40 Minutes

- What does PPACA do in next few years
- Emphasize vocabulary, resources, citations to help you do research
- Rigidly refuse to answer questions until the end
- Not deal with provider-insurer issues
- Ignore Medicare, Medicaid, TRICARE, Workers Comp, Indian Health
- Just spend one minute on constitutional challenges to the law
Presentation in one minute

• To resolve a health insurance dispute you will need
  • a copy of your health insurance contract or plan
  • a copy of your “EOB”
  • know whether your plan is provided by your employer or not
  • if it is employer provided, is it
    • self-funded
    • grandfathered

• There are new sources of help in shopping for and obtaining insurance
  • in appealing claim denials more efficiently
  • You can find the law to know your rights in more detail
  • Get a lawyer who specializes in this area
  • health insurance law is unbelievably complicated
Premium Escalation and Contribution Hikes

EXHIBIT A

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2001–2011

2001

$7,061

$5,269

$1,787

2011

$15,073

$10,944

$4,129

113% Premium Increase

131% Worker Contribution Increase

What sort of health insurance is being provided by employers?

### Exhibit 6: Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Conventional</th>
<th>HMO</th>
<th>PPO</th>
<th>POS</th>
<th>HDHP/SO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>73%</td>
<td>16%</td>
<td>11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td>46%</td>
<td>21%</td>
<td>26%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>27%</td>
<td>31%</td>
<td>39%</td>
<td>28%</td>
<td>14%</td>
</tr>
<tr>
<td>1999</td>
<td>10%</td>
<td>28%</td>
<td>39%</td>
<td>26%</td>
<td>7%</td>
</tr>
<tr>
<td>2000*</td>
<td>8%</td>
<td>29%</td>
<td>42%</td>
<td>24%</td>
<td>21%</td>
</tr>
<tr>
<td>2001*</td>
<td>7%</td>
<td>24%</td>
<td>46%</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>2002*</td>
<td>4%</td>
<td>27%</td>
<td>52%</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>5%</td>
<td>24%</td>
<td>54%</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>5%</td>
<td>25%</td>
<td>55%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>2005*</td>
<td>3%</td>
<td>21%</td>
<td>61%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>3%</td>
<td>20%</td>
<td>60%</td>
<td>13%</td>
<td>4%</td>
</tr>
<tr>
<td>2007</td>
<td>3%</td>
<td>21%</td>
<td>57%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>2008*</td>
<td>1%</td>
<td>20%</td>
<td>58%</td>
<td>12%</td>
<td>8%</td>
</tr>
<tr>
<td>2009</td>
<td>1%</td>
<td>20%</td>
<td>60%</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>2010*</td>
<td>1%</td>
<td>19%</td>
<td>58%</td>
<td>8%</td>
<td>13%</td>
</tr>
<tr>
<td>2011*</td>
<td>1%</td>
<td>17%</td>
<td>55%</td>
<td>10%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Distribution is statistically different from the previous year shown (p<.05). No statistical tests were conducted for years prior to 1999. No statistical tests are conducted between 2005 and 2006 due to the addition of HDHP/SO as a new plan type in 2006.

Note: Information was not obtained for POS plans in 1988. A portion of the change in plan type enrollment for 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits for additional information.

## Premium distributions

### EXHIBIT C

**Distribution of Premiums for Single and Family Coverage Relative to the Average Annual Single or Family Premium, 2011**

<table>
<thead>
<tr>
<th>Premium Range, Relative to Average Premium</th>
<th>Single Coverage</th>
<th>Family Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Premium Range, Dollar Amount</td>
<td>Percentage of Covered Workers in Range</td>
</tr>
<tr>
<td>Less than 80%</td>
<td>Less Than $4,344</td>
<td>21%</td>
</tr>
<tr>
<td>80% to Less Than 90%</td>
<td>$4,344 to &lt;$4,886</td>
<td>15%</td>
</tr>
<tr>
<td>90% to Less Than Average</td>
<td>$4,886 to &lt;$5,429</td>
<td>20%</td>
</tr>
<tr>
<td>Average to Less Than 110%</td>
<td>$5,429 to &lt;$5,972</td>
<td>15%</td>
</tr>
<tr>
<td>110% to Less Than 120%</td>
<td>$5,972 to &lt;$6,515</td>
<td>11%</td>
</tr>
<tr>
<td>120% or More</td>
<td>$6,515 or More</td>
<td>18%</td>
</tr>
</tbody>
</table>

