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Medical Coverage for Adopted Children Under the Omnibus Budget Reconciliation Act of 1993

by Michael S. Melbinger

On August 10, 1993, President Clinton signed into law the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).[1] OBRA '93 added Section 609(c) to the Employee Retirement Income Security Act (ERISA).[2] Section 609(c) requires employer-sponsored group health plans that offer coverage to employees' biological dependent children also offer the same coverage to children placed with employees for adoption. This change is revolutionary because it represents the first time since ERISA's promulgation in 1974 that a particular benefit has been mandated under medical benefit plans governed by ERISA. Until the passage of OBRA '93, ERISA only **regulated** employers' health care plans. It did not **mandate** specific benefits under those plans. This article will discuss the following issues: (i) the interaction of state and federal laws applicable to employers' group health plans; (ii) the impact of newly created Section 609 on employers' group health plans; and (iii) the possible impact of President Clinton's health care reform proposal.

I. ERISA COVERS EMPLOYER-SPONSORED GROUP HEALTH PLANS

ERISA, as defined in ERISA Section 3(1), applies to any employer-sponsored group health plan that is an "employee welfare benefit plan."[3] Virtually every health or medical plan maintained or contributed to by an employer in the United States is subject to ERISA.[4] The only meaningful exceptions to ERISA's coverage are for group health plans[5] that are either government[6] or church plans.[7] While the ERISA exclusion for government and church plans would seem to be significant because of the sheer number of individuals employed by these entities, such plans remain subject to state or federal laws mandating coverage.

Until the passage of OBRA '93, ERISA only regulated employers' health care plans. It did not mandate specific benefits under those plans.

II. ERISA PREEMPTS STATE LAWS

ERISA Section 514 expressly provides that its provisions "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."[8] Preemption of state law by ERISA has been interpreted broadly by the United States Supreme Court.[9] ERISA's preemption provision, however, includes a "savings clause" that provides an exemption of state laws that regulate insurance.[10] This savings clause applies to employers' medical benefit plans that are insured but does not apply to employers' self-insured plans. Thus, state laws mandating specific coverage, including coverage for adopted children,[11] apply to employers' plans that are insured, but not to employers' self-insured plans. Only ERISA governs benefit coverage under an employer's self-insured plan.

III. INSURED MEDICAL BENEFIT PLANS VS. SELF-INSURED PLANS

The vast majority of employers with more than 500 employees do not provide group health benefits to their em-

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ployees through the purchase of insurance or an insurance policy. These employers are said to be "self-insured" because they pay employees' medical benefit claims from general corporate assets or a dedicated trust fund. Although an insurance company may process claims, the company in this situation is only providing an administrative service, not "insurance."

But determining whether an employer's medical benefit plan is an insured or self-insured plan can be difficult. Many self-insured plans are administered by an insurance company under what is known as an administrative services only (ASO) contract.[12] Courts have uniformly held that an ASO arrangement does not render an employer's plan insured.[13]

Most self-insured employers also maintain a "stop-loss" insurance policy on their medical benefit plans.[14] The vast majority of courts have held that as long as sufficient risk remains with the employer, the existence of a stop-loss policy does not render an employer's plan insured. In other words, as long as the insurance truly is stop-loss or excess claims insurance, the employer's plan will be deemed self-insured and preemption by ERISA will apply.[15]

The new law requires any "group health plan" that provides coverage for biological dependent children must also provide identical benefits to dependent children placed with participants for adoption.

Finally, some employers' medical benefit plans are operated under a so-called "minimum premium contract" with an insurance company.[16] Most courts have held that a minimum premium arrangement does not create an insured plan as long as such an arrangement shifts the risk of loss to the employer by requiring continued premium contributions as employees submit claims.[17]

Each of the fifty states has adopted expansive and detailed lists of the types of coverage, benefits, and provisions that must be contained in policies covering persons employed within its borders.[18] Some states have adopted provisions that are similar to those of newly created Section 609 of ERISA,[19] but those states are in the minority.

