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Federal Regulation Comes 
To Private Health Care Financing: 
The Group Health Insurance Provisions 
of the Health Insurance Portability 
and Accountability Act of 1996

Jack A. Rovner*

I. ORIGIN AND OVERVIEW OF HIPAA’S FEDERAL HEALTH 
INSURANCE REFORMS

In 1993, newly inaugurated President Bill Clinton announced 
national health insurance reform to be a top priority of his ad-
ministration.1 But his Health Security Act,2 proposing compre-
hensive federalization of health care financing, generated a 
firestorm of controversy and opposition.3 It went down in 
flames with the Republican sweep of the 1994 congressional 
elections; federalization of health care financing was thought to 
be dead.4

As the 1996 national elections loomed, however, Congress 
cought health insurance reform fever and passed, with near una-
nimity, the Kassenbaum-Kennedy Bill.5 President Clinton 
promptly signed the bill into law as the Health Insurance Porta-
bility and Accountability Act of 1996 (“HIPAA”) on August 21,
Congress then took little more than a month to amend HIPAA and add the Newborns' and Mothers' Health Protection Act of 1996\(^7\) and the Mental Health Parity Act of 1996,\(^8\) both of which President Clinton signed into law on September 26, 1996.\(^9\) Federal regulation of the content of private health care financing was upon us.\(^{10}\)

Supposedly intended to make "modest" reforms to perceived health insurance market imperfections,\(^{11}\) HIPAA broadly affects every employer-sponsored health benefits plan and every health insurance issuer. It establishes federal limitations on the use of preexisting condition exclusions,\(^{12}\) federal rights for enrollment of spouses and dependents,\(^{13}\) federal minimum hospital lengths of stay after childbirth,\(^{14}\) federal requirements for financial parity of mental health benefits with medical benefits,\(^{15}\) and federal standards for guaranteed issuance and renewal of health care

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10. Employer-sponsored health benefits plans have been subject to exclusive federal supervision since the enactment of ERISA. See ERISA § 514. But unlike HIPAA, as discussed in this Article, ERISA does not regulate the content of employer-sponsored plans. It leaves benefit design to the employer-employee relationship and focuses instead on ensuring that employees are told of and receive the benefits employers offer. See id. § 1(b).

11. See, e.g., 142 Cong. Rec. H9807 (daily ed. Aug. 1, 1996) (remarks of Representative Costello that bill "makes modest, basic changes to our health care system... by prohibiting insurance companies and Health Maintenance Organizations (HMO's) from denying health care coverage to workers who move to another company or lose their jobs").

12. See infra section II(A).

13. See infra section II(B).

14. See infra section II(D).

15. See infra section II(E).
coverage for small groups and individuals. Its basic purpose is to guarantee continued availability of health care coverage to employees and their spouses and dependents who have group health insurance, without regard for medical condition and without additional periods of preexisting condition exclusion. It does this by adding:

(a) new Part 7 to the Employee Retirement Income Security Act of 1974 ("ERISA"), which federalizes regulation of employer-sponsored health benefits plans;

(b) new Title XXVII, Part A, to the Public Health Service Act ("PHS"), which brings federal regulation to private health insurance issuers that before had been primarily subject to state regulatory control; and

16. See infra section III.

17. The General Accounting Office reported that HIPAA's provisions should allow nine million job changers with five million dependents to continue health coverage without facing additional preexisting condition exclusions, and another three million job changers with two million dependents to face reduced preexisting condition exclusion periods prior to receiving full health care coverage. See Interim Rules for Health Insurance Portability for Group Health Plans, 62 Fed. Reg. 16,894, 16,909-10 (1997) [hereinafter "Interim Rules"].


HIPAA section 111(a) imposed federal reforms on health insurance markets for individual coverage by adding title XXVII, part B, to PHS. The requirements of the Newborns' and Mothers' Health Protection Act also apply to individual insurance markets, while those of the Mental Health Parity Act do not. Compare Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, Pub. L. No. 104-204, § 605, 110 Stat. at 2935 with Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, Pub. L. No. 104-204, § 703, 110 Stat. at 2944.

21. See McCarran-Ferguson Act, 15 U.S.C. § 1011-1015 (1997). Congress, in enacting HIPAA, showed sensitivity to state control of private health insurance issuers. It expressed the "inten[t] to defer to States, to the maximum extent practicable, in carrying out such requirements with respect to insurers and health maintenance organizations that are subject to State regulation, consistent with the provisions of the Employee Retirement Income Security Act of 1974." HIPAA § 195(a). ERISA preempts state regulation of employer-sponsored benefit plans, but not of insurance issuers. Compare ERISA § 514(a) with ERISA § 514(b)(2). Nonetheless, finding that "preexisting condition exclusions impact the ability of employees to seek employ-
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(c) new Subtitle K, chapter 100, and section 4980D to the Internal Revenue Code of 1986 ("I.R.C.")\textsuperscript{22} which conform the I.R.C.'s group health plan provisions to those HIPAA added to ERISA and PHS.\textsuperscript{23}

HIPAA provides a federal baseline for group health insurance that guarantees portability and renewal of health insurance coverage to those already with coverage. Specifically, HIPAA requires group insurers and plans\textsuperscript{24} to make their health insurance coverage\textsuperscript{25} available to anyone who has had health insurance

\textsuperscript{22} 26 U.S.C. §§ 1-9806 (1994 & Supp. 1996). Subtitle K, chapter 100, and section 4980D were added by HIPAA sections 401(a) and 402(a), respectively. Section 1531 of the Taxpayer Relief Act of 1997 added the requirements of the Newborns' and Mothers' Health Protection Act and the Mental Health Parity Act as I.R.C. sections 9811 and 9812, respectively, and renumbered I.R.C. sections 9804-9806 to sections 9831-9833. See Taxpayer Relief Act of 1997, Pub. L. No. 105-34, § 1531(a)(4), 111 Stat. 788, 1081, 1083 (1997).

\textsuperscript{23} HIPAA does many things aside from setting national minimum requirements for the portability and renewal of health care financing coverage. It substantially expands government authority and funding to combat health care fraud and abuse, see HIPAA §§ 201-264, 271; authorizes a four-year test for the issuance of advisory opinions on compliance with the anti-kickback statute, see HIPAA § 205; establishes a four-year pilot program for "medical savings accounts," see HIPAA § 301; and mandates the adoption and implementation of uniform national standards for the secure electronic transmission of health transactions and for the confidentiality of individualized health data, see HIPAA §§ 261-264. For a summary of these HIPAA provisions, see Jack A. Rovner, Analysis of the Provisions of the Health Insurance Portability and Accountability Act of 1996, 9 HEALTH LAW., No. 3, 1996, at 1. For a detailed review of the fraud and abuse control provisions of HIPAA, see Jack A. Rovner, Health Care Fraud and Abuse Control After HIPAA, 9 HEALTH LAW., No. 6, 1997, at 17.

\textsuperscript{24} HIPAA's group insurance provisions define a "group health plan" as "an employee welfare benefit plan to the extent that the plan provides medical care . . . to employees or their dependents . . . directly or through insurance, reimbursement or otherwise." ERISA § 733(a)(1); PHS § 2791(a)(1). The provisions define a "health insurance issuer" as "an insurance company, insurance service, or insurance organization (including a health maintenance organization . . .) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance [except it] does not include a group health plan." ERISA § 733(b)(2); PHS § 2791(b)(2).

Consistent with these statutory definitions, this Article uses the term "plan" to reference an employer-sponsored health benefits plan subject to ERISA and preempted from state regulation, and the term "insurer" to reference a health insurance issuer (including a health maintenance organization) subject to state licensure and regulatory control.

\textsuperscript{25} HIPAA defines "health insurance coverage" as "benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health main-
and who otherwise meets HIPAA's coverage eligibility requirements. In addition, insurers and plans offering dependent coverage must enroll dependents of insured individuals without waiting periods or preexisting condition exclusions, provided such dependents are enrolled within thirty days of marriage, birth, or adoption. Individuals who had, but are no longer eligible for, group health coverage, and who are not eligible for Medicare or Medicaid, must be accepted by health insurers offering individual coverage without preexisting condition exclusion, provided the individuals opted for and exhausted any available COBRA continuation coverage, had at least eighteen months of prior health insurance coverage or were enrolled as dependent children under HIPAA's special enrollment rights, have no other health insurance, and did not allow the lapse between their most recent group health coverage and their application for individual health coverage to exceed sixty-three days.

27. See infra section II(B).
29. COBRA continuation coverage allows an enrollee in a large-employer group health plan to continue the plan's coverage for up to eighteen months after employment ends or work hours are reduced, provided the enrollee pays the premiums for the coverage. COBRA added part 6 to ERISA, title XXII to PHS, and section 4980B to I.R.C. See Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (1986).
30. The option to obtain health coverage will not disqualify an individual otherwise eligible for individual market health coverage; the individual must have health insurance to lose guaranteed issue in the individual market. See Interim Rules, 62 Fed. Reg. at 16,986-87.
31. PHS §§ 2741, 2701 (added by HIPAA section 111). Individuals and dependents who do not meet HIPAA's eligibility requirements for guaranteed access to individual market health coverage are not guaranteed access to health insurance and are not protected from the imposition of preexisting condition exclusion periods.

