American Bar Association
Health Law Section, Gilda’s Club Louisville, Health Enterprises Network, James Graham Brown Cancer Center, Louisville Bar Association, Nucleus, University of Louisville

Present . . .

Legal Advocacy for Women with Breast Cancer

Insurance and Benefits Issues

Christopher S. Sears, Ice Miller LLP, Indianapolis, IN
Threshold Tasks: Gathering the Facts

- Does your client have insurance?
  - If so, what kind?
    - Private insurance
      - employer-sponsored benefits (who’s the employer?)
      - individually purchased policy
    - Coverage under public programs
  - If not, what next?

- Are issues other than benefits involved?
  - Employment issues (especially FMLA and ADA)
Is Your Client Insured?

- If **YES** – determine the source of coverage
  - **Private insurance**
    - Most individuals have health insurance through the workplace
      - Private sector employers
        - Most subject to Employee Retirement Income Security Act of 1974 (ERISA) (fully-insured plans are also indirectly subject to state insurance law through state regulation of insurance product bought by the plan)
        - ERISA doesn’t cover health plans offered by governments, churches, church-related agencies and institutions for their employees
      - Government employers – plans not covered by ERISA; relevant Federal, state or local law applies
        - State employee health benefit plans
        - TRICARE (formerly CHAMPUS)
        - CHAMP/VA
        - Federal Employees Health Benefits Plan (FEHBP)
  - A small number of individuals may have purchased insurance for themselves – these policies are not covered by ERISA; state law applies
Is Your Client Insured, cont.

- Public Health Insurance Programs include:
  - Medicare
  - Medicaid
  - SCHIP

- Although some information about public health insurance programs and health insurance provided by government employers is provided in the Breast Cancer Legal Advocacy Guide, this presentation will not focus on them.
Key Issues Relating to ERISA-Covered Health Plans

- Most private-sector employees, including those whose coverage arises under a collective bargaining agreement, who have insurance will be covered under an ERISA plan.

- Key questions include:
  - What type of plan is it?
    - Single-employer/corporate (collectively bargained or not)
    - Multiemployer (collectively bargained; two or more employers with agreements from one national or international union)
    - Multiple employer welfare arrangement (MEWA) (covers several employers belonging to the same business association)
  - Is the plan fully-insured or self-insured?
  - What type of plan administration is used and who administers claims for benefits and benefit appeals?
    - Self-administered plan – handles own claims
    - Claims administration contracted out to third party administrator (can be individual or firm/insurance company or MCO)
Key Issues Relating to ERISA-Covered Health Plans, cont.

- **Key questions, cont.**
  - Who decides claims?
    - Named fiduciary or other plan fiduciary
    - Function can be delegated to TPA or claims administrator
    - Two important questions:
      - who makes initial decision?
      - who makes appeals decision?
  - Who bears ultimate financial responsibility for paying claims?
    - Fully insured (insurer or managed care plan bears insurance risk)
    - Self-insured or self-funded (employer or other plan sponsor retains insurance risk)
Key Issues Relating to ERISA-Covered Health Plans, cont.

- The primary sources of information about coverage under an ERISA plan are:
  - The “Summary Plan Description” or “SPD” and any amendments that have not been incorporated into main document
  - The actual plan itself (could be a trust agreement or insurance contract)
  - Sometimes a single document serves as both

- Tip: always be sure you have a copy of the relevant documents as they existed when the claim was incurred (i.e., the service or treatment denied) as well as current documents

- The plan administrator is required to provide an SPD automatically and the actual plan document upon request. **ASK FOR THEM.**
A Brief Overview of Non-ERISA Plans

- **Governmental plans may be** sponsored by Federal, state or local governments

- State and local governmental plans
  - Typically cover many types of public employees, including teachers, public safety employees (police and fire), legislators and their staff, judges and their staff
    - Usually state or local law governs
    - In some states, health benefits are administered by state retirement plan staff, but teachers often receive health benefits through individual school districts
    - Sources of information: Plans may publish an SPD-like document; sometimes can get information from governmental website
Examples of Non-ERISA Federal Governmental Plans

- TRICARE (formerly CHAMPUS)
  - Program administered by Secretary of Defense
  - Covers active duty military and their dependents and military retirees and their dependents
  - Benefits provided through regional managed care networks
  - Source of information: www.tricare.osd.mil
Federal Non-ERISA Plans, cont.

- **CHAMPVA**
  - Run by Department of Veterans Affairs
  - Only veterans and dependents not eligible for TRICARE are eligible
  - Services provided through VA health care facilities

- **FEHBP**
  - Covers Federal employees in legislative, executive and judicial branches
  - Administered by Office of Personnel Management through contracts with private sector carriers
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<thead>
<tr>
<th>Question</th>
<th>Before Diagnosis</th>
<th>After Diagnosis</th>
<th>After Treatment</th>
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<tbody>
<tr>
<td>When Does the Client Come To Your</td>
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<td>For Advice?</td>
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<td>When Benefits are Denied</td>
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Questions Common to All Stages

- Does your client have health insurance? If so, what does the insurance contract or benefit plan say about her right to treatment and her ability to challenge denials?

