Comments

JOB LOCK: WILL HIPAA SOLVE THE JOB MOBILITY PROBLEM?

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I. INTRODUCTION: THE SIGNIFICANCE OF AN EMPLOYMENT-BASED HEALTH INSURANCE SYSTEM

One hallmark of the American health insurance network is the degree to which it is a voluntary, employment-based system. As of 1995, over 85% of all insured Americans received their health insurance through a job—either their own or that of a family member.1 Employers often participate in the current health insurance system by paying for a portion of their employees’ insurance premiums and by choosing the type of health plan offered to their employees.2 Because health insurance access is so inextricably linked to the job market and is such an important asset in this era of spiraling health care costs, people often take health insurance concerns into account when making employment decisions. Employees are generally reluctant to change jobs when they stand to receive inferior insurance or to be excluded from coverage, either partially or entirely, by the terms of a prospective employer’s plan. The impact of health insurance benefits on employment decisions is so significant that the term “job lock” has come into use to refer to the phenomenon whereby individuals choose to forego objectively superior employment opportunities based on health

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insurance concerns. As one commentator colorfully described the concept:

There's no shortage of sad stories about health insurance. But for pure frustration, nothing beats job lock: being frozen in a job you hate because leaving it means losing key health benefits. You're stuck because you have a bad knee, your daughter has diabetes or your wife has emphysema. No new insurer wants your family unless it can draw a big red circle around your maladies and refuse to cover everything inside.3

Although this description may appear to overstate the problem, the circumstances described reflect the bitter reality that many American workers face in today's fluid job market.

In response to growing concern over the job mobility problem, Congress enacted the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").4 HIPAA tackles, among other serious concerns such as Medicare fraud and abuse, the matter of health insurance portability. HIPAA attempts to increase health insurance portability by limiting preexisting condition exclusions,5 prohibiting discrimination against individuals based on health status,6 and guaranteeing renewability and availability of certain types of insurance plans.7 HIPAA creates an unfunded mandate by setting minimum standards with which state insurance regulatory schemes must comply.

In the wake of HIPAA's enactment, critics have begun to consider whether the statute will ultimately serve its primary purpose: alleviation of job lock. Legal commentators have not yet analyzed comprehensively HIPAA's probable efficacy, perhaps because HIPAA was first put into effect over the course of 1997-1998. Only time will tell whether HIPAA will, in fact, stave off job lock. However, the early data do not reflect favorably on the statute.

This Comment begins by tracing the statutory landscape prior to HIPAA's enactment in order to clarify Congress' motivation to enact legislation that explicitly addresses health insurance portability. It then focuses on the piecemeal solution Congress fashioned when it passed HIPAA. In particular, this Comment addresses specific aspects of HIPAA's language that are likely to limit the statute's efficacy in eliminating job lock. It concludes that although HIPAA will make it easier for previously insured individuals to secure insurance in the future if they change jobs, HIPAA fails to provide a complete solution, mainly because it

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5. See HIPAA § 101(a), 110 Stat. at 1939.
7. See HIPAA § 101(a), 110 Stat. at 1946.
does not guarantee the affordability of replacement insurance.

II. THE JOB LOCK PHENOMENON IN DETAIL

As previously noted, most Americans receive their health insurance through their employers. The link between health insurance and employment originated in the 1930s when employers first offered health insurance as a fringe benefit. This link became entrenched after World War II as unions began to negotiate for health insurance as part of their collective bargaining agreements. Currently, employer-provided insurance exists in two basic forms: employment-based group health plans and employer-funded self-insurance plans. The minority of insured Americans who do not receive health insurance through employers either purchase it individually, obtain it through groups unrelated to employment (such as a geographically-based groups or religious and fraternal organizations), or receive it through state or federal programs, such as Medicare and Medicaid.

In employment-based group health plans, employers contract with health insurance plans on behalf of their employees and the insurance plan ultimately bears the risk of loss. In group insurance plans, all members of the group receive health benefits under a single policy. Each employee's premium is identical and it is set through "experience rating," which bases premiums on the whole enrollment group's "average level of health" and

8. See STARR, supra note 2, at 59-60.
9. See Joondeph, supra note 1, at 1251.
11. Medicare is a federally funded health insurance program established to provide medical benefits to the following individuals without regard to income: individuals aged 65 and older, disabled individuals who have been entitled to receive Social Security cash benefits for at least two years, and individuals suffering from end-stage renal disease. See id. at 72. Part A covers hospital inpatient costs, skilled nursing facility benefits, post-hospital home health services, and hospice care for the terminally ill. See id. at 72-74. Part B pays for services provided by individual providers. See id. at 74-75.
12. Medicaid provides medical benefits for certain categories of low-income individuals. Medicaid sets minimum eligibility and rate requirements that state health care plans must meet to receive partial federal funding. See id. at 110. The federal requirements mandate that states include individuals on federal cash-assistance programs but also enable states to cover other groups of medically needy people as they see fit. See id. at 110. As one commentator noted, "Medicaid is not a program for all the poor or for only the poor." Id. at 112.
13. These plans can consist of not-for-profit Blue Shield plans, for-profit private insurance plans, a health maintenance organization ("HMO") (a system of providers which provides health benefits in exchange for a flat enrollment fee), or other integrated health delivery systems.
“average utilization of medical services” in the past. Relatively sick individuals are enrolled unconditionally when the whole group is enrolled; they are not excluded or charged a variable premium rate under the group enrollment scheme.

Employer-funded self-insurance plans differ from employer-based group insurance plans in that the employer pays for the health care costs of its employees directly “by 'setting aside' assets—either by accounting entries or by actually establishing a special fund—from which it will pay such claims, rather than by purchasing insurance.” In self-funded plans, the employer bears the risk that insurance claims will exceed the amount of money set aside. Notwithstanding these characteristics, self-insured plans may look like purchased plans because employers often hire experienced insurance companies to carry out the administrative duties associated with running the plan.

Both the employment-based group enrollment scheme and the employer-funded self-insurance scheme provide significant advantages. First, they both avoid adverse selection, because the employer provides the plan to all employees. Second, rather than leaving individuals to seek coverage on their own, these two schemes permit enrollment of a large number of individuals at one time, thereby diluting the burden of high-risk individuals on the system. Third, both schemes are subject to tax preferences.

Perhaps the most favorable aspect of employer-provided health insurance schemes is that individuals avoid seeking their health insurance through either the individual enrollment or non-employment-based group markets, where insurance companies restrict access in three significant ways. First, insurance companies often limit the scope of these policies so as to exclude coverage for preexisting illnesses, conditions an individual

16. See id.
17. Keeton & Widiss, supra note 14 § 1.3(b)(3), at 13.
19. Adverse-selection occurs when individuals purchase health insurance knowing they are at increased risk of developing an illness. See Starr, supra note 2, at 59.
21. Tax benefits drive the employment-based system because section 106 of the Internal Revenue Code excludes employer contributions to health insurance from an employee’s taxable income, while section 162(a)(1) also allows employers to completely deduct the cost of health benefits purchased for their employees. See Joondeph, supra note 1, at 1230.
had prior to seeking the insurance plan.23 Second, insurance companies generally charge higher premiums for people who have health conditions at the time of enrollment.24 Finally, insurance companies sometimes flatly refuse to accept applicants with particular conditions, even at higher rates.25

Despite the benefits of employment-based health insurance, individuals enrolled in these plans are confronted with two considerations when they consider changing jobs. First, the individual, or a member of his family, may be exposed to a waiting period under a new insurance plan.26 Second, the new job may offer a comparable health insurance package at a price that is prohibitively expensive. These considerations may incline the individual to reject the new employment opportunity.

The phenomenon whereby an individual passes up an employment opportunity due to the impact on his health insurance benefits is known as job lock.27 Job lock occurs when: (1) an individual is barred entirely from enrolling in the prospective employer’s health plan, (2) the preexisting condition exclusions of the prospective plan are more extensive than those in the employee’s current plan, or (3) the premium prices are higher for the prospective employer’s plan.28 As one expert summarized the problem, job lock occurs when:

the premium is higher at the prospective job than at the initial job, the benefits package is less generous, or selected conditions are not covered (i.e.: a preexisting condition clause may discourage a worker from leaving the current job and health insurance plan to move to a new plan that does not cover a given health condition).29

Where health care benefits are unequal, workers will only take advantage of a new job opportunity if the non-health care compensation offsets the difference.30 If an individual is completely ineligible to enroll in the new plan, it is doubtful that any pay increase will ever justify taking the new job.

