

## **Caution: Legislators At Work: A Survey Of Recent Federal Healthcare Legislation.**

**By: T. Daniel Hollaway, Esquire**

As an attorney involved in representing health care providers for many years, I have become familiar with the various roles of different groups of management within the healthcare industry, and the functions of those various levels of management. We all have procedures that we follow within our respective organizations and we, of course, train our employees to follow those procedures. The common thread of all policy and procedure within our respective organizations is that all of it is derived from federal and state law. Our federal and state legislatures are still very much of a mind to "reform" health care in this country and they have been very busy since 1997. A great deal of new law affecting health care has been recently enacted into law at both the federal and state level, much of which has gone unnoticed by the average citizen. Much of the effect of these new laws has yet to be felt by corporate America and our health care institutions. In an effort to keep our Lone Star Chapter members informed, we will now survey some recent developments in the law which affect the public's access to health care services, the way we deliver the services, and methods of payment for such services. We will focus in this article primarily on recent changes in federal law, then analyze and discuss how recent federal legislation is being implemented at the state level in subsequent articles in this series.

"There were three new pieces of legislation enacted by the United States Congress in 1996 and 1997 which deserve our attention. They are the Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996 and the Mental Health Parity Act of 1996. As is the case with Medicare, HCFA is the federal agency charged with administration of the Medicare programs in the United States. On April 1, 1997, the United States Departments of Labor, Health and Human Services and the Treasury issued interim regulations interpreting the many provisions of these new laws. The

Department of Labor, which has enforcement authority over private sector, as well as some public employee welfare benefit plans, i.e., "ERISA" plans, issued regulations interpreting amendments made to the Employee Retirement Income Security Act of 1974, referred to by the now fairly well-known acronym, ERISA. We shall now examine the major features of these new laws.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) was signed into law on August 21, 1996. This law provides new safeguards in obtaining and maintaining health insurance for workers and members of their families who have pre-existing medical conditions. The provisions of HIPAA amend certain provisions of Title I of ERISA. Other changes in the law due to the enactment of HIPAA also amended certain provisions of the Internal Revenue Code and the Public Health Service Act. The provisions of HIPAA which address individuals with pre-existing conditions have drawn a great deal of attention and should be of interest to healthcare providers, which are often denied reimbursement due to the pre-existing condition clauses contained within many health plans. First of all, just what exactly is a pre-existing condition? It is really about as simple as it sounds. A "pre-existing condition" is a condition present before your enrollment date in a health plan. So what's the fuss...where's the rub? The problem that most individuals have with pre-existing condition provisions in health plans is twofold. First, the length of time that must pass before pre-existing conditions are covered has tended to vary greatly between different insurers and plans. Secondly, pre-existing conditions have often had the effect of hindering people's job mobility, due to the fear of not being able change health plans without having to "start over" with a new pre-existing condition period to satisfy, or they have been afraid of not being able to get coverage at all. HIPAA addresses this problem in the following manner. Under HIPAA, a group health plan or insurance company offering group health plan coverage may impose a pre-existing condition exclusion only if the following requirements satisfied: (1) a pre-existing condition exclusion must relate to a condition for which medical advice, diagnosis, care or treatment was recommended or

received during the 6- month period prior to an individual's enrollment date (2) a pre-existing condition exclusion may not last for more than 12 months (18 months for late enrollees) after an individual's enrollment date, and (3) the 12 (or 18) month period must be reduced by the number of days of the individual's prior creditable coverage, excluding coverage before any break in coverage of 63 days or more. As one can readily see, this greatly reduces the number of persons who might go without coverage as a result of a change in employment. Under HIPAA, a person who has already satisfied a 12-month pre-existing condition clause in their health plan (without a break of 63 days or more) will not have to start over with a new pre-existing condition waiting period if they change jobs.

