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Health Care Benefits on Divorce

Health Care and Family Law: An Unhealthy Alliance

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Introduction

Health care has been and continues to be one of this nation's major unsolvable dilemmas. We still have more than 41.2 million Americans without medical insurance coverage.[1] In California alone, there are more than 6.3 million uninsured.[2] Those who are uninsured are not the only ones who suffer from the health care crisis. Individuals and families who do have coverage have seen their medical insurance coverage, independent choice of physicians, and point of service plans slide into the managed care system with cries of discontent by patients and providers alike.[3] Doctors lament loss of patient contact, falling income, overwhelming bureaucracy, loss of autonomy, and necessity of defensive medical procedures to ward off malpractice suits. The failed Clinton Healthcare Initiative in 1993-1994 revealed the necessity and near impossibility of a cure.

In the midst of this unfortunate morass, juxtaposed with continuing progress in medical technology and biotech advances, the changing composition of the modern American family doesn't fare very well. Health care coverage for the increasingly varied constellations of family units has become a major social, political, and economic issue. Single parents, same sex domestic partners, changing job patterns, and constantly changing insurance coverage modules combine to create a dangerous quagmire for continuing, affordable, and available healthcare.

The interplay between health care concerns and family law issues makes it critical that family law practitioners be aware of the major components of health care coverage. This article addresses important areas of health care law which must be the subject of technical attention and wise counsel in advising clients in the midst of personal and family transition.

Consolidated Omnibus Budget Reconciliation Act of 1985

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")[4] is a major area of health care law with which family law practitioners should be familiar. COBRA provides that employers who provide their employees with medical coverage must provide continuation coverage to employees and their families[5] who would otherwise lose coverage under the employer's plan as a result of a qualifying event.[6] Qualifying events include: (a) a covered employee's divorce or legal separation; (b) death of a covered employee; termination of a covered employee other than by reason of the employee's gross misconduct; or (d) a reduction in a covered employee's hours of employment.[7] Once a qualifying event occurs, the covered employee, his or her spouse, or dependents seeking COBRA coverage must elect such coverage within 60 days of the occurrence of the qualifying event and must pay the required premiums.[8]

There are four critical points of the COBRA legislation with which family law practitioners should be aware. First, continuation coverage under COBRA normally lasts for a maximum of eighteen months.[9] When the qualifying event, however, is a covered employee's divorce or legal separation, COBRA coverage lasts for thirty-six months.[10] Second, an employer may not deny COBRA coverage to a qualified beneficiary merely because he or she has other group health care coverage at *the time* of the COBRA election (i.e., through another family member).[11] In the event of a divorce, for example, there may be circumstances in which a wife or husband may be entitled to receive "double coverage."[12] That is, a party may be eligible to receive coverage from his or her own employer, as well as from the employer of his or her former spouse.[13] COBRA, however, provides that an employer can terminate a qualified beneficiary's continuation cover-

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age if he or she becomes covered under another group health insurance plan *after* electing COBRA coverage. But an employer may only terminate a qualified beneficiary's continuation coverage in such circumstances if the other plan does not exclude coverage for a preexisting condition that is afflicting the beneficiary.[14]

Third, when an employer withdraws from a prior insurance plan and establishes a new one for its remaining employees, the employer may not transfer the COBRA beneficiary's coverage that originated under the beneficiary's old plan.[15] For example, if a wife upon divorce elects COBRA coverage under Blue Shield and her former husband's employer later decides to switch its group coverage from Blue Shield to Kaiser Health Plan, the wife would still be entitled to coverage under Blue Shield. This results from the fact that a plan sponsor of a group health plan must offer continuation coverage to its employees, their spouses, and dependents who become qualified for such coverage while covered by the plan, and that coverage is to be provided under the health coverage plan in which the beneficiary participated at the time of the event.[16] The rationale behind this rule is to forbid plan sponsors from discriminating between COBRA beneficiaries and active employees under a single plan.[17] An employer, however, such as in the example above, who maintains coverage under two distinct plans, may and in fact must treat COBRA beneficiaries differently than its other active employees.[18] Thus, in the example above, the wife would be entitled to coverage under Blue Shield because that is the coverage under which she was insured and elected at the time of her divorce.