HIPAA does not require portability from one individual market health coverage to another individual market health coverage. See Interim Rules, 62 Fed. Reg. at 16,987. Consequently, an individual, otherwise eligible to purchase an individual market policy, who takes a conversion policy upon leaving a group health plan or COBRA continuation coverage, forfeits HIPAA's guaranteed access to individual market health coverage because that individual would "have other health insurance" (the conversion policy), which coverage is not from a "group health plan." See id. Interestingly, an insurer is not permitted to terminate or decline to renew individual market health coverage because of Medicare eligibility, though the coverage may, if state law per-
HIPAA does not mandate that plans or insurers offer any specific health care coverage. To the contrary, HIPAA expressly states that none of its provisions “shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.”

Not even the Newborns’ and Mothers’ Health Protection Act or the Mental Health Parity Act requires plans or insurers to offer maternity or mental health benefits. What HIPAA and its amendments do is mandate that if medical, maternity, or mental health benefits are offered, they satisfy the federal minimums set by these enactments.

In setting these federal minimums, Congress did not address the cost of health insurance or the predicament of the uninsured. This omission leaves to state regulation or market forces how HIPAA’s insurance reforms will impact the cost of health coverage. While it seems likely that HIPAA will cause premium increases as plans and insurers cannot avoid or discriminate against risks based on preexisting conditions or health status, its impact on premiums may be tempered since it levels the playing field for health plans and insurers. All plans and insurers will be required to adhere to the federal minimums on preexisting condition exclusion periods and the federal ban on discrimination in enrollment and premiums based on medical or mental conditions. Such adherence should limit opportunities for plans and insurers to “cherry-pick” risks and for healthy enrollees to use adverse selection to opt for “low-priced” plans and insurers. Premiums may well increase, but the increases should be spread across all players in health coverage, thereby helping to ensure


32. HIPAA §§ 101, 102; ERISA § 731(c); PHS § 2723(c).

33. The amendments to ERISA, PHS, and I.R.C. made by the Newborns’ and Mothers’ Health Protection Act specify that the requirements “shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.” ERISA § 711(c)(2); PHS § 2704(c)(2); I.R.C. § 9811(c)(2). The amendments to ERISA, PHS, and I.R.C. made by the Mental Health Parity Act similarly specify that “[n]othing in [the mental health parity provisions] shall be construed ... as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits ....” ERISA § 712(b); PHS § 2705(b); I.R.C. § 9812(b).

34. The Congressional Budget Office concluded that “because HIPAA does not impose limits on premiums issuers may charge, insurance coverage, though available, may be expensive.” Interim Rules, 62 Fed. Reg. at 16,911. HIPAA therefore may “make insurance more portable for some people, [but] it would not dramatically increase the availability of insurance in general.” See id.
that increases are relatively even across plans and insurers, and relatively evenly borne by all with health care coverage.

HIPAA's group health coverage reforms became effective for most plans and insurers with the start of their plan years beginning after June 30, 1997. Group health plans maintained under collective bargaining agreements in place prior to August 21, 1996 became subject to HIPAA with their plan years starting after June 30, 1997 or the expiration of the last of the collective bargaining agreements, whichever is later. The maternity length-of-stay and the mental health parity provisions became effective with the start of plan years beginning after December 31, 1997. The mental health parity provisions will expire on September 30, 2001.

HIPAA required the Departments of Labor, Health and Human Services, and Treasury to cooperate and issue implementing regulations by April 1, 1997. Although the task was substantial, the Agencies proved up to the challenge. On April 8, 1997, the Pension and Welfare Benefits Administration ("PWBA") of the Department of Labor, the Health Care Financing Administration ("HCFA") of the Department of Health and Human Services, and the Internal Revenue Service ("IRS") of the Department of Treasury jointly issued interim final regulations for HIPAA's insurance reforms. Interim final

35. See HIPAA §§ 101(g)(1), 102(c)(1), 401(c)(1).
36. See HIPAA §§ 101(g)(3), 102(c)(3), 401(c)(3).
37. See Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, Pub. L. No. 104-204, §§ 603(c), 604(c), 702(c), 703(b), 110 Stat. at 2935, 2944.
38. See ERISA § 712(f); PHS § 2705(f); I.R.C. § 9812(f).
40. See Interim Rules, 62 Fed. Reg. at 16,894. The regulations implementing HIPAA's group insurance requirements became effective June 1, 1997 and are codified as follows:

(1) The rules issued by PWBA appear in 29 C.F.R. part 2590. These regulations generally apply to employer-sponsored group health plans and to insurers providing health coverage in connection with such ERISA plans. 29 C.F.R. §§ 2590.701-1 to .736 (1997).

(2) The rules issued by HCFA appear in 45 C.F.R. parts 144 and 146. These regulations generally apply to group health insurers and to certain state and local government plans. 45 C.F.R. §§ 144.101-103, 146.101-.184 (1997).


HCFA also issued interim final regulations to implement the reforms of HIPAA section 111 applicable to individual health insurance markets. These regulations became effective on Apr. 8, 1997. See 45 C.F.R. §§ 144.101-.103, 148.101-.220 (1998).
II. FEDERAL GROUP HEALTH INSURANCE REQUIREMENTS

A. Controls on Preexisting Condition Exclusion

HIPAA controls the use of preexisting condition exclusions.42 Plans and insurers may not impose a preexisting condition exclusion period, except (a) on an individual (including a dependent who has not been enrolled under a special enrollment right) who has yet to satisfy the maximum permitted preexisting condition exclusion period,44 or (b) on an individual (including a dependent) who failed to obtain new health insurance within sixty-three days after the termination of the individual’s prior health insurance.45

1. Duration Limits

A preexisting condition exclusion cannot exceed twelve months after the individual’s “enrollment date” in the plan or coverage, except for “late enrollees.”46 Preexisting condition exclusion for “late enrollees” may extend to eighteen months after the “enrollment date.”47

The “enrollment date” is the day that health coverage begins, but if a plan or insurer imposes a “waiting period” before coverage starts, the “enrollment date” is then the day that the “wait-

42. See ERISA § 701(a); PHS § 2701(a); I.R.C. § 9801(a).
43. No preexisting condition exclusion periods may be imposed on dependents who enroll under special enrollment rights. See ERISA § 701(d)(1), (d)(2), (f)(2); PHS § 2701(d)(1), (d)(2), (f)(2); I.R.C. § 9801(d)(1), (d)(2), (f)(2). See infra section II(B).
44. See ERISA § 701(a)(3); PHS § 2701(a)(3); I.R.C. § 9801(a)(3).
45. See ERISA § 701(c)(2)(a), (d)(4); PHS § 2701(c)(2)(a), (d)(4); I.R.C. § 9801(c)(2)(a), (d)(4). The Congressional Budget Office estimated that approximately 300,000 individuals will gain group health coverage, at a cost of approximately $300 million per year, as a result of HIPAA’s limitations on use of preexisting condition exclusion periods. See Interim Rules, 62 Fed. Reg. at 16,911.
46. See ERISA § 701(a)(2); PHS § 2701(a)(2); I.R.C. § 9801(a)(2). The regulations indicate that the twelve-month preexisting condition exclusion period is to be measured by 365 days. See 29 C.F.R. § 2590.701-4(c)(6)(ii) (1997); 45 C.F.R. § 146.113(c)(7)(ii) (1997); 26 C.F.R. § 54.9801-4T(c)(6)(ii) (1997).
47. See ERISA § 701(a)(2); PHS § 2701(a)(2); I.R.C. § 9801(a)(2). The regulations indicate that the eighteen-month preexisting condition exclusion period for “late enrollees” is to be measured by 546 days. See 29 C.F.R. § 2590.701-4(c)(6)(ii) (1997); 45 C.F.R. § 146.113(c)(7)(ii) (1997); 26 C.F.R. § 54.9801-4T(c)(6)(ii) (1997).
ing period” begins. A “waiting period” is a delay between the first day of employment and the first day of health coverage. HIPAA permits “waiting periods” for new employees, but bars “waiting periods” for dependents enrolled under a special enrollment right. Because “enrollment date” is defined to start concurrently with the start of a “waiting period,” the preexisting condition exclusion period runs concurrently with the running of a “waiting period.”

A “late enrollee” is an individual who does not enroll when first eligible under a plan or under one of HIPAA’s special enrollment rights. The period during which a “late enrollee” did not carry the plan’s coverage is not considered a plan “waiting period.” Consequently, the preexisting condition exclusion period for “late enrollees” begins on the day that coverage begins.

Health maintenance organizations (“HMOs”) may use an “affiliation period” instead of a preexisting condition exclusion period. The “affiliation period” may not exceed two months (three months for “late enrollees”), and it must start on the “enrollment date.” Like a preexisting condition exclusion period, an “affiliation period” runs concurrently with any plan “waiting period.” An “affiliation period” must be applied uniformly to all HMO enrollees without regard to health-related status. No premiums may be charged for the “affiliation period,” but no benefits need be provided either.

48. See ERISA § 701(b)(2); PHS § 2701(b)(2); I.R.C. § 9801(b)(2); see also 29 C.F.R. § 2590.701-3(a)(2)(i); 45 C.F.R. § 146.111(a)(2)(i); 26 C.F.R. § 54.9801-3T(a)(2)(i).
49. See ERISA § 701(b)(4); PHS § 2701(b)(4); I.R.C. § 9801(b)(4).
50. See ERISA § 701(f)(2)(C); PHS § 2701(f)(2)(C); I.R.C. § 9801(f)(2)(C).
51. See ERISA § 701(b)(2); PHS § 2701(b)(2); I.R.C. § 9801(b)(2).
52. See ERISA § 701(b)(3); PHS § 2701(b)(3); I.R.C. § 9801(b)(3).
54. See id.
55. See ERISA § 701(g); PHS § 2701(g).
56. See ERISA § 701(g)(1)(C), (g)(2)(B); PHS § 2701(g)(1)(C), (g)(2)(B).
57. See ERISA § 701(g)(2)(C); PHS § 2701(g)(2)(C).
58. See ERISA § 701(g)(1)(B); PHS § 2701(g)(1)(B).
59. See ERISA § 701(g)(2)(A); PHS § 2701(g)(2)(A). HIPAA permits an HMO to use any alternative to an “affiliation period” that is approved by the applicable state insurance commission to control adverse selection. See HIPAA § 101(a); ERISA § 701(g)(3).
2. Preexisting Conditions

Only medical or mental conditions existing six months before an individual’s “enrollment date” qualify as preexisting conditions. Qualifying preexisting conditions may be physical or mental. Pregnancy may never be treated as a preexisting condition.