Job lock is noticeable in the following situations. The first involves a

23. The term “preexisting condition” covers conditions as extraordinary as coronary disease and as mundane as asthma. See id.
24. See id.
25. See id.
27. See id.
29. Id.
30. See Gruber & Madrian, supra note 20, at 86.
job change from a large to small employer. Even though many employers provide health care benefits, smaller companies do so less frequently than larger corporations. Roughly only one-third of all companies with one hundred or fewer employees offer health benefits. Consequently, employees have an incentive not to accept job offers at small firms because employees at these companies are thrown into the individual enrollment market, where premium rates are generally higher.

The second scenario involves individuals who know they, or a family member, are sick. Such individuals are less likely to change jobs, even if the prospective employer offers a health insurance plan, where the terms of the new plan include a preexisting condition exclusion that applies to the diagnosed individual. It is significant to note, however, that preexisting condition provisions are not limited to medical conditions that have already been diagnosed at the time of enrollment. Preexisting condition clauses also bar coverage of health care expenses attributable to conditions that existed undiagnosed at the time of enrollment. Thus, any individual who knows of these exclusions and believes that he may have an as-of-yet undiagnosed infirmity, or even a genetic predisposition to future disease, may also hesitate before changing jobs.

One General Accounting Office survey estimates that as many as four million Americans are victims of job lock. Academics postulate that there are three possible strategies that could eliminate the problem: (1) "remove the link between health insurance coverage and the employment relationship;" (2) "ensure full portability of coverage across jobs;" or (3) "forbid the exclusion from coverage of preexisting medical conditions and conditions discovered in a mandatory initial physical examination."

Until recently, however, there was no comprehensive federal legislation addressing the job lock phenomenon. The Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") established limited circumstances where an individual could continue coverage under an old plan for eighteen to thirty-six months after changing or leaving jobs. Yet, COBRA’s provisions failed to provide a complete solution.

Growing concern over data indicating that many Americans passed up job offers solely based on health care benefits prompted Congress to craft

31. See Joondeph, supra note 1, at 1248-49.
32. See id.
33. See id.
35. Gruber & Madrian, supra note 20, at 86.
legislation aimed specifically at solving job lock. In 1996, as the result of a bipartisan effort, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") passed both houses of Congress and was signed into law.\[38\]

III. THE PRE-HIPAA HEALTH CARE REGULATORY FRAMEWORK

A. \textit{Early Supreme Court Precedent and the McCarran-Ferguson Act of 1945}

Early judicial precedent and the McCarran-Ferguson Act\[39\] permitted the states to exercise significant control over insurance regulation. As early as 1869, the Supreme Court made it clear that the states had authority to regulate the insurance industry when the Court refused to find that insurance constitutes "commerce" within the meaning of the Commerce Clause.\[40\] The Court reached this decision by construing insurance transactions as personal contracts rather than as exchanges of goods or services.\[41\] In 1914, when the Supreme Court readdressed the issue, it held again that the federal government could not regulate insurance. The Court's reasoning was still based on the Commerce Clause, but this time, instead of relying on the lack of a contractual relationship, the Court concluded that the power to regulate the insurance industry fell within the states' police power.\[42\]

The Court finally retreated from its position in 1944, when it reversed itself and held that insurance is interstate commerce.\[43\] This doctrinal reversal did not significantly impact the insurance industry, however, because the following year, after lobbying by the states and insurance companies, Congress passed the McCarran-Ferguson Act of 1945.\[44\] The Act granted significant control of the insurance industry to the states by declaring that state insurance regulation preempts all federal laws except those which explicitly relate to insurance.\[45\] The McCarran-Ferguson Act


\[41\] \textit{See} Ladenheim, \textit{supra} note 40, at 38.

\[42\] \textit{Id.} (citing German Alliance Ins. Co. v. Lewis, 233 U.S. 389 (1914) (concerning fire insurance)).


\[45\] \textit{See} Ladenheim, \textit{supra} note 40, at 38. The McCarran-Ferguson Act also exempted insurers from some antitrust laws. \textit{See id.}
did not return exclusive authority over the insurance industry to the states, but it did permit states to pass insurance legislation, and it gave this legislation precedence over all but explicit federal legislation.

B. Employee Retirement Income Security Act of 1974

Congress did not seriously begin to unravel state control over the insurance industry until it enacted the Employee Retirement Income Security Act of 1974 ("ERISA"). Even then, ERISA did not completely undermine state control because it only addressed employment-based insurance benefits. ERISA, which explicitly preempts all state laws that "relate to any employee benefit plan," was enacted as a response to abuse in both employee pension and welfare plans. ERISA targeted these two categories of plans because evidence indicated that they frequently were subject to general employer mismanagement and unreasonable requirements which prevented many individuals from qualifying for benefits.

ERISA is composed of four titles: Title I "protects the rights of employees and permits them to bring civil actions to recover benefits, clarify their rights and remedy breaches of fiduciary duty" under employer benefit plans; Title II, which overlaps with Title I, "contains contribution and benefit limits for pension plans;" Title III "divides the regulatory jurisdiction over employee benefit plans between the Department of the Treasury and the Department of Labor;" and Title IV "establishes the Pension Benefit Guaranty Corporation (PBGC) which pays pensions to participants in certain defined benefit pension plans when the plans cannot."

The core of ERISA is in the disclosure requirements it imposes on employers with respect to their employee benefit plans. Employers must

47. Id. § 1144(a).
48. To qualify as an employee benefit plan, the plan must be: "(1) a plan or program, (2) established or maintained by an employer (3) for the purpose of providing to its participants (4) benefits, through the purchase of insurance or otherwise, (5) in the event of sickness, accident, disability, death, unemployment, vacation, or in the event of retirement." Rita B. Gylys, Employee Benefits: What They Look Like Today and How They Will Change Tomorrow, in INSURANCE LAW 1997, at 211, 214 (PLI Litig. & Admin. Practice Course Handbook Series No. 563, 1997) (citing ERISA § 1002(1)). If a plan provides benefits for retirement, it is a pension benefit plan; otherwise it is a welfare benefit plan. See id.
49. See Ehlers, supra note 18, at 38.
50. Id.
51. Id.
52. Id.
53. Id.
provide employees with information regarding the terms of these plans detailed sufficiently to permit employees to police plan management.\textsuperscript{54} Under ERISA, employers must provide summaries that describe the plans’ major terms in simple and clear language, and must also detail the rights employees have under these plans.\textsuperscript{55} For example, an employer is required to notify an employee, as soon as he or she is hired, of the right to the continuation of medical expense benefits after termination of employment.\textsuperscript{56} Furthermore, employers must provide to employees, upon request, information regarding plan benefits as well as reports detailing benefits accrued to date.\textsuperscript{57}

Although ERISA generally supersedes state laws relating to employee benefit plans, there are exceptions to the preemption provision for state insurance, banking, and securities laws.\textsuperscript{58} Judicial interpretation has often diminished the impact of these exceptions, however, and has thereby strengthened the supremacy of federal law in opposition to the principle behind the McCarran-Ferguson Act. Courts have minimized the significance of the ERISA exceptions by finding that most employee benefit plans are not insurance plans subject to state law regulation, but rather self-insurance plans that fall within ERISA’s regulatory scheme.\textsuperscript{59}

On its own, ERISA alleviates some degree of job lock even though it was drafted to stem abuse in employee benefit management. ERISA’s disclosure requirements ensure that employers provide employees with essential information about whether employees can continue to collect benefits, including health care insurance, under their current plan even after they change jobs, retire, quit, or are terminated. This information allows employees to make informed decisions about whether or not to remain at a given job. If employees know that the benefit package at a particular job does not currently meet their medical needs, or will fail to meet them in the future, they may decide to seek employment at a different firm. However, ERISA’s impact on job portability is merely incidental. ERISA’s enactment left significant gaps in portability regulation that Congress addressed more directly in 1985, when it enacted the Consolidated Omnibus Budget Reconciliation Act of 1985.

