A Different Kind Of 'New Federalism'? The Health Insurance Portability And Accountability Act Of 1996

The new law has raised both hopes and fears about the role of the federal government in health insurance reform.

by Len M. Nichols and Linda J. Blumberg

ABSTRACT: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 has been praised and criticized for asserting federal authority to regulate health insurance. We review the history of federalism and insurance regulation and find that HIPAA is less of a departure from traditional federal authority than it is an application of existing tools to meet evolving health policy goals. This interpretation could clarify future health policy debates about appropriate federal and state responsibilities. We also report on the insurance environments and the HIPAA implementation choices of thirteen states. We conclude with criteria for judging the success of HIPAA and the evolving federal/state partnership in health insurance regulation.

THE OVERRIDING POLICY GOAL of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 is to increase the number of persons who have and maintain access to health insurance. This is the same goal that many state legislatures pursued during the 1990s with small-group and individual market reforms similar to and in some cases stronger than those codified in HIPAA. The primary method of increasing access under HIPAA and most existing state laws is to make it more difficult for insurers to segment insurance risk pools and deny or revoke access to specific individuals or groups on the basis of health status. HIPAA accomplished this with a variety of specific provisions for both the group and individual

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health insurance markets, which we discuss below. Some provisions, specifically the ones applicable to employer-sponsored group health plans protected from state law by the federal Employee Retirement Income Security Act (ERISA) of 1974, impose requirements that states were not permitted to impose on their own. In addition to its specifics, then, HIPAA reflects a certain point of view about the proper balance of state and federal authority over health insurance regulation in the United States.

HIPAA has been celebrated as the "first national health policy with such far-reaching implications since the enactment of Medicare and Medicaid in 1965."[1] It also has been condemned for pushing us further down the slippery slope toward socialized medicine: "Liberals in Congress and elsewhere, who have a clear vision of their goal of a government-run and government-managed health care system, would seize on any regulatory problem created by this legislation as an excuse to extend federal regulation."[2]

HIPAA may have raised both expectations and fears about an expanded federal role in health insurance reform that are overstated relative to the law's content, congressional intent, and a fair reading of the history of federalism in this area. This paper offers an interpretation of HIPAA that is designed to clarify its relation to all three. This clarification may be useful background for future health policy debates about the appropriate and efficient distribution of responsibilities between federal and state governments. Perceptions of current roles of state and federal governments may be more restrictive than our history and law suggest they should be. HIPAA is a good vehicle for reexamining our perceptions of these roles. We also report on the implementation choices that have been made by the thirteen case-study states of the Assessing the New Federalism (ANF) project.[3] Finally, we identify emerging policy research issues to monitor as the implementation of HIPAA proceeds and as federal and state health insurance policy evolves.

History Of Federalism And Insurance Regulation

In the fifty years prior to HIPAA, the federal government passed four major pieces of legislation with implications for private health insurance markets: the McCarran-Ferguson Act (1945), the Health Maintenance Organization (HMO) Act (1973), ERISA (1974), and the Medigap reform provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1990. Each had a very specific goal.

■ **McCarran-Ferguson.** A U.S. Supreme Court decision first applied federal scrutiny to insurance markets in 1944. An antitrust dispute led the court to rule that insurance transactions were indeed interstate commerce and thus subject to federal antitrust laws.[4]

Largely at the behest of insurers who feared activist federal oversight, the very next year Congress passed the McCarran-Ferguson Act, which exempted health insurance markets (and the "business of insurance" generally) from federal antitrust prosecution as long as those markets were regulated by the states.[5] The immediate policy concern at the time was collusive price-fixing by insurers. Congress wanted to prevent that but preferred to depend upon state regulation rather than federal antitrust enforcement to do so. Regardless of the specific issue of the day, the Supreme Court ruling and the statute combined to establish two important federalism contours: (1) The federal government has constitutional jurisdiction over insurers when they are engaged in interstate commerce (as they virtually always are); and (2) in 1945 Congress delegated regulatory responsibility over insurance markets to the states.

Although Congress certainly intended to protect insurers from federal antitrust enforcement, at the same time McCarran-Ferguson expressed a federal judgment that detailed regulation of insurance markets to protect consumers could be done more effectively at the state level than at the federal level. The act delegated insurance regulation to the states on condition that that regulation not contradict federal purposes. In 1945, pursuant to the prior Supreme Court ruling, the federal purpose was the prevention of price-fixing, but federal goals for interstate commerce can evolve, as we shall see.

As a practical matter, most states focused their regulatory attention on assuring insurers' solvency, imposing only minimal "file and use" regulation of insurers' pricing. Solvency protections enhance consumers' faith that their contingent insurance contracts will be honored after premiums are paid. Thus, solvency protection is the essential first step toward enabling insurance markets to continue to exist. Much less attention was paid to effective competition or health policy issues—that is, how well existing insurance markets actually worked—until the 1970s.

■ **HMO Act.** The HMO Act was the first major federal foray into health insurance markets specifically.[6] Here the intent was to promote competition by encouraging the development of cost-effective systems of delivery and of alternatives to indemnity insurance. The act fostered the development of qualifying HMOs by overriding state statutory and common-law prohibitions on the operation of prepaid group practices and the corporate practice of medicine.