IV. NEW SECTION 609

OBRA '93 added Section 609, entitled "Additional Standards for Group Health Plans to ERISA."[20] ERISA Section 600 contains provisions requiring that group health plans offer employees and their dependents the right to continued coverage under their employer's group health plan following an event that would cause termination of that coverage, *e.g.*, a termination of employment, death, divorce, or loss of dependent status.[21] Indeed, subsection (a) of Section 609 is entitled, "Group Health Plan Coverage Pursuant to Medical Child Support Orders."

The provisions affecting coverage of adopted children are spelled out in Section 609(c), which reads in relevant part:

> (c) GROUP HEALTH PLAN COVERAGE OF DEPENDENT CHILDREN IN CASES OF ADOPTION --
>
> (1) COVERAGE EFFECTIVE UPON PLACEMENT FOR ADOPTION.
> In any case in which a group health plan provides coverage for dependent children of participants or beneficiaries, such plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries under the plan, irrespective of whether the adoption has become final.

The 1993 Amendment to ERISA: The Cure for an Adoptive Family Problem

by Steve Humerickhouse

For a long time, families have had difficulty obtaining health insurance for their adopted children through either their employer or a private plan. While children with special medical needs or preexisting medical conditions have been affected the most significantly, even adopted children in perfect health were often denied health insurance, merely because they were adopted. In recent years the situation has worsened as a greater number of employers and insurers have sought to decrease their risks by dropping or limiting coverage for certain groups of people. Even if parents were able to overcome the difficulty of finding health insurance for an adopted child, the insurance was usually only available at exorbitant rates.

But on August 10, 1993, the Employee Retirement Income Security Act of 1974 (ERISA), which governs all employer-group health care plans, was amended when four paragraphs were added to the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). These paragraphs included a mandate that adopted children receive the same health care coverage as birth children. This article explains the plight of adoptive families before and after the enactment of the ERISA amendment.

Historically, adoptive families have faced a two-fold problem under the structure of the existing health care system. One difficult problem was the amount of time it takes for an adoption to become final. While the parents needed insurance from the time the child was

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placed in the home, the insurance companies often did not want to insure the child until after the adoption was final, which could take years. The second problem concerns adopted children who have preexisting health conditions. These conditions expose insurance companies to greater risk, which makes them less likely to cover a child. The ERISA amendment was designed to remedy both of these circumstances.

An adoptive placement period can range anywhere from three months to several years. During that time, the family is financially responsible for the care of the child. The problem was compounded if after the adoption became final, an insurer imposed a waiting period before coverage began. This waiting period could last for one year or more. Thus, the total possible period of time before coverage began may have been three or four years. During this time, the prospective families had to pay all medical expenses for the child.

Before passage of OBRA '93, the decision by a health care provider to offer coverage for a child from the beginning of placement or not until after finalization of the adoption was discretionary on the part of the provider. Health care providers also were free to deny coverage to children who had preexisting conditions.

Over the last several years, Adoptive Families of America (AFA) gathered much information about adoptive families and the problems they encountered in trying to obtain health insurance coverage for their children who were either adopted or pending adoption. The following circumstances, taken from AFA's files, may help illustrate the scope of the problem for families before the amendment to ERISA was passed. These cases do not necessarily represent the majority of adoptions in the United States.

• In Minnesota, a couple caring for a "special needs" child in foster care sought to adopt the child. The child had a severe disability, which resulted in medical expenses averaging about $200,000 per year. The couple contacted their self-insured, labor union plan about possible health care coverage for the child. The union plan refused to cover the child and, as a result, the child remained in foster care because the parents could not afford to adopt him and pay for private health care coverage. Shortly after the family's inquiry, the union plan changed their policy so that adopted children who had preexisting conditions before the finalization of their adoptions would no longer be covered by the plan.

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(2) RESTRICTIONS BASED ON PREEXISTING CONDITIONS AT TIME OF PLACEMENT FOR ADOPTION PROHIBITED.
A group health plan may not restrict coverage under the plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of such child at the time that such child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.[22]

These provisions apply to children who have not turned 18 at the time of adoption or placement.[23]

The new law requires any "group health plan" that provides coverage for biological dependent children must also provide identical benefits to dependent children placed with participants for adoption.

