Health Disclosure and Claims Issues: Fiscal Year 2001 Compliance Project Report

U.S. Department of Labor
Pension and Welfare Benefits Administration

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HEALTH CARE COMPLIANCE ASSISTANCE PLAN OVERVIEW

In 1996 and 1998 Congress amended the Employee Retirement Income Security Act (ERISA) with new provisions governing health care benefits. This presented a new challenge for the Department of Labor's Pension and Welfare Benefits Administration (PWBA), which is charged with administration of ERISA. To implement these health care provisions and to provide broad-based compliance assistance to the regulated community, PWBA developed comprehensive interpretive guidance at the earliest stages of implementation. In addition, PWBA did extensive compliance assistance outreach to group health plan sponsors, health insurance issuers, and other affected parties.

In fiscal years (FY)[1] 1997 and 1998, PWBA published regulations implementing the health care provisions, initiated an education outreach campaign, and developed compliance assistance publications. Compliance assistance outreach continued through FY 1999 with the development of a pilot program, under which more than 200 health plans were reviewed for compliance with the new health care provisions. In FY 2000, PWBA assessed the results of the pilot program and made adjustments to expand its existing outreach and compliance assistance efforts, as well as to develop internal quality control for completing health plan reviews. Then, in FY 2001, PWBA undertook its Health Disclosure and Claims Issues (HDCI) FY 2001 Compliance Project (project), during which the Agency reviewed a large number of plans to assess the level of compliance with the new health care provisions. It was anticipated that this project would give the Agency a baseline for assessing compliance on a specific provision-by-provision basis.

The project was undertaken very early in the implementation period of the new health care laws; compliance reviews were begun only 2 years after the new health laws became applicable. However, early reviews were important to enable the plan community and the Agency to identify areas of misunderstanding and to enable the Agency to focus its efforts on clarifying those requirements. Specifically, based on the results of the project (which are presented in detail in this report), PWBA is announcing its HIPAA Compliance Assistance Program (H-CAP), which is comprised of three strategies, each with an action plan. After identifying problem areas through the project and introducing H-CAP to target these problems, PWBA anticipates that compliance rates will rise.

H-CAP's first strategy is to develop and distribute additional publications and other educational materials. PWBA is publishing three new publications to assist group health plans and health insurance issuers in complying with the new health laws. These materials will be distributed through the Agency's toll-free publications line, at all workshops and compliance assistance activities, through industry groups and industry newsletters, through the trade press and other interested media, and via the Agency's Web site.

The first is a *Self-Audit Checklist*. This checklist, similar to the HIPAA checksheet used by PWBA investigators to determine compliance, will be a useful tool for plans and issuers to assess their compliance line-by-line with the health laws. In addition, *Compliance Assistance for Group Health Plans*, PWBA's current publication highlighting the top 10 most common errors made by health plans, has been updated with 5 additional tips for group health plans, based on common mistakes found in the project. It also includes advice on how to avoid these mistakes. Finally, a *New Health Laws Notice Guide* has been developed summarizing all of the new health law notice requirements, including sample language that can be used by plans.

H-CAP's second strategy is to dedicate a section of the compliance assistance page on PWBA's Web site to the new health care laws, making it easier for plans, issuers, and other service providers to find, in one location, all of the regulations, publications, frequently asked questions, and other guidance. The new, dedicated section will supplement compliance assistance efforts PWBA has already made, including making its benefits advisors available through a toll-free telephone number, 1-866-275-7922, and electronically at www.askpwba.dol.gov to answer questions about the new health law requirements.

[1] PWBA's fiscal year runs from October 1 through September 30.

The third strategy will be to participate in new, live workshops around the country where trained staff will meet with plan administrators, plan sponsors, attorneys, consultants, and other service providers to apply the *Self-Audit Checklist* to various sample plan provisions and documents. These live workshops will supplement the Health Benefits Education Campaign Compliance Assistance Seminars already conducted by the Agency, which address a wider variety of health plan topics, including the new health laws.

EXECUTIVE SUMMARY OF THE FY 2001 COMPLIANCE PROJECT RESULTS

In October 2000, PWBA initiated the project, during which 1,267 investigations were conducted of group health plans and their compliance with the new health care laws in Part 7 of Title I of ERISA. The new health laws are the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Mental Health Parity Act of 1996 (MHPA), the Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act), and the Women's Health and Cancer Rights Act of 1998 (WHCRA). Each law provides new Federal protections to individuals in employment-based group health plans.

Because these laws generally became effective only about 2 years before the project began, implementation by group health plans seems to have progressed steadily. Most group health plans made changes to comply with the new health care laws. However, some plans experienced start-up, implementation issues, particularly with respect to certain notice provisions and certain discrete substantive provisions that are technical in nature. In such cases, correction of these problems was obtained through voluntary compliance by the plans and their service providers.

The FY 2001 Compliance Project was a review of group health plans for compliance with 42 specific requirements of the new laws. Generally, PWBA found that group health plans are in compliance with the substantive provisions of the new health care laws—that is, the provisions other than the notice requirements. However, implementation problems exist, particularly with respect to certain notice provisions, as well as regarding certain discrete substantive provisions that are technical in nature. To address these problems, PWBA has developed the HIPAA Compliance Assistance Program (H-CAP). H-CAP, which is discussed in more detail below, should improve compliance by partnering with the regulated community to address problem areas identified in the project.

Data from the project revealed that only 8 percent of plans were cited with a violation of MHPA.[2] This rate shows a sustained improvement from the 14 percent noncompliance rate found by the General Accounting Office (GAO) using survey data reported as of December 1999. (See *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited* (GAO/HEHS-00-95, May 10, 2000.)

With respect to WHCRA, only 4.5 percent of plans were cited with a violation of WHCRA's substantive provisions (that is, the provisions other than the notice requirements). This number increased, however, when taking into account WHCRA's notice requirements; the investigations resulted in 21.8 percent of plans being cited with a violation of WHCRA. Some of the WHCRA violations may have resulted from a lack of formal guidance or a communication gap with health insurance issuers about the required elements and timing for notices.

Similarly, regarding the Newborns' Act, only 5.2 percent of plans were cited with a violation of the substantive provisions. Again, the number increased, however, when taking into account the notice requirements; 35.0 percent of plans were cited with a violation. In this regard, there may have been some confusion among plan administrators and health insurance issuers regarding the applicability of the Newborns' Act notice requirements, which may account for the high rate of noncompliance.

Data from the project also revealed that 28.1 percent of plans were cited with at least one violation of HIPAA's substantive portability (including the certificate of creditable coverage requirements) or nondiscrimination provisions. Many of the violations involved discrete plan provisions, such as "hidden" preexisting condition exclusions or nonconfinement clauses. In these instances, PWBA found that one plan provision caused multiple HIPAA violations. Moreover, notice problems played a role again; 35.9 percent of plans in the sample were cited with at least one violation of HIPAA when taking into account the notice provisions.

After reviewing all of the data, PWBA also observed certain trends. Plans were reviewed for compliance with 42 health care provisions, 6 of which were notice provisions. Most of the violations cited involved these

[2] For simplicity, this report references the percentage of plans cited with a violation. However, these percentages are actually weighted violation rates, which are explained in footnote 15 of this report.

notice requirements. In addition, small and large single-employer plans had the lowest noncompliance rates (as opposed to mid-sized, single-employer plans). Among multiemployer plans, violation rates, which were generally higher than among single-employer plans, also peaked in the mid-sized range.

Combining the data, 30.7 percent of plans were not in compliance with at least one of the 36 substantive provisions of the four health care laws. After factoring in noncompliance rates with the six notice provisions, the data reveal that 45.3 percent of group health plans were cited with a violation of at least one provision of the four laws. In many cases, noncompliance may have been the result of a mistake in understanding and complying with the laws. Given the fact that the project was initiated in the very early stages of the laws' implementation process, and taking into account the size of the ERISA health plan universe (approximately 2.5 million plans), this confusion in implementation is not unexpected. To address these implementation issues, PWBA is initiating H-CAP to launch a partnership effort with the regulated community to provide targeted compliance assistance and to rapidly improve compliance rates.

I. INTRODUCTION

Because, traditionally, Federal law did not regulate the provision of specific health benefits, the enactment of these new health care laws presented a challenge for PWBA. As mentioned earlier, before it undertook the broader FY 2001 Compliance Project, PWBA launched a 1999 pilot project. This pilot project involved the review of approximately 225 group health plans to determine initial levels of compliance with these newly enacted laws. The Office of Enforcement (OE) and investigators from regional offices worked with group health plans, group health insurance issuers (issuers),[3] and other service providers regarding their responsibilities under the new health care provisions. To assist investigators with their reviews of plans and to establish uniform standards for review, the Office of Health Plan Standards and Compliance Assistance (OHPSCA) developed a HIPAA checksheet. This checksheet summarized the various requirements of each law line by line and established standardized questions for group health plan reviews. An updated, self-audit version of this checksheet is being made publicly available simultaneously with the publication of this report.

The FY 1999 pilot project succeeded in introducing investigators to Part 7 compliance work and informed PWBA as to what additional measures would be needed before investigations could be conducted by regional investigators on a broader scale. Accordingly, in FY 2000, PWBA expanded its internal education program and developed a variety of quality control measures to make health plan investigations more efficient and effective. These efforts included making new use of technology to develop printed and electronic materials as well as new, faster methods of communication, as described below. Also in FY 2000, and drawing from its growing experience with health plan investigations, PWBA implemented HDCI, a national project reflecting the Agency's increased commitment to reviewing health plans. Later, in March 2000, PWBA published its Strategic Enforcement Plan that identified health plan issues as one of the Agency's national priorities. PWBA's primary focus in this area is to ensure that health plans with trusts are financially sound and plan operators run the health plan prudently and in the participants' sole interests. Regional offices were directed to perform a detailed Part 7 review in cases opened under the project.

Although historically PWBA had a presence in civil and criminal health care enforcement, prior efforts targeted issues such as delinquent participant contributions to health plans, fraudulent multiple employer welfare arrangements, and the failure to transmit to plans fee reductions and discounts received from doctors and hospitals negotiated by administrative service providers. HDCI represented a major shift in emphasis in enforcing all the provisions of ERISA affecting group health plans, including Part 1 (relating to reporting and disclosure), Part 4 (relating to fiduciary responsibility), Part 6 (relating to continuation health coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)), and Part 7.

OE also recognized the need for specialized training for investigators and, thus, prepared and presented to each region during its annual field training session modules on the health care industry, health care contracts, health plan criminal investigations, claims processing, remedies, and the COBRA health coverage continuation provisions.

The project evolved as an outgrowth of HDCI and was designed specifically to ascertain the level of compliance with the new Part 7 health care laws throughout the employee health benefit plan universe. Data derived from the project and presented in this report reflect, among other outcomes, a baseline of overall compliance by group health plans with the Part 7 statutes and regulations. The report includes an overview of the statutory and regulatory provisions of Part 7; a discussion of regional office investigator training; an explanation of the sampling methodology and field implementation of the project; a presentation and interpretation of data; and a discussion of the impact the investigations had on issuers and third-party administrators (TPAs).

The data presented in this report illustrate compliance with Part 7 overall and with each of the individual laws that are the framework of Part 7. Additionally, the data show violation rates by plan size (large or small) and

[3] An issuer is generally an insurance company or health maintenance organization that is required to be licensed and that is subject to State law that regulates insurance. See 29 CFR § 2590.701-2.

plan type (single or multiemployer). Analysis of these results assisted PWBA in the development of H-CAP, and will influence how PWBA will implement additional, future interpretive and compliance assistance activities.

II. OVERVIEW OF THE PART 7 STATUTES

1. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

a. *Legislative History*

HIPAA was enacted on August 21, 1996, to provide for, among other things, improved portability and continuity of health care coverage.[4] First, HIPAA places limitations on a plan's or issuer's ability to impose a preexisting condition exclusion. Specifically, a preexisting condition exclusion must relate to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on an individual's enrollment date. The exclusion period cannot extend for more than a maximum of 12 months (18 months for late enrollees) after the enrollment date, offset by the days of an individual's prior health coverage. The primary way that individuals provide evidence of their prior health coverage is through a certificate of creditable coverage provided to them by their prior health plan or issuer when coverage ends. Accordingly, HIPAA also sets forth a process for transmitting certificates and other health coverage information to a new group health plan or issuer. In addition, HIPAA creates special enrollment rights, which allow an individual to enroll in a group health plan for which he or she is otherwise eligible when he or she loses eligibility for other health coverage or has a new dependent. HIPAA also prohibits discrimination based on health factors against individuals and their dependents in enrollment and premiums. Finally, HIPAA preserves, through narrow preemption provisions, the States' traditional role in regulating health insurance, including State flexibility to provide greater protections.

b. *Regulatory History*

After inviting comments from the regulated community and other interested parties,[5] interim final regulations implementing HIPAA were published on April 8, 1997 (62 Fed. Reg. 16894). The regulations clarify the statutory provisions and provide protections for individuals seeking health coverage while minimizing burdens on plans and issuers. The regulations reduce burdens by providing model language for HIPAA disclosures (including a model certificate of creditable coverage), reducing unnecessary duplication in the issuance of certificates, including flexible rules for dependents to receive the coverage information they need, and allowing coverage information to be provided by telephone if all parties agree. The regulations protect and assist participants and their dependents by ensuring that individuals are notified of the length of time that a preexisting condition exclusion clause in any new health plan may apply to them after taking into account their prior creditable coverage, ensuring that individuals are notified of their rights to special enrollment under a plan, permitting individuals to obtain a certificate before coverage under a plan ceases, and creating practical ways for individuals to demonstrate creditable coverage to a new plan (if, for example, the individual does not receive a certificate for the individual's prior health coverage). Additional regulations implementing HIPAA's nondiscrimination provisions were published on January 8, 2001 (66 Fed. Reg. 1378). The Departments of Labor, the Treasury, and Health and Human Services (HHS) are presently drafting final rules on HIPAA's portability provisions. These rules will reflect further comments received from interested parties representing the experience they have had with the interim regulations.[6]

c. *Effective Dates*

The HIPAA provisions first became applicable to group health plans and issuers under two separate time lines. One was a general time line for the majority of the provisions, which were generally effective for plan years beginning on or after July 1, 1997, representing a staggered effective date for the provisions. For collectively bargained plans, there is a special effective date under HIPAA. For plans maintained pursuant to collective bargaining agreements (CBAs) ratified before

[4] HIPAA amended ERISA, the Internal Revenue Code (Code), and the Public Health Service Act (PHS Act) with parallel provisions. Generally, ERISA covers private-sector group health plans and health insurance issuers. However, the Department of Labor does not enforce the provisions of Part 7 directly against issuers, which are under the jurisdiction of the States or the Department of Health and Human Services (HHS).

[5] See Solicitation of Comments published on December 30, 1996 (61 Fed. Reg. 68697).

[6] See Solicitation of Comments published on October 25, 1999 (64 Fed. Reg. 57520).

August 21, 1996, the majority of the provisions apply to plan years beginning on the later of July 1, 1997, or the date on which the last of the CBAs relating to the plan terminates (determined without regard to any extension agreed to after August 21, 1996). The effective date for HIPAA's certification provisions for all group health plans and health insurance issuers is July 1, 1996, to give individuals evidence of creditable coverage prior to the July 1, 1997, effective date for the other provisions.

The effective dates for the 1997 interim regulations regarding HIPAA's portability and nondiscrimination provisions mirror the statutory effective dates. The 2001 regulations on HIPAA's nondiscrimination provisions are generally effective for plan years beginning on or after July 1, 2001, and therefore were generally not considered when determining group health plan compliance during the project.

2. Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act)

a. *Legislative History*

The Newborns' Act was enacted on September 26, 1996.[7] The law provides new protection for mothers and their newborn children with regard to the length of hospital stays following the birth of a child. Specifically, the Newborns' Act provides a general rule under which a group health plan and an issuer may not restrict a mother's or newborn's benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. The Newborns' Act permits an exception to the 48-hour (or 96-hour) general rule if the attending provider decides, in consultation with the mother, to discharge the mother or her newborn earlier.

b. *Regulatory History*

On October 27, 1998, the Departments of Labor, the Treasury, and HHS published interim final regulations for group health plans and issuers under the Newborns' Act, after inviting comments from the regulated community and other interested parties.[8] Among other things, the regulations clarify when the 48-hour (or 96-hour) period begins, provide that the determination as to whether a hospital admission is in connection with childbirth is a medical decision to be made by the attending provider, define who may be an attending provider, and clarify the applicability of State law to insured arrangements.

c. *Effective Dates*

The statutory provisions apply to group health plans and issuers for plan years beginning on or after January 1, 1998. Clarifications contained in the interim final rules apply for plan years beginning on or after January 1, 1999.

3. Mental Health Parity Act of 1996 (MHPA)

a. *Legislative History*

MHPA was enacted on September 26, 1996.[9] MHPA provides for parity in the application of aggregate lifetime dollar limits, and annual dollar limits, between mental health benefits and medical/surgical benefits. MHPA's requirements apply regardless of whether the mental health benefits are administered separately under the plan. Nevertheless, MHPA does not require a group health plan or health insurance coverage offered in connection with a group health plan to provide mental health benefits.

b. *Regulatory History*

The Departments of Labor, the Treasury, and HHS published interim final regulations implementing the MHPA provisions on December 22, 1997, after inviting comments from the regulated community and other interested parties.[10] Among other things, the regulations clarify the application of the MHPA provisions to group health plans with varying types of dollar limitations (including inpatient/outpatient limits and in-network/out-of-network limits) and the procedures a plan would undertake to elect the 1 percent increased cost exception permitted under the statute.

[7] Initially, the Newborns' Act amended only ERISA and the PHS Act. The Taxpayer Relief Act of 1997 was enacted on August 5, 1997, and added provisions substantially similar to those in the Newborns' Act to the Code.
[8] See Solicitation of Comments published on June 26, 1997 (62 Fed. Reg. 34604).

[9] Initially, MHPA amended only ERISA and the PHS Act. The Taxpayer Relief Act of 1997 was enacted on August 5, 1997, and added provisions substantially similar to those in MHPA to the Code.
[10] See Solicitation of Comments published on June 26, 1997 (62 Fed. Reg. 34604).

c. *Effective Date*

In general, MHPA and the interim final rules apply to group health plans and issuers for plan years beginning on or after January 1, 1998.[11]

4. Women's Health and Cancer Rights Act of 1998 (WHCRA)

a. *Legislative History*

WHCRA was enacted on October 21, 1998.[12] WHCRA requires group health plans and issuers that offer medical and surgical benefits with respect to a mastectomy to provide reconstructive breast surgery if a participant or beneficiary is receiving benefits in connection with a mastectomy, elects reconstruction, and the reconstruction is in connection with such mastectomy. In particular, WHCRA requires coverage of the following reconstructive surgery benefits: 1) all stages of reconstruction of the breast on which the mastectomy was performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of the mastectomy, including lymphedemas.

The Departments published a Solicitation of Comments on issues arising under WHCRA on May 28, 1999 (64 Fed. Reg. 29186). Question-and-answer guidance (Q&As), including model language that may be used to satisfy WHCRA's disclosure requirements, was issued in May 1999 and updated in October 1999. Additional guidance is currently under development.

b. *Effective Date*

WHCRA applies to group health plans and issuers for plan years beginning on or after October 21, 1998.

[11] Initially, MHPA included a sunset provision under which the requirements did not apply to benefits for services furnished on or after September 30, 2001. Through a series of legislative enactments, the sunset date has been extended to December 31, 2003. See Pub. L. 107-116, Pub. L. 107-147, and Pub. L. 107-313.

[12] The statute amended ERISA and the PHS Act and is administered by the Departments of Labor and HHS.

