

Special
points of interest:

- **Proposed Substance Abuse Parity**
- **Common HIPAA Portability & Discrimination Issues**

The following are excerpts from Spencer Research Reports:

Proposed Substance Abuse Parity

Rep. Jim Ramstad (Minn.) has introduced the Time for Recovery and Equal Access to Treatment in America (TREAT America) Act of 2005 (H.R. 1258), which would amend ERISA, the Internal Revenue Code, and the Public Health Service Act (PHSA) to provide parity for substance abuse treatment under group health plans and health insurance coverage. The bill was referred to the Ways and Means, Energy and Commerce, and Education and the Workforce committees.

Specifically, H.R. 1258 would amend ERISA, the Tax Code, and the PHSA to specify that, in the case of a group health plan or health insurance coverage that provides both medical and surgical benefits and substance abuse treatment benefits, the plan or coverage could not impose treatment limitations or financial requirements on the substance abuse treatment benefits unless similar limitations or requirements are imposed for medical and surgical benefits. However, the bill would not require a plan to provide any substance abuse treatment benefits.

Like the Mental Health Parity Act, H.R. 1258 would provide an exemption for employers with 50 or fewer employees. In addition, the bill would provide an exemption if the application of the provisions of the legislation results in an increase in the cost under the plan of at least 1%.

H.R. 1258 defines "substance abuse treatment benefits" as including inpatient treatment, including detoxification; non-hospital residential treatment; outpatient treatment, including screening and assessment, medication management, individual, group, and family counseling, and relapse prevention; and prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for substance abuse. Plans would be required to provide a notice to participants describing the protections of the bill.

If enacted, the provisions of the bill would apply with respect to plan years beginning on or after January 1, 2006.

BAS will keep you informed of the status of this proposed bill.

Common HIPAA Portability & Discrimination Issues

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Beginning in 1997, the Health Insurance Portability and Accountability Act established a variety of portability and discrimination rules for group health plans.

In terms of portability, HIPAA allows individuals whose coverage under one health care plan ends to maintain health care coverage (other than through COBRA continuation) in a new employer's group

health plan or in individual coverage, regardless of any preexisting medical conditions. Group health plans or their insurers may not deny coverage or apply preexisting conditions exclusions to individuals who had prior health coverage for at least 12 months, without a significant break.

HIPAA's nondiscrimination provisions generally prohibit a group health plan or group health insurer from using any health factors affecting an individual to deny that individual eligibility for benefits and to

charge a higher premium than they would charge a similarly situated individual without those health factors.

The following provides answers to common questions that have arisen regarding compliance with these HIPAA provisions.

Discrimination Prohibited In Eligibility

Q: I understand that a plan cannot deny eligibility for benefits or charge a higher premium based on a health factor. What are the health status-related factors?

A: The health status-related factors are: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. The term "evidence of insurability" includes conditions arising out of acts of domestic violence, as well as participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

HIPAA Preexisting Condition Rules Regarding Newborns

Q: An employee's newborn child as a congenital heart condition. The employee immediately enrolls the child in his group health plan, and the charges for his child's condition are covered. One month after the child is born, the employee is terminated and he finds a new job within a week. The new employer tells the employee that the child's congenital condition will not be covered until the child is covered for 11 months (one month credit is given for prior coverage).

Have there been any rulings or guidance concerning the amount of credit that must be applied to a preexisting condition if a child's age is less than a plan's preexisting limitation period?

A: HIPAA prohibits applying preexisting condition exclusions to newborn or adopted children younger than age 18, who are/were covered within 30 days of becoming eligible for previous or current coverage, as long as there is no significant break in coverage (63 days). Specifically, the HIPAA statute states that a group health plan may not impose any preexisting condition exclusion in the case of:

1. an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage;

2. a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage; and
3. pregnancy.

Thus, in this particular case, the new group insurance must cover all applicable treatment for the new employee's newborn child.

Application To Benefits

Q: May a group health plan impose a 12-month pre-existing condition exclusion period but waive the exclusion period after the first six months since enrollment for individuals who have not had any claims during that time?

A: No. A group health plan may impose a preexisting condition exclusion period, but the exclusion must be applied uniformly to all similarly situated individuals. In the situation in question, the plan's provisions do not apply uniformly because individuals who have medical claims during the first six months following enrollment are not treated the same as similarly situated individuals with no claims during that period. Therefore, the plan provision violates the HIPAA nondiscrimination provisions.

Non-Confinement, Actively-At-Work Provisions

Q: A group health plan has a non-confinement provision which states that if an individual is confined to a hospital at the time enrollment eligibility begins, such eligibility is postponed until that individual is no longer confined. Is this permissible?

A: No. A group health plan may not restrict an individual's eligibility, benefits, or the effective date of coverage based on the individual's confinement to a hospital or other health care facility. Additionally, a health plan may not set an individual's premium rate based on the individual's confinement.

Q: A group health plan has a 90-day waiting period for enrollment. Under the terms of the plan, if an individual is actively-at-work on the 91st day, health coverage becomes effective on that day. If an individual is not actively-at-work on the 91st day, the effective date of coverage is delayed until the first day the indi-

vidual is actively-at-work. If an individual misses work on the 91st day due to illness, can he or she be excluded from coverage under the plan's actively-at-work provision?