Employers' group health plans rarely contain an express exclusion from coverage for adopted children. Some employers' plans, however, excluded adopted children of employees from eligibility until the adoption became final.[24] Section 609 specifies that its requirements apply **regardless of whether the adoption has become final**.

In addition, under Section 609, an employer's group health plan may **not** restrict the coverage of any dependent child adopted, or placed for adoption, solely on the basis of a preexisting condition if the child would otherwise be eligible for coverage under the plan and the adoption or placement occurred while the participant was eligible for coverage. Preexisting condition clauses are a common feature in most employers' group health plans. Such a clause is designed to limit the employer's medical benefit expenses by limiting its liability for costly treatments and conditions possibly in existence when the employee is hired by the employer.[25]

For adopted children to be entitled to coverage under an employer's medical benefit plan, an adoptive parent must be a plan participant and eligible to elect family coverage under the plan. An adoptive parent also must follow all other applicable requirements for coverage under the plan. Before August 10, 1993, an adopted child (or a child living with adoptive parents prior to finalization) could be denied coverage by an employer because of a preexisting condition. But Section 609 now appears to mandate coverage in such circumstances if the adoptive parents otherwise meet the eligibility and participation requirements of the employer's plan.

For adopted children to be entitled to coverage under an employer's medical benefit plan, an adoptive parent must be a plan participant and eligible to elect family coverage under the plan.

There still may be circumstances and plans under which an adopted child would not be eligible for medical coverage or would be subject to an exclusion of coverage because of a preexisting condition. For example, if an employee adopted a child at a time when the employee was not eligible to elect coverage under the employer's medical plan, any preexisting condition clause might still apply. Similarly, if the employee/parent changed jobs, any preexisting condition clause in the new employer's plan could be applicable. Finally, any exclusions or limitations that apply to all participants and dependent children under an employer's medical plan would also apply to adopted children. The plan need not provide coverage to adopted children that is better than the coverage provided to other children.[26]

The new law took effect on August 10, and applies retroactively to children adopted or placed prior to the effective date as well as to those placed or adopted after it. Thus, a child adopted by an employee prior to August 10, 1993 with a health problem that was excluded from coverage by an employer's preexisting condition clause prior to August 10, is entitled to full coverage of that condition under the employer's health plan on and after August 10.

However, questions regarding this interpretation may arise in the future because there is no legislative history detailing the meaning of Section 609.[27] There are two reasons that such questions may arise. First, the language of Section 609 did not appear in either the House or the Senate versions of the budget act. It only appeared during the joint House-Senate conference. Second, OBRA '93 contained several controversial revenue provisions that dominated the discussions.

Under Section 609, many employers will be required to amend their group health benefit plans to remove preexisting condition clauses or other differences in treatment applicable to adopted dependent children. The only way that an employer's plan could reduce benefits for, or eliminate the coverage of, adopted children today would be to reduce or eliminate such coverage for all dependent children.[28]

V. THE IMPACT OF HEALTH CARE REFORM

On October 27, 1993, the Clinton administration released a second draft of the Health Security Act ("HSA"), its proposal to reform the United States' health care delivery system. The fundamental tenet of the HSA is to insure health benefit coverage for all Americans and legal residents.[29] Under the HSA, every American would receive health care coverage through either a "regional health alliance" or a "corporate health alliance."[30] Most citizens, including the self-employed, persons on Medicaid, and individuals and families who work for employers with fewer than 5,000 employees, would purchase their health coverage through a common entity called a "regional health alliance."[31] Employers with more than 5,000 employees would be able to establish a "corporate health alliance" and buy health coverage directly from health plans without participating in a regional alliance.[32]

Although no one expects the HSA to be approved as drafted, even in its current form the HSA does not render Section 609 irrelevant. It appears that while regional health alliances would be fully governed by the mandated benefit and coverage features of the HSA, corporate health alliances would still enjoy some level of flexibility under HSA and preemption from state laws under ERISA.[33] However, it seems likely that, even if ERISA preemption survives as to most state law matters, minimum benefit packages and employee coverage features would be mandated for all employer's health benefit plans.