III. FY 2001 COMPLIANCE PROJECT: SUMMARY

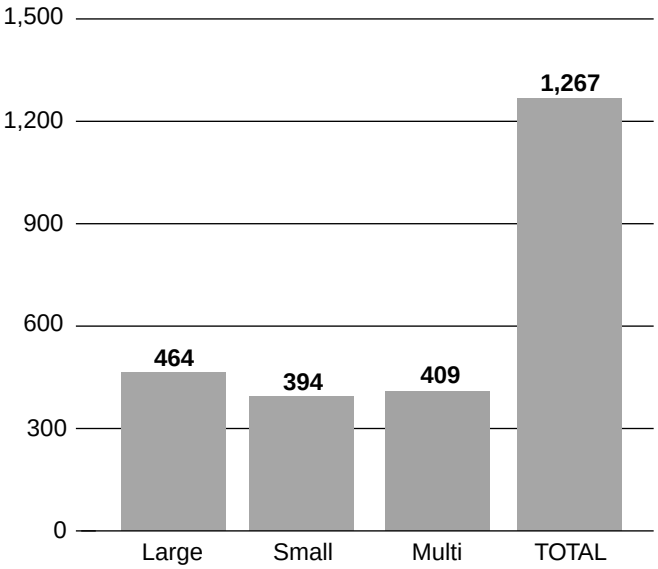
1. Collection and Coordination of Data

a. *Identification of Plans to Review*

The project involved 1,267 investigations of large and small single-employer group health plans and multiemployer plans. (See Table 1 and Chart 1.) The Office of Policy and Research (OPR) prepared a Sample Design, which describes in depth the sampling methodology. (See Appendix.) The project encompassed three distinct samples: multiemployer, small single-employer (<100 employees), and large single-employer (≥100 employees) plans. The multiemployer and single-employer samples were selected from distinct data sources because no central source identifies whether a given private-sector single employer offers a group health plan covered by Title I of ERISA. However, PWBA already possessed enough information from Annual Report Form 5500 filings to select the multiemployer sample.

The referrals to regional offices involved three distinct steps: (1) randomly selecting a pool of entities suitable for investigation, (2) transmitting referrals and opening cases, and (3) replacing entities found to be out-of-scope with more entities. These steps were intended to preserve a minimum of 399 multiemployer plans, 444 large-employer plans, and 448 small-employer plans.

Chart 1
Investigations Conducted by Sample*



*Number of plans investigated by sample.

b. *Referral of Multiemployer Plans*

The Office of Information Management had available certain data on multiemployer plans, such as the plan sponsor and the plan administrator, address and telephone number of both parties, total plan assets, and plan sponsor's Employer Identification Number (EIN). These plan data are derived from Annual Report Form 5500 filings.

As an initial step, OPR provided OE with the basic information described above for 398 multiemployer plans. OE referred these plans to PWBA regional offices in August 2000 with instructions to open cases on or after October 1, 2000. Regional offices determined some plans to be out-of-scope or otherwise ineligible for case opening. The most common reason was that the selected multiemployer plan had merged with another plan, effectively terminating the plan selected for investigation. Plans that were already under investigation or had been investigated within the preceding 12 months were also withdrawn because ERISA section 504(b) prohibits a PWBA investigation under these circumstances absent "reasonable cause." Plans offering only excepted benefits such as certain dental and vision benefit plans, as defined in regulation 29 CFR § 2590.732(b), were also considered out-of-scope and were withdrawn from the potential referrals.

Replacement of out-of-scope multiemployer plans occurred in two batches. OE made the first set of replacements on March 30, 2001, and the second set was disseminated on June 26, 2001. These replacements restored the number of in-scope multiemployer plans to 409.

c. *Referral of Single-Employer Plans*

The task of assembling enough single-employer firms with group health plans to maintain the goals of 444 (large firms) and 448 (small firms) was much more complicated and resource intensive. PWBA obtained from Dun and Bradstreet (D & B) basic information on

2,226 randomly selected large and small firms in the 50 States and the District of Columbia. The information included the name of the company, address, EIN, telephone number, number of employees, and whether the company was a subsidiary. PWBA requested that certain known church or government organizations be excluded from the records because Title I of ERISA does not cover plans sponsored by such entities.[13] OPR divided the large and small samples by PWBA region and provided individual contact sheets for the single employers. National office staff (primarily OE coordinators and OHPSCA staff) then attempted to contact each firm directly by telephone to verify coverage. In a few instances – particularly for large firms – staff could verify through an Internet search that a firm offered a group health plan. When staff determined that a firm was unreachable or out of scope, the next firm in sequence was contacted so that each contact had a disposition. Staff entered each disposition, along with other information gleaned from the contact, on the standard contact sheet. OE then consolidated the dispositions on a master spreadsheet. Once a sufficient number of referrals was amassed, they were batched together by region and referred to regional offices on spreadsheets. The spreadsheets (tracking files) were used throughout the project to match project referrals with the corresponding cases in the Enforcement Management System (EMS) in order to link with data on Part 7 violations. (See Table 10 for the list of EMS codes used.) Ultimately, each of the firms and multiemployer plans had a case number in the tracking file or a coded disposition (e.g., U-unreachable, C-church plan) entered on a master tracking file.

After OE made each set of referrals, regional coordinators typically distributed the potential cases throughout their region. Regional managers determined which investigators were assigned project investigations. The regional coordinators reported back to the national coordinator when specific referrals could not be investigated, for tracking and replacement purposes. The regional coordinators also raised interpretive and procedural issues encountered during the investigations.

OE made the initial assignment of 476 large-firm referrals to the field on October 25, 2000. Along with the referrals, OE issued a guidance memorandum. Among other items, the guidance provided a dedicated EMS National Project code to be used exclusively for these and subsequent project referrals. OE referred a set of large-firm replacements on September 4, 2001. The entire allotment of large-firm records selected by D & B was exhausted by this date.

OE made the initial batched referral of 151 small firms with plans on January 26, 2001. Staff attempting to contact companies had found many small firms either did not offer a covered plan, or were unreachable.[14] It was not possible at that date to refer a greater number, because more time and resources were needed to reach the target of 448 small firms with plans. By January 26, 2001, 485 contacts had identified 151 small firms with plans. The second batch of 310 referrals was made on March 27, 2001. Staff had contacted over 1,300 small firms by this date. OE sent small-firm replacements to regional offices on November 1, 2001. By this date, staff had attempted to contact 1,604 small firms.

OE directed regional offices to enter Part 7 violations data in EMS by the end of calendar year 2001. After January 1, 2002, OPR and OE verified the accuracy of tracking files and EMS data fields. OPR then produced statistical tables for comment and analysis.

2. Investigative Procedures

The project was part of the Program Operating Plan (POP) Guidance for 2001. The POP Guidance instructed regional offices to use the HIPAA checksheet and other compliance materials created by OHPSCA. The guidance also requested that in these project cases regions should take the opportunity to undertake any other reasonable investigative steps to ensure that no other problems exist in the plan regarding claims payments, financial soundness, reporting, disclosure, or fidelity bond issues.

To reinforce these points, the October 25, 2000, transmittal of the partial large-firm sample included an "Investigative Guidance" section. This section reiterated that the primary goal of the project was to gauge Part 7 compliance, but it also stated the need to perform a sufficient review of compliance with Parts 1, 4, and 6 of ERISA.

To increase efficiency, some regions developed standard opening letters for multiemployer and single-employer plans. Generally, these document request letters evolved

[13] ERISA section 4(b).

[14] See Table 1, which indicates that of 1,604 small firms, 1,045 such companies were either unreachable (298) or did not offer a covered group health plan (747).

from those used for general health plan investigations. Another efficiency strategy was to group referrals by geographic location or by third-party administrator.

Regions used the HIPAA checksheet in the project as a guide in investigations. The checksheet also served as a training tool and as a means for managers to monitor progress. Certain regions also created their own investigative guides tailored to the project. For example, one region's guide prompted the investigator to address parent/subsidiary relationships, EMS reporting requirements, and contact information.

Once the investigations were underway, investigators could draw from various sources of expertise. Some regions held periodic meetings to discuss compliance issues. Regional offices raised novel voluntary compliance issues with OE and OHPSCA. OE presented a module on the project to all regional office staff during its summer 2001 training. This module addressed technical and procedural issues such as remedies, subpoenas, and coordination with State insurance commissions. National office and regional managers continuously discussed the project in routine conference calls and meetings. OE and OHPSCA also held several organized teleconferences with all regional coordinators, in addition to informal teleconferences with individual regions. These discussions covered technical and procedural issues and offered the opportunity for regional office staff to raise questions.

3. Education Program and Quality Control

a. *Internal Education and Support Regarding Group Health Plan Compliance Assistance*

1. *New Training Tools*

The national office worked closely with the regions to modify the HIPAA checksheet and to develop additional materials to assist the regional offices with investigations. PWBA's benefit advisors, who receive public inquiries and participate in compliance assistance outreach regarding the provisions of Part 7 of ERISA, would also use these tools. Examples of the various materials developed include:

- *HIPAA Checksheet* — OHPSCA retooled the HIPAA checksheet, which was designed for investigators to determine whether health plans are in compliance with the law. Updates were made and modifications were added in accordance with suggestions made by the regional offices following the FY 1999 pilot project.

- *The HIPAA Binder* — This binder contains: (a) Q&As on recent changes in health care law, (b) outlines explaining each new statute that was enacted, (c) the Federal regulations, (d) information regarding comparable State laws, (e) PWBA health publications, and (f) PWBA regional office and State insurance department contacts. OHPSCA regularly updates this binder to include new developments and publications related to health care law.

- *Lessons Learned Charts* — These charts, generated by OHPSCA, contain dozens of examples of commonly used plan provisions and practices that investigators should be aware of when conducting compliance reviews of health plans.

2. *New Delivery Mechanisms*

PWBA also made effective use of computer technology to provide the regional offices with the most up-to-date materials in real time and to communicate quickly with investigators on specific cases. Examples of the information delivery mechanisms used by PWBA include:

- *Easy-access Intranet* — This PWBA internal-only Web site was created to provide investigators and benefit advisors with direct access in real time to the most recent Part 7 compliance materials, such as: (a) the HIPAA Binder materials (including the regulations and outlines), (b) the Lessons Learned Charts, (c) HHS and Treasury Department publications, and (d) additional State law and contact information.

- *Rapid Response Phone and Email Team* — Through creation of a HIPAA contact network, staff from OHPSCA and OE are available to provide immediate technical assistance to investigators and benefit advisors with respect to compliance-related inquiries.

- *Training Seminars and Teleconferences* — Throughout the year, staff from OHPSCA and OE travel to regional offices to provide training seminars for investigators and benefit advisors. In addition, OHPSCA and OE conduct periodic teleconferences to discuss their experiences and any substantive and procedural issues that may arise.

- *Data Codes* — To facilitate the tracking of Part 7 violations, PWBA created new data codes (each representing a particular Part 7 violation) for EMS. Four new codes allowed plans to be identified as not subject to each of the Part 7 statutes.

b. *Compliance Assistance Activities for the Regulated Community*

1. *Compliance Assistance Materials*

In addition to the quality control materials created for PWBA staff, compliance materials were also developed to increase the public's awareness and understanding of HIPAA, the Newborns' Act, MHPA, and WHCRA. The following are examples of such materials:

- *Qs&As Regarding Changes in Health Care Laws* — PWBA published *Qs&As: Recent Changes in Health Care Laws*, which provides employers and employees with information regarding their rights and obligations under the health care laws. The information in this booklet is currently being updated and converted into two new publications — one for employers and one for employees.

- *Frequently Asked Questions/Tips* — Drawing from its experience in the FY 1999 pilot project, PWBA published *Compliance Assistance for Group Health Plans*, which provides 10 key compliance considerations for group health plans and tips on how to bring plans into compliance with Part 7 of ERISA. Simultaneously with the release of this report, this publication was also updated to a list of 15 key compliance considerations.

- *Posters and Information Cards* — PWBA developed several posters and information cards to increase the public's awareness of health care laws. One poster, which provided information on the Newborns' Act, was distributed in FY 2001 to doctors' offices (particularly obstetricians' offices), drug stores, and hospitals. Another poster provided information to help workers and their families when their health benefits claims were denied. A card was also developed to explain key protections under MHPA.

- *Form M-1 Worksheets* — Worksheets were included with the Form M-1 Annual Report for multiple employer welfare arrangements for administrators to use as a self-audit tool for the provisions of Part 7 of ERISA. The worksheets were updated in 2001 to include compliance tips.

2. *Compliance Assistance Outreach Programs*

PWBA also expanded its outreach programs to deliver these materials to the public efficiently. These programs include:

- *Internet* — All of PWBA's publications and regulations are available on its Internet site at www.dol.gov/pwba.

- *Public Outreach* — Throughout the year, representatives from the Agency's national office and regional offices participate in seminars and presentations to educate and familiarize employees, employers, plan administrators, issuers, third-party administrators (TPAs), and State insurance department staff with Part 7 of ERISA.

- *Expanded Participant and Compliance Assistance Program* — PWBA increased the number of benefit advisors in response to the significant rise in health care inquiries. These benefit advisors handle written and telephone inquiries from the public and conduct public outreach. They also participate in rapid response programs following events such as plant closings and employer bankruptcies to inform dislocated workers and their families about their rights to private-sector health care.

- *Health Benefits Education Campaign* — This campaign, which was launched in FY 1999, is comprised of over 70 partners, representing a wide range of interests from employees to employers to health care providers. Through the campaign, PWBA distributes information on Federal health care laws to employees, employers, plan administrators, issuers, TPAs, and State insurance department staff. PWBA also participates in the campaign's compliance assistance seminars that take place across the country to help increase awareness regarding Part 7's provisions and to answer questions from the regulated community on its requirements.

IV. PRESENTATION AND INTERPRETATION OF DATA

The following summary addresses noncompliance with the new health care laws individually and overall. It also examines noncompliance with these laws by sample (small single-employer plans, large single-employer plans, and multiemployer plans). In doing this, it is important to realize that the goal of the project was to measure the presence, rather than the extent, of violations in sample plans. Therefore, if a plan is cited with any violation, the plan is treated as being out of compliance. Thus, the weighted violation rates[15] found in the tables include plans that may have been cited with one or numerous violations. Moreover, the rates do not take into account the number of participants and beneficiaries affected by a violation, which varies by individual provision and individual plan.

1. Noncompliance Rates

Based on the data, it appears implementation of the requirements of Part 7 by group health plans has progressed steadily. Only 8 percent of plans were cited with a violation of MHPA. This low violation rate may have resulted from the narrow scope of MHPA's provisions and the relatively simple changes that plans made in order to come into compliance.

The investigations showed that 4.5 percent and 5.2 percent of plans were cited with a violation of the substantive provisions of WHCRA and the Newborns' Act, respectively (that is, the provisions of these laws other than the notice requirements). Most violations of these two laws involved problems with adequate or timely notices. Specifically, after taking into account the notice requirements, 35.0 percent and 21.8 percent of plans were cited with a violation of the Newborns' Act and WHCRA, respectively.

Regarding HIPAA, the data reveal that 28.1 percent of plans were cited with at least one violation of HIPAA's substantive portability or nondiscrimination provisions. Many of the violations involved discrete plan provisions. In these instances, PWBA found that a single plan provision could violate multiple HIPAA requirements. After factoring in the notice requirements, 35.9 percent of plans in the sample were cited with at least one violation.

Accordingly, after taking into account all of the violations cited, the data reveal that 30.7 percent of plans were cited with at least one violation of the 36 substantive requirements under the four laws. After factoring in the six additional notice provisions, 45.3 percent of group health plans were cited with at least one violation. In many cases, noncompliance may have been the result of a mistake in understanding and complying with the laws. Given the short implementation period since the provisions of Part 7 and the regulations became effective, and taking into account the size of the ERISA health plan universe (approximately 2.5 million plans), this confusion in implementation is not unexpected.

a. *MHPA Noncompliance Rates*

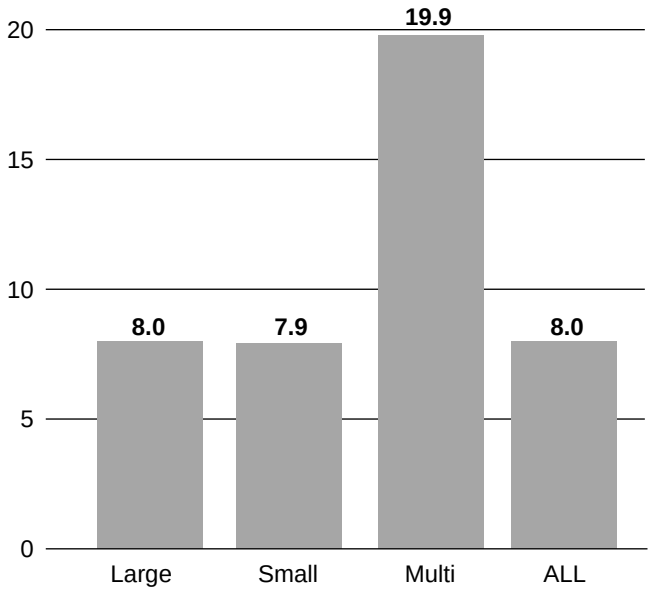
Among the four health care laws, MHPA was found to have the lowest noncompliance rate, 8.0 percent. (See Table 6 and Chart 2.)[16] One explanation of the low violation rate could be that the GAO published its May 2000 report involving MHPA compliance[17] before PWBA initiated the project, which may have caused a decrease in the number of MHPA violations. Thus, GAO's focus on MHPA compliance may have contributed to additional MHPA compliance among other plan sponsors and administrators throughout the country. This may also explain why noncompliance rates fell

[15] Probabilities of selection vary widely between samples, being highest for multiemployer plans, and lowest for plans of small firms. (See Appendix.) Statistical weights correct for these intended differences in probabilities of selection. Statistical weights also correct for the anticipated, but unintentional, differences in probabilities of selection that arise from plans that cover workers at multiple subsidiaries of the same firm. Such plans had multiple chances of selection, because all subsidiaries are listed in the D & B database used as the sampling frame. The same plan would have been investigated if any of its subsidiaries had been selected, leading to a higher probability of selection, and a lower weight for such plans. The very low probability of selection for plans of small firms translates into a very high statistical weight for these plans. As a result, violation rates from the small firm sample dominate the overall weighted violation rates for all plans, which are nudged only slightly in the direction of the large firm and multiemployer rates. In simple terms, the violation rate for all plans resembles the violation rate for small plans, because most plans are small.

[16] Because MHPA has no notice requirements, the noncompliance rate is the same in Table 7, which excludes the effect of the notice provisions and cites noncompliance with only the substantive provisions of the new health care laws.

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

Chart 2
MHPA Violations*



*Percentage of plans with at least one MHPA violation.

from 14 percent when the GAO did its 1999 survey to 8 percent in this FY 2001 project.

Further, because MHPA is very narrowly focused on annual and lifetime dollar limits and some plans never included these limits, these plans were automatically in compliance with the law. Finally, another reason for the high compliance rate could be that compliance with MHPA is fairly easy and inexpensive — plans can merely delete annual and lifetime dollar limits on mental health benefits while retaining other restrictions such as visit and network limits.

Nonetheless, annual dollar limits and constructive annual dollar limits comprised the majority of the violations cited. Examining all of the plans cited with MHPA violations, 58 percent included annual dollar limits and 53 percent included constructive annual dollar limits that were out of compliance with MHPA. (Derived from violation rates in Table 6.) This may be because annual limits are more prevalent than lifetime limits and, therefore, are more likely to be out of parity.

