



# HIV/AIDS and Health Insurance

TABLE OF CONTENTS

Introduction ..... 3

Give Your Health Plan a Checkup..... 3

Situations..... 5

*I'm Hiring a New Employee, and I'm Concerned About AIDS* ..... 5

*I Have an Employee Who Has Tested HIV-Positive*..... 6

*My Employee Is No Longer Able to Work*..... 9

For Help or More Information ..... 11

Glossary..... 13

The information in this publication is solely for general information and for educational purposes and is not intended to be legal advice. Businesses, unions, and individuals should consult an attorney for specific legal advice.

## **INTRODUCTION**

If you are an employer who offers health care coverage to employees, you face all kinds of questions and concerns about plan benefits and costs. In addition to running a business, making appropriate decisions about your employee health plan requires you to be a benefits manager, communications specialist, and financial analyst. It is difficult enough to fill these roles when employees have routine health problems, but when catastrophic illness like cancer, heart disease, a sick or premature baby, or AIDS strikes an employee, you may face some difficult issues.

Treating HIV and AIDS is expensive. However, don't check compassion, reason, and common sense at the door when trying to respond to AIDS.

AIDS treatment is no more expensive than treatment of several other conditions, including breast cancer, severe head injury treatment and rehabilitation, and the care of a premature, low-birth-weight baby.

This brochure is intended to help employers who are concerned about the impact of AIDS and other expensive illnesses on their health care costs and their businesses, especially employers with fewer than 100 employees. The brochure can be useful to any employer who wants to maintain health insurance for employees in the face of rising costs or who self-insures (see Glossary). AIDS is only one of many issues you should consider when deciding how to design and manage your health plan.

## **GIVE YOUR HEALTH PLAN A CHECKUP**

In reviewing your health plan, there are a number of issues to consider, including coverage of preventive and diagnostic services, catastrophic coverages, and co-payment/deductibles. Here are some features of health plans you may consider to keep your costs under control:

### **Incorporate Preventive Care Into Your Plan**

Many businesses are looking at preventive care coverage. Also learn which screening and medical tests, including HIV/AIDS counseling and testing, are cost-beneficial and incorporate them into your plan. Until there is a cure for HIV/AIDS, education and prevention are the key. (See *Educating Your Workforce: A Guide for Managers*.)

### **Check Your Plan's Co-payment and Deductible Provisions**

Your employees' routine health care can provide some of your best opportunities to save on the costs of coverage. A plan that offers low or no deductibles and low or no co-payments by participants, is paying many small and relatively predictable health care bills. Raising deductibles and employee co-payments could reduce your plan cost significantly.

### **Check Your Plan's Limits**

Spend some of your savings from increased deductibles and co-payments on better protection against catastrophic health care expenses. Make sure your plan's annual limits on participants' out-of-pocket expenses, as well as annual and/or lifetime lim-

its on benefits, reflect both inflation and the growing cost of modern medical technology. Make sure you learn your plan's cap on prescription drug coverage. Some insurance plans have relatively low caps for prescription drugs and do not provide ample coverage for the new antiretroviral drug therapies. These protease inhibitors can stave off many opportunistic infections, adding to the overall productivity of your employees. Your employees may be more willing to accept lower coverage for small, routine expenses if they know they will be protected when they need it most.

#### **Investigate Managed Care (See Glossary)**

Many small employers report that managed care plans help them maintain affordable coverage. Such plans limit employees' ability to choose their physicians or hospitals but may offer significant benefits in return. Employers are becoming increasingly interested in prevention programs to keep their employees healthy and productive. Employers get significant price discounts as well as other services aimed at delivering cost-effective health care that meets or exceeds acceptable standards of medical care. Employees, in turn, get plans that are simpler to use, with little or no paperwork or cost sharing, and physicians who coordinate all aspects of their health care.

#### **Check Whether Your Plan Will Pay for Care Delivered in Alternative Settings**

AIDS patients, as well as those with any other serious illness, may in some cases be better off with home care or in a hospice, nursing home, or other facility than they would be in a hospital. Make sure your plan provides adequate coverage for such care (see also the discussion of case management on page 23).

