March of Dimes
Saving babies, together.

Office of Government
1146 St. NW, Sixth
Washington, DC
Telephone (202) 659-
Fax (202) 296-

March 25, 2005

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue NW, Room C-5331
Washington, DC 20210

Attention: Benefit-Specific Waiting Period Comments

The March of Dimes submits the following comments in response to the Request for Information on Benefit-Specific Waiting Periods Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Titles I and II published by the Departments of Labor, Treasury, and Health and Human Services on December 30, 2004.

We appreciate the Departments' request for information regarding benefit-specific waiting periods, and whether such a policy would constitute a preexisting condition exclusion under HIPAA. HIPAA was enacted "to provide for.... improved portability and continuity of health coverage in the group market... by limiting exclusions for preexisting conditions and providing credit for prior coverage, guaranteeing availability of health coverage for small employers, prohibiting discrimination against employees and dependents based on health status, and guaranteeing renewability of health insurance coverage for employers and individuals."[1] Benefit-specific waiting periods compromise these critical protections and could place at risk the health of pregnant women, infants, and children needing continual care.

1) Benefit-Specific Waiting Periods Under HIPAA

The March of Dimes believes the Departments should issue a rule prohibiting benefit-specific waiting periods for people with a history of group health coverage and who are covered by ERISA group health plans. In HIPAA, Congress made clear its intent in establishing standards for use of preexisting condition exclusions.

"Millions of Americans have medical histories or preexisting conditions that make it difficult to get comprehensive insurance coverage. As many as 81 million

[1] Proposed Rule, December 30, 2004 *Federal Register* 69(250) p. 78826

March 30, 2005

VIA ELECTRONIC TRANSMISSION

CC:PA:LPD:PR (REG-130370-04)
Courier's Desk
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue, NW
Room C-5331
Washington, DC 20210
ATTN: Benefit-Specific Waiting Period Comments

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

(Submitted electronically 3/30/2005 at 4:00 pm to: E-OHPSCA.EBSA@dol.gov)

Attn: Request for Information on Benefit-Specific Waiting Periods Under HIPAA Titles I & IV

On behalf of the undersigned organizations representing the interests of consumers covered by ERISA group health plans, Families USA, and the undersigned groups, submit the following comments on the Request for Information on Benefit-Specific Waiting Periods Under HIPAA Titles I and IV published by the Department of Labor on December 30, 2004.

We applaud the Department's consideration of whether a benefit-specific waiting period used by a group health plan or issuer should be considered a preexisting condition exclusion under HIPAA. A rule clarifying that benefit-specific waiting periods for people with a history of health coverage violate HIPAA is critical for millions of Americans covered by ERISA health plans.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted to provide improved portability and continuity of health coverage in the group market. In particular, HIPAA was designed to limit exclusions for preexisting conditions and to prohibit discrimination against employees and dependents based on health status so that people with a history of coverage who switch jobs could continue to access health care. In other words, one of HIPAA's goals was to address the problem of "job-lock," where a worker (and his or her family)

is essentially "trapped" in a job because of concerns that a preexisting medical problem would render him or her unable to get new employer-sponsored health coverage if he or she changed jobs. Allowing benefit-specific waiting periods would violate critical protections provided by HIPAA, exceeding the Department's administrative authority, contradicting congressional intent, and undermining good public policy.

1) Allowing benefit-specific waiting periods exceeds the Department's authority.

Allowing benefit-specific waiting periods would be an impermissible exception to HIPAA's standards for preexisting condition exclusions and would create a new general exception to HIPAA's portability rules. This would exceed the Department's administrative authority, result in an impermissible *legislative* action by a federal agency—a primary function of Congress—and violate the separation of powers doctrine under the U.S. Constitution.

Generally, an executive agency's authority is limited to implementing laws and to clarifying ambiguities in statutes where such exist. Chevron U.S.A., Inc. v. Natural Resources Defense Council, 467 U.S. 837 (1984) "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." Chevron, 467 U.S. 842-843. "The power of an administrative agency to administer a congressionally created ... program necessarily requires the formulation of policy and the making of rules to fill any gap left ... by Congress.... If Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation." Chevron, 467 U.S. 843-844.

In HIPAA, Congress established specific standards for the use of preexisting condition exclusions. Such standards seek to protect people with past or present medical conditions who enroll in new group health plans. Similar to preexisting condition exclusions, benefit-specific waiting periods apply to newly enrolled employees and dependents and seek to exclude a particular condition from coverage for a period of time. For a person with a medical condition at the time of enrollment, and for a person with a chronic condition like diabetes (it is estimated that half of the population in the United States has a chronic condition), a benefit-specific waiting period would always function like a preexisting condition exclusion and thus would need to comply with HIPAA's limitations on such exclusions (including a requirement to reduce the exclusion period if the person had prior creditable coverage and a maximum allowable exclusion period of 12 months/18 months for late enrollees). Because a benefit-specific waiting period functions like an exclusion period for preexisting conditions, the Department should remind plans that the use of such waiting periods must be consistent with preexisting condition exclusion periods.

If the Department allows plans to treat a benefit-specific waiting period differently from a preexisting condition exclusion period, then the new loophole would eviscerate HIPAA's protections and restrictions for use of preexisting conditions. Health plans could use condition-specific waiting periods to avoid giving credit for prior coverage and to exclude conditions from coverage for longer than the 12 months allowed under HIPAA. Permitting such periods would create an exception to HIPAA's preexisting condition requirements that does not exist in statute.

Under HIPAA, Congress authorized the Department to "promulgate such regulations as may be necessary or appropriate to carry out the provisions of this part." ERISA Title I, Part 7, Section 707. Congress did not, however, authorize the U.S. Department of Labor to administratively create exceptions to the strict standards in HIPAA for preexisting condition exclusions, especially an exception that would eviscerate the rule. With respect to preexisting conditions and exceptions to the statutory standards, Congress was unambiguous. Furthermore, there is no specific grant of authority to fill in gaps because Congress did not envision additional exceptions to coverage rules. Therefore, allowing benefit-specific waiting periods would exceed the Department's administrative authority and result in the Department making laws—a function of Congress—and violating the separation of powers principle under the U.S. Constitution.

Congress also did not give the Department authority to create an additional category of allowable exclusions from coverage. Such an action by the Department is neither necessary nor appropriate and exceeds both the specific grant of authority in HIPAA to issue rules that are "necessary or appropriate" and the general authority an executive agency has to implement laws.

Congress recognized and allowed three categories when—under certain conditions—plans can refuse to cover benefits for newly-enrolled individuals and families. These three categories include 1) preexisting condition exclusions, 2) waiting periods, and 3) affiliation periods (in case of an HMO) (ERISA, Title I, Part 7, section 701). Congress established standards and restrictions on the use of each category. Nowhere in Part 7 of ERISA is there a grant from Congress authorizing the Department to create a *fourth* category—benefit-specific waiting periods—that would allow plans to refuse to cover specific conditions or deny treatment benefits for a period of time for people who newly enroll.