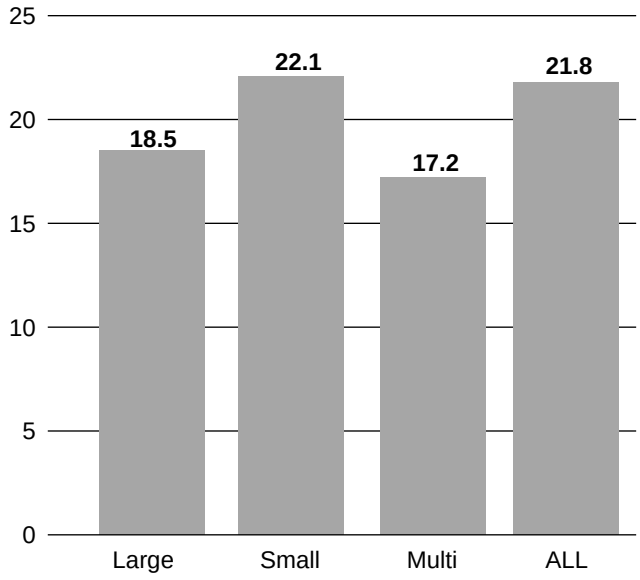
PWBA investigators cited constructive dollar limits when a plan had a combination of a fixed limit on the number of visits per year and a fixed limit on the payment per visit that effectively imposed a ceiling on annual mental health benefits that was lower than for medical/surgical benefits. For example, suppose a plan has no dollar limit or visit limit on medical/surgical benefits, but has a 30-visit limit per year on mental health benefits coupled with a $100 maximum payment by the plan per visit. The plan, in effect, has a $3,000 annual limit on mental health benefits while having no such limit on medical/surgical benefits.[18] In situations such as these, violations of MHPA's annual dollar limit provisions were cited.

To help increase compliance with MHPA's annual dollar limit provisions, PWBA's publication *Compliance Assistance for Group Health Plans* warns plans and issuers about constructive dollar limits and provides tips on how to bring plans into compliance.

b. ***WHCRA Noncompliance Rates***

Regarding WHCRA, noncompliance with the substantive provisions (that is, the provisions other than the notice requirements) was generally low; only 4.5 percent of plans were cited with a substantive violation. (See Table 7.) However, taking into account the notice requirements, noncompliance was higher. As Table 6 and Chart 3 show, PWBA cited 21.8 percent of plans for a violation of WHCRA. The effect of the notice violations is more prominent when examining the percentage of all plans that were cited with failing to provide WHCRA's annual and/or enrollment notice (17.7

Chart 3
WHCRA Violations*



*Percentage of plans with at least one WHCRA violation.

[18] For purposes of its enforcement, PWBA did not attempt to construct a maximum payment in cases where a plan limited payments by a certain percentage of usual, customary, and reasonable rates for providers in that area.

percent). (See Table 6.)[19] Moreover, 8.8 percent of plans were cited for failing to provide WHCRA's one-time, January 1999 notice.[20] Small plans were responsible for most of the violations. (With respect to small plans, 18.0 percent were cited for failure to provide the annual and/or enrollment notice and 8.9 percent were cited for failure to provide the one-time notice.)

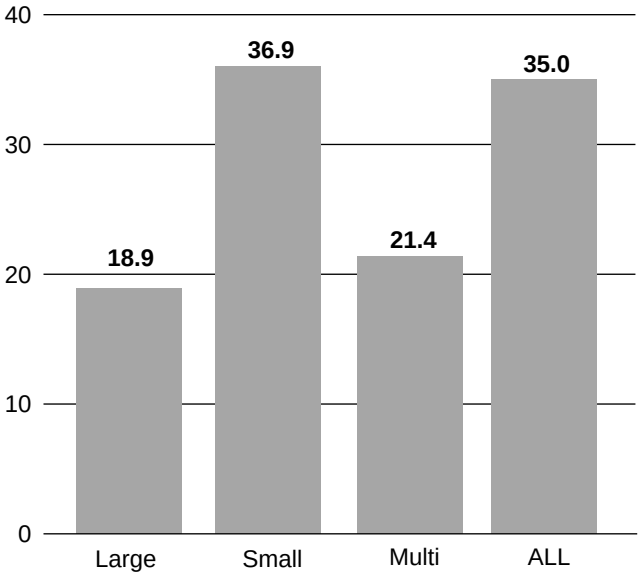
The reason for this high rate of noncompliance may be that WHCRA regulations are still under development. PWBA did publish guidance on the WHCRA notice requirements and provided model notices in 1999. However, some plans may not have found this guidance, which is available on PWBA's Web site, but was not published in the Federal Register because it is informal guidance rather than a regulation. Issuers in particular may not be accustomed to contacting PWBA for compliance assistance, which may have impacted the small plan noncompliance rate especially because small plans are more likely to be insured. [21]

To coordinate more closely with issuers and to help them use PWBA as a resource, the Agency began to sponsor compliance assistance seminars targeted towards issuers, TPAs, and other service providers. PWBA held five of these seminars in calendar year 2001 and held four seminars in calendar year 2002. These seminars are jointly sponsored with State insurance departments and take place across the country.

c. *Newborns' Act Noncompliance Rates*

Noncompliance with the substantive provisions of the Newborns' Act was also low; only 5.2 percent of plans were cited with a substantive violation (See Table 7.) However, similar to WHCRA, notice requirements were problematic. Among all of the plans investigated, 32.5 percent were cited with a violation of the notice requirements and, overall, 35 percent of plans were cited with a violation. (See Table 6 and Chart 4.) Accordingly, of the plans that were cited with Newborns' Act violations, 93 percent involved notice violations. Moreover, small plans were much more likely to have violated the Newborns' Act notice provisions than large or multiemployer plans. (As Table 6 and Chart 5 show, 34.2 percent of small plans were cited with Newborns' Act notice violations.) One reason for this high incidence of violations may be confusion as to the applicability of the Newborns' Act.

Chart 4
Newborns' Act Violations*



*Percentage of plans with at least one Newborns' Act violation.

All self-insured plans are required to comply with the Newborns' Act, including its notice provisions. In contrast, insured plans in States that have a State law applicable to insurance and that meets certain requirements are not subject to the substantive provisions of the Newborns' Act.[22] Nonetheless, these insured plans are

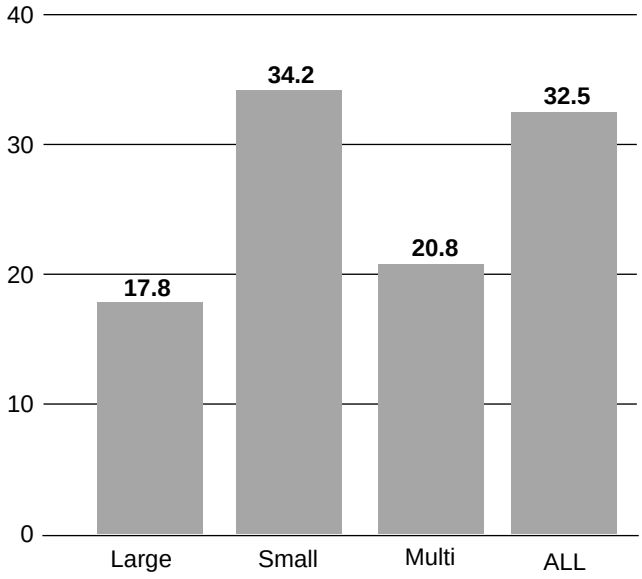
[19] Under ERISA section 713(a), plans must deliver to the participant written notice of the availability of WHCRA coverage upon enrollment and annually thereafter. Under ERISA section 713(b), plans are required to provide a one-time notice to each participant and beneficiary regarding the coverage required by WHCRA. This notice is required to be transmitted — (1) in the next mailing to the participant or beneficiary; (2) as part of any yearly informational packet sent to the participant or beneficiary; or (3) not later than January 1, 1999; whichever is earlier.

[20] The data reflect that, with respect to the annual and/or enrollment notices, 81 percent of the plans that were cited with a WHCRA violation failed to provide one or both of these notices. In addition, 40 percent of the plans that were cited with a WHCRA violation failed to provide the one-time notice.

[21] See The Employee Benefits Research Institute fact sheet, "Employment-Based Health Care Benefits and Self-Funded Employment-Based Plans: An Overview" (April 2000) at p. 5 (citing 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey), *available at* http://www.ebri.org/facts/0400fact.pdf.

[22] "(1) In general. — The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 731(d)(1)) for a State that regulates such coverage that is described in any of the following subparagraphs:
(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section.
(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.
(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother." ERISA section 711(f).

Chart 5
Newborns' Act Notice Violations*



*Percentage of plans with Newborns' Act notice violations.

still required to make certain disclosures with respect to hospital stays in connection with childbirth.[23]

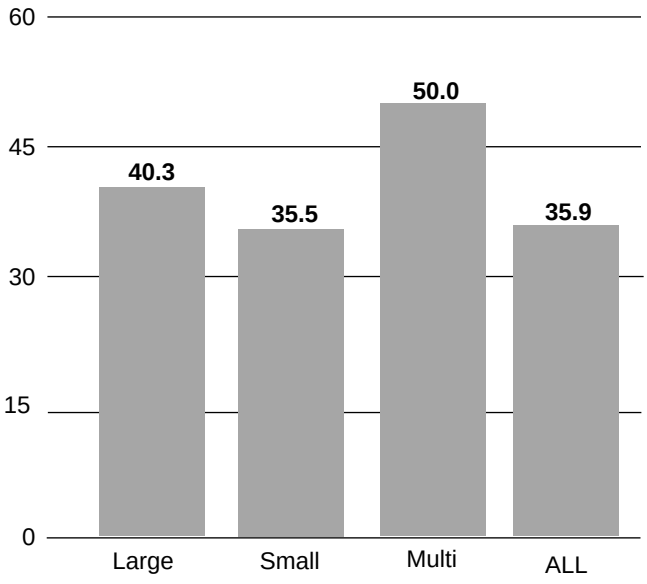
Perhaps, because small plans are more likely to be insured and because there may have been some confusion among the issuers as to whether ERISA requires disclosures by insured plans regarding hospital stays in connection with childbirth, a high number of these violations were cited. Even though the error might have originated with the issuer, the plan administrator is ultimately responsible for compliance with ERISA and, thus, was cited in these instances.

In addition, because the original regulation addressing the Newborns' Act notice required plans to describe the provisions of the Federal law and most insured plans are subject to State law requirements rather than the Federal law,[24] there may have been some resistance by issuers for insured plans to make such disclosures. In an attempt to address legitimate concerns by some issuers and insured plans, PWBA worked with these entities to develop language that could be used to meet their obligations under ERISA while also summarizing accurately the rights of participants and beneficiaries to hospital stays in connection with childbirth under State law. The Newborns' Act notice regulation was revised in November 2000 to decrease confusion and uncertainty regarding this requirement.[25]

d. ***HIPAA Noncompliance Rates***

Among the four health care laws, HIPAA had the highest rate of noncompliance; 28.1 percent of plans were cited with a substantive violation. (See Table 7.) After taking into account the effect of notice violations, the noncompliance rate was 35.9 percent. (See Table 6 and Chart 6.) The HIPAA violations may be divided into four categories: 1) impermissible preexisting condition exclusions; 2) nondiscrimination violations; 3) failure to provide complete certificates of creditable coverage; and 4) special enrollment violations. With regard to impermissible preexisting condition exclusions, 23.8 percent of plans were cited with a violation. (See Table 6.) This relatively high rate of noncompliance may be due to the presence of violations for three discrete issues. First, PWBA investigators identified "hidden preexisting condition exclusions" in a number of plans.

Chart 6
HIPAA Violations*



*Percentage of plans with at least one HIPAA violation.

[23] See ERISA section 711(d) and the applicable regulations at 29 CFR § 2520.102-3(u).

[24] It appears that insured coverage in all States except Wisconsin, Puerto Rico, the Virgin Islands, American Samoa, Wake Island, and the Northern Mariana Islands is subject to State law requirements that meet the criteria in ERISA section 711(f), rather than the Federal Newborns' Act provisions.

[25] A group health plan's summary plan description (SPD) should include a statement describing any requirements under Federal or State law applicable to the plan, and any health insurance coverage offered under the plan, relating to a hospital length of stay in connection with childbirth for the mother or newborn child. If Federal law applies in some areas in which the plan operates and State law applies in other areas, the statement should describe the different areas and the Federal or State law requirements applicable in each. See 29 CFR § 2520.102-3(u)(1).

Second, PWBA identified nonconfinement clauses in 4.9 percent of plans, which resulted in violations of both the preexisting condition exclusion provisions and the nondiscrimination provisions. (See Table 6.) Third, some plans and issuers improperly calculated the beginning of the 12-month (or 18-month) look-forward period and the end of the 6-month look-back period. (PWBA cited 9.5 percent of plans for violating the 12-month (or 18-month) look-forward provision and 11.7 percent of plans for violating the 6-month look-back provision, some of which is attributable to a miscalculation as to the start or end of the period. (See Table 6.)) All of these problems are explained below.

Hidden preexisting condition exclusions may not have been apparent to some plan administrators, issuers, and TPAs although PWBA investigators were specifically trained to identify these types of violations. As explained earlier, a plan seeking to impose a preexisting condition exclusion is required to comply with HIPAA's limitations on preexisting condition exclusions, including the 6-month look-back limitation, 12-month look-forward limitation offset by creditable coverage, general notice, and individual notice. Rather than make all of these changes, some plan sponsors chose to eliminate their plan's overall preexisting condition exclusion. However, remaining plan exclusions may have had some form of timing provision that made the exclusion preexisting in nature. Because these plans may not have realized that these exclusions are considered preexisting condition exclusions, they did not comply with HIPAA's limitations on such plan provisions and multiple violations of HIPAA were cited.

An example of a hidden preexisting condition exclusion is a plan provision that covers treatment for injuries in connection with an accident only if the accident occurred while the individual was covered under the plan. Another example is a plan provision that excludes coverage for cosmetic surgery unless it is required by reason of a congenital defect and the individual has been continuously covered under the plan since birth.

When these hidden preexisting condition exclusions were detected, violations of HIPAA's 6-month look-back period, 12-month look-forward period, offset by creditable coverage, general notice, and individual notice provisions were cited. (See Table 9 regarding high correlations among these violations.) Accordingly, a single mistake by a plan caused multiple citations for HIPAA violations in these instances.

To raise awareness regarding hidden preexisting condition exclusions, PWBA published *Compliance Assistance for Group Health Plans*, which sets forth ten key compliance considerations and tips on how to bring the plan into compliance. Hidden preexisting condition exclusions are highlighted as the number one compliance consideration.

Another violation cited by some PWBA investigators involved a plan's imposition of a nonconfinement clause. (See Table 6, which identifies 4.9 percent of plans being cited with nonconfinement clause violations.) An example of a nonconfinement clause is a plan provision stating that if a dependent is in a hospital or other health care facility on the date coverage is otherwise to become effective, the effective date of coverage is delayed until the dependent is released from the hospital or health care facility. Because these plan provisions deny benefits for a condition based on the fact that the condition was present before the effective date of coverage, they are preexisting condition exclusions. As with hidden preexisting condition exclusions, when nonconfinement clauses were found, multiple violations of the preexisting condition exclusion provisions were cited by PWBA investigators. In addition, because these plan provisions deny eligibility based on a health factor, they are also violations of HIPAA's nondiscrimination provisions and were cited as such.

To help raise awareness as to the impermissibility of nonconfinement provisions, PWBA collaborated with the Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration) to publish Insurance Standards Bulletins 00-01 and 00-04, which describe different types of nonconfinement provisions and explain the multiple HIPAA provisions they violate.

The third reason some plans were cited with violations for an impermissible preexisting condition exclusion is that the plan improperly calculated the beginning of the 12-month (or 18-month) look-forward period and the end of the 6-month look-back period. Under HIPAA, these periods are measured from an individual's enrollment date. The enrollment date is defined as the first day of coverage under the plan, or if there is a waiting period for coverage, the first day of the waiting period.[26] Therefore, if an individual begins work on January 15 and coverage does not begin until the first day of the next calendar month (February 1), the individual has a

[26] See 29 CFR § 2590.701-3(a)(2).

17-day waiting period for coverage. Moreover, the individual's enrollment date is January 15, the first day of the waiting period, and the 12-month look-forward and 6-month look-back periods should be measured from this date. PWBA found that some plans that included a waiting period calculated these periods from the first day of coverage (February 1 in this example), rather than the first day of the waiting period. This was apparent particularly when health coverage was offered through an issuer or through a multiemployer plan, where these parties may be further removed from the employer and less likely to know an individual's date of hire.

Because these miscalculations result in longer preexisting condition exclusions for individuals than is permissible and to increase awareness among the regulated community regarding this issue, PWBA included in its publication *Compliance Assistance for Group Health Plans* information on enrollment dates and tips on how to bring the health plan into compliance. At seminars with issuers and multiemployer plans, PWBA representatives also encouraged these entities to coordinate with employers to get information on individuals' dates of hire to avoid this problem.

With respect to HIPAA's certificate provisions, 7.3 percent of plans were cited with a violation. (See Table 6.) This rate of noncompliance initially caused concern because the certificate provisions are so important – certificates provide individuals with evidence of their creditable coverage, which may be used to reduce a future preexisting condition exclusion and to gain guaranteed access to health coverage in the individual insurance market.[27] However, after closer inspection, in many of the plans it was not that plans were failing to issue certificates of creditable coverage. Rather, certificates were being provided, but they were incomplete. Two pieces of information that some plans were missing were waiting period information and dependent information.

Specifically, under HIPAA, there are seven data elements required to be included on a certificate of creditable coverage: the date of the certificate; the name of the group health plan; the name of the participant (or dependent) and his or her identification number; certain identifying information regarding the plan administrator or issuer who is required to provide the certificate; the telephone number to call for further information regarding the certificate; the individual's creditable coverage information (which includes, if the individual has less than 18 months of creditable coverage, the date any waiting period began and the date coverage began); and the date coverage ended (if it ended). Participants and their dependents each have an independent right to certificates of creditable coverage, although plans can combine creditable coverage information for families on a single certificate, which may be copied, if the information is the same.

Based on PWBA's experience, it seems that some plans were neither providing certificates to dependents, nor identifying dependents on the certificate of creditable coverage provided to participants. In these cases, the certificates were incomplete because they did not provide dependents with any evidence of creditable coverage, as required by HIPAA, and were cited accordingly. Other plans were not including waiting period information on certificates of creditable coverage. This information is important because, under HIPAA, time spent in a waiting period for coverage tolls any significant break in coverage that might otherwise occur with respect to the individual.[28] As such, it is required to be reported on the certificate of creditable coverage for individuals with less than 18 months of creditable coverage.

To increase compliance assistance and awareness as to the importance of including this information on certificates of creditable coverage, PWBA's publication *Compliance Assistance for Group Health Plans* discusses the inclusion of dependent and waiting period information on certificates of creditable coverage.

Regarding special enrollment rights, 15.9 percent of plans were cited with a violation, which occurred most often with respect to the notice of special enrollment rights. (See Table 6, which shows that 12.1 percent of plans were cited with a violation of the special enrollment notice provision while only 5.2 percent of plans were cited for failing to provide substantive special

[27] Section 2741 of the PHS Act guarantees access to individual health insurance coverage without a preexisting condition exclusion for eligible individuals. Eligible individuals are individuals who have had coverage for at least 18 months without a significant break in coverage where the most recent period of coverage was under a group health plan; did not have their group coverage terminated because of fraud or nonpayment of premiums; are ineligible for Medicare, Medicaid, or a group health plan; do not have other insurance coverage; and are ineligible for continuation coverage under COBRA or if offered COBRA continuation coverage (or continuation coverage under a similar State program) have both elected and exhausted their continuation coverage.