The official purpose of these prohibitions was to prevent quackery and commercial exploitation of an "untutored public."[7] They also addressed physicians' economic fear that employers would hire physicians to provide care to their workers at low rates.[8] Workers in the early part of the twentieth century opposed employers' picking their

doctors for them, anyway.[9] These arguments were refined over time to support the prohibitions in the name of opposing "lay interference . . . [and the] division of loyalty between patients' interests and those of the corporation."[10] These laws and doctrines effectively stifled the development of prepaid group practices and HMOs as we know them today.

The HMO Act also required employers with more than twenty-five employees that offered at least one health insurance plan to also offer an HMO if requested by a local HMO. The law originally offered start-up grants to new HMOs that met certain federal requirements (regarding services covered and risk-pooling methods). Thus, the federal government actively sought to promote enrollment in and use of private HMOs.

Still, the federal focus was not on the regulation of specific health insurance markets, but on assuring maximum opportunity for qualifying HMOs to be able to compete for private employers' business. In a sense, this was the use of federal power to make a health insurance and delivery alternative more widely available than it might have ever been because of state laws that protected indemnity insurers and fee-for-service medicine from competition of this sort. This was the federal government pursuing health policy objectives in the private insurance market for the first time. The HMO Act circumscribed the boundaries within which states could regulate health insurance markets and prevented states from making it impossible for HMOs to compete.

■ **ERISA.** The primary purpose of ERISA (passed just one year after the HMO Act) was to protect private employee pension plans from abuse and mismanagement by imposing and enforcing federal standards for those plans.[11] There is some dispute about whether Congress also intended or was even aware that ERISA as written would preempt state regulation of self-funded health plans. This confusion apparently stems from the relative emphasis on pension abuses in the legislative hearings, the expectation that national health insurance legislation would be passed that session and render moot all existing regulation of private health plans, and statements by Sen. Daniel K. Inouye (D-HI) in support of Hawaii's exemption from ERISA, which were widely cited at the time.[12]

Subsequently, however, the U.S. Supreme Court left no doubt that Congress included specific language and exhibited sufficient legislative intent to extend ERISA protection to employee health plans.[13] A report by a former counsel to the late Sen. Jacob Javits (R-NY) and the relevant committee makes clear that at least the House-Senate conferees who actually wrote ERISA were fully aware that both unions and large employers were concerned that conflict-

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ing state laws could impose impossible compliance burdens on their multistate health care plans and could threaten hard-fought collective-bargaining agreements over health care arrangements.[14]

ERISA allows employers, unions, and some groups of employers acting in concert to be exempt from all state laws regulating health insurance if they set up their own self-funded plan or plans and bear the insurance risk of that plan.[15] In essence, ERISA says that employers can choose to engage in the business of health insurance for their own employees, and as long as they meet certain federal reporting and solvency requirements, they will be exempt from state laws designed to regulate the business of insurance.

ERISA, like the HMO Act before it, is a manifestation of federal power to supersede state laws when the federal government decides that those laws threaten or contradict some federal purpose. In ERISA's case, the federal purpose in relation to health plans was and remains to preserve the freedom of larger, self-insured firms to fashion their own employee benefits through collective bargaining or other worker/management processes, rather than being subject to the potentially conflicting details of fifty different states' laws. Thus, in 1974 Congress again circumscribed the broad authority it had granted the states to regulate insurance arrangements in McCarran-Ferguson nearly thirty years before.

■ **Medigap reform.** This reform is more like HIPAA than the other three cases are. Since its beginning in 1965, the Medicare benefits package has always had two glaring shortcomings compared with most employer-sponsored private insurance plans: no prescription drug coverage and no out-of-pocket maximum.[16] These coverage gaps have led to a thriving market for insurance policies to supplement Medicare coverage with insurance for beneficiary copayment obligations and for uncovered services.[17]

Experiences with this so-called Medigap market have been well documented elsewhere.[18] We merely note that seniors apparently bought many duplicative and low-value policies because of confusion surrounding the vast array of Medigap products on the market. In 1980 Congress signaled its dissatisfaction with this market with the Baucus amendments, which called for voluntary standards to be implemented by states and Medigap insurers.[19] Although much was done in this regard, during the 1980s it remained clear that consumers still faced hundreds of Medigap policy options. So in 1990 Congress acted to reduce the number of Medigap plans that could be

offered to ten different, standardized plans (Plans A–J). By most accounts, the Medigap market is functioning much more effectively today.[20] In this case, Congress determined that the private Medigap market, historically within the delegated purview of the states, was not functioning well for the beneficiaries of the federal Medicare program and acted to standardize the rules of competition within that private market across all states.

HIPAA: A Major Departure For Federal Policy?

