Congress of the United States
Washington, DC 20515

April 13, 2005

The Honorable Elaine Chao
Secretary
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

The Honorable Michael Leavitt
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable John Snow
Secretary
U.S. Department of Treasury
1111 Constitution Avenue, N.W.
Washington, D.C. 20224

Dear Secretaries Chao, Leavitt, and Snow:

We, the undersigned ranking members of the key Committees and Subcommittees in the U.S. House of Representatives with jurisdiction over the major federal health regulation laws, hereby submit the following comments on the joint proposed and final regulations issued by the Departments on the Health Insurance Portability and Accountability Act of 1996 (HIPAA), issued in the Federal Register on December 30, 2004. As you know, HIPAA was a bipartisan effort by the Congress to address many long-standing problems in both the individual and group health insurance markets, particularly to allow individuals changing jobs to do so without losing health benefits. The problems with adequate access to health insurance and fair delivery of promised benefits have been well documented. The intent of HIPAA was to reduce and eliminate many of these abuses. However, even though HIPAA has been effective in several areas, skyrocketing health care costs continue to create incentives for employers and insurers to reduce access to coverage and limit the provision of promised benefits. HIPAA was specifically intended to establish a fair set of rules to protect individuals and prevent unfair employer and insurer practices, for example, preventing discrimination in gaining access to coverage based on a pre-existing illness.

In issuing proposed and amended HIPAA regulations, we urge the Departments to adhere to the fundamental purpose and intent of HIPAA. Of course, we believe the Departments should establish rules that are simple and administratively feasible for employers and insurers. However, the Departments should not adopt rules that reflect an attempt by employers and

insurers to reduce costs by limiting access and denying coverage. To allow such actions would be moving us backwards, leaving consumers with the problems they faced prior to HIPAA's enactment. Employers and insurers must separately and straight-forwardly address issues related to cost. The primary focus of the Departments in these regulations should be to fulfill the intent of HIPAA, that is, to establish a fair set of rules to provide adequate access to health insurance and benefits for consumers – in a manner that is least burdensome and most administratively feasible for employers and insurers.

Our specific comments detailing our areas of concern in the regulations are attached. In addition to the proposed rules and request for information, we are submitting comments on several issues in the final rules that do not meet the spirit of HIPAA. For example, we were surprised to find that the Departments did not correct the problem of military benefits not qualifying for HIPAA protections (see page 5 for the discussion of this issue). We ask that the Departments address these concerns through the issuance of modifications to the final rule. We look forward to your response.

Respectfully submitted,

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Committee on Energy
and Commerce

GEORGE MILLER
Ranking Member
Committee on Education
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CHARLES B. RANGEL
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PETE STARK
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Committee on Ways and
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Subcommittee on Health

Comments on HIPAA Portability Regulations
26 CFR Parts 54, 29 CFR Part 2590, 45 CFR Part 146

Proposed Rules and Request for Information

Rules Relating to Creditable Coverage

We are concerned that as currently drafted, individuals who are unaware that their coverage was terminated still may not be afforded the legal protection of having 63 days during which to find new coverage without facing insurer discrimination. Under current law, individuals have 63 days from the time their coverage is terminated to find new coverage. However, those who do not receive notice of termination have no way of knowing they should begin the search for new coverage. Extending the allowable time, as the proposal would do, is a nice gesture, but it will not address cases where notice was not given or was not given in a timely manner.

Instead of extending the maximum allowable days, as the proposed rule would do, we urge the Departments to use the date that **notice** of termination of coverage is received as the point from which to begin counting toward a significant break in coverage. This means that for purposes of determining a significant break in coverage, the day the notice is received, not the last day of coverage would be counted as the first day toward a break. This change would address more directly the inequity that occurs when an individual's coverage is terminated without his awareness.

Special Enrollment Periods

Special Rules – Excepted Plans and Excepted Benefits

The anti-abuse rule prohibits employers from establishing multiple health plans in order to avoid HIPAA protections. The proposed rules would require the government to prove that an employer's "principal purpose" in establishing separate health insurance plans for individual employees is to evade HIPAA regulations. Proving that an entity's principal purpose or intent is to evade legal requirements would be extremely difficult and would place an unnecessarily heavy burden of proof on the government. Instead of applying this standard, the practice of enrolling single employees in (or disaggregating employees into) separate health plans should be prohibited.