[28] ERISA section 701(c)(2)(B).

enrollment rights to individuals upon loss of coverage and only 3.0 percent of plans were cited for failing to provide special enrollment after gaining a new dependent.) Of the plans cited for a special enrollment violation, 76 percent involved a special enrollment notice violation.

PWBA was concerned that 12.1 percent of plans were cited for violations of the special enrollment notice provisions, especially in light of the fact that the regulations provide a model notice.[29] (See Table 6.) Some of the noncompliance may be attributed to the fact that a number of plans provided special enrollment under their own terms before the passage of HIPAA. These plans likely assumed that no additional changes were required in order to comply with the special enrollment provisions – overlooking the special enrollment notice requirement. For some violations, PWBA found that plans did provide the special enrollment notice, but did not provide the notice within required time frames. The special enrollment notice must be provided to an employee on or before the time the employee is offered the opportunity to enroll in the plan.[30] Some plans that were cited included the special enrollment notice in the plan's summary plan description (SPD), which is a permissible form of disclosure, but which has separate timing requirements. If a plan provided employees with the SPD after enrollment, a violation of the special enrollment notice provisions was cited.

e. ***Overall Part 7 Noncompliance Rate***

After taking into account all of the violations cited under the four health care laws, the data reveal that 30.7 percent of group health plans were cited with a violation of at least one substantive provision of the new health care laws. After taking into account violations of notice requirements, 45.3 percent of group health plans were cited with a violation of at least one provision of Part 7. While this may initially seem relatively high to some, several mitigating factors should be considered when interpreting this number. As explained earlier, PWBA investigators were highly trained in identifying violations of discrete and sometimes technical areas of the law. Their expertise, combined with the large number of Part 7 requirements, may help explain the relatively high rate of noncompliance found. Moreover, when violations were detected, PWBA investigators were generally able to secure voluntary compliance with the law.

[29] See 29 CFR § 2590.701-6(c).
[30] Id.

2. Trends Within the Numbers

a. ***High Compliance Rates Observed for Certain Part 7 Provisions***

The attached tables show that a majority of group health plans are in compliance with certain Part 7 provisions. One of HIPAA's most important provisions relates to group health plans providing certificates of creditable coverage. As Table 6 shows, most plans (92.7 percent) complied with this requirement. In addition, after excluding violations cited for nonconfinement clauses, compliance with HIPAA's nondiscrimination requirements was also very high (96 percent).[31] Compliance with MHPA (92 percent) and the substantive provisions (excluding the notice requirements) of the Newborns' Act (94.8 percent) and WHCRA (95.5 percent) was also high. (See Table 7.)

b. ***Many Violations Involved Part 7 Notice Requirements***

Many of the violations cited in the project involved noncompliance with one or more of Part 7's notice requirements. Excluding certificates of creditable coverage, plans are required to make six disclosures under Part 7, many of which are often made in the SPD. These six disclosures are: (a) a general notice of preexisting condition exclusions (for plans imposing a preexisting condition exclusion); (b) individual notices of preexisting condition exclusions (for plans imposing a preexisting condition exclusion); (c) a notice of special enrollment rights; (d) a Newborns' Act notice; (e) WHCRA annual and enrollment notices; and (f) a WHCRA one-time notice. Of those plans that were required to provide these notices, 14.5 percent of plans were cited for failure to provide an adequate general notice of preexisting condition exclusion (so that 40 percent of plans cited with a HIPAA violation failed to provide the general notice) and 10.5 percent of plans were cited for failure to provide an adequate individual notice of preexisting condition exclusion (so that 29 percent of plans cited with a HIPAA violation failed to provide the individual notice). With respect to the special enrollment notice, violations were cited in 12.1 percent of plans (so that 34 percent of plans cited with a HIPAA violation failed to provide the special enrollment notice). As mentioned earlier, violations of the

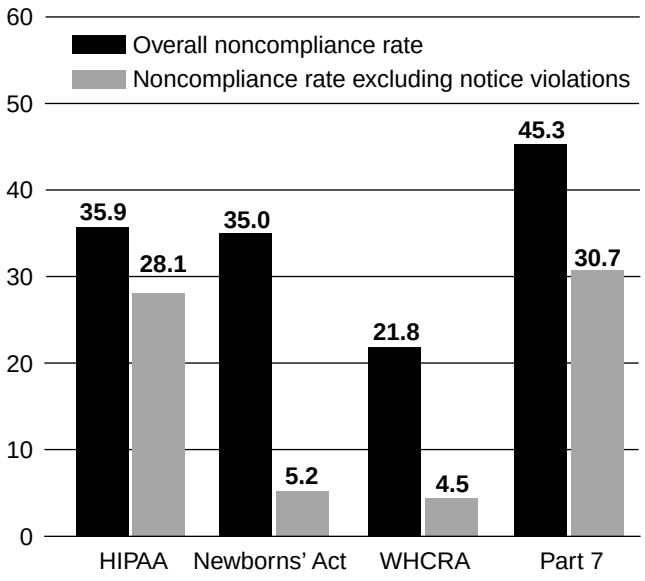
[31] Although not reflected in the attached tables, after excluding violations cited for nonconfinement clauses, plans were found to have the following HIPAA nondiscrimination violation rates: 7.0 percent for large plans; 6.8 percent for multiemployer plans; 3.8 percent for small plans; and 4.0 percent for all plans.

notice requirements accounted for most of the overall noncompliance rates for the Newborns' Act (32.5 percent) (so that 93 percent of plans cited with a Newborns' Act violation failed to provide this notice) and WHCRA (17.7 percent and 8.8 percent) (so that 81 percent of plans cited with a WHCRA violation failed to provide the annual and/or enrollment notice and 40 percent of plans cited with a WHCRA violation failed to provide the one-time notice). Interestingly, MHPA, which has no notice requirement, had the lowest noncompliance rate of the four health care laws.

In some cases, noncompliance was cited because the plan failed to provide any notice. In other cases, notice was provided but was found to be inadequate. In either case, the development and distribution of model notices by PWBA should lead to increased future compliance. PWBA intends to issue model language for the two notices of preexisting condition exclusion when it publishes its final HIPAA portability regulations. As described earlier, PWBA has made changes to the Newborns' Act notice requirement and is developing regulations for distribution of the model language for WHCRA disclosures to a wider audience.

As illustrated in Table 7 and Chart 7, by not taking into account violations with respect to the Part 7 notices, the overall noncompliance rate decreases from 45.3 percent to 30.7 percent. HIPAA noncompliance in particular decreases from 35.9 percent to 28.1 percent and noncompliance with the Newborns' Act and WHCRA decrease dramatically from 35.0 percent and 21.8 percent to 5.2 percent and 4.5 percent, respectively. As such, PWBA hopes that taking the relatively simple steps outlined above regarding compliance assistance with the notice provisions will lead to greatly increased overall Part 7 compliance rates in the future.

Chart 7
Effect of Notice Violations*



*Prevalence of notice violations among violations cited.

c. *Effect of Issuers*

As noted above, one survey found that most small companies do not self-insure their health benefits.[32] Instead, most small firms obtain group health coverage through a health insurance issuer. Among the findings in a recent GAO survey of the small group health insurance market is that the median market share of each State's largest insurance carrier was approximately 33 percent in the States surveyed.[33] Plan sponsors of any size may purchase coverage (including model plan documents) from issuers and contract for provision of certificates and notices by issuers. The tendency of small firms to contract with issuers and the dominant market share of certain issuers in some markets suggests a potential multiplier effect. For example, a fully compliant prototype plan document benefits each group health plan that follows the provisions. Conversely, confusion concerning one issuer's notice and disclosure obligations would generally affect multiple plans. For the reasons discussed in Section V below, PWBA intends to explore this possible effect.

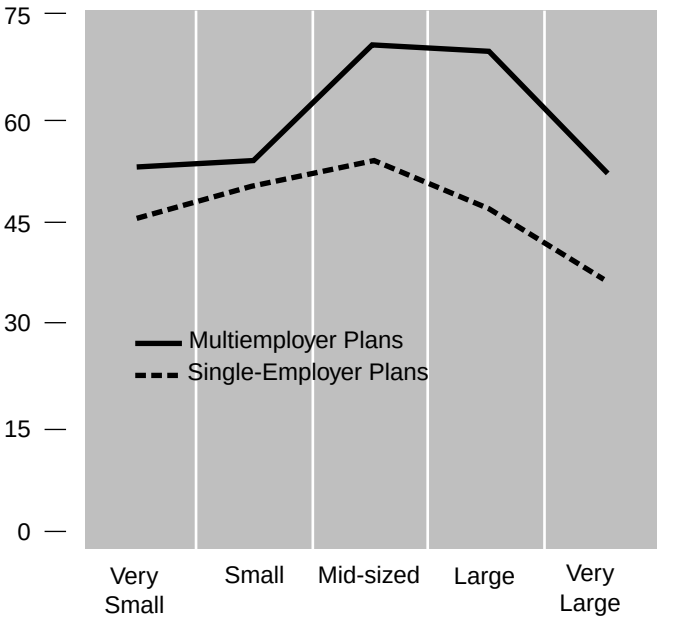
d. *Small and Large Plans Have Lowest Overall Noncompliance Rates*

The project was designed, in part, to measure compliance among large and small single-employer plan sponsors, determined by taking into account the number of employees reported. In contrast, Table 5A and Chart 8 indicate violation rates by single-employer plans broken down by the number of participants reported in the plan. This table shows that mid-sized plans experienced higher noncompliance rates than small and large plans. Very small plans (those with 2-9 participants) and

[32] See *supra*, note 21. The survey indicated that 4 percent of participants in plans sponsored by employers with fewer than 50 employees are in self-funded plans. The percentage increased to 8 percent for participants in plans sponsored by companies with 50-99 employees.

[33] The GAO also found that "[t]he five largest carriers, when combined, represented three-quarters or more of the market in 19 of the 34 states supplying information, and they represented more than 90 percent in 7 of these states." March 25, 2002 letter from Kathryn G. Allen, Director, Health Care — Medicaid and Private Health Insurance Issues to The Honorable Christopher "Kit" Bond concerning *Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market*.

Chart 8
Relationship Between Noncompliance Rates and Plan Size



small plans (those with 10-24 participants) had overall Part 7 noncompliance rates of 43.2 percent and 48.8 percent, respectively. Part 7 noncompliance peaked for mid-sized plans (those with 25-99 participants) at 52.3 percent. Then, noncompliance fell again for large plans (those with 100-500 participants) and very large plans (those with 500 participants or more), which had noncompliance rates of 46.0 percent and 37.0 percent, respectively.

PWBA observed a similar trend among small and large multiemployer plans. Very small multiemployer plans (those with 2-99 participants) and small multiemployer plans (those with 100-499 participants) had overall Part 7 noncompliance rates of 50.0 percent and 52.3 percent, respectively. With respect to mid-sized multiemployer plans (those with 500-999 participants), Part 7 noncompliance peaked at 68.0 percent. For large multiemployer plans (those with 1,000-4,999 participants) and very large multiemployer plans (those with 5,000 or more participants), the noncompliance rates were 67.9 percent and 51.3 percent, respectively. (See Table 5B and Chart 8.)

One reason that compliance among very small and small plans may have been higher is the effect of issuers in the small group health plan market.[34] Issuers' policies may be more likely to comply with Part 7 for several reasons. First, many State insurance departments review insurance policies for compliance with health care laws before they are approved for marketing to employers. Second, many issuers tend to hire general counsel specializing in health care laws. Moreover, large and very large plan sponsors may also have human resource departments and general counsel specializing in health care laws.

Conversely, mid-sized plan sponsors may lack the expertise of an issuer and the resources of larger plans. Some of these mid-sized employers, when deciding the terms of the plans they sponsor, may mirror provisions in their stop-loss insurance policies[35] without taking additional steps to comply with applicable law. Because stop-loss insurers are not separately subject to Part 7, these policies may contain provisions that violate Part 7. Therefore, unless the plan sponsor takes steps to ensure compliance, violations may exist.

e. *Multiemployer Plans Have Highest Overall Noncompliance Rate*

Multiemployer plans are established through collective bargaining between one or more labor unions and two or more employers. In contrast to the single-employer plans reviewed, multiemployer plans have a board of trustees comprised of an equal number of representatives from labor and management. The governance and service provider relationships unique to multiemployer plans may account for the relatively high noncompliance rate of 60.1 percent. (See Table 2 and Chart 9.)

Experience has shown that some multiemployer plan documents were drafted decades earlier and are rewritten over the years. Accordingly, piecemeal compliance may result. In addition, the effective date for some multiemployer plans may have been more recent than the effective date for single-employer plans. Some multiemployer plans may have had a shorter time frame within which to understand and implement HIPAA's provisions. Finally, PWBA found that a multitude of plans could be impacted as a result of misunderstandings by TPAs regarding the implementation of the new health care laws. As a result of these misunderstandings,

[34] See *supra*, note 21.

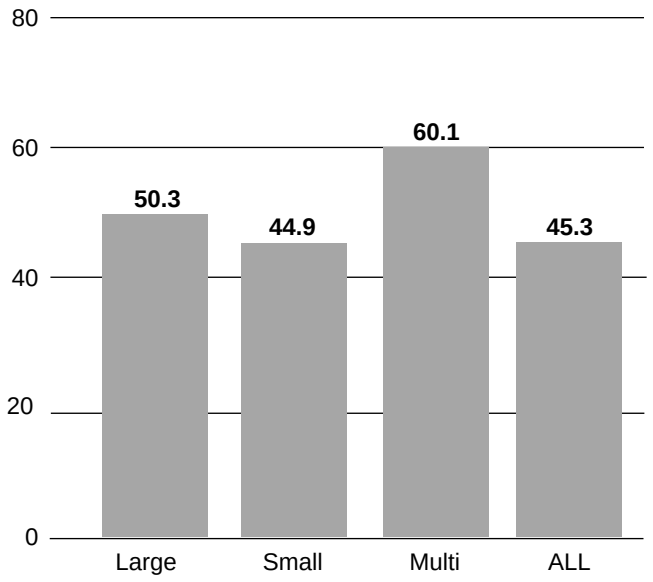
[35] Stop-loss insurance is generally protection purchased by self-funded plans or their plan sponsors against the risk of large losses or severe adverse claims experience. In some cases, this type of coverage merely indemnifies the plan or the plan sponsor if aggregate claims reach a certain attachment point. In other cases, the insurance coverage may cover claims under terms similar to that in a health insurance policy.

a multiplier effect could have occurred among plans in the nation and the sample. To the extent that TPAs can have such a large impact on compliance, PWBA may be able to work with these entities in the future and leverage its enforcement resources to obtain broad-based compliance from many multiemployer plans. (In this regard, see also the discussion of Supplemental Benefits under Section V, below.)

f. *Other Correlations Between Violations*

Table 9 sets forth the highest correlations between violations that were cited for all three samples pooled. Having a correlation coefficient[36] closer to 1.0 indicates that if one of the violations occurs, there is a very high probability the other violation will also occur. As Table 9 shows, a plan that was cited for a violation of one of the preexisting condition exclusion period provisions was likely to have been cited for a violation of other preexisting condition exclusion period provisions. Of the top 10 pairs of violations having the highest correlations, 7 pairs involved correlations of HIPAA preexisting condition exclusion periods. (PWBA found correlations ranging from 0.796 to 0.504 for these 7 pairs.)[37] These correlations are consistent with PWBA's finding of hidden preexisting condition exclusions and nonconfinement clauses in some plans, which resulted in citations for multiple preexisting condition exclusion period violations by those plans. In addition, a plan that was cited for a violation of one of the substantive special enrollment provisions was likely to have been cited for a violation of the other substantive special enrollment provisions. (PWBA found a 0.478 correlation between violations of provisions governing special enrollment triggered by a new dependent and those triggered by loss of other coverage.) Violations of MHPA's annual and lifetime provisions were also closely correlated. (PWBA found a 0.601 correlation between these violations.)

Chart 9
Part 7 Violations*



*Percentage of plans with at least one Part 7 violation.

[36] Technically, the correlations reported are Pearson correlation coefficients. A correlation of 0 indicates statistical independence, that is, the existence of one violation has no effect on the likelihood of the other. All of the correlations discussed in this section or shown in Table 9 are statistically significant at the 1 percent level.

[37] There was a 0.796 correlation between violations of HIPAA's look-forward and look-back rules, a 0.689 correlation between violations of HIPAA's individual notice and general notice rules, a 0.648 correlation between violations of HIPAA's rules governing impermissible preexisting condition exclusions on adopted children and newborns, a 0.639 correlation between violations of HIPAA's creditable coverage offset rule and its look-forward rule, a 0.623 correlation between the violations of HIPAA's creditable coverage offset rule and its look-back rule, a 0.516 correlation between the violations of HIPAA's general notice provision and the look-back rule, and a 0.504 correlation between violations of HIPAA's general notice provisions and the look-forward rule.

V. SUPPLEMENTAL BENEFITS OF THE FY 2001 COMPLIANCE PROJECT: INCREASED ISSUER AND THIRD PARTY ADMINISTRATOR COMPLIANCE

During the project, PWBA focused its investigative efforts primarily on compliance with respect to specific group health plans. Although most of these plans agreed to amend their plan documents to comply with Part 7, a more global effect emerged as a result of the investigations. PWBA determined that noncompliance for some plans originated with their service providers (that is, their issuers or TPAs). Specifically, some plan provisions that were cited for a violation of Part 7 were derived from policies or model plan documents generated by issuers or TPAs with standard provisions. In these cases, the simple amendment of an issuer's policy or TPA's document results in a one-time correction for a much larger universe, particularly if the issuer or TPA operates nationwide.

Some investigators pursued this broad-based compliance assistance effort in the project and other cases by attempting to work with issuers and TPAs on standard provisions that were in violation of a Part 7 provision. PWBA determined that when the issuers and TPAs agreed to amend policy terms or model documents, thousands of plans and millions of participants were affected by the corrections. At the close of the first quarter of FY 2002, four regional offices were able to estimate the number of participants and plans affected by this type of compliance. Those estimates reflected that amendments made to 9 different standard insurance policies or model documents resulted in corrections for over 2.7 million participants and nearly 14,000 insured plans. [38]

The primary challenge to pursuing this type of blanket correction is that, under ERISA, PWBA does not have direct enforcement authority over issuers for the provisions of Part 7.[39] Therefore, these compliance gains were generally the result of voluntary compliance work. In some cases, issuers and TPAs agreed to correct standard provisions to ensure that all ERISA-covered group health plans they serviced were in compliance with Part 7. In other cases, PWBA worked with State insurance departments, who retain direct enforcement authority against issuers, to raise Part 7 awareness and increase broad-based compliance for standard policies and model documents. Using both compliance methods, PWBA was able to help bring about additional, far-reaching compliance assistance by working directly with issuers and TPAs.

[38] In one region, amendments to the policy terms of a single nationwide issuer affected 2.55 million participants and 5,000 plans.
[39] See ERISA section 502(b)(3).

VI. CONCLUSION: INTRODUCING H-CAP

The project was a review of group health plans for compliance with 42 specific requirements of the new laws. Generally, PWBA found that group health plans are in compliance with the substantive provisions of the new health care laws (that is, the provisions other than the notice requirements). Given the very large and complex universe of ERISA-covered health plans, it was not unexpected that confusion would arise with respect to implementing the various, sometimes technical requirements of the new health care laws. In this regard, the project was initiated in the early stages of the implementation process – generally only 2 years after the law became effective for most plans.

However, implementation problems exist, particularly with respect to certain notice provisions, as well as regarding certain discrete substantive provisions that are technical in nature. To address these problems, PWBA is initiating H-CAP, which is comprised of three strategies, each with an action plan.