By allowing benefit-specific waiting periods, the Department would exceed its regulatory authority by creating a *fourth* category of temporary exclusions from coverage for newly enrolled people. Congress did not authorize the Department to expand allowable temporary coverage exclusions under HIPAA. Therefore, such an expansion fails to meet the test of being "necessary" or "appropriate" under the grant of authority to the Department under HIPAA. Additionally, such action would not be considered a reasonable agency interpretation of the law under the *Chevron* standard. The interpretation of the statute would contradict the clear intent of Congress expressed in the statute (through specifically identified permissible exclusion periods) and also contradict legislative intent evidenced in the legislative history discussed below.

2) Allowing benefit-specific waiting periods contradicts clear congressional intent.

A benefit-specific waiting period is contrary to congressional intent. One goal of HIPAA legislation was to address "job lock" that was caused by plans not covering new employees (and their dependents) if they had prior or existing medical conditions.

> "Millions of Americans have medical histories or preexisting conditions that make it difficult to get comprehensive insurance coverage. As many as 81 million Americans have preexisting medical conditions that could affect their insurability. Many people are locked in their jobs because they fear they will be unable to obtain comprehensive insurance in new jobs."[i]

Another purpose of HIPAA was to encourage people to stay insured continuously (rewarding those who stayed insured with credit for prior coverage and limitations on coverage exclusions).

> "It makes elemental and much-needed improvements in health care coverage for Americans by guaranteeing 'portability' of health insurance for employees who change jobs...." [ii]

> "The American Cancer Society estimates that more than one million people will be diagnosed with cancer this year. Ten million Americans alive today have a history of cancer. Under current insurance practices, many of these people will be denied coverage if they change jobs or lose their job, or they will be squeezed out of their existing plan because of their health status. The health insurance reform bill addresses these critical issues by limiting preexisting condition restrictions and ensuring greater portability of coverage."[iii]

These important public policy goals were accomplished through strict "portability" standards in the group market. Benefit-specific waiting periods would allow plans to exclude from coverage a particular benefit for a period of time for new employees and dependents. This would establish new obstacles and create job lock—precisely the issues that Congress was trying to address in 1996. Benefit-specific waiting periods are contrary to the clear congressional intent of HIPAA.

3) Benefit-specific waiting periods are not good public policy.

Insurers claim that the purpose of preexisting condition exclusions is to prevent people from "gaming" the system by purchasing coverage only when they get sick. Benefit-specific waiting periods have the same affect, yet they are indefensible. Benefit-specific waiting periods would apply to people who have done the right thing and maintained their health coverage during a loss of a job or a job change. People who have faithfully paid their premiums, in particular, should not have to start over again with a new exclusion period if they change jobs or lose their coverage. Benefit-specific waiting periods therefore do not accomplish the goal of encouraging people to stay insured. Instead, they set up significant new obstacles, punishing those who change employers and who need medical care in their new plan.

Furthermore, allowing employers and insurers to force workers to wait for coverage of a specific benefit for years would deter people with that medical condition from working for that employer—and might deter them from looking for work altogether. For example, workers with a history of cancer would not be inclined to work for an employer that has instituted a waiting period for chemotherapy or radiation treatment. Or, for example, workers with a history of back pain would not be inclined to work for an employer that has instituted a waiting period for herniated disk surgery or physical therapy. A person with diabetes would not work for an employer that requires three years on the job before the worker could qualify for benefits that covered diabetes treatment. In this way, employers and insurers can discourage people with expensive medical conditions from applying, hiring only those workers who do not have costly

medical conditions. This is precisely what Congress intended to prohibit. Allowing benefit-specific waiting periods thus clearly contradicts public policy.

In closing, benefit-specific waiting periods allow employers and insurers to game the system, preventing sick employees from accessing critical treatments and screening out workers who may have costly medical conditions. Federal consumer protections under HIPAA were designed to limit the ability of employers and insurers to exclude coverage for preexisting conditions so that plans could not deny treatments to specific workers with health conditions and so that employers and insurers could not discriminate against workers based on their health status.

Under current law, employers and insurers looking to circumvent the intent of HIPAA can make all workers wait years before they can access critical treatments, by using benefit-specific waiting periods. Just like preexisting condition exclusions, these benefit-specific waiting periods prevent workers who have health conditions from getting the critical health care treatments they need. We ask that you clarify that benefit-specific waiting periods violate HIPAA and should be prohibited altogether, or if allowed, should be subject to the rules that apply to preexisting conditions and general waiting periods under HIPAA.

We thank you for your consideration of these comments and would be glad to meet with you to discuss our concerns in greater detail. Please direct any specific questions or concerns to Sonya Schwartz at Families USA at 202-628-3030 or at sschwartz@familiesusa.org.

Sincerely,

Families USA
AIDS Action Committee of Massachusetts, Inc.
AIDS Foundation of Chicago
AIDS Legal Council of Chicago
Alliance for Children and Families
American Association of People with Disabilities
American Association on Mental Retardation
American Counseling Association
American Federation of State, City and Municipal Employees
American Network of Community Options and Resources
American Nurses Association
Boston AIDS Consortium
California Association of Social Rehabilitation Agencies (CASRA)
Center for Medicare Advocacy, Inc.
Community HIV/AIDS Mobilization Project
Health Care For All
Health Law Advocates
HIV Medicine Association
Housing Works, Inc.
National Alliance of State and Territorial AIDS Directors
National Council on Independent Living

National Education Association
National Health Law Program
National Hemophilia Foundation
National Mental Health Association
National Multiple Sclerosis Society
National Partnership for Women and Families
National Respite Coalition
Public Justice Center
RESULTS
San Francisco AIDS Foundation
Service Employees International Union
South Shore AIDS Project
Title II Community AIDS National Network
USAction

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[i] S. Conf. Rep. No. S9515 (August 02, 1996).
[ii] S. Conf. Rep. No. S9505 (August 02, 1996).
[iii] S. Conf. Rep. No. S9502 (August 02, 1996).

