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United States General Accounting Office
Washington, DC 20548

May 7, 2001

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

Subject: Private Health Insurance: Federal Role in Enforcing New Standards
Continues to Evolve

Dear Mr. Chairman:

In recent years, the Congress has passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and three subsequent laws¹ that create new federal standards for private health insurance, which covers nearly 175 million Americans under the age of 65. These laws include standards guaranteeing access to health insurance for small employers and individuals with existing health conditions as well as requirements for health plans regarding mental health services, hospital care for mothers and newborns following childbirth, and reconstructive surgery following a mastectomy. Responsibility for enforcing the new federal standards established by these four laws is divided among state insurance regulators and three federal agencies. Specifically, states maintain their traditional responsibility for regulating insurance products sold in their states, but if they fail to substantially enforce the minimum federal standards, the Department of Health and Human Services (HHS), through the Health Care Financing Administration (HCFA), is responsible for enforcing the federal laws. HCFA is also responsible for enforcing the federal standards for nonfederal government health plans, such as health plans offered to state and local government or school district employees. These laws also expanded the Department of Labor's responsibilities for ensuring that private employer-sponsored group health plans meet federal requirements and provided the Department of the Treasury with new authority to impose an excise tax on employers found to violate the federal standards.

Because the Congress is currently considering new patient protection standards—and because some proposals would model enforcement on the approach used in HIPAA and other laws—you asked us to provide an update on federal agencies' enforcement of the existing health insurance standards. Specifically, we examined

¹The 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.

- HCFA's progress in enforcing these new federal health insurance standards,
- Labor's enforcement of standards on private employer-sponsored health plans, and
- Treasury's imposition of an excise tax for noncompliant employers.

To address these objectives, we interviewed headquarters and regional representatives of HCFA, officials from Labor and Treasury, and insurance regulators in several states, and we obtained and reviewed documents from HCFA and Labor. We conducted our work in March and April of 2001 in accordance with generally accepted government auditing standards.

In brief, federal agencies have continued to make progress in developing and implementing mechanisms to ensure that employers and carriers comply with new federal health insurance standards. HCFA's enforcement role has evolved since our last report in March 2000 when the agency was largely responding to consumer complaints and attempting to ascertain the scope of its responsibilities in view of state responsiveness to the legislation.² Since that time, HCFA has completed its review of state laws related to three of the four recent federal laws and identified five states—Colorado, Delaware, Massachusetts, Missouri, and Wisconsin—where it is necessary for HCFA to enforce federal standards. The agency has not fully assessed state conformance with the Mental Health Parity Act, which is scheduled to sunset later this year. The agency has undertaken relatively comprehensive enforcement activities in Missouri—including reviews of carriers' policy forms and business practices and responding to consumers' complaints—where it has had a role enforcing HIPAA standards since 1997 when the state notified HCFA that it was not enforcing the federal law. HCFA has more recently initiated enforcement activities in the remaining four states. HCFA's role in enforcing federal standards for nonfederal government health plans in all states has been limited to responding to a relatively small number of inquiries and complaints from participants in these plans.

The Department of Labor's enforcement activities for private employer-sponsored health plans have also expanded from its complaint-driven enforcement of limited federal reporting and disclosure requirements under the Employee Retirement Income Security Act of 1974 (ERISA). The agency has undertaken a more proactive role in measuring health plan compliance with the new federal standards. In particular, Labor has developed and implemented a system to conduct random compliance reviews of employer-sponsored health plans so that next year it can estimate the extent of HIPAA compliance nationwide. Finally, the Department of the Treasury has not yet developed an enforcement strategy focused specifically on the new federal standards, nor has it exercised its new authority to impose an excise tax on noncompliant employers. We provided a draft of this report to the three agencies for their review. In written comments, HCFA and Labor generally agreed with our characterization of their evolving enforcement roles. Treasury did not provide written comments.

²*Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States* (GAO/HEHS-00-85, March 31, 2000). A list of related products is included at the end of this letter.

BACKGROUND

Since 1996, the Congress has passed four laws that establish new federal standards for private health plans. HIPAA includes minimum standards to improve the access, portability, and renewability of health insurance coverage in employer-sponsored group plans and individually purchased nongroup plans. Subsequent laws established minimum requirements for health plans covering mental health services, hospital maternity care, and mastectomies. Specifically, see the following.

- HIPAA (1) requires insurance carriers to offer coverage to all small employers (defined as those with 2 to 50 employees) that apply (a standard known as guaranteed issue), (2) requires all health coverage to be renewable upon expiration of the policy term (guaranteed renewal), (3) prohibits excluding an employee from a group health plan, or varying benefits, premiums, or employer contributions, on the basis of health status (nondiscrimination), (4) sets a maximum length of time that group health plans may exclude coverage for preexisting conditions, (5) provides credit against any preexisting condition exclusion for individuals with prior continuous coverage (group-to-group portability), and (6) guarantees eligible individuals losing group coverage access to coverage through individually purchased insurance or alternatives, such as state-sponsored high-risk pools (group-to-individual portability).³
- The Mental Health Parity Act of 1996 prohibits group plans that provide mental health benefits from imposing annual and lifetime dollar limits that are more restrictive for mental health benefits than for other medical and surgical benefits.⁴
- The Newborns' and Mothers' Health Protection Act of 1996 prohibits plans that provide maternity benefits from restricting benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section.⁵
- The Women's Health and Cancer Rights Act of 1998 requires all plans that provide mastectomy coverage to also provide coverage for related reconstructive surgery and certain other follow-up care.

