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Panelists: THOMAS F. WILDSMITH
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Recorder: THOMAS F. WILDSMITH

Summary: The Health Insurance Portability and Accountability Act affects all exchanges of health information. It has a major impact on health-care management and the distribution of health information used in underwriting and claim management practices for all medical and non-medical lines. Panelists discuss the Health Insurance Portability and Accountability Act and other timely issues, such as enterprise risk legislation and a patient's bill of rights. Panelists also discuss recent developments in federal legislation and their implications for insurers, providers, and employers.

MR. THOMAS F. WILDSMITH: This session deals with recent federal legislation and current legislative proposals. It is my pleasure and honor to introduce Cori Uccello. She is the new Senior Health Fellow at the AAA, and, speaking as a member of the Academy, we are very glad to have her on staff. Before joining the Academy, she was with the Urban Institute, which is one of the premier public policy think tanks in the Washington area. While at Urban, she did research on health-care issues and retirement issues.

MS. CORI E. UCCELLO: Instead of talking about recent health legislation that has already been enacted, I'm going to talk about what's currently being proposed and debated. Congress is now debating two types of health reform issues. The first deals with health insurance coverage expansions and the second deals with Medicare reform—both in terms of structural reform and updating the Medicare benefit package. In particular, adding a prescription drug benefit to Medicare is a hot topic these days.

I thought it would be a good idea if we took a quick look at health insurance expansions and who the uninsured are. In terms of age, about two-thirds of the uninsured are the working-age population between ages 19 and 54. In terms of income, about two-thirds of the uninsured are either poor—with incomes below

100% of the federal poverty line, or near poor—with incomes between 100% and 200% of the federal poverty line. In terms of work status, the vast majority of the uninsured are either working themselves or are in a household with a full-time or a part-time worker. In fact, only 18% of the uninsured are in households where neither they are working themselves nor is anyone else working.

What are the general types of health insurance expansion proposals? Well, there are two basic ways that we can expand health insurance coverage. One is through the public sector and the other is by expanding private health insurance. In terms of expanding public coverage, there are a few ways that can be done, and the first way is to increase Medicaid or the Children's Health Insurance Program (CHIP) enrollment for those who are currently eligible but not participating. Both Medicaid and CHIP are targeted toward low-income children. Two-thirds of the uninsured children are actually eligible for either Medicaid or CHIP. Increasing participation among those eligible would decrease the number of uninsured children.

A second way to expand public coverage is to expand Medicaid or CHIP eligibility. You can either make higher income people eligible for the programs or increase eligibility for adults and, in particular, have parents of eligible children also be eligible for either Medicaid or CHIP. Now the third way to expand public insurance is to expand eligibility for Medicare and, in particular, have Medicare buy-in allowed for early retirees and have those be subsidized for the low-income, early-retiree population.

In terms of expanding private insurance coverage, there are two ways that are currently being discussed. The first is to provide tax credits to individuals that they would then use to purchase health insurance in the private market. Another way is to provide tax credits to employers that subsidize insurance coverage for their employees. Most of the action in Congress these days is focused on providing tax credits to individuals, so that's where I'm going to focus most of my remarks.

In terms of a tax-credit program, the old saying that the devil is in the details is particularly true. How you design a tax-credit program will affect who will participate in the program and then, ultimately, how many people will become newly insured. One of the key issues is, what can the credit be used toward? Can it be used for employer-sponsored insurance (ESI), or can it only be used in the non-employer group market? In other words, will people have to go out into the individual market to purchase their coverage with a tax credit?

One of the effects of whether or not the credit is available for employer group coverages is, how will employers react? There's some concern that if the tax credit is only usable in the individual health insurance market, then employers might drop their coverage. In that case, you could actually end up with more people being uninsured than you started out with. Some proposals try different ways to address this potential problem. Another option is to combine the tax credit with CHIP funds so that families can buy family coverage in the private insurance market.