Within this historical context, HIPAA represents less of a departure from traditional federal policy toward health insurance markets than a reappraisal of the effectiveness of existing state regulation of insurance markets to accomplish evolving federal goals. States had already concluded that laissez-faire in insurance markets was not ideal, for forty-seven states passed some small-group or individual market reforms between 1989 and 1996.[21] These reforms take many forms, but overall their intent and effect are to increase the degree of health risk pooling—that is, to reduce the natural risk segmentation that is most profitable for most insurers under a laissez-faire policy.[22] Yet even after all of these state reforms have been implemented, small firms are still less likely than large firms are to offer health insurance to their workers, and workers in small firms are much more likely than workers in large firms are to be uninsured.[23] Indeed, the total number of uninsured persons continues to rise, despite considerable expansions in Medicaid coverage.[24]

■ **Removal of health status from the equation.** After rejecting more comprehensive reform approaches such as President Bill Clinton's Health Security Act, Congress determined in 1996 that small-group and individual health insurance market performance could and should be enhanced with the explicit articulation of new federal goals. Policymakers in states that had already passed substantial reforms encouraged and welcomed federal action of this type. In effect, HIPAA establishes a federal floor for a degree of assurance that health status will render neither individuals nor their dependents uninsurable in the group market or even, under certain conditions, in the individual market. HIPAA expressly leaves the direct regulation to the states in the first instance but provides for federal regulation in the event that the states choose not to pass and enforce the new federal standards for insurance market performance. A component of the legislation that could not have been accomplished at the state level is the application and enforcement of certain dimensions of this federal floor to ERISA plans. This more active federal regulation of ERISA plans also contributed to some state regulators' support for HIPAA, as it served to somewhat "level

the playing field" between ERISA plans and fully insured products that could be fully regulated at the state level. For example, heretofore ERISA plans had been allowed to impose preexisting condition exclusions and exclude persons because of their health status.[25]

■ **Extension of federal involvement.** Although HIPAA is consistent with the federalism principles long established for insurance, it also represents an extension of federal involvement in private insurance markets in two ways. First, by specifying detailed rules of issue and renewability that are minimally acceptable in all states, HIPAA did for the under-age-sixty-five market what Congress had already done for the Medigap market: It circumscribed the range of permissible state regulations. Second, by providing for direct federal regulation of ERISA plans and as a fallback mechanism for fully insured plans, HIPAA created the possibility that private insurance markets (beyond the Medigap market) within a particular state will be regulated primarily by the federal government.

This assertion of latent federal power surprised many observers in 1996 not because it represented a usurpation of states' constitutional authority over insurance markets, for that issue had been settled by the Supreme Court in 1944, but rather, because of HIPAA's contrast with most initiatives of the 104th and 105th Congresses, which tended to elevate state over federal power.

Given some of the rhetoric surrounding the defeat of comprehensive health care reform plans in 1993–1994, quite a few health policy analysts were surprised that the 104th Congress effectively acknowledged that health insurance markets needed specific intervention, especially federal intervention. Of course, as has been noted, the kinds of reforms embodied in HIPAA were exactly what many people told pollsters during 1992–1994 they really wanted.[26]

■ **Retention of state regulation.** Still, Congress made very clear in the legislative debate that the states are still expected to be the primary enforcement agent of most of these new federal requirements.[27] Thus, the 104th Congress did not express the judgment that it had lost faith in the states' abilities to regulate insurance markets, just that all states should enforce at least the minimal standards of HIPAA and that the federal government would apply some of these standards to ERISA plans as well. HIPAA expressly granted the states considerable flexibility regarding implementation of the specific requirements of the law in their own environments, although states' implementation plans must be approved by the secretary of health and human services.

HIPAA's Health Insurance Reforms

HIPAA set minimum standards for access to health insurance by

groups and certain eligible individuals throughout the country and established procedures for federal oversight of state regulation of these standards as well as for direct federal enforcement, if necessary. This law also applied some provisions to self-insured firms that previously had been and are still exempted from state insurance regulations by ERISA. Thus, HIPAA took some steps, albeit incremental, toward unifying the complex patchwork of regulatory frameworks that insurers, firms, and individuals navigate each time they transact health insurance business in the United States.

■ **Preexisting condition exclusions and portability.** Specifically, the first step HIPAA took to enhance access to coverage for the sick was to place restrictions on preexisting condition exclusions in both the small- and large-group markets. HIPAA requires that all group health plans, including ERISA plans, limit to no more than twelve months their period of excluded coverage for conditions for which medical advice, diagnosis, care, or treatment was recommended or received in the previous six months. In addition, employers and insurers now must acknowledge prior coverage when computing allowable preexisting condition exclusions. Most states had already imposed limits (sometimes of shorter length) on preexisting condition exclusions for small groups, and many had similar laws for individuals.

Considerable policy interest has centered on the research findings that people appear reluctant to leave a job with health insurance because they are afraid that they or some family member may be denied health insurance in general or coverage for a preexisting condition in a new job.[28] HIPAA's "portability" provisions effectively guarantee group-to-group portability for job changers who have had eighteen months of continuous prior coverage and thereby reduce the bases for such fears. However, HIPAA's portability provisions do not guarantee that persons can keep their current health insurance policy, just that they will be granted access to the policy(ies), if any, offered by their new employer.