*Note: The average annual premium is $5,429 for single coverage and $15,073 for family coverage.*

Employer Norms

**EXHIBIT F**

Percentage of Firms Offering Health Benefits, by Firm Size, 1999–2011

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3–9 Workers</td>
<td>55%</td>
<td>57%</td>
<td>58%</td>
<td>58%</td>
<td>55%</td>
<td>52%</td>
<td>47%</td>
<td>49%</td>
<td>45%</td>
<td>50%</td>
<td>47%</td>
<td>59%*</td>
<td>48%*</td>
</tr>
<tr>
<td>10–24 Workers</td>
<td>74%</td>
<td>80%</td>
<td>77%</td>
<td>70%</td>
<td>76%</td>
<td>74%</td>
<td>72%</td>
<td>73%</td>
<td>76%</td>
<td>78%</td>
<td>72%</td>
<td>76%</td>
<td>71%</td>
</tr>
<tr>
<td>25–49 Workers</td>
<td>88%</td>
<td>91%</td>
<td>90%</td>
<td>87%</td>
<td>84%</td>
<td>87%</td>
<td>87%</td>
<td>83%</td>
<td>90%</td>
<td>87%</td>
<td>92%</td>
<td>85%*</td>
<td></td>
</tr>
<tr>
<td>50–199 Workers</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
<td>92%</td>
<td>93%</td>
<td>92%</td>
<td>94%</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>93%</td>
</tr>
<tr>
<td>All Small Firms</td>
<td>65%</td>
<td>68%</td>
<td>67%</td>
<td>65%</td>
<td>65%</td>
<td>62%</td>
<td>59%</td>
<td>60%</td>
<td>59%</td>
<td>62%</td>
<td>59%</td>
<td>68%*</td>
<td>59%*</td>
</tr>
<tr>
<td>(3–199 Workers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Large Firms</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>98%*</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>(200 or More Workers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALL FIRMS</td>
<td>66%</td>
<td>68%</td>
<td>68%</td>
<td>66%</td>
<td>66%</td>
<td>63%</td>
<td>60%</td>
<td>61%</td>
<td>59%</td>
<td>63%</td>
<td>59%</td>
<td>69%*</td>
<td>60%*</td>
</tr>
</tbody>
</table>

*Estimate is statistically different from estimate for the previous year shown (p<.05).

Note: As noted in the Survey Design and Methods section, estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits. In 2011 changes were made to the survey’s firm weights decreasing estimates of the overall offer rate by 1% in 2000, 2007 and 2009. Please consult the Survey Design and Methods section for additional information on changes made to the 2011 survey.

Retiree Health Benefits in Large Firms

Exhibit 11:
Among All Large Firms (200 or More Workers) Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, 1988-2011

Note: Tests found no statistical difference from estimate for the previous year shown (p<.05). No statistical tests are conducted for years prior to 1999. Data have been edited to include the less than 1% of large firms who report "yes, but no retiree" responses in 2011. Historical numbers have been recalculated so that the results are comparable.