Another key issue is, how is the credit advanced? Is it a refundable credit or is it non-refundable? Clearly for low-income families who do not have any tax obligations, if the tax credit is not refundable, then they're not really getting any benefit from the program and shouldn't be expected to increase their insurance coverage. Second, is the credit advanceable or not advanceable? By that I mean, is it available in the beginning of the year for the insurance purchased for that year or is it only available at the end of the year for the insurance purchased? Clearly, for low-income people who don't have significant funds readily available, whether or not the credit is advanceable is a key issue, because they may find it more difficult to actually purchase the coverage unless the tax credit is advanceable.

An additional issue is whether, if the credit is based on income, the tax credit is reconciled or not reconciled. If the credit is advanceable, you get it at the beginning of the year. What happens if your income goes up during the year, do you have to actually pay back part of that tax credit? If that is the case, families might be hesitant to use a tax credit and purchase insurance coverage if they're afraid that they might have to actually pay some of the credit back at the end of the year.

The final key issue affecting participation is the amount of the credit and who is eligible for the credit. Clearly, as you go up the income scale and make more people eligible for the program, you'll increase participation and get more newly insured. Also, the higher the tax credit is, the more likely it will be used to purchase private insurance coverage. Another thing to keep in mind is whether the credit is a flat-dollar credit or premium related. A flat-dollar credit of, say, $1,000 might not be a large share of the premium cost for older people who might have some health problems; therefore, they might not end up using the credit to purchase insurance, and it might not do much to increase coverage.

What are some of the actual specific proposals that Congress is considering? I'm going to talk about three specific proposals. The first one is President Bush's plan, which is what he talked about during the campaign and then recently introduced. This would be up to a $1,000 tax credit for singles and up to a $2,000 tax credit for families. These are targeted to low- and moderate-income families for whom eligibility for the tax credit would range from about $35,000-45,000 for singles to about $45,000–55,000 for families. Under President Bush's plan, the tax credit could not be used toward employer-sponsored coverage. It would have to be used in the individual health insurance market. To increase participation, however, he has suggested that the credit be refundable, advanceable, and not reconciled.

The second proposal is one put forth by Senator Jim Jeffords (I-NH) and some of the moderate Democrats and Republicans. He would give a slightly more generous benefit to families: $1,000 for singles and up to $2,500 for families. Unlike the president's plan, however, the credits would be usable in the employer group market, but lower amounts would be available. You would get up to $400, if you were single to use toward your employee contribution for your employer coverage and up to $1,000 for family coverage. Another interesting part of the Jeffords plan is that you can use the tax credit in combination with funds available through the

CHIP program so that the family can go and purchase private insurance coverage either through the employer or in the individual health insurance market.

The final proposal is one put forth by Representative Richard K. Armey (R-TX) and some of the other Republican House members. This would be a $1,000 credit for singles and up to a $3,000 credit for families. Now, like the president's proposal, the tax credit could not be used toward employer coverage, whereas the Jeffords plan uses a carrot approach to provide incentives and subsidies for employers to continue providing health coverage. The Armey plan actually uses a stick approach and would penalize employers who drop coverage. There's also a "maintenance of effort" requirement in his plan.

Those are the basic proposals that are out there, but there are some outstanding issues to consider. First and foremost, how will employers respond? Will they drop the coverage? Will they shift more of the cost to the employees? How employers will respond will depend in part on whether the credit is available for use in the employer group market and the amount of the credit. If the credit is a low amount, and it's not available for use in the employer group market, employers probably won't drop their coverage, because their workers won't have access to subsidized coverage elsewhere. If the size of the tax credit is fairly high and would be a large share of the cost of a premium in the individual health market and the credit would not be available for employer coverage, we might see more employers actually dropping coverage.

Another question is, how will the non-employer group market respond? Will the individual health insurance market have affordable policies that people who claim the tax credit can actually use their credits for? And on a related issue, will purchasing pools crop up, especially for those people who have health conditions? Will they have access to affordable policies? How many individuals and families will participate, and, of those, what share of participants will be newly insured? In other words, how well targeted is the program? And, of course, the true bottom line, how much will it cost?