■ **Guaranteed issue and renewal.** HIPAA took two additional steps to improve access specifically in the group market. First, it requires insurers operating in the small-group market (defined in federal law as two to fifty employees, with flexibility for states to include additional group sizes in this definition) to guarantee issue of all products they offer in this market to all small groups and to all eligible individual members of those groups, regardless of health status. This change required many states to expand their definition of a small group. Furthermore, prior to HIPAA, many states had required small-group carriers to guarantee issue of only two specific products; HIPAA's provision thereby enhanced access to a broader

array of products in all states. As a second additional step, HIPAA requires all group carriers, in both the small- and large-group markets, to guarantee renewal of their products.

■ **Group-to-individual market portability.** Finally, HIPAA took an initial step to enhance portability and access between the group and individual markets. At the time of HIPAA's passage, some states had portability provisions in the individual market, and a smaller number of states required individual insurers to guarantee issue of products. HIPAA provided enhanced portability and access to coverage for a statutorily defined class of "eligible individuals." HIPAA did not assure access for all persons previously covered under the group market who move into the individual market, nor did it address portability into the individual market from another individual product or from a publicly funded program such as Medicaid. HIPAA also has no general premium rating restrictions, although there are limits on premiums that may be charged eligible persons in a state high-risk pool, as described below.

HIPAA's "eligible individuals" have had eighteen months of continuous prior coverage (no coverage gap lasting longer than sixty-two days), most recently group coverage; have exhausted any Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits to which they were entitled and have no current access to group insurance or a public program; and are eligible for some type of guaranteed issue coverage in the individual market.[29] States have considerable latitude to define the type of coverage available and to broaden the class of "eligible individuals." These provisions, which effectively guarantee group-to-individual portability for certain persons, stirred considerable controversy prior to passage, as some feared that individual premium rates would rise substantially as a result of this provision, while others predicted much more modest effects.[30] HIPAA also required that all coverage in the individual market be guaranteed renewable.

States' Implementation Choices Under HIPAA

The fundamental issue in all health insurance reform is risk pooling: Should government require dissimilar health risks to be pooled, and if so, how and how much? Profit-seeking insurers want to segment risks as much as possible, for this allows them to earn a profit on each segmentable group. Policymakers are essentially asked to decide how much segmentation they will allow, while weighing the gains of pooling to the sick against the cost of pooling to insurers and to those who expect to be healthy.

Although federal premium rating restrictions are imposed only when states use their public high-risk pools for eligible persons,

"HIPAA guarantees the opportunity to purchase insurance. It does not guarantee that insurance will be affordable."

HIPAA does exert gentle pressure on private risk pools to be more inclusive and heterogeneous in two ways. First, by restricting preexisting condition exclusions for all privately insured persons, HIPAA extends existing coverage over more people for a slightly larger fraction of their lifespans and health expenses. Although this must add to premium costs, on average, most states and analysts have concluded that the cost of restricting (but not eliminating) preexisting condition exclusions is very small. Second, by guaranteeing issue and renewal of health insurance for small groups and certain individuals, HIPAA guarantees the opportunity to purchase insurance, and at least some of those purchasers will be pooled with others who would have had access to insurance without HIPAA. Importantly, HIPAA does not guarantee that insurance will be affordable. Affordability and attractiveness of policies to various types of consumers will, in large part, be a function of choices that states make about premium rating restrictions—with whom will HIPAA eligibles be pooled—as well as subsidization or cost containment approaches, if any. It is unlikely that HIPAA will expand coverage much without additional subsidies.

In general, HIPAA allows states three broad implementation choices: (1) pass laws congruent with or stronger than the federal floor specified in HIPAA and enforce them using state agencies; (2) create an acceptable alternative mechanism for eligible persons in the individual market and enforce it with state agencies; or (3) decline to pass new laws or strengthen existing laws and leave enforcement of the HIPAA provisions directly to the federal government. Which of these three a state decides to pursue is largely determined by its existing health insurance market and regulatory environment.

■ **Case-study states.** Exhibit 1 presents some basic facts about the thirteen states in which the Urban Institute conducted case studies for the ANF project, including (1) their 1995–1996 rate of uninsurance; (2) whether their state law prior to HIPAA was already consistent with HIPAA; and (3) the specific choice made for implementing group-to-individual portability for eligible persons, by far the most complicated implementation choice. The states are grouped by the amount of new legislation that was needed to bring themselves into compliance with HIPAA, from least to most. These thirteen states illustrate the heterogeneity of uninsurance, the comprehensiveness of prior laws, and HIPAA implementation choices that are present throughout the United States.

EXHIBIT 1
Selected States' Health Insurance Reform Environments And HIPAA Implementation Choices

		Group market		Individual market	
ANF states	Share of population uninsured, 1995–1996	Were prior state laws in compliance with HIPAA rules?	Additional legislative activity	Were prior state laws in compliance with HIPAA rules?	Strategy for implementing group-to-individual market portability
States that had or nearly had HIPAA-type reforms already					
New Jersey	14.6%	Yes	–[a]	Yes	GI of all private products
New York	16.8	Yes	–[a]	Almost	GI of all private products
Washington	12.9	Yes	–[a]	Yes	GI of all private products
States that had or nearly had HIPAA-type reforms in the small-group market					
California	19.7	Yes	–[a]	No	Federal enforcement
Colorado	14.0	Almost	Passed new law	No	Federal fallback
Florida	19.2	Almost	Passed new law	No	Conversion policies/ federal fallback
Massachusetts	12.6	Yes	–[a]	No[b]	All carriers provide 3 products
Minnesota	9.2	Yes	–[a]	No	Existing high-risk pool
Texas	23.9	Almost	Passed new law	No	New high-risk pool
States that had much reform to pass to be compliant with HIPAA					
Alabama	16.9	No	Passed new law	No	New high-risk pool[c]
Michigan	10.4	No	New law not yet passed	No	Insurer of last resort (Blue Cross/Blue Shield)[d]
Mississippi	20.1	No	Passed new law	No	Existing high-risk pool
Wisconsin	8.6	No	New law not yet passed	No	Existing high-risk pool[e]