# Guide to major federal health insurance laws

<table>
<thead>
<tr>
<th>Act</th>
<th>When</th>
<th>Abbreviation</th>
<th>Summary</th>
<th>Relevant Codifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Service Act</td>
<td>1942</td>
<td>PHSA</td>
<td>Regulates insurance provided by employers and to individuals</td>
<td>42 U.S.C. ch 6A</td>
</tr>
<tr>
<td>Employee Retirement Income Security Act</td>
<td>1974</td>
<td>ERISA</td>
<td>Regulates insurance provided by employers (“plans”); pre-empts state insurance laws</td>
<td>42 U.S.C. § 12181+</td>
</tr>
<tr>
<td>Consolidated Omnibus Budget Reconciliation Act</td>
<td>1986</td>
<td>COBRA</td>
<td>Accords limited rights to persons losing employer-provided health insurance</td>
<td>29 U.S.C. § 1161+</td>
</tr>
<tr>
<td>HIPAA</td>
<td>1996</td>
<td>HIPAA</td>
<td>Limits health insurance underwriting (important until 2014) (amends ERISA &amp; PHSA)</td>
<td>42 U.S.C. § 300gg+</td>
</tr>
<tr>
<td>Patient Protection and Affordable Care Act</td>
<td>2010</td>
<td>PPACA &amp; HCERA</td>
<td>Changes everything (amends PHSA, and lots more)</td>
<td>Codified all over; Pub. L. No. 111-148; 111-152</td>
</tr>
</tbody>
</table>
How to find and read PPACA

- H.R. 3590 Enrolled Version
- H.R. 4872 Enrolled Version

Careful: a lot of erroneous or unamended versions


Section by section summaries:
http://tinythom.as/hr3590/gt
http://www.rules.house.gov/111_hr4872_secbysec.html

The secret codification table is at http://uscode.house.gov/classification/tbl111pl_2nd.htm
### What has already happened?

<table>
<thead>
<tr>
<th>#</th>
<th>Change</th>
<th>Provision</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Interim federal insurance for persons with pre-existing conditions</td>
<td>PPACA § 1101, 42 U.S.C. § 18001</td>
<td>June 21, 2010</td>
</tr>
<tr>
<td>2</td>
<td>Internet website providing chart on “affordable health insurance options”</td>
<td>PPACA § 1102, 42 U.S.C. § 18002</td>
<td>July 1, 2010</td>
</tr>
<tr>
<td>3</td>
<td>Rescissions only for fraud or intentional misrepresentation</td>
<td>PPACA § 1001; PHSA § 2712; 42 U.S.C. § 300gg-12</td>
<td>September, 2010</td>
</tr>
<tr>
<td>4</td>
<td>Annual caps for essential health benefits limited</td>
<td>PPACA § 10101(a); PHSA § 2711; 42 U.S.C. § 300gg-11</td>
<td>September, 2010</td>
</tr>
<tr>
<td>5</td>
<td>Lifetime caps prohibited on inessential health benefits</td>
<td>PPACA § 10101(a); PHSA § 2711; 42 U.S.C. § 300gg-11</td>
<td>September, 2010</td>
</tr>
<tr>
<td>6</td>
<td>No cost sharing for five categories of preventative care</td>
<td>PPACA 1001; PHSA § 2713; 42 U.S.C. § 300gg-13</td>
<td>September, 2010</td>
</tr>
<tr>
<td>7</td>
<td>Emergencies and PCP Designation</td>
<td>PPACA § 10101(h); PHSA § 2719A; 42 U.S.C. § 300gg-19a</td>
<td>September, 2010</td>
</tr>
<tr>
<td>8</td>
<td>Federal cost restrictions in group and individual markets</td>
<td>PPACA § 10101(f); PHSA § 2718; 42 U.S.C. § 300gg-18</td>
<td>January 1, 2011</td>
</tr>
<tr>
<td>9</td>
<td>New claims processing rules</td>
<td>PPACA § 10101(g); PHSA § 2719; 42 U.S.C. § 300gg-19a</td>
<td>January 1, 2011</td>
</tr>
</tbody>
</table>
Interim federal insurance for persons with pre-existing conditions

- **Eligibility**
  - citizen, LPR, lawfully present
  - no creditable coverage for 6 months
  - has pre-existing condition

- **Policy**
  - 65% “actuarial value”
  - OOP limits: $5,800 individual; $11,600 family

- **Pricing**
  - age & tobacco rated only
  - based on standard rate for standard population

- **Warnings**
  - Only $5 billion allocated to subsidize claims

---

**Actuarial value** = \[	ext{expected payments of insurer} \over \text{total expected payments for covered benefits}\]
PCIP Premiums in Texas

- Not run by state; run by federal agency (HHS)
- Only 2,276 Texans enrolled
## PCIP Benefits in Texas

