

# The Politics Of The Health Insurance Portability And Accountability Act

*The “Kassebaum-Kennedy” act—perhaps the most significant federal health care reform in a generation—raises new issues of implementation for states and their insurance commissioners.*

BY BRIAN K. ATCHINSON AND DANIEL M. FOX

THE HEALTH INSURANCE Portability and Accountability Act of 1996 (HIPAA) could be the most significant federal health care reform in a generation. Called “Kassebaum-Kennedy” after its sponsors, former Sen. Nancy Kassebaum (R-KS) and Sen. Edward M. Kennedy (D-MA), the act creates the first national standards for the availability and portability of group and individual health insurance coverage, relies on the states as well as the federal government to enforce those standards, begins the development of federal policy for the electronic transfer of medical information, provides tax incentives to purchase long-term care insurance, increases the tax deductibility of health insurance premiums paid by self-employed persons, permits terminally and chronically ill persons to receive life insurance benefits tax-free, and strengthens federal authority to regulate health care fraud and abuse.<sup>1</sup>

HIPAA affects all working Americans and their employers, three federal agencies, and the governments of all fifty states. This is the first national health policy with such far-reaching implications since the enactment of Medicare and Medicaid in 1965. The law makes significant changes in the Employee Retirement Income Security Act (ERISA), the

Public Health Service Act, and the Internal Revenue Code. Taken together, these changes prohibit employers who offer coverage and the insurance industry from avoiding sick people. Through tax law, the changes also reduce financial barriers to care for persons who are self-employed and those with serious chronic and terminal illnesses.

HIPAA enacts several concepts that were initially highly controversial but that gained wider acceptance through debate. Nevertheless, some health policy experts have concentrated not on what the act does but on what it does not do. The act changes neither how health care is delivered nor how it is financed. It does not increase access to health insurance for persons who are currently uninsured, nor does it give small businesses greater ability to join together to strengthen their purchasing power. Moreover, it does not make insurance more affordable by regulating the rates insurers and health plans can charge the insured. And it establishes a controversial experiment with medical savings accounts (MSAs).

HIPAA does respond to major issues underlying the profound discontent that Americans have felt about their health care coverage. ERISA, for example, prohibited the states from regulating the health insurance of almost

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60 percent of U.S. workers, those whose employers chose to self-insure. As a result, every state's insurance commissioner and many legislators often heard anguished stories from persons they could not help, even though forty-seven states regulate commercial and Blue Cross insurance. Some were persons whose employers self-insured and whose coverage was terminated when they or members of their families became seriously ill. Others could not continue coverage when they lost jobs or changed employers. Many feared changing jobs because they risked losing coverage for themselves and their dependents.

HIPAA addresses concerns beyond the self-insured sector. Many self-employed persons could not afford premiums for health insurance without an income tax exclusion that was comparable to what other employees enjoyed. Individuals and employees who wanted to purchase insurance for long-term care had been lacking clear direction as to whether they could exclude premiums from taxation. Persons with terminal illnesses faced burdensome taxes on the accelerated death benefits or life insurance settlements with which they paid their medical and living costs. Some persons avoided seeking care because they feared that their medical records would not remain confidential.

## AVAILABILITY AND PORTABILITY

HIPAA sets new standards for health insurance coverage in five areas. It assigns responsibility for regulating and enforcing these standards to both the federal government and the states.<sup>2</sup>

■ **PREEXISTING CONDITIONS.** Group health insurers (including health maintenance organizations [HMOs]) and self-insured employers may not limit or deny coverage for preexisting conditions for more than twelve months. The right to full coverage after this waiting period (and to credit for any portion of the waiting period already elapsed) is "portable" if the employee changes jobs or the employer changes health plans. No new preexisting condition restrictions may ever be imposed if coverage is maintained with no gap

longer than sixty-three days. Moreover, a preexisting condition restriction may only be imposed for a medical condition that was diagnosed or treated at some time during the six months immediately preceding the twelve-month waiting period and cannot be imposed at all on pregnant women or on newborns or newly adopted children.

■ **AVAILABILITY OF COVERAGE FOR SMALL EMPLOYERS.** Insurance carriers and health plans cannot refuse to offer any small-group products to employers that have between two and fifty employees.

■ **AVAILABILITY OF COVERAGE FOR INDIVIDUALS.** Insurers and health plans must offer coverage to persons who have had group health insurance for at least eighteen months, who have exhausted coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and who are ineligible for coverage under any other employment-based health plan. States may enact individual market reforms to meet the criteria for individual coverage. If a state does not opt to enact reforms, insurers are required to offer eligible persons access to coverage under every insurance policy they sell in a state, or their two most popular policies, or two policies that are designed to provide a choice between a higher and a lower level of coverage and that spread and adjust risks in order to limit costs for sick persons who enroll.