SOURCES: Urban Institute estimates using the Current Population Survey for 1995–1996; Blue Cross and Blue Shield Association, 1996; National Association of Insurance Commissioners, 1997; and Communicating for Agriculture, 1997.
NOTES: HIPAA is Health Insurance Portability and Accountability Act. ANF is Assessing the New Federalism (project). GI is guaranteed issue.
[a] Not applicable.
[b] State has yet to pass a law requiring guaranteed renewability to all persons.
[c] Only open to federally eligible persons.
[d] Michigan has yet to pass a law that would require the insurer of last resort to enroll federally eligible persons without preexisting condition limitations. Currently, there is a six-month preexisting condition exclusion for all enrollees.
[e] Wisconsin has yet to pass a law that would limit the premiums for federally eligible persons enrolling in the high-risk pool to 200 percent of standard market premiums. Currently, premiums are set to recover 60 percent of program costs, and low-income subsidies are also available; consequently, the state's policies may be at least as generous as HIPAA requirements.

There appear to be no obvious relationships among uninsurance rates, prior health insurance market reforms, and HIPAA implementation choices, since states with both high and low uninsurance rates made similar choices (for example, high-risk pools), as did states with extensive and with relatively few prior reforms. Still, Exhibit 1 does reveal some consistent patterns. Most of our case-study states had already passed small-group provisions that were at least as strong as those in HIPAA, but few afforded eligible persons guaranteed issue as now required by law. After HIPAA more states opted to use their state-sponsored high-risk pools for eligible persons than they did any other single mechanism, although a fairly large number are requiring private insurers to accept them. This choice highlights the risk pool issue very well, which we discuss at some length below. As of this writing, not all states had decided exactly how they were

going to implement and enforce HIPAA's individual market provisions. These patterns depicted in our ANF case-study states are roughly consistent with those observed in all fifty states.[31]

HIPAA allows states considerable flexibility in implementing the group-to-individual portability provisions. The bill provides for guaranteed issue of all private insurers' products to eligible individuals, and states that had already reformed both the small-group and the individual market will require this. But HIPAA also allows insurers, under state oversight but in the absence of new state law, to limit their guaranteed offerings to at least two products that meet certain standards. This flexibility would allow insurers to shield most individual-market products from HIPAA's guaranteed-issue requirements and any adverse-selection possibilities that might ensue. This flexibility also might lead to higher premiums for eligible persons than for others insured through the individual market, if they can indeed be segmented into separable markets and eligible persons turn out to be higher risks on average. This is especially likely if state law permits individual-market insurers to underwrite all non-HIPAA eligibles in the individual market, as most do. A "limited number of private products" option will be in place in Colorado and Massachusetts and probably in California as well.[32] Eligible persons in Michigan and Florida also will have access to private insurance, through a Blue Cross/Blue Shield insurer of last resort and enhanced group conversion policies, respectively. Eligible persons coming from ERISA plans in Florida will have access to two private products from each nongroup insurer.

HIPAA also provides a third alternative for group-to-individual portability. States may establish an acceptable alternative mechanism (AAM) for assuring access to individual market coverage for eligible persons, as long as the mechanism imposes no preexisting condition exclusions (for eligible persons), provides for some choice of plan, and has some mechanism for spreading risk. The most popular mechanism among states is a state-run high-risk pool, which segments eligible persons away from commercial insurance products. High-risk pool products are modeled after commonly available private products in the nongroup market but typically have higher deductibles and tighter coverage limits. Some version of the high-risk pool option will be implemented in Minnesota, Texas, Alabama, Mississippi, and Wisconsin.

The high-risk pool approach combines eligible persons with otherwise uninsurable persons.[33] Whether this makes insurance more or less affordable than other mechanisms do will depend upon premium pricing rules inside and outside the high-risk pool. The drafters of HIPAA anticipated the affordability problem and required high-risk

pools that are to be used as acceptable alternative mechanisms to be consistent with a National Association of Insurance Commissioners (NAIC) model act that limits premiums charged to no more than twice the standard rate.[34] Although a ceiling this high may keep health insurance out of the reach of some eligible persons, the limit also forces the state to subsidize high-risk pool premiums with other funds. All states do this now in their risk pools, and at present most of these funds are drawn from state premium taxes. Thus, using a high-risk pool as an acceptable alternative mechanism does not shield the private commercial market completely—HIPAA in effect requires some cross-subsidy by setting a high-risk pool premium limit.