### What you pay for care

<table>
<thead>
<tr>
<th>Deductible type</th>
<th>Standard Option</th>
<th>Extended Option</th>
<th>HSA Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separate medical &amp; prescription deductibles</td>
<td>$2,000</td>
<td>$1,000</td>
<td>$2,500</td>
</tr>
<tr>
<td>In-network</td>
<td>Out-of-network</td>
<td>In-network</td>
<td>Out-of-network</td>
</tr>
<tr>
<td>$3,000</td>
<td>$3,000</td>
<td>$1,500</td>
<td>$4,000</td>
</tr>
<tr>
<td>$7,000</td>
<td>$7,000</td>
<td>$7,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>Inpatient Hospital Services*</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>$25 copay</td>
<td>$25 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Annual Preventive Care Office Visit</td>
<td>Nothing</td>
<td>Nothing</td>
<td>Nothing</td>
</tr>
<tr>
<td>Preventive Care – Other</td>
<td>Nothing</td>
<td>Nothing</td>
<td>Nothing</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Lab – Outpatient</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>X-Ray* &amp; Other Diagnostic Tests</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Maternity &amp; Newborn Care*</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Therapy Services*</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)*</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Skilled Nursing Facility**</td>
<td>Benefits limited to $700 day</td>
<td>Benefits limited to $700 day</td>
<td>Benefits limited to $700 day</td>
</tr>
<tr>
<td>Home Health Care – skilled nursing, IV therapy*</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>(Limited to 25 in-home visits per calendar year)</td>
<td>All charges</td>
<td>All charges</td>
<td>All charges</td>
</tr>
<tr>
<td>Hospice (combination inpatient &amp; outpatient)</td>
<td>Benefits limited to $15,000</td>
<td>Benefits limited to $15,000</td>
<td>Benefits limited to $15,000</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse</td>
<td>Same as medical conditions</td>
<td>Same as medical conditions</td>
<td>Same as medical conditions</td>
</tr>
</tbody>
</table>

### Prescription Drugs:

<table>
<thead>
<tr>
<th>Rx Deductible</th>
<th>Formulary</th>
<th>Non-formulary</th>
<th>Formulary</th>
<th>Non-formulary</th>
<th>Formulary</th>
<th>Non-formulary</th>
</tr>
</thead>
<tbody>
<tr>
<td>$500</td>
<td>$250</td>
<td>$750</td>
<td>$375</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

### Retail – up to a 30-day supply each fill

<table>
<thead>
<tr>
<th>Generic – First Two Fills</th>
<th>Greater of $4 or 50%</th>
<th>Greater of $4 or 50%</th>
<th>Greater of $4 or 50%</th>
<th>Greater of $4 or 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic – 3rd Fill &amp; After</td>
<td>Greater of $4 or 50%</td>
<td>Greater of $4 or 50%</td>
<td>Greater of $4 or 50%</td>
<td>Greater of $4 or 50%</td>
</tr>
<tr>
<td>Brand – First Two Fills</td>
<td>$40</td>
<td>$80</td>
<td>$30</td>
<td>$60</td>
</tr>
<tr>
<td>Brand – 3rd Fill &amp; After</td>
<td>Greater of $40 or 50%</td>
<td>All charges</td>
<td>Greater of $30 or 50%</td>
<td>All charges</td>
</tr>
<tr>
<td>Specialty</td>
<td>25%, $150 max</td>
<td>50%, $300 max</td>
<td>25%, $150 max</td>
<td>50%, $300 max</td>
</tr>
</tbody>
</table>

### Mail Order – 90-day supply

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>$10</td>
<td>$100</td>
<td>$350 max</td>
</tr>
</tbody>
</table>
healthcare.gov
Fun at healthcare.gov: What’s the MLR?

Blue Cross Blue Shield of Texas Medical Loss Ratio (MLR)

The term "medical loss ratio" (or MLR) refers to the amount of insurance premiums that an insurer spends on health care and activities that improve health care quality.