Here are some of the other expansion proposals that are being considered by Congress. There was a budget resolution a few weeks ago that would give $28 billion to help provide health insurance to the uninsured. There were no specifics along with this resolution. It's non-binding, but it's thought that they would use this money to increase Medicaid eligibility or CHIP eligibility to those parents of Medicaid and CHIP children.

There are several Medicare buy-in proposals out there as well that would base eligibility on age, whether you're a displaced worker, or your retiree health insurance was dropped. A key question regarding Medicare buy-in proposals is, what will the impact be on work, health, and retiree health insurance coverage? Many studies have found that if workers have access to health insurance coverage outside of employment, they retire somewhat earlier than people whose only source of coverage is through the workplace. That's something that needs to be considered as well.

There are a number of issues that are being considered in terms of Medicare reform. How do you restructure the Medicare program so that you can rein in some of the cost? There are three general approaches to this. First, you can modernize the current fee-for-service system in terms of negotiating pricing; second, modernize the Medicare + Choice system, which usually would entail competitive bidding; and third, implement a Federal Employees Health Benefits Program (FEHBP) type premium support system. This would give Medicare enrollees a fixed subsidy that they can then use to purchase a privately competing plan as well as the current Medicare or fee-for-service plan. They would then have to pay out of pocket any difference between the premium cost for that plan and their fixed subsidy.

In terms of updating the benefit package, there's debate on whether or not we should add a prescription drug benefit to the Medicare program, and there are also considerations on limiting out-of-pocket spending. On one hand there's concern that people aren't sensitive enough to the costs under the Medicare program because it has some limitedcost sharing, especially if you have a Medicare supplement policy. On the other hand, some people are spending a lot of money out of pocket, so there's concern about putting some stop-loss limit on out-of-pocket cost.

The Congressional Budget Office (CBO) estimates that spending for prescription drug coverage will amount to $104 billion in the year 2004. The majority of Medicare enrollees do, in fact, already have some prescription drug coverage; however, 27% of the Medicare population does not. And even for those who do have coverage, sometimes this coverage can be fairly limited.

There are four proposals that are out there to reform the Medicare system. The first two, President Bush's plan and Senator Tom Daschle's (D-ND) plan would add a prescription drug benefit to the program but not do anything else with respect to comprehensive Medicare reform. The two proposed plans by Senators John Breaux (D-LA) and William Frist (R-TN) will not only add a prescription drug benefit but also initiate some comprehensive Medicare reform.

President Bush's proposal is a short-term plan that's targeted toward low-income Medicare beneficiaries, and it will be administered through the states as opposed to the Medicare system. There would be free coverage to low-income seniors who have incomes below 135% of the federal poverty line; this will be on a sliding scale. No one over 175% of the poverty line will be eligible for a premium subsidy for prescription drug coverage. However, regardless of income level, everyone would have a stop-loss protection of $6,000.

The president also has a forthcoming, longer-term comprehensive Medicare reform plan that will include prescription drug coverage. Another prescription drug-only plan has been put forth by Senator Daschle and has a lot of support from congressional Democrats. This would be a voluntary prescription drug benefit offered through the Medicare Part D voluntary prescription drug system. It would be free for seniors up

to 135% of the federal poverty line, but everyone, regardless of income, would get a subsidy of at least 55% of the premium.

The two Breaux-Frist plans would not only implement prescription drug coverage, but would also make some reforms to the current Medicare system. The Breaux-Frist II plan is an incremental approach to Medicare reform. Voluntary prescription drug benefits would be available as a separate part of Medicare. There would be full coverage of premiums and co-pays for seniors with incomes below 135% of the poverty line, and everyone would get a subsidy of at least 25% of the premium. There would also be stop-loss protection above $6,000. In addition to providing the voluntary prescription drug benefits, the Breaux-Frist II plan would also modernize the current system and, in particular, implement a competitive bidding system for Medicare + Choice plans.