Generally, each regional health alliance would need to make available at least three coverage options: (i) a fee-for-service (or indemnity plan) under which individuals have the most flexibility to choose their own health care provider but receive less reimbursement for services rendered;[34] (ii) a health maintenance organization (HMO) under which individuals can choose only from physicians and providers within the organization;[35] and (iii) a combination of the two in something akin to a preferred provider organization (PPO), under which individuals pay one rate to utilize physicians outside of the organi-

> ***The new law took effect on August 10, and applies retroactively to children adopted or placed prior to the effective date as to those placed or adopted after it.***

Cure for Adoptive Family Problem, cont.

• The employer of an Ohio family, whose six adopted children had special needs, terminated health care coverage for the family without notice. The family had been covered for several years and had not considered finding a new insurer. After inquiry, the employer reportedly told the parents that it would reinsure them only if they would sign a waiver stating that they would not try to reinstate the children's coverage.

Although four of the children had Medicaid coverage through adoption assistance agreements with the state, these grants are not usually large enough to cover all of the medical expenses of a child. Plus, two of the children were not covered by an adoption assistance agreement. Thus, in order to receive health care coverage for these two children through Medicaid, the family had to meet that program's financial eligibility requirements, which essentially required the family to impoverish itself. To achieve this end, the employer agreed not to pay the father more than $15,480 per year, the Medicaid eligibility income requirement for a family of eight.

• Four children in Tennessee were voluntarily surrendered by their birth parents and later placed with two separate families for adoption. Doctors examined each child and determined that the children were healthy and did not have any preexisting conditions. Because Medicaid coverage for a child expires when the adoption becomes final, the prospective parents needed to find a private health insurer for the children. Unfortunately, neither family was able to find an insurance company willing to provide health care coverage for their children.

While it may be understandable from a business point of view why employers or insurance companies would not want to cover children with expensive medical conditions, what surprised most people was that insurance companies refused to cover perfectly healthy children just because they were adopted.

Adoptive families have asked for equal treatment by the health care industry for their adopted children. Biological children do not have placement or waiting periods attached to their health care coverage. Biological children are defined as not having preexisting conditions, regardless of medical realities or whether their parents were informed while the child was still in utero that the child would have disabilities, defects, or illnesses. Biological children with such conditions are automatically accepted into the health care system at birth. Yet, health care plans in recent years, whether privately pur-

chased or provided by employers, have increasingly sought to exclude adopted children from coverage.

But with the passage of the ERISA amendment, adoptive families covered by employer group health plans will now have coverage for their children from the beginning of placement, without restrictions on their preexisting conditions. ERISA, however, does not cover children of parents who work for the federal government, some state and local governments, as well as many church-related organizations.

Questions remain, however, concerning the amendment to ERISA. AFA has already received numerous inquiries from families whose children were adopted before the enactment of the amendment. These families have health care coverage through an employer who refused coverage to their adopted children. The yet unanswered question is whether these children are now covered. The answer is equally unclear when we consider the issue of placement. Under the ERISA amendment, it is unclear at what stage in the adoption process an employer's health insurance program must cover a child.

A dispute also exists as to whether collective bargaining agreements were constructively altered by the signing of OBRA '93 to include coverage for adopted children or whether this provision becomes effective at the resolution of a final bargaining agreement when the next contract is negotiated. Although many federal laws are written so that a new law is presumed included at the beginning of a succeeding contract, the amendment to ERISA was not written this way.

Other areas for clarification include apparent conflicts of jurisdiction between state and federal law, especially where church organizations and local government employers are concerned.

In addition to enforcing compliance with the new ERISA standard, a majority of the states should enact state laws to fill in the gaps and guarantee coverage to adopted children in areas not covered by the ERISA amendment. Currently, only ten states have laws which mandate that adopted children be covered from the start of placement. But attempts are being made to require complete coverage of adopted children in Michigan, Pennsylvania, Kentucky, and Tennessee.