\textsuperscript{54} See id. at 39.
\textsuperscript{55} See Gylly, supra note 48, at 216.
\textsuperscript{57} See Ehlers, supra note 18, at 39.
\textsuperscript{58} See id. at 42.
\textsuperscript{59} See id. In fact, the Supreme Court itself has upheld this position. See id. (citing FMC Corp. v. Holliday, 498 U.S. 52 (1990)).
C. Consolidated Omnibus Budget Reconciliation Act of 1985

The Consolidated Omnibus Budget Act of 1985 ("COBRA") amends both ERISA and the Internal Revenue Code of 1954, which has since been amended and restated as the Internal Revenue Code of 1986. COBRA requires employers with twenty or more employees that provide group benefit plans to their employees to allow employees "who would lose coverage under the plan as a result of a qualifying event... to elect... continuation coverage under the plan." COBRA defines "qualifying event" to include:

1. The death of the covered employee.
2. The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.
3. The divorce or legal separation of the covered employee from the employee's spouse.
4. The covered employee becoming entitled to benefits under Title XVIII of the Social Security Act... [Medicare].
5. A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.
6. A proceeding in a case under Title 11... with respect to the employer from whose employment the covered employee retired at any time.

If an individual elects to extend coverage under COBRA, the coverage applies to both the worker and any spouse or dependents.

COBRA further specifies that the quality of the continuing coverage must be "identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred," and the extension period must last from eighteen to thirty-six months, varying with the type of qualifying event.

63. Id. § 1161(a).
64. Id. § 1163.
65. Id. § 1162(1).
66. See Gylys, supra note 48, at 219. Employees can continue coverage for up to 18 months (or 29 months if disabled) if employment is terminated for reasons other than for gross misconduct or if hours of work are reduced below the level for which coverage is normally provided. See 29 U.S.C. § 1162(2)(A).
Employees must pay for this continuing coverage themselves, but COBRA places a cap on the premium rates that an employer can charge. The maximum premium rate is 102% of the "applicable premium" for the previous period of coverage.\textsuperscript{67} Under COBRA, the "applicable premium" generally equals "the cost to the plan... for similarly situated beneficiaries... (without regard to whether such cost is paid by the employer or employee)."\textsuperscript{68} In the case of a self-insured plan, however, the applicable premium is calculated as the "reasonable estimate of the cost of providing coverage... for similarly situated beneficiaries..."\textsuperscript{69}

The original purpose behind COBRA was to ensure continuous health insurance coverage during transitional periods for individuals changing from one job to another and, therefore, from one insurance policy to another.\textsuperscript{70} COBRA's most significant benefit is that it allows employees to continue coverage under a previous plan while simultaneously enrolling under a new plan. This allows employees to retain coverage while riding out exclusion periods imposed by the new plan.\textsuperscript{71} Thus, COBRA acts as a safety valve that eliminates some of the gaps in coverage that inevitably result from moving from one position to another.

Although COBRA addresses the job lock dilemma more directly than ERISA, it does not provide for total portability. There are several reasons for COBRA's limited impact. First, workers cannot continue their old coverage indefinitely after changing or leaving jobs. The maximum extension period is thirty-six months.\textsuperscript{72} Second, COBRA neither ensures that an alternative plan will enroll an individual (and his or her family members) nor prohibits a plan from permanently denying coverage for preexisting conditions.\textsuperscript{73} COBRA only allows an employee to extend his old coverage while waiting out an exclusion period imposed on the preexisting condition by the new employer's plan. In order to do this, however, an individual must be willing to pay for the extended coverage under COBRA in addition to the cost of the new coverage.\textsuperscript{74} Finally, for reasons commentators cannot fully explain, individuals do not tend to take advantage of COBRA's extended coverage provisions. Several studies found that only 19.6% of the 14.5% of individuals eligible for COBRA coverage requested it in 1994.\textsuperscript{75} In total, this evidence shows that COBRA made further strides toward reducing the severity of job lock, but fell short

\textsuperscript{67} See 29 U.S.C. § 1162(3)(A).
\textsuperscript{68} Id. § 1164(1).
\textsuperscript{69} Id. § 1164(2)(A).
\textsuperscript{70} See Fronstin Statement, supra note 28.
\textsuperscript{71} See id.
\textsuperscript{73} See Fronstin Statement, supra note 28.
\textsuperscript{74} See id.
\textsuperscript{75} See id. (citing a study by Charles D. Spencer & Associate, Inc.)
of effectively addressing the problem.

IV. GROWING CONCERN OVER THE JOB LOCK ISSUE: SOWING THE SEEDS FOR HIPAA

After the failure of President Clinton's Health Security Act of 1993, election surveys taken on the eve of the 1994 congressional elections indicated that Americans wanted health care reform which would allow them to remain continuously covered by insurance following a job change. By 1996, a poll conducted by ABC News showed that 88% of Americans supported portability legislation.

Public opinion polls have demonstrated a significant connection between health benefits and job mobility. One poll showed that 20% of Americans passed up job opportunities solely due to health care benefits and that the four most commonly cited reasons for the failure to change jobs based on health benefits were: (1) prospective employers did not provide a benefits package; (2) the new job offered less comprehensive coverage; (3) the new coverage contained preexisting condition exclusions; and (4) the new coverage was too expensive.

The states responded quickly to the public call for reform. By 1996, nearly forty-five states passed health insurance portability provisions limiting the waiting period for preexisting conditions in group health plans; forty-three states enacted "guaranteed renewal" requirements for small groups whereby insurance companies could not refuse to continue insuring an individual unless he or she failed to pay a premium or the plan was terminated; and thirty-seven states instituted "guaranteed issue" provisions that required insurers to cover any individual or group seeking insurance.

State portability legislation, however, was not enough to alleviate the job lock problem. As explained above, although the McCarran-Ferguson Act authorizes states to largely regulate insurance companies and HMOs, ERISA revoked state authority over self-funded employer health plans. Given that a significant number of insured Americans are covered by self-funded plans, and that state portability provisions mainly addressed

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78. See id. at 83.
79. See id.
80. See Fronstin Statement, supra note 28.
81. See Ladenheim, supra note 40, at 40-41.
82. See id.
83. A 1995 General Accounting Office study estimated that 44 million Americans are covered by self-funded employer plans. See GAO Portability Report, supra note 34.
employees hired by small firms, the federal government was left to fill in the holes in the legislative landscape.

In July 1995, Congress began to consider enacting federal portability legislation. Senator Nancy Landon Kassebaum (R-KY), Senate Labor and Human Resources Committee Chairman, and Senator Edward Kennedy (D-MA), Ranking Minority Member on the Senate Labor and Human Resources Committee, introduced a bill entitled the Health Insurance Reform Act of 1995 ("HIRA"). The Act was the first outright attempt to alleviate job lock through increased health insurance portability. HIRA received unanimous committee support upon its introduction by Senators Kassebaum and Kennedy and was soon adopted by the entire Senate.

The House of Representatives unveiled and adopted its own health care legislation in March of 1996. The House bill, entitled the Health Coverage Availability and Affordability Act of 1996 ("HCAAA"), contained portability provisions similar to those in its Senate counterpart. In contrast to HIRA, however, HCAAA included additional provisions for medical savings accounts, medical malpractice reform, increased tax deductions for the self-employed, administrative streamlining, enhanced fraud and abuse penalties, and new rules to stimulate small firm group enrollment.

The Senate and House eventually consolidated the two bills into the Health Insurance Portability and Accountability Act (HIPAA), which President Clinton signed into law on August 21, 1996. HIPAA's path through the final approval process was not smooth. The statute precipitated extensive and protracted debates in the Senate concerning numerous provisions included in the House's bill. As the description below will further indicate, the resulting compromise legislation contains some, but not all, of the initiatives that the House supported.

84. See Smith & Kendall, supra note 77, at 84-85.
87. See Smith & Kendall, supra note 77, at 86.
88. See id. at 87.
90. See infra Part VI.B.
91. See Smith & Kendall, supra note 77, at 87.
V. OVERVIEW OF HIPAA’S MAJOR PROVISIONS

The drafters of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") stated that the purposes of the Act were, among others, to:

amend the Internal Revenue Code of 1986, to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance . . . .

HIPAA implements these goals by amending the Internal Revenue Code of 1986, Title I of ERISA, and the Public Health Service Act.