A plan or insurer generally must determine if an individual has a qualifying preexisting condition by examining medical records such as diagnosis codes on bills, physician’s notes, prescription records, HMO encounter data, or similar evidence that medical services were recommended or received. A plan or insurer may not use a “prudent person” standard, which tests for preexisting conditions based on whether a prudent person would have sought medical care for the condition. This means that a medical condition identified by a medical examination conducted after an individual’s “enrollment date” cannot serve as a basis for imposing a preexisting condition exclusion unless there is independent medical evidence that such condition existed within the six month period prior to the individual’s “enrollment date.” Accordingly, if medical examinations are used to determine preexisting conditions, they should be administered before the individual begins employment. However, to avoid violating the Americans with Disabilities Act, regulators caution that such medical examinations should not be administered until after the individual has been offered employment.

3. Determining Duration: “Creditable Coverage”

An individual must receive credit toward any preexisting condition exclusion period for each day he or she is enrolled in any other health insurance or plan, the “creditable coverage”, provided that the individual has applied for new health insurance.
within sixty-three days of the end of enrollment of the prior health insurance. Because preexisting condition exclusion periods run from an individual’s “enrollment date,” individuals enrolled when HIPAA became applicable to a plan are entitled to “creditable coverage” from their enrollment dates, not from the HIPAA applicability date.69

All forms of health insurance qualify as “creditable coverage.”70 This includes health insurance from the group market, from the individual market, from private plans, from government plans (including Medicare, Medicaid, the Civilian Health and Medical Program of the Uniformed Services (“CHAMPUS”)),71 the Federal Employee Health Benefit Program (“FEHBP”),72 and state-sponsored risk pools), and from other domestic public plans,73 regardless of the duration of the coverage.74

“Creditable coverage” does not include days in a plan “waiting period”.75 “Creditable coverage” also does not include insurance providing no medical benefits, such as policies limited to dental, vision, long-term or nursing home care, a specific disease or illness, hospital indemnity or other fixed indemnity, or Medigap or similar supplemental insurance.76

A break of sixty-three consecutive days during which an individual has no health insurance results in the loss of all “creditable coverage” accrued before the start of the break.77

70. See ERISA § 701(c)(1); PHS § 2701(c)(1); I.R.C. § 9801(c)(1).
71. CHAMPUS is the federal program that provides health insurance to the eligible civilian family members of the uniformed service members. See 10 U.S.C. §§ 1071-1106 (1994).
72. FEHBP is the program that provides health insurance to federal employees. See 5 U.S.C. §§ 8901-8914 (1994).
73. The Agencies have requested public comment as to whether insurance provided under the public health systems of foreign countries, such as Canada or England, should be considered “creditable coverage.” See Interim Rules, 62 Fed. Reg. at 16,897.
74. See 29 C.F.R. § 2590.701-4(a)(1); 45 C.F.R. § 146.113(a)(1); 26 C.F.R. § 54.9801-4T(a)(1).
75. See 29 C.F.R. § 2590.701-4(a)(2); 45 C.F.R. § 146.113(a)(2); 26 C.F.R. § 54.9801-4T(a)(2).
76. See ERISA §§ 701(c)(1), 733(c); PHS §§ 2701(c)(1), 2791(c); I.R.C. §§ 9801(c)(1), 9832(c). HIPAA also does not apply to workers’ compensation, automobile, accident, disability, liability, and similar insurance which may provide medical care as benefits secondary or incidental to the primary purpose of the coverage. See HIPAA § 101(a); ERISA § 733(c)(1); PHS § 2791(c)(1); I.R.C. § 9832(c)(1).
77. See ERISA § 701(c)(2)(A), (d)(4); PHS § 2701(c)(2)(A), (d)(4); I.R.C. § 9801(c)(2)(A), (d)(4).
calculating a coverage break, time in a plan “waiting period” or HMO “affiliation period” is not taken into account even if the group coverage is never actually obtained (for example, a probationary employee leaves before expiration of the plan “waiting period”).

“Creditable coverage” may be calculated using the “standard method” or the “alternative method.” Under the standard method, “credible coverage” includes each day during which an individual carried health insurance. The benefits mix of the health insurance is irrelevant. If an individual had coverage from more than one plan or insurer on a particular day, the individual receives credit for only one day of coverage.

Under the alternative method which takes into account types of coverage, a plan or insurer is permitted to determine “credible coverage” independently for five categories of benefits: (a) mental health, (b) substance abuse treatment, (c) prescription drugs, (d) dental care, and (e) vision care. The plan or insurer may use the alternative method with any one or more of these benefit categories and may apply a different preexisting condition exclusion period with respect to each category (as well as to coverage not within a category). The alternative method must be applied uniformly to all plan participants.

78. See ERISA § 701(c)(2)(B); PHS § 2701(c)(2)(B); I.R.C. § 9801(c)(2)(B).
79. See Interim Rules, 62 Fed. Reg. at 16,898. The time for processing a substantially complete application for health insurance in the individual market is not taken into account in determining a break period, provided (unlike with group coverage) the individual ultimately purchases that individual coverage. See 29 C.F.R. § 2590.701-2; 45 C.F.R. § 144.103; 26 C.F.R. § 54.9801-1T. The purchase requirement to effect a tolling of the running of the break period is intended to prevent the use of repeated applications for individual coverage to evade the break period. See Interim Rules, 62 Fed. Reg. at 16,898.
80. See 29 C.F.R. § 2590.701-4(b); 45 C.F.R. § 146.113(b); 26 C.F.R. § 54.9801-4T(b).
81. See ERISA § 701(c)(3)(A); PHS § 2701(c)(3)(A); I.R.C. § 9801(c)(3)(A).
82. See 29 C.F.R. § 2590.701-4(b)(2); 45 C.F.R. § 146.113(b)(2); 26 C.F.R. § 54.9801-4T(b)(2).
83. See 29 C.F.R. § 2590.701-4(c)(3); 45 C.F.R. § 146.113(c)(3); 26 C.F.R. § 54.9801-4T(c)(3).
84. See 29 C.F.R. § 2590.701-4(c)(1); 45 C.F.R. § 146.113(c)(1); 26 C.F.R. § 54.9801-4T(c)(1).
85. See ERISA § 701(c)(3)(B); PHS § 2701(c)(3)(B); I.R.C. § 9801(c)(3)(B). The alternative method is applied by first determining an individual’s days of “credible coverage” under the standard method. This identifies the “determination period.” Each day within this “determination period” during which the individual had coverage for the benefits subject to the alternative method (whether consecutive or intermittent and without regard to any coverage breaks of sixty-three days or more) is counted as “credible coverage” applicable to the preexisting condition exclusion
A plan or insurer must, within a reasonable time after receiving evidence of "creditable coverage," determine whether the affected individual is subject to a period of preexisting condition exclusion. If a preexisting condition exclusion period is imposed, the affected individual must be given written notice, stating the basis for the determination, explaining any appeal procedures, and providing a reasonable opportunity for submitting additional evidence of "creditable coverage."

4. Proving Duration: "Creditable Coverage" Certificates

HIPAA establishes a process for providing individuals with evidence of "creditable coverage" through the issuance of certificates. Plans and insurers must track the periods of "creditable coverage" for each benefit category. See 29 C.F.R. § 2590.701-4(c)(6); 45 C.F.R. § 146.113(c)(7); 26 C.F.R. § 54.9801-4T(c)(6). The standard method is used for all benefits not within a benefit category for which the plan or insurer is using the alternative method. See 29 C.F.R. § 2590.701-4(c)(1); 45 C.F.R. § 146.113(c)(1); 26 C.F.R. § 54.9801-4T(c)(1).

Plan disclosure statements must specify each benefit category for which the alternative method is being used, and describe the effect of using the alternative method for that benefit category. This disclosure must be given to each enrollee at the time of enrollment. See ERISA § 701(c)(3)(C); PHS § 2701(c)(3)(C); I.R.C. § 9801(c)(3)(C). Insurers must make similar disclosure in coverage descriptions for enrollees and to each employer offered or sold coverage that uses the alternative method. See PHS § 2701(c)(3)(D).

The reasonableness of the determination time is measured "based on the relevant facts and circumstances," including whether imposing a preexisting condition exclusion period "would prevent an individual from having access to urgent medical services." See 29 C.F.R. § 2590.701-5(a)(1); 45 C.F.R. § 146.115(a)(1); 26 C.F.R. § 54.9801-5T(d)(1).

