# STATEMENT OF

# THE AMERICAN INSURANCE ASSOCIATION

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**National Committee on Vital and Health Statistics**

**Subcommittee on Standards**

**on the**

**Applicability of Standards to Other Insurance Types**

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Introduction

This hearing stems from the Secretary's charge, under section 10109 of the Patient Protection and Affordable Care Act (PPACA), with reviewing the applicability of health data transaction standards to non-covered programs denoted under sections 1173 and 1172(a) of the Social Security Act, including health care transactions involving automobile insurance and workers' compensation. Property and casualty insurance was exempted from data transaction standards pursuant to sections 1173 and 1172(a), enacted with the Health Insurance Portability and Accountability Act (HIPAA), because Congress recognized that data requirements in group health payment systems and liability insurance systems differed. Still, as a practical matter, non-covered program payors recognize the need to ensure data standards applicable to these programs align as closely as possible to those applicable for group health purposes; the overwhelming percentage of health care spending funded through group health programs.

Regulations implementing HIPAA Standards for Privacy of Individually Identifiable Health Information Recognition also recognize distinctions between group health and liability systems. That regulation defines "health plan," "consistent with other titles of HIPAA . . . [to] not include certain types of insurance entities, such as workers' compensation and automobile insurance carriers, other property and casualty insurers, and certain forms of limited benefits coverage, even when such arrangements provide coverage for health care services."[1] In fact, the final rule clarifies that "excepted benefits" including "property and casualty benefit providers, are not health plans for the purposes of this rule."[2]

Although the focus of your inquiry is whether health data transaction standards should be uniformly applicable to exempted programs, we wanted to reinforce a broader point – of Congress' consistent recognition of the difference between health payment systems and liability systems – and the translation of that policy throughout federal healthcare legislation, including the Public Health Service Act and, subsequently, HIPAA, itself. In turn, the foundation for these exemptions lies in ERISA's exemption of property/casualty insurance from its definition of "group health plans" and its exemption of "workers' compensation plans" from preemption of state laws "relating to employee benefit plans."

Accordingly, there is a fabric of statutory and regulatory precedent distinguishing health plans and liability systems, including workers' compensation, and it is therefore critically important, in evaluating threads of this fabric, to take cognizance of its entirety.

Distinctions Between Health Plans and Liability Systems

There are distinctions because Congress recognized that not all systems were the same with the same informational needs. Workers' compensation payors – insurers

[1] 65 Federal Register No. 250; December 28, 2000; p. 82479. This distinction was preserved in the Department's reconsideration of the rule [67 Federal Register No. 157; August 14, 2002].
[2] Ibid, p. 82578.

and self-insured employers – require unimpeded access to medical information, to evaluate compensability and to effectively manage disability.

HIPAA rules, in section 164.512(l), expressly account for the distinction between workers' compensation insurance and health insurance, in adopting an exemption to an authorization, applicable to disclosures from covered entities, where the disclosure of "protected health information [is] authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault." In the context of this review of the application of HIPAA health data transaction standards to property and casualty insurance, it is useful to recall the broader policy basis on which insurers urged – and the Department agreed – to recognizing the different informational needs of workers' compensation insurers.

Property and casualty insurance differs from health and other types of insurance. The policyholder is typically not the party claiming benefits but rather is a party *against whom a third party is asserting legal rights* and to whom the insurer owes a contractual duty to defend and indemnify. The information a property and casualty insurer needs in evaluating and settling claims is not information in its possession but is information in the hands of the claimant-third party. It is critical for property and casualty insurers, most critically, workers' compensation insurers, to have unimpeded and timely access to medically related information to meet their obligations to their policyholders and under law. If not carefully crafted, medical privacy rules could give adverse third-party claimants the ability to circumscribe a carriers' need to share information with innumerable parties that are inherently part of claims evaluation and disability management.

Medical privacy rules must protect a workers' compensation insurer's ability to obtain, use, and disclose health-related information without an authorization, and it must not permit such exchanges to be subject to conditional release by an injured worker who has placed his or her medical condition at issue. Where an authorization for the release of medical records is obtained, in connection with other property and casualty claims (e.g., auto, liability), medical privacy rules must not impeded the carrier's ability to exchange information with other downstream parties for carrying out the carrier's legitimate insurance functions.

The bright-line distinction between obtaining a release for medical information in connection with a liability claim and exempting workers' compensation from authorization requirements is grounded on this fact: In property and casualty insurance (other than workers' compensation), a party still must prove *fault.* Failure to provide information necessary for the insurer to make a judgment about the merits of a party's claim means the plaintiff will be unable to prosecute the claim. At least up to the point where unfair claims settlement practice laws would apply (i.e., when liability and damages are reasonably ascertainable), the insurer could refuse further consideration of the claim. The key objective for liability insurance is to prevent interference with the downstream disclosures of information that embody legitimate insurance functions, such as exchanging information with industry data bases and protecting against fraud.

However, workers' compensation is a *no-fault* system. The insurer's obligation is to pay benefits – and to do so within a brief period following filing of a claim. The absence of an authorization requirement in workers' compensation ensures the carrier is able to obtain medical information expeditiously to make a timely judgment about the merits of the claim. Having made a timely judgment in favor of the claimant ensures benefits will be initiated promptly, as the statute requires. For this reason, it is imperative for the insurer to have unimpeded access to medical information to evaluate the merits of the claim and, subsequently, to manage medical treatment in order to ensure an expeditious recovery and return to work. A prompt return to work is important, not only in the interest of the injured worker but to limit the employer's exposure for payment of benefits for lost wages.