March 30, 2005

CC:PA:LPD:PR (REG-120270-04)
Internal Revenue Service
POB 7604, Room 5203
Ben Franklin Station
Washington, DC 20044

U.S. Department of Labor
Employee Benefits Security Administration
Attn: Proposed Portability Requirements
200 Constitution Avenue, NW, Room C-5331
Washington, DC 20210

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2158-P
PO Box 8017
Baltimore, MD 21244-8010

RE: **Comments on the Notice of Proposed Rulemaking for Health Coverage Portability: Tolling Certain Time Periods for Interaction with the Family and Medical Leave Act Under HIPAA Titles I and IV**

To Whom It May Concern:

The Society for Human Resource Management (SHRM) is pleased to provide the following comments in response to the proposed regulations providing guidance on certain portability requirements under Title I of the Health Insurance Portability and Accountability Act (HIPAA). The proposed regulations were issued by the Treasury Department, the Department of Labor, and the Department of Health and Human Services (collectively referred to hereinafter as "the Agencies") and published in the *Federal Register* on December 30, 2004.[1] SHRM commends the Agencies for taking the initiative to provide this helpful guidance.

[1] 69 Fed. Reg. 78800

1800 DUKE STREET
ALEXANDRIA, VA 22314-3499 USA
(703) 548-3440 FAX; (703) 836-0367 TDD: (703) 548-6999
WORLD WIDE WEB: HTTP://WWW.SHRM.ORG

SHRM is the world's largest association devoted to human resource management. Representing more than 190,000 individual members, SHRM's mission is to serve the needs of human resource (HR) professionals by providing the most essential and comprehensive resources available. As an influential voice, SHRM's mission is also to advance the HR profession to ensure that HR is recognized as an essential partner in developing and executing organizational strategy. Founded in 1948, SHRM currently has more than 550 affiliated chapters and members in more than 100 countries.

I. Statement of Interest

A motivated and productive workforce is key to the success of any organization. HR professionals play a critical role in identifying organizational strategies to ensure that the workforce is engaged and performing effectively. Clearly, welfare and health care benefits are a crucial component of any strategy to recruit and retain talented employees. The ability to provide health care to employees and their dependents, as well as ensure that employees are protected from losing health insurance, has always been a critical issue for SHRM and its members. The ability to provide benefits is even more critical now, since health care coverage is one of the most expensive, but expected benefits that employers offer employees. Even with rising health care costs, SHRM members seek ways to continue to offer health insurance to their employees. In fact, according to a June 2004 SHRM health care survey that assessed how employers manage rising health care costs, 99 percent of survey respondents (selected randomly from SHRM's membership database) stated that their organizations continue to offer health care coverage to their workforces. [2]

As noted above health care coverage is an important benefit and an effective recruitment and retention tool. To that end, HR professionals design and implement health and welfare plans that are appropriate for their workforces. Therefore, SHRM is well positioned to offer insight on the issues surrounding health care coverage and the workplace. SHRM's members are also concerned with health care coverage for employees transitioning from one job to another and from one health care plan to another, which is covered by HIPAA. To comply with HIPAA's requirements, HR professionals must operate within the parameters set by health plans, third party administrators (TPAs) and insurers, especially regarding rules for pre-existing conditions and future health care coverage. Because there are various requirements that govern health care coverage especially during periods of employee transition, SHRM commends the Agencies for drafting regulations that will increase protection for employees moving between employer-provided health care plans as well as minimizing the burdens on subsequent health care plans and issuers. SHRM supports the proposed rulemaking and offers for the Agencies' consideration the following comments, which we believe will provide greater clarification of HIPAA obligations for health plan and issuers as well as provide even stronger protections for transitioning employees.

II. Discussion

[2] Collison, J. (2004, June), SHRM Health Care Survey Report. Alexandria, VA: Society for Human Resource Management

A. ***Rules Relating to Creditable Coverage — 26 CFR 54.9801-4, 29 CFR 2590.701-4, 45 CFR 146.113: Tolling of the 63-Day Break in coverage Rule.***

HIPAA provides protection to health plan participants transitioning from one job to another by providing them with 63 days to obtain new health care coverage before they are considered to have a significant break in coverage. A break in coverage can expose plan participants to pre-existing condition rules when they seek health care coverage under a new plan. The proposed regulations substantively modify the 63-day break in coverage rules for health plan participants who are not provided a certificate of creditable coverage on or before the day their coverage ceases. In this instance, the proposed regulations allow the start date for determining a break in coverage to be tolled (held and not counted) until a certificate of creditable coverage is provided to the participant (tolling rule). The tolling rule provides plan participants losing health care coverage under a plan with additional protection if they have not received a notice of creditable coverage from the previous health care plan.

Additionally the proposed regulations limit the tolling period to 44 days. The tolling period limitation will help to lower the financial burden that future health plan providers and issuers could encounter with an open-ended tolling period. SHRM believes the Agencies' decision to adopt a 44-day limitation is reasonable given its consistency with the timing rules provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for required qualifying event notices to be provided to participants (see Internal Revenue Code (IRC) section 4980B(f)(6)).

SHRM supports the seamless integration of health care coverage for employees switching health plans. Plan participants can be disadvantaged when they do not receive certificates of creditable coverage from their health care providers upon termination of their coverage. They are often unaware that their health care coverage under a plan has ended and new health care coverage must be obtained within 63 days or they will possibly be subject to pre-existing condition limitations in their future health care coverage. Furthermore, the tolling rule minimizes burdens on subsequent plans and issuers that were not responsible for the missing or untimely certificate of coverage without imposing significant liability on any party.

While the proposed tolling rule is a beneficial change to HIPAA, SHRM believes the proposed regulation, as written, has the potential for misinterpretation and could lead to unnecessary confusion. To that end, SHRM suggests a clarification of the tolling rule language as proposed by the Agencies. The ambiguity in the proposed regulations stems from the language regarding how to assess the start date for determining whether a significant break in coverage has occurred. According to the proposed regulations, the start date will be either A) The date that a certificate of creditable coverage with respect to that cessation ***is provided***; or B) The date 44 days after coverage ceases (emphasis added), whichever is earlier.[3] As written, it is difficult to determine whether "is provided" refers to the date the certificate was sent by the plan sponsor or issuer, or whether it refers to the date the certificate was received by the individual. The

[3] Section 54.9801-4(b)(2)(iv)(A)and(B)

uncertainty of the exact meaning of "is provided" could lead to unintended consequences and unnecessary litigation. Therefore, SHRM suggests clarifying the precise meaning of "is provided" to refer to the date the certificate was sent. In addition, SHRM requests including this date on the model certificate, as noted below in section 2(b) of this comment letter.

B. ***Evidence of Creditable Coverage — 26 CFR 54.9801-5, 29 CFR 2590.701-5, 45 CFR 146.115: Information in Certificate and Model Certificate.***

The proposed regulations provide a new model certificate of creditable coverage (referred to hereinafter as "the model certificate") that includes a disclosure about the Family and Medical Leave Act (FMLA). SHRM appreciates this modification, because it furthers the goal of protecting plan participants. Under the proposed regulations, group health plans and issuers will have the option of using the proposed regulations' model certificate or the model notice provided in the Final Regulations for Health Care Portability[4] (referred to hereinafter as "HIPAA's final portability rule"). While we believe it is important to disclose information regarding the FMLA in the certificate of creditable coverage, SHRM also believes that permitting group health plans and issuers to use either of the proposed model certificates until the model notices become applicable is equitable and provides plan sponsors with appropriate flexibility.