■ **DISCRIMINATION BASED ON HEALTH STATUS.** Employers who offer health coverage may not exclude an employee or a dependent from coverage, drop an employee or a dependent from coverage, or charge an employee higher premiums because of that person's or a dependent's health status or medical history (including disability, genetic information, episodes of domestic violence, and previous health care).

■ **RENEWABILITY.** Insurers are required to renew coverage to all employers as long as premiums are paid, except when there is evidence of fraud or misrepresentation by an employer.

## POLITICAL HISTORY

■ **PREPARING THE WAY.** During the

1993–1994 debate over the Clinton administration's health care reform proposals, members of Congress from both parties and representatives of diverse interest groups acknowledged the need for changes in insurance markets. Members had been hearing about problems of availability and portability from their constituents, state legislators, and insurance commissioners. In hearings on health care reform, officers of the National Association of Insurance Commissioners (NAIC) brought considerable evidence of the problems in health insurance markets to the attention of Congress and congressional staff.<sup>3</sup>

In the summer and fall of 1994, representatives of more than thirty of the largest self-insured employers told members of Congress and officials of nine states loosely organized as the Reforming States Group that they might be willing, someday, to eliminate employees' anxieties about portability and renewability in exchange for maintaining employers' freedom under ERISA from state regulation and premium taxes.<sup>4</sup> Other employers, relieved by avoiding a federal insurance mandate, signaled their willingness to support reforms that would improve standards of coverage. The insurance industry was eager to avoid additional regulation and mandates, but it supported bringing self-insured employers under the same rules that applied to commercial insurance. Moreover, the industry could easily oppose protecting the market against rapacious conduct by a handful of carriers.

■ **JOURNEY TO PASSAGE.** When Senators Kassebaum and Kennedy introduced their bill in the spring of 1995, they attracted strong support and encountered little public opposition. Supporters of the bill included the AFL-CIO, the American Association of Retired Persons, the Blue Cross and Blue Shield Association (still the insurers of last resort in many

states), and the NAIC.

Neither the Group Health Association of America (now the American Association of Health Plans) nor the Health Insurance Association of America strongly opposed the bill, although they predicted that portability reform would cause premiums to rise, particularly in the individual market. The American Academy of Actuaries disagreed. At a pivotal point it insisted that rate increases as a result

of portability were likely to be minimal. After the Independent Insurance Agents of America expressed its strong support at a White House meeting and press conference, enactment seemed possible.

By the late fall of 1995, the staff of Senator Kassebaum counted more than eighty votes for the bill, if they could get it to the Senate floor. Several senators placed holds on the bill, and action stalled. Some of the holds seemed to be the result of advocacy by pro-

ponents of MSAs, others of efforts by small business to get ERISA preemption for purchasing pools. Moreover, then Sen. Robert Dole (R-KS), some observers say, believed that killing the bill would help his cause in the approaching Republican presidential primaries.

Similar conflicts in the House had accounted for some of the earlier delays. Advocates for small business, for instance, sought preemption under ERISA for multiple-employer welfare arrangements (MEWAs). Early in 1996 Senator Kassebaum publicly asked Senator Dole to allow a vote on the bill. Then she began an intense campaign for support in the Senate, in alliance with members of both houses and both parties who wanted insurance reform before the November election. After strenuous debate in committees and on the floor of both houses, the bill eventually passed. When it stalled again, in conference committee, Senate Republicans and the White House engineered a compromise, creating a pilot pro-

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gram that MSA opponents could grudgingly support.

## IMPLICATIONS FOR HEALTH CARE REFORM

This political history suggests that the minimal conditions needed for national health care reform in our time are consensus on the existence of a problem, the proposal of an effective solution, and the absence of significant impact on the federal budget. Only when these conditions were met did lobbyists and members of Congress work seriously to craft the legislation that became HIPAA. The result was an act that, whatever else it does and does not do, for the first time allocates regulatory responsibilities for health coverage to both the federal government and the states.

The politics of consensus building also added provisions to the act that are tangential to the reform of health insurance markets, and some argue that these provisions may be detrimental. The most publicized example was the provision for MSAs. Proponents argued that MSAs would enhance affordability and consumer choice; opponents feared that they would encourage the healthy to go uninsured or to purchase high-deductible policies that would shrink the pool of individuals with standard policies.