The medical loss ratio is one way the Affordable Care Act makes sure you get better value for your health care dollars. The law requires that 80% to 85% of the money collected by insurance companies be spent on health care services and health care quality improvement rather than overhead and administrative costs.

Starting in 2012, an insurer that does not spend enough on health care or quality-improving activities must give a rebate to people enrolled in the plan or the small business that purchased it.

Coming in 2012: MLR Reporting
Beginning in 2012, insurers' medical loss ratios will be reported on this site. In the meantime, you can learn more about MLR and the Affordable Care Act here.
Finding coverage?

Find Insurance Options
See which public, private and community programs meet your needs

- OK. Based on your choices, there are 3 options you should look into:

Explore these options:

1. Health Insurance Plans for Individuals & Families
   Learn More
   
   If you do not have job-based or other coverage, you may want to buy a policy from a private insurer.

2. Pre-Existing Condition Insurance Plan (PCIP)/High Risk Pool
   Learn More
   
   You may qualify for a pre-existing condition insurance plan or a high risk pool, which helps people who have a hard time getting insurance find coverage.

3. Finding Care You Can Afford
   Learn More
   
   There may be local facilities that provide free or reduced-cost care, whether you’re insured or not. What you pay depends on your income.

If you need additional help looking for health insurance that fits your needs or if you are having trouble with your current insurance, there may be resources available to you in your state.
Find a doctor

Physician Compare

126 Dermatology Physicians within 150 miles of 80545

Viewing 1 - 10

Sort by: Closest Practice Location

Peter Bachmann, MD
Dermatology
1136 Alpine Ave Ste 310
Boulder, CO 80304
79.2 Miles
(303) 449-3500
Additional Info
- Male
- Accepts Medicare-approved amount on all claims
- French, German, Italian, Spanish

Group Practice Locations
Longmont Clinic PC

James Swinehart, MD
Dermatology
950 E Harvard Ave Ste 630
Denver, CO 80210
115.4 Miles
(303) 744-1202
Additional Info
- Male
- Accepts Medicare-approved amount on all claims

Group Practice Locations
Colorado Medical Center Inc

Mary Blattner
Dermatology
View the profile page for practice locations
The grandfathering issue

Exhibit 15:
Percentage of Firms and Covered Workers Enrolled in Plans Grandfathered under the Affordable Care Act (ACA), by Firm Size, 2011

*Estimate is statistically different between All Small Firms and All Large Firms within category (p<.05).

Some notation

- Applies even to grandfathered plans
- Does not apply to grandfathered plans
Rescissions Only For Fraud

- In most states insurers *already* did not have the right to rescind other than for fraud

- Texas *already* required proof of deceptive intent or fraud to rescind
  - Texas rescission rate had been 0.2%
Annual Caps

- Simply not true that annual caps are gone
- but we are up to $1.25 million for plans starting now
- no new waivers being granted (2% of employees are in waived “mini-med” plans)
- Secretary of HHS gets to determine annual caps on essential health benefits
- balance access to needed services against “minimal impact on premiums”
- Annual caps not prohibited by PPACA on inessential health benefits
Lifetime Caps

- Truly gone
“Free” Preventative Services

- strongly recommended or recommended by USPSTF
- CDC recommended immunizations (http://www.cdc.gov/vaccines/recs/schedules/Adult-schedule.htm)
- HRSA “evidence-informed” guideline treatments for infants, children and adolescents (?)
- HRSA “evidence-informed” guideline treatments for women (?)
- Breast cancer screening and prevention as NOT recommended in November 2009 by the USPSTF

PHSA § 2713
Interim federal cost restrictions

- In effect through 2013
- Insurers must rebate premiums to customers to the extent that expenditures on “other non-claims costs” (excluding State taxes, licensing and regulatory fees) exceed x% of premiums
  - For group coverage, x=20
  - For individual coverage, x=25
  - State can lower these numbers
  - Secretary of HHS can raise them if they would “destabilize the existing individual market in such state”
  - Nine states, including Texas, are requesting a waiver. Maine has one; Delaware rejected

I wonder if insurers will raise premiums or cut costs to comply?
Emergencies & PCP Designation

Emergencies

- in network cost-sharing
- no prior authorization needed
- no “terms and conditions” other than cost-sharing (!)