Title I of HIPAA addresses health care access and portability issues and contains the following significant provisions: (1) a limitation on preexisting condition exclusions; (2) a prohibition against exclusions based on health status; and (3) guaranteed availability and ability to renew health insurance in certain circumstances. Although some of the portability provisions are applicable to both the private group and individual markets, the Act focuses primarily on employer-sponsored group health plans.

Title II takes steps towards preventing health care fraud and abuse by including, among other provisions, a requirement that the Department of Health and Human Services establish a fraud and abuse control program that will coordinate federal, state, and local anti-fraud efforts; a Medicare Integrity Fund; and a Beneficiary Incentive Program that encourages individuals to report health care fraud. Title II also includes various provisions imposing criminal and civil sanctions for fraud committed in connection with health care.

Title III contains many tax-related provisions. One notable provision creates a limited number of tax deductible “trusts,” called medical savings

93. HIPAA preamble, 110 Stat. at 1936.
94. See HIPAA §§ 101(a)-(g), 110 Stat. at 1936-55.
97. On September 30, 1999, Representative James M. Talent (R-MO), Chairman, Small Business Committee, introduced the Quality of Care for the Uninsured Act of 1999, H.R. 2990, 106th Cong. (1999), in the House of Representatives. This Act would remove the cap on the number of MSAs available. The Senate received the bill and amended its language on October 14, 1999. See S. 1344, 106th Cong. (1999). Both houses will confer over the final version of the bill in the near future, but commentators anticipate that negotiations will be difficult because there is disagreement over a different portion of the bill which would grant insureds the right to sue health plans. See Plan Regulation: Beyond Liability, Vast Differences Are Seen in House, Senate Managed Care Reform Bills, 7 Health Care Pol’y Rep. (BNA) No. 1621, at 7 (Oct. 18, 1999).
accounts ("MSAs"), into which small business employees and the self-employed can deposit money to pay the medical expenses of the account holder, a spouse, or any dependents. Another provision phases in an increased tax deduction for insurance costs incurred by self-employed individuals.

Titles IV and V contain HIPAA's procedural provisions. Title IV provides for the application and enforcement of the group health plan portability, access, and renewability requirements contained within the statute and delineates the penalties for failure to comply with specific statutory provisions. Title IV further requires the adoption of national health data standards for the electronic transfer of administrative and financial medical information. Title V pertains to revenue offsets triggered by HIPAA.

Although HIPAA has many functions beyond simply improving portability—perhaps, most notably, the fraud and abuse provisions—this Comment addresses only the portability provisions and the provision establishing MSAs.

VI. HIPAA'S PORTABILITY AND MEDICAL SAVINGS ACCOUNT PROVISIONS IN DETAIL

A. Portability

"Portability" has an extremely narrow definition under HIPAA. One commentator has explained that:

"Portability"... does not entail carrying a specific package of health benefits from one job to another or into periods of unemployment. It simply captures the notion that if an individual has maintained coverage through an employer or individual plan, the next employer plan must waive or limit any [preexisting condition exclusion] that would otherwise apply. An individual may still move from a job with comprehensive coverage to a job

98. See HIPAA § 301, 110 Stat. at 2037. The Quality of Care for the Uninsured Act would make all employers, not just small employers, eligible to offer MSAs. See H.R. 2990 §103.

99. See HIPAA § 311, 110 Stat. at 2053. The Quality of Care for the Uninsured Act would permit deduction of 100% of the health insurance costs of self-employed individuals by 2001, two years earlier than under HIPAA. See H.R. 2990 §102. The Act also would permit deduction of 100% of the health insurance costs of individuals who pay at least half of their premiums themselves by 2007. See id.

100. See HIPAA §§ 401-21(e), 110 Stat. at 2073-89.

101. See id.

102. See HIPAA §§ 500-521(b), 110 Stat. at 2089-2103.
with significantly inferior coverage or none at all. Additionally, coverage may be interrupted by eligibility waiting periods.\textsuperscript{103}

In other words, HIPAA's portability provisions allow previously-covered individuals to use evidence of prior coverage to reduce or eliminate any otherwise applicable preexisting condition exclusion periods when they move from one group plan to another. In certain limited circumstances, HIPAA's provisions also apply to movement from a group plan to an individual policy. Unlike the protection COBRA provides,\textsuperscript{104} portability under HIPAA does not mean that an insured individual actually retains the same policy.

It is important to note that HIPAA does not require subsequent health plans to provide any particular level of coverage. When a person changes jobs, therefore, HIPAA does not guarantee that the coverage he receives will be substantially similar to that which he had before.

1. Limitation on Preexisting Condition Exclusions

HIPAA limits both the types of conditions that may be excluded and the length of preexisting condition exclusions.\textsuperscript{105}

\textit{a. Excludable Conditions}

Two of HIPAA's provisions significantly limit the conditions to which health plans may apply preexisting condition exclusions. First, HIPAA states that unless "medical advice, diagnosis, care, or treatment was recommended or received" for a condition within the six months prior to enrollment in the new plan, health plans are barred from classifying the condition as preexisting.\textsuperscript{106} Second, HIPAA explicitly exempts genetic information from the definition of preexisting condition in the "absence of a diagnosis of the condition related to such information."\textsuperscript{107}

\textit{b. Maximum Period of Exclusion}

HIPAA also reduces the duration of waiting periods in two ways. First, the Act sets a maximum waiting period of twelve months (or eighteen months for "late enrollees"\textsuperscript{108}). Second, HIPAA allows individuals to

\textsuperscript{103} Smith & Kendall, supra note 77, at 85.
\textsuperscript{104} See Dees, supra note 61.
\textsuperscript{105} See HIPAA § 101(a), 110 Stat. at 1939-40.
\textsuperscript{106} Id.
\textsuperscript{107} Id.
\textsuperscript{108} A "late enrollee" is an individual who forgoes the opportunity to enroll in a health plan upon first becoming eligible. See id. In general, employees first become eligible for
offset the twelve or eighteen month waiting period with any period of prior "credible coverage." HIPAA defines "credible coverage" as the number of months for which the individual was previously covered without a break in coverage exceeding sixty-three days. Almost any kind of prior health coverage counts as "credible coverage" under the statute, including prior coverage under a government or church group plan, group or individual health insurance, Medicare, Medicaid, or military-sponsored health care, provided that there is no break in coverage exceeding sixty-three days. The effect of the credible coverage offset is that a previously insured individual who has already waited out one exclusion period will never again be subjected to a waiting period, provided he has been continuously covered for twelve months, unless he suffered a break in coverage exceeding sixty-three days.

109. See id. "Credible coverage" includes coverage under any of the following:

A. A group health plan.

B. Health insurance coverage.

C. Part A or part B of title XVIII of the Social Security Act.

D. Title XIX of the Social Security Act.

E. Chapter 55 of title 10, United States Code.

F. A medical care program of the Indian Health Service or of a tribal organization.

G. A State health benefits risk pool.

H. A health plan offered under chapter 89 of title 5, United States Code.

I. A public health plan . . . .

J. A health benefit plan under section 5(e) of the Peace Corps Act . . . .

Id. §101(a), 110 Stat. at 1940-41.

2. Prohibition Against Discrimination Based on Health Status

   a. Eligibility Nondiscrimination

   In addition to limiting the types of conditions subject to preexisting condition exclusions, HIPAA also limits discriminatory enrollment requirements in even self-funded and group health plans. HIPAA provides that health plans may not establish "rules for eligibility," on the basis of "health status related factors" including: "(A) Health Status; (B) Medical condition (including both physical and mental illnesses); (C) Claims experience; (D) Receipt of health care; (E) Medical history; (F) Genetic information; (G) Evidence of insurability (including conditions arising out of acts of domestic violence); [or] (H) Disability." This eligibility provision even applies to individuals who were not previously eligible for health insurance before HIPAA's enactment and who are enrolling in a plan for the first time in the wake of the statute. The effect of this provision is two-fold; it permits enrollment of employees who were previously excluded from coverage by their current employer's plan, and it decreases the probability that employees changing jobs will be barred from enrollment by their future employer's plan.

   b. Premium Nondiscrimination

   HIPAA disallows health plans to charge one individual a premium higher than the premium charged to a "similarly situated individual" already enrolled in the plan on the basis of any "health status-related factor" of that individual (or of a dependent of the individual). This provision prevents differential treatment, but fails to provide an absolute cap on premium prices. There is one significant loophole in this provision: premium deductions are still allowed if an individual adheres to a disease prevention program.