The Breaux-Frist I plan is a more comprehensive Medicare reform package, and it's based on the '99 Medicare Bipartisan Commission plan. This plan would be a premium support plan. Enrollees would receive a fixed subsidy, and any difference between the subsidy and the premium cost of the plan would have to be paid for out of pocket. It would include voluntary prescription drug coverage through a high-option plan. Any entity that wanted to offer a competitive plan would have to offer both a high-option plan and a low-option plan, and the high-option plan would have to include prescription drug coverage whose value is at least $800. It would also limit out-of-pocket costs for current benefits—that is, the non-prescription drug benefits—at $2,000.

Previously it looked like Congress was going to focus on adding a prescription drug benefit and implementing some comprehensive Medicare reform along the lines of the Breaux-Frist II plan, which would make an incremental reform to Medicare. However, since Senator Jeffords has left the Republican Party, and the Democrats have gained control of the Senate, it appears that Congress will focus mostly on just adding a prescription drug benefit and worry about Medicare reform later.

What would be the effect of a prescription drug coverage benefit on employers? The addition of a benefit to Medicare could potentially reduce costs under the retiree health insurance system, but that depends on a few features of the plan. Will employers be eligible for subsidies and/or reinsurance payments? Is there a maintenance of effort provision? And how would retiree health insurance coverage coordinate with a Medicare drug benefit? How will employers react? Will they drop their retiree health insurance coverage altogether or just the drug coverage itself or will they address the drug coverage so that it wraps around the new Medicare benefit?

Some surveys have asked employers what they would do if a prescription drug benefit were added to Medicare, and it appears in the short run that employers wouldn't make drastic changes. However, I think it's important to not just look at the short-term effects but also to consider the long-term effects. I think employers might be less likely to do something in the short term, but in the long term they may be more apt to make some changes. Current employers notwithstanding, we

need to consider what will happen when new firms crop up. Will they even offer retiree health insurance?

MR. WILDSMITH: My topic is federal regulation, and I will focus on the regulations implementing legislation that has already been enacted. Now, we've traditionally thought of insurance as being regulated at the state level. In particular, although the feds have always had something to say to employee benefit plans, we've tended to think of compliance as fundamentally a state issue. Compliance departments have been very plugged in with state laws and regulations. We are now facing a major sea change stemming from the federal legislation in the mid '90s, particularly the Health Insurance Portability and Accountability Act (HIPAA). Developing federal regulations is a slow and agonizing process—one that takes years to complete. The regulations stemming from HIPAA in '96 are now becoming final, and soon they will begin affecting the business of health plans in very fundamental ways.

HIPAA granted rather sweeping authority to regulate health plans under the rubric of privacy and administrative simplification. Again, the rules are just now becoming final. In general, there's a two-year period provided to allow affected parties to get into compliance with the new rules, but the clock is ticking now, and health plans need to be ready to comply with these rules as required.

The Clinton administration was also rather activist, and it's not just new legislation that health plans need to be concerned about. Some new rules are being issued under ERISA that do not reflect new federal legislation. These new regulations are being released under the aegis of existing statute because the Clinton administration wanted to get at some things that they were not able to get at legislatively. Since we only have a limited amount of time, I want to focus on the HIPAA administrative simplification and privacy rules because they're the newest things out there.

The regulations governing electronic transactions, the code sets used in those transactions, and the privacy rules for administrative simplification are out there now. This is going to reach down into your day-to-day operations in a way that the federal government has not done in the past. And, very significantly, we have not seen all of the regulations that HIPAA authorized in final form yet. The transactions and code set regulations are designed to standardize methods of transmitting information between different parties involved in health care.

They should standardize and simplify a lot of things. But because the rules are coming out incrementally and aren't coordinated with the security or privacy rules authorized by the HIPAA, you may find yourselves updating and changing your systems to bring them into federal compliance multiple times over the future year. A coordinating approach to issuing these rules would be much preferable. If anything, you want the security rules in place before you start bouncing this information around in standardized form.