#### **Band Together With Other Small Employers to Purchase Insurance**

You may be able to buy health care coverage through a multiple-employer trust in which several small employers join together to obtain the buying power available to larger groups. Such trusts may be offered through your trade association or professional association, your local Chamber of Commerce, or other groups. Before joining, however, have your accountant or attorney check out the financial soundness of the trust and how it is regulated.

#### **Check Whether Your Plan Pays for Experimental Drugs or Treatments**

It is important to understand what, if any, experimental treatments, including experimental use of approved drugs, are covered by your plan. This is an area where there can be costly misunderstandings — costly in dollars as well as employee relations. “Experimental” can mean one thing to a layman and another thing to the doctor and insurance company or managed care plan. It can also have different meanings among insurance and managed care companies. Although it has been, and in many cases continues to be, standard procedure for private and public health plans to exclude all experimental treatments from coverage, this is changing.

Because AIDS relies on experimental drug treatments and therapies, such as protease inhibitors and other antiretroviral drugs, there are clinical trials that determine the effectiveness of their efforts.

## SITUATIONS

The following sections will help answer any questions you may have when providing coverage for HIV-positive employees.

### **Situation I'm Hiring a New Employee, and I'm Concerned About AIDS**

Some employers' fear of AIDS has led them to consider testing employees before hiring them or enrolling them in a health plan. Here's what some employers ask:

- Can I require that an applicant be tested for antibodies to the human immunodeficiency virus (HIV) before offering him or her a job?

No. Both State and Federal laws cover pre- and post-employment. The Federal Americans with Disabilities Act (ADA) forbids pre-offer medical inquiries or examinations, including HIV antibody tests. At the post-offer, pre-employment stage, employers can require applicants to submit to HIV tests or inquire about HIV status if the tests are required or inquiries are made of all new employees in the same job category. However, since almost no employer can withdraw a job offer based on a positive test result, it is not recommended that employers engage in such screening.

- Can I require that an employee be tested for HIV antibodies?

The ADA prohibits employers from requiring HIV tests of incumbent employees, except in the very limited circumstance that a positive test result would mean that the employee could no longer safely and effectively perform the essential job duties, with or without reasonable accommodation. Medical tests and inquiries about disability, including HIV and AIDS, must be shown to be job-related and consistent with business necessity. Even if your company is too small to be covered by the ADA because it has fewer than 15 employees, State laws may prohibit HIV testing of applicants and employees or prohibit employers from discriminating against individuals who test positive. Employers should remember that they must comply with Federal and State confidentiality requirements.

- What about my insurance company? Can it require new employees to undergo HIV tests before enrolling them in my health insurance plan?

Insurers generally do not require medical reports for new employees who decide to join an ongoing health plan. However, some insurers do require medical underwriting of new employees joining a group in a very small firm. Medical reports may also be required if an employee first decides not to join the plan and later changes his or her mind. However, most States would allow insurers to administer HIV tests to an individual or small group.

- Once enrolled, is my employee covered for all conditions he or she may have?

Pre-existing condition clauses (see Glossary) do not violate the ADA if they are not a subterfuge to evade the purposes of the ADA. The ADA identifies four basic requirements in the area of health insurance:

1. Disability-based insurance distinctions are permitted only if the employer-based health insurance plan is bona fide and if the distinctions are not being used as a subterfuge for purposes of evading the Act.
2. Decisions about the employment of an individual with a disability cannot be motivated by concerns about the impact of the individual's disability on the employer's health plan.
3. Employees with disabilities must be accorded equal access to whatever health insurance the employer provides to employees without disabilities.
4. An employer cannot make an employment decision about any person, whether or not that person has a disability or based on the disability of someone with whom that person has a relationship, because of concerns about the impact on the employer's health plan.

- What happens when I employ individuals who previously received Medicare or Medicaid?