H-CAP's first strategy is to develop and distribute additional publications and other educational materials. PWBA is publishing three new publications to assist group health plans and health insurance issuers in complying with the new health laws. These materials will be distributed through PWBA's toll-free publications line, at all workshops and compliance assistance activities, through industry groups and industry newsletters, through the trade press and other interested media, and via PWBA's Web site.

Specifically, a *Self-Audit Checklist* has been developed. This checklist, similar to the HIPAA checksheet used by PWBA investigators to determine compliance, will be a useful tool for plans and issuers to assess their compliance line-by-line with the health laws. In addition, *Compliance Assistance for Group Health Plans*, PWBA's current publication highlighting the top 10 most common errors made by health plans, has been updated with 5 additional tips for group health plans, based on common mistakes found in the project. It also includes advice on how to avoid these mistakes. Finally a *New Health Laws Notice Guide* has been developed summarizing all of the new health law notice requirements, including sample language that can be used by plans.

H-CAP's second strategy is to dedicate a section of PWBA's compliance assistance page on PWBA's Web site to the new health care laws, making it easier for plans, issuers, and other service providers to find in one location all of the regulations, publications, frequently asked questions, and other guidance. The new, dedicated section will supplement compliance assistance efforts PWBA has already made, including making the Agency's benefits advisors available, through a toll-free telephone number, 1-866-275-7922, and electronically at www.askpwba.dol.gov to answer questions about the new health law requirements.

The third strategy is to participate in new, live workshops around the country where trained staff will meet with plan administrators, plan sponsors, attorneys, consultants, and other service providers to apply the *Self-Audit Checklist* to various sample plan provisions and documents. These live workshops will supplement the Health Benefits Education Campaign Compliance Assistance Seminars already conducted by the Agency, which address a wider variety of health plan topics, including the new health laws.

In addition to H-CAP, PWBA intends to implement several changes to its interpretive program. Specifically, PWBA would like to provide additional clarity and model notices in future interpretive guidance. PWBA intends to amend its regulations to include sample language that could be used by plans and issuers providing the general and individual notices of preexisting condition exclusions. In addition, PWBA intends to amend its regulations to include model educational information about the HIPAA provisions to be included in the certificate of creditable coverage. This model language was suggested by the GAO[40] and PWBA hopes this type of education will increase awareness about and compliance with HIPAA's provisions. PWBA also intends to provide additional regulatory guidance on issues such as hidden preexisting condition exclusions.

PWBA is optimistic that these partnership efforts with plans, issuers, and other service providers will lead to increased understanding about the new health care laws and increased compliance rates as well.

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

TABLES

Table 1. Final Status of Sample Plans and Firms (Unweighted Counts)

	Status	Sample			Total
		Large	Small	Multi	
Investigation conducted	Investigation conducted	464	394	409	1,267
	Total	464	394	409	1,267
Out-of-scope	Church plan	9	6	.	15
	Fewer than 2 common law employees	2	76	.	78
	Public sector plan	20	10	2	32
	Plan terminated after merger	.	.	46	46
	Employer participating in multi plan	5	8	2	15
	No plan	63	747	.	810
	Out-of business	5	63	.	68
	Plan covers retirees only	.	.	3	3
	Single-employer plan in multi sample	.	.	2	2
	Plan terminated	1	.	11	12
	Excepted benefits	1	.	8	9
	Total	106	910	74	1,090
Recent investigation	Prior not usable	8	2	16	26
	Prior used	5	.	7	12
	Total	13	2	23	38
Unreachable	Unreachable	40	298	4	342
	Total	40	298	4	342
Total		623	1,604	510	2,737

Table 2. Weighted Summary of Violation Rates

Statute - Measure		Large	Small	Multi	All
700 - Part 7 Provisions	Plans subject to statute	91,459	1,217,807	1,759	1,311,026
	Plans with violations	46,048	547,086	1,058	594,192
	Weighted violation rate	50.3%	44.9%	60.1%	45.3%
700.1 - HIPAA Violations	Plans subject to statute	91,459	1,217,807	1,759	1,311,026
	Plans with violations	36,890	432,723	879	470,493
	Weighted violation rate	40.3%	35.5%	50.0%	35.9%
700.2 - Mental Health Parity Act Violations	Plans subject to statute	81,458	194,725	1,670	277,854
	Plans with violations	6,488	15,454	332	22,274
	Weighted violation rate	8.0%	7.9%	19.9%	8.0%
700.3 - Newborns' and Mothers' Health Protection Act Violations	Plans subject to statute	39,220	343,088	1,309	383,617
	Plans with violations	7,406	126,726	281	134,413
	Weighted violation rate	18.9%	36.9%	21.4%	35.0%
700.4 - Women's Health and Cancer Rights Act Violations	Plans subject to statute	91,459	1,217,807	1,759	1,311,026
	Plans with violations	16,964	268,907	303	286,174
	Weighted violation rate	18.5%	22.1%	17.2%	21.8%

Table 3. 95% Confidence Limits for Weighted Violation Rates in All Plans

Confidence Limits for Violation Rates				
Statute	**Violation Rate**	**Standard Error**	**Lower 95% Confidence Limit**	**Upper 95% Confidence Limit**
700 - Part 7 Provisions	45%	2.3%	41%	50%
700.1 - HIPAA Violations	36	2.2	31	40
700.2 - Mental Health Parity Act Violations	8.0	2.4	3.3	13
700.3 - Newborns' and Mothers' Health Protection Act Violations	35	4.1	27	43
700.4 - Women's Health and Cancer Rights Act Violations	22	1.9	18	26

Table 4A. 95% Confidence Limits for Weighted Violation Rates in Each Sample

Large Firms

Confidence Limits for Violation Rates				
Statute	**Violation Rate**	**Standard Error**	**Lower 95% Confidence Limit**	**Upper 95% Confidence Limit**
700 - Part 7 Provisions	50%	2.4%	46%	55%
700.1 - HIPAA Violations	40	2.3	36	45
700.2 - Mental Health Parity Act Violations	8.0	1.4	5.3	11
700.3 - Newborns' and Mothers' Health Protection Act Violations	19	2.9	13	25
700.4 - Women's Health and Cancer Rights Act Violations	19	1.9	15	22

Table 4B. 95% Confidence Limits for Weighted Violation Rates in Each Sample

Small Firms

Confidence Limits for Violation Rates				
Statute	**Violation Rate**	**Standard Error**	**Lower 95% Confidence Limit**	**Upper 95% Confidence Limit**
700 - Part 7 Provisions	45%	2.5%	40%	50%
700.1 - HIPAA Violations	36	2.4	31	40
700.2 - Mental Health Parity Act Violations	7.9	3.4	1.1	15
700.3 - Newborns' and Mothers' Health Protection Act Violations	37	4.6	28	46
700.4 - Women's Health and Cancer Rights Act Violations	22	2.1	18	26

Table 4C. 95% Confidence Limits for Weighted Violation Rates in Each Sample

Multiemployer Plans

Confidence Limits for Violation Rates				
Statute	**Violation Rate**	**Standard Error**	**Lower 95% Confidence Limit**	**Upper 95% Confidence Limit**
700 - Part 7 Provisions	60%	2.2%	56%	64%
700.1 - HIPAA Violations	50	2.2	46	54
700.2 - Mental Health Parity Act Violations	20	1.8	16	23
700.3 - Newborns' and Mothers' Health Protection Act Violations	21	2.1	17	26
700.4 - Women's Health and Cancer Rights Act Violations	17	1.7	14	20

Table 5A. Violation Rates for Single-Employer Plans by Statute and Plan Size (Weighted Violation Rates)

Number of Participants	700 - Part 7 Provisions		700.1 - HIPAA Violations		700.2 - Mental Health Parity Act Violations		700.3 - Newborns' and Mothers' Health Protection Act Violations		700.4 - Women's Health and Cancer Rights Act Violations	
	Number of Cases	Violation Rate	Number of Cases	Violation Rate	Number of Cases	Violation Rate	Number of Cases	Violation Rate	Number of Cases	Violation Rate
None or not reported	12	23.2%	12	1.5%	4	0.0%	2	50.0%	12	10.9%
2-9	208	43.2	208	34.3	11	27.3	50	44.8	208	20.6
10-24	108	48.8	108	40.6	11	5.9	33	35.6	108	23.0
25-99	169	52.3	169	40.3	101	5.6	52	41.3	169	31.0
100-500	212	46.0	212	33.0	205	8.3	101	7.5	212	15.9
500 or more	154	37.0	154	34.9	152	1.9	84	14.2	154	10.9
All	863	45.3	863	35.9	484	7.9	322	35.1	863	21.8

Table 5B. Violation Rates for Multiemployer Plans by Statute and Plan Size (Weighted Violation Rates)

Number of Participants	700 - Part 7 Provisions		700.1 - HIPAA Violations		700.2 - Mental Health Parity Act Violations		700.3 - Newborns' and Mothers' Health Protection Act Violations		700.4 - Women's Health and Cancer Rights Act Violations	
	Number of Cases	Violation Rate	Number of Cases	Violation Rate	Number of Cases	Violation Rate	Number of Cases	Violation Rate	Number of Cases	Violation Rate
2-99	34	50.0%	34	44.1%	18	22.2%	16	18.8%	34	11.8%
100-499	111	52.3	111	41.4	109	15.6	84	22.6	111	14.4
500-999	95	68.0	95	53.1	93	21.8	74	26.1	95	25.0
1,000-4,999	122	67.9	122	60.5	121	23.3	95	20.1	122	17.6
5,000 or more	54	51.3	54	42.0	54	16.8	41	14.8	54	12.0
All	416	60.1	416	50.0	395	19.9	310	21.4	416	17.2

Table 6. Detailed Violation Rates by Sample (Weighted Violation Rates)

Violation	Large	Small	Multi	All
700 - Part 7 Provisions	50.3%	44.9%	60.1%	45.3%
700.1 - HIPAA Violations	40.3	35.5	50.0	35.9
H1 - Impermissible preexisting condition exclusion	26.5	23.6	31.8	23.8
701(a)(1) - 6-Month look-back violation	12.3	11.7	17.2	11.7
701(a)(1) [using 701(b)(1) definition] - Preex on genetic information	0.0	0.5	1.0	0.5
701(a)(2) - 12 Month (or 18 month) look-forward violation	10.4	9.4	18.4	9.5
701(a)(3) [using 701(c) definition] - Failure to offset	6.4	6.3	9.7	6.4
701(d)(1) - Impermissible preex on newborns	1.2	0.5	4.6	0.6
701(d)(2) - Impermissible preex on children adopted or placed for adoption	1.3	0.8	4.4	0.8
701(d)(3) - Pregnancy preex	1.4	3.3	5.1	3.2
29 CFR 2590.701-3(c) - Failure to give adequate generalized notices of preex	15.5	14.5	18.6	14.5
29 CFR 2590.701-5(d) - Failure to give adequate individualized notices of preex	11.7	10.4	10.9	10.5
Other - Impermissible preex	6.5	4.8	6.6	4.9
H2 - Failure to Provide Certificates	9.5	7.1	11.5	7.3
701(e)(1)(A)(i) - Automatically upon loss of coverage (COBRA covered plan)	4.0	0.8	5.6	1.0
701(e)(1)(A)(i) - By Plan (COBRA Covered)	3.0	0.8	5.3	0.9
701(e)(1)(A)(i) - By Issuer only pursuant to agreement (COBRA Covered)	1.0	0.0	0.2	0.1
701(e)(1)(A)(ii) - Automatically upon loss of coverage (Non COBRA covered)	0.5	2.3	0.5	2.2
701(e)(1)(A)(ii) - By Plan (Non COBRA Covered)	0.2	2.3	0.5	2.1
701(e)(1)(A)(ii) - By Issuer only pursuant to agreement (Non COBRA Covered)	0.2	0.0	0.0	0.0
701(e)(1)(A)(iii) - Upon request	2.6	2.8	1.9	2.8
701(e)(1)(A)(iii) - By Plan (Upon Request)	1.6	2.5	1.9	2.5
701(e)(1)(A)(iii) - By Issuer only pursuant to agreement (Upon Request)	1.0	0.3	0.0	0.3
29 CFR 2590.701-5(a)(2) - Within required time frames	2.7	0.8	2.4	0.9
29 CFR 2590.701-5(a)(2) - By Plan (W/In Req'd Timeframes)	2.2	0.8	2.2	0.9
29 CFR 2590.701-5(a)(2) - By Issuer with agreement (W/In Req'd Timeframes)	0.5	0.0	0.2	0.0
Other - Failure to Provide Certificates	3.6	2.5	4.7	2.6
H3 - Special Enrollment Violation	10.9	16.2	15.5	15.9
701(f)(1) - Failure to allow special enrollment upon loss of other coverage	3.1	5.3	3.6	5.2
701(f)(2) - Failure to allow dependant special enrollment	2.1	3.0	3.1	3.0
29 CFR 2590.701-6(c) - Failure to give notice of special enrollment rights	7.8	12.4	12.3	12.1
Other - Special Enrollment Violation	1.5	1.5	0.5	1.5

Table 6. Detailed Violation Rates by Sample (Weighted Violation Rates) *(continued)*

Violation	Large	Small	Multi	All
H4 - Nondiscrimination Violation	13.2%	6.9%	23.0%	7.3%
702(a) - Nonconfinement clause that delays eligibility	9.2	4.6	17.7	4.9
702(a) - Other violation of eligibility discrimination provision	5.0	3.6	6.3	3.7
702(b) - Nonconfinement clause that raises premiums	0.0	0.0	0.0	0.0
702(b) - Other violation of premium discrimination provision	0.2	0.0	0.0	0.0
Other - Nondiscrimination Violation	1.9	0.3	1.0	0.4
H5 - 701(g) - HMO Affiliation Period Violation	0.0	0.0	0.0	0.0
H6 - 703 - MEWA or Multiemployer Plan Failure to Provide Guaranteed Renewability	0.0	0.0	0.0	0.0
700.2 - Mental Health Parity Act Violations	8.0	7.9	19.9	8.0
Not Subject to Mental Health Parity Act	10.9	84.0	5.1	78.8
Mental Health Parity Act Violation	8.0	7.9	19.9	8.0
M1 - 712(a)(1) - Lifetime Dollar Limit	4.1	3.2	6.1	3.5
M2 - 712(a)(1) - Constructive (Straight math) Lifetime Dollar Limit	0.5	1.6	1.3	1.3
M3 - 712(a)(2) - Annual Dollar Limit	4.1	4.8	6.4	4.6
M4 - 712(a)(2) - Constructive (Straight math) Annual Dollar Limit	2.6	4.8	10.7	4.2
M5 - 29 CFR 2590.712(b)(4) - Substance Abuse Offsets Mental Health Limit	1.6	4.8	2.5	3.8
M6 - Other	0.5	0.0	0.0	0.2
700.3 - Newborns' and Mothers' Health Protection Act Violations	18.9	36.9	21.4	35.0
Not Subject to Newborns' and Mothers' Health Protection Act	57.1	71.8	25.6	70.7
Newborns' and Mothers' Health Protection Act Violations	18.9	36.9	21.4	35.0
N1 - 711(a)(1)(A) - Violation of 48/96 Hour Stay Rule	1.6	3.6	1.3	3.4
N2 - 711(a)(1)(B) - Provider Required to Obtain Authorization From Plan	1.7	2.7	1.6	2.6
N3 - 711(b) - Incentives to Mothers or Doctors	0.0	0.9	0.6	0.8
N4 - 711(d) - Notice Violation	17.8	34.2	20.8	32.5
N5 - Other	0.0	0.0	0.0	0.0
700.4 - Women's Health and Cancer Rights Act Violations	18.5	22.1	17.2	21.8
Not Subject to Women's Health and Cancer Rights Act	0.9	1.5	0.7	1.5
Women's Health and Cancer Rights Act Violation	18.5	22.1	17.2	21.8
W1 - 713(a) - Not Providing the Three Required Coverages	3.1	3.3	2.4	3.3
W2 - 713(a) - Annual and/or Enrollment Notice Violation	13.3	18.0	10.6	17.7
W3 - 713(b) - One-Time Notice Violation	8.4	8.9	8.5	8.8
W4 - 713(c) - Incentive Problem	0.0	0.0	0.0	0.0
W5 - Other	0.8	1.3	1.9	1.2
Average Number of Part 7 Violations per Case	1.6	1.5	2.2	1.5

Table 7. Detailed Substantive Violation Rates by Sample (Excluding Notice Requirements) (Weighted Violation Rates)

Violation	Large	Small	Multi	All
700 - Part 7 Provisions	37.2%	30.2%	51.7%	30.7%
700.1 - HIPAA Violations	33.0	27.7	44.4	28.1
H1 - Impermissible preexisting condition exclusion	20.4	18.3	28.0	18.4
701(a)(1) - 6-Month look-back violation	12.3	11.7	17.2	11.7
701(a)(1) [using 701(b)(1) definition] - Preex on genetic information	0.0	0.5	1.0	0.5
701(a)(2) - 12 Month (or 18 month) look-forward violation	10.4	9.4	18.4	9.5
701(a)(3) [using 701(c) definition] - Failure to offset	6.4	6.3	9.7	6.4
701(d)(1) - Impermissible preex on newborns	1.2	0.5	4.6	0.6
701(d)(2) - Impermissible preex on children adopted or placed for adoption	1.3	0.8	4.4	0.8
701(d)(3) - Pregnancy preex	1.4	3.3	5.1	3.2
Other - Impermissible preex	6.5	4.8	6.6	4.9
H2 - Failure to Provide Certificates	9.5	7.1	11.5	7.3
701(e)(1)(A)(i) - Automatically upon loss of coverage (COBRA covered plan)	4.0	0.8	5.6	1.0
701(e)(1)(A)(i) - By Plan (COBRA Covered)	3.0	0.8	5.3	0.9
701(e)(1)(A)(i) - By Issuer only pursuant to agreement (COBRA Covered)	1.0	0.0	0.2	0.1
701(e)(1)(A)(ii) - Automatically upon loss of coverage (Non COBRA covered)	0.5	2.3	0.5	2.2
701(e)(1)(A)(ii) - By Plan (Non COBRA Covered)	0.2	2.3	0.5	2.1
701(e)(1)(A)(ii) - By Issuer only pursuant to agreement (Non COBRA Covered)	0.2	0.0	0.0	0.0
701(e)(1)(A)(iii) - Upon request	2.6	2.8	1.9	2.8
701(e)(1)(A)(iii) - By Plan (Upon Request)	1.6	2.5	1.9	2.5
701(e)(1)(A)(iii) - By Issuer only pursuant to agreement (Upon Request)	1.0	0.3	0.0	0.3
29 CFR 2590.701-5(a)(2) - Within required time frames	2.7	0.8	2.4	0.9
29 CFR 2590.701-5(a)(2) - By Plan (W/In Req'd Timeframes)	2.2	0.8	2.2	0.9
29 CFR 2590.701-5(a)(2) - By Issuer with agreement (W/In Req'd Timeframes)	0.5	0.0	0.2	0.0
Other - Failure to Provide Certificates	3.6	2.5	4.7	2.6
H3 - Special Enrollment Violation	5.3	7.4	5.6	7.2
701(f)(1) - Failure to allow special enrollment upon loss of other coverage	3.1	5.3	3.6	5.2
701(f)(2) - Failure to allow dependant special enrollment	2.1	3.0	3.1	3.0
Other - Special Enrollment Violation	1.5	1.5	0.5	1.5
H4 - Nondiscrimination Violation	13.2	6.9	23.0	7.3
702(a) - Nonconfinement clause that delays eligibility	9.2	4.6	17.7	4.9
702(a) - Other violation of eligibility discrimination provision	5.0	3.6	6.3	3.7