The new regulatory structure will affect all sorts of electronic transactions. One of the key issues you need to be looking at is the concept of a maximum data set.

The Department of Health and Human Services (HHS) wanted to prevent health plans or employers from rejecting transactions because there wasn't enough information. Therefore, under the new rules, what's included in these standards is all you can ask for in a given transaction, and if it has everything that the regulation makes provision for, you have to accept it. Of particular concern is that the standard for claims attachments is not out yet. There is a standard for claims transactions, but it's routine to go back and ask for additional information on a claim. That's what the claims attachments are going to deal with.

What the provider community would like is a fairly tight definition of what a claims attachment is because that definition would effectively put a box around the additional information a health plan could go back and ask for. If that box is too tight, it's going to severely limit what you may or may not be able to do. It's very, very important to watch this. Again, I think the concept is fair. You want a standard that defines everything in a transaction in a way that everyone involved can communicate effectively, efficiently, and cheaply. But what you need to keep your eye on are the side effects that limit what you can do when adjudicating a difficult claim or when monitoring for fraud, abuse, waste, or other legitimate reasons.

Code sets are standardized by the new rules. Again, we've been moving toward standardized code sets for a long time for a number of good reasons. However, setting this in federal regulations eliminates the remaining wiggle room you had in the market for doing something non-standard with your own codes. That wiggle room may have already disappeared. Routine changes in coding are going to become very important because they're going to define the universe of what you use for communicating with everyone you do business with.

Privacy is a hot political issue for a number of reasons. The public is concerned about inadvertent or malicious disclosure of personal information. Most health information has serious personal consequences. It may even have implications for family members, particularly when you get into genetic information. The public is honestly very concerned about private health information. A recent Gallup survey showed that 85% of people did not want health insurers to have access to information on their claims without explicit permission. To gauge the intensity of public feeling on this, it's important to realize that 74% of the respondents didn't want their doctors to have access to their medical records without their permission.

We understand why we use health information, but people are understandably concerned, and that gives this issue real political traction. There's also a strongly held ideological line of reasoning that says that health information should not be used for any purposes other than guiding medical treatment and should certainly never be used against a person, particularly if it's something that he or she could not help.

There are many people who are perfectly comfortable with the fact that their smoking is used against them, but basically nothing else is fair game. That is not, in my opinion, the most common reason given for the privacy legislation, but it's certainly something in the background that drives many of the proposals you'll see.

When you get into the details, they really don't like the idea of underwriting and would like to use genetic testing or privacy proposals as the vehicle to prohibit it. HIPAA set up a fallback mechanism such that if Congress did not enact privacy legislation, the secretary of HHS would do it. My expectation was that Congress would not let the secretary take this out of its hands. I was wrong. Congress punted. And that's why HHS developed privacy regulations under the Clinton Administration. The Bush Administration decided to take a second look, held the effective date of the regulations up, and opened up a second comment period. They caught a whole lot of political flak. Understandably enough, they made what I think was a shrewd but disappointing political decision to let it lapse without changing the regulations.

HHS Secretary Tommy Thompson did say that there would be some guidance coming out that would give them the opportunity to fine-tune some of the problems in the regulations. Don't hold your breath for any fundamental changes. They likely will resort to relatively minor tinkering that administratively does not require opening up a new comment period. In my opinion that's the only prudent thing they can do in the current political environment. We will welcome anything they do to make the regulations better, but don't think they're going away. I'm a finance person, and I cannot give you legal advice, but don't be misled. These regulations have come out, and they will affect you. No one's going to save you.

Who does HIPAA affect? Health-care providers, health plans, and health clearinghouses—essentially, anyone in the business. The scope of the new regulations is very broad. It includes long-term care. It excludes disability income. If you're a disability insurance provider, there may be some side effects for your business.