Fourth, "an employer that provides conversion rights from a group policy to an individual policy for eligible active participants must make the same coverage rights available to expiring COBRA beneficiaries."[19] The participant should therefore contact the plan administrator and inquire into the conversion policy for active participants and COBRA beneficiaries.[20] If the employer does offer such a conversion policy, the insurer will be required to make available an individual health care policy to a former spouse at the expiration of his or her COBRA coverage, although he or she may not have otherwise have been eligible for such coverage.[21]

The Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA")[22] is another important aspect of health care law which should command the attention of family law practitioners. HIPAA, when it was initially enacted, had addressed numerous topics but had two primary goals. The first was to ensure portability of an employee's health care coverage after leaving an employer. This goal placed significant emphasis on limiting the time period within which a new health care insurance plan could exclude coverage of an individual's preexisting condition.[23] This intended purpose provided that a health plan could not discriminate against an individual and deem the person ineligible for enrollment in the plan strictly because of that person's health status.[24] The portability and limitation on preexisting condition exclusions of this federal law are particularly important to family units in transition because of the crucial issues of health care coverage incident to a change of employment.

A second primary goal of HIPPA was an attempt to improve the efficiency and effectiveness of the health care system.[25] HIPAA sought to achieve this goal by requiring the U.S. Department of Health and Human Services to adopt national standards for electronic health care transactions.[26] In doing so, Congress realized that advances in electronic technology could potentially erode the privacy of health information.[27] To prevent this from occurring, Congress mandated that provisions be incorporated into HIPAA that mandated adoption of federal privacy guidelines and protection for certain individually identifiable health information.[28] Federal regulations were adopted and were recently implemented effective April 14, 2003.[29]

HIPPA promulgates new standards and rules concerning medical privacy rights and the release of health care information. This can be vitally important in dealing with health care coverage and treatment needs in blended and nontraditional family units.

Qualified Medical Child Support Orders

Qualified Medical Child Support Orders ("QMCSOs") represent another area of health care law too often overlooked. Prior to the Omnibus Budget Reconciliation Act of 1993 ("OBRA-93"),[30] employees covered under their employer's health care plans could generally provide coverage to their children under the plan only if the children met the plan's definition of dependency.[31] One of the criteria customarily included in the dependency test was that a child must *reside with* the employee in order to be eligible for health care coverage.[32] Many times, however, as the result of a divorce proceeding, an employee would lose primary residential custody of a child, yet would still be required to provide health care coverage for such child under the terms of the divorce decree.[33] While the employee would be obligated to follow the court order regarding the provision of health care coverage, the employer-sponsored health care plan was under no similar obligation.[34]

With OBRA-93, when a plan administrator is served with a QMCSO that satisfies the requirements of ERISA § 609, the employer is obligated to adhere to its terms

regarding provision of group health care coverage for its employee's noncustodial child.[35] To satisfy the requirements of ERISA § 609, the QMCSO must specify: (1) the name and last known mailing address (if any, of the participant and the name and mailing address of each alternate recipient covered by the order); (2) a reasonable description of the type of coverage to be provided by the plan to each alternate recipient, or the manner in which such type of coverage is to be determined; (3) the period to which such order applies; (4) each plan to which such order applies; (5) provide for child support with respect to a child of a participant under a group health plan provide for health benefit coverage to such a child; (6) is made pursuant to a state domestic relations law; (7) must relate to benefits under such plan; (8) enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan; or (9) not require a plan to provide any type or form of benefit or any option not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act.[36]

There are two important points about QMCSO's concerning which family law practitioners need to be aware. First, when a noncustodial parent is required under a divorce decree to provide health care coverage for his or her children, the attorney representing the noncustodial parent must pay careful attention to the language drafted in the decree.[37] Specifically, the attorney for the noncustodial parent should avoid inclusion of language that reads: "Husband shall provide all health care coverage for noncustodial children." The reason is that this seemingly straightforward sentence could end up costing that party hundreds of thousands of dollars out of his or her own pocket.[38] An example better illustrates the point.[39] Hypothetical employee Michael M. chose a managed health care network for his employer-provided health coverage. Under this plan, Michael is required to seek treatment from a network panel physician or hospital to obtain reimbursement. If he seeks treatment from an out-of-network physician or hospital, he will not be reimbursed. Michael's divorce decree contains language that requires him to provide health care coverage for his noncustodial children. Six months after entry of the dissolution judgment, Michael is notified by the plan administrator that his former wife obtained treatment for their son at an out-of-network hospital. Michael is also advised by the plan administrator that he will not be reimbursed for these expenses because his former wife went outside of the plan. From a strict reading of the divorce decree, the entire hospital bill is Michael's responsibility.