Table 7. Detailed Substantive Violation Rates by Sample (Excluding Notice Requirements) (Weighted Violation Rates) *(continued)*

Violation	Large	Small	Multi	All
702(b) - Nonconfinement clause that raises premiums	0.0%	0.0%	0.0%	0.0%
702(b) - Other violation of premium discrimination provision	0.2	0.0	0.0	0.0
Other - Nondiscrimination Violation	1.9	0.3	1.0	0.4
H5 - 701(g) - HMO Affiliation Period Violation	0.0	0.0	0.0	0.0
H6 - 703 - MEWA or Multiemployer Plan Failure to Provide Guaranteed Renewability	0.0	0.0	0.0	0.0
700.2 - Mental Health Parity Act Violations	8.0	7.9	19.9	8.0
Not Subject to Mental Health Parity Act	10.9	84.0	5.1	78.8
Mental Health Parity Act Violation	8.0	7.9	19.9	8.0
M1 - 712(a)(1) - Lifetime Dollar Limit	4.1	3.2	6.1	3.5
M2 - 712(a)(1) - Constructive (Straight math) Lifetime Dollar Limit	0.5	1.6	1.3	1.3
M3 - 712(a)(2) - Annual Dollar Limit	4.1	4.8	6.4	4.6
M4 - 712(a)(2) - Constructive (Straight math) Annual Dollar Limit	2.6	4.8	10.7	4.2
M5 - 29 CFR 2590.712(b)(4) - Substance Abuse Offsets Mental Health Limit	1.6	4.8	2.5	3.8
M6 - Other	0.5	0.0	0.0	0.2
700.3 - Newborns' and Mothers' Health Protection Act Violations	3.3	5.4	2.9	5.2
Not Subject to Newborns' and Mothers' Health Protection Act	57.1	71.8	25.6	70.7
Newborns' and Mothers' Health Protection Act Violations	3.3	5.4	2.9	5.2
N1 - 711(a)(1)(A) - Violation of 48/96 Hour Stay Rule	1.6	3.6	1.3	3.4
N2 - 711(a)(1)(B) - Provider Required to Obtain Authorization From Plan	1.7	2.7	1.6	2.6
N3 - 711(b) - Incentives to Mothers or Doctors	0.0	0.9	0.6	0.8
N5 - Other	0.0	0.0	0.0	0.0
700.4 - Women's Health and Cancer Rights Act Violations	4.0	4.6	4.4	4.5
Not Subject to Women's Health and Cancer Rights Act	0.9	1.5	0.7	1.5
Women's Health and Cancer Rights Act Violation	4.0	4.6	4.4	4.5
W1 - 713(a) - Not Providing the Three Required Coverages	3.1	3.3	2.4	3.3
W4 - 713(c) - Incentive Problem	0.0	0.0	0.0	0.0
W5 - Other	0.8	1.3	1.9	1.2
Average Number of Part 7 Violations per Case	0.9	0.7	1.5	0.8

Table 8A. Part 7 Violations by Decreasing Prevalence (Weighted Violation Rates)

Large Firms

Statute	Violation	Rate
NMHPA	N4 - 711(d) - Notice Violation	17.8%
HIPAA-H1 (Preex)	29CFR 2590.701-3(c) - Failure to give adequate generalized notices of preex	15.5
WHCRA	W2 - 713(a) - Annual and/or Enrollment Notice Violation	13.3
HIPAA-H1 (Preex)	701(a)(1) - 6-Month look-back violation	12.3
HIPAA-H1 (Preex)	29 CFR 2590.701-5(d) - Failure to give adequate individualized notices of preex	11.7
HIPAA-H1 (Preex)	701(a)(2) - 12 Month (or 18 month) look-forward violation	10.4
HIPAA-H4 (Nondiscrim)	702(a) - Nonconfinement clause that delays eligibility	9.2
WHCRA	W3 - 713(b) - One-Time Notice Violation	8.4
HIPAA-H3 (Sp Enroll)	29 CFR 2590.701-6(c) - Failure to give notice of special enrollment rights	7.8
HIPAA-H1 (Preex)	Other - Impermissible preex	6.5
HIPAA-H1 (Preex)	701(a)(3) [using 701(c) definition] - Failure to offset	6.4
HIPAA-H4 (Nondiscrim)	702(a) - Other violation of eligibility discrimination provision	5.0
MHPA	M1 - 712(a)(1) - Lifetime Dollar Limit	4.1
MHPA	M3 - 712(a)(2) - Annual Dollar Limit	4.1
HIPAA-H2 (Certif)	Other - Failure to Provide Certificates	3.6
HIPAA-H3 (Sp Enroll)	701(f)(1) - Failure to allow special enrollment upon loss of other coverage	3.1
WHCRA	W1 - 713(a) - Not Providing the Three Required Coverages	3.1
HIPAA-H2 (Certif)	701(e)(1)(A)(i) - By Plan (COBRA Covered)	3.0
MHPA	M4 - 712(a)(2) - Constructive (Straight math) Annual Dollar Limit	2.6
HIPAA-H2 (Certif)	29 CFR 2590.701-5(a)(2) - By Plan (W/In Req'd Timeframes)	2.2
HIPAA-H3 (Sp Enroll)	701(f)(2) - Failure to allow dependant special enrollment	2.1
HIPAA-H4 (Nondiscrim)	Other - Nondiscrimination Violation	1.9
NMHPA	N2 - 711(a)(1)(B) - Provider Required to Obtain Authorization From Plan	1.7
NMHPA	N1 - 711(a)(1)(A) - Violation of 48/96 Hour Stay Rule	1.6
MHPA	M5 - 29 CFR 2590.712(b)(4) - Substance Abuse Offsets Mental Health Limit	1.6
HIPAA-H2 (Certif)	701(e)(1)(A)(iii) - By Plan (Upon Request)	1.6
HIPAA-H3 (Sp Enroll)	Other - Special Enrollment Violation	1.5
HIPAA-H1 (Preex)	701(d)(3) - Pregnancy preex	1.4
HIPAA-H1 (Preex)	701(d)(2) - Impermissible preex on children adopted or placed for adoption	1.3
HIPAA-H1 (Preex)	701(d)(1) - Impermissible preex on newborns	1.2
HIPAA-H2 (Certif)	701(e)(1)(A)(i) - By Issuer only pursuant to agreement (COBRA Covered)	1.0
HIPAA-H2 (Certif)	701(e)(1)(A)(iii) - By Issuer only pursuant to agreement (Upon Request)	1.0

Table 8A. Part 7 Violations by Decreasing Prevalence (Weighted Violation Rates) *(continued)*

Large Firms

Statute	Violation	Rate
WHCRA	W5 - Other	0.8%
MHPA	M2 - 712(a)(1) - Constructive (Straight math) Lifetime Dollar Limit	0.5
MHPA	M6 - Other	0.5
HIPAA-H2 (Certif)	29 CFR 2590.701-5(a)(2) - By Issuer with agreement (W/In Req'd Timeframes)	0.5
HIPAA-H2 (Certif)	701(e)(1)(A)(ii) - By Plan (Non COBRA Covered)	0.2
HIPAA-H2 (Certif)	701(e)(1)(A)(ii) - By Issuer only pursuant to agreement (Non COBRA Covered)	0.2
HIPAA-H4 (Nondiscrim)	702(b) - Other violation of premium discrimination provision	0.2
HIPAA-H1 (Preex)	701(a)(1) [using 701(b)(1) definition] - Preex on genetic information	0.0
HIPAA-H4 (Nondiscrim)	702(b) - Nonconfinement clause that raises premiums	0.0
HIPAA-H5	H5 - 701(g) - HMO Affiliation Period Violation	0.0
HIPAA-H6	H6 - 703 - MEWA or Multiemployer Plan Failure to Provide Guaranteed Renewability	0.0
NMHPA	N3 - 711(b) - Incentives to Mothers or Doctors	0.0
NMHPA	N5 - Other	0.0
WHCRA	W4 - 713(c) - Incentive Problem	0.0

Table 8B. Part 7 Violations by Decreasing Prevalence (Weighted Violation Rates)

Small Firms

Statute	Violation	Rate
NMHPA	N4 - 711(d) - Notice Violation	34.2%
WHCRA	W2 - 713(a) - Annual and/or Enrollment Notice Violation	18.0
HIPAA-H1 (Preex)	29 CFR 2590.701-3(c) - Failure to give adequate generalized notices of preex	14.5
HIPAA-H3 (Sp Enroll)	29 CFR 2590.701-6(c) - Failure to give notice of special enrollment rights	12.4
HIPAA-H1 (Preex)	701(a)(1) - 6-Month look-back violation	11.7
HIPAA-H1 (Preex)	29 CFR 2590.701-5(d) - Failure to give adequate individualized notices of preex	10.4
HIPAA-H1 (Preex)	701(a)(2) - 12 Month (or 18 month) look-forward violation	9.4
WHCRA	W3 - 713(b) - One-Time Notice Violation	8.9
HIPAA-H1 (Preex)	701(a)(3) [using 701(c) definition] - Failure to offset	6.3
HIPAA-H3 (Sp Enroll)	701(f)(1) - Failure to allow special enrollment upon loss of other coverage	5.3
HIPAA-H1 (Preex)	Other - Impermissible preex	4.8
MHPA	M3 - 712(a)(2) - Annual Dollar Limit	4.8
MHPA	M4 - 712(a)(2) - Constructive (Straight math) Annual Dollar Limit	4.8
MHPA	M5 - 29 CFR 2590.712(b)(4) - Substance Abuse Offsets Mental Health Limit	4.8
HIPAA-H4 (Nondiscrim)	702(a) - Nonconfinement clause that delays eligibility	4.6
NMHPA	N1 - 711(a)(1)(A) - Violation of 48/96 Hour Stay Rule	3.6
HIPAA-H4 (Nondiscrim)	702(a) - Other violation of eligibility discrimination provision	3.6
HIPAA-H1 (Preex)	701(d)(3) - Pregnancy preex	3.3
WHCRA	W1 - 713(a) - Not Providing the Three Required Coverages	3.3
MHPA	M1 - 712(a)(1) - Lifetime Dollar Limit	3.2
HIPAA-H3 (Sp Enroll)	701(f)(2) - Failure to allow dependant special enrollment	3.0
NMHPA	N2 - 711(a)(1)(B) - Provider Required to Obtain Authorization From Plan	2.7
HIPAA-H2 (Certif)	701(e)(1)(A)(iii) - By Plan (Upon Request)	2.5
HIPAA-H2 (Certif)	Other - Failure to Provide Certificates	2.5
HIPAA-H2 (Certif)	701(e)(1)(A)(ii) - By Plan (Non COBRA Covered)	2.3
MHPA	M2 - 712(a)(1) - Constructive (Straight math) Lifetime Dollar Limit	1.6
HIPAA-H3 (Sp Enroll)	Other - Special Enrollment Violation	1.5
WHCRA	W5 - Other	1.3
NMHPA	N3 - 711(b) - Incentives to Mothers or Doctors	0.9
HIPAA-H1 (Preex)	701(d)(2) - Impermissible preex on children adopted or placed for adoption	0.8
HIPAA-H2 (Certif)	701(e)(1)(A)(i) - By Plan (COBRA Covered)	0.8
HIPAA-H2 (Certif)	29 CFR 2590.701-5(a)(2) - By Plan (W/In Req'd Timeframes)	0.8

Table 8B. Part 7 Violations by Decreasing Prevalence (Weighted Violation Rates) *(continued)*

Small Firms

Statute	Violation	Rate
HIPAA-H1 (Preex)	701(a)(1) [using 701(b)(1) definition] - Preex on genetic information	0.5%
HIPAA-H1 (Preex)	701(d)(1) - Impermissible preex on newborns	0.5
HIPAA-H2 (Certif)	701(e)(1)(A)(iii) - By Issuer only pursuant to agreement (upon Request)	0.3
HIPAA-H4 (Nondiscrim)	Other - Nondiscrimination Violation	0.3
HIPAA-H2 (Certif)	701(e)(1)(A)(i) - By Issuer only pursuant to agreement (COBRA Covered)	0.0
HIPAA-H2 (Certif)	701(e)(1)(A)(ii) - By Issuer only pursuant to agreement (Non COBRA Covered)	0.0
HIPAA-H2 (Certif)	29 CFR 2590.701-5(a)(2) - By Issuer with agreement(W/In Req'd Timeframes)	0.0
HIPAA-H4 (Nondiscrim)	702(b) - Nonconfinement clause that raises premiums	0.0
HIPAA-H4 (Nondiscrim)	702(b) - Other violation of premium discrimination provision	0.0
HIPAA-H5	H5 - 701(g) - HMO Affiliation Period Violation	0.0
HIPAA-H6	H6 - 703 - MEWA or Multiemployer Plan Failure to Provide Guaranteed Renewability	0.0
MHPA	M6 - Other	0.0
NMHPA	N5 - Other	0.0
WHCRA	W4 - 713(c) - Incentive Problem	0.0

Table 8C. Part 7 Violations by Decreasing Prevalence (Weighted Violation Rates)

Multiemployer Plans

Statute	Violation	Rate
NMHPA	N4 - 711(d) - Notice Violation	20.8%
HIPAA-H1 (Preex)	29 CFR 2590.701-3(c) - Failure to give adequate generalized notices of preex	18.6
HIPAA-H1 (Preex)	701(a)(2) - 12 Month (or 18 month) look-forward violation	18.4
HIPAA-H4 (Nondiscrim)	702(a) - Nonconfinement clause that delays eligibility	17.7
HIPAA-H1 (Preex)	701(a)(1) - 6-Month look-back violation	17.2
HIPAA-H3 (Sp Enroll)	29 CFR 2590.701-6(c) - Failure to give notice of special enrollment rights	12.3
HIPAA-H1 (Preex)	29 CFR 2590.701-5(d) - Failure to give adequate individualized notices of preex	10.9
MHPA	M4 - 712(a)(2) - Constructive (Straight math) Annual Dollar Limit	10.7
WHCRA	W2 - 713(a) - Annual and/or Enrollment Notice Violation	10.6
HIPAA-H1 (Preex)	701(a)(3) [using 701(c) definition] - Failure to offset	9.7
WHCRA	W3 - 713(b) - One-Time Notice Violation	8.5
HIPAA-H1 (Preex)	Other - Impermissible preex	6.6
MHPA	M3 - 712(a)(2) - Annual Dollar Limit	6.4
HIPAA-H4 (Nondiscrim)	702(a) - Other violation of eligibility discrimination provision	6.3
MHPA	M1 - 712(a)(1) - Lifetime Dollar Limit	6.1
HIPAA-H2 (Certif)	701(e)(1)(A)(i) - By Plan (COBRA Covered)	5.3
HIPAA-H1 (Preex)	701(d)(3) - Pregnancy preex	5.1
HIPAA-H2 (Certif)	Other - Failure to Provide Certificates	4.7
HIPAA-H1 (Preex)	701(d)(1) - Impermissible preex on newborns	4.6
HIPAA-H1 (Preex)	701(d)(2) - Impermissible preex on children adopted or placed for adoption	4.4
HIPAA-H3 (Sp Enroll)	701(f)(1) - Failure to allow special enrollment upon loss of other coverage	3.6
HIPAA-H3 (Sp Enroll)	701(f)(2) - Failure to allow dependant special enrollment	3.1
MHPA	M5 - 29 CFR 2590.712(b)(4) - Substance Abuse Offsets Mental Health Limit	2.5
WHCRA	W1 - 713(a) - Not Providing the Three Required Coverages	2.4
HIPAA-H2 (Certif)	29 CFR 2590.701 - 5(a)(2) - By Plan (W/In Req'd Timeframes)	2.2
HIPAA-H2 (Certif)	701(e)(1)(A)(iii) - By Plan (Upon Request)	1.9
WHCRA	W5 - Other	1.9
NMHPA	N2 - 711(a)(1)(B) - Provider Required to Obtain Authorization From Plan	1.6
NMHPA	N1 - 711(a)(1)(A) - Violation of 48/96 Hour Stay Rule	1.3
MHPA	M2 - 712(a)(1) - Constructive (Straight math) Lifetime Dollar Limit	1.3
HIPAA-H1 (Preex)	701(a)(1) [using 701(b)(1) definition] - Preex on genetic information	1.0
HIPAA-H4 (Nondiscrim)	Other - Nondiscrimination Violation	1.0
NMHPA	N3 - 711(b) - Incentives to Mothers or Doctors	0.6

Table 8C. Part 7 Violations by Decreasing Prevalence (Weighted Violation Rates) *(continued)*

Multiemployer Plans

Statute	Violation	Rate
HIPAA-H2 (Certif)	701(e)(1)(A)(ii) - By Plan (Non COBRA Covered)	0.5%
HIPAA-H3 (Sp Enroll)	Other - Special Enrollment Violation	0.5
HIPAA-H2 (Certif)	701(e)(1)(A)(i) - By Issuer only pursuant to agreement (COBRA Covered)	0.2
HIPAA-H2 (Certif)	29 CFR 2590.701-5(a)(2) - By Issuer with agreement(W/In Req'd Timeframes)	0.2
HIPAA-H2 (Certif)	701(e)(1)(A)(ii) - By Issuer only pursuant to agreement (Non COBRA Covered)	0.0
HIPAA-H2 (Certif)	701(e)(1)(A)(iii) - By Issuer only pursuant to agreement (Upon Request)	0.0
HIPAA-H4 (Nondiscrim)	702(b) - Nonconfinement clause that raises premiums	0.0
HIPAA-H4 (Nondiscrim)	702(b) - Other violation of premium discrimination provision	0.0
HIPAA-H5	H5 - 701(g) - HMO Affiliation Period Violation	0.0
HIPAA-H6	H6 - 703 - MEWA or Multiemployer Plan Failure to Provide Guaranteed Renewability	0.0
MHPA	M6 - Other	0.0
NMHPA	N5 - Other	0.0
WHCRA	W4 - 713(c) - Incentive Problem	0.0

Table 9. The 40 Pairs of Violations Having the Highest Correlations
Unweighted Correlations from All Three Samples Pooled

First Violation	Second Violation	Correlation
HIPAA-H1 (Preex)-Look-fwd	HIPAA-H1 (Preex)-Look-back	0.796
HIPAA-H1 (Preex)-Ind. notices	HIPAA-H1 (Preex)-Gen. notices	0.689
HIPAA-H1 (Preex)-Adoption	HIPAA-H1 (Preex)-Newborns	0.648
HIPAA-H1 (Preex)-No offset	HIPAA-H1 (Preex)-Look-fwd	0.639
HIPAA-H1 (Preex)-No offset	HIPAA-H1 (Preex)-Look-back	0.623
HIPAA-H2 (Certif)-Time-I	HIPAA-H2 (Certif)-Auto-C-I	0.611
MHPA-M3 (Annual limit)	MHPA-M1 (Life limit)	0.601
HIPAA-H1 (Preex)-Gen. notices	HIPAA-H1 (Preex)-Look-back	0.516
HIPAA-H1 (Preex)-Gen. notices	HIPAA-H1 (Preex)-Look-fwd	0.504
HIPAA-H3 (Sp Enroll)-Dependent	HIPAA-H3 (Sp Enroll)-Cov loss	0.478
HIPAA-H1 (Preex)-Ind. notices	HIPAA-H1 (Preex)-Look-fwd	0.461
HIPAA-H1 (Preex)-Ind. notices	HIPAA-H1 (Preex)-No offset	0.460
HIPAA-H1 (Preex)-Ind. notices	HIPAA-H1 (Preex)-Look-back	0.455
MHPA-M5 (Subst abuse offset)	MHPA-M1 (Life limit)	0.425
HIPAA-H1 (Preex)-Gen. notices	HIPAA-H1 (Preex)-No offset	0.416
HIPAA-H2 (Certif)-Auto-NC-I	HIPAA-H2 (Certif)-Auto-C-I	0.407
HIPAA-H2 (Certif)-Time-I	HIPAA-H2 (Certif)-Req-I	0.406
WHCRA-W2 (Annual notice)	WHCRA-W3 (One-time notice)	0.397
MHPA-M5 (Subst abuse offset)	MHPA-M3 (Annual limit)	0.350
HIPAA-H2 (Certif)-Req-P	HIPAA-H2 (Certif)-Auto-NC-P	0.331
HIPAA-H2 (Certif)-Req-I	HIPAA-H2 (Certif)-Auto-C-I	0.330
NMHPA-N2 (Plan authoriz)	NMHPA-N3 (Doc/mom incent)	0.328
HIPAA-H2 (Certif)-Time-P	HIPAA-H2 (Certif)-Auto-C-P	0.326
WHCRA-W1 (Missing cov)	NMHPA-N1 (48/96 hour rule)	0.322
HIPAA-H3 (Sp Enroll)-No notice	HIPAA-H3 (Sp Enroll)-Cov loss	0.303
HIPAA-H2 (Certif)-Req-I	NMHPA-N1 (48/96 hour rule)	0.299
HIPAA-H1 (Preex)-Adoption	HIPAA-H1 (Preex)-Look-back	0.273
HIPAA-H3 (Sp Enroll)-No notice	HIPAA-H3 (Sp Enroll)-Dependent	0.272
NMHPA-N4 (Notice viol)	HIPAA-H3 (Sp Enroll)-No notice	0.269
HIPAA-H1 (Preex)-Adoption	HIPAA-H1 (Preex)-Look-fwd	0.268
HIPAA-H1 (Preex)-Adoption	HIPAA-H1 (Preex)-No offset	0.252
WHCRA-W2 (Annual notice)	WHCRA-W1 (Missing cov)	0.252
HIPAA-H2 (Certif)-Time-P	HIPAA-H2 (Certif)-Req-P	0.237
WHCRA-W1 (Missing cov)	NMHPA-N4 (Notice viol)	0.234
WHCRA-W2 (Annual notice)	NMHPA-N4 (Notice viol)	0.232

See Table 10 for an explanation of the meaning of the short violation names used above.