■ **HIPAA AND ERISA.** The outstanding achievement of the persons who crafted HIPAA and secured its passage was establishing the portability and accountability of both commercial and self-insured health coverage. HIPAA preserved ERISA preemption of state taxes on premiums and mandated benefits while creating a structure for further federal regulation of self-funded and, perhaps eventually, insured health plans. Protected by a coalition of large employers and labor unions, preemption had withstood two kinds of legislative attacks for twenty-two years. One

type of attack was for exemptions for particular states; Congress granted only one such exemption (to Hawaii). The other was an attempt to puncture the vacuum that was created by preemption by enacting national health care reform. The health policy vacuum that was created by ERISA preemption politics was in stark contrast to ERISA pension regulation, whereby the federal government has set standards for employee health plans for two decades.

Congress demonstrated the importance of HIPAA in establishing a federal framework for regulating insurance standards for both ERISA and insured plans within a month after HIPAA's passage by legislating standards for hospitalization following childbirth and parity for mental health coverage. As a result of HIPAA, these standards apply to all health coverage.

## THE STAKES NOW

Although three federal agencies (Department of Health and Human Services [HHS], Department of Labor, and Department of the Treasury) are writing regulations and enforcing deadlines that began in July 1996 and continue until December 2000, the most significant controversy over implementation of HIPAA is now about how states will require insurers to make health insurance available to eligible individuals. The act requires the states to decide whether they will follow the federal "fallback standards" or (as most states say they plan to do) implement one of the alternative mechanisms permitted by the act: various forms of guaranteed issue, a high-risk pool, or an innovative state reform that has been cleared by HHS as meeting the act's access goals. At stake in this decision are the range of consumers' choices of policies, the costs of insurance for individuals, and to whom those costs are allocated.

■ **GUARANTEED ISSUE.** Thirteen states now guarantee the issuance of health insur-

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ance to all individuals. Proponents of this mechanism argue that it expands access at a reasonable cost. Opponents charge that it raises the price of insurance for individuals, thus increasing the number of uninsured persons, and causes many carriers to stop offering coverage, which eventually will reduce competition and limit consumer choice.

■ **HIGH-RISK POOLS.** Some insurance companies and their allies in small business are lobbying state officials to designate their existing high-risk insurance pools as their alternative mechanism. Under this proposal these risk pools would have to be modified to eliminate waiting periods for persons with preexisting conditions and, its advocates claim, could be funded by the reinsurers that sell stop-loss coverage to self-insured plans as well as by commercial insurance companies.<sup>5</sup> Opponents of the proposal claim that relying on high-risk pools instead of opening access to standard coverage violates the intent of the act by constraining consumer choice. Moreover, it could raise premiums for persons who are self-employed by requiring them to join pools of persons who are uninsurable because of disabling conditions. Insurance companies prefer state-run risk pools to adding more expensive risks to their own policyholder base.

■ **OTHER ISSUES.** The insurance and information sections of HIPAA raise other controversial issues. These include the division of responsibility between the federal government and the states in enforcing HIPAA and clarification about which state laws are superceded by the act. To what extent, for example, will states be able to go beyond federal standards for insured plans?

Still other questions will be debated: What coverage of long-term care will be excluded from federal income taxes? Will the precedent set by the prohibition against including long-term care insurance in employers' cafeteria plans be extended to other benefits? Will the federal government intervene if aggressive carriers sell more MSA policies than the 750,000 set as a limit in the act? How will providers, consumers, carriers, health plans,

and the media affect implementation of HIPAA's information policy requirements?

HIPAA and market-driven reorganization together are creating the conditions for deciding how to achieve better access to care for persons without health insurance. If this fusion someday leads to new increments of reform for persons with relatively low incomes, it would not be the first time that social and economic policy designed to help a majority of Americans eventually benefited all of us.

## NOTES

1. P.L. 104-191, H.R. 3103.
2. See "Summary, The Health Insurance Portability and Accountability Act, H.R. 3103," prepared by staff of the Senate Labor and Human Resources Committee and the Senate Finance Committee, August 1996; and "Draft Template for State Implementation of the HIPAA of 1996" (Washington: National Association of Insurance Commissioners, 1996).
3. This political history is based mainly on the direct observations of one of the authors (Atchinson) and on interviews.
4. K.S. Andersen, "The Reforming States Group and the Milbank Memorial Fund," unpublished paper, January 1997; and C. Rydell for the Reforming States Group, "An Agenda for Federalism from State Leaders," *Health Affairs* (Winter 1994): 252-255.
5. See, for example, letter from Americans for Responsible Reform, Washington, D.C., to Governor Angus King, Augusta, Maine, 2 December 1996. Each governor received a similar letter.