86. See 29 C.F.R. § 2590.701-5(d)(1); 45 C.F.R. § 146.115(d)(1); 26 C.F.R. § 54.9801-5T(d)(1). No notice is required if the determination is that no preexisting condition exclusion will be imposed. See Interim Rules, 62 Fed. Reg. at 16,901. A plan or insurer may reconsider and modify its determination based on evidence showing the individual did not have the claimed "creditable coverage." The plan or insurer must give the individual notice of the reconsideration, and must act in accordance with the initial determination until the further determination is made. See 29 C.F.R. § 2590.701-5(d)(2); 45 C.F.R. § 146.115(d)(2); 26 C.F.R. § 54.9801-5T(d)(2).

88. See HIPAA §§ 101(g)(2)(B), 102(c)(2)(b), 401(c)(2)(B). HIPAA required issuance of certificates starting on June 1, 1997. See id. HIPAA did not require the issuance of "creditable coverage" certificates before June 1, 1997. See HIPAA §§ 101(g)(2)(B)(i); 102(c)(2)(B)(i); 401(c)(2)(B)(i). Still, insurers and plans had to issue certificates no later than June 1, 1997, for each individual whose "creditable coverage" had ended between Oct. 1, 1996, and May 31, 1997. See Interim Rules, 62 Fed. Reg. at 16,906. HIPAA does not require the issuance of certificates for an individual whose coverage ended between June 30, 1996, and Oct. 1, 1996, unless the individual makes a written request for the certificate to the plan or insurer. See HIPAA §§ 101(g)(2)(B)(ii); 102(c)(2)(B)(ii); 401(c)(2)(B)(ii). As virtually no "creditable coverage" accrued prior to July 1, 1996, see HIPAA §§ 101(g)(2)(A)(i),
coverage” of their enrollees and enrollees’ dependents so that “creditable coverage” certificates can be issued to the enrollees and their dependents when their health insurance coverage ends and, again, when any COBRA continuation coverage ends.89 Certificates must also be issued upon written request by or on behalf of an individual within twenty-four months after the end of health insurance coverage or COBRA continuation coverage, whichever is later.90

102(c)(2)(A)(i), 401(c)(2)(A)(i), there is no requirement that plans and insurers issue certificates for periods before July 1, 1996. See 29 C.F.R. § 2590.736(b)(2); 45 C.F.R. § 146.125(b)(2); 26 C.F.R. § 54.9833-1T(b)(2). HIPAA permits individuals who need to establish “creditable coverage” for periods preceding July 1, 1996 to use “other credible evidence” in lieu of plan-issued or insurer-issued certificates. See HIPAA §§ 101(g)(2)(A)(ii), (g)(2)(C); 102(c)(2)(B)(ii), (c)(2)(C); 401(c)(2)(B)(ii), (c)(2)(C).

The Agencies estimated that the administrative cost to plans and insurers to issue “creditable coverage” certificates during 1997 would be $98 million and that the annual cost of certificate issuance after 1997 would be $84 million to provide approximately 59 million certificates each year. See Interim Rules, 62 Fed. Reg. at 16,917.

89. See ERISA § 701(e)(1)(A); PHS § 2701(e)(1)(A); I.R.C. § 9801(e)(1)(A). The certificate must issue within the time required for issuance of a COBRA notice. See 29 C.F.R. § 2590.701-5(a)(2)(ii)(A); 45 C.F.R. § 146.115(a)(2)(ii)(A); 26 C.F.R. § 54.9801-5T(a)(2)(ii)(A). COBRA notices must issue within fourteen days of the COBRA-qualifying event. See ERISA § 606(c); PHS § 2206; I.R.C. § 4980B(f)(6). Individuals without COBRA rights must receive their certificates within a reasonable time after the end of their health insurance coverage. See 29 C.F.R. § 2590.701-5(a)(2)(ii)(B); 45 C.F.R. § 146.115(a)(2)(ii)(B); 26 C.F.R. § 54.9801-5T(a)(2)(ii)(B). These “automatic certificates” need reflect only the most recent period of “creditable coverage” provided by the plan or insurer issuing the certificate. See 29 C.F.R. § 2590.701-5(a)(3)(iii); 45 C.F.R. § 146.115(a)(3)(iii); 26 C.F.R. § 54.9801-5T(a)(3)(iii).

90. See ERISA § 701(e)(1)(A)(iii); PHS § 2701(e)(1)(A)(iii); I.R.C. § 9801(e)(1)(A)(iii). Requested certificates must reflect each period of “creditable coverage” that occurred within the twenty-four months immediately preceding the date of the request. See 29 C.F.R. § 2590.701-5(a)(3)(iii); 45 C.F.R. § 146.115(a)(3)(iii); 26 C.F.R. § 54.9801-5T(a)(3)(iii).

“Creditable coverage” certificates must be provided in writing. See ERISA § 701(e)(1)(B); PHS § 2701(e)(1)(B); I.R.C. § 9801(e)(1)(B). The only exception permitted is when an individual requests that the certificate be sent to a plan or insurer, and that plan or insurer agrees to accept the certificate information by means such as telephone or electronic transmission. See 29 C.F.R. § 2590.701-5(a)(3)(i)(B); 45 C.F.R. § 146.115(a)(3)(i)(B); 26 C.F.R. § 54.9801-5T(a)(3)(i)(B).

The certificate must disclose: (a) its issuance date; (b) the plan or insurer that provided the “creditable coverage”; (c) the name of the participant or dependent to whom the certificate applies; (d) the individual’s “enrollment date” (the date that any plan “waiting” or HMO “affiliation period” began, if such a period was imposed before coverage began); (e) the date health insurance coverage began (if different from the “enrollment date” because of the use of plan “waiting” or HMO “affiliation periods”); and (f) the date health insurance coverage ended or, if appropriate, a statement that coverage is continuing as, for example, under COBRA. See 29 C.F.R. § 2590.701-5(a)(3)(ii); 45 C.F.R. § 146.115(a)(3)(ii); 26 C.F.R. § 54.9801-5T(a)(3)(ii).

Both plans and insurers bear the obligation to issue “creditable coverage” certificates. The regulations clarify that once one satisfies the obligation, the other is deemed in compliance. A plan can, therefore, satisfy its obligation by entering into an agreement with an insurer whereby the insurer accepts the certificate issuance obligation. Who bears the cost of tracking coverage and preparing and issuing certificates is left to negotiation among plans, insurers, and administrators. None may charge the individuals entitled to certificates for their issuance.

An insurer is not required to provide coverage information for coverage periods for which it was not responsible. Hence, if a plan replaces an insurer before an individual’s coverage ends or if an individual switches insurers by changing coverage op-

Reg. at 16,899 n.11. The certificate of a plan or insurer participant may include information about the participant’s dependents, provided that the certificate gives sufficient information to allow determination of the “creditable coverage” period of each individual included on the certificate. See 29 C.F.R. § 2590.701-5(a)(3)(iv); 45 C.F.R. § 146.115(a)(3)(iv); 26 C.F.R. § 54.9801-5T(a)(3)(iv). The certificate must give the name, address, and telephone number of the plan administrator or insurer required to issue the certificate and a telephone number where further information may be obtained. See 29 C.F.R. § 2590.701-5(a)(3)(ii); 45 C.F.R. § 146.115(a)(3)(ii); 26 C.F.R. § 54.9801-5T(a)(3)(ii). Certificates may be mailed first class to the individual’s last known address. If a dependent’s last known address is different from the participant’s, the dependent’s certificate must be sent to the dependent’s last known address. See 29 C.F.R. § 2590.701-5(a)(4)(i); 45 C.F.R. § 146.115(a)(4)(i); 26 C.F.R. § 54.9801-5T(a)(4)(i).

For individuals with at least eighteen months of “creditable coverage” not interrupted by a disqualifying sixty-three-day break, the certificate need state only that fact and the date coverage ended. See 29 C.F.R. § 2590.701-5(a)(3)(ii)(F)(1); 45 C.F.R. § 146.115(a)(3)(ii)(F)(1); 26 C.F.R. § 54.9801-5T(a)(3)(ii)(F)(1). This is because there is never a need to establish more than eighteen months of “creditable coverage” without a disqualifying break. See Interim Rules, 62 Fed. Reg. at 16,899. A plan or insurer using the alternative method of calculating “creditable coverage” may request of the certificate issuer information needed to determine the individual’s “creditable coverage” for any one or more of the five permitted benefit categories. See ERISA § 701(e)(2); PHS § 2701(e)(2); I.R.C. § 9801(e)(2). The requester may also ask for the plan’s summary plan description. See Interim Rules, 62 Fed. Reg. at 16,900. The plan or insurer providing the requested information may charge the requester the reasonable cost of providing the information requested. See ERISA § 701(e)(2)(B); PHS § 2701(e)(2)(B); I.R.C. § 9801(e)(2)(B).