In the proposed regulations, the Agencies specifically request comments relating to the applicability date for the proposed regulations' model certificate. SHRM recommends that the Agencies allow plan sponsors to begin using the proposed model certificate at the beginning of their next plan year after the final regulations are issued. This will ensure that HR professionals, employers and insurers have sufficient time to customize and begin sending new certificates to plan participants, especially for plans that used the model notice published in HIPAA's final portability rule. If using a new plan year for compliance with the model certificate is not feasible, SHRM recommends that plans have, at a minimum, a 90-day implementation period from the date of the final regulations.

In addition, SHRM suggests two minor changes to the proposed model certificate:

- **Update to Model Certificate** — SHRM recommends that the model certificate include an explanation and examples of the newly proposed tolling rule for the 63-day break in coverage. This language will enable participants to accurately calculate the number of days they have to file for new coverage without experiencing a significant break in coverage.

  For example, if an employee is sent a certificate of creditable coverage 15 days after losing coverage under group health plan A, she may think she has only 48 days (63 minus 15) to enroll in group health plan B without experiencing a significant break in coverage. However, if she is given a

[4] 26 CFR Parts 54 and 602, 29 CFR Part 2590, and 45 CFR Parts 144 and 146

certificate of creditable coverage with language explaining the new tolling period, she will know that her 63-day time period is tolled for 15 days and that she has 63 days remaining from the date that group health plan A provided the certificate of creditable coverage to enroll in group health plan B.

- **Clarify Ambiguity** — Earlier in these comments, SHRM requested clarification of "is provided" as found in the proposed regulations at section 54.9801-4(B)(2)(iv)(A). In addition to the recommendation offered, SHRM seeks to modify the model certificate to include a space for plan sponsors or issuers to specify the date the original certificate is sent (assuming it differs from the "issued" date already on the certificate) to avoid potential confusion when a second notice is requested. This suggested modification will enhance the protections provided by the 44-day tolling limitation to future health plan providers and issuers, especially when duplicate certificates are requested.

  For example, when a participant loses coverage and receives a certificate of creditable coverage (which generally contains a date of issuance), but then loses the certificate and requests a duplicate, the duplicate certificate will generally contain a new date of issuance. In such a case, the date the certificate was "issued" may not necessarily be the same date the certificate was "provided" (actually sent). Without this modification, the request for a duplicate certificate could enable individuals seeking coverage to manipulate the dates used to determine significant breaks-in-coverage.

  Generally, the date the document is posted in the mail and dated (referred to hereinafter as the "mailbox rule") applies; however, not all plan participants will keep the postmarked envelopes and if a duplicate certificate is requested and sent, the mailbox rule could lead to confusion as to the correct date the certificate "is provided." Including a space directly on the certificate for plan sponsors to specify when the certificate is sent will eliminate much of the confusion.

C. Special Enrollment Periods — 26 CFR 54.9801-6, 29 CFR 2590.701-6, 45 CFR 146.117: Tolling of the Special Enrollment Period; Modification of Special Enrollment Procedures and When Coverage Begins Under Special Enrollment

1. Tolling of the Special Enrollment Period

The proposed regulations also provide a special tolling rule for special enrollment periods. Under HIPAA, the 1997 interim rules and HIPAA's final regulations, special enrollment following a loss of coverage generally must be requested within 30 days after loss of eligibility, termination of employer contributions or exhaustion of COBRA. The proposed regulations toll the 30-day time period for individuals whose coverage ceases

and a certificate of creditable coverage is not provided on or before the date coverage ceases. Specifically, under the proposed regulations, the special enrollment period ends at the end of the 30-day time period that begins on the day after either A) the date that the certificate of creditable coverage is provided or B) the 44 days after coverage ceases, whichever is earlier. Like the tolling period proposed for the 63-day break in coverage, SHRM believes the tolling period for special event enrollment is sound public policy.

2. Modification of Special Enrollment Procedures and When Coverage Begins Under Special Enrollment

The proposed regulations clarify that during periods of special enrollment, individuals need only make a request for special enrollment within the allotted 30-day time frame, but are not required to meet all of the application requirements when all requirements cannot reasonably be completed within the 30-day time frame. According to HIPAA's statutory language, individuals must make special enrollment requests no later than 30 days after the occurrence of a special enrollment event (such as marriage or the birth/adoption of a child). However, the April 1997 interim rules did not establish special procedures for this statutory requirement. The lack of any such guidance has allowed plans and issuers to require individuals requesting special enrollment to file completed applications for health coverage by the end of the 30-day special enrollment period. In some instances, the requirements necessary to fully complete the application cannot reasonably be completed in the 30-day period which can effectively deny some individuals their rights to special enroll their dependents.

The proposed regulations limit plans and issuers from requiring individuals to finalize all procedural application requirements for special enrollment within the 30-day statutory time frame. The proposed regulations clarify that an individual seeking special enrollment is required only to provide a written or oral request for special enrollment within the 30-day special enrollment period. After a timely request, the plan or issuer may then require the individual to complete all enrollment material within a reasonable amount of time after the end of the special enrollment period. The proposed regulations allow for enrollment material deadlines; however, the deadline must be extended for information that cannot reasonably be obtained within the deadline (e.g., Social Security numbers for newborns). Additionally, the proposed regulations limit the enrollment procedure requirements to information required from individuals who enroll when first eligible and information about the special enrollment event.

SHRM applauds the Agencies for clarifying the unresolved issue from the 1997 interim guidance, and believes individuals should be given sufficient time, not limited to the 30-day special enrollment period, to meet the special enrollment requirements as stated by the plan or issuer. However, we would like to offer two suggestions. First, SHRM recommends that only written requests for special enrollment be actionable. Allowing for oral notification could cause administrative delays and many unintended, yet costly, consequences. For instance, not all insurance companies and claims administrators are equipped to receive and track calls from individuals about events that qualify for a special enrollment period. The insurance companies and claims administrators are also not likely

to be prepared to turn around and notify employers of the special enrollment events. Generally, individuals who give oral notification are instructed to contact their employers' HR or employee benefits departments. Requiring issuers and plan administrators to add processes and procedures to track oral notice of special enrollment events and also notify employers would add significant delays in enrollment. These delays would then create a variety of problems with back premiums and the collection of back premiums on a timely basis, not to mention the inconvenience to employees and plan participants.