- What laws apply and what do the relevant state and/or federal laws and case law say?

- Who is making the decision to deny coverage or treatment? How can this decision be appealed?

- What information is needed to perfect the claim or appeal the decision?
Before Diagnosis

- Primary Question:
  - Will my screening or testing be covered?
- Strategy:
  - Check the plan or policy language
  - If the plan is subject to state law, check to see if the service is mandated (begin with list of mandated services in Breast Cancer Legal Advocacy Guide)
After Diagnosis

- Primary Questions:
  - Can I get health insurance coverage if I don’t have it?
  - How can I keep the coverage I have?
  - Does my plan/policy cover the recommended treatment?
    - Follow up, testing
    - Chemotherapy, radiation
    - Rx
    - Other
  - How do I handle workplace issues related to my need for treatment?
Getting and Keeping Health Insurance Coverage

- Strategy:
  - If the individual believes she has coverage, confirm it is in effect
    - Premiums paid up?
    - If employer coverage, is individual still eligible as an employee or dependent?
  - If individual coverage, is policy still in effect
    - state law governs
    - contact State Insurance Commissioner for help
Getting Insurance

- **Strategy:**
  - If individual is eligible for employer-sponsored coverage but not signed up, counsel signing up as soon as possible, but
    - There may be a waiting period, or
    - Certain types of treatment may not be available immediately because of pre-existing conditions
  - Federal law: Health Insurance Portability and Accountability Act ("HIPAA")
  - Possibly state protections as well for fully-insured employer-sponsored coverage
Keeping Insurance (COBRA/state continuation laws)

- If an individual covered under an employer plan loses coverage because of a "qualifying event", she may be eligible to elect continuation coverage
  - under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) for most ERISA plans
  - under state law for certain ERISA plans of small employers, for certain non-Federal governmental plans and for certain non-ERISA plans
  - under Federal law for federal employees covered by the FEHBP
“Qualifying Events” under Federal COBRA are:
- Death of covered employee
- Divorce or legal separation from covered employee
- Termination of employment of covered employee (other than for “gross misconduct”) or reduction in covered employee’s hours
- Medicare eligibility of covered employee
- Loss of “dependent” status under the plan or insurance contract
- Loss or substantial elimination of retiree coverage through bankruptcy of the employer

For any of the above events to be a “qualifying event”, loss of coverage must result
- Each individual losing coverage may independently elect to continue coverage
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) also guarantees an individual the right to coverage under an ERISA-covered health plan without having to satisfy a new waiting period or pre-existing condition exclusion if she has been continuously covered under another group plan for a period at least as long as the period of exclusion and has not had a gap in coverage for 63 or more days.

Employees of state and local governments may be covered under these HIPAA rules unless the government elects not to be covered (most have opted out).

What’s a preexisting condition under HIPAA?

Group health plans and issuers cannot impose a preexisting condition limitation or exclusion (or waiting period) of more than 12 months for any condition that was present in the 6 months before the earlier of:

- individual’s enrollment date, or
- beginning of waiting period
Keeping Insurance, cont.

- HIPAA’s exclusion for “preexisting conditions”
  - Permissible exclusion only applies to conditions (physical or mental) for which medical advice was sought or treatment was recommended or received during the 6 months prior to enrollment date.
  - Maximum duration:
    - 12 months initial or special enrollment
    - 18 months for late enrollment
Coverage for Treatment

- Plan provisions that can trip you up
  - “medically necessary”
  - “experimental”
  - specific plan exclusions, including exclusion for participation in clinical trials

- For non-ERISA plans and fully-insured ERISA plans, state laws may mandate coverage

- Your client’s ability to pursue coverage under state law in an ERISA-covered plan is limited
  - Coverage versus treatment decision?
Coverage for Treatment, cont.

- Women’s Health and Cancer Rights Act of 1998 (WHCRA)
  - Requires certain reconstructive surgery if plan provides benefits for mastectomies
    - Reconstruction of breast
    - Other surgery and reconstruction to promote symmetrical appearance and
    - Prostheses and coverage of physical complications
  - No inducement for lesser care permitted
  - Penalties – same as HIPAA
  - Notice to participants at enrollment and annually.
  - State laws enforceable if more generous to individual
Claims Disputes Under ERISA Plans

- ERISA prescribes rules governing a plan’s internal claims and appeals decision-making
- Rules are both procedural and substantive
- Sec. 503 (29 USC 1133) of ERISA governs
- Courts have required participants to exhaust their internal appeals before going to court, unless one of three exceptions is met: futility, denial of meaningful access to plan procedures and irreparable harm
Basic ERISA Rule on Internal Plan Claims Decisions

- Statutory rule:
  - every employee benefit plan must:
    - provide adequate notice in writing when claim denied “setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant”
    - afford reasonable opportunity for a “full and fair review” by “the appropriate named fiduciary” of the denial decision
What Must ERISA Group Health Plans Do?

- All plans must:
  - establish and maintain a reasonable procedure for
    - claims filing and decision-making
    - notification of benefit determinations
    - appeal of adverse benefit determination
ERISA Plan Must, cont.