91. See ERISA § 701(e)(1)(A); PHS § 2701(e)(1)(A); I.R.C. § 9801(e)(1)(A).
92. See 29 C.F.R. § 2590.701-5(a)(1)(ii); 45 C.F.R. § 146.115(a)(1)(ii).
93. See ERISA § 701(e)(1)(C); PHS § 2701(e)(1)(C); I.R.C. § 9801(e)(1)(C).
94. See ERISA § 701(e)(1)(A); PHS § 2701(e)(1)(A).
tions, the original insurer is obligated only to provide to the plan or subsequent insurer the data regarding the original insurer's coverage for the "creditable coverage" certificate which the plan or subsequent insurer will be required to issue when the individual's coverage ends. 96

The regulations acknowledge that plans and insurers often do not know the identity of dependents unless claims have been filed. 97 The regulations accordingly gave plans and insurers to June 30, 1998, to develop systems to capture the information needed to issue "creditable coverage" certificates for dependents. 98 After June 30, 1998, plans and insurers are required to use reasonable efforts to identify dependents and their coverage information and to issue "creditable coverage" certificates to them. 99 A plan or insurer is, however, not required to issue an automatic certificate for a dependent until it learns that the dependent's coverage has ended. 100 Plans and insurers must, however, make reasonable efforts to determine at least annually which dependents had coverage that ended, entitling the dependents to automatically be issued "creditable coverage" certificates. 101

An individual has the right to demonstrate "creditable coverage" even if no certificate has been issued. 102 Plan administrators and insurers are required to consider all information presented in determining whether "creditable coverage" exists and must treat an individual (including a dependent) as having provided a certificate if the individual: (a) attests to "creditable coverage" (or to dependency); (b) presents corroborating evi-

98. During the transition period of June 1, 1997, to June 30, 1998, plans and insurers were permitted to identify in the "creditable coverage" certificate only the covered participant and the type of coverage provided (e.g., family or employee-and-spouse). See 29 C.F.R. § 2590.701-5(a)(5)(iii)(A); 45 C.F.R. § 146.115(a)(5)(iii)(A); 26 C.F.R. § 54.9801-5T(a)(5)(iii)(A). If asked, a plan or insurer had to make reasonable efforts to identify covered dependents during that transition period. See 29 C.F.R. § 2590.701-5(a)(5)(iii)(B); 45 C.F.R. § 146.115(a)(5)(iii)(B); 26 C.F.R. § 54.9801-5T(a)(5)(iii)(B).
100. See 29 C.F.R. § 2590.701-5(a)(1)(ii); 45 C.F.R. § 146.115(a)(1)(ii); 26 C.F.R. § 54.9801-5T(a)(1)(ii).
101. See 29 C.F.R. § 2590.701-5; 45 C.F.R. § 146.115; 26 C.F.R. § 54.9801-5.
102. See ERISA § 701(c)(4); PHS § 2701(c)(4); I.R.C. § 9801(c)(4).
ence; and (c) cooperates with plan or insurer efforts to verify the “creditable coverage.”

B. Provision of Special Enrollment Rights

HIPAA provides special enrollment rights to newborns and adopted children, to new spouses, and to individuals losing other health coverage. No preexisting condition exclusion or coverage “waiting periods” may be imposed on newborns, adopted children, or children placed for adoption who are enrolled pursuant to their special enrollment rights.

Employees or their dependents who declined to enroll in a group plan when first eligible because they were covered under other health insurance are entitled to enroll within thirty days after losing eligibility for the other coverage. An employee or dependent may also take advantage of this special enrollment right if an employer providing the other coverage stops making contributions for the coverage.

If the other coverage is COBRA continuation coverage, COBRA must be exhausted before the thirty day special enrollment period begins. An individual is not, however, required to take COBRA to preserve this special enrollment right. An individual who loses coverage because of failure to pay premiums or for cause also loses this special enrollment right.

103. See 29 C.F.R. § 2590.701-5(c); 45 C.F.R. § 146.115(c); 26 C.F.R. § 54.9801-5T(c). Plans and insurers imposing preexisting condition exclusions must disclose this fact in written enrollment material for new participants and inform the participants of the right: (a) to apply prior “creditable coverage” toward the exclusion period; (b) to obtain “creditable coverage” certificates from prior plans or insurers or otherwise prove prior “creditable coverage”; and (c) to have the plan or insurer assist in obtaining such certificates. Plans and insurers may not impose preexisting condition exclusions until these disclosures are made. See 29 C.F.R. § 2590.701-3(c); 45 C.F.R. § 146.111(c); 26 C.F.R. § 54.9801-3T(c).

104. See ERISA § 701(f); PHS § 2701(f); I.R.C. § 9801(f). The Agencies estimated that HIPAA’s special enrollment rights will make 734,000 families eligible for health coverage because of marriage, and 701,000 families eligible for health coverage because of births. See Interim Rules, 62 Fed. Reg. at 16,912.


106. See ERISA § 701(f)(1); PHS § 2701(f)(1); I.R.C. § 9801(f)(1).


110. See 29 C.F.R. § 2590.701-6(a)(5)(ii)(B); 45 C.F.R. § 146.117(a)(5)(ii)(B); 26 C.F.R. § 54.9801-6T(a)(5)(ii)(B).
individuals enrolling under this special enrollment right are not "late enrollees," but are treated as though they were enrolling when first eligible and therefore, are subject to not more than twelve months of preexisting condition exclusion. Coverage obtained by this special enrollment right begins no later than the first day of the month following the request to enroll the employee or dependent. Therefore, no "waiting period" or HMO "affiliation period" between enrollment and coverage can be applied.

New spouses, newborns, adopted children, and children placed for adoption are eligible for coverage without preexisting condition exclusion or "waiting periods" if enrolled within thirty days of marriage, birth, adoption, or placement. A spouse may enroll when a newborn or adopted child enrolls under a special enrollment right. A child becoming a dependent as a result of marriage may be enrolled within thirty days of the marriage. The employee may also enroll within this thirty day period, though the preexisting condition exclusion provisions will apply fully to the employee.

Coverage obtained by special enrollment rights for newborns and children adopted or placed for adoption begins on the date of birth, adoption, or placement; coverage obtained by the special enrollment right for marriage begins no later than the first day of the month following the special enrollment request. Hence, no plan "waiting period" or HMO "affiliation period" can be applied to delay the start of coverage. Employees enrolling under these special enrollment rights are not "late enroll-

111. See 29 C.F.R. § 2590.701-6(a)(6); 45 C.F.R. § 146.117(a)(6); 26 C.F.R. § 54.9801-6T(a)(6).
112. See 29 C.F.R. § 2590.701-6(a)(7); 45 C.F.R. § 146.117(a)(7); 26 C.F.R. § 54.9801-6T(a)(7).
113. See 29 C.F.R. § 2590.701-6(a)(7); 45 C.F.R. § 146.117(a)(7); 26 C.F.R. § 54.9801-6T(a)(7).
114. See ERISA § 701(d)(1), (d)(2), (f)(2); PHS § 2701(d)(1), (d)(2), (f)(2); I.R.C. § 9801(d)(1), (d)(2), (f)(2). A plan or insurer need not offer dependent coverage, see ERISA § 701(f)(2)(A); PHS § 2701(f)(2)(A), but should it later elect to do so, it must provide this thirty-day special enrollment period to all plan participants and their dependents. See Interim Rules, 62 Fed. Reg. at 16,902.
118. See ERISA § 701(f)(2)(C); PHS § 2701(f)(2)(C); I.R.C. § 9801(f)(2)(C).
C. Prohibition of Coverage or Premium Discrimination

Plans and insurers may not use as rules of eligibility an individual’s health status, medical or mental condition, claims experience, medical treatment history, genetic information, disability, or evidence of insurability. Nor may plans and insurers charge disparate premiums to similarly situated enrollees based on health status.

HIPAA permits plans and insurers to select, on a nondiscriminatory basis, the coverage and benefits they wish to offer and the premiums they want to charge. State insurance laws, however, may regulate insurers with respect to both. For example, an insurer may exclude benefits for AIDS or cancer in its policies, but cannot deny coverage to an individual with AIDS or cancer when its policies otherwise provide AIDS or cancer coverage. Plans and insurers may also offer, on a nondiscriminatory basis, premium discounts, rebates, or modified copayments or deductibles to promote bona fide wellness programs and disease prevention.

The implementing regulations leave much regarding these nondiscrimination provisions unresolved. The Agencies requested further comment on a number of open issues, and indicated an intent to issue further regulations. Among the open

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120. See 29 C.F.R. § 2590.701-6(c); 45 C.F.R. § 146.117(c); 26 C.F.R. § 54.9801-6T(c). Plans must provide notice of these special enrollment rights to each individual who declines coverage when first eligible. See 29 C.F.R. § 2590.701-6(c); 45 C.F.R. § 146.117(c); 26 C.F.R. § 54.9801-6T(c). A model notice is provided in the implementing regulations.

A plan may, but need not, require an employee who declines coverage to declare in writing if the reason is other health insurance coverage. If the writing is required, the plan must provide a notice at the time an employee declines to enroll that failure to provide the written declaration will mean forfeiture of special enrollment rights. See ERISA § 701(f)(1)(B); PHS § 2701(f)(1)(B); I.R.C. § 9801(f)(1)(B).

121. See ERISA § 702(a)(1); PHS § 2702(a)(1). Department of Labor surveys suggest that approximately 135,000 workers will obtain health coverage because of these federal restrictions. See Interim Rules, 62 Fed. Reg. at 16912.