> For example, A participant in Employer A's group health plan, becomes a new father and calls the plan's TPA to report the birth. Rather than referring him to Employer A's HR department, the TPA enrolls the baby in employer A's group health plan and sends the father an ID card in the baby's name. However, since Employer A did not receive notice of the new child, the baby was not added to the employer's weekly electronic data transfers to the TPA, and the TPA then cancels the baby's enrollment. In such situations, the employee often is not aware that the child's coverage has been cancelled and does not learn of the lack of coverage until the child's claims are denied. These cases require a great amount of time to verify the facts with the TPA, request the necessary enrollment materials from the participant, calculate retroactive premiums due and request that the TPA reprocess any denied claims.

To rectify this potential problem, SHRM offers its second suggestion, namely that special enrollment registration follow the procedures set forth in the plan's summary plan description (SPD), so long as those procedures are consistent with the remaining provisions of the regulations. An SPD generally describes the documentation necessary for special enrollment and outlines the process to be used to provide the employer with the appropriate documents. Following a plan's SPD will ensure that the employer, the related TPA and the insurer all receive the same information in an organized and centralized method regarding the individual eligible for special enrollment.

D. Special Rules — Excepted Plans and Excepted Benefits — 26 CFR 54.9831-1, 29 CFR 2590.732, 45 CFR 146.145.

The proposed regulations establish the "default rule" that states all medical care benefits made available by an employer generally constitute one group health plan. SHRM appreciates the Agencies' clarification of how plan sponsors should determine the number of plans they offer for the purpose of HIPAA. The default rule will make plan administration simpler for plan sponsors with multiple benefit options and reduce unnecessary paperwork and confusion for plan participants.

The default rule, however, is inconsistent with the special enrollment rule outlined in HIPAA's final portability rule that was issued on the same day as the proposed regulations. HIPAA's final portability rule states that when an individual experiences a special enrollment event, he or she (and any affected dependents) may elect coverage under ***any benefit package*** under the plan (emphasis added).[5] Combining the special enrollment rule from the proposed regulations and the special enrollment rule from HIPAA's final portability rule would lead to conflicted results.

> For example, by combining the two rules, an individual who first enrolls in an HMO (one benefit option) and later gets married (a special enrollment event) could switch not only from employee-only coverage to employee-plus-one coverage, but the individual could also switch to a totally different plan (e.g., from the HMO to an indemnity option).

The public policy rationale of special enrollment is to make group health plan coverage available to individuals who experience special enrollment events. As stated in HIPAA's legislative history, "[t]he conference agreement requires special enrollment periods for certain individuals losing other coverage and for certain dependent beneficiaries. It requires group health plans, and health insurance issuers offering group health insurance coverage, to permit eligible employees or dependents who lose other coverage to enroll under the terms of the ***plan*** if each of the following conditions is met...." (emphasis added).[6]

According to the legislative history, the available option for an individual who experiences a special enrollment event should be coverage under that ***particular plan*** and not necessarily every ***option*** under the employer's plan (unless the individual had not previously elected coverage)(emphasis added).[7] This same concept is followed by the COBRA rules.[8] Under COBRA, qualified beneficiaries are only entitled to continue the type of coverage they received immediately before a qualifying event.

If the approach suggested in the proposed regulations combined with the final regulations is preserved, it could create adverse selection among the plan options and therefore raise the costs for health care plans who will then pass the cost onto employers. In other words, based on a special enrollment event, individuals will be more aware of future risks and expenses and would be able to switch plans mid-plan year. This will raise the risks in certain plans and have the adverse effect of causing a potential rise in premiums. In addition, if this provision is coupled with the longer period for making elections,[9] the administrative burden associated with reconciling invoices and claims processing will also increase.

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[5] See *Special Enrollment Periods — 26 CFR 54.9801-6, 29 CFR 2590.701-6, 45 CFR 146.117*
[6] See Conference Report 104-736, July 31, 1996
[7] Id.
[8] See Internal Revenue Code section 4980B(f)(2)(A) and Internal Revenue Service final regulations section 54.4980B-5, question 4(a)
[9] As described in *Special Enrollment Periods — 26 CFR 54.9801-6, 29 CFR 2590.701-6, 45 CFR 146.117*

SHRM requests that the Agencies address HIPAA's final portability rules and conform them to the special enrollment provisions outlined in the proposed regulations. The portion of HIPAA's final portability rule that allows individuals who experience special enrollment events to elect coverage under any benefit package was not addressed in previous proposed regulations. Therefore, SHRM and other affected parties did not have the opportunity to voice any concerns or suggest improvements. Conforming HIPAA's final portability rules to the proposed default rule, which essentially creates a group plan of all medical care benefits made available by an employer, will simplify plan administration, limit paperwork and ease understanding for plan participants.

III. Conclusion

SHRM appreciates the opportunity to submit these comments and thanks you for your consideration of them. Should you have any questions, please contact me at maitken@shrm.org or by phone at 703-535-6027.

Sincerely,

Michael P. Aitken
Director, Governmental Affairs
Society for Human Resource Management

Cc: Tami Simon and Judy Bauserman
Mercer Human Resource Consulting
1255 23rd Street, NW, Suite 250
Washington, DC 20037-1198

LEONARD
STREET
AND
DEINARD

150 SOUTH FIFTH STREET SUITE 2300
MINNEAPOLIS, MINNESOTA 55402
612-335-1500 MAIN
612-335-1657 FAX

(612) 335-1510
angela.bohmann@leonard.com

March 29, 2005

Department of Labor
Via E-mail: E-OHPSCA.EBSA@dol.goc

Re: Request for Information on Benefit-Specific Waiting Periods Under HIPAA Titles I & IV

Dear Reader:

I am writing in response to the request of the Departments of Labor, Treasury, and Health and Human Services for information relating to waiting periods for health services under employer group health plans, including waiting periods for transplants. Thank you for soliciting public comment on the issue.

I represent an employer that has for a number of years imposed a waiting period under its self-funded medical plan for transplants. While the normal waiting period for coverage under the plan is 30, 60 or 90 days of employment, depending upon job classification, the employer has imposed a five year waiting period for certain transplants, specifically, autologous and allogeneic bone marrow transplants, heart transplants, heart/lung transplants, lung transplants, kidney transplants, and kidney/pancreas transplants. The employer has so designed its plan in part to limit health care costs and in part to reward employees who remain with the employer for a significant period of time. The employer is in the trucking business and experiences annual driver turnover of more than 100%. It cannot afford to provide expensive health coverage to an employee with a limited attachment to the work force.

Under ERISA employers have few constraints on the design of their self funded medical plans. Employers can design plans without any coverage for transplants, some of which can cost hundreds of thousands of dollars. If employers cannot impose waiting periods to make sure that such expensive benefits are provided only to employees (and family members) with a significant attachment to the work force, employers may choose simply to remove all transplant coverage from their plans or to provide such coverage only to employees in selected job classifications in which turnover is not so high.