PCP Designation

- Can pick any available participating PCP
- Can pick pediatrician for kids
- No gatekeeping for obstetrician or gynecologist visits

PHSA § 2719A
Claims Processing

Rules

• Prior law

• Texas law applied to individual policies and employer “insured policies”

• Federal law applied to self-insured policies from an employer
Self-Funded Plans

Exhibit 12:
Percentage of Covered Workers in Partially or Completely Self-Funded Plans, 1999-2011

*Tests found no statistical difference from estimate for the previous year shown (p<.05). No statistical tests are conducted for years prior to 1999.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011
<table>
<thead>
<tr>
<th>Internal appeals</th>
<th>Court</th>
</tr>
</thead>
<tbody>
<tr>
<td>External review</td>
<td></td>
</tr>
</tbody>
</table>
Internal appeals

• notify enrollee “in culturally and linguistically appropriate manner” of internal and external appeals and availability of government-subsidized help

• must use the “2560.503-1” rules

• enrollee must “receive continued coverage pending the outcome of the appeals process”
The 2560.503-1 Rules

- no fees for pursuing claims
- attorneys and representatives allowed
- specific EOBs
- no more than two appeals as prerequisite to lawsuit
- “full and fair review” of adverse decisions
- free access to records; some “discovery”
- 180 days to appeal (usually)
- appeal must be resolved within 72 hours (urgent) to 60 days (post-service)
- no deference
- state law may also be used sometimes (complicated!)
# 2560-503-1 Timelines

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Initial Decision</th>
<th>Extensions</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent</td>
<td>up to 72 hours</td>
<td>Nope</td>
<td>Pronto kick back of defective claims</td>
</tr>
<tr>
<td>Concurrent</td>
<td>24 hours*</td>
<td>Nope</td>
<td></td>
</tr>
<tr>
<td>Pre-Service</td>
<td>15 days</td>
<td>15 days</td>
<td></td>
</tr>
<tr>
<td>Post-Service</td>
<td>30 days</td>
<td>15 days</td>
<td></td>
</tr>
</tbody>
</table>

Beware: There are comparable deadlines for claimants!
External Review

- asymmetric binding
- binding on insurer
- not binding on insured (basically)
- must comply with more draconian of ...
- state external review procedures
- NAIC ‘s Uniform External Review Model Act
- unless self-insured or state does not meet NAIC standard
  - then use HHS Secretary standards
    - 29 CFR 2590.715-2719

Tx. Ins. Code sec. 4202.001 & regs
NAIC External Review

- Available for ...
  - medical necessity, appropriateness, setting, level of care, effectiveness
- Contact state insurance commissioner
- Use random “independent review organization”
- Paid for by health insurer
- **You can use (and probably should strongly consider using) an attorney**

Reviewers supported to be truly independent, expert and accredited

30 dense pages of procedures
A new resource

Have a health insurance question or concern?

The Texas Consumer Health Assistance Program can help you:
- Learn about your rights under federal health care reform and state law
- Enroll in a health plan, including the Pre-Existing Condition Insurance Plan
- Appeal a health plan's denial of a treatment or service
- Resolve a complaint against your health plan or insurer
- Obtain the health care premium tax credit (for small businesses)

Texas Consumer Health Assistance Program
1-855-TEX-CHAP (1-855-839-2427) toll-free
www.TexasHealthOptions.com

The Texas Consumer Health Assistance Program (CHAP) is operated by the Texas Department of Insurance to help Texas consumers with health insurance issues. We do not sell insurance. Texas CHAP is part of a network of state consumer assistance programs funded by a grant from the U.S. Department of Health and Human Services. If you are deaf, hard of hearing, or speech impaired, you may contact us using the relay service of your choice.

When scanned with a cell phone barcode reader app, the image on the left will automatically take you to www.TexasHealthOptions.com.