The responsibility for ensuring that consumers receive these protections is shared by the states and multiple federal agencies. State insurance regulators have primary

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 certain other reasons including fraud. To meet the group-to-individual portability requirement, states may require individual market carriers to offer coverage to eligible individuals or use an alternative means, such as a high-risk pool.

⁴The Mental Health Parity Act applies only to groups with more than 50 employees.

⁵In contrast to the other laws that establish minimum federal standards, under the Newborns' and Mothers' Health Protection Act certain state laws that meet some, but not all, of the federal requirements are deemed to be acceptable.

enforcement authority for insurance carriers in states that have laws that substantially conform to or exceed these federal standards or that otherwise substantially enforce the federal standards.⁶ HCFA is responsible for directly enforcing the federal health insurance standards for carriers in states that fail to substantially enforce the federal standards. 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 business practices, and imposing civil monetary penalties on noncomplying carriers.⁷ In all states, HCFA is generally required to enforce the federal standards for nonfederal government health plans, such as plans covering state and local government employees. Enforcement responsibility for the standards under HIPAA and the related federal laws was added to Labor's existing oversight role for private employer-sponsored benefits established under ERISA. HIPAA also provided Treasury with authority to impose an excise tax on noncompliant employers and plan administrators.

In March 2000, we reported that nearly 4 years after HIPAA's enactment, HCFA was still in the early stages of fully identifying where federal enforcement was needed. We recommended that HCFA promptly complete its determination of which states required federal enforcement and develop a consistent strategy for doing so. The agency had assumed enforcement activities, such as reviewing carrier policies and business practices in three states (California, Missouri, and Rhode Island) that had voluntarily notified HCFA of their failure to enforce some HIPAA standards. However, the agency was still in the process of fully determining state conformance with the standards under HIPAA and the related laws and was largely reacting to consumers' inquiries and complaints. HCFA had contacted states without conforming laws to determine whether they were substantially enforcing the federal standards through other means, such as regulations or advisory bulletins. It had yet to fully determine its enforcement responsibilities among nonfederal government plans and was also relying on complaints from enrollees to identify compliance problems. In earlier reports, we also examined Labor's increased enforcement responsibilities under HIPAA, and we found that the agency tended to rely largely on consumer complaints to identify noncompliance.⁸ Recognizing the increased scope and complexity of its responsibilities under HIPAA and related federal laws, Labor was attempting to enhance its customer service function. It increased the number of customer service staff available to respond to public inquiries, provided consumer education materials, and was undertaking other improvements, such as conducting compliance reviews of randomly selected employers.

⁶HCFA officials said, absent conforming laws, they consider states to be substantially enforcing the federal standards if alternative means exist, such as regulations, advisory bulletins, or other guidance issued by state regulatory agencies directing insurers to meet standards consistent with the federal requirements.

⁷HIPAA 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.

⁸*Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards* (GAO/HEHS-99-100, May 12, 1999).

THE SCOPE OF HCFA'S ENFORCEMENT RESPONSIBILITIES CONTINUES TO EVOLVE

HCFA has completed its review of state laws for conformance with three of the four statutes with new federal health insurance standards. In doing so, it has accomplished an important task it had previously identified as needed to clarify the scope of its enforcement role and has largely responded to the recommendation we made in our March 2000 report. The agency identified five states—Colorado, Delaware, Massachusetts, Missouri, and Wisconsin—that do not substantially enforce at least one of the four federal standards, thus requiring HCFA to assume a direct enforcement role. Although the agency has undertaken fairly extensive enforcement activities in Missouri, where it has had a role enforcing HIPAA standards since 1997, in the remaining four states it is in the initial stages of enforcement activities. In addition to specific enforcement responsibilities in these five states, HCFA will regularly reevaluate conformance with the federal standards in the remaining states and continue to field inquiries and complaints from consumers nationwide. HCFA continues to rely on consumer complaints to enforce standards on nonfederal governmental plans, but limited consumer knowledge of their rights may hinder the effectiveness of this approach. HCFA staff dedicated for the enforcement of these federal standards has declined as its role has diminished and become more clearly defined. Several factors, however, including the possible reauthorization of the Mental Health Parity Act, could change the scope of HCFA's enforcement responsibilities in the future.