What's protected? Any individually identifiable health information, that's been electronically transmitted or stored. If it's solely oral, or it's only on paper, it's not protected. If it ever goes through a fax machine, that's electronic. The odds are if you ask for it, it's protected—even down to the level of basic demographic information such as age and sex.

If you're into the legal jargon, HIPAA has an opt-in requirement as opposed to the Gramm-Leach-Bliley financial services legislation, which uses an opt-out approach. What that means is rather than telling people you're going to use the information and they're asking you not to, you'll have to ask them for permission to use it, unless you're using it for treatment purposes, payment purposes, or health-care operations. Fortunately, because of a great deal of work by the industry, most of what a health insurance plan would do routinely with the information is subsumed under health-care operations. Explicit authorization is required for everything else, including any sort of marketing.

The rights granted to consumers under HIPAA are quite expansive, and they're going to affect how you do your business. One thing that's particularly unfortunate is that consumers are granted the right to ask you to restrict the use you make of the information for these otherwise protected provisions of health-care, payment

and health-plan operations. That sets up some expectations that may not be met. You're not required to grant those restrictions. If you dogrant a request to restrict your use of private information, though, you're then bound by those restrictions. Unfortunately, explicitly granting consumers the right to ask for these restrictions, as if there was something out there preventing them from asking for them, is going to create some unfortunate expectations.

You have to keep an account, going back for six years, of everything you do with the information other than for payment, provision of care, and health-care operations. If one of your enrollees says, "OK, you have a lot of information about me on file, let me see it," you must let them see it. If they say something's wrong, you have to fix it. If they ask whom have you given it to in the last six years, you have to tell them. This is fairly intrusive, and it's likely to affect how you work on a clerical level.

The scope of who's affected is broad. HHS wishes the statute were broader. The administrative requirements are fairly extensive. Now, I'm convinced that the industry has done an exemplary job of ensuring the privacy and confidentiality of health information. But even if you have protected the confidentiality and security of your enrollees' health information ever since you began doing business, administratively you will have to do things the HHS way to comply with the new rules. You must have designated privacy officials and contacts. You must have written policies and procedures. And at the end of the day you will have to document that you complied with this regulation, which is far beyond anything the feds have done in the past.

Plan sponsors are not within the scope of HIPAA. HHS wishes they were. Thus, there are certain things you will have to do before you can give them protected health information. Essentially HHS is finessing the regulations to broaden the scope of the protections beyond what the statutory language contemplated. You can't give protected health information to plan sponsors until you're comfortable that the plan documents provide for its protection. The plan sponsors must be required by the plan documents to limit the use of this information to the operation of the plan and must be prohibited from tapping it for some extraneous employment-related purpose. Again, you can see the motivation for this. However, none of this is in the statutory language. It really is going further than Congress contemplated or authorized.

What is more problematic is that HHS really wants to regulate all the business associates with whom you might share information. These would include all your subcontractors or anyone else that you've shared information with in the routine course of business. There are limits on your liability, but, bottom line, your contracts with your business associates will require them to protect the information the way HHS wants, just like you're required to protect it. The statutory language did not grant HHS the power to regulate these entities, but technically what they are doing is regulating you by requiring you to put certain protections into your contractual language with your subcontractors.

One fundamental concept is that of a "minimum necessary" standard. I don't think we understand all the implications of this yet. Whenever you ask for or use or share information you must limit it to the minimum necessary required for that protected purpose. My suspicion would be that this would be a ripe area for litigation. It's certainly something you need to bear in mind. It is of particular concern because it may have the effect of limiting the information you get in ways that serve the purpose for that immediate transaction, but doesn't give you what you need to go back for anti-fraud, anti-abuse, and anti-waste initiatives that are really needed to control spending.

Since the feds are regulating us, does that help us on the state side? No, states can still do anything they want. In fact, state regulations can be different from the federal law and more stringent. So all the state regulations still apply.