If a state does not use a high-risk pool to satisfy HIPAA, there are no federal statutory limits on what insurers may charge eligible persons.[35] Reasonable analyses of the likely effects of guaranteeing issue to eligible persons suggested that negligible to small effects (1–5 percent) on average premiums are most likely.[36] However, these were projections based on equilibrium assumptions about health risks. If eligible persons turn out to be sicker than anticipated or if insurers charge high premiums in the short run because of uncertainty about their relative cost, premiums in the private market for HIPAA eligibles could be much higher than 200 percent of the standard rate. This is especially likely if states do not have premium rating restrictions in the private nongroup market, as most do not.

If states do have premium restrictions in the nongroup market, as Minnesota, Massachusetts, New Jersey, New York, and Washington do, then they are legislating a kind of cross-subsidy of the bad risks that is financed by higher premiums on the good risks in the nongroup market. This is qualitatively equivalent to partially financing state high-risk pool products with assessments on insurers or premium taxes. The difference is, the subsidized risk-pool approach spreads the risk evenly across insurers (typically proportional by private market share), whereas the premium rate-band approach forces insurers to cross-subsidize within their own pool of insured persons. If all nongroup insurers are large, this effect is negligible, but if some insurers are small and if high-risk persons sort themselves unevenly, those insurers may bear disproportionate burdens. All insurers fear being made uncompetitive by randomly attracting bad risks, ergo the popularity of the high-risk pool option among insurers, especially the smaller ones.

California, as usual, merits particular attention, for that state has left enforcement of HIPAA's individual market provisions to the Health Care Financing Administration (HCFA). The other states that requested direct federal enforcement, Missouri and Rhode Island (not states where the ANF team conducted site visits), had not

"The major question will be the extent to which guaranteed issue affects individual insurance markets and access to coverage."

had much history of detailed insurance regulation and apparently feared that they did not have adequate regulatory capacity to ensure compliance with the complicated law. Although California has been much more active in regulating the small-group market than it has the individual market, it also has a high-risk pool and a state-run purchasing cooperative that probably could have formed the basis for an acceptable alternative mechanism of some kind. Neither Congress nor HCFA anticipated direct federal regulatory responsibility in a state as large as California, and delays of implementation and enforcement may be inevitable there.

Issues To Monitor, Data To Track

Since a large number of states were already in substantial compliance with HIPAA group health insurance market rules, health policy analysts are likely to focus on the effects of HIPAA in the individual market. The major question will be the extent to which guaranteed issue for eligible persons affects individual-insurance markets (including private insurers and public high-risk pools) and access to coverage. Specific questions to consider are: (1) How will premiums in the individual market and within existing high-risk pools change as a function of the implementation of HIPAA? (2) To what extent will HIPAA lead to a shortening or elimination of preexisting condition exclusion periods, and what is the effect of this on utilization, total costs, and out-of-pocket costs? (3) Will more people gain coverage than lose it (because of premium increases) as a result of HIPAA? Will they be different kinds of people; for example, will those who gain coverage be in worse health than those who drop it? (4) Will effective access and insurance coverage for eligible persons increase, or will more explicit premium regulation be perceived to be necessary? Will this perception vary systematically by implementation strategy? If perceived to be necessary, will states or Congress implement individual-market rating restrictions? (5) What effect will HIPAA have on the exit and entrance of insurance carriers and health plans in various states? Will most carriers that exit be small? What will be the positive and negative ramifications of these changes in market structure? Will this effect vary by HIPAA implementation strategy? (6) Will purchasers feel that they are receiving a better value for their insurance dollar since the implementation of HIPAA makes their coverage more secure, and will this value outweigh the (probably modest) premium in-

crease that will likely occur? A report issued recently by the General Accounting Office suggests that some insurers are pricing premiums for HIPAA-eligible individuals at 140 percent to 600 percent of the standard rate and segmenting healthy eligibles into separate plans from unhealthy eligibles and that consumer confusion about rights under HIPAA is widespread.[37]

The difficult research issue that underlies each of these questions is how to effectively design an analysis of policy reforms that affect relatively small numbers of persons. Usual sources of survey data may be unhelpful for these purposes because their sample sizes are likely to be too small to capture a significant number of persons who are eligible under HIPAA. Similarly, looking for a quantitative impact of HIPAA on some measure of average small-group and individual premiums also may prove to be problematic, both because of the absence of first-rate baseline data and for the sample-size reasons discussed earlier. If there are relatively few eligible persons, as most objective analysts expect, granting guaranteed issue cannot possibly have much of an impact on average premiums. In a very real sense, the appropriate analysis of the success of HIPAA may be more qualitative (what is the nature of eligible persons' complaints about access to health insurance?) than econometric (did individual-market premiums increase as a result of HIPAA?).

With regard to the group-market reforms, much analysis will focus on those states that had not previously had strong small-group insurance market reforms. The ANF case-study states that fall into this category are Michigan, Wisconsin, Alabama, and Mississippi. There is some evidence that guaranteed issue in the small-group market may decrease rates of uninsurance.[38]

Another group provision that represents significant change is guaranteed issue of all products. Prior to HIPAA, most states that did have guaranteed issue for groups required it only for two products. HIPAA thus outlaws multiple employer trusts (METs), which are groups of employers that are pooled together and quoted common rates for specific policies by aggressive insurers. Employers with bad or unknown risks often did not even know that MET products existed, for METs served as successful risk-segmentation devices for quite some time.[39] Thus, HIPAA could broaden the range of accessible insurance products for quite a few employer groups. Of course, HIPAA also might lead to the demise of some of those products as risk segmentation becomes more difficult (and less profitable).