HCFA Has Identified Five States Where It Will Enforce Federal Standards

HCFA has completed its analysis of state laws to determine conformance with standards contained in three laws—HIPAA, the Newborns' and Mothers' Health Protection Act, and the Women's Health and Cancer Rights Act—and has determined that five states lack laws, regulations, or administrative mechanisms that address the requirements of one of the federal statutes, requiring HCFA to assume enforcement responsibilities.⁹ HCFA did not make a determination as to whether each state fully conformed to the Mental Health Parity Act. Rather, because the federal parity law will sunset on September 30, 2001, unless reauthorized by the Congress, the agency chose to confirm only that each state had some standard related to parity in mental health coverage, but not that the standard fully met the federal minimum requirement. HCFA officials told us they intend to more fully determine each state's conformance if the Congress acts to extend or modify the federal parity law.

HCFA determined that each of the five states did not conform with only one of the three laws. For HIPAA, Missouri remains the only state without conforming legislation. Two of the three states in which HCFA had assumed HIPAA enforcement activities for the past several years—California and Rhode Island—passed

⁹For the Newborns' and Mothers' Health Protection Act, HCFA relied on Labor's analysis of state conformance.

conforming legislation in 2000. Accordingly, HCFA has largely phased out enforcement activities in these states. HCFA determined that Wisconsin does not fully conform to the Newborns' and Mothers' Health Protection Act, and Colorado, Delaware, and Massachusetts do not fully conform to the Women's Health and Cancer Rights Act.¹⁰ (See table 1.)

Table 1: States That Do Not Fully Conform With Three Federal Laws

	HIPAA	Newborns' and Mothers' Health Protection Act	Women's Health and Cancer Rights Act
Colorado			X
Delaware			X
Massachusetts			X
Missouri	X		
Wisconsin		X	

Source: HCFA, April 2001.

State officials in some of these states commented on the likelihood of passing conforming legislation in the future. While a Delaware official told us that the state was likely to enact conforming legislation this year, officials in Colorado, Massachusetts, and Wisconsin said they did not believe that their states would pass conforming legislation in the near term and therefore would require an ongoing role by HCFA. Some of these officials suggested that their state legislatures did not view enactment as a high priority, believing most carriers complied with the federal standards even without the state taking any action. For example, the Colorado Division of Insurance conducted a survey of the 10 largest carriers in the state and determined that each already provided coverage for reconstructive surgery after a mastectomy, even though the state had not passed conforming legislation. Based on the survey results and lack of consumer complaints related to the issue, the state decided not to pursue conforming legislation.

HCFA Has Direct Enforcement Authority in Five States and Assumes a More Limited Role in the Remaining States

Although HCFA has been actively enforcing HIPAA in Missouri for several years, its enforcement activities in the other four states have generally just begun. In addition, HCFA's activities in California and Rhode Island, where it has had an enforcement role since 1997, are being phased out because both states passed HIPAA conforming legislation in 2000.

In 1997 when Missouri notified HCFA of its failure to pass HIPAA conforming legislation, HCFA assumed enforcement responsibilities in the state for several

¹⁰HCFA earlier determined that North Dakota did not conform to the Women's Health and Cancer Rights Act and initiated enforcement activities by sending letters to issuers in the state in January 2001. However, the state has since passed conforming legislation and has assumed enforcement responsibility for the standard.

HIPAA standards in both the individual and group markets. Although HCFA's enforcement role began with responding to consumer inquiries and complaints, its Kansas City regional office began reviewing carrier policies for compliance in 1998 and has since reviewed policies representing approximately 95 percent of the state's small group, individual, and health maintenance organization markets.¹¹ In addition, the regional office began on-site market conduct examinations in June 1999. In a market conduct examination, HCFA's contractor reviews a carrier's business practices for compliance with HIPAA standards. As of April 2001, HCFA had completed two market conduct examinations and an additional six were under way. These eight carriers collectively insure about 60 percent of Missouri's private insurance market. A common problem identified during policy and market conduct reviews was lack of guaranteed access to individual insurance market products for eligible individuals. For example, HCFA officials said that some carriers in Missouri did not attempt to determine whether an applicant was eligible for group-to-individual portability under HIPAA and did not inform eligible individuals about the availability of guaranteed issue products. In the market conduct reviews, HCFA also identified problems with HIPAA's guaranteed issue standard in the small group market. Officials cited examples of carriers structuring agent commissions in a manner that discouraged the referral of very small groups.

Because of the expertise it has developed in Missouri, HCFA has decided to centralize responsibility for enforcement of the applicable federal standards in the remaining four states in the Kansas City regional office. Much as it did in Missouri, HCFA will field consumer inquiries and complaints, review policies, and conduct market examinations related narrowly to provisions of the Newborns' and Mothers' Health Protection Act or Women's Health and Cancer Rights Act with which the four states are not in conformance. However, although the coordination between HCFA and each state is delineated in letters sent to the states last year, regulatory and enforcement activities are essentially just under way in three of the four states. For example, HCFA has recently sent letters to carriers operating in Colorado, Delaware, and Massachusetts notifying them of its intent to enforce the Women's Health and Cancer Rights Act and requesting policies to review. Enforcement efforts are further along in Wisconsin, where HCFA has sent letters to the 37 largest carriers notifying them of HCFA's role in enforcing the Newborns' and Mothers' Health Protection Act and has reviewed policies representing about 40 percent of the state's group market and 10 percent of its individual market.