What are some of the bottom-line, critical issues? The privacy, the transactions, and the security standards should be coordinated; however, it appears that they are not being coordinated as well as they should be. These regulations are coming out incrementally, and that may well mean that you're facing multiple systems upgrades, enhancements, and revisions, to keep you in compliance with a moving target. The minimum necessary standard may compromise quality control, anti-fraud, and other things that you need to be doing. The indirect regulation of business partners and plan sponsors is very troublesome. It shows a willingness to do things through regulation that someone reading the statutory language would not have understood congress was contemplating. It's a bad precedent for regulatory creep, which is probably not something we want in this area.

Disease management, preventive care, and wellness programs are considered "marketing" under the new regulations. That's not the way we've been thinking of them. I'm sure many health plans have pointed to the presence of these programs in their marketing materials as something that a potential purchaser might be interested in. But, we've never thought of them as being in and of itself as marketing. You will now need authorization to use the information for these purposes. This may well limit the growth of these programs and how effective they can be in the future.

In addition, as an aside, the rules for the use of information in research appear to be fairly strict, particularly the hoops you have to go through to make information anonymous for use in research. There's a conceptual firewall that's been created. You can do things with the information for quality improvement internally, but if you go to apply it in a broader context or to publish it as research applying to the health-care system more generally, it becomes research. A whole new set of rules and restrictions apply that may create a certain chill on the willingness of health plans to take internal quality control information and data and, when something interesting shows up, further develop it and make it available to the research community as a whole.

We're in a federally regulated industry. What we're seeing now is the fallout from the enactment of HIPAA in '96. If you've been watching, you know that Congress is

still considering many other regulatory requirements for health insurance. If, for instance, the patient's bill of rights passes this year, you're going to see a second wave of regulation that will have sweeping implications for what we do on a day-to-day basis. For years we've said that health insurance is regulated by the states. It's not that simple anymore. The federal regulation of health insurance is rapidly becoming very significant, and if Congress does much more, it may become equally as significant as state regulations.

MR. MARK ST-GEORGE: You mentioned that plan sponsors are indirectly regulated by the HIPAA legislation. Would that also apply to self-funded employers or would they be treated more as if they were a health plan and regulated directly? And how do you see HIPAA in general affecting employers who aren't really focused on this as much because it's not their core business?

MR. WILDSMITH: My understanding is most self-funded employers generally use someone outside their staff to do the routine administration. In that case it would be the TPA or the insurer doing the ASO contract that would fall directly under the scope of HIPAA. The health-plan issuer or administrator is restricted in what he or she can give to the health-plan sponsor unless the health-plan sponsor promises to protect it in accordance with HIPAA.

You ask a very important question, though. If the self-insured employer actually administers the plan, I suspect that would bring them under the scope of HIPAA. My guess is that self-insured employers are going to become even more conscious of wanting to have a firewall between the sponsorship of the plan and the administration of the plan, which I think would be a very prudent thing for them to do.

MR. PETER J. HENDEE: Are there specific penalties such as the $25 per 1099 you don't send out in this law, or is it pretty much up to the trial lawyers to enforce this?

MR. WILDSMITH: There are specific civil penalties. I believe it's $50,000 a year for a specific violation. Unfortunately there are also criminal penalties that are fairly extensive under the privacy law. I can get those for you. But opening it up and saying that they're criminal penalties I think is enough to get the trial bar in the door and is certainly cause for concern.

MR. BRIAN G. SMALL: Are there going to be any changes to the claim form under the HIPAA administrative simplifications? I read somewhere that there might be a merger of the UB-92 with the HCFA-1500.

MR. WILDSMITH: HIPAA doesn't require that. I wouldn't be surprised if it happened. What HIPAA specifically speaks to is the electronic transmission. What it addresses is what constitutes a claim if a provider wants to submit it electronically. If the provider chooses to submit it electronically, and everything in the standard is in that electronic transmission, you have to accept it. If you choose to ask for something on the paper form that is not in this electronic transaction standard, it

essentially becomes irrelevant because you cannot require people to use the paper form.