Table 9. The 40 Pairs of Violations Having the Highest Correlations Unweighted Correlations from All Three Samples Pooled *(continued)*

First Violation	Second Violation	Correlation
HIPAA-H1 (Preex)-Genetic	HIPAA-H1 (Preex)-Pregnancy	0.230
HIPAA-H1 (Preex)-Newborns	HIPAA-H1 (Preex)-Pregnancy	0.229
NMHPA-N1 (48/96 hour rule)	HIPAA-H3 (Sp Enroll)-Cov loss	0.218
MHPA-M3 (Annual limit)	HIPAA-H1 (Preex)-Gen. notices	0.217
NMHPA-N1 (48/96 hour rule)	HIPAA-H3 (Sp Enroll)-Other	0.217

Table 10. Meaning of Short Violation Names

Short Violation Name	Long Violation Name/EMS Code
	700 - Part 7 Provisions
	700.1 - HIPAA Violations
	H1 - Impermissible preexisting condition exclusion
HIPAA-H1 (Preex)-Look-back	701(a)(1) - 6-Month look-back violation
HIPAA-H1 (Preex)-Genetic	701(a)(1) [using 701(b)(1) definition] - Preex on genetic information
HIPAA-H1 (Preex)-Look-fwd	701(a)(2) - 12 Month (or 18 month) look-forward violation
HIPAA-H1 (Preex)-No offset	701(a)(3) [using 701(c) definition] - Failure to offset
HIPAA-H1 (Preex)-Newborns	701(d)(1) - Impermissible preex on newborns
HIPAA-H1 (Preex)-Adoption	701(d)(2) - Impermissible preex on children adopted or placed for adoption
HIPAA-H1 (Preex)-Pregnancy	701(d)(3) - Pregnancy preex
HIPAA-H1 (Preex)-Gen. notices	29 CFR 2590.701-3(c) - Failure to give adequate generalized notices of preex
HIPAA-H1 (Preex)-Ind. notices	29 CFR 2590.701-5(d) - Failure to give adequate individualized notices of preex
HIPAA-H1 (Preex)-Other	Other - Impermissible preex
	H2 - Failure to Provide Certificates
	701(e)(1)(A)(i) - Automatically upon loss of coverage (COBRA covered plan)
HIPAA-H2 (Certif)-Auto-C-P	701(e)(1)(A)(i) - By Plan (COBRA Covered)
HIPAA-H2 (Certif)-Auto-C-I	701(e)(1)(A)(i) - By Issuer only pursuant to agreement (COBRA Covered)
	701(e)(1)(A)(ii) - Automatically upon loss of coverage (Non COBRA covered)
HIPAA-H2 (Certif)-Auto-NC-P	701(e)(1)(A)(ii) - By Plan (Non COBRA Covered)
HIPAA-H2 (Certif)-Auto-NC-I	701(e)(1)(A)(ii) - By Issuer only pursuant to agreement (Non COBRA Covered)
	701(e)(1)(A)(iii) - Upon request
HIPAA-H2 (Certif)-Req-P	701(e)(1)(A)(iii) - By Plan (Upon Request)
HIPAA-H2 (Certif)-Req-I	701(e)(1)(A)(iii) - By Issuer only pursuant to agreement (Upon Request)
	29 CFR 2590.701 - 5(a)(2) - Within required time frames
HIPAA-H2 (Certif)-Time-P	29 CFR 2590.701 - 5(a)(2) - By Plan (W/In Req'd Timeframes)
HIPAA-H2 (Certif)-Time-I	29 CFR 2590.701 - 5(a)(2) - By Issuer with agreement (W/In Req'd Timeframes)
HIPAA-H2 (Certif)-Other	Other - Failure to Provide Certificates
	H3 - Special Enrollment Violation
HIPAA-H3 (Sp Enroll)-Cov loss	701(f)(1) - Failure to allow special enrollment upon loss of other coverage
HIPAA-H3 (Sp Enroll)-Dependent	701(f)(2) - Failure to allow dependant special enrollment
HIPAA-H3 (Sp Enroll)-No notice	29 CFR 2590.701-6(c) - Failure to give notice of special enrollment rights
HIPAA-H3 (Sp Enroll)-Other	Other - Special Enrollment Violation

Short Violation names are used in Table 9.

Table 10. Meaning of Short Violation Names *(continued)*

Short Violation Name	Long Violation Name
	H4 - Nondiscrimination Violation
HIPAA-H4 (Non-dscrm)-Ncfmnt	702(a) - Nonconfinement clause that delays eligibility
HIPAA-H4 (Non-dscrm)-Other elig	702(a) - Other violation of eligibility discrimination provision
HIPAA-H4 (Non-dscrm)-Ncfmnt-prem	702(b) - Nonconfinement clause that raises premiums
HIPAA-H4 (Non-dscrm)-Other prem	702(b) - Other violation of premium discrimination provision
HIPAA-H4 (Non-dscrm)-Other	Other - Nondiscrimination Violation
HIPAA-H5 (HMO Affil Period)	H5 - 701(g) - HMO Affiliation Period Violation
HIPAA-H6 (Multi No renew)	H6 - 703 - MEWA or Multiemployer Plan Failure to Provide Guaranteed Renewability
	700.2 - Mental Health Parity Act Violations
	Not Subject to Mental Health Parity Act
	Mental Health Parity Act Violation
MHPA-M1 (Life limit)	M1 - 712(a)(1) - Lifetime Dollar Limit
MHPA-M2 (Constr life Limit)	M2 - 712(a)(1) - Constructive (Straight math) Lifetime Dollar Limit
MHPA-M3 (Annual limit)	M3 - 712(a)(2) - Annual Dollar Limit
MHPA-M4 (Constr annual Lim)	M4 - 712(a)(2) - Constructive (Straight math) Annual Dollar Limit
MHPA-M5 (Subst abuse offset)	M5 - 29 CFR 2590.712(b)(4) - Substance Abuse Offsets Mental Health Limit
MHPA-M6 (Other)	M6 – Other
	700.3 - Newborns' and Mothers' Health Protection Act Violations
	Not Subject to Newborns' and Mothers' Health Protection Act
	Newborns' and Mothers' Health Protection Act Violations
NMHPA-N1 (48/96 hour rule)	N1 - 711(a)(1)(A) - Violation of 48/96 Hour Stay Rule
NMHPA-N2 (Plan authoriz)	N2 - 711(a)(1)(B) - Provider Required to Obtain Authorization From Plan
NMHPA-N3 (Doc/mom incent)	N3 - 711(b) - Incentives to Mothers or Doctors
NMHPA-N4 (Notice viol)	N4 - 711(d) - Notice Violation
NMHPA-N5 (Other)	N5 – Other
	700.4 - Women's Health and Cancer Rights Act Violations
	Not Subject to Women's Health and Cancer Rights Act
	Women's Health and Cancer Rights Act Violation
WHCRA-W1 (Missing cov)	W1 - 713(a) - Not Providing the Three Required Coverages
WHCRA-W2 (Annual notice)	W2 - 713(a) - Annual and/or Enrollment Notice Violation
WHCRA-W3 (One-time notice)	W3 - 713(b) - One-Time Notice Violation
WHCRA-W4 (Incentive prob)	W4 - 713(c) - Incentive Problem
WHCRA-W5 (Other)	W5 – Other

Short Violation names are used in Table 9.

Appendix:
Sample Design and Reliability of Estimates

1. Sample Design

The statistical goal of the project was to measure year-to-year change in the extent to which health plans subject to Part 7 of Title I of ERISA were in compliance with various provisions of that Part. For purposes of this project, the universe of private-sector health plans was divided into three segments – multiemployer plans, single-employer plans sponsored by large firms, and single-employer plans sponsored by small firms. Firms with 100 or more employees were considered to be large. A separate compliance measurement effort was conducted for each of the three segments of the health plan universe.

The same statistical goal applied to measurements for each of the three segments of the universe – to measure year-to-year changes in violation rates to within 10 percentage points with probabilities of type I and type II error of 5 percent or less. The caps on the two types of error guard against erroneous conclusions that PWBA could draw after completing its project and a follow-up project in some future year. Type I error would arise if the true universe violation rate had not changed at all and PWBA falsely concluded that the violation rate had changed. Type II error would arise if the true universe violation rate changed by 10 percentage points, and PWBA falsely concluded that it had not significantly changed.

The sample size calculations were implemented using two sample size calculation tools:

1) The sample size calculation routine based on a "two-sample t-test" that is built into the SAS Analyst application; and

2) SAS code for calculating the power of a two by two chi-square test downloaded from the SAS Web site [http:\ftp.sas.com/techsup/download/stat/].[1]

In applying the sample size calculation based on the two-sample t-test, the first sample is the base year (2001) sample, the second is the sample from whatever future year the project is repeated. The second tool does not compute sample size directly. It computes power[2] for a specified range of sample sizes. Each run of the program reports the statistical power that results from 10 to 20 sample sizes evenly spaced across a specified interval. By running this program three or four times and adjusting the specified sample size interval as necessary, it is a simple matter to zoom in on the minimum sample size that produces the power of 95 percent or more. Compared to the second tool, the first has the advantage of computing sample size in a single run rather than through a sequence of runs. It has the disadvantage of requiring that the standard error of an estimated percentage p be approximated as the square root of p(1-p). As discussed below, the approximation turns out to be quite good, so both tools were used.

Both of the sample size calculation tools assume that the universe size is infinite. The sample size computed using these tools was therefore adjusted downward to account for actual sizes of the three universes using the standard formula for finite population correction[3].

a. *Multiemployer Sample*

The sample size can be calculated to achieve the target variance provided the estimated violation rate does not exceed a specified level. For surveys where no ceiling on the percentages to be estimated can be provided, a variance-maximizing estimate of 50 percent can be used. The problem with this approach is that the sample size will be larger than necessary if the estimated

[1] The statistical basis for this code is: Agresti, A. (1990), Categorical Data Analysis, New York: John Wiley & Sons, Inc. SAS and all other product or service names are registered trademarks of SAS Institute, Inc., Cary, NC, U.S.A.

[2] Power is defined as one minus the probability of type II error. For this initiative, it is the probability of correctly concluding that the true universe violation rate has changed given that it actually did change by 10 percentage points. The goal of capping the probability of type II error at 5 percent may also be stated as achieving power of at least 95 percent.

[3] If a simple random sample size of n' achieves the target variance for an infinite population, then the sample size n that achieves the same variance in a population of size N is:

$$n = \frac{n'}{1 + \frac{n'}{N}}$$

percentages turn out to be much lower than 50 percent.[4] For the multiemployer sample, the violation rate ceiling used was 25 percent, based on an earlier PWBA project that estimated violation rates for Part 7 of ERISA.

Using these assumptions, a sample size of 488 was computed based on the chi-square sample size routine. The two-sample t-test requires the standard deviation, which was approximated as the square root of .25(1-.25) which is .433. The routine based on the two-sample t-test also requires specification of null and alternate hypotheses. The null hypothesis is that the base year mean is 25 percent. The alternate hypothesis is that the initial rate of 25 percent changes by 10 percentage points. The sample size produced using the two-sample t-test procedure is 489, which is nearly identical to the chi-square sample size, whether the alternate hypothesis is specified as 15 percent or 35 percent.

The sampling frame for multiemployer plans was the 1997 5500 file maintained by PWBA's Office of Information Management for purposes of the Freedom of Information Act. It includes all types of employee benefit plans. Health plans were identified based on a question on the Form 5500 that indicates all of the types of welfare benefits that the plan provides. A code of 'A' flags health benefits. Plans entering an 'A' were classified as health plans regardless of what other codes were entered. Other codes that can be entered in this field identify dental and vision plans. Plans indicating that they provide dental or vision benefits were not included unless they also indicated provision of health benefits.

Multiemployer plans were identified based on an entry of 'C' (multiemployer plan) or 'D' (multiple-employer-collectively bargained plan) in the type of plan entity field. Plans entering plan entity code 'F' (group insurance arrangement) were also classified as multiemployer plans if they also indicated that they were collectively bargained. It was clear from the sponsor names that many of the plans identifying themselves as multiemployer plans did so incorrectly. The list was therefore manually reviewed to eliminate all obvious single-employer plans.

The edited samples frame that resulted from this process numbered 2,169 multiemployer plans. Correcting the infinite population sample size of 489 (the more conservative of the two estimates) for the size universe results in a multiemployer sample size of 399.

b. ***Concepts for Large and Small Firm Sample Design***

Sampling single-employer health plans is not as easy as sampling multiemployer plans because there is no satisfactory sampling frame for these plans. The series 5500 reports do not constitute a satisfactory sampling frame because most health plans are exempt from filing under ERISA. To our knowledge, no firm or government agency maintains a comprehensive national list of health plans. It may be possible to construct a list of insured plans by obtaining lists of insurers from the States and lists of health plans from insurers. A sample frame could then be constructed by combining this list with a list of self-insured plans based on 5500 filings. That process was considered time-consuming, expensive, and uncertain. It was therefore decided to sample single-employer health plans via the firms that sponsor them.

In the parlance of sampling theory, firms serve as the "primary sampling units" because it is firms that are directly selected for the sample. Because the analysis is conducted at the plan level, plans are the elementary units. This type of divergence between the primary sampling units and the elementary units implies that the sample is a cluster sample rather than a simple random sample. If each firm had no more than one plan, then plan characteristics could be regarded as firm characteristics, and the sample as a simple random one. Because some firms sponsor more than one health plan, the large and small firm samples are properly regarded as cluster samples. Because a large majority of firms sponsor only one health plan, this cluster sample is close to being simple random.

Three alternative rules could have been used to associate health plans with sample firms:

1. Any plan that covers workers at sample firms, even if sponsored by a parent company;
2. Any plan sponsored by a sample firm or any of its branches or subsidiaries; or
3. Plans sponsored by sample firms (or their branches), but not by their subsidiaries.

All of these alternatives were considered statistically viable. The first introduces a statistical weighting issue, but was selected because it was considered to be the

[4] For example, the assumption that estimated percentages will not exceed 25% reduces sample size by 25% compared to the sample size calculated using no advance knowledge and assuming that variance-maximizing estimates of 50% are possible.

most consistent with procedures normally followed in PWBA investigations. Under this approach, plans covering workers of a parent firm and at least one subsidiary would require investigation if the parent or any of the participating subsidiaries fell into the sample. The probability of selection for each plan therefore depends on the probabilities of selection for the subsidiaries that participate in the plan. The probability of selection for each subsidiary depends only on whether it is large or small (with 100 employees being the dividing line). To accurately compute statistical weights, national office coordinators were asked to determine, and investigators to verify, counts of the number of large and small subsidiaries participating in each plan.

To compute sizes of the large and small firm samples using cluster sampling theory would require three kinds of information about the health plan universe in addition to that required for a simple random sample:

1) The distribution of the number of plans per firm;
2) An estimate of within-firm homogeneity (delta) in violation rates;
3) A distribution of single-employer health plans by the number of subsidiaries participating in the plan.

All three of these data requirements pose serious problems.

Data to meet the first requirement initially appeared to be available. The Bureau of Labor Statistics once published an article in the *Monthly Labor Review* that reported a distribution of firms by number of health plans based on its Employee Benefit Surveys. Foster-Higgins-Mercer and KPMG each report distributions of health plans per firm based on annual surveys conducted by each of those firms. For two reasons, each of these sources significantly overestimates the number of ERISA plans that PWBA would have to investigate.

First, these surveys included plans for workers at all locations of multilocation firms. Given the chosen strategy for associating plans with sample firm locations, the fact that each of a firm's subsidiaries sponsors their own plans has no bearing on cluster size. Whether the parent, or one of the subsidiaries it covers falls in the sample, investigators would find only one plan covering workers of that firm. Thus data from any of these surveys would overestimate cluster size for this project.

The second reason that these surveys would overestimate cluster size arises from the ambiguity concerning the word "plan." In response to surveys such as those above, many companies that offer health insurance from multiple carriers would count each carrier's offering as a separate plan. The entire set of health insurance offerings may be regarded as one plan under ERISA, however. Based on the ERISA definition, PWBA would recognize one plan and would open only one case that examines health insurance offered to the plan by any of the carriers.

Employer identification numbers (EINs) on the series 5500 data could also be used to count the number of health plans per firm. In addition to being subject to the multiple-location problem mentioned above, large firms may sponsor small plans, most of which would be exempt from filing. Thus 5500 data are also unable to provide usable estimates of health plans offered at individual firm locations.

The second data requirement (within-firm homogeneity in violation rates) is highly problematic. Not only does it require knowledge of the quantities PWBA is attempting to measure (violation rates) before they are measured, but it requires knowledge of the extent to which those quantities vary from plan to plan within firms having more than one plan. It seems reasonable to speculate that there would be a substantial tendency for plans within the same firm to be uniform in their compliance status. It does not seem reasonable to quantify that speculation in the absence of any supporting data.[5]

The third data requirement is to estimate the distribution of plans by the number of subsidiaries they cover. Within the large firm sample, the probability of selection for firms is designed to be uniform. Probabilities of selection for plans will not be uniform, however. As explained above, plans covering workers at multiple subsidiaries will be investigated if the parent or any of the subsidiaries it covers is selected for the sample. We are aware of no data that permit an estimate of the distribution of plans by the number of subsidiaries they cover, so this data requirement also remains unfulfilled.