In addition to specific enforcement responsibilities in these five states, HCFA will regularly update its legislative review of other states' laws to ensure that they continue to substantially enforce the federal standards. HCFA will also continue to field inquiries and complaints from all states. Since January 1997, the agency has been recording inquiries and complaints it has received related to the federal standards. To collect consistent data from across all regions, HCFA developed an electronic complaint tracking system that was implemented in June 2000. From March 2000 through March 2001, HCFA documented 1,492 inquiries and 133

¹¹According to regional officials, HCFA is likely to conduct a comprehensive rereview of Missouri carrier policies for HIPAA compliance on a 3-year cycle similar to many state insurance departments. HCFA will conduct more frequent reviews if complaints received indicate nonconformance.

complaints; over half of the complaints dealt with the standards for the individual market.¹² A common complaint involved allegations that carriers delayed processing applications, which resulted in qualified individuals becoming ineligible for HIPAA's protections.

Although HIPAA 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, HCFA has yet to impose such a penalty on a carrier. In lieu of civil monetary penalties, officials in the Kansas City regional office said that they have successfully negotiated voluntary settlements totaling \$187,000 with several carriers that agreed to pay consumers for claims that were wrongly denied.

HCFA's Enforcement Efforts for Nonfederal Governmental Plans Have Been Limited

HCFA is also responsible for enforcing federal insurance standards on state and local government health plans, such as health plans for public universities and city, county, and state governments.¹³ Unlike private employer-sponsored plans, nonfederal government plans are generally not subject to many of the employee benefit protections under ERISA. For example, these plans are not required to file plan information with the federal government or provide participants with a description of their plans. In addition, HIPAA and the related laws permitted self-funded, nonfederal government plans to exempt themselves from federal standards related to access, portability, and renewability, as well as those related to mental health, hospital stays connected with childbirth, and reconstructive surgery following a mastectomy.

HCFA maintains responsibility for enforcing the federal standards on self-funded, state and local government plans that do not exempt themselves from the standards. However, according to HCFA officials, the agency lacks authority to collect information from states regarding the number of nonfederal government plans operating in them and is not otherwise aware of reference sources that would provide such information. Thus, HCFA has been unable to determine the universe of nonfederal government plans for which it has responsibility and has instead relied on consumer complaints to identify possible areas of noncompliance. Few such

¹²According to HCFA officials, about 35 to 40 percent of the complaints originated in states where HCFA had enforcement authority.

¹³Nonfederal government health plans that elect exemption from one or more of the standards must file or renew their exemptions with HCFA annually under procedures set out in regulation, notify participants about the election, and provide for the certification and disclosure of creditable coverage. As of March 2001, 533 plans in 35 states had exempted themselves from at least one of the standards. About 90 percent opted out of standards related to limits on preexisting condition exclusion periods, special enrollment periods, prohibition against discrimination based on an individual's health status, and mental health parity; nearly three-quarters opted out of the standards related to newborns and mothers; and about one-third opted out of the requirement to provide reconstructive surgery following a mastectomy. A fully insured nonfederal government plan that buys insurance coverage from a carrier does not have the ability to opt out since the carrier must comply with all HIPAA group market standards.

complaints have been received—less than 10 percent of the HIPAA-related complaints received in the last year were related to nonfederal governmental plans. However, enrollees’ potential lack of knowledge about their rights and the appropriate manner in which to pursue grievances may limit the effectiveness of HCFA’s complaint-driven oversight approach for these plans.

Number of HCFA Staff Needed for HIPAA Enforcement Has Continued to Decline, but Questions Remain About the Extent of HCFA’s Future Enforcement Responsibilities

As of April 2001, HCFA had about 16 full-time equivalent (FTE) staff assigned to HIPAA implementation and enforcement efforts. Of this total, 10 were assigned to HCFA’s central office within the Center for Medicaid and State Operations, 3.5 to the Kansas City regional office and about 0.25 FTE to each of the remaining nine regional offices.¹⁴ These 16 FTEs—which include former state insurance regulators, attorneys, and an insurance examiner—represent a continued decline in HCFA staff dedicated to enforcing these standards, from about 39 in July 1998 and 31.5 in March 2000. HCFA officials told us that its resources are adequate for its current enforcement activities because its enforcement role is now more clearly defined and the need for resources has been reduced, in part, because several states have recently passed laws to enforce HIPAA at the state level. In addition, officials said they have benefited from the experience gained in conducting insurance regulatory functions over the past few years.