To prevent such a scenario, the following specific points should be covered in a divorce decree to protect a noncustodial parent: (1) cost-sharing by both parties for premiums, deductibles, coinsurance, noncovered or limited coverage expenditures, and plan penalties; (2) required adherence to health plan provisions; (3) financial responsibility for unilateral choices of medical treatment; and (4) other plans of coverage if children become eligible for coverage under another plan, at less or no cost (if so, such coverage should be obtained, with the noncustodial parent paying or sharing in any additional premiums).[40]

Second, while a company is in the process of determining whether a QMCSO should be deemed qualified, it may want to consider adopting interim health care coverage for noncustodial children under QMCSOs that have not yet qualified.[41] The reason is to avoid the catastrophic situation that would occur if a noncustodial child were to incur a large health care expense before his or her effective date of coverage.[42] Any associated premiums due for such interim coverage would be deducted from the participant's compensation.[43] A company that adopts such interim coverage should include written confirmation of its QMCSO procedures, including the time frame for such interim coverage and the company's procedures for implementing such coverage.[44] Interim coverage would serve the best interests of the child and would also help the company avoid liability should the noncustodial child incur a significant medical expense and it is later determined that the company failed to review the QMCSO in a timely manner.[45]

Health Care Benefits for Domestic Partners

Health care benefits, decision-making authority, inheritance rights and tax relief provisions are part of the evolving package of rights afforded to domestic partners in California.[46] Hospitals and other health facilities must allow a patient's registered domestic partner to visit and must also afford visitation privileges to children of the patient's domestic partner, and to the domestic partner of the patient's parent or child.[47] Such visitation rights need not be granted if: (a) no visitors are allowed; (b) the facility reasonably determines the presence of a particular visitor would endanger the health or safety of a patient, member of the staff or other visitor, or would significantly disrupt the facility's operations; or the patient has indicated to a staff member that he or she does not want the person to visit.[48] Domestic partners have no greater health facility visitation rights than do other family members and health facilities remain free to establish reasonable restrictions upon visitation, including restricting the hours of visitation and number of visitors.[49]

Registered domestic partners are treated as dependents or family members for certain health insurance coverage purposes. Group health care service plans must offer

employers coverage for their employees' domestic partners "to the same extent, and subject to the same terms and conditions" as the employees' dependents.[50] Under such coverage, a domestic partner is enrolled and treated as an employee's dependent. The plan may require documentation verifying the domestic partnership registration, and notification upon its termination.[51] As with group health plans, group disability insurers must offer employers coverage for registered domestic partners of employees, insured or policyholders "to the same extent, and subject to the same terms and conditions" as the employee-insured's dependents.[52] If a patient lacks the capacity to make a health care decision, his or her registered domestic partner has the same authority as a spouse to make the decision on his or her behalf.[53]

Tax relief is provided by California statute to permit a taxpayer's registered partner to be treated as a spouse in order to obtain deductions for medical expenses and health insurance costs under a variety of specified provisions of the Internal Revenue Code.[54]

Health Insurance Benefits as a Divisible Community Asset

Health insurance coverage has become an important and valuable family asset and its attendant cost has become a continuing necessary expense. Employer-sponsored subsidies of health insurance premiums have become an increasingly frequent retirement benefit for retiring employees. Actuaries and valuation experts can argue about the value of such an important economic benefit, but the condition precedent to reaching that issue is whether or not the benefit constitutes a divisible community asset.