Please contact me if I can be of further assistance.

Thank you for your consideration.

Very truly yours,

LEONARD, STREET AND DEINARD
PROFESSIONAL ASSOCIATION

Angela M. Bohmann

Angela M. Bohmann
AMB:ll

2594249v1

March 30, 2005

Employee Benefits Security Administration
Department of Labor

These comments on the notice of proposed rulemaking for health coverage portability (29 CFR Part 2590) are submitted on behalf of the Society of Professional Benefit Administrators (SPBA).

SPBA is the national association of Third Party Administration (TPA) firms that are hired by employers and employee benefit plans to provide outside professional management of their employee benefit plans. The relationship is similar to the situation when a law firm or CPA firm is hired on a long-term basis to provide services. It is estimated that 66% of US workers in non-federal health coverage are in plans administered by some form of TPA. The clients of TPA firms include every size and format of employment, including large and small employers, state/county/city employees, union, non-union, and employees of religious groups. 400 TPA firms are currently members of the SPBA, covering an estimated 55% of non-federal US employees in benefit plans.

Rules Relating to Creditable Coverage

The proposed rule to extend the starting date to determine a significant break in coverage when a certificate of creditable coverage is not provided on or before the day coverage ceases is not workable and should not be adopted. Under this proposal, the significant break in coverage period does not begin until the earlier of the provision of a certificate of coverage, or 44 days after coverage ceases.

The proposed rule would bring a high degree of uncertainty into determining when the significant break in coverage begins. Health benefit plans must know the exact date that a significant break in coverage begins. TPAs report that unless they can prove a beginning date for a significant break in coverage, stop-loss carriers will not honor the stop-loss policy and provide reimbursements. Under the current rule, health benefit plans look to the date coverage ended, which is stated clearly on the certificate of creditable coverage.

The provision date in the proposed rule ("the date that a certificate of creditable coverage with respect to that cessation is provided") is unclear. What does it mean for the certificate of creditable coverage to be provided? Is this the date the certificate of creditable coverage is postmarked? Is this the date the certificate of creditable coverage is received by the individual? Is this the date the certificate of creditable coverage was completed by the issuing plan? All three of these possibilities pose problems.

If the date of provision is the postmark date, then the plan receiving the certificate would need to see the envelope that was used to mail the first certificate of creditable coverage

to verify the date. However, the envelope will not be acceptable to the stop-loss carrier as individuals could lose the first certificate they receive and request the former plan to send another certificate of creditable coverage. The envelope postmark date would reflect the second mail date and therefore would not be an accurate indicator of the first date that the certificate of creditable coverage was provided. TPAs report that they often must produce additional certificates of creditable coverage for the same individual because the first one sent was lost or the dog destroyed the certificate.

If the date of provision is the date the individual received the certificate, there would be no way to verify this date.

If the date of provision is the date the certificate of creditable coverage was completed by the plan, this would not be reliable. For the same reasons mentioned above, plans often must reissue a certificate of creditable coverage and the date placed on the certificate would be the most recent issue date.

The proposed rule presents savvy individuals with an easy way to toll a significant break by telling the new plan that they simply never received a certificate of creditable coverage. This would place the new plan in a very awkward situation. If the new plan called the prior plan and was told that standard procedures were followed, the new plan would not know whether the old plan made an administrative error and failed to send the certificate or if the individual simply lost the envelope with the certificate before opening it. The new plan has no way of proving to the stop-loss carrier that a certificate was not actually received.

We recognize that the Departments are concerned about individuals who do not learn of the termination of their coverage until well after the termination occurs and that this proposed rule was designed to address this situation. In most cases however, the individual is aware that termination from their health coverage has occurred, even though a certificate has not been issued. Most events that trigger a loss of coverage are well known to individuals: termination of employment, reduction in hours, or an individual's failure to pay the premium. The Departments have fashioned a rule to address an infrequent event, namely an employer's or insurer's failure to issue a certificate, that will turn the administration of certificates and determining when significant breaks of coverage occur into a nightmare for all health plans subject to the rules.

We strongly urge the Departments to drop the proposed rule that would expand the significant break in coverage rules.

Applying for Special Enrollment

The proposed rule that would permit individuals to preserve their right to a special enrollment period by making an oral request to the plan administrator, the insurance issuer, the TPA, or any other designated representative is unworkable and must not be adopted.

We understand that the Departments would like an individual to be able to make a last minute decision to request special enrollment without being hindered by any written application forms. However, oral notifications are very problematic because employers do not have sound procedures for handling oral requests or for conveying oral requests to their TPAs for processing. Even if employers did have procedures in place, oral requests would be a constant trap for well-intentioned employers, with employees claiming that they made an oral request when none was made.

Instead of oral requests, we suggest that the notification of the intent to enroll be provided with a very short written request, as simple as, "I request a special enrollment," with a signature and a date. The application form would follow shortly thereafter and the individual would be given a reasonable time to complete the form.

We strongly urge the Departments not to require plans to honor oral requests.

The section of the proposed rule entitled *applying for special enrollment* also needs to be changed to accommodate eligibility and enrollment procedures of employee benefit plans. Under the proposed rule, any written request made to the plan administrator, the insurance issuer, the TPA, or any other designated representative would constitute a request for enrollment. TPAs typically do not interface directly with the clients' plan participants for enrollment purposes. The entity who customarily handles claim administration for a plan does not customarily handle enrollment. Claims administration and enrollment are two very different functions in the employee benefits world. The regulation should not dictate to whom a request for enrollment can be made and overstep the procedures TPAs and their clients have in place.

We strongly urge the Departments to eliminate references to specific entities who must handle a request for enrollment. Instead, the language should provide that any written request made to the plan's designated enrollment representative will constitute a request for enrollment.

Tolling of Period for Requesting Special Enrollment

The proposed rule extending the time period an individual has to request a special enrollment based on when the individual was provided with a certificate of creditable coverage is replete with problems. It is impossible for plans to know with any certainty when the certificate is provided, for all the reasons noted above concerning the significant break in coverage.

We strongly urge the Departments not to adopt the proposed rule on tolling the period for requesting special enrollment.

Special Rules for Certificates of Creditable Coverage

Under the proposal, if an employer switches from a self-funded plan to a fully-insured plan and no participants lose coverage under the plan, the self-funded plan would need to

issue certificates of creditable coverage to the participants. This would be very confusing to plan participants who would mistakenly believe that they were losing coverage under the employer's plan, when in reality they would not be losing employer plan coverage.