From a federalism perspective, the important HIPAA-related question is whether federal/state cooperation can effectively enforce the letter and spirit of a complicated health in-

surance market reform law. If it can, then HIPAA may have created a practical formula for governmental success in health care reform. However, if these two levels of government do not succeed in coordinating the implementation of the multiple provisions encompassed in HIPAA amidst contradictory agendas, heterogeneous constituencies, and inevitable administrative complications, then perhaps another reevaluation of this "different federalism" will be forthcoming. Given the competing agendas that led to HIPAA's passage (it was supported by those who think that the law is more than is necessary to "fix" health insurance markets and by those who expect it to be merely the first federal step in "fixing" these markets once and for all), both sides will be quick to interpret the results of HIPAA to suit their prior political positions. The evolution of perceptions about HIPAA's impact and enforcement may be as important to future policy decisions as its objective and measurable effects are. Inferences about HIPAA's successes and failures are likely to shape health care reform discussions in the United States for some time to come.

The Assessing the New Federalism project is supported by funding from the Annie E. Casey, Henry J. Kaiser Family, W.K. Kellogg, John D. and Catherine T. MacArthur, McKnight, Robert Wood Johnson, Charles Stewart Mott, and Weingart Foundations and the Commonwealth Fund and the Fund for New Jersey. Additional support is provided by the Joyce Foundation and the Lynde and Harry Bradley Foundation through grants to the University of Wisconsin-Madison. The authors are grateful to their colleagues Randy Bovbjerg, John Holahan, and Alan Weil for comments on earlier drafts. The authors retain responsibility for all errors. The opinions expressed herein are those of the authors alone and do not represent those of the Urban Institute, its trustees, or its sponsors.

NOTES

1. B.K. Atchinson and D.M. Fox, "The Politics of the Health Insurance Portability and Accountability Act," *Health Affairs* (May/June 1997): 146–150.
2. R.E. Moffit, "What to Do about the Kassebaum-Kennedy Bill," *Heritage Foundation Issue Bulletin* 226 (5 June 1996).
3. See A. Kondratas, A. Weil, and B. Goldberg, "Assessing the New Federalism: An Introduction," in this volume, for details on the project.
4. *United States v South-Eastern Underwriters Association*, 322 U.S. 533 (1944).
5. 59 Stat. 33 (1945), 61 Stat. 448 (1947), 15 U.S.C.A. sec. 1101, 1012 (1987).
6. P.L. 93-222.
7. Note, "The Role of Prepaid Group Practice in Relieving the Medical Care Crisis," *Harvard Law Review* (February 1971): 886–1001.
8. P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 198.
9. Ibid., 202.
10. E.H. Forgotson et al., "Innovations in the Organization of Health Services: Inhibitive vs. Permissive Regulation," *Washington University Law Quarterly* 1

(1967): 400, 413, quoted in Note, "The Role of Prepaid Group Practice."
11. U.S. Department of Labor, "PWBA History and ERISA," www.dol.gov/pwba/public/aboutpwba/history4.htm (March 1998).
12. R.R. Bovbjerg and W.G. Kopit, "Coverage and Care for the Medically Indigent: Public and Private Options," *Indiana Law Review* 19, no. 4 (1986): 857–917. Sen. Inouye said that ERISA's preemption of state regulation of private health plans was the product of "inadvertent legislative oversight." See, for example, D.M. Fox and D.C. Shaffer, "Semi-Preemption in ERISA: Legislative Process and Health Policy," *American Journal of Tax Policy* (Spring 1988): 47–69.
13. *N.Y. State Conference of Blue Cross and Blue Shield Plans et al. v Travelers Insurance Company et al.*, 514 U.S. 645 (1995), and the cases, recitation of congressional intent, and legislative history cited therein.
14. M.S. Gordon, "The History of ERISA's Preemption Provision and Its Bearing on the Current Debate over Health Care Reform" (Presentation at the George Washington University's National Health Policy Forum, Washington, D.C., 18 November 1992), as cited in "Health Care Reform: Managed Competition and Beyond," *Employee Benefit Research Institute Issue Brief* 135 (March 1993). Michael Gordon, a former counsel to the late Senator Javits and the Senate Labor and Public Welfare Committee, helped to draft the ERISA legislation.
15. They are allowed to buy stop-loss insurance for their plans, and most do.
16. Federal legislation addressing these coverage gaps was famously passed and repealed in the so-called Medicare catastrophic coverage debates of 1988–1989. See M. Moon, *Medicare Now and in the Future* (Washington: Urban Institute Press, 1997), for a useful summary of the issues.
17. G.S. Chulis et al., "Health Insurance and the Elderly: Data from MCBS," *Health Care Financing Review* (Spring 1993): 163–181.
18. L.A. McCormack et al., "Medigap Reform Legislation of 1990: Have the Objectives Been Met?" *Health Care Financing Review* (Fall 1996): 157–174.
19. P.L. 96-265.
20. McCormack et al., "Medigap Reform Legislation of 1990."
21. Blue Cross and Blue Shield Association, *State Legislative Health Care and Insurance Issues: 1996 Survey of Plans* (Chicago: BCBSA, 1997).
22. See L.J. Blumberg and L.M. Nichols, "First, Do No Harm: Developing Health Insurance Market Reform Packages," *Health Affairs* (Fall 1996): 35–53, for a discussion of many health insurance reform options.
23. See L. Nichols et al., *Small Firms, Their Diversity, and Health Insurance* (Washington: Urban Institute Press, 1997).
24. L. Dubay and G. Kenney, "Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?" *Health Affairs* (January/February 1997): 185–193; and J. Holahan, "Crowding Out: How Big a Problem?" *Health Affairs* (January/February 1997): 204–206.
25. However, unlike fully insured plans, post-HIPAA ERISA plans will still be able to change the structure and amount of benefits for any particular services and diagnoses (see *H&H Music v McGann*, U.S. Court of Appeals, 5th Circuit, 4 November 1991), since HIPAA neither does nor does not allow state law to constrict these plans' ability to redesign their benefit packages.
26. This point is made by Haynes Johnson and David Broder in their book, *The System: The American Way of Politics at the Breaking Point* (Boston: Little, Brown and Company, 1996), 62–63.
27. The relevent federal agencies made this even more clear in regulations. See "Interim and Final Rule Issued by the Department of Health and Human Services Covering Portability from Group to Individual Coverage, Federal Rules for Access in Individual Market, and State Alternative Mechanisms to Federal Rules," *Health Care Policy Report*, Supplement (Washington: Bureau of