[5] An examination of records from a 1999 pilot project coordinated by the PWBA Office of Health Plan Standards and Compliance Assistance found no more than three firms where more than one plan was investigated. This number was judged too small to provide usable empirical information, especially since the cases were not randomly targeted.

The lack of data with which to credibly estimate any of these data requirements leads to acceptance of a simple random design as the only feasible approach. To the extent that firms offer only one health benefits package at each location or consider the variety of benefits packages offered to be a single ERISA plan, the approximation is accurate. In the small firm sample, the approximation is undoubtedly very accurate. In the large firm universe, the available data can provide only an (possibly substantial) overestimate of the extent to which firms have multiple ERISA health plans covering workers at individual locations.

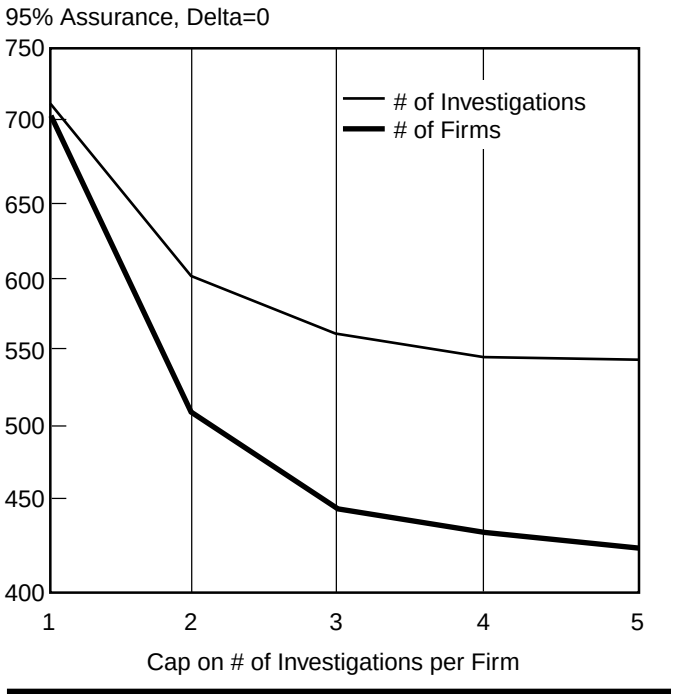
Textbook formulas for computing the size of cluster samples cover only the simplest cluster sample designs where either cluster size is constant or the sampling fraction within each cluster is uniform. Cluster size for this project (number of ERISA health plans per location of a firm) is clearly not constant. Uniform sampling fractions are problematic when many clusters are of size one, because any sampling fraction less than one will cause entire clusters to drop out of the sample. Fortunately there are software packages that can be used to estimate variance for more complex cluster sample designs.

Despite large gaps in the data required to implement a sample design for this project, cluster design tools offer the only approach to answering one fundamental design question – the number of plans to investigate for firms with multiple plans. Simple random samples do not involve subsampling, so the associated theory offers no guidance on this subject. This question is not trivial because most cluster samples present a tradeoff between some number of clusters sub-sampled at one rate and a higher number of clusters sub-sampled at a lower rate, where both designs achieve the target variance, and thus precision. The choice between the alternative designs is normally made on the basis of cost.

To answer the question of the optimal number of plans to investigate per firm, the Office of Policy and Research used a software package capable of estimating variance from complex surveys, version 8.0 of the SAS/STAT software, which includes a variance estimation procedure called PROC SURVEYMEANS. The analysis using this procedure required estimates of the three factors mentioned above as necessary for estimating the size of cluster samples. Guesses regarding these factors were used, and the sensitivity of the conclusion to these guesses was examined. The SAS program simulates the consequences of alternative ceilings or caps on the number of plans investigated per firm. A cap of three, for example, would mean that all plans of firms with three or fewer plans would be investigated. At firms with more than three plans, three plans would be randomly selected for investigation.

The simulations showed that estimated variance varied considerably between simulations with the same assumptions due solely to chance, and that the distribution of plans per sample firm was an important determinant of the variance. Thus to assure that the target variance would be met with a high degree of assurance, the program computes the 95th percentile of the variance. For each set of assumptions, the sample size was selected to achieve the target variance in 95 percent of the simulations. The figure shows how the number of large firms to be sampled and the number of plans to be investigated varies with the cap. Because the numerical assumptions underlying these estimates are mere guesses, the sample size estimates are not usable. The usable conclusion is that investigating all plans of sample firms minimizes not only the number of firms to be visited, but also the number of plans to be investigated. Fortunately, this conclusion proved insensitive to reasonable changes in the three determining factors.[6] For this reason, it was decided to investigate all health plans covering workers at the selected location of each sample firm.

Chart 10
Hypothetical Sample Size



Two of the ERISA Part 7 statutes[7] are applicable only to plans having at least two participants who are current employees. To reduce the chances that plans located would be exempt from these statutes it was decided to limit the universe to firms having at least three employees.

A comprehensive database of U.S. companies maintained by Dun and Bradstreet (D & B) was selected as the sampling frame. This database includes records for branch locations. According to the D & B definition, branches are locations of a company with no separate legal responsibility for their debts. For this reason, branch locations were believed to lack the authority to sponsor their own health plans. Although it is possible that a small number of firms sponsor separate health plans for one or more of their branches, including branches in the samples would have complicated the investigation of health plans for branches in the far more common situation where branch workers are covered under a headquarters plan. Experienced PWBA investigators judged the existence of separate plans for branches to be too rare to justify the added investigatory complexity. Branches were therefore excluded from the sample.

The universe for the study was restricted in two other ways intended to simplify investigations and reduce their cost without significantly compromising the findings. First, sponsor firms were geographically limited to those sponsored in either the District of Columbia or one of the 50 States. Second, firms were limited to those having at least three employees. Although some firms with fewer than three employees sponsor ERISA health plans, most firms that small do not sponsor health plans, and many of those that do are not ERISA plans. The effort to screen large numbers of such tiny firms for ERISA health plans was judged too great to justify the small expansion in the scope of the study.

At the request of PWBA, D & B drew two separate simple random samples from their database — 1,604 private-sector firms having 3-99 employees, and 622 private-sector firms with 100 or more employees. These numbers of firms were calculated so that the number of in-scope firms with health plans would at least equal the target sample sizes.

The D & B database has no flag to distinguish private-sector from public-sector organizations. It does have an eight-digit Standard Industrial Code (SIC) code. A list of 17 D & B SIC codes (or ranges of codes) was used to exclude from the D & B sampling frame organizations such as public secondary schools that were clearly public-sector organizations and organizations whose plans were judged likely to qualify for the ERISA church plan exemption. (See Attachment 1.)

c. *Calculation of Large and Small Firm Sample Sizes*

In the PWBA project that was the source of the estimated 25 percent violation rate ceiling, plans were selected for investigation through PWBA's normal targeting methods rather than through random sampling. Violation rates in randomly targeted cases will undoubtedly be lower than in targeted cases, but the magnitude of the difference is unclear. The sample size calculation for the large and small firms was based on a 22 percent violation rate ceiling. This ceiling resulted from the judgment that three percentage points is the smallest conceivable amount by which single-employer violation rates in targeted cases could exceed those for random cases.

Just as in the multiemployer sample, the infinite population sample size was computed using both of the available tools. The sample size computed using the t-test procedure was 448. The chi-square sample size procedure estimated a sample size of 446. The larger, and thus more conservative, sample size of 448 was corrected for the actual finite populations. After adjustment for a population size[8] of 134,016, the large firm sample size became 444. The small firm population size of 4,957,773 was sufficiently large to leave the infinite population sample size of 448 unaffected by the finite population correction after rounding. These estimates of the size of the large and small firm universes were provided by D & B at the time of sample selection.

d. *Strategy for Contacting Firms and Multiemployer Plans*

Achieving the target number of investigations of small firm plans, large firm plans, and multiemployer plans required contacting more than the target number of

[6] It was also fortunate that there was no need to choose a subsampling fraction on the basis of cost, because the relationship between sample design and travel cost would have been difficult to estimate.

[7] Namely, the Health Insurance Portability and Accountability Act (HIPAA) and the Women's Health and Cancer Rights Act (WHCRA).

[8] See footnote #3 for formula.

sample units due to firms/plans being out-of-scope, unreachable, or the subject of a non-project investigation in the past 12 months.[9] (The most common reason that firms, especially small firms, were out-of-scope was that they did not sponsor health plans.[10]) The number of firms and plans to contact was, therefore, unknown at the start of the project. An approximation of the number of firms and plans to contact could have been calculated given estimates of the rates at which contacts would yield in-scope health plans, but a more accurate method was chosen.

A longer-than-needed list of sample units was prepared for each of the three samples and sorted into random order. The first round involved contacting firms and plans up to the target number of investigations from the top of the randomly ordered list. Based on experience from this round, the size of the second round of contacts was estimated. The target number of investigations for each sample was thus approached incrementally.

e. *Calculating Sample Weights*

The sample weights are the ratio of the universe size to the sample size. For purposes of the weighting calculation, the sample size is the number of attempted contacts, as opposed to the number of plans investigated. Weights computed in this manner support estimates of the results that would have been found had the project screening and investigation methodology been applied to the universe of private-sector health plans. Attempted contacts to sample units that did not lead to investigations because the sample unit was out-of-scope, unreachable, or ineligible for investigation due to a recent prior investigation (See Table 1) thus represent corresponding segments of the health plan universe that would not have led to investigation had the project targeted the entire universe. Among unreachable sample units (multiemployer plans or firms), there were an unknown number of in-scope plans. No attempt has been made to impute the number of such plans or their violation rates. The inability to represent this portion of the universe results in some degree of underestimation of health plans in Table 2. Violation rates could be biased for the same reason in either direction, depending on whether violation rates among plans of unreachable firms were higher or lower than rates among reachable plans.

Due to the incremental contact strategy, the number of attempted contacts was not known until near the end of the project. The final counts (including plans investigated under recent, non-project Part 7 investigations) are shown in the sample size column below and in Table 1.

The probabilities of selection are therefore:

Sample	Universe Size	Sample Size	Prob. of Selection	Reciprocal of Prob. Of Select.
Large firm	134,016	623	0.00465	215.11
Small firm	4,957,773	1,604	0.000324	3090.88
Multis	2,169	510	0.2351	4.25
Total	5,093,958	2,737		

For multiemployer plans and for plans of large and small firms that cover no subsidiaries, the statistical weights are simply the reciprocals of the probabilities of selection, as shown in the last column. The probability of selection, P_i, for a plan i that covers L_i large subsidiaries[11] and S_i small subsidiaries is:

$$P_i = 1 - (1 - P_S)^{S_i} (1 - P_L)^{1+L_i}$$

P_S and P_L are the probabilities of selection for small and large firms (or subsidiaries). This formula, which is derived in Attachment 2, was applied solely in the large firm sample because no plans covering subsidiaries were identified through the small firm sample.

The weight for plan i is the reciprocal of P_i. Some of the weights that result from applying this formula using the large and small firm probabilities of selection shown above are:

[9] The random identification of the multiemployer and single-employer plans meant that we did not have reasonable cause under Section 504(b), so we did not open a new case on a sample entity's health plan for which we had an open case or closed case in the preceding 12 months. Section 504(b) of ERISA states that: "The Secretary may not under the authority of this section require any plan to submit to the Secretary any books or records of the plan more than once in any 12-month period, unless the Secretary has reasonable cause to believe there may exist a violation of this title or any regulation or order thereunder."

[10] Table 1 provides the complete list of the reasons why firms/plans were found to be out-of-scope along with frequency counts for each reason and sample.

[11] Parent companies are assumed to be large, so the number of large firms or subsidiaries is one more than the reported number of large subsidiaries.

Probabilities of Selection and Weights for Plans Covering Selected Numbers of Large and Small Subsidiaries

Subsidiaries Covered by Plan			
Large firms	Small firms	Plan Prob. Of Selection	Weight
0	0	0.004641	215.47
0	1	0.004963	201.51
0	2	0.005284	189.25
1	0	0.009260	107.99
1	1	0.009580	104.38
1	2	0.009900	101.01
2	0	0.013858	72.16
2	1	0.014177	70.54
2	2	0.014495	68.99
2	3	0.014814	67.50

2. Reliability of Estimates

PWBA attempted to minimize all types of error in this project. Nevertheless, violation rates estimated from this survey may differ from the true universe violation rates for a number of reasons:

- Sampling error
- Response bias
- Error in identification of firms with in-scope plans
- Sampling frame noncoverage
- Investigator error

a. ***Sampling Error***

This error refers to the risk that the true violation rate among sample plans and firms differed from the true violation rate among all plans and firms simply because the random sample did not perfectly represent the corresponding universe. This is the error that sampling theory attempts to control and statistical theory attempts to measure with tools such as confidence intervals.

Tables 3 and 4 provide lower and upper 95 percent confidence limits for violation rates for each sample and statute. The first row of Table 3, for example, shows a lower confidence limit of 41 percent and an upper confidence limit of 50 percent for the 45 percent point estimate of the overall Part 7 violation rate for all plans. The confidence limits indicate that there is a 95 percent chance that the interval from 41 percent to 50 percent brackets the true overall Part 7 violation rate.

b. ***Response Bias***

If the sample units from whom data cannot be collected are meaningfully different from sample units from whom data can be collected, the resulting response bias is a source of measurement error. Although response bias generally cannot be directly measured, a response rate is often computed to assess the potential for response bias. In this project, the response rate concept can be applied to phase I, to phase II, and to the project as a whole. For the large and small firm samples, the first phase involved calls by national office coordinators to sample firms provided by D & B. Coordinators were unable to contact 342 firms, 87 percent of which were in the small plan sample (Table 1). Thus for this phase of the effort, the response rate was 87.3 percent. Table A shows the derivation of this percentage and the considerable variation in these response rates across samples.

The second phase of the project was the investigation of plans determined in the first phase to be in-scope. PWBA has authority to investigate all in-scope health plans and consistently invoked this authority to achieve a 100 percent rate of response for the second phase.

Computing the response rates for phase 1 and 2 combined is more difficult because there is no way of knowing the percentage of unreachable firms that sponsored in-scope health plans, so the denominator of the overall response rate is not known. Because 70 percent of small firms that could be contacted were out-of-scope, it seems likely that among unreachable firms, the percentage out-of-scope would be at least that high. That assumption underlies the estimates that appear in the bottom row of Table A.

Because the actual percentage of unreachable firms that were out-of-scope could be as low as 0 percent or as high as 100 percent, combined phase 1-phase 2 response rates are also computed using these assumptions. The result is a range of possible overall response rates from a low of 78 percent (if all unreachable firms are in-scope) to a high of 98 percent (if all unreachable firms are out-of-scope). The response rate derived from the assumption that unreachable firms are in-scope to the same extent as reachable firms is 86 percent, and it seems reasonable to hope that this estimate is low.

c. ***Error in Identification of Firms with In-Scope Plans***

National office coordinators contacted sample firms to determine whether they sponsored health plans. Sample firms determined to have in-scope health plans were referred to the field for investigation. In some cases, the investigators found that the initial determination by the national office was wrong and that, in fact, the firm did not sponsor an in-scope plan. There was no comparable check for firms determined by the national office not to have health plans. Thus it is likely that national office coordinators failed to identify all firms that had health plans.

Coordinators began their contacts with firms by identifying themselves as employees of the Pension and Welfare Benefits Administration because less direct approaches were regarded as unethical. One reason that in-scope health plans may have been missed is that firms falsely claimed not to have a health plan because they knew they were speaking to a representative of the agency that investigates health plans. It is likely that violations rates among plans that were not identified were different from the violation rates measured, especially if deliberate evasion occurred.

d. ***Sampling Frame Noncoverage***

PWBA relied on the Form 5500 filings as the sampling frame for multiemployer plans, and on D & B for firm data. It is possible that multiemployer plans or firms with plans were missing from these frames. The potential for error from this source is probably small, however. Plans as large as most multiemployer plans are very unlikely to avoid filing partly because PWBA has a Division of Reporting Compliance that identifies nonfilers. Maintenance of the D & B database is a high priority for that company as it is the foundation for a number of that company's products. It is frequently used as a sampling frame for surveys of firms.

e. ***Investigator Error***

As described in the body of the report, PWBA devoted considerable resources to training investigators for Part 7 investigations. Nevertheless, human error in identification or reporting of violations may have occurred.

Table A. Response Rates in the Three Project Samples

Response Rate for	Sample			Total		
	Large	Multi	Small	Numerator	Denominator	Percent
Phase I - Determining if sample unit has in-scope plan	93.4%	99.2%	81.4%	1,267+1,090	1,267+1,090+342	87.3%
Phase II - Investigating in-scope plans	100	100	100			100
Phases I and II combined - Percentage of in-scope units with usable data						
Assuming unreachables are always out-of-scope	98.3	96.3	99.5	1,267+12	1,267+38	98.0
Assuming unreachables are always in-scope	90.7	95.4	56.8	1,267+12	1,267+38+342	77.7
Percentage of reachables found to be in-scope	81.4	84.7	30.2	1,267	1,267+1,090	53.8
Assuming unreachables are in-scope to the same extent as reachables	92.0	95.5	81.1	1,267+12	1,267+38+342x.538	85.9

Source: Table 1.

Attachment 1

Standard Industrial Classification Codes of Organizations Excluded from the Universes for the Samples of Large and Small Firms	
SIC	**Meaning**
43xx xxxx	U.S. Postal Service
8049 9905	Christian Science practitioner
8211 01xx	Catholic elementary and secondary schools
8211 03xx	Public elementary and secondary schools
8211 99xx	Elementary and secondary schools, nec[12]
8221 0202	Theological seminaries
8222 xxxx	Junior colleges
8299 9904	Bible school
8299 9913	Religious school
8231 03xx	General public libraries
8412 0101	Art gallery, noncommercial
8422 0103	Zoological garden, noncommercial
8661 xxxx	Churches, temples, and shrines and non-church religious organizations (convent, monastery, religious instruction)
8699 0201	Christian Science reading room
8699 0204	Reading room, religious materials
8999 0601	Christian Science lecturers
9xxx xxxx	Governmental and non-classifiable organizations

[12] Nec means "not elsewhere classified." Such schools would include non-Catholic religious schools, and possibly public-private hybrid schools such as charter schools.

Attachment 2

Computation of Plan Probability of Selection

A plan i is in the sample if the sponsoring firm or any of its subsidiaries that have employees covered under plan i is in the sample. Assume that firms with subsidiaries have 100 or more employees and therefore fall into the large category.

Let L_i be the number of large subsidiaries having employees covered under plan i.
Let S_i be the number of small subsidiaries having employees covered under plan i.

Let P_L be the probability of selection for large firms.
Let P_S be the probability of selection for small firms.

Let P_i be the probability of selection for plan i.

$1+L_i$ is the number of large subsidiaries or parents covered under plan i.
$1-P_L$ is the probability that one large subsidiary or parent is **not** in the sample.

$(1-P_L)^{1+L_i}$ is the probability that none of $1+L_i$ large firms or subsidiaries fall in the sample.

$1-P_S$ is the probability that one small subsidiary is **not** in the sample.

$(1-P_S)^{Si}$ is the probability that none of S_i large subsidiaries fall in the sample.

$1-P_i$ = P (Plan i is **not** in the sample)

= P (none of the S_i small covered subsidiaries are in the sample and none of the L_i large covered subsidiaries are in the sample)

= P (none of the S_i small covered subsidiaries are in the sample) × P (none of the L_i large covered subsidiaries are in the sample)

Substituting the two expressions derived above, we have:

$$1 - P_i = (1 - P_S)^{S_i} (1 - P_L)^{1+L_i}$$

solving for P_i yields:

$$P_i = 1 - (1 - P_S)^{S_i} (1 - P_L)^{1+L_i}$$