122. See ERISA § 702(b)(1); PHS § 2702(b)(1); I.R.C. § 9802(b)(1).

123. See HIPAA § 101(a); ERISA § 702(a)(2), (b)(2)(A); PHS § 2702(a)(2), (b)(2)(A); I.R.C. § 9802(a)(2), (b)(2)(A).

124. See ERISA § 702(b)(2)(B); PHS § 2702(b)(2)(B); I.R.C. § 9802(b)(2)(B).

125. See Interim Rules, 62 Fed. Reg. at 16,902. Plans and insurers will continue to have good-faith compliance protection from HIPAA enforcement regarding the benefits and coverage aspects of the non-discrimination provisions until these further regu-
issues are whether the nondiscrimination provisions should be construed to prohibit plans and insurers from providing lower benefits to certain individuals based on health-related factors, or from limiting benefits based on source of injury (for example, excluding coverage for injury sustained skiing or riding a motorcycle, snowmobile, all-terrain vehicle, or horse).\textsuperscript{126} Other open issues include whether "similarly situated" means plans and insurers may distinguish among employee groups with respect to benefits and premiums, as for example, between full-time and part-time employees, or among employees in different geographic areas, or among employees in different collective bargaining units.\textsuperscript{127} Also under consideration for further regulations are standards for determining bona fide programs to promote health and prevent disease, such as programs granting premium discounts for nonsmokers.\textsuperscript{128}

\textbf{D. Protection for Maternity Length-of-Stay}

The Newborns' and Mothers' Health Protection Act prohibits insurers and plans from restricting hospital length-of-stay in connection with childbirth to less than forty-eight hours for normal vaginal births or ninety-six hours for cesarean births.\textsuperscript{129} A new mother and baby may leave earlier when authorized by their attending provider,\textsuperscript{130} but no insurer or plan may attempt to influence the provider or the new mother to make such a determination.\textsuperscript{131} No insurer or plan can deny a new mother or newborn continued enrollment or renewal of coverage solely to avoid the length-of-stay mandates, offer monetary or other incentives to encourage attending providers to authorize or new mothers to take early discharge, or reduce or limit reimbursement of or otherwise penalize an attending provider that keeps a new mother and newborn in the hospital for the lengths permitted by the Act.\textsuperscript{132} The Act does \textit{not} require hospital birth or inclusion of maternity benefits in health insurance policies or benefits plans.\textsuperscript{133}
E. Parity for Mental Health Benefits

The Mental Health Parity Act requires that any aggregate lifetime or annual dollar coverage limits for mental health benefits be not less than any such limits for substantially all medical and surgical benefits. This mandate applies to plans sponsored by employers with more than fifty employees that provide both medical and surgical benefits and mental health benefits, and to insurers offering coverage to such plans. It does not apply to small employers with an average of two but less than fifty employees, or if it increases a plan’s cost of health coverage by one percent or more. The parity requirement expires on September 30, 2001.

The mental health parity requirements apply whether plans administer their mental health benefits with or separately from their medical and surgical benefits. Hence, a plan may not avoid mental health parity by offering mental health benefits in coverage separate from medical/surgical benefits. However, because the mandate applies independently to each benefits package option offered by a plan (for example, a plan that offers employees choice between indemnity insurance and an HMO, or a plan that provides a different benefits package to employees than it provides to retirees), mental health benefits within an option need match only the medical and surgical benefits of that option. Further, an aggregate lifetime or annual dollar coverage limit may be applied per enrolled individual or per group considered a “single unit,” such as a family or an employee and spouse.

Significantly, the Act does not require the inclusion of mental health coverage, nor does it affect cost-sharing, limits on visits,
or days of coverage, or otherwise affect the amount, duration, or scope of mental health benefits beyond the mandated financial parity. Nonetheless, the Equal Employment Opportunity Commission has cautioned that the Americans with Disabilities Act ("ADA") prohibits disability-based distinctions in an employer-provided health plan, including in the provision of mental health benefits, unless the plan falls within one of ADA’s health insurance risk or bona fide benefit plan exclusions.

1. Parity Compliance Standards

The implementing regulations prohibit any aggregate lifetime or annual dollar coverage limits on mental health benefits for plans that impose no such limits on medical and surgical benefits or that apply such limits to less than one third of their medical and surgical benefits. Plans that apply aggregate lifetime or annual dollar coverage limits to at least two thirds of their medical and surgical benefits must either: (a) adopt a single aggregate lifetime or annual dollar coverage limit for both medical and surgical benefits and mental health benefits; or (b) impose an aggregate lifetime or annual dollar coverage limit on mental health benefits that is not less than the limits imposed on medical and surgical benefits. A plan that satisfies neither the less-than-one-third nor the at-least-two-thirds standard must either: (a) eliminate aggregate lifetime or annual dollar coverage limits on mental health benefits; or (b) use the weighted average of each aggregate lifetime or annual dollar coverage limit that it

141. See ERISA § 712(b); PHS § 2705(b); I.R.C. § 9812(b). The Agencies estimated that the cost of mental health parity will be approximately $261 million per year, after accounting for possible responses by plans affected by the parity provisions such as amending, curtailing, or dropping mental health benefits. See Interim Rules for Mental Health Parity, 62 Fed. Reg. at 66,943.


143. See 29 C.F.R. § 2590.712(b)(2); 45 C.F.R. § 146.136(b)(2); 26 C.F.R. § 54.9812-1T(b)(2).

144. See 29 C.F.R. § 2590.712(b)(3); 45 C.F.R. § 146.136(b)(3); 26 C.F.R. § 54.9812-1T(b)(3). The less-than-one-third and at-least-two-thirds standards are calculated based on the dollar amount of all plan payments for medical and surgical benefits expected to be made during the plan year or that portion of the plan year after a benefits change that affects such limits. A plan may use "any reasonable method" to calculate whether the dollar amount expected to be paid will meet one of these standards. See 29 C.F.R. § 2590.712(b)(5); 45 C.F.R. § 146.136(b)(5); 26 C.F.R. § 54.9812-1T(b)(5).

Private Health Care Financing

applies to each category of medical and surgical benefits to
determine the limits it may impose on mental health benefits.146

The Act excludes treatment for substance abuse or chemical
dependency from the mental health benefits to which parity ap-
plies.147 Accordingly, plans may not include benefits for the
treatment of substance abuse or chemical dependency in deter-
mining the aggregate lifetime or annual dollar coverage limits
for mental health benefits.148 One potential effect of this exclu-
sion may be to discourage plans from offering substance abuse
and chemical dependency benefits as the cost of such programs
will be in addition to a plan's mental health parity compliance
obligation. The potential disincentives created by the Act for
substance abuse and chemical dependency treatment programs
is not clear.

2. Cost Increase Exemption

A plan satisfying and electing to take the one percent cost
increase exemption from the parity mandate will remain exempt
for the life of the Act, until September 30, 2001, even if the plan
thereafter changes benefits structure or insurers.149 To qualify
for the exemption, a plan must demonstrate that providing
mental health parity will increase cost by at least one percent
based on the following ratio:

\[
\frac{\text{IE}}{\text{IE} - (CE + AE)} \geq 1.01000
\]

IE represents a plan's actual "incurred expenditures" during the
"base period"; CE represents incurred "claims expenditures"
during the "base period" that would have been denied but for

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146. See 29 C.F.R. § 2590.712(b)(6)(i)(B); 45 C.F.R. § 146.136(b)(6)(i)(B); 26 C.F.R. § 54.9812-1T(b)(6)(i)(B). The weighted average is calculated by determining the weighted average of each aggregate lifetime or annual dollar limit imposed on each category of medical and surgical benefits to which the plan applies different limits. The weighing is done by the ratio of the dollar amounts of plan payments per category of medical and surgical benefits expected to be made during the plan year or that portion of the plan year after a benefits change that affects dollar limits. See 29 C.F.R. § 2590.712(b)(6)(i)(B), (b)(6)(ii); 45 C.F.R. § 146.136(b)(6)(i)(B), (b)(6)(ii); 26 C.F.R. § 54.9812-1T(b)(6)(i)(B),(b)(6)(ii).

147. See ERISA § 712(e)(4); PHS § 2705(e)(4); I.R.C. § 9812(e)(4).

148. See ERISA § 712(e)(4); PHS § 2705(e)(4); I.R.C. § 9812(e)(4).

149. See 29 C.F.R. § 2590.712(f)(1), (g)(2); 45 C.F.R. § 146.136(f)(1), (g)(2); 26 C.F.R. § 54.9812-1T(f)(1), (g)(2). A Price Waterhouse LLP study concluded that approximately ten percent of plans affected by the Mental Health Parity Act, covering about eleven million individuals, would incur cost increases of at least one percent to comply with the Act. See Interim Rules for Mental Health Parity, 62 Fed. Reg. at 66,940, 66,943.
the mental health parity requirements; and AE represents “administrative expenditures” attributable to complying with the parity requirements.\textsuperscript{150}

The “base period” begins at the start of the plan year in which the plan provided mental health parity and extends for at least six consecutive months thereafter, though the “base period” cannot begin before September 26, 1996, the date the Mental Health Parity Act became law.\textsuperscript{151} Consequently, a plan must implement mental health parity for at least six consecutive months to develop the kind of data the regulations require to be able to determine if the plan qualified for the cost increase exemption for the remainder of the life of the Act.\textsuperscript{152} Since dropping benefits may be problematic for employee relations, plans that qualify for the exemption based on six consecutive months of actual experience may nonetheless elect not to invoke it.\textsuperscript{153}

\textsuperscript{150} See 29 C.F.R. § 2590.712(f)(2); 45 C.F.R. § 146.136(f)(2); 26 C.F.R. § 54.9812-1T(f)(2). “Incurred expenditures” are defined as “actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical and surgical benefits, during the base period,” but excluding premiums. 29 C.F.R. § 2590.712(f)(2)(iii); 45 C.F.R. § 146.136(f)(2)(iii); 26 C.F.R. § 54.9812-1T(f)(2)(iii).


\textsuperscript{152} The Agencies characterized this construction of the cost increase exemption as a “modified retrospective approach” which, by using a six-month base period, should “assure the accurate measurement of increased costs while minimizing the burden on plan sponsors who wish to exercise the exemption as soon as accurate measurement can be made.” See Interim Rules for Mental Health Parity, 62 Fed. Reg. at 66,942. The Agencies adopted this approach because they concluded that the exemption should be “based on actual experience under the MHAP’s parity requirements and not on projections or estimates of such experience.” Id.