The federal government should also protect its own employees. Federal and military workers are not covered by ERISA. Thus, until all of the states have assured families of coverage or until President Clinton's health care reform bill is enacted, which affords health care coverage to everyone, some adoptive families will remain vulnerable.

zation and pay a lower rate for services provided within the organization.[36] Everyone, regardless of age, health, or occupation, would be able to purchase a health policy providing specifically mandated benefits from one of several competing local health plans for an annual fee. Prices would vary among the three options described above, and could vary among the providers offering those options within the region. But health plans within the same region would have to charge everyone about the same price with some variation allowed for age of enrollees.[37]

Under Section 609, many employers will be required to amend their group health benefit plans to remove preexisting condition clauses or other differences in treatment applicable to adopted dependent children.

Each optional health plan made available by a regional alliance would have to cover at least a standard set of benefits. The proposed standard benefits package would emphasize primary and preventive care. Included would also be all "medically necessary" services such as physician care, inpatient and outpatient hospital care, emergency care, diagnostic laboratory, and radiological services as well as some home care.[38] Each competing health plan could offer additional benefits as a means of attracting business.

Each employer must provide or contribute to the cost of coverage for all of its full-time employees.[39] An employer's contribution to its regional alliance for health care for its employees would be equal to 80 percent of the product of the number of full-time equivalent employees it employs in a month multiplied by the weighted average premium for health insurance coverage in the regional alliance.[40] An employee would pay 20 percent of the cost of his coverage if he elected the average cost plan provided by the alliance.[41] If the employee were to elect a more costly plan made available by the alliance, his employer would pay the same amount, and the employee would pay the difference between the cost of the more expensive plan and the employer's required contribution. If the employee elected a plan costing less than the average, the employee could pay less than 20 percent of the cost of his coverage.

If the HSA or a similar universal health coverage statute becomes law, all employees and their dependents could enjoy medical benefit coverage at nearly identical costs. A standard benefits package would be mandated. Preexisting condition restrictions would be eliminated.[42]

VI. CONCLUSION

The provisions of Clinton's health reform proposals may not be enacted for several years and are destined to be phased-in over a period of several years.[43] In the years prior to the final enactment of health care reform legislation, benefit costs are likely to continue to rise rapidly and employers are likely to continue to attempt to control those costs. However, an employer no longer will have the flexibility to pro-

The requirement that employers provide equal coverage under their health benefit plans to adopted children will not substantially increase most employers' group health plan costs. Employers should be much more concerned about the fact that for the first time since 1974, mandated benefit provisions have been added to the terms of ERISA.

vide benefits to a dependent child who is adopted by an employee that differ from those the employer provides to a dependent child who is born to an employee.

The requirement that employers provide equal coverage under their health benefit plans to adopted children will not substantially increase most employers' group health plan costs. Employers should be much more concerned about the fact that for the first time since 1974, mandated benefit provisions have been added to the terms of ERISA. Employers should be concerned that Congress, having overcome its aversion to mandating benefits under ERISA, might continue to add required benefits to ERISA between now and the time health care reform becomes law. ❖

ENDNOTES

1 Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66 § 4301 (1993) U.S.C.C.A.N. (107 Stat.) 312, 317 (to be codified at 29 U.S.C. § 609 (c)).

2 OBRA '93 also mandates that an employer's group health plan "may not reduce its coverage of the costs of pediatric vaccines" below the level of coverage provided as of May 1, 1993. OBRA '93 § 4301 (1993), 29 U.S.C.A. §§ 1001-1461 (West 1985), Employment Retirement Income Security Act of 1974, Pub. L. No. 93-405, §§ 1-4082 88 Stat. 829 (1974).

3 The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or any employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. ERISA § 3(1).

4 ERISA's coverage is intended to be broad. ERISA § 4(a) expressly provides that the provisions that follow "shall apply to any employee benefit plan if it is established or maintained -- (1) by any employer engaged in commerce or in any activity affecting commerce."