Benefit-Specific Waiting Periods

We strongly oppose benefit-specific waiting periods, for example, prohibiting coverage of pregnancy-related services for a period of time. Carving out coverage of medical benefits for certain expensive conditions would effectively impose a pre-existing condition exclusion on individuals with medical problems. Such practices not only undermine the intent behind HIPAA, but also are unsound health policy. Health insurance does no good if it does not provide benefits for individuals when they are sick or in need of care. Allowing employers and insurers to circumvent provision of health benefits to the sick would leave individuals with the enormous

financial responsibility of paying for their own medical care and will have a profound influence on their ability to seek care. People will either forego necessary medical care – which in the case of an illness like organ transplantation will increase the likelihood of rejection and the loss of the already scarce organ – or will drive them into bankruptcy. Neither scenario is appropriate in a society that values individuals regardless of their financial worth.

Final Rules

Pre-existing Condition Exclusion Issues

Pregnancy, Prescription Drugs, and Diabetes

The final rules include examples of situations where health plans may not be responsible for covering certain medical conditions. We were surprised to see the Departments provide guidance on how insurance companies can avoid meeting their financial obligations to enrollees. Instead of encouraging anti-beneficiary behavior, the Departments should eliminate these loopholes. Denying women coverage for prenatal and pregnancy-related care for extended periods, not covering treatment of diabetes, and providing disincentives for chronically ill individuals to continue their prescription therapies is not only a violation of the legislative intent behind HIPAA's non-discrimination and portability provisions, it is also bad policy.

Notice

The notice provisions must be strengthened. Under the final rules, a plan is only required to notify an individual of pre-existing condition exclusions within a "reasonable time." An individual does not have the right to know within a definite time period if he/she is eligible for coverage of certain conditions. In addition, plans are permitted to merely indicate that a pre-existing condition exclusion period will apply without identifying specific conditions that are excluded from coverage. The lack of clarity in these instances unnecessarily prevents proper access to services due to uncertainty about coverage. The effect of these provisions is contrary to the notice requirements and portability protection of HIPAA. We urge the Departments to correct these problems in the proposed rules by establishing a specific timeframe for notice with a special exception for hardship. An objective general rule is far fairer than a subjective rule that may not be fair and is more likely to lead to litigation.

Special Enrollment Issues

S-CHIP

The final rules allow individuals to enroll in group health plans in special circumstances outside of the health plan's ordinary open enrollment periods. Comments on the interim rules sought clarification about whether such a special enrollment should be triggered if a child suddenly becomes eligible for an employer health plan under the S-CHIP program. The rules do not provide for special enrollment in the case of addition of coverage (i.e., when a child is newly eligible for coverage), but only when there is a loss of coverage. As currently written, children could face an 18-month pre-existing condition exclusion in their parent's group health plan. We

recommend that the rules be modified to extend the special enrollment rights to low-income children who become eligible for S-CHIP.

Reduction of Employer Contributions

The final rules should be amended to allow for special enrollment rights in cases where the employer reduces benefits or contributions to the point that coverage becomes unaffordable for the employee, not just when the employer terminates their contributions entirely. In a climate of rising health care costs, employers are cost-shifting more and more to employees. In many cases, the effect of an employer decreasing contributions is the equivalent of terminating coverage because the employee may no longer be able to afford the premium and therefore may be forced to drop coverage. The rules should provide special enrollment for this situation in order to preserve HIPAA's portability protection, the continuation of insurability.

Reaching Annual Limits

In addition to extending the special enrollment protections for individuals who reach lifetime limits on coverage, we urge that there be a special enrollment for those at their annual limit on coverage as well. When an individual reaches his or her annual insurance limit, they effectively become uninsured for the remainder of the year. In this instance individuals should have the option to enroll in their spouse's (or other eligible) plan. There is no question that reaching an annual limit presents an emergency situation for individuals who will find themselves without access to medical care. In keeping with the spirit of HIPAA, these individuals should be offered the opportunity to enroll in alternative coverage.

COBRA

The final rules require COBRA exhaustion in order to trigger special enrollment (or guaranteed access to individual health insurance). However, if an individual moves out of his COBRA plan's particular service area, and therefore has access to only emergency services or greatly reduced benefits, the rules do not provide for HIPAA protections. A significant reduction in benefits is similar to losing coverage completely and should be treated as such. This omission undermines the intent of the legislation to assure that individuals do not face a break in insurance coverage.

Issues Not Addressed In Final Rules

Military Exclusion

U.S. soldiers discharged from the military would not currently be protected by HIPAA in the individual market. This is because military health plans are not considered group health plans under the law, and only those leaving group health plans have HIPAA protection for mandatory access to individual health insurance policies. Consequently, a soldier discharged from the military who needed an individual policy would likely be subject to underwriting, and possibly deemed ineligible for insurance. Lack of protection for members of our armed forces under these rules is a glaring omission, and should be rectified.