado regulators, for example, commended an enforcement bulletin issued by HCFA identifying specific carrier practices that undermine HIPAA protections. 23 State regulators were able to cite this bulletin as added authority for curbing abuses and publicized it widely to carriers, agents, and consumers.

HCFA’s well-attended conference with state regulators in Au-
August 1999 was another example of constructive outreach between the two levels of government. Federal and state regulators met in San Francisco to discuss a wide range of policy, implementation, and enforcement issues. Participants characterized this meeting as a welcome and relatively private forum for the frank exchange of ideas between regulators. Finally, HCFA has outlined an approach to triggering federal enforcement that appears to emphasize flexibility, discussion, and respect for the states’ traditional regulatory role.

Even so, a partnership between federal and state regulators has not been fully achieved. The federal response to state inquiries has been slow. Some states continue to suspect that federal intervention in their regulatory duties will add little value because of the lack of federal expertise in health insurance regulation; others may find it unwelcome.

**Lesson 8: Need For Public Education About Health Insurance Reforms**

The GAO has reported that consumers are still unfamiliar with HIPAA. As a result, people may be unable to exercise their rights. Enforcement efforts, which depend largely on consumers’ complaints, may be hindered. Unfortunately, HIPAA had no provisions addressing public education.

Creating greater public awareness is a priority for regulators, though funds for this purpose are limited. New Jersey, for example, undertakes extensive public education, including free consumer guides, a Web site, and a twenty-four-hour telephone hotline that handles more than 1,200 calls per month. South Carolina regulators also distribute consumer guides and have conducted extensive outreach to agents. Federally, the PWBA embarked on a ten-city tour to brief employers and others on HIPAA. Both the PWBA and HCFA have begun to use the Internet and other outreach methods. Even so, all regulators interviewed agreed that more could be done and would be beneficial.

**Conclusions And Policy Implications**

A common thread running through these lessons is incrementalism. HIPAA changed the content of consumer protections and the process of insurance regulation incrementally. However, by deliberately setting out to fix some problems while leaving others unaddressed, Congress diluted the impact of its reforms.

With respect to the content of consumer protections, HIPAA market reforms must be viewed as two distinct laws: one for group coverage and a second for individual coverage. The law’s incremental changes for group coverage were significant. Broad guaran-
“By not providing resources for enforcement, oversight, and public education, Congress ensured that HIPAA would be imperfect.”

...issue requirements, in combination with existing state rating reforms, increased coverage choices for small groups. HIPAA also set standards for preexisting condition exclusions that are uniform for insured and self-funded plans throughout the nation. It created new protections for pregnant women and for persons with identifiable genetic traits. Perhaps most important, it created substantive standards for ERISA plans, thereby filling a regulatory vacuum that had existed for twenty-two years. These are major achievements.

In the individual market, however, HIPAA produced few uniform protections across states and did little to improve consumers' access to coverage. In particular, Congress's failure to address rating was deliberate and the consequences predictable. By avoiding this issue, Congress did not address the reality that coverage, even if “accessible,” is often unaffordable. Greater gains in access might be accomplished in the future if incremental reforms include rating limits and are accompanied by public funds to subsidize the purchase of health coverage. Balanced budgets and federal surpluses have created an opportunity that did not exist in 1996.

HIPAA's approach to changing the process of health insurance regulation was also incremental. Here, too, it solved some problems while creating new ones. It established a base for future reforms. It helped states to enforce their rules in some cases and created the opportunity for a partnership that could strengthen insurance regulation nationwide. At the same time, though, by creating a federal role in insurance regulation without providing resources for enforcement, oversight, and public education, Congress ensured that implementation of HIPAA would be slow and imperfect.

Today's conventional wisdom favors incremental reform over more sweeping change because it is simpler and more possible. HIPAA implementation demonstrates that even incremental reform of health insurance regulation is a complex undertaking. The law’s provisions have had some serious, unintended consequences, and its omissions have created problems.

Implementing managed care consumer protection legislation at the federal level will pose these same challenges and new ones. Many states divide authority among more than one agency for enforcement of health care quality protections. Moreover, such protections are much more qualitative and difficult to define or measure than many of HIPAA’s provisions. If Congress enacts such legisla-
tion, its success will require careful attention to these complexities, a willingness to set a national standard high enough to help consumers as well as achieve uniformity, and a commitment of significant federal resources.