Several factors could change the scope of HCFA’s enforcement responsibilities in the future. Some of the five states where HCFA has an enforcement role may come into conformance, thus diminishing HCFA’s role. Also, HCFA’s plan to regularly update its legislative review of other states’ laws to ensure that they continue to substantially enforce the federal standards could also increase or decrease its level of effort. Further, because HCFA has not fully established whether states are substantially enforcing the Mental Health Parity Act, HCFA will need to review state laws if the Congress decides to reauthorize the law beyond September 30, 2001. We previously reported that, as of March 2000, laws in eight states and the District of Columbia might not conform to the federal parity law, and seven states had no law addressing mental health coverage.¹⁵ Although several of these states have since enacted laws, several may remain out of conformance. Unless these states issue regulatory bulletins or otherwise demonstrate that they are substantially enforcing the federal standards, HCFA could be required to take an enforcement role in the states. Finally, HCFA’s enforcement role could expand if the Congress enacts patient protection legislation that requires HCFA to assume similar enforcement responsibilities.

¹⁴HCFA also uses an external contractor to perform market conduct examinations.

¹⁵*Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited* (GAO/HEHS-00-95, May 10, 2000).

LABOR HAS EXPANDED ITS ENFORCEMENT ACTIVITIES TO BETTER ENSURE PRIVATE EMPLOYER COMPLIANCE

Labor has had a long-standing responsibility for ensuring that private employer-sponsored group health plans meet certain fiduciary, reporting, and disclosure requirements related to the provision of health benefits under ERISA. Its enforcement approach has traditionally been largely complaint-driven. Because of the increased scope and complexity of its role in enforcing new federal standards under HIPAA and the related laws, Labor has modified this process to better ensure that these health plans comply also with these new standards and has increased the level of resources devoted to health plan enforcement.¹⁶ For example, it has implemented a system of coding consumer inquiries and complaints to better capture information related specifically to standards under HIPAA and the related federal laws. In addition, it has developed and refined a checklist that it uses for conducting compliance reviews of private employers. The checklist includes specific steps for its investigators to follow in examining health plan compliance. Labor officials note that all compliance reviews now include a full review for all federal standards under HIPAA and the related laws, regardless of the initial reason for the review. Officials told us that they have adequate resources to meet their increased responsibilities.

In fiscal year 1999, Labor undertook a pilot project to conduct compliance reviews of a sample of private employer-sponsored health plans.¹⁷ The agency conducted about 230 of these reviews in fiscal year 1999 and an additional 356 from fiscal year 2000 through the second quarter of fiscal year 2001. The agency plans to conduct about 1,250 additional, randomly selected reviews this fiscal year. This random selection method will, for the first time, enable the agency to project these results nationally. This will provide a baseline for assessing the extent to which private, employer-sponsored group health plans are complying with the federal standards, and the results are expected to be available in the second quarter of fiscal year 2002.

In its fiscal year 1999 pilot reviews, Labor found noncompliance rates of about 21 percent for certain HIPAA standards, 12 percent for Mental Health Parity Act standards,¹⁸ and 26 percent for the Newborns' and Mothers' Health Protection Act standards.¹⁹ According to Labor officials, many of the violations are largely technical in nature, such as employers or plan administrators who do not update their plan

¹⁶Labor FTEs devoted solely to health related activities grew from about 66 in 1997 to about 101 currently. This number includes FTEs allocated to compliance assistance and outreach activities.

¹⁷These audits are in addition to those it conducts in response to consumer complaints.

¹⁸We previously reported that a significant minority of private employers may not be fully complying with the federal Mental Health Parity Act (GAO/HEHS-00-95). Based on a random sample of nearly 900 private employers in 26 states and the District of Columbia with laws not more comprehensive than the federal standards, we reported that about 14 percent of plans were not compliant in that they had annual or lifetime dollar limits for mental health benefits that were more restrictive than those for medical and surgical benefits.

¹⁹The Women's Health and Cancer Rights Act was passed more recently than HIPAA and the related laws and was therefore not addressed in the pilot audits.

documents to reflect required changes or issue required notices to enrollees concerning new protections. Another relatively common violation is the imposition of a “hidden” preexisting condition exclusion clause. Under such a clause, a health plan excludes coverage for a certain condition without specifically referring to it as a preexisting condition exclusion clause. Upon identifying a violation, Labor will send a letter to the employer or plan administrator outlining the violation and initiating a dialogue seeking voluntary correction. Accordingly, the vast majority of compliance problems are resolved voluntarily, according to Labor officials. The agency has not resorted to legal action or made any referrals to the Department of the Treasury for the imposition of an excise tax.

TREASURY RELIES ON VOLUNTARY COMPLIANCE AND REFERRALS FROM LABOR

Treasury’s enforcement of the standards under HIPAA and the related laws currently relies on voluntary employer compliance and referrals from Labor. The divisions within Treasury that have enforcement authority were created following a recent agencywide reorganization and, according to officials, as of April 2001, they have not yet begun to develop a strategy focused on these standards. Nevertheless, agency staff said that employers are responsible for ensuring that their health plans comply with the standards and for correcting any areas of noncompliance. Also, to help ensure that employer-sponsored health plans are designed in accordance with federal standards, Treasury regularly provides guidance to employee benefits advisors. Officials told us they did not believe the agency has assessed, nor has any employer voluntarily paid, an excise tax associated with noncompliance. Officials also said they would impose an excise tax penalty in response to violations identified and referred by Labor, but indicated they have not received any such referrals.