Get about 100 calls per day
Court

• You will need a lawyer
• ERISA preemption
• ERISA remedies
• Texas remedies
ERISA Preemption

• State law remedies “pre-empted” for claims relating to an ERISA plan (employer provided health and other benefits)

• Concurrent jurisdiction in state or federal court

• Defendant likely to “remove” you to federal court
ERISA Remedies

- What insurer owed you in the first place
- Interest
- Attorneys fees (discretionary)
- No punitive damages
- No emotional distress

You can also get the court to order the Plan to provide coverage
Texas Remedies

- Breach of contract
- Bad faith breach of insurance contract
- Arnold & Aranda
- Texas Insurance Code Chapter 541
- Conceivably consequential damages
- Very difficult to get punitive damages

Not available when your employer provides the relevant health insurance
What happens next

• Taxes
  • FICA hike (2013)
  • Medical deduction threshold increased to 10% (2013)
• Individual mandate (2014)
• Employer failure to provide (2014)
• Employer inadequate provision (2014)
## Essential Health Benefits

<table>
<thead>
<tr>
<th>Ambulatory Patient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
</tr>
<tr>
<td>Hospitalization</td>
</tr>
<tr>
<td>Maternity and newborn care</td>
</tr>
<tr>
<td>Mental health + substance abuse</td>
</tr>
<tr>
<td>Prescription drugs</td>
</tr>
<tr>
<td>Rehab services and devices</td>
</tr>
<tr>
<td>Laboratory services</td>
</tr>
<tr>
<td>Preventative + Wellness</td>
</tr>
<tr>
<td>Chronic disease management</td>
</tr>
<tr>
<td>Pediatric (including oral + vision)</td>
</tr>
</tbody>
</table>

### Refinements

- Scope of benefits: parity with typical current employer plans
- Shouldn’t discriminate because of age, disability or expected length of life
- Not subject to denial against wishes on basis of age or expected length of life

More specifics coming Oct. 7 from Institute of Medicine
The Constitutional Issues

• The federal government, the National Federation of Independent Businesses and 26 states have filed “certiorari petitions” in the United States Supreme Court requesting it to overturn a decision by the 11th Circuit Court of Appeals striking down the individual mandate but upholding other parts of the law.

• Due to “circuit split” and importance, now seems likely US Supreme Court will decide case, quite possibly before November 2012.

• The individual mandate: can this be justified as necessary and proper to other forms of regulation of interstate commerce in insurance?

  • If not, what other portions, if any of PPACA are “inseverable” and are thus unconstitutional too.

• Can the federal government condition Medicaid funds on state’s acceptance of significant expansion of Medicaid.
An attorney quiz

How did PPACA change ERISA preemption? [it didn’t, although federal law now governs more claims]

What do the numbers 2560.503-1 mean to you? [CFR section that governs claims]

• Does the attorney ask for the basic information: contract, EOB, employer provided, grandfathered, self-funded

• Don’t hire anyone who starts in on “fair”
### Other Resources

- thomas.loc.gov
- http://www.tdi.state.tx.us/ (Texas Department of Insurance)
- http://www.statutes.legis.state.tx.us/ (Texas Insurance Code)
- http://www.txhealthpool.com/ (Texas Health Insurance Pool)
- http://healthreform.kff.org/ (Kaiser Family Foundation Health Reform Site)
- http://www.law.cornell.edu/uscode/ (Almost all federal laws; not 100% up to date)
- http://scholar.google.com/ (click on legal opinions button; tons of cases; secondary materials)

### Other Statutes

<table>
<thead>
<tr>
<th>Act</th>
<th>When</th>
<th>Abbreviation</th>
<th>Summary</th>
<th>Relevant Codifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>American with Disabilities Act</td>
<td>1990</td>
<td>ADA</td>
<td>Provides minimal protection against discrimination by health insurers against disabled</td>
<td>42 U.S.C. § 12201</td>
</tr>
<tr>
<td>Genetic Information Non-Discrimination Act</td>
<td>2008</td>
<td>GINA</td>
<td>Bars health insurers from discriminating on the basis of non-manifest genetic predispositions</td>
<td>42 U.S.C. § 300gg-1(b)</td>
</tr>
</tbody>
</table>
The End