

SPAN NJ Health Advocacy Teleconference, August 15, 2007
Federal and State Health Consumer Law

I. DOES STATE OR FEDERAL LAW APPLY?

- A. If your health plan is self-funded, federal law applies, but not state law. The agency with jurisdiction over complaints is the U.S. Department of Labor (DOL).
- B. If your health plan is fully insured, both state law and federal law apply. But since New Jersey law is generally more protective of consumers rights than federal law, you generally look to state law. The agency with jurisdiction over state-law complaints is the New Jersey Department of Banking and Insurance (DOBI). (See Section III, below.)
- C. *How to determine whether your plan is self-funded or fully insured:* Ask your Human Resources department or look in your policy booklet (“Summary Plan Description,” or SPD). If the section on grievances and appeals refers to ERISA as the controlling law and refers you to DOL, it’s self-funded. If it refers you to DOBI or the NJ Department of Health & Senior Services (DHSS),¹ then it’s fully insured. Most self-insured plans are administered by an insurance company, so you may have a card that looks just like any insurance card and still be in a self-funded plan.
- D. Medicare is federal law, but medigap supplementary plans are regulated by DOBI.
- E. Medicaid is a combination of federal and state law. It was covered in previous teleconference presentations, so I won’t go into it today.
- F. Some people have 2 or even 3 forms of insurance (employer group plan, Medicare and Medicaid). It’s important to coordinate benefits with all plans and to understand when Medicare is primary and when it’s secondary. Medicaid is always the payer of last resort.

II. FEDERAL LAWS

- A. **ERISA** (Employee Retirement Income Security Act of 1974), *29 USC §1001 et seq.*; *29 CFR §2510, 2520*
 - 1. Protects beneficiaries of private sector employee benefit plans.
 - 2. Exempt from ERISA: government programs such as Medicare, Medicaid, Federal Employee Health Benefits Plan, and State Health Benefits Plan.
 - 3. Main remedy is through litigation.
 - 4. ERISA plans are exempt from state law.
 - 5. You can complain to DOL about procedural matters, such as the plan

¹Until October 2005, DHSS handled medical necessity appeals. The appeals program was then transferred to DOBI. (See Section III.A, below.) Many SPDs have not yet caught up with this change.

administrator or employer not providing you with a Summary Plan Description.

6. ERISA regulations require plans to establish a reasonable claims procedure with no more than 2 levels of internal appeals. There are also time deadlines for reviewing the appeal, depending on the urgency of the medical condition.

B. HIPAA (Health Insurance Portability and Accountability Act of 1996), P.L. 104-196, amending ERISA

1. *Portability*

- a. Limits waiting period for coverage of a preexisting condition to 12 months (18 months if a late enrollee).
- b. Preexisting condition is one for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period prior to enrollment.
- c. Insured gets credit for length of time had prior continuous coverage without a break of 63 days or more, reducing the exclusion period by “creditable coverage.” (See NJ law on Individual Health Coverage plans and Small Employer Health Benefit plans, Section III.B, below.)
- d. Preexisting condition waiting period can’t be applied to a newborn, adopted child under age 18, or child under 18 placed for adoption as long as child became covered under health plan within 30 days of birth . (Newborns are covered from birth through first 30 days even if dependents not allowed under policy.)

2. *Privacy (45 CFR Parts 160 and 164)*

- a. Regulations restrict how “covered entities” (health plans, health care providers) may use and disclose protected health information (PHI) and guarantee consumers’ right to inspect, obtain a copy of, and amend their own medical records.
- b. Consumer can file a complaint with U.S. Department of Health & Human Services, Office for Civil Rights, Region II (212-264-3313), <http://www.hhs.gov/ocr/hipaa>
- c. Consumer must be allowed to inspect or obtain a copy of PHI within 30 days of request, but covered entity may charge a reasonable fee for providing information. Entity may deny request under certain circumstances, but must provide written explanation and information on how to file a complaint.
- d. Consumer access not required for:
 - Psychotherapy notes,
 - Information compiled in anticipation of civil, criminal, or administrative action,
 - Research that includes treatment,
 - Information obtained under promise of confidentiality.

- e. Consumers have right to amend or supplement their own PHI. Covered entity must act on written request within 60 days; if it denies request, must do so in writing and give information on how to file a complaint.
- f. Consumers may authorize covered entity to disclose PHI to anyone they choose (“personal representative,” family member, friend).

