Contamination, or What is the Price of the HIPAA?

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Administrative simplification is more than a cliche; it is the Holy Grail for each of us who has to file income tax returns, fill in census forms, or even apply for credit cards, driver’s licenses, or passports. Certain professions, businesses, and governmental bureaucracies exist to assist us in our form-filling, filing, and applying. Wouldn’t it be great if the systems were such that data, once entered, would simply be manipulated and not require any re-entering? If the entered data could be reformatted to supply information to those who legitimately require it and then processed for our benefit, it would be a godsend. Such was the case with the administration of health data and claims. Indeed, if every health care service were to be entered and billed electronically, there would be significant savings compared with a paper process. During the 1980s, the Medicare administration, through its part B carriers, encouraged the electronic submission of claims by offering the provider a faster payment cycle. Not only did the Health Care Financing Administration (HCFA) encourage part B carriers to increase the receipt of electronic transmission, they gave them bonuses for reaching certain targets. To aid the carriers, the HCFA allowed them to treat faxed claims as electronic submissions in the calculation of their bonus payments.

However, once the claims became electronic, certain privacy and confidentiality concerns needed to be raised regarding individually identifiable health care information. Congress recognized the need for legislation, and the HCFA responded. Conceptually, privacy and confidentiality are not issues when a patient, an applicant for insurance, the requester for a driver’s license or passport, or the income tax filer willingly enters information in an electronic format and distributes it to a distinct entity for a specific purpose. However, this is not the way in which these transactions occur in health plans, health care clearinghouses, or with health care providers. After a physician or other health care provider sees a patient, diagnostic and procedure codes are recorded and filed, as are both date and location of service. A financial charge is affixed to the data, then adjudicated and resolved. There may not be a guarantee as to the secondary use of these data, which are identifiable and can be attributed to an individual. The diagnostic and procedure codes reveal much about an individual, as does the frequency and location of service as well as the financial data.

The desire to provide privacy and confidentiality to the electronic transmission of individually identifiable medical data is an estimable goal. The means by which this can be achieved range from a voluntary action to legislative direction. The latter may be a specifically targeted and focused approach or a broad governmental catchall–sledgehammer remedy. We in the life insurance industry are rapidly approaching a deadline to decide whether the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a targeted and focused enough approach to a problem of the health insurers, or if it is the
proverbial sledgehammer that will include us, the life insurers, if not intentionally.

The intent of the Act seems fairly clear. It was written to improve the portability and continuity of individual and group health insurance; to combat waste, fraud, and abuse in health insurance and health care delivery; to improve access to long-term care services and coverage; and to simplify the administration of health insurance. Originally, life insurance activities were not even included in the list of exclusions, for the authors of the legislation did not foresee a situation in which the applicant for an insurance policy, who had voluntarily submitted medical data directly or through a health care provider for purposes of risk selection, needed to be protected.

An issue that remains for life insurers is the health care plans, and providers may be confused as to which benefits are accepted under the HIPAA. Some providers may not be able to distinguish between health insurance and life insurance. Some may know that the payer is a health insurer who also sells long-term care insurance, both of which fall under the legislation. However, providers may fail to appreciate that the same insurer has a worker’s compensation book of business, insures motor vehicles, and issues life policies that do not fall under the legislation. At risk of incurring civil penalties of $100 per violation (to a total of $25,000 per patient) or even criminal penalties, the provider may plan to play on the safe side and assume that anything regarding health falls under the legislation.

Upon reviewing the ever-unfolding requirements of the HIPAA, some of the main issues are the intent, such as those that are covered; the services that are covered; and the business associates, affiliate entities, hybrid entities, and employees of a covered entity. The intent of the legislation is to provide a standard format for the electronic transmission of medical and claims data and to provide an assurance that the data or information derived from it are used in ways in which the patient understands and gives permission. Although the life insurance underwriter reviews medical data in the form of attending physician statements, blood tests, and electrocardiograms, how well is this differentiation understood by the health plan, health care clearinghouse, health care provider, patient, or applicant? Will the intent become so clouded that life insurance will be swept into covered entities or be treated de facto as covered entities on the coattails of those falling under the HIPAA regulations?

Those covered include health plans, health care clearinghouses, and health care providers. Although it is not the apparent intent of the legislation to sweep life insurance activities into covered entities, I believe that the clearinghouse designation, when defined as public or private entities that process or facilitate the processing of electronic health information, makes the status of the laboratory services provided by the insurance laboratories become murky in their designation. Certainly, the blanket of the HIPAA coverage seems to be avoided by laboratories that arrange for blood, urine, or oral fluid to be collected and processed for a variety of hematological, chemical, and other tests to screen for risk stratification for the offering of a life insurance policy. But what happens when the results are transmitted to the applicant’s primary care physician for the treatment of a previously unknown condition? What happens when a similar set of body fluids is submitted for analysis for the Employee Assistance Program or for work-site drug screening?

Similarly, what is the status of the health care provider of an electrocardiogram (ECG) who transmits both recording and interpretation electronically to the life insurance company, subsequently to discover that the tracing demonstrates an acute abnormality that requires immediate attention by a treating physician? Presumably, the service taking the electrocardiogram need not be HIPAA compliant to transmit the ECG and interpretation to a life insurance company. But to forward the same data to the applicant’s treating physician, HIPAA compliance must be present.

Services covered include a list of directly
covered entities (namely, health plans, healthcare clearinghouses, and healthcare providers) and indirectly covered persons or entities (namely, business associates, affiliated entities, hybrid entities [covered health care components], and employees of a covered component). Business Associate includes those who are covered with respect to another covered organization and applies to the performance of a function or activity involving the disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing. This does not apply only to the health care provider; specifically mentioned are providers of legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, and financial services. Affiliates include different services under a corporate structure as a life insurance operation that is owned by a health plan.

How will the rights of the patient play with the issuing of life insurance? Specifically, these rights include the right to review and amend but not to change medical records, to restrict disclosure, to limit psychiatric notes to the summary of the diagnosis and to make changes in authorizations, and to revoke an authorization.

In summary, what could contaminate life insurance companies and make them fall under the HIPAA regulations? We know that a completely paper-run office of a health care provider does not fall under the Act. If one set of records or tests is accepted in electronic format, then the office falls under the HIPAA. We know that faxes containing individually identifiable medical data are counted as electronic transfers, but are voice mail or telephone calls included? Is there a firewall between the part of the company that offers group health and group life insurance coverage and the part that offers life insurance and long-term care? How is the firewall constructed if the life insurer also operates a company health plan for its employees? At what point does a foreign-based life insurance company become contaminated by its other holdings or operations in the USA and conflict with the US law? What relationship does the law attribute to a life insurer and its agent? Perhaps some of these privacy issues fall under the Gramm-Leach-Bliley Act, but that is grist for another mill!

Editor’s note: The Editor was helped with the facts of the HIPAA by a number of individuals, including J. Huguenard, MD, and R. Gleeson, MD. The Editor, however, takes full responsibility for the content of the editorial and assures readers that it is not necessarily the position of the American Academy of Insurance Medicine. The main objective of the editorial is to stimulate thought, question, and comment in the life insurance industry about potential legislative challenges to our industry.