A: No. A group health plan or issuer generally may not refuse to provide benefits because an individual is not actively-at-work on the day the individual would otherwise become eligible for benefits. However, these actively-at-work clauses are permitted if the plan treats individuals who are absent from work due to a health factor (for example, individuals taking sick leave) as if they are actively-at-work for purposes of health coverage. Nonetheless, a plan may require an individual to **begin** work before coverage may become effective. Additionally, plans may distinguish among groups of similarly situated individuals (for example, a plan may require an individual to work full time, such as 250 hours per quarter or 30 hours per week) in their eligibility provisions.

Enrollment Date

Q: What is the HIPAA definition of the enrollment date for health care plans?

A: HIPAA defines enrollment date as the first day of coverage or, if there is a waiting period, the first day of the waiting period (typically the date employment begins). The individual's enrollment date remains the same for an individual if, subsequent to initial enrollment, a group health plan changes benefit package options, or if the plan changes group health insurers.

This definition is important in several parts of HIPAA:

- A pre-existing condition exclusion must relate to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date. Any permitted pre-existing condition exclusion period is measured from the individual's enrollment date in the plan (even if the enrollment date is before the statutory effective date).
- The exclusion period cannot extend for more than 12 months (18 months for late enrollees) after the enrollment date.
- The pre-existing condition exclusion period is reduced by the individual's days of creditable coverage as of the enrollment date.
- The enrollment date for a late enrollee or anyone who enrolls on a special enrollment date is the first date of coverage. Thus, the time between the date a late

enrollee or special enrollee first becomes eligible for enrollment under the plan and the first day of coverage is not treated as a waiting period.

Special Enrollment

Q: When a HIPAA special enrollment event arises, such as a birth, adoption, or marriage, must all eligible dependents be allowed to enroll in the group health plan (although the law says that the employee can enroll himself and his wife in the event of a child's birth)?

A: Department of Labor regulations for HIPAA specify that eligible individuals who previously turned down coverage under the employee's plan may qualify for a special enrollment when they lose other group health coverage or they "acquire" a new dependent through marriage, birth or adoption. For loss of other coverage, the employee may enroll himself/herself and/or the employee's eligible dependents who lost other coverage.

In cases of birth, marriage, adoption, or placement for adoption, the regulations specify that the employee and the spouse can enroll, along with a new dependent. A child who becomes a dependent of a participant or eligible employee as a result of marriage, birth, adoption, or placement for adoption may be enrolled when the child becomes a dependent, as long as the employee is enrolled. Although it is not specifically addressed in HIPAA or the DOL regulations, it appears that, as provided in the health plan's enrollment provisions, when an employee can enroll himself/herself and the employee's dependents, all of the eligible dependents may be enrolled.

Final regulations issued on December 30, 2004, clarify that individuals who enroll during a special enrollment period must generally be treated the same as individuals who enroll when first eligible. That is, relative to similarly situated individuals who enroll when first eligible, special enrollees must be offered all the same benefit packages, cannot be required to pay more for coverage, and cannot be subject to a longer pre-existing condition exclusion.

Thus, as provided in the health plan's enrollment provisions, when an employee can enroll himself/herself and/or the employee's dependents, all of the eligible dependents may be enrolled. And when a dependent is first being enrolled during a special enrollment period, an employee who: did not enroll in the group health plan when first eligible also may enroll herself and all other qualified dependents; or is already enrolled in a benefit package may change enrollment to another benefit pack-

age under the plan.

An individual also has a special enrollment right when a claim is incurred that would exceed a lifetime limit on all benefits from another health plan, and the right continues at least 30 days after the earliest date that a claim is denied due to the lifetime limit. However, generally, a dependent child's becoming eligible for a state's Child Health Insurance Program (S-CHIP) is not a special enrollment event.

For example, Mr. & Mrs. Jones and their three-year-old son, Sam, did not enroll in Mrs. Jones's employer's plan when they were first eligible, but when their second child is born, they decide to enroll the family. The HIPAA regulations say that Mrs. Jones may enroll herself and Mr. Jones and their new child during a special enrollment, and since the plan says eligible employees can enroll themselves and their eligible dependents, Mrs. Jones can enroll the entire family, including Sam at the same time.

Q: Is a HIPAA special enrollment period triggered when a group health plan for an employee's spouse raises the premium substantially or by a certain percentage?

A: No. HIPAA does require group health plans to provide special enrollment periods during which individuals who previously declined coverage, or newly acquired dependents, may enroll without having to wait until the plans' next open enrollment period (when available). However, special enrollments are required only in the following circumstances: a person with other health coverage loses that coverage; or a person becomes a dependent through marriage, birth, adoption or placement for adoption. No special enrollment period applies if the other health coverage was terminated due to non-payment of premiums.

HIPAA's special enrollment provisions should not be confused with the IRS's regulations for Sec. 125 cafeteria plans, which allow a plan to permit election changes in response to "significant" premium increases.