There are provisions under Medicare that States can adopt in order to continue Medicaid coverage of individuals who may become ineligible for cash assistance under Temporary Aid to Needy Families. This continued coverage will be for a specified length of time for those persons who are making the transition from public support to self-sufficiency through employment. The Social Security Administration has programs for people collecting either Social Security Disability Insurance or Social Security Insurance that permit them to maintain their eligibility for these programs as they transition back to substantial gainful activity. During this process individuals will most likely retain their Medicare or Medicaid coverage.

**Situation I Have an Employee Who Has Tested HIV-Positive**

You probably have many questions and concerns about what you should do if an employee tests positive for HIV. One of the major concerns for small employers is the effect that an employee with HIV will have on insurance costs and coverage. It is important to note that there may be a long period of time — up to 10 years or more — before an employee who is infected with HIV will develop the serious symptoms of AIDS, if at all. These are a few of the questions employers often ask:

- What will happen to my firm's health care costs if one of my employees is diagnosed as HIV-positive?

Your costs may rise when an employee develops any serious or chronic illness. However, the costs associated with AIDS treatment may not show up right away. Keep in mind that experimental drugs and treatments (which are discussed later)

may delay or even prevent the onset of some of the debilitating diseases associated with AIDS and, in effect, reduce the long-term costs of care.

Two major factors affect the cost of your plan: One is how your insurer sets your premiums, and the other is the benefits you offer in your plan, or plan design.

- Don't all insurers set health insurance premiums the same way?

No. There are several ways in which insurance companies set rates for small firms, and the use of different methods will have different end results, depending on the health condition of the group. Ask your insurer how your rate is set.

- Will having an HIV-positive employee keep my firm from getting insurance or hurt my chances of changing my insurer?

Depending on State law and on the insurance company's practices, an employee with a serious or chronic illness could cause an insurance company to reject your whole group if you are applying for insurance or trying to change insurers. For example, some health maintenance organizations (HMOs), Blue Cross/Blue Shield plans, and possibly other types of insurance that accept small groups do not consider your group's medical condition during certain times of the year called open enrollment, making them a good source of health care coverage for small businesses.

- What effect does plan design have on my rates?

Plan design includes the benefits you offer in your plan and who delivers them, such as an HMO or preferred provider organization (PPO) network. It also includes the deductibles, employee co-payments for care, and special payments such as prescription drug and dental benefits. The insurance plan design defines what your insurance will pay and what employees will pay when they use medical services. The cost of medical services is the primary element affecting premium rates.

- My health plan is self-insured, so it is not subject to certain State insurance laws. May I exclude an HIV-positive employee or family members from the plan?

Under the ADA, an employer cannot exclude an HIV-positive employee based on the employee's diagnosis.

- My health plan is self-insured. Can I cut AIDS benefits?

Under the ADA, a self-insured plan may put a cap on a treatment or a therapy, but not on a diagnosis. The cap must apply across all diagnoses to which that treatment or therapy applies.

- Can I do anything to reduce the cost of care for a seriously ill employee?

Case management (see Glossary) can cut costs and also improve the quality of care. Case management is one way for patients with high-cost, serious illnesses to get the

most of their insurance coverage. Once a patient is referred for case management, the patient, physician, and case manager (who works for the insurer or managed care provider) coordinate the care. Case managers can sometimes make arrangements for services that are not in the contract if they better meet the patient's needs.

Case management works best when eligible patients are identified early in the course of their illnesses. Through early identification of illness, antiretroviral drug therapies can delay or prevent symptoms such as Pneumocystis Carinii Pneumonia (PCP), Mycobacterium Avium Complex (MAC), or Cytomegalovirus (CMV), which can cause disability. However, sometimes employees who are HIV-positive or have AIDS are not identified early because they are concerned about confidentiality. You should ask your insurance company or managed care provider about case management.

- One of my employees who does not belong to my health care plan is now HIV-positive and wants to join the plan. How will this affect my plan?

Many people who were eligible to join an employer's health plan when they were first hired, but didn't, try to join the plan later when they need medical care. Some employees may have to provide evidence of good health. If they have chronic or serious illnesses, they may be rejected by the insurer or may not be covered for pre-existing conditions for a time period specified in the policy.