3. Guaranteed Issuance to Small Employers

   HIPAA takes significant strides towards allowing small businesses to purchase group insurance plans without fear of rejection by insurance companies. HIPAA accomplishes this goal by requiring health insurance

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111. HIPAA § 101(a), 110 Stat. at 1945.
112. Id.
114. See HIPAA § 101(a), 110 Stat. at 1946.
115. See HIPAA § 101(a), 110 Stat. at 1946
issuers offering coverage in the small group market in a given state (including insurance companies and HMOs, but not group health plans) to provide group coverage to all small employers who apply for coverage in that state. HIPAA defines small employers as having between two and fifty employees.

HIPAA does not provide equivalent protection for employers with more than fifty employees. However, the statute authorizes the Department of Health and Human Services to ask each state governor to provide a report by the year 2000 assessing whether large employer groups have easy access to health coverage. The results of these reports may prompt Congress to extend availability guarantees to the large group market in the future.

4. Guaranteed Availability of Health Coverage for Individuals Leaving a Health Plan

As mentioned above, HIPAA's availability guarantees are more limited outside the small group sphere. HIPAA does, however, provide protection for employees of large (and small) employers who were previously covered by an employment-based group plan. HIPAA requires every health insurer in the individual market to provide coverage for employees who have left a group insurance plan, who have exhausted their COBRA coverage, and who are not eligible for coverage under another group plan, Medicare or Medicaid. There is one large limitation on this guarantee: the employee must have been continuously covered under a previous group plan for eighteen months without a break in coverage exceeding sixty-three days. Without eighteen months of prior continuous coverage, an insurer is free to turn down the individual or to exclude preexisting conditions indefinitely.

This coverage will help a covered person who quits a job and either does not find a new job or goes to work for an employer that lacks a group health plan. The guarantee, however, is available only to individuals leaving a group plan. It does not apply to employees who are forced to seek coverage in the individual coverage market after leaving an employer that did not offer health care coverage.

The precise type of coverage that will be accessible to individuals under this provision will vary from state to state. HIPAA gives the states the authority to determine how to administer the specifics of its

117. See HIPAA § 102(a), 110 Stat. at 1976.
119. See HIPAA § 101(a), 110 Stat. at 1943.
120. See HIPAA § 101(a), 110 Stat. at 1941.
requirements.\textsuperscript{121} States are free, for example, to take individuals into their high-risk pools (which are underwritten by a group of insurance companies which share the losses), to require group health plans to offer individual policies for departing workers, or even to require health insurers to accept all applicants. Given the variability in available coverage, prices inevitably fluctuate. Individual coverage plans are expensive at best and high-risk plans can cost twice as much.

5. Renewability Guarantee

HIPAA's renewability guarantee prohibits any multi-employer plan, small or large group insurance provider, or individual market insurance provider from refusing to renew coverage, except in the event of premium nonpayment, fraud, noncompliance of insured with policy provisions, or the cessation of coverage in the given geographic area or market.\textsuperscript{122} In the individual market, an insurer can also refuse to renew coverage if the individual moves outside of the insurer's service area.\textsuperscript{123}

6. Parsing HIPAA

The HIPAA provisions described above reduce to the following basic scenarios. If an individual changes jobs and his new employer has a health plan:

1. If the individual was previously covered by another group plan for at least twelve months without a sixty-three day break in coverage, the new employer's plan must insure him without delay. The individual also must receive instant protection for preexisting conditions, provided he is not a late enrollee.

2. If the individual was previously covered by a group plan for less than twelve months or with a sixty-three day break in coverage, the new employer's plan must enroll him immediately but can impose a preexisting condition waiting period equal to the difference between twelve months (or eighteen if he is a late enrollee) and the number of months for which he was previously and consecutively covered.

3. If the individual previously had no coverage or was carrying an individual plan, the new plan must enroll him immediately and the waiting period for preexisting condition coverage is determined through the same analysis as above.

\textsuperscript{121} See HIPAA § 626, 110 Stat. at 2021.
\textsuperscript{122} See HIPAA § 101(a), 110 Stat. at 1946.
\textsuperscript{123} See HIPAA § 111(a), 110 Stat. at 1982.
If an individual had group coverage in the past but (1) his new job comes without health insurance or (2) he becomes self-employed:

1. If he has eighteen months of prior, continuous coverage, the law guarantees him access to an individual policy that he must buy for himself.

2. If he has less than eighteen months of prior coverage, insurers are free to turn him down or to exclude preexisting conditions indefinitely.

B. Medical Savings Accounts

Medical savings accounts, otherwise known as "medical IRA[s]," are savings accounts earmarked to pay medical expenses in conjunction with a high deductible health plan. These accounts can be funded by individuals or through employer contributions, but not by both. Contributions are generally tax-free to the extent that they are used to pay for current medical expenses or are saved to cover future expenses. If the MSA-holder uses money deposited in an MSA for non-health care purposes, however, it is subject to a 15% excise tax if used before the individual turns sixty-five years old, dies, or becomes disabled. Any balance remaining in an MSA at the end of the year rolls over to the next year and is available to satisfy future medical costs. Upon turning sixty-five, the MSA-holder can withdraw the remaining sum without tax penalties.

In theory, MSAs create tax incentives to spend health care dollars wisely. As long as the money deposited in the account is used only to pay insurance deductibles or other health care expenses, the MSA-holder can earn tax-free interest on the account's balance. As a result, "MSAs encourage consumers to shop the market for the best prices, creating


126. See id. MSA deposits are also tax-deductible in over twenty states. See Margaret O. Kirk, Medical Savings Accounts Get Check Up, J. REC. (Okla. City), Mar. 12, 1997, available in 1997 WL 14388256.

127. See MICHAEL J. CANAN & WILLIAM D. MITCHELL, EMPLOYEE FRINGE AND WELFARE BENEFIT PLANS § 10.2A (1997 ed.).

128. See id.

129. See id.
competitive pressures that will drive costs lower.”

At the time HIPAA was passed, the MSA pilot program was perhaps the most controversial aspect of the statute. Although the House of Representatives adopted a bill which would have allowed tax deductions for money deposited in MSAs, bitter debate in the Senate over this issue resulted in a bill that ignored the issue of MSAs altogether. As a result of the controversy surrounding MSAs, the MSA pilot program implemented by HIPAA contains many limitations.

First, HIPAA permits only a limited number of taxpayers to file MSA returns. The number of MSAs filed could not exceed 375,000 by April 30, 1997; 525,000 by June 30, 1997; 600,000 by April 15, 1998; or 750,000 by April 15, 1999. HIPAA mandated that the program would terminate early on October 1, 1999 if the threshold was exceeded in any given year. However, these numbers were not exceeded, so the program will terminate in the year 2000, as planned, unless Congress extends it.

Second, HIPAA contains strict eligibility requirements. To be eligible to contribute (or to receive employer contributions): (1) an individual must participate in a “high deductible health plan,” established and maintained by an employer; and (2) the total “annual out-of-pocket expenses required to be paid out under the plan (other than premiums) for covered benefits” must not exceed $3000 for an individual and $4500 for a family.