CONCLUDING OBSERVATIONS

Since HIPAA’s enactment in 1996, federal agencies’ enforcement roles have continued to evolve as they have established new or expanded existing enforcement activities to ensure compliance with standards under HIPAA and the related federal laws. Agency officials state that they have an appropriate level of staff resources and expertise to carry out their current enforcement responsibilities. HCFA’s future role remains contingent on the actions of states in enforcing the federal standards, as well as on congressional decisions about whether to reauthorize the Mental Health Parity Act or to enact additional patient protection legislation. In addition, the scope of Labor’s future enforcement activities may depend on the extent of noncompliance determined through its compliance reviews of a nationwide random sample of employer-sponsored health plans. The audit results could lead to Labor’s referral of noncompliant plans to Treasury for the imposition of an excise tax. Thus, while the agencies have been able to carry out their required enforcement roles, the scope and extent of these agencies’ continuing enforcement roles will depend on the actions of employers, carriers, states, and the Congress.

AGENCY COMMENTS

We provided a draft of our report to HCFA, Labor, and Treasury for comment. In its written comments, HCFA noted that, at the time of HIPAA's enactment, it had not anticipated that it would have to assume a role in directly enforcing the federal insurance standards. (See enclosure I.) Given this unanticipated role, HCFA highlighted the progress it has made in working closely with the states and in developing and implementing mechanisms to ensure that health carriers comply with HIPAA and the related laws. HCFA also noted that its ability to determine the universe of nonfederal government plans is limited; however, individuals in fully insured, nonfederal government plans are generally subject to state oversight with respect to compliance with these standards. In its written comments, Labor generally concurred with our findings and highlighted the compliance assistance and education and outreach activities it is undertaking to heighten consumer and employer awareness of the protections and responsibilities under the federal health insurance standards. (See enclosure II.) Treasury did not provide written comments. Each agency provided technical comments and suggestions for clarification that we incorporated as appropriate.

As we agreed with your office, unless you publicly announce the contents of this correspondence earlier, we plan no further distribution of it until 30 days after its issue date. We will then send copies to the Honorable Michael McMullan, Acting Deputy Administrator of the Health Care Financing Administration; the Honorable Elaine L. Chao, Secretary of Labor; the Honorable Paul H. O'Neill, 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 correspondence was developed by Susan Anthony, John Dicken, and Randy DiRosa. Please call me at (202) 512-7118 if you have any questions.

Sincerely yours,



Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

Enclosures - 2



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: MAY -1 2001

TO: Kathryn G. Allen
Director, Health Care—Medicaid and
Private Health Insurance Issues

FROM: Michael McMullan 
Acting Deputy Administrator

SUBJECT: General Accounting Office (GAO) Draft Report: *Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve* (GAO-01-652R)

Thank you for the opportunity to review your draft report to Congress concerning our enforcement efforts in states that have failed to substantially enforce requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or related Federal statutes.

We appreciate GAO's recognition that the Health Care Financing Administration (HCFA) has continued to make progress in developing and implementing mechanisms to ensure that health insurance issuers comply with HIPAA. HCFA has established targets for enforcement activities to be conducted in the five states (Colorado, Delaware, Massachusetts, Missouri, and Wisconsin) in which HCFA has direct enforcement and has shared these expectations with the regional office responsible for enforcement of the applicable Federal statutes.

Attached are our comments on the specific findings in the report. We look forward to working with GAO on this and other issues.

Attachment

Comments of the Health Care Financing Administration
on the General Accounting Office (GAO) Draft Report
Private Health Insurance: Federal Role in Enforcing New Standards
Continues to Evolve (GAO-01-652R)

The promise of HIPAA was to afford millions of Americans greater security in their health insurance coverage through improved access, portability, and renewability in the group and individual markets. Helping to ensure that HIPAA delivers on this promise has been a complicated and challenging undertaking for HCFA. While it was clear on the day of enactment that HIPAA required HCFA to assume a new role in overseeing state regulation of health insurance, neither Congress nor the Administration anticipated that HCFA would be involved in direct regulation of the insurance industry. The HCFA assumed enforcement activities in three states that had notified HCFA of their failure to enforce HIPAA standards. HCFA worked closely with state officials in these efforts, and developed positive working relationships. Since that time, two of the states have enacted laws addressing the HIPAA provisions. After extensive analysis, HCFA concluded that each of these state's laws substantially conformed to HIPAA. As a result, HCFA has transitioned enforcement responsibilities to each of these states.