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NOTES

1. The authors also have written state-specific consumer guides describing people’s rights to buy and keep health insurance under HIPAA and related state laws. Unless otherwise cited, information about states’ laws and implementation presented in this paper was gathered in the course of researching these consumer guides. They can be found on the Internet at www.georgetown.edu/research/hicrp/hipaa (February 1998).
3. A study by Charles D. Spencer and Associates found that the proportion of employer-sponsored health plans imposing no preexisting condition exclusion periods increased from 29 percent prior to HIPAA to 49 percent following HIPAA. B. Carlson, “What’s Happened to HIPAA in the Real World?” Business and Health (March 1999): 59.
4. In some states small-group protections were not found in the insurance code. For example, Hawaii’s small-group protections were accomplished indirectly through the state’s employer-mandate requirements.
5. In Hawaii, Pennsylvania, and Michigan community rating by certain carriers is achieved through mechanisms other than state insurance statutes.
6. Illinois repealed small-group rating reform as part of its HIPAA implementation legislation but has subsequently reinstated it. West Virginia loosened its rating limits. New Jersey and South Carolina also modified small-group rating reforms as part of their HIPAA-implementing bills, but the decisions to make these changes had been reached prior to HIPAA. New Jersey halted its planned phase-in to pure community rating, retaining modified community rating for its small-group market. South Carolina replaced its small-group modified community ratings with rating bands.
7. Arkansas, Louisiana, Missouri, North Dakota, Oregon, Tennessee, and Virginia.
8. This discussion of how HIPAA changed health insurance reforms is based on a survey of states conducted by the authors, as well as Institute for Health Policy Solutions, “Baseline Information for Evaluating the Implementation of HIPAA: Final Report” (Unpublished report for RAND, 1998).
In a few states federally eligible persons have much broader access to private coverage than they did before HIPAA. New Mexico, for example, opened its small-employer purchasing alliance to federally eligible persons, who can now purchase the same plans sold to small employers at group community rates plus a surcharge. Florida, Georgia, and Ohio strengthened their conversion laws to guarantee persons leaving group plans access to better coverage for more affordable premiums than they could get prior to HIPAA.

Arizona, Colorado, Delaware, Hawaii, Maryland, North Carolina, Tennessee, and West Virginia adopted the federal fallback provisions. The District of Columbia adopted them as an alternative mechanism. They are federally enforced in California, Missouri, and Rhode Island. Kentucky also adopted the federal fallback standards, although these provisions amended other guaranteed-issue rights that applied in the entire individual market and were coupled with rating limits.

Maryland is the only federal fallback state that applies some rating limits. Premiums for high- and low-option “representative” products sold by carriers to federally eligible persons cannot exceed 200 percent of the rate that the carrier normally would charge other persons for the same or a similar product. A Colorado Division of Insurance survey found that 145 residents gained individual coverage as a result of HIPAA. Preliminary results from a survey by Maryland regulators suggest that perhaps 1,400 residents have obtained individual-market coverage as a direct result of HIPAA.

Virginia’s alternative mechanism is very similar to the federal fallback standard and does not include rating protections.

Washington recently repealed guaranteed-issue rights in the individual market.

Communicating for Agriculture, Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 10th, 11th, and 12th eds. (Fergus Falls, Minn.: Communicating for Agriculture, 1996–1998); and authors’ survey of states conducted for this paper.

Some states permit “tier” and “durational” rating in the individual market, under which carriers can raise premiums for a consumer whose health status declines. Many other states limit renewal-rate increases for consumers based on their own experience. However, if states also permit carriers to create new insurance products that only healthy customers can buy, enrollees can effectively be sorted according to health status, with sick customers stranded in health plans whose premiums may spiral upward.

Health Care Financing Administration, Group Size Issues under Title XXVII of the Public Health Service Act, Insurance Standards Bulletin Series, Pub. no. 99-03 (Baltimore: HCFA, 1999), 5.

This exemption can be found at 29 CFR, sec. 2520.104-20.

Fiscal year 1998 funding permitted the DOL to hire thirty-three new health investigators and twenty benefit advisers. In FY 1999 thirty additional benefit adviser positions were funded, for a total of ninety benefit advisers: seventy-five in field offices and about a dozen in Washington, D.C.

Limited clarification has been offered on how these standards apply to flexible spending accounts and to persons who had been denied access to group coverage prior to HIPAA as a result of a health status–related factor.

See 42 U.S. Code, sec. 300gg-22(a)(2); and 42 U.S. Code, sec. 300gg-61(a)(2).