- How much should that employee tell the insurance company?

An employee should answer questions honestly. Otherwise, the insurer may decide not to pay claims because of misrepresentation in the application. Also, since the insurance company or managed care provider may ask to contact the employee's physician, any attempt to misrepresent the employee's health status is likely to backfire.

- Can I provide health insurance for some employees outside my group health plan?

If certain employees are uninsurable, you may be able to enroll them in a risk pool, which covers people who are otherwise uninsurable. Approximately 27 States have some form of risk pool providing comprehensive coverage. Generally, the State forms an association of all health insurance companies doing business in the State, and one organization is selected to administer the plan. The State sets guidelines for benefits, premiums, and other plan terms. Some States have funds to help low-income policy owners pay premiums.

- Are there waiting periods?

There are usually waiting periods for pre-existing conditions, though they are waived in some States if the participants pay a premium surcharge or if their coverage is terminated by their existing health insurer. Some States give AIDS patients automatic eligibility.

- Can I require an HIV-positive employee to take sick or disability leave?

Under the ADA, you can require such leave only if the employee is unable to perform the essential functions of the job. Remember, the employer is obligated to make reasonable accommodation to an employee's disability in decisions about continuing employment. Such accommodation could include changes in the job duties, providing a flexible work schedule, or allowing the employee to work part-time. If the employee cannot perform the essential functions of the job and refuses to accept an appropriate accommodation, he or she may no longer be a qualified individual with a disability.

- I have an employee with a family member who has AIDS. Am I required to allow time off for my employee to be a caregiver?

Under the Family and Medical Leave Act, if you employ 50 or more people, you are obligated to allow an employee 12 weeks of unpaid leave in any 12-month period to care for his or her own illness or the illness of a family member.

**Situation My Employee Is No Longer Able to Work**

In time, many HIV-positive employees may no longer be able to work, regardless of the accommodation you make for them. Here are some frequently asked questions:

- I have heard that former employees may continue to be part of my health plan. Is this true for HIV-positive former employees?

A Federal law known as COBRA\* gives your former employees and their dependents (qualified beneficiaries) the right to continue coverage under your health plan for a certain amount of time after coverage would normally end due to the employee's death or certain other events. These other events include termination of employment other than for gross misconduct, the employee's legal separation or divorce, the employee's entitlement to Medicare benefits, and the employer's filing for bankruptcy. Dependent children who stop being dependents under the terms of the plan may also choose COBRA coverage. The coverage should be the same as before the employee became eligible for COBRA. The type of illness has nothing to do with whether a former employee or dependents of a former employee can choose to continue coverage under your plan.

COBRA applies to both insured and self-insured firms. It is a very complex law, and a full explanation is beyond the scope of this brochure. For instance, finding out whether your company is large enough to be subject to COBRA is a complicated procedure. Talk to your insurance company, attorney, accountant, or regional office of the U.S. Department of Labor for advice on what you need to do and what you need to tell your employees. There can be significant financial penalties if you do not obey the law.

\*Consolidated Omnibus Budget Reconciliation Act of 1986

■ Who pays for COBRA coverage?

Your former employee or other COBRA participants can be required to pay all or part of the premium, plus an administrative fee of no greater than 2 percent of the premium.

If your State law provides a lower limit, the State limit applies. If you pay part of the insurance premium for your employees or their dependents, you are not required to continue to do so for COBRA participants. However, if you choose to pay part of the premium, be consistent in your payments. If you decide to pay part of the premium for some of your COBRA participants and not for others, you may jeopardize the tax status of the plan.

Some States have programs to pay COBRA premiums for low-income, previously employed persons, including persons with AIDS. Check with your State's social services agency to see if your State has such a program.

■ For how long is COBRA coverage available?

COBRA is designed to make sure that people have the opportunity to continue health care coverage until they can get new coverage. COBRA participants may purchase these benefits for periods ranging from 18 to 36 months, depending on the reason that they became eligible for COBRA. If an employee loses his or her job due to disability, up to 29 months of coverage is available.