Third, HIPAA only makes MSAs available to self-employed individuals and employees of small businesses. This requirement is the

130. Stevens, supra note 125, at 11 (citation omitted).
131. See HIPAA § 301, 110 Stat. 2037.
133. See id.
134. See HIPAA § 301(a), 110 Stat. at 2046-47.
135. See HIPAA §301(a), 110 Stat. at 2047-48.
136. Only 42,477 taxpayers filed tax returns for MSAs in 1998. Of this number, 10,106 were from taxpayers who were previously uninsured and, therefore, could not be counted towards the termination threshold. As of September 30, 1999, the Internal Revenue Service predicted that only 44,784 MSAs would be filed in 1999. See Medical Savings Accounts: Tax Returns for MSAs Fall Far Short of Trigger for Early Cutoff, IRS Announces, 7 Health Care Pol’y Rep. (BNA) No. 1548 (Oct. 4, 1999).
137. The Quality of Care for the Uninsured Act would remove the cap on MSAs if passed. See H.R. 2990, 106th Cong. §103 (1999).
138. This term, as it is defined in HIPAA, is analogous with what is frequently referred to as “catastrophic coverage.” See Shultz & Greenman, supra note 110, at 102. HIPAA defines a “high deductible plan” as having an annual deductible amount between $1500 and $2250 per year for an individual coverage plan, and between the amounts of $3000 and $4500 for a family coverage plan. See HIPAA § 301(a), 110 Stat. at 2039. House Bill 2990 would decrease the amount of this deductible. See H.R. 2990 § 103.
139. See HIPAA § 301(a), 110 Stat. at 2039.
140. See HIPAA § 301(a), 110 Stat. at 2037
logical corollary of the requirement that the individual participate in a "high deductible" plan established by a small employer. HIPAA defines small employers as any employer which employed an average of fifty or fewer employees on business days during either of the two preceding calendar years.\(^{141}\)

Fourth, the maximum annual contribution that an individual or his employer can make to a MSA is 65% of the deductible for an individual health plan and 75% of the deductible for a family health plan.\(^{142}\)

Even though HIPAA's MSA project has several significant limitations, it is notable for its novelty. HIPAA implemented MSAs for the first time, thereby allowing Congress to gather critical empirical data about their efficacy. In fact, MSAs have been so successful that Congress is now considering extending the program. House Bill 2990 and Senate Bill 1344, which were both introduced last fall, would: (1) repeal the limitation on the number of MSA accounts; (2) make all employers eligible to offer accounts; (3) reduce high-deductible health plan deductibles; and (4) increase the cap on MSA contributions.\(^{143}\) Although the MSA project was controversial at its inception in 1996, it clearly has gained congressional support in the interim.

VII. INTERIM FINAL REGULATIONS IMPLEMENTING HIPAA

On April 8, 1997, the agencies regulating and enforcing HIPAA\(^{144}\) issued two sets of interim final rules. The first of the two regulations applies to the group health insurance market and details how an individual’s previous health coverage is counted and documented when changing to a new plan or policy; establishes coverage and payment limits for preexisting condition exclusions; and prohibits discrimination based on health status.\(^{145}\) The second regulation governs the individual market and details HIPAA’s guaranteed issue and renewability requirements.\(^{146}\) The individual market rules give states two options: enact legislation

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\(^{141}\) See HIPAA § 301(a), 110 Stat. at 2040. House Bill 2990 would make all employees eligible for MSAs. See H.R. 2990 §103.

\(^{142}\) See Stevens, supra note 125, at 10.

\(^{143}\) See H.R. 2990 §103; S. 1344, 106th Cong. § 502 (1999).

\(^{144}\) HIPAA’s group market provisions amend ERISA, the Internal Revenue Code, and the Public Health Service Act, and are thus within the combined regulatory jurisdiction of the Department of the Treasury, the Department of Labor and the Department of Health and Human Services, Health Care Financing Administration ("HCFA"). See HIPAA §104, 110 Stat. at 1978. The individual market provisions only amend the Public Health Service Act and are regulated by the Department of Health and Human Services in conjunction with the states. See HIPAA §111, 110 Stat. at 1978.


conforming with HIPAA’s minimum requirements or implement an "alternative mechanism" to provide individuals with coverage at least comparable to HIPAA’s.\(^{147}\) Thus, HIPAA establishes the minimum amount of health care portability that must be made available to Americans entering the individual market after a period of coverage in the group market.\(^{148}\)

As of yet, there are no final rules for HIPAA’s portability provisions. In the interim, however, there have been developments in other aspects of HIPAA. After Congress missed an August 21, 1999 deadline to establish privacy standards for electronic medical records under HIPAA Title II,\(^{149}\) the Department of Health and Human Services published a proposed rule on November 3, 1999.\(^{150}\) Furthermore, on August 8, 1999 the HCFA published regulations explaining how it will enforce HIPAA in states that do not do so themselves.\(^{151}\)

Although agency agendas indicated that final rules for HIPAA’s portability provisions could have appeared as early as December 1998, final rules still are not in place.\(^{152}\) In the meanwhile, the government’s inaction is tantamount to an endorsement of the status quo. The longer the interim final rules remain in place, the less likely it becomes that there will be a significant departure from them in the future.

Since there are no final rules yet, and the interim final rules have been in place for a significant period of time, the remainder of this Comment will be devoted to HIPAA’s effectiveness under both the statutory language and the language of the 1997 interim final rules.

\(^{147}\) See Landenheim, supra note 40, at 44–46.

\(^{148}\) The HCFA can impose civil monetary fines and an enforcement scheme on any state that fails to comply with HIPAA. See Health Care Financing Administration on “Health Insurance Portability and Accountability Act” Before the House Committee on Ways and Means Subcommittee on Health, 105th Cong. (1997) [hereinafter Moore Statement] (statement of Judith D. Moore, Deputy Director, Center for Medicaid and State Operations, Health Care Financing Administration), available in 1997 WL 603221.

\(^{149}\) See HIPAA § 264, 110 Stat at 2033.


\(^{151}\) See 64 Fed. Reg. 45,785 (1999). Five states have failed to pass conforming legislation: California, Massachusetts, Michigan, Missouri, and Rhode Island; however, by the fall of 1999, the HCFA only was enforcing HIPAA in California, Missouri, and Rhode Island. See Plan Regulation: HCFA Issues Rule on Backup Enforcements of HIPAA Consumer Protections in States, 7 Health Care Pol’y Rep. (BNA), at 1368 (Aug. 23, 1999).

\(^{152}\) See David Nather, Still No Word On Final HIPAA Regulations; Some Interim Rules May Be Permanent, 6 Health Care Pol’y Rep. (BNA) No. 23, at 933 (June 8, 1998).
VIII. HIPAA'S LIMITATIONS: WILL HIPAA REALLY SOLVE THE JOB LOCK PROBLEM?

At best, HIPAA is an incremental solution to the job lock problem. HIPAA makes significant strides towards removing the bite from preexisting condition exclusions by severely limiting the set of circumstances to which full waiting periods apply. However, preexisting condition exclusions are only one factor contributing to job lock as defined in this paper. “Job lock” under this definition refers to reduced job mobility as a result of preexisting condition exclusions, more restrictive plan coverage, or higher premiums.

In a survey conducted by the Employee Benefit Research Institute, only 16% of people complaining of job lock attributed their problem to preexisting conditions. Of those remaining, 36% acknowledged that a prospective employer’s plan was too expensive and 25% claimed that prospective plans offered narrower coverage. Therefore, although HIPAA significantly decreases the sting of preexisting illness exclusions, it addresses only a small part of the total problem. HIPAA, thus, will alleviate—but not eradicate—job lock.

A. Prohibition Against Preexisting Condition Requirements Only Applies in Absence of Break in Coverage of Sixty-Three Days

While HIPAA’s preexisting condition restriction goes a long way towards alleviating job lock, there is one significant loophole that may pose problems in the future. HIPAA currently provides that in order for an individual to be exempt from preexisting condition exclusions, he must demonstrate that there was no break in his prior coverage exceeding sixty-three days. There is evidence, however, that insurers are dragging their feet while processing applications. This causes people to go without coverage for over sixty-three days and thereby become ineligible under HIPAA.

153. As previously discussed, more restrictive terms may either exclude an individual (or a dependent) entirely, or permanently exclude from coverage only certain of the individual’s (or dependent’s) conditions. The latter is distinguishable from preexisting condition exclusions because preexisting condition exclusions temporarily exclude certain conditions from coverage whereas strict terms may permanently bar these conditions from coverage.


155. See id.

156. HIPAA’s efficacy in alleviating job lock may also be affected because “consumers are not fully aware of their rights under the law or are totally unfamiliar with it.” Insurance: Small Employers, Individuals Not Aware of HIPAA Rights, Responsibilities, GAO Says, 7 Health Care Pol’y Rep. (BNA), at 1025 (June 21, 1999).

157. See Testimony on Health Insurance Portability Act Before the House Committee on
In some instances, it is claimed that insurers may even delay processing an entire group’s application, providing these insurers with a justification for applying a waiting period to the whole group. 158 If insurers are allowed to continue these practices, HIPAA’s provisions clearly will not be able to relieve job lock. Although this loophole is not the result of faulty drafting, it is, nonetheless, a practical obstacle to job mobility.