National Affairs, 7 March 1997): 5.

28. P.F. Cooper and A. Monheit, "Does Employment-Related Health Insurance Inhibit Labor Mobility?" *Inquiry* (Winter 1993): 400–416; and B. Madrian, "Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job-Lock?" *Quarterly Journal of Economics* (February 1994): 27–54.
29. COBRA (P.L. 99-272) of 1986 requires firms of twenty or more workers to offer persons with qualifying events continuing insurance coverage. There are two types of qualifying events: work-related and family-related. Work-related events are voluntary or involuntary termination of employment or a decrease in the number of hours worked, resulting in loss of coverage. Family-related events are divorce, legal separation from or death of an insured worker, loss of dependent child status, or loss of dependent coverage because of the worker's Medicare entitlement. COBRA coverage is available for up to eighteen months for work-related events (twenty-nine months for disability-related events) and thirty-six months for family-related events. See P. Flynn, "COBRA Qualifying Events and Elections, 1987–1991," *Inquiry* (Summer 1994): 215–220.
30. American Academy of Actuaries, "Comments on the Effect of S. 1028 on Premiums in the Individual Health Insurance Market" (Washington: AAA, 20 February 1996); and T. Stoiber, "Estimating the Impact of S. 1028—Premiums in the Individual Insurance Market" (Testimony on reforming the small-business marketplace and the individual market, before the House Commerce Subcommittee on Health and the Environment, 7 March 1996).
31. J. Musser, testimony of the National Association of Insurance Commissioners' (Ex) Special Committee on Health Insurance before the House Ways and Means Subcommittee on Health, on HIPAA implementation, 25 September 1997.
32. Although Colorado will rely on the federal floors established in HIPAA, Massachusetts has an alternative mechanism that includes the offer of three uniform products by all carriers to all eligibles.
33. In the case of Alabama, the high-risk pool separates federal eligibles from all others.
34. NAIC, *Model Health Plan for Uninsurable Individuals Act*, I-85-1. The standard rate is the premium that would be charged in the nongroup market to a person of average risk.
35. There is, however, a provision of HIPAA that requires a state using an alternative mechanism other than a high-risk pool that does not adopt a relevant NAIC model act to "provide for risk adjustment, risk spreading, or a risk spreading mechanism or otherwise provide for some financial subsidization for eligible individuals." The legislation does not specify the type of risk spreading required, nor does it specify the magnitude of the redistribution.
36. AAA, "Comments on the Effect of S. 1028 on Premiums;" Stoiber, "Estimating the Impact of S. 1028;" and J. Klerman, "New Estimates of the Effect of Kassebaum-Kennedy's Group-to-Individual Conversion Provision on Premiums for Individual Health Insurance," *RAND Research Report*, RAND/DRR-1341-1-DOL (Santa Monica, Calif.: 1996).
37. U.S. General Accounting Office, "Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators," GAO/HEHS-98-67, Report to the Chairman, Committee on Labor and Human Resources, U.S. Senate (Washington: U.S. GAO, February 1998).
38. S. Zuckerman and S. Rajan, "Is Insurance Reform Reducing the Rate of Uninsurance? Evidence from the Current Population Survey," Urban Institute Working Paper (Washington: Urban Institute, November 1997).
39. See A. Leibowitz, C. Damberg, and K. Eyre, "Multiple Employer Welfare Arrangements," in *Health Benefits and the Workforce*, U.S. Department of Labor/Pension and Welfare Benefits Administration (Washington: U.S. GPO, 1992).