However, COBRA coverage ends sooner if one of the following events occurs:

- the employer ends all its group health plans
- the participant's premium payments are not made on time
- the participant becomes covered under another group health plan
- the participant becomes eligible for Medicare

If the participant becomes covered under another group health plan — that of a spouse, for example — he or she may keep COBRA coverage if the new plan does not cover or limits coverage of pre-existing conditions. In such a case, participants may continue to purchase COBRA coverage until no longer eligible to do so or the new plan's pre-existing condition limits run their course, whichever occurs first.

■ How much time do I give these former employees or participants to make their COBRA premium payments?

Generally they must have a grace period of 30 days from the due date to make any required payments. If active employees have a longer period to make their payments, or if your insurance company gives your firm a longer period to make its payments, COBRA beneficiaries must have the longest grace period. A special grace period applies when employees first become eligible for COBRA coverage and are deciding whether to use it.

- Do I have to do anything once COBRA coverage ends?

Maybe. The COBRA beneficiaries must be allowed to enroll in an individual conversion health plan if your plan provides one.

- What happens to the COBRA participants if I change insurers?

They must be allowed to continue their enrollment. However, your new policies may contain cost-reducing features that limit plan benefits and sometimes reduce the value of COBRA coverage to disabled participants.

COBRA does require that participants receive the same coverage that other employees in a similar situation receive. For instance, if your new policy limits coverage of pre-existing conditions, COBRA beneficiaries' coverage will also be limited.

Some States regulate these types of policy transfers so that benefit losses are limited. In such cases, COBRA beneficiaries must receive the old policy's benefits unless the new policy would have paid less even without the new policy's limits.

#### **FOR HELP OR MORE INFORMATION**

These are some of the people and groups that can provide information on questions you may have:

- An insurance company or agent

Insurance companies can provide information on the most cost-effective policies. Independent insurance agents can shop around for you.

- Your State's insurance commissioner

Insurance companies and policies and other plans, such as HMOs, are licensed and regulated by the State. If you have a question about a policy or company, your State's insurance department should be able to help. If you have trouble finding the right office, call the National Association of Insurance Commissioners for information (816-842-3600).

- CDC Business and Labor Resource Service

The CDC Business and Labor Resource Service (BLRS), part of the CDC National AIDS Clearinghouse, provides information and material for employees on national, State, and local resources related to HIV/AIDS in the workplace.

Visit the BLRS home page at [www.brta-lrta.org](http://www.brta-lrta.org), or call or fax.

1-800-458-5231

301-519-6616 (fax)

■ Medicaid and Medicare information sources

The sources for information on Medicaid and Medicare are different. State Medicaid agencies are responsible for administering the Medicaid program. You can get more information about Medicaid through your local welfare or medical assistance office. For information about eligibility for Medicare or how to enroll, contact your local Social Security office or call 1-800-772-1213 toll-free on business days from 7 a.m. to 7 p.m. You can request a copy of Social Security's brochure *Medicare* (Publication No. 05-10043) from either the local Social Security office or the toll-free number.

■ Equal Employment Opportunity Commission Americans with Disabilities Act Information Line

1-800-669-EEOC (voice)  
1-800-800-3302 (TDD)

■ State and local health agencies and AIDS service organizations

These organizations may be able to provide additional information about State laws and services available to individuals with AIDS. Check your local telephone directory or call the CDC National AIDS Hotline at 1-800-342-AIDS (2437).

■ Your trade association

Many trade associations have developed information on insurance for their members, and some have developed information on AIDS in the workplace. Most associations have national offices that pursue their business and legislative interests, as well as State and local offices. If you do not know which association represents your line of business, ask your local library for *Who's Who in Association Management*, a directory of associations, or call the American Society of Association Executives (202-626-ASAE). Two associations that represent small businesses are the U.S. Chamber of Commerce (202-659-6000) and the National Federation of Independent Business (202-554-9000).