In addition to reviewing the three states which advised us at the outset that they would not have the necessary state laws or regulations in place, HCFA also reviewed the statutory and regulatory underpinnings of HIPAA-related programs in the remaining states to determine whether their laws and regulations substantially conformed to subsequent, related laws. Using contractors and HCFA staff, we examined each state's HIPAA-related laws and regulations, and compared them provision-by-provision to the Federal law. The resources invested in this review helped to uncover apparent discrepancies in several states. After discussion with each state, if HCFA determined that significant discrepancies did exist, HCFA worked with that state to comply with the Federal law.

As noted in the GAO report, HCFA also identified four states that have no provision allowing even one of the laws that followed HIPAA, either the Women's Health and Cancer Rights Act of 1998 (WHCRA) or the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA). The HCFA currently is directly enforcing the relevant law in each of those states, and will continue this enforcement until each state enacts a law of its own.

The report states that HCFA sent letters to carriers in Wisconsin on NMHPA, but does not discuss those sent on WHCRA. As Kansas City reported to GAO during its interview, while the Wisconsin review was (and is) further along in the process, HCFA had by that time sent 254 letters to issuers in the three WHCRA states.

The report states, "Unlike employer sponsored plans under ERISA, nonfederal governmental plans are generally not required to (1) file certain plan information with the Federal government, (2) notify enrollees about certain rights under HIPAA and related laws, and (3) provide enrollees a Federal contact to direct questions." Item number (2) is

overstated. Presently, nonfederal governmental plans that are not exempt from HIPAA requirements (insured plans and self-funded plans that have not opted-out) are required (by regulation) to notify plan enrollees regarding special enrollment periods, a preexisting condition exclusion period under the plan, and the effects of creditable coverage on an exclusion period. Additionally, these plans must notify enrollees regarding required coverage of reconstructive surgery following a mastectomy, as required by WHCRA, and prohibition of plans and issuers from restricting the length of a hospital stay in connection with childbirth, as required by NMHPA.

The GAO states that because HCFA has not determined the universe of nonfederal governmental plans for which it has responsibility, its enforcement efforts have been limited. The GAO further notes that HCFA generally must rely on consumer complaints, and that enrollees' potential lack of knowledge about their rights and the appropriate manner to pursue grievances may diminish the effectiveness of the complaint-driven oversight approach to nonfederal governmental plans.

The HCFA's ability to determine the universe of nonfederal governmental plans is extremely limited. We have no information collection authority to require a governor, a state insurance commissioner, or any other state or local entity to collect information regarding the number of nonfederal governmental plans that operate in a state, and to forward that information to HCFA. We are not aware of any alternative reference sources that would provide accurate data on the number of nonfederal governmental plans nationwide. Moreover, in addressing the issue of determining the universe of nonfederal governmental plans as raised in GAO's March 2000 report, we responded that identifying the universe is not critical to enforcing Federal standards for these plans. For instance, we pointed out that when a plan is fully insured, the insurance carrier generally is subject to state oversight with respect to HIPAA compliance. The GAO agreed that HCFA's position represented a reasonable approach.

The GAO states that HCFA's resources are adequate for the current enforcement activities because our enforcement role is more clearly defined. We would like to clarify that the need for resources has been reduced, in part, because states have since passed laws to enforce HIPAA at the state level.

In all of these efforts, HCFA is working effectively with the states to ensure maximum protection for consumers within the HIPAA framework Congress created. The vast majority of states currently have laws and regulations that ensure substantial compliance with HIPAA and its subsequent, related laws. In the few cases where laws and regulatory infrastructure are lacking, HCFA has been working together with the states to establish appropriate laws and regulations, and where necessary has provided direct Federal enforcement of the law. The HCFA will continue to build on and improve its efforts regarding HIPAA implementation and enforcement. We will also build on this foundation to implement any future additions to the HIPAA statute.

U.S. Department of Labor

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

MAY 3 2001

Ms. Kathryn G. Allen
 Director, Health Care– Medicaid
 and Private Health Insurance Issues
 United States General Accounting Office
 Washington, D.C. 20548

Dear Ms. Allen:

Thank you for providing the Department of Labor (DOL) with the opportunity to comment on the General Accounting Office's draft report entitled "Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve" (GAO-01-625R). I want to take this opportunity to offer a few general comments on the draft report.

Initially, I want to acknowledge our agreement with the draft report's assessment of the DOL's implementation efforts with regard to carrying out our investigative responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As the draft report points out, DOL will continue to actively monitor the implementation process in the group market to ensure problems do not arise.

In this regard, I believe a successful implementation effort involves more than carrying out investigations of private sector employer-sponsored group health plans. Consequently, the DOL has and will continue to devote significant time and resources to the implementation process including our compliance assistance, education and outreach activities. I believe these activities are essential to a successful implementation effort and heighten consumer and employer awareness of the protections and responsibilities under these important health care provisions.