Under current practice, plans provide the necessary information to the new plan so that the new plan can provide accurate certificates in the future. In some cases, the prior plan provides the information using certificates but does not actually issue the certificates to plan participants. The current practice is working well and should not be altered.

We strongly urge the Departments not to require plans to issue certificates of creditable coverage to participants when they are changing benefit plans of the same employer as this will only cause confusion and frustration for plan participants.

Interaction with the Family and Medical Leave Act

The proposed rule permitting an individual to demonstrate FMLA leave for purposes of tolling a significant break in coverage should be changed to be more similar to the rules for demonstrating creditable coverage. Under the proposed rule, a plan must treat an individual as having been on FMLA leave for a period if the individual attests to the period of FMLA and the individual cooperates with the plan's efforts to verify the individual's FMLA leave. This is not enough assistance for the plan to make a determination that an individual has been on a period of FMLA leave and will make it impossible for the plan to verify a FMLA leave to the stop-loss carrier.

The proposed rule must be changed to require the individual to present the FMLA leave letter from the employer showing the beginning date of FMLA leave, or other corroborating evidence demonstrating the need for FMLA leave, such as medical certifications, or a birth certificate, in addition to the items required in the proposed rule.

Thank you for considering these comments.

Anne C. Lennan
Vice President
SPBA
Two Wisconsin Circle, Suite 670
Chevy Chase, MD 20815
(301) 718-7722

406 Packard Av
Pocatello ID 83201
January 29, 2005

U.S. Department of Labor
Employee Benefits Security Administration
Office of Regulations and Interpretations
200 Constitution Avenue, NW, Suite N-5669
Washington, DC 20210

To whom it may concern:

I would appreciate your interpretation of the provisions of 29 CFR §2590.71-3 as it relates to the following question:

> Can medical care, advice, diagnosis and treatment provided in a foreign country during the 6-month look-back period ending on the enrollment date be utilized as evidence of a pre-existing condition thus triggering a pre-existing condition exclusion? The individuals providing this care were not, to the best of my knowledge, licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law. I am using the definition of "State" found in 29 CFR §2590.701.2.

Thank you for your consideration of this matter.

Sincerely,

Michael Brennen

Michael Brennen

DRAFT

March 24, 2005

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue, NW
Room C-5331
Washington, DC 20210

Also submitted electronically at: E-OHPSCA.EBSA@dol.gov

Attn: Request for Information on Benefit-Specific Waiting Periods Under HIPAA Titles I & IV

On behalf of the undersigned organizations representing the interests of consumers covered by ERISA group health plans, Bazelon Center for Mental Health Law submits the attached comments on the Request for Information on Benefit-Specific Waiting Periods Under HIPAA Titles I and II published by the Department of Labor on December 30, 2004.

We applaud the Department's efforts in considering whether a benefit-specific waiting period utilized by a group health plan or issuer is a pre-existing condition exclusion under HIPAA. A rule prohibiting benefit-specific waiting periods for people with a history of group health coverage would be a critical step forward for millions of Americans now covered by ERISA group health plans, by ensuring that American workers and their families are able to access the health care they need.

The Health Insurance Portability and Accountability Act of 1996 was enacted to provide improved portability and continuity of health coverage in the group market. In particular, HIPAA was designed to limit exclusions for preexisting conditions, and prohibit discrimination against employees and dependents based on health status so that people with a history of coverage who switch jobs could continue to access health care. In other words, one of HIPAA's goals was to address the problem of "job-lock" – workers and their families being trapped in a job (due to medical problems that were covered by their existing health plan but would be excluded from their new health plan because of a preexisting condition). Allowing benefit-specific waiting periods would violate critical protections provided by HIPAA, exceeding the Department's administrative authority, contradicting congressional intent, and undermining good public policy.

1) Allowing benefit-specific waiting periods exceeds the Department's authority.

Allowing benefit-specific waiting periods would be an impermissible exception to HIPAA's standards for preexisting condition exclusions and would create a new general exception to HIPAA's portability rules. This would exceed the Department's administrative authority, result in an impermissible *legislative* action by a federal agency – a primary function of Congress – and violate the separation of powers doctrine under the U.S. Constitution.

Generally, an executive agency's authority is limited to implementing laws and to clarifying ambiguities in statutes where such exist. Chevron U.S.A., Inc. v. Natural Resources Defense Council, 467 U.S. 837 (1984) "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." Chevron, 467 U.S. 842-843. "The power of an administrative agency to administer a congressionally created...program necessarily requires the formulation of policy and the making of rules to fill any gap left...by Congress....If Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation." Chevron, 467 U.S. 843-844.

In HIPAA, Congress established specific standards for use of preexisting condition exclusions. Such standards seek to protect people with past or present medical conditions who enroll in a new group health plan. Similar to preexisting condition exclusions, benefit-specific waiting periods seek to exclude a particular condition from coverage for a period of time and apply to newly enrolled employees and dependents. For a person with medical conditions at the time of enrollment and for one with a chronic condition like diabetes (it is estimated that half of the population in the United States has a chronic condition), a benefit-specific waiting period would always function like a preexisting condition exclusion and thus would need to comply with HIPAA's limitations on such exclusions (including a requirement to reduce the exclusion period if the person had prior creditable coverage and a maximum allowable exclusion period of 12 months/18 months for late enrollees). Because a benefit-specific waiting period functions like an exclusion period for preexisting conditions, the Department should remind plans that the use such waiting periods must be consistent with preexisting condition exclusion periods.

If the Department allows plans to treat a benefit-specific waiting period differently from a preexisting condition exclusion period, then the new loophole would eviscerate HIPAA's protections and restrictions for use of preexisting conditions. Plans would use condition specific waiting periods to avoid giving credit for prior coverage and to exclude conditions from coverage for longer than the allowable 12 months under HIPAA. Allowing such periods would create an exception to HIPAA's preexisting condition requirements that does not exist in statute.

Under HIPAA, Congress authorized the Department to "promulgate such regulations as may be necessary or appropriate to carry out the provisions of this part." ERISA Title I, Part 7, Section 707. Congress did not, however, authorize the U.S. Department of Labor to administratively create exceptions to the strict standards in HIPAA for preexisting condition exclusions, especially an exception that would eviscerate the rule. With respect to preexisting conditions and exceptions to the statutory standards, Congress was unambiguous. Furthermore, there is no specific grant of authority to fill in gaps because Congress did not envision additional exceptions to coverage rules. Therefore, allowing benefit-specific waiting periods would exceed the Department's administrative authority and result in the Department making laws – a function of Congress – violating the separation of powers principle under the U.S. Constitution.

Congress also did not give the Department authority to create an additional category of allowable exclusions from coverage. Such an action by the Department is neither necessary nor appropriate and exceeds both the specific grant of authority in HIPAA to issue rules that are "necessary or appropriate" and general authority an executive agency has to implement laws.