Another significant feature of HIPAA is the fact that it prevents pregnancy from being treated as a pre-existing condition. Pre-existing condition exclusions cannot be applied to pregnancy, regardless of whether the woman had previous coverage. Additionally, a pre-existing condition exclusion cannot be applied to a newborn, adopted child under age 18 or a child under 18 placed for adoption, as long as the child became covered under the health plan within 30 days of birth, adoption or placement for adoption, and provided the child does not incur a subsequent 63-day break in coverage. These provisions on pregnancies and newborns are a welcome change in the law for families. It has always seemed a very cold practice of insurance companies to deny coverage for childbirth on the basis of a pre-existing condition exclusion because the mother either was pregnant, or became pregnant during the 12-months before enrollment in a health plan, but it has been a common insurance practice. Bear these new provisions of HIPAA in mind when confronted with a pre-existing condition denial on childbirth.

It should also be noted that an individual's period of COBRA continuation coverage can be counted as "creditable coverage" for purposes of the pre-existing condition rules. In other words, if an individual who timely elected

COBRA continuation coverage after experiencing a qualifying event under COBRA (the most common being termination from employment) did not have any lapse in coverage, or no greater lapse than 63 days during the time period they were subscribing to COBRA continuation coverage, that individual would not have to start over with satisfying a pre-existing condition clause.

HIPAA also made two changes to the length of the COBRA continuation coverage period. Effective January 1, 1997, qualified beneficiaries who are determined to be disabled under the Social Security Act within the first 60 days of COBRA continuation coverage will be able to continue their COBRA coverage for an additional 18 months beyond the initial 18-month coverage period. This differs from the old version of the law, which provided that, in order to be eligible to obtain the additional 11 months of continuation coverage, the individual had to be disabled at the time of the "qualifying event" that triggered their eligibility for COBRA continuation coverage.

HIPAA also contains certain anti-discrimination provisions for protection against "cherry-picking" and other abusive underwriting practices of insurers. Under HIPAA, individuals may not be excluded from coverage under the terms of a group health plan, or charged more for benefits offered by a health plan, based on specified factors relating to health status. Furthermore, group health plans may not establish rules for eligibility of any individual to enroll in a group health plan based upon health status related factors. These factors are those customarily associated with insurance underwriting and include health status, medical condition (physical or mental), claims experience, receipt of health care services, medical history, and genetic information or evidence of insurability or disability.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT of 1996 (NMHPA) was enacted on September 26, 1996. The NMHPA provides that insurance companies, group health plans and MCOs which offer maternity

coverage must provide coverage for a minimum period of time. As an example, a hospital stay following a normal vaginal delivery may generally not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with a cesarean delivery may generally not be limited to less than 96 hours for both the mother and the newborn. This new law also imposes certain limitations on required deductibles and coinsurance payments that can be required in connection with OB patients.

The requirements of the NMHPA apply to group health plans, insurance companies and MCOs for plan years that begin on or after January 1, 1998.

THE MENTAL HEALTH PARITY ACT of 1996 (MHPA) was enacted into law on September 26, 1996 and it provides for parity in the application of limits on certain mental health benefits. Under the MHPA, group health plans, insurance companies and HMOs that offer mental health benefits will not be allowed to set annual or lifetime limits on mental/nervous benefits that are lower than any such limits for medical/surgical benefits. A health plan that does not impose an annual or lifetime limit on medical and surgical benefits may not impose such a limit on mental/nervous benefits. Sound too good to be true? It is! MHPA does not apply to benefits for substance abuse or chemical dependency. This writer's recommendation is, as always, document those verifications of coverage and precertification records thoroughly and at or before admission. A further caveat, MHPA does not apply to "small employers" which have between 2 and 50 employees, or to any group health plan whose costs increase one percent or more due to the application of the requirements of MHPA. This law applies to group health plans for plan years beginning on or after January 1, 1998. It also has a built-in sunset provision that states that the requirements of MHPA will cease to apply to benefits for services furnished on or after September 31, 2001. As is apparent from the rather gaping holes in this legislation, the insurance lobby saw this one coming, but it may be of some utility until it expires by its own terms for those that treat non chemical-dependency cases.