\textsuperscript{153} A plan that qualifies for, and elects to invoke, the cost increase exemption must provide notice of the election to participants, beneficiaries, and the appropriate federal agency. See 29 C.F.R. § 2590.712(f)(3); 45 C.F.R. § 146.136(f)(3); 26 C.F.R. § 54.9812-1T(f)(3). For plans subject to ERISA, that federal agency is PWBA; for nonfederal government plans, the agency is HCFA; church plans must provide the notice to IRS. See Interim Rules for Mental Health Parity, 62 Fed. Reg. at 66,937; 29 C.F.R. § 2590.712(f)(3)(ii); 45 C.F.R. § 146.136(f)(3)(ii); 26 C.F.R. § 54.9812-1T(f)(3)(ii).

The exemption does not become effective until thirty days after the notice has been delivered. See 29 C.F.R. § 2590.712(f)(1); 45 C.F.R. § 146.136(f)(1); 26 C.F.R. § 54.9812-1T(f)(1). Delivery of the notice may be by first-class mail or any other method permitted by ERISA § 104(b)(1). The notice is to be directed to each participant’s last known address and if a dependent’s last known address is different from the participant’s, separate notice must be directed to the dependent’s last known address. See 29 C.F.R. § 2590.712(f)(3)(i)(C); 45 C.F.R. § 146.136(f)(3)(i)(C); 26 C.F.R. § 54.9812-1T(f)(3)(i)(C).
Insurers may elect to limit their health insurance products in a state to one or more of the following market segments: (a) large groups defined as employers who employ more than fifty persons; (b) small groups defined as employers who employ between two and fifty persons; (c) members of a “bona fide association”; or (d) employers whose eligible individuals live or work within the service area of a “network plan.”154 Group insurers serving the small-group market,155 multiemployer plans,156 and ERISA multiple-employer welfare arrangements157 must continue in force and renew their coverage at the option of the plan or employer sponsoring or participating in the coverage unless there has been nonpayment of premiums, fraud, or violation of employer premium contribution or employer or em-
ployee participation rules. An insurer electing to serve a state’s small-group market must make available to every small employer in the state every small-group health insurance product the insurer actively markets in the state. If state insurance law permits, the insurer may require small employers to make minimum contributions toward premiums and have minimum levels of participation by the eligible individuals, but the insurer must enroll each individual who elects the coverage when first eligible under the plan or under one of HIPAA’s special enrollment rights without regard to the individual’s health status. Insurers in the small-group market are not required to accept “late enrollees.”

An insurer serving a state’s small-group market may deny coverage to additional small employers only because of inadequate underwriting capacity and on a nondiscriminatory basis, but that insurer will thereafter be precluded from offering further small-group coverage in the state for the longer of 180 days or until the state’s insurance commission is satisfied that the insurer has the financial capacity to service that market.

An insurer offering a “network plan,” a plan that furnishes services by a defined panel of contract providers, can deny coverage to an employer with no eligible individuals living or working inside the network’s service area. A “network plan”

158. See ERISA § 703; PHS §§ 2711(a), (e), 2712(a), (b); I.R.C. § 9803. At submission of this Article, no regulations had been issued to implement ERISA § 703 and I.R.C. § 9803 relating to multiemployer plans and multiple-employer welfare arrangements. See Interim Rules, 62 Fed. Reg. at 16,903-04.

159. See PHS § 2711(a)(1)(A); Interim Rules, 62 Fed. Reg. at 16,904. Insurers serving a state’s small-group market must disclose in their marketing materials that employers may have the following information upon request: (a) insurer’s right to change premiums and the factors that may affect premium changes; (b) coverage renewal options; (c) preexisting condition exclusions, including whether the insurer uses the alternative method of calculating “creditable coverage”; (d) if an HMO, any “affiliation period” and the geographic area served; and (e) the benefits and premiums of all health insurance coverage for which the small employer qualifies. See PHS § 2713. The information must be presented in language understandable by the average small employer and sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage. See id.

160. See PHS § 2711(e). Although HCFA has solicited comments on whether these terms should be defined by the HIPAA regulations, the implementing regulations leave to state law the definition of employer premium contributions and employee participation. See Interim Rules, 62 Fed. Reg. at 16,905.

161. See PHS § 2711(a)(1)(B).

162. See id.

163. See id. § 2711(d).

164. See id. § 2791(d)(10).

165. See id. §§ 2711(c)(1)(A), 2712(b)(5).
may decline to accept additional employers on a nondiscrimina-
tory basis if it demonstrates to the state’s insurance commission
that its network lacks the capacity to service the additional em-
ployers, but the insurer offering the “network plan” is thereafter
barred from offering further group coverage in the network’s
service area for 180 days.\textsuperscript{166}

An insurer offering coverage only through “bona fide associa-
tions” need not offer the coverage to nonmembers of the associ-
ation and may discontinue or refuse to renew coverage for a
member who leaves the association.\textsuperscript{167} A “bona fide associa-
tion” is an organization that has been in existence for at least
five years and was formed and is maintained for purposes other
than obtaining insurance.\textsuperscript{168} A “bona fide association” sponsor-
ing health coverage may not condition membership on health
status\textsuperscript{169} and the insurer providing the association’s coverage
must make it available to every association member without re-
gard to the health status of the member’s employees and depend-
ts.\textsuperscript{170} An association may not offer its health coverage to
nonmembers.\textsuperscript{171} If an association ceases to sponsor health cov-
erce for its membership, the insurer must continue in force and
renew the coverage it had offered through that association at the
option of each association member who had the coverage.\textsuperscript{172}

An insurer is permitted to modify its benefits packages at the
time of coverage renewal, provided the modifications are consis-
tent with state insurance law and, with respect to small groups,
are applied on a uniform basis to all participants using the modi-
fied benefits package.\textsuperscript{173} An insurer may discontinue particular
insurance products or withdraw completely from any one or all
of the market segments it serves within a state to the extent that
state insurance laws allow.\textsuperscript{174} An insurer discontinuing a partic-

\textsuperscript{166}. \textit{See id.} § 2711(c)(1)(B), (c)(2).

\textsuperscript{167}. \textit{See id.} §§ 2711(f), 2712(b)(6); Interim Rules, 62 Fed. Reg. at 16,905.

\textsuperscript{168}. \textit{See} PHS § 2791(d)(3)(A), (d)(3)(B). The regulations deem college health
plans as group coverage through “bona fide associations.” \textit{See} Interim Rules, 62 Fed.
Reg. at 16,919. Covered students accordingly earn “creditable coverage” while under
the college health plan, but do not have coverage continuation or renewal rights upon
leaving college and the plan. \textit{See id.}


\textsuperscript{172}. \textit{See} 45 C.F.R. § 145.152(b)(6).

\textsuperscript{173}. \textit{See} PHS § 2712(d).

\textsuperscript{174}. \textit{See id.} § 2712(c). If state insurance laws allow, an insurer that withdraws
completely from a particular market segment may still offer in the state HIPAA “ex-
cepted benefits,” such as policies limited to dental, vision, long-term or nursing home
ular product in a particular market segment within a state must provide the health plan sponsors, participants, and beneficiaries who had that product at least ninety days prior notice and offer the health plan sponsors the option to purchase other coverage the insurer offers to that market segment within the state.\(^{175}\) The product discontinuation must be uniformly applied within the affected market segment within the state.\(^{176}\)

An insurer withdrawing completely from a market segment within a state must provide the state insurance commission and the health plan sponsors, participants, and beneficiaries who had the insurer’s coverage at least 180 days prior notice.\(^{177}\) Once withdrawn, the insurer may not reenter that market segment within that state for at least five years.\(^{178}\)

IV. FEDERAL-STATE RELATIONS

A. State Law Preemption

State law that is inconsistent with the renewal, portability, childbirth length-of-stay, and mental health parity provisions of HIPAA is preempted.\(^{179}\) States may impose on insurers, though not on plans subject to ERISA, shorter preexisting condition exclusion periods or prohibit or further restrict their use, longer or expanded special enrollment rights, shorter HMO “affiliation periods,” and longer coverage break periods than required by HIPAA.\(^{180}\) States may also require insurers to offer more favorable mental health benefits than mandated by the Mental Health Parity Act.\(^{181}\) Consequently, multistate insurers may face different preexisting condition exclusions, special enrollment rights, break periods, and mental health parity obligations.