5 ERISA § 4(b).

6 Government plan is defined in ERISA § 3(32) as "a plan established or maintained for its employees by the government of the United States, by the government of any state or political subdivision thereof, or by any agency or instrumentality of any of the foregoing."

7 The term "church plan" is defined in ERISA § 3(33) to include "a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from taxes" under the Internal Revenue Code § 501 (1954).

8 ERISA § 514(a).

9 *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Shaw v. Delta Airline, Inc.*, 463 U.S. 85 (1983).

10 ERISA § 514(b)(2)(A): "[N]othing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

11 Minn. Stat. Ann. ¶ 62A.27 (West Supp. 1993) (Coverage for Adopted Children).

12 Insurance companies are still the recognized experts at administering medical benefit plans and paying claims. Thus, most self-insured employers continue to utilize an insurance company for administration of their medical plans.

13 *See Insurance Bd. v. Muir*, 819 F.2d 408, 413 (3d Cir. 1987); *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419, 421 (4th Cir. 1985), *cert. denied*, 476 U.S. 1179 (1986).

14 Stop-loss insurance is designed to protect the self-insured employer from excessive losses due to catastrophic claims. Typically an employer's stop-loss policy will pay individual and group claims in excess of certain predetermined maximums.

15 *See United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1158 (9th Cir. 1986); *Thompson v. Talquin Bldg. Prod. Co.*, 928 F.2d 649 (4th Cir. 1991). *But see Michigan United Food & Commercial Workers Unions v. Baerwaldt*, 767 F.2d 308, 312 (6th Cir. 1985), *cert. denied,* 474 U.S. 1059 (1986).

16 A "minimum premium arrangement" combines the ASO arrangement and stop-loss insurance coverage. The employer pays a minimal premium amount and is obliged to make additional payments

17 *See supra* note 19.

18 *See* Ill. Ann. Stat. Ch. 73, ¶ 963B-1 (Smith-Hurd Supp. 1992); Minn. Stat. Ann. ¶ 62A.

19 *See supra* note 22.

20 OBRA '93 § 4301.

21 These provisions are commonly referred to as "COBRA" rights. COBRA is an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985, which established the provisions under ERISA and the Internal Revenue Code.

22 OBRA '93 § 4301.

23 OBRA '93 § 4301, ERISA § 609(c)(3).

24 Generally, this exclusion was thought to avoid covering medical expenses for children who were placed with the employee temporarily, and expenses prior to the time a child became "officially" a dependent of the employee. ERISA § 203.

25 A practical effect of preexisting condition clauses in employers' health plans is to deter employees whose health conditions are likely to adversely affect the employer's health claims experience from seeking or accepting employment with the employer. The skyrocketing cost of providing medical benefits, however, has led many employers to take this risk.

26 Welfare benefits do not "vest" in a employee the way that pension benefits do (ERISA § 203). Thus, an employer could amend or terminate its group health benefit plan at any time, on a prospective basis.

27 The Conference Report of the Committee on the Budget House of Representative contains just two short sentences parroting the terms of Section 609. By contrast, the Conference Report devotes five full pages to the $1 million ceiling on deductible executive compensation. These five pages contain detailed descriptions and examples which flesh out the bare bones of the statutory provisions upon which executive compensation practitioners rely heavily on advising clients. H.R. Conf. Rep. No.____; 103rd Cong., 1st Sess. 378 (1993).

28 *See supra* note 29, regarding ERISA § 203.

29 HSA § 1001.

30 HSA § 1301, § 1311.

31 Id.

32 HSA § 1311 (b)(1)(B)(ii).

33 HSA § 8402.

34 HSA § 1133.

35 HSA § 1132.

36 HSA § 1134.

37 HSA § 6122.

38 HSA §§ 1101-1128.

39 HSA § 1901(b)(2), § 6121.

40 HSA § 6122.

41 HSA § 1131.

42 HSA § 1402(b).

43 HSA § 1006(c). In the Act, the "general effective date" means January 1, 1998. Id.