Congress recognized and allowed three circumstances for plans to use in order to not cover benefits (some or all) under the group health plan for an individual (and families) who newly enroll. These three circumstances include preexisting condition exclusions, waiting periods, and affiliation periods (in case of an HMO) (ERISA, Title I, Part 7, section 701). Congress established standards and restrictions on the use of each. No where in Part 7 of ERISA is there a grant from Congress authorizing the Department to create a fourth category, benefit-specific waiting periods, that would allow plans to exclude covering specific conditions or treatment benefits for a period of time for people who newly enroll. By allowing benefit-specific waiting periods, the Department would exceed its regulatory authority by creating a *fourth* category of temporary exclusions from coverage for newly enrolled people. Congress did not authorize the Department to expand allowable temporary coverage exclusions under HIPAA. Such expansion fails to meet the test of being "necessary" or "appropriate" under the grant of authority to the Department under HIPAA. Additionally, such action would not be considered a reasonable agency interpretation of the law under the *Chevron* standard. The interpretation of the statute would contradict the clear intent of Congress expressed in the statute (through specifically identified permissible exclusion periods) and also contradict legislative intent evidenced in legislative history discussed below.

2) Allowing benefit-specific waiting periods contradicts clear congressional intent.

A benefit-specific waiting period is contrary to congressional intent. A goal of HIPAA was to address job-lock that was caused by plans not covering new employees (and their dependents) if they had prior or existing medical conditions.

"Millions of Americans have medical histories or preexisting conditions that make it difficult to get comprehensive insurance coverage. As many as 81 million Americans have preexisting medical conditions that could affect their insurability. Many people are locked in their jobs because they fear they will be unable to obtain comprehensive insurance in new jobs."[i]

Another purpose of HIPAA was to encourage people to stay insured continuously (rewarding those who stayed insured with credit for prior coverage and limitations on coverage exclusions).

"It makes elemental and much-needed improvements in health care coverage for Americans by guaranteeing `portability' of health insurance for employees who change jobs...."[ii]

"The American Cancer Society estimates that more than one million people will be diagnosed with cancer this year. Ten million Americans alive today have a history of cancer. Under current insurance practices, many of these people will be denied coverage if they change jobs or lose their job, or they will be squeezed out of their existing plan because of their health status. The health insurance reform bill addresses these critical issues by limiting preexisting condition restrictions and ensuring greater portability of coverage."[iii]

These important public policy goals were accomplished through strict "portability" standards in the group market. Benefit-specific waiting periods would allow plans to exclude from coverage a particular benefit for a period of time for new employees and dependents. This would establish new obstacles, creating job-lock – precisely what Congress was trying to address in 1996. Benefit-specific waiting periods are contrary to the clear Congressional intent of HIPAA.

3) Benefit-specific waiting periods are not good public policy.

Insurers claim that the purpose of pre-existing condition exclusions is to prevent people from 'gaming' the system by purchasing coverage only when they get sick. Benefit-specific waiting periods have the same affect, yet are indefensible. Benefit-specific waiting periods would apply to people who have done the right thing and maintained their health coverage through a loss of a job or a job change. People who have faithfully paid their premiums, in particular, should not have to start over again with a new exclusion period if they change jobs or lose their coverage. Benefit-specific waiting periods therefore do not accomplish the goal of encouraging people to stay insured. Instead, they set up significant new obstacles for people, punishing people who change employers and those who need medical care in their new plan.

Furthermore, allowing employers to force workers to wait for coverage for a specific benefit for years would deter people with that medical condition from

working for that employer. For example, workers with a history of cancer would not be inclined to work for an employer where there is a waiting period for chemotherapy or radiation treatment. Or, for example, workers with a history of back pain would not be inclined to work for an employer where there is a waiting period for herniated disk surgery or physical therapy. A person with diabetes would not work for an employer that requires for example three years on the job to qualify for diabetes benefits. In this way, employers can discourage people with expensive medical conditions from applying and hire only those workers who do not have costly medical conditions. This is precisely what Congress intended to prohibit. Allowing benefit-specific waiting periods, thus, contradicts public policy.

In closing, benefit-specific waiting periods allow employers, health plans and issuers to game the system, preventing sick employees for accessing critical treatments and screening out workers who may have costly conditions. Federal consumer protections under HIPAA were designed to limit the ability of employers, health plans, and insurers to exclude coverage for preexisting conditions so that plans cannot deny treatments to specific workers with health conditions and so that employers, health plans and insurers cannot discriminate on workers based on their health status.

To circumvent the intent of HIPAA, under current law, employers can instead make all workers wait years before they can access critical treatments such as organ transplants by using benefit-specific waiting periods. Just like preexisting condition exclusions, these benefit-specific waiting periods prevent workers who have health conditions from getting the critical health care treatments they need. Benefit-specific waiting periods should be prohibited altogether or if allowed, should be subject to the rules that apply to preexisting conditions and general waiting periods under HIPAA.

We thank you for your consideration of these comments and would be glad to meet with you as you develop these criteria to discuss our concerns in greater detail. Any specific questions or concerns you would like to discuss with us should be directed to Chris Koyanagi at the Bazelon Center for Mental Health Law (202) 467-5730 or at thompson@bazelon.org .

Sincerely,

Chris Koyanagi
Policy Director

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[i] S. Conf. Rep. No. S9515 (August 02, 1996).
[ii] S. Conf. Rep. No. S9505 (August 02, 1996).
[iii] S. Conf. Rep. No. S9502 (August 02, 1996).

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Agency : EMPLOYEE BENEFITS SECURITY ADMINISTRATION
Title : Notice of Proposed Rulemaking for Health Coverage Portability: Tolling Certain T Periods and Interaction With the Family and Medical Leave Act Under HIPAA Tit and IV
Subject Category : Health coverage portability; tolling certain time periods and interaction with Famil Medical Leave Act Excise taxes: Health coverage portability; tolling certain time periods and interaction with Family and Medical Leave Act Health coverage portal tolling certain time periods and interaction with Family and Medical Leave Act
Docket ID : 1210-AA54
CFR Citation : 29 CFR 2590
Published : December 30, 2004
Comments Due : March 30, 2005
Phase : PROPOSED RULES

Your comment has been sent. To verify that this agency has received your comment, please contact the agency directly. If you wish to retain a copy of your comment, print out a copy of this document for you

Please note your REGULATIONS.GOV number.

Regulations.gov #: EREG - 1 Submitted Mar 28, 2005

Author : Mrs. Beth Noffze
Organization : MSU Extension, Alpena County
Mailing Address :
Attached Files :

Comment : At a training that I was giving, someone asked, how long you need to keep divorce papers and when would you be required to show them?