B. HIPAA Does Not Clearly Prohibit Employers from Designing Health Plans to Restrict Coverage for High-Cost Participants

In the past, employers were free to pick the benefits offered by their health plans. Employers often utilized price cutting measures such as eligibility restrictions, benefit caps, elimination of coverage for expensive or experimental treatments, and “wellness incentives” that reward participants for healthy behavior. 159 Although courts could have interpreted both ERISA and the Americans with Disabilities Act (“ADA”) 160 to protect individuals against unfair health plan design, they have not allowed individuals to challenge health plans under either of these two statutes. 161 HIPAA fails to explicitly close the loopholes that courts have read into ERISA and the ADA concerning health plan design. The only HIPAA provision which potentially could restrict employers’ discretion over health plan design is the rule prohibiting discrimination between “similarly situated individuals” on the basis of “health status.” 162

In contrast to federal legislation, many states have enacted laws regulating the terms of health insurance. 163 These state laws do not protect most workers, however, because ERISA preempts state insurance laws with respect to the very self-insured employer plans through which many insureds receive coverage.

ERISA does not provide the same protections that state laws have conferred. From the time ERISA first was enacted until now, courts have frequently declined to read employee protections into ERISA. Courts consistently have held that even though ERISA imposes fiduciary duties on employers—such as providing written disclosure of the terms of self-funded plans—the statute does not prevent employers from modifying the

158. See id.
161. See Barker & O’Brien, supra note 161, at 5.
162. Id. at 9.
163. See id. at 6.
terms and conditions of these plans.\textsuperscript{164} Furthermore, the courts have explicitly held in many cases that ERISA does not trigger fiduciary duties at all when employers design health plans.\textsuperscript{165}

Apart from ERISA, until HIPAA's enactment, the ADA was the only statute under which individuals could challenge health plan design. The ADA, which was enacted "to provide a clear and comprehensive mandate for the elimination of discrimination against individuals with disabilities,"\textsuperscript{166} prohibits discrimination against disabled individuals in relation to the "terms, conditions, and privileges of employment,"\textsuperscript{167} including benefits programs.\textsuperscript{168} Although some ADA claims have succeeded, the ADA only provides limited protection because an individual must be "disabled" before he or she has standing. The stigmatizing effect of the term "disabled" alone may prevent individuals from pressing claims under the ADA.

As explained in the preceding section, HIPAA clearly imposes rules limiting the extent to which group plans can exclude coverage for preexisting conditions. HIPAA also limits the ability of group or individual plans to refuse to enroll individuals previously covered by a group plan. HIPAA is not clear, however, about whether or not an insurer can restrict the benefits it grants to enrollees. Some analysts acknowledge that self-funded employer plans must retain this discretion as a matter of "sound policy," due to the voluntary nature of employer participation in providing health care.\textsuperscript{169} If Congress mandated the minimum amount of coverage employers are required to provide, or enumerated mandatory benefits, many employers who currently provide at least some degree of health care probably would no longer provide any because of the huge financial burden.\textsuperscript{170} Consequently, many employees would be left in a worse position because they would be forced to seek coverage in the more precarious individual market. Therefore, HIPAA only restricts health plan design indirectly through its eligibility, nondiscrimination, and cost

\textsuperscript{164} See, e.g., Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73 (1995) (holding that ERISA does not create an entitlement to welfare benefits, leaving employers free to adopt, modify, or terminate welfare benefit plans for any reason).


\textsuperscript{166} 42 U.S.C. § 12101(b)(1994).

\textsuperscript{167} Id. § 12112(a).

\textsuperscript{168} See Barker & O'Brien, supra note 161, at 7.

\textsuperscript{169} See Smith & Kendall, supra note 77, at 89.

\textsuperscript{170} See id. Other employers might pass along the increased costs to the employees by demanding increased employee premium contributions. See id.
nondiscrimination rules.  

1. Eligibility Nondiscrimination Rule

HIPAA’s eligibility nondiscrimination rule prohibits health plans from establishing eligibility rules on the basis of “health status related factors.” HIPAA explains this rule’s practical impact as follows. First, it states that the rule does not require a plan to provide “particular benefits other than those provided under its terms.” Second, it explains that the rule does not prevent “limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals . . . .” Third, HIPAA announces that waiting periods constitute a “rule for eligibility” and, therefore, are subject to the eligibility nondiscrimination rule.

The courts have not yet decided any cases challenging HIPAA’s prohibition against eligibility discrimination. For this reason, it is still too soon to conclude how courts will judge different types of eligibility requirements, such as caps and exclusions on benefits and waiting periods applied to all employees (not just those with health conditions). Academics predict that courts will likely uphold these plan restrictions even in light of HIPAA’s eligibility nondiscrimination rule.

2. Cost Nondiscrimination Rule

HIPAA’s cost nondiscrimination rule prohibits health plans, as a condition of enrollment, from charging any individual a premium higher than it charges any “similarly situated individual” due to any “health status related factor.” The Act further elaborates on this rule by stating that it does prohibit premium discounts, co-payment modifications, and deductible modifications granted in return for adherence to programs of “health promotion and disease prevention.”

The cost nondiscrimination rule makes it clear that a plan cannot charge higher premiums or contributions as a condition of enrollment in the plan. However, the rule does not prohibit all differential cost treatment. For example, the Act does not necessarily prohibit plans from charging

171. See Barker & O’Brien, supra note 161, at 8.
172. HIPAA § 101(a), 110 Stat. at 1945.
173. Id.
174. HIPAA § 101(a), 110 Stat. at 1946.
175. Id.
177. HIPAA § 101(a), 110 Stat. at 1946.
178. Id.
higher deductibles for different treatment plans where the difference is due, not to differences between individuals, but rather to differences in the benefits that the individual will receive.\textsuperscript{180}

3. Failure to Adequately Define the Meaning of “Similarly Situated” As it Pertains to Both Rules

The failure of both HIPAA itself and the regulation implementing it to define adequately when two individuals are “similarly situated” further complicates interpretation of the eligibility and cost nondiscrimination rules.\textsuperscript{181} As one NAIC representative remarked during congressional testimony, pinning down a precise definition for this ambiguous statutory language will be particularly significant in the small group market “where there is great potential for adverse selection and gaming.”\textsuperscript{182} As of yet, the government has not clarified whether “similarly situated” means “all individuals seeking similar treatment,” “all individuals who have comparable health conditions,” or even “all individuals whose medical conditions are equally costly.”\textsuperscript{183} The final rules regulating HIPAA may clarify this issue if and when they are enacted. In the meantime, however, it is difficult to determine HIPAA’s proper application.\textsuperscript{184}

Because HIPAA fails to prohibit restrictive health plans or insurance policies, it effectively allows insurers to structure their benefits to “act[] as preexisting condition exclusion[s].”\textsuperscript{185} By designing the terms of a plan to exempt certain conditions from coverage for a set period of time, insurers obtain nearly the same result as if they had implemented preexisting condition exclusions.\textsuperscript{186} The difference is that, whereas preexisting condition exclusions apply only to individuals who have manifested the condition during the specified “look back” period, benefit plans can be designed to exclude coverage for the condition in question for all insureds with the condition.\textsuperscript{187} However, the result is the same in both instances. Individuals will be unable to obtain immediate coverage for the condition in question. This break in coverage may be enough to convince individuals

\textsuperscript{180} See id.


\textsuperscript{182} Musser statement, supra note 157.


\textsuperscript{185} Musser statement, supra note 157.

\textsuperscript{186} See id.

\textsuperscript{187} See id.
not to leave their current job and health care benefits package behind.

C. HIPAA Does Not Prohibit Rate Hikes

Although HIPAA eliminates the eligibility obstacles for individuals previously covered by a group health plan, it does not ensure that individuals can afford the coverage that is theoretically available to them. HIPAA fails to guarantee affordable health care coverage because it does not prohibit rate hikes.