\(^{175}\) See PHS § 2712(c)(1)(A), (c)(1)(B).
\(^{176}\) See id. § 2712(c)(1)(C).
\(^{177}\) See id. § 2712(c)(2)(A).
\(^{178}\) See id. § 2712(c)(2)(B).
\(^{179}\) See ERISA § 731(b)(1); PHS § 2723(b)(1). There is no preemption of state law that regulates insurers in connection with their group health insurance coverage “except to the extent that such standard or requirement prevents the application of a requirement” of HIPAA. See ERISA § 731(a)(1); PHS § 2723(a)(1). HIPAA reaffirms preemption of state law affecting employer-sponsored welfare benefits plans. See ERISA § 731(a)(2); PHS § 2723(a)(2).
\(^{180}\) See ERISA § 731(b)(2); PHS § 2723(b)(2).
States may replace the federal childbirth length-of-stay mandates of the Newborns’ and Mothers’ Health Protection Act either with coverage requirements consistent with guidelines set by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations, or with the requirement that decisions on childbirth length-of-stay be left to the attending provider in consultation with the new mother without interference from the insurer or plan.182 Interestingly, state laws that satisfy these standards, thereby avoiding preemption, are not preempted by ERISA.183

B. Compliance Enforcement184

HIPAA favors state enforcement of HIPAA compliance by insurers.185 Only if HCFA determines that a state is failing substantially to enforce the requirements of HIPAA is federal enforcement against insurers permitted.186 HCFA is authorized to enforce HIPAA compliance by nonfederal government group health plans.187

In those situations where HCFA has enforcement authority, HIPAA empowers it to impose civil monetary penalties of up to $100 per day for each individual affected by the compliance failures.188 No penalty may be assessed, however, if the insurer or government plan did not know and, exercising reasonable diligence, would not have known of the compliance failures, or if the failures were due to reasonable cause and were not the result of willful neglect and are corrected within thirty days after

182. See ERISA § 711(f)(1); PHS § 2704(f)(1).
183. See ERISA § 711(f)(2); PHS § 2704(f)(2).
184. Before Jan. 1, 1998, plans and insurers complying in good faith with HIPAA and its implementing regulations were protected from enforcement. See HIPAA §§ 101(g)(5); 102(c)(5); 401(c)(5). Since Jan. 1, 1998, plans and insurers have been subject to HIPAA compliance enforcement, except for the benefits and coverage aspects of HIPAA’s nondiscrimination provisions and mental health parity compliance. The mental health parity implementing regulations protect plans trying to comply in good faith from compliance enforcement until the earlier of the first day of their plan years starting after Mar. 31, 1998, or Jan. 1, 1999. See 29 C.F.R. § 2590.712(h)(2); 45 C.F.R. § 146.136(h)(2); 26 C.F.R. § 54.9812-1T(h)(2).
185. See PHS § 2722(a)(1).
186. See id. § 2722(a)(2), (b)(1)(A).
187. See id. § 2722(b)(1)(B).
188. See id. § 2722(b)(2)(C)(i). HCFA is required to consider the compliance history of the violator and the seriousness of the violations in determining the amount of any civil monetary penalty to impose. See id. § 2722(b)(2)(C)(ii).
States are not permitted to enforce HIPAA against employer-sponsored welfare benefits plans; such plans are instead subject to ERISA enforcement provisions and the supervision of PWBA. Group health plans not in HIPAA compliance are subject to a tax penalty of $100 per day for each individual affected by the compliance failure. The tax penalties can reach $500,000 or more in specified situations.

As noted, plans and employers are not subject to the penalty taxes if they can establish that they did not know and, exercising reasonable diligence, would not have known of their compliance failures, or the compliance failures are due to reasonable cause and are promptly corrected after the compliance failures are discovered or, exercising reasonable diligence, should have been discovered. Correction of compliance failures means they are retroactively undone to the extent possible and the individuals affected are placed in the financial position they would have enjoyed had there not been compliance failures. Small employers that obtain health coverage from insurers are not exposed to tax penalties for HIPAA compliance failures caused solely by the coverage provided by the insurers.

C. State and Local Government Plan Opt-Out

Nonfederal government group health plans that are self-funded in whole or in part may, with respect to the self-funded

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189. See PHS § 2722(b)(2)(C)(iii). The insurer or nonfederal government plan has the burden of satisfying HCFA that it meets one or more of these exculpatory provisions. See 45 C.F.R. § 146.184(d)(7)(iii)(C). Penalties assessed by HCFA are subject to administrative appeal and judicial review. See PHS § 2722(b)(2)(D), (b)(2)(E).

190. See ERISA §§ 502, 504. PWBA has reserved issuance of specific HIPAA enforcement regulations. See 29 C.F.R. § 2590.734.

HIPAA does not authorize PWBA to enforce HIPAA compliance against insurers, even if the insurers are providing coverage in connection with group health plans. See HIPAA § 101(b) (adding ERISA section 502(b)(3)). HIPAA does authorize the Department of Labor to enter into agreements that empower the states to enforce some or all of HIPAA's requirements against multiple-employer welfare arrangements. See HIPAA § 101(e)(3) (adding ERISA section 506(c)).


192. See id. § 4980D(b), (c).

193. See id. § 4980D(c)(1), (c)(2).

194. See id. § 4980D(f)(3).

195. See id. § 4980D(d)(1).
portion, opt out of HIPAA’s insurance requirements. An opt-out is valid for the specified plan year or, with a collective bargaining agreement, for the term of the agreement. The opt-out must be renewed before each plan year, or for each new collective bargaining agreement, to remain in effect. An opt-out does not affect the obligation to provide “creditable coverage” certificates; and does not affect the obligation of insurers underwriting products for a nonfederal government plan to comply with all HIPAA insurance requirements.

V. FURTHER FEDERALIZATION OF PRIVATE HEALTH CARE FINANCING?

HIPAA is the first federal foray into regulation of private market health care financing. Medicare made the federal government a substantial purchaser of provider services, but Medicare is a government insurance program, not an effort to regulate private offerings for elderly coverage. ERISA freed employers from state regulation at the price of Department of Labor oversight, but ERISA also left benefit design primarily to

196. See PHS § 2721(b)(2). A state or local government plan electing to opt-out must provide written notice to plan participants at the time of enrollment and annually thereafter of the opt out election and the effect of that election on the participants’ coverage. See id. § 2721(b)(2)(C)(i). The notice must: (a) describe the HIPAA protections regarding limits on preexisting condition exclusion, rights to special enrollment, prohibitions on discrimination based on health status, protections for newborns and mothers, and parity for mental health benefits; (b) state that, pursuant to the HIPAA option which permits nonfederal government plans to elect exemption from any one or more of these protections for the self-funded portions of coverage, the plan has so elected; (c) identify the self-funded portions of coverage and the HIPAA protections affected by that election; and (d) identify any HIPAA protections the plan voluntarily (or as a requirement of applicable state law) is providing, notwithstanding its election to be exempt. See 45 C.F.R. § 146.180(g). Failure to make timely and sufficient notice voids the election. See id. § 146.180(i).

The opt-out is made by filing an election with HCFA which: (a) identifies the plan and gives the name and address of the plan administrator; (b) includes the notice to plan participants; (c) states that the plan is self-funded or identifies the portion of the plan underwritten by health insurers; (d) complies with all plan sponsor rules, including any required public hearings; and (e) is signed by an authorized plan representative. See id. § 146.180(b). The election must be received by HCFA at least the day before the beginning of the plan year or, if subject to a collective bargaining agreement, by the 30th day after the date of the collective bargaining agreement or its ratification. See id. § 146.180(c).

197. See PHS § 2721(b)(2)(B).
198. See id.
199. See id. § 2721(b)(2)(C)(ii).
201. See supra note 28.
employer-employee negotiation, not to federal decree. HIPAA ventures into the uncharted territory of federal control of private health insurance markets, historically the province of the states.

HIPAA has opened the door for federal solutions to perceived private market failures in health care financing. How far federalization of health care financing will go is hard to predict. A recent editorial in the Chicago Tribune observed that “[l]awmakers on both sides of the aisle, along with President Bill Clinton, are hot to pass a ‘bill of rights’ protecting consumers from unfair treatment by tight-fisted health-insurance plans,” and “to mandate coverage for one benefit or another . . . .” Will Congress, for example, move beyond protecting maternity length of stay to mandating maternity benefits? If Congress concludes that substance abuse is interfering with national economic productivity, will it require ERISA plans and health insurers to provide substance abuse treatment benefits? What of access to affordable private health coverage by the uninsured? Congress has the power to address such issues. HIPAA and its amendments suggests Congress has some appetite to do so. Just how wise is the federalization of private health care financing and how far should it go?

The federal approach can set minimum denominators that may force the expansion of risk pools to help combat adverse selection and improve access to coverage for high-risk individuals. However, spreading risk in this manner would likely mean higher premium costs for healthy insureds to subsidize the cost to insure heavy consumers of health care. As premium costs increase, so too may the numbers who cannot or choose not to afford insurance and who thereby increase the ranks of the uninsured. Significant premium cost increases could spur calls for cost controls and artificial premium caps which may result in short-term relief and often in longer-term decreases in available health insurance options.

Federal floors, as in HIPAA, leave much latitude for states to regulate. There are significant benefits to having fifty separate laboratories for social engineering to address perceived health care financing needs. Different states have taken differing approaches to mandating coverage, controlling premium cost, and

203. See supra note 21.
increasing availability. The results of these varying approaches provide invaluable information regarding the practical effects of different programs which may make access to health care affordable for wider segments of the population.

Multiple state regulation of health care financing does increase cost and compliance complexity for multistate insurers. Adding federal layers underneath or adjacent to the state requirements may only increase cost and compliance complexity. Avoiding the complexity of complying with the variety of conflicting state coverage mandates and other requirements was one of the rationales for ERISA's preemption of state regulation of employer-sponsored benefits plans. However, doing so leaves only congressional action to address perceived imperfections in employer-sponsored coverage. HIPAA's limitations on preexisting condition exclusion evidence this; no state could enforce such limits on employer-sponsored plans.

As reflected by ERISA, federalization of private health care financing could move beyond setting floors to setting the standards and occupying the field. The full impact of a federal takeover of private health care financing is difficult to fathom, and would almost certainty result in unintended and unanticipated effects. For these reasons, as well as our historical distrust of national power and preference for state regulation of insurance, Congress should be and is likely to remain quite reluctant to replace the states as the primary regulators of private health care financing. On the other hand, the speed and near unanimity with which Congress enacted HIPAA, then the Newborns’ and Mothers’ Health Protection Act and Mental Health Parity Act, suggest that further, perhaps substantial federalization of private health care financing is not as improbable as it may have once appeared.