The recent case of *In re Marriage of Ellis*[55] held that a postretirement subsidized health insurance premium is not a divisible community asset. In *Ellis*, Harold Ellis had worked for the City of Los Angeles for more than 20 years. When he was ready to retire, his employer-sponsored postretirement health insurance included a subsidized premium. During the dissolution proceeding, his wife contended that the premium subsidy was a community asset subject to division by the court. The trial court ducked the issue by reserving jurisdiction until the time Harold actually retired. When that time finally arrived 10 years later, the trial court bifurcated the issue whether there was a community property interest in the premium subsidy and determined there was a community interest because Harold's right to the postretirement health insurance premium subsidy was, at least in part, the result of his employment. Harold's appeal was treated as a writ petition by the court of appeal, which issued a writ vacating the trial court ruling and holding that subsidized health insurance premiums are not a divisible community property asset, following the ruling of *In re Marriage of Havins*.[56] Other cases have found a community property interest in early retirement benefits,[57] postretirement group term life insurance,[58] and other types of employer "fringe benefits,"[59] but *Havins*, said the *Ellis* opinion, set forth a bright-line rule regarding subsidized postretirement health insurance premiums.

The *Ellis* holding produced swift commentary disagreeing with it's conclusion. Professor Grace Blumberg argued that postretirement subsidized health insurance premiums do represent a valuable community asset and should be divided.[60] In her view, *Havins*, upon which *Ellis* relied, was wrongly decided because *Havins* confused the right to renew health insurance[61] with the postretirement right to a subsidy of the cost of that insurance.[62] The correct issue in *Ellis*, according to Professor Blumberg, was not term health insurance *per se*, but rather the right to a dollar subsidy of postretirement health insurance, a right in the nature of a pension right earned during marriage by community property labor. Her view is that this right was a divisible community property asset, that the trial court was correct, and that the Court of Appeal should have reconsidered and departed from the *Havins* "bright-line" rule. It is certain we have not seen the last of attempts to value and divide health insurance benefits.

Conclusion

Even in biblical times, health care issues were of concern to families and the societies in which they lived. In the Book of Genesis,[63] Joseph is told that his father, Jacob, is ill. The biblical text does not tell us who delivered the news of his father's failing health. Nor are we told why Joseph was not aware of his father's diminishing condition and had to learn the sad news from someone else.

This ancient literature embraces issues of health, family communication, and impending death and carries with it a message that modern family law practitioners would be well advised to follow. Issues concerning proper health insurance coverage and advance planning for the financial handling of medical expenses are part of the advice and counsel needed by clients in the midst of personal life transitions. Familiarity with the complex interface of health care and family law has become essential. The wise maxim "There is no wealth like health"[64] illustrates that when addressing the myriad of money issues in a family law proceeding, attention to health care issues should be one of the most important aspects, not a mere afterthought or boilerplate provision which either accomplishes nothing or does more harm than good. With health care concerns and issues clearly in focus, attorneys can preserve and protect the best interests of their clients in these critically important areas.

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[1] U.S. Census Bureau at http://www.census.gov.

[2] *The High Cost of Health*, Julie Severns Lyons, California, Journal, p. 14 (April 2003).

[3] Susan Brink, *Living on the Edge*, U.S. News & World Report, 58 (2002).

[4] 29 U.S.C. § 1161.

[5] Families, meaning spouse and dependents. For a discussion on same sex benefits, see discussion of Health Care Benefits for Domestic Partners.

[6] 29 U.S.C. § 1161; Health & Safety Code § 1366.20. Federal COBRA applies to employers who employ at least 20 employees. California has a comparable statute, Cal-COBRA, that applies to employees. There are some key areas in which Cal-COBRA differs from federal COBRA. One of these key differences is discussed later in this section of the article.

[7] 29 U.S.C. § 1163.

[8] *Id.*

[9] *Id.*

[10] *Id.*

[11] Geissal v. Moore Medical Corporation (1998) 524 U.S. 74; Bradley J. Gersich, *Employment Law Update: Special COBRA Update*, at http://www.articles.corporate.findlaw.com.

[12] *Id.*

[13] *Id.*

[14] *Id.*

[15] South Central United Food & Commercial Workers Unions & Employers Health & Welfare Trust v. Apple Tree Markets, Inc (1994) 19 F.3d 969. Under Cal-COBRA, pursuant to Health & Safety Code § 1366.27(b), however, beneficiaries are not afforded the same protection as they are under federal law. In California, when an employer withdraws from a prior insurance plan and establishes a new one for it's remaining employees, that employer may also transfer the COBRA beneficiary's coverage that originated under their old plan. This is problematic because it affords beneficiaries under Cal-COBRA less protection than beneficiaries under federal COBRA.) This result also seems inconsistent with the Legislative History of § 1366.27(b), which provides that Cal-COBRA was enacted to permit employers to provide extended coverage to eligible former employees, their spouses, and their dependents *to the same extent* as an employer whose plan is subject to federal COBRA.