Evidence is already beginning to accumulate indicating that health care providers can circumvent HIPAA's portability provisions by passing costs along to insureds.\textsuperscript{188} For example, in testimony before the House Ways and Means Committee, Jay Angoff, Director of the Missouri Department of Insurance, stated that there have already been complaints that at least one insurance company had marked up premiums by 500% for individuals supposedly guaranteed coverage under HIPAA's availability provisions.\textsuperscript{189} Angoff explained that even though HIPAA "[a]rguably ... forbids rate regulation ... insurers do not believe HIPAA limits rates in any way, and they are acting accordingly."\textsuperscript{190} Angoff believes that, due to this limitation, HIPAA will probably only help approximately 3000 individuals in the whole state of Missouri.\textsuperscript{191}

Other critics have reiterated these concerns. For example, Willis Gradison, President of the Health Insurance Association of America ("HIAA"), noted in his congressional testimony that the "entire market could be destabilized" by HIPAA's individual market guaranteed issue requirement.\textsuperscript{192} Although Gradison conceded that it is still too early to judge HIPAA's full impact,\textsuperscript{193} his words warn against future consequences. Indeed, the premium rates that we are witnessing already seem to disproportionately impact small businesses, which are insured through small groups.\textsuperscript{194} Insiders speculate that insurance companies are beginning to underwrite in groups of fifty or less, whereas previously, insurance

\textsuperscript{189} See id.
\textsuperscript{190} Id.
\textsuperscript{191} See id.
\textsuperscript{193} See id.
\textsuperscript{194} See Richard Curtis, Small Firms See Huge Health Rate Jumps: Health Insurance Rates Have Risen, but Large Firms Have Escaped the Worst Hikes, CINCINNATI BUS. COURIER, Aug. 22, 1997, at 1.
companies only were concerned about risk spreading in groups of twenty or less.195

The General Accounting Office presented further evidence of rate hikes in the report it released on March 10, 1998. In this report, the GAO cited numerous ways that insurance carriers discourage consumers from receiving coverage under HIPAA, including charging premiums that are 140% to 600% higher than their standard premiums.196 Critics of the GAO report argue that the report was conducted too early and took too few states into consideration to present an accurate picture of HIPAA’s effect on the health insurance market.197 Such critics note that the GAO’s study did not include any states using high-risk pools, which spread the cost of HIPAA’s group-to-individual plans over a larger number of insureds.198 Instead, the GAO report focused on thirteen states that established separate pools for HIPAA individuals.199

If significant rate increases continue, the cost of HIPAA to individuals may well outweigh any benefits. After all, health insurance portability is effective only if individuals (or employers on behalf of their employees) can afford to purchase new insurance. As Representative Dennis Hastert of Illinois pithily explained the problem: “There are a lot of Mercedes and Rolls-Royces out there that are available. The problem is, people don’t drive them because they can’t afford them . . . that’s the same way in health care.”200

It is possible that the premium hikes witnessed shortly after HIPAA’s enactment are the result of an initial “knee jerk reaction” on the part of the insurance companies and will subside when insurers are better able to assess the increased costs associated with HIPAA. However, the problem is significant enough that it prompted Senator Kennedy, one of HIPAA’s original sponsors, to introduce a proposal in response to the March 10, 1998 GAO report that would cap premium rates.201 Premium hikes and their consequences may well be here to stay. Only time will tell for certain whether they will become a lasting phenomenon.

195. See id.
198. See id.
200. Suzy Szasz, Limited Reform in Health “Reform” Measure, St. Louis Post-Dispatch, Oct. 15, 1996, at 11B.
D. Insurance Companies Can Temporarily Opt Out of the Market

HIPAA's ability to stem job lock is further hindered because the Act fails to prevent insurance companies from backing out of undesirable insurance markets altogether. Both the availability and renewability guarantees in HIPAA only require insurers to provide or continue coverage if they choose to insure some individuals in the market in question. Evidence shows that many insurance companies are using this loophole to their advantage by pulling out of certain markets, at least in the short run, to avoid enrolling the backlog of high-risk individuals expected to seek coverage as HIPAA becomes effective. In the meanwhile, if an individual leaves an old job that provides coverage, there is no guarantee that HIPAA-compliant health insurers providing replacement coverage will exist in that market.

E. Current Insurance Company Practices Undermine the Guaranteed Issue Requirement

In general, insurance companies pay insurance brokers commissions equal to a percentage of the premiums for policies sold. These commissions vary inversely with the number of individuals in the group. The NAIC reports that, in some states, insurance companies are either withholding commissions from brokers who sell policies to small groups and individuals eligible under HIPAA, or they are reducing dramatically the amount of these commissions. If insurance companies continue these practices, they may succeed in negating the intent behind the guaranteed issue plans created by HIPAA. Insurance brokers will find it economically disadvantageous to continue enrolling groups and individuals under the guaranteed issue provision.

F. Opt-Out for Self-Funded, Non-Federal Government Plans

Finally, HIPAA allows self-funded plans administered by branches of the government, other than the federal government, to opt out of HIPAA's group market requirements. As HCFA representatives explained in their congressional testimony, this exemption would affect a large number of individuals, such as school teachers, who receive health insurance through

202. See id.
203. See Musser statement, supra note 157.
204. See id.
205. See id.
206. See HIPAA § 102(a), 110 Stat. at 1967.
local school districts. As of mid-September 1998, at least 200 non-federal government plans were exercising this option.

IX. AN ALTERNATIVE TO THE EMPLOYMENT-BASED HEALTH SYSTEM: THE MEDICAL SAVINGS ACCOUNT PILOT PROGRAM

HIPAA's MSA experiment establishes a maximum of 750,000 accounts. MSAs, which first became available to the self-employed and the employees of small businesses on January 1, 1997, may provide an efficient alternative to the rest of HIPAA's health care regulatory framework.

MSAs give individuals more control over their health insurance dollars while simultaneously attenuating the relationship between health insurance and the job market. Rather than purchasing a comprehensive health insurance plan for employees who have MSAs, employers may purchase a low-cost, high-deductible catastrophic coverage policy for these employees and deposit into the MSA the remaining cash designated for individuals' health insurance benefits. This system shifts more responsibility onto employees because it requires them to make deductible payments out of their MSAs. Any money left in the account at the end of the year rolls over to the next year without being taxed.

Critics claim that MSAs will not solve the portability dilemma because the only people who will opt for them are either healthy enough not to require much health care or wealthy enough to afford the high-deductible payments of a catastrophic policy. Furthermore, detractors claim that MSAs will bankrupt the current health insurance system by allowing low-risk, wealthy individuals to drop out of mainstream coverage, leaving behind a pool of individuals who will drive up the insurance rates. Another potential problem with MSAs is that the law of several states may outlaw high-deductible policies, a prerequisite for MSA eligibility. However, allowing Americans to secure health insurance coverage through MSAs could possibly alleviate the job lock problem because changing jobs would not necessarily require workers to change

207. See Moore statement, supra note 148.
208. See id.
211. See id.
212. See id.
213. See id.
214. See id.
215. See Bradley & Dalton, supra note 211, at 76.
from one plan to another.\footnote{216}

Despite the factors undermining MSAs, the pilot program may serve as a significant starting point for future legislation divorcing health care coverage from the employment relationship. The fact that Congress has recently introduced a bill whose passage would extend the scope and availability of MSAs evidences that at least some legislators believe that MSAs are a viable alternative to the current health insurance system.

X. CONCLUSION

Although HIPAA fails to establish universal health care coverage or to ensure that all employers provide health care coverage, it will help prevent some insureds from losing their coverage. However, as the preceding analysis suggests, HIPAA is not likely to fully unravel the job lock problem. The Act appears to be only an incremental health care reform, enacted in the wake of the Clinton administration's unsuccessful campaign to provide universal health insurance.

Rate hikes are perhaps the most ominous problem discussed above. Although HIPAA takes steps towards reducing the restrictions that can be used to deny an individual's coverage when she changes jobs, nothing in HIPAA ensures that an individual will be able to afford the health coverage offered by a new employer. Until HIPAA's final rules are in place and comprehensive studies interpreting HIPAA's impact are conducted, however, it is too soon to fully assess the statute's efficacy.

To be fair, many of the areas in which HIPAA seems to fail are those in which strict enforcement would provide a solution. Yet HIPAA's most serious shortcoming—its failure to curb rate increases—results from a statutory omission that simply cannot be remedied by mere careful implementation.

It remains to be seen how courts will construe HIPAA in case law. A recent challenge by an employee claiming that his insurance provider impermissibly denied coverage, and thus violated the nondiscrimination provision of HIPAA, was dismissed on summary judgment.\footnote{217} The court asserted that the Act did not apply because the application for coverage was effective January 1, 1998, while the Act did not become effective until February 1, 1999. Thus, the explicit provisions of HIPAA itself were not

addressed. Certainly, future decisions will reveal how courts will construe insurer activities that violate HIPAA's intent without violating its explicit provisions.