■ Insurance industry associations

Some insurance industry associations have developed information on small-business health insurance. Among these associations are the Independent Insurance Agents of America, which also has State and local offices; the National Association of Life Underwriters, which also has State and local offices; and the Health Insurance Association of America. The National Consumer Helpline (1-800-942-4242) also has a staff to help explain insurance terms and answer questions. In addition, the Business and Labor Resource Service (1-800-458-5231) can provide a comprehensive listing of insurance associations.

## GLOSSARY

**Americans with Disabilities Act** — Federal legislation covering employers of 15 or more employees that protects employees or applicants with a covered disability from discrimination.

**Case Management** — A process for directing ongoing patient treatment to ensure that it occurs in the most appropriate setting and that the best form of services is selected.

**COBRA** — Consolidated Omnibus Budget Reconciliation Act of 1986, which provides the opportunity for an employee to continue health insurance coverage after termination of coverage by the employer.

**Co-payment** — The portion of covered health care expenses an insured person must pay in addition to a deductible. Often described as a percentage, such as “80/20,” whereby the insurance company will pay 80 percent of covered expenses and the insured person will pay 20 percent.

**Deductible** — The amount of covered expenses that an insured person must pay during each benefit period before the insurer begins to pay allowable claims.

**Family and Medical Leave Act** — Federal legislation that provides employees with the opportunity to take up to 12 unpaid weeks of leave in a 12-month period to care for their own serious illness or that of a family member.

**Health Maintenance Organizations (HMOs)** — These organizations deliver pre-paid health care services. Those enrolled must generally use the HMO’s doctors or hospitals except in an emergency. Employees usually pay modest out-of-pocket costs for doctor visits, prescriptions, and other care.

**Insured Plans** — Traditionally, these plans cover benefits under conditions listed in the insurance policy. The employee goes to the doctor or hospital of his or her choice, and the insurance company pays its share for care under the policy’s terms. Sometimes the employee pays the bill and is reimbursed by the insurance company for some or all of the costs, and sometimes the insurance company directly reimburses the health care provider.

**Limitations** — Conditions or circumstances under which plan will not pay or will limit payments.

**Managed Care Plans** — One or more products that integrate financing and management with the delivery of health care services to an enrolled population; employ or contract with an organized provider network that delivers services and that (as a network or individual provider) either shares financial risk or has some incentive to deliver quality, cost-effective services; and use an information system capable of monitoring and evaluating patterns of covered persons’ use of medical services and the cost of those services.

**Maximum Out-of-Pocket** — The maximum amount of money a plan participant will pay in a benefit period, in addition to regular plan contributions. Usually this is a maximum of the sum of the co-payment and deductibles. Non-covered expenses

are the employee's responsibility in addition to the above out-of-pocket amounts and do not count toward the maximum out-of-pocket.

**Pre-existing Condition** — A medical condition that existed before a participant obtained plan coverage and for which a reasonably prudent person would seek medical treatment. Also, a condition for which an insured person received medical advice, consultation, prescription drugs, or treatment during a specified time period before the effective date of coverage.

**Preferred Provider Organizations (PPOs)** — PPOs are networks of doctors and hospitals that agree to provide discounts to particular employers or their insurers. Employees still can use doctors or hospitals that do not belong to the network, but they will pay more than if they used doctors or hospitals in the network. These plans are offered by insurance companies or by companies that provide only this service.

**Self-Insured Plans** — Plans under which, instead of buying policies from insurance companies, employers pay for health care claims as they occur, either out of their general revenues or out of separate trusts set up for paying claims. These employers generally purchase stop-loss insurance, which protects them against the risk of unusually high claims. State insurance laws generally do not cover self-insured plans, though Federal laws that apply to employee benefits must be obeyed. Employers with self-insured plans may hire insurance companies or other third-party administrators to run the plans and process claims.

**Third-Party Administrator (TPA)** — A company or broker that handles the administration of a health plan. The TPA may collect premiums, pay claims, and handle routine underwriting and administrative functions. It acts on guidelines the plan establishes.

**Underwriting** — The process by which an insurer or plan administrator determines whether and on what basis it will accept an application for plan coverage.