[16] 29 U.S.C. § 1161(a).

[17] 29 U.S.C. § 1161(a).

[18] *Id.*

[19] Gary A. Shulman, *Qualified Medical Child Support Order Handbook,* (2002) p. 43.

[20] *Id.*

[21] *Id.*

[22] 42 U.S.C. § 300gg-1.

[23] 42 U.S.C. § 300gg. A plan may only exclude coverage of a pre-existing condition for a period of twelve months. However, this time period may be reduced by the aggregate of the periods of creditable coverage, meaning coverage of the individual under a previous health care plan. California also has a comparable statute for implementing HIPAA provisions, set forth in Health & Saf. Code § 130301.

[24] 42 U.S.C. § 300gg-1.

[25] Centers for Disease Control and Prevention, HIPAA Privacy Rule and Public Health: Guidance from CDC and the U.S. Department of Health and Human Services, MMWR 2003; 52 (Early Release).

[26] *Id.*

[27] *Id.*

[28] *Id.*

[29] *Id.*; 45 CFR §§ 164.500 -164.534. The protection afforded to individuals under HIPAA provide patients with more control over their health information; set boundaries on the use and release of health records; and hold violators civilly and criminally accountable for violating a patient's privacy rights. Comprehensive guidance and answers to questions concerning HIPAA are available at http://www.hhs.gov/ocr/hipaa.

[30] 42 U.S.C. § 1396g-1.

[31] *Id.*

[32] *Id.*

[33] *Id.*

[34] *Id.*

[35] *Id.*

[36] *Id.*

[37] *Shulman,* n.19, *above*, at 45.

[38] *Id.*

[39] *Id.*

[40] *Id.* At 47-48.

[41] *Id.*

[42] *Id.*

[43] *Id.*

[44] *Id.*

[45] *Id.*

[46] Fam. Code §§ 297-297.6. These sections set forth the procedures in California for registration of domestic partners. The legal effect and limitations of domestic partnerships are contained in Fam. Code § 299.5. *See* Prob. Code §§ 37, 6402 (operative July 1, 2003) regarding inheritance rights of domestic partners.

[47] The Rutter Group, Cal. Prac. Guide, Family Law, Ch. 20. Nonmarital Cohabitation; E. Domestic Partnership, §§ 20:200 et seq.; Health & Saf. Code § 1261(a)(c).

[48] Health & Saf. Code § 1261(a)(1)-(3).

[49] *Id.* § 1261(b).

[50] Id. § 1374.58 (added Stats. 2001, Ch. 893); *see* Health & Saf. Code § 1374.58(a).

[51] *Id.* § 1374.58(b), (d).

[52] Ins. Code § 10121.7; Ins. Code § 10121.7(a).

[53] Prob. Code § 4716; Marshall S. Zolla & Deborah Elizabeth Zolla, *Lasting Wishes*, 23 Los Angeles Lawyer 42 (2000).

[54] Rev. & Tax. Code § 17021.7.

[55] In re Marriage of Ellis (2002) 101 Cal. App. 4th 400.

[56] In re Marriage of Havins (1996) 43 Cal. App. 4th 414.

[57] In re Marriage of Lehman (1998) 13 Cal.4th 169.

[58] Estate of Logan (1987) 191 Cal. App. 3d 319; In re Marriage of Spengler (1992) 5 Cal. App. 4th 288

[59] In re Marriage of Schulze (1997) 60 Cal. App. 4th 519; In re Marriage of Doherty (2002) 103 Cal. App. 4th 895.

[60] Commentary by Grace Ganz Blumberg, *California Family Law Monthly* (Oct. 2002) pp. 267-269 [Matthew Bender & Co.]

[61] *Id.*

[62] *Id.*

[63] Parashat Vayechi, Genesis 47: 28-50:26.

[64] The Apocrypha: Wisdom of Sirach.