Furthermore, requiring, or providing for revocation of, an authorization at any state of a workers' compensation claims proceeding or payment period is completely unworkable, because the relative positions of the insurer (on behalf of its policyholder) and the employee may be and frequently are, adverse, during the claim evaluation and benefit payment period.

In order to effectively manage disability, workers' compensation insurers need the unimpeded ability to exchange medical information with a wide variety of participants to the workers' compensation system: employers, treating physicians, disability evaluators, vocational rehabilitation specialists, other insurers, anti-fraud databases, and state agencies responsible for administering the workers' compensation system. In some circumstances, the employee (and his or her attorney) may not view granting an authorization to be in the employee's legal interest; in other circumstances, an employee may not view granting an authorization as having an impact on the claim; and in still other circumstances, the employee may not be available for granting an authorization.

A workers' compensation insurer has a legitimate need to share information about an employee's injury with the employer, its policyholder. The employer-policyholder has a legitimate interest in the nature and extent of a loss and the impact on reserves and its experience modification, important in insurance pricing. The employer needs to know the prospects for and duration of the workers' recovery and whether job modifications will be necessary. The insurer and employer have a legitimate interest in improving the employer's ability to control losses.

Mandating an authorization in connection with a workers' compensation claim, where employees refused an authorization, would drive up medical treatment and indemnity costs, because the insurer would be required to continue treatment and wage loss payments pending the outcome of a hearing on the insurer's need for the information, or because the insurer would be required to seek a subpoena to otherwise obtain the information. Either way, the result will be extensive dispute and litigation – greater attorney involvement – in the workers' compensation system.

Other components of health-plan-focused medical privacy rules more adversely affect property and casualty insurance because of the legally adverse position of those asserting claims against policyholders' insurers are obligated to defend and indemnify

and the wider circle of contacts typically involved in resolving a property and casualty claim. However, property and casualty insurers' need for information is limited to that necessary for defending their policyholders. Medical information is not sold for marketing purposes.

More generally, property and casualty insurance should not be included in broad-based medical privacy rules designed to address confidentiality issues surround health plan practices. Any privacy rules affecting property and casualty insurance need to carefully consider the relative positions of the parties to a property and casualty insurance transaction, where a legally adverse party has placed his or her medical information at issue. And, finally, particular care needs to be taken in designing any medical privacy rules affecting workers' compensation, in view of the potential for undermining disability management and driving up employer costs.

Final HIPAA Rules Recognize Workers' Compensation Insurers' Informational Needs

As noted, HIPAA rules promulgated in late 2000, as well as those promulgated following further review in August 2002, expressly account for the different informational needs of workers' compensation programs. However, it is useful to restate the Department's analysis in reaching this conclusion, for it was carefully considered, in the context of Congress' prior history in excepting certain benefits from statutory definitions of "health plans."

> In drafting the proposed rule, the Secretary was faced with the challenge of trying to carry out the statutory mandate of safeguarding the privacy of individually identifiable health information by regulating the flow of such information from covered entities while at the same time respecting the Congressional intent to shield workers' compensation carriers and other excepted benefit plans from regulation as covered entities.
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> In the final rule, we include a new provision in this section that clarifies the ability of covered entities to disclose protected health information without authorization to comply with workers' compensation and similar programs established by law that provide benefits for work-related illnesses or injuries without regard to fault. Although most disclosures for workers' compensation would be permissible under other provisions of this rule, particularly the provisions that permit disclosures for payment and as required by law, we are aware of the significant variability among workers' compensation among workers' compensation and similar laws, and include this provision to ensure that existing workers' compensation systems are not disrupted by this rule.[3]
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> ……..

[3] 65 Federal Register No. 250, December 28, 2000, p. 82542.

In connection with the Department's re-evaluation of HIPAA rules at the outset of the Bush Administration, the re-issued rule retained the workers' compensation authorization exemption and re-stated its intent not to disrupt workers' compensation systems. Workers' compensation insurers had urged the Department to exempt, as well, workers' compensation from application of the "minimum necessary" information standard, contending that this standard effectively required medical providers to make legal judgments about the relevancy of medical information. Although the industry's request was rejected, the Department expressed again its intent not to disrupt workers' compensation systems:

> The Department understands concerns about the potential chilling effect of the Privacy Rule on the workers' compensation system. Therefore, as the Privacy Rule is implemented, the Department will actively monitor the effects of the Rule on this industry to assure that the Privacy Rule does not have any unintended negative effects that disturb the existing workers' compensation systems. If the Department finds that, despite the above clarification of intent, the Privacy Rule is being misused and misapplied to interfere with the smooth operation of the workers' compensation systems, it will consider proposing modifications to the Rule to clarify the application of the minimum necessary standard to disclosures for workers' compensation purposes.[4]

## Conclusion

What is abundantly clear from an extensive record of Congressional and Executive Branch actions spanning decades is a conscious recognition of the different informational needs of different payment systems, whether reflected in health data transactions or health privacy rules. We trust the Committee is equally cognizant of this long history, in its evaluation of the application of health data transaction standards to certain "excepted benefits," as well as any consideration of eliminating important distinctions in the Privacy Rule.

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[4] 67 Federal Register No. 157, August 14, 2002, p. 53199.