Since your last report on HIPAA implementation the DOL's Pension and Welfare Benefits Administration (PWBA) has implemented several ongoing compliance assistance, education, and outreach programs. Although your draft report only focuses on implementation efforts with regard to our direct investigative activities, I think you should be aware of some of our other ongoing implementation programs that are facilitating compliance and understanding of the rights and responsibilities under HIPAA. These implementation efforts include the following:

Compliance Assistance Activities

- PWBA has conducted several compliance assistance seminars around the country to increase awareness of the Agency as a resource for employees, their families and employers with regard to health care issues. These compliance assistance seminars include:
 - ▶ Throughout FY2001, PWBA is conducting numerous compliance assistance seminars around the country. This effort includes seven full-day compliance assistance seminars to discuss HIPAA and other relevant health care issues with plan administrators, employers, and health care consumers. We have invited other

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federal and state agencies, and nonprofit organizations to participate in these seminars to increase awareness of PWBA as a resource for employees, their families and employers with regard to HIPAA and other health care issues.

- ▶ As a part of the compliance assistance seminars, PWBA has developed a publication outlining 10 key compliance “tips” for administrators of group health plans. The compliance tips were developed as a result of our ongoing experience with compliance reviews, technical assistance, and numerous inquiries received by the Agency. A copy of this publication is enclosed.
- ❑ The number of health inquiries continues to significantly rise as PWBA’s implementation efforts expand. In this regard, during FY1999, our Benefits Advisors responded to 88,242 health inquiries (both written and by telephone) from participants and beneficiaries, as well as the regulated community. In FY2000, our Benefit Advisors responded to 99,240 health inquiries and through the 2nd Quarter of FY2001, we have already responded to 54,203 health inquiries.
- ❑ PWBA has also implemented a new enforcement program (the Rapid ERISA Action Team or REACT) to better protect the rights and benefits of American workers and their families when their employer faces severe financial hardship or bankruptcy and their pension and health benefits are in jeopardy. While still in its early stages, we have initiated 164 REACT investigations and filed proofs of claim in bankruptcy in nine instances.
- ❑ PWBA’s Dislocated Workers’ Program provides information on health and pension benefits for workers affected by plant and business closings, downsizing, etc. Field Office staff participated in 50 on-site briefings for participants and employers during FY2000 and already participated in 65 through the 2nd quarter of FY2001. During these events workers and their families are provided information on their health care options and rights and our Field Office staff answers any questions they may have.

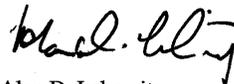
Development of Outreach and Educational Materials

- ❑ In late FY1999, the Department established its Health Benefits Education Campaign. The Department has been joined by over 70 partners in the Campaign, including members of the private sector representing a wide range of interests from employee, to employer, to health care providers.
- ❑ PWBA, through its Health Benefits Education Campaign, has published and distributed a number of tools for employees and employers. To date, we have distributed a combined total of over 1.5 million of the publications listed below. In addition to creating and distributing these publications, we have made all of our educational information accessible on our internet website. These publications include:
 - ▶ “Questions and Answers: Recent Changes in Health Care Law,”
 - ▶ “Top Ten Ways to Make Your Health Benefits Work for You,”

- ▶ “Life Changes Require Health Choices, Know Your Benefits Options,”
 - ▶ “Work Changes Require Health Choices, Protect Your Rights,” and
 - ▶ “Questions and Answers for Dislocated Workers.”
- ❑ PWBA has developed two posters holding information cards that can be taken free of charge by the public. These posters and cards were developed during FY2000 and distributed in the first quarter of FY2001. The first poster and card provide important information on the Newborns’ and Mothers’ Health Protection Act. We worked with the Health Benefits Education Campaign partners to display the poster and cards in doctors’ offices, especially OB/GYN offices, drug stores and hospitals. The second poster and card provide information to help workers and their families when their health benefits claims are denied is now being distributed through similar partnerships.
- ❑ PWBA has also disseminated printed Public Service Announcements (PSAs) that provide key information about HIPAA and other new health care provisions. These PSAs appeared in over 160 publications, reaching over four million Americans.
- ❑ The Agency has also been developing an E-laws interactive health advisor internet website relating to HIPAA and other recently enacted health care provisions. The E-laws health advisor is near completion and will be comprised of a decision tree enabling workers and employers to enter facts pertaining to their individual situation and receive advice and information on specific laws and regulations administered by the Department of Labor.

I hope that the enclosed information, as well as our technical comments provided during this process, are helpful for your preparation of your updated report on HIPAA implementation. If there are any questions on these comments, please contact Daniel J. Maguire, Director, Office of Health Plan Standards and Compliance Assistance at (202) 219-8951.

Sincerely,



Alan D. Lebowitz
Acting Assistant Secretary

Enclosure

RELATED GAO PRODUCTS

Mental Health Parity Act: Employers' Mental Health Benefits Remain Limited Despite New Federal Standards (GAO/T-HEHS-113, May 18, 2000).

Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited (GAO/HEHS-00-96, May 10, 2000).

Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States (GAO/HEHS-00-85, March 31, 2000).

Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards (GAO/HEHS-99-100, May 12, 1999).

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

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

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

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

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

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