- ensure that
  - claims are decided in accordance with governing plan documents
  - plan provisions are applied consistently for similarly situated claimants
- be able to demonstrate consistency if challenged
What is a “Claim”? 

- A request for plan benefits or payment
- Made in accordance with the plan’s reasonable procedures
- General eligibility requests are not claims but refusal to provide treatment based on eligibility is a denied claim
What Types of Health Claims Are Covered?

- Pre-service
- Post-service
- Concurrent
- Urgent
- Different time frames for deciding each type of health claim (also special rules for disability claims, not covered in this session)
- Health claims administered by HMOs for ERISA plans not exempt from DOL regulations
# Health Plan Decisions – Initial Claims

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<th>Urgent</th>
<th>Pre-Service</th>
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<td>Initial benefit</td>
<td>72 hours</td>
<td>15 days</td>
<td>30 days</td>
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<tr>
<td>determination</td>
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<tr>
<td>Extension</td>
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<td>15 days</td>
<td>15 days</td>
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<tr>
<td>Time allowed for</td>
<td>48 hours</td>
<td>45 days</td>
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<td>more information</td>
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# Health Plan Claims – Appeals Decisions

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<th>Urgent</th>
<th>Pre-Service</th>
<th>Post-Service</th>
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<tr>
<td>Time to file appeal</td>
<td>180 days</td>
<td>180 days</td>
<td>180 days</td>
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<tr>
<td>Initial review determination</td>
<td>72 hours</td>
<td>30 days (1 appeal)</td>
<td>60 days (1 appeal)</td>
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<tr>
<td></td>
<td></td>
<td>15 days (2 appeals)</td>
<td>30 days (2 appeals)</td>
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<tr>
<td>Extension</td>
<td>None</td>
<td>None</td>
<td>None</td>
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Time to file appeal: 180 days
Initial review determination: 72 hours
Extension: None
What Are the Required Appeals Procedures?

- Claimant has at least 180 days to appeal
- Review must be *de novo* (no deference to original decision)
- Decision-maker on appeal cannot be the same person who decided the initial claim or that person’s subordinate
- Claimant can submit additional information
Appeals Procedures, cont.

- If decision requires medical judgment, reviewer must consult “appropriate health professional” (and disclose identity upon request)
- Claimant must have reasonable access to “relevant information” (upon request and free of charge)
Appeals Procedures, cont.

- What is relevant information?
  - relied on in making benefit determination
  - submitted, considered or generated while making benefit determination
  - statements of policy or guidance concerning denied treatment or benefit even if not relied on
Appeals Procedures, cont.

- No more than two levels of mandatory appeals permitted (but must complete both within applicable timeframe)
- But plan can offer additional voluntary options for appeal
Appeals Procedures, cont.

- Can’t require binding arbitration
- Non-binding arbitration permitted as one level of appeal, but must observe applicable timeframes for decision
- May offer voluntary binding arbitration
What Are the Special Rules for Urgent Appeals?

- Expedited review required
- Request for review may be oral or written
- Necessary information can be transmitted between plan and claimant/providers by phone or fax
- Provider’s assertion of urgency must be honored
Benefit Denial Notices

- Must refer to specific plan provision supporting denial (all plans)
- If health or disability claim denial based on internal rule, guideline or protocol:
  - must be referenced in denial notice
  - must either be provided or claimant must be told of right to receive copy on request free of charge
Benefit Denial Notices, cont.

- If denial based on medical necessity, experimental treatment, or other medical judgment, claimant must be given explanation of clinical basis for judgment or told of right to request information.
What Happens If Plan Doesn’t Follow the DOL Claims Rules?

- Claimant can go directly to court without exhausting administrative procedures
- Plan may lose benefit of “arbitrary and capricious” standard of review for fiduciary decision-making
External Review of Denial Under State Law

- Often available for coverage disputes involving HMOs under non-ERISA plans or fully-insured ERISA plans
- Check to see if state law requires mandatory independent external appeal
  - HMO usually bound by decision of independent reviewer
  - For fully-insured ERISA plans, claimant may have to go to court if HMO refuses to comply
Judicial Review of Denial

- ERISA Plans
  - Usually in Federal court
  - Remedies

- Non-ERISA Plans
  - State court
  - Remedies
Suit under ERISA Plans

- Federal court
- Remedies:
  - Payment of benefits
  - Declaratory relief
  - “Other equitable” remedies (but not money damages)
  - No compensatory damages
  - No pain and suffering
  - No punitive damages
- State tort remedies preempted

- No juries
- Discretionary Attorneys’ fees
  - Statutory language suggests damages may be awarded to either party
  - Damages are awarded in only about half of cases where plaintiffs win

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Damages are awarded in only about half of cases where plaintiffs win
Suit under Non-ERISA Plans

- State law governs
- Juries
- In certain cases, may be able to get support of state’s Attorney General

Remedies
- Declaratory relief
- Compensatory damages possible in certain states
- Punitive damages possible in certain states
Thank You

Christopher S. Sears
Ice Miller LLP
Indianapolis, Indiana
sears@icemiller.com
(317) 236-5891