C. **COBRA** (Consolidated Omnibus Budget Reconciliation Act of 1985), 29 USC §1162 et seq.; 29 CFR Part 2590

1. Applies to employers with 20 or more employees that offer group insurance program, but not to churches or the federal government.
2. Requires covered employers to offer workers and their families the option of keeping their group health plan coverage for 18 months, 29 months, or 36 months (depending on circumstances) after they would normally lose coverage. (See #4, below.)
3. Qualifying events:
 - Voluntary or involuntary termination (except gross misconduct),
 - Reduction in hours of employment,
 - Entitlement to Medicare for covered employee,
 - Divorce or legal separation from covered employee,
 - Death of covered employee,
 - Loss of dependent child status under plan rules,
 - If covered under a retiree health plan, Chapter 11 bankruptcy of the employer.
4. Maximum COBRA period:
 - 18 months for employee, spouse, and dependent children when termination or reduction in hours is qualifying event;
 - 29 months for employee, spouse, and dependent children if employee approved for Social Security Disability Insurance during initial 18 months;
 - 36 months for spouse and dependent children if employee becomes entitled to Medicare, dies, gets divorced or separated, or there is a second qualifying event during first 18 months; also for dependent child who loses dependent child status.
5. Employee pays group rate, plus up to an additional 2% administrative fee.
6. Employer must notify employee of COBRA rights and employee has 60 days to elect continuation coverage. (Sooner is better if you’re electing COBRA coverage, to avoid provider confusion.
7. Employee must notify employer of qualifying events (e.g., a child ceases to be a full-time student and loses dependent status).
8. When COBRA coverage ends, in New Jersey there is a right to convert the policy to an Individual Health Coverage Plan through the same insurer. The IHC plan would no longer be priced at the group rate. (See Section III.B, below.)

III. NEW JERSEY STATE LAWS

- A. In October 2005, the Office of Managed Care was transferred from the NJ Department of Health & Senior Services to DOBI. Now all consumer complaints and the Independent Health Appeals Program (third-stage external review of medical necessity appeals by Independent Utilization Review Organizations) is done at DOBI: 1-888-393-1062; 609-232-5316, ext. 50998; www.state.nj.us/dobi. All of the regulations have also been moved from the Health title to the Insurance title: *NJAC 11:24-1.1 to 18.4*.
- B. Special protections over and above federal requirements apply to members of Individual Health Coverage (IHC) plans and Small Employers Health Benefit (SEHB) plans (2-50 employees).
1. *SEHB*
 - a. No SEHB group or member may be denied coverage, regardless of health, prior claims experience, age, gender, occupation, nature of business, or location of business. The group is guaranteed renewal of coverage unless it fails to pay its premiums, commits fraud, or fails to meet the insurance carrier's participation or contribution requirements.
 - b. Preexisting condition exclusion if in an SEHB plan with 2-5 employees: 6 months. If in an SEHB plan with 6-50 employees, no waiting period except for late enrollees (60 months at most). (Late enrollee is someone who requests enrollment in plan following initial 30-day enrollment period.) Waiting period may be reduced by prior creditable coverage that has not lapsed for more than 90 days.
 2. *IHC*
 - a. If you're eligible for an IHC plan (you're a NJ resident and ineligible for Medicare, a group health plan, government plan, or church plan), you can't be denied coverage due to past or current health condition. You're guaranteed renewal as long as you remain a resident of NJ, don't become eligible for a group plan, pay your premium on time, and don't commit fraud.
 - b. Preexisting condition waiting period of up to 12 months if you've been uninsured for more than 31 days before effective date of coverage.
 3. IHC and SEHB programs are administered by DOBI: 609-633-1882, ext. 50302. The IHC regulations are at *NJAC 11:20-1.1 to 24.5*. The SEHB

regulations are at *NJAC 11:21-1.1 to 23.6*.

- C. Continuation of Coverage for Dependents until Age 30, P.L. 2005, c. 375**
1. Children of people covered under group health policies issued, executed, or renewed after May 12, 2006, can maintain dependent coverage after reaching the limiting age specified in the plan as long as they are:
 - Under age 30,
 - Unmarried,
 - Have no dependents of their own,
 - Are residents of NJ or enrolled as a full-time student in college or graduate school (can be out of state),
 - Are not covered as named policy holder on another health insurance policy or not entitled to Medicare through Social Security Disability (SSD).
 2. Doesn't apply to self-funded plans.
 3. Dependent has to extend coverage by making a written election for further coverage within 30 days of aging out or within 30 days of becoming a qualified dependent.
 4. Before dependent's 30th birthday, can drop and reinstate coverage any number of times.
 5. Dependent can lose coverage when:
 - No longer meets requirements for dependent status,
 - Fails to make timely premium payment,
 - Named insured loses coverage under policy.
 6. Named insured is responsible for making premium payments.
 7. The cost of dependent coverage is capped at 102% of the portion of premium paid for that dependent's coverage prior to "aging out."
- D. Health Care Carrier Accountability Act ("Right to Sue" law), NJSA 2A:53A-30 to -36**
1. Since October 28, 2001, insured consumers can sue their health insurance carriers (including dental benefits plans) for economic and noneconomic loss that results from carrier's negligence in denying or delaying approval for medically necessary covered services.
 2. Doesn't apply to self-funded plans.
 3. Must first exhaust internal and external administrative appeals, unless serious or significant harm has occurred or will imminently occur. Then can go to court and request injunctive relief (order the insurer to cover the medically necessary treatment).
 4. No attorney-fee-shifting provision (i.e., requiring defendant to pay plaintiff's legal fees if plaintiff wins case). Plaintiffs have to pay their attorneys whether they win or lose. Can be difficult to find an attorney to take these cases.

- E. **Domestic Partnership/Civil Union Act, P.L. 2003, c. 246 & P.L. 2006, c. 103; NJSA 37:1-7**
1. The Domestic Partnership Act, which went into effect in 2004, required health insurers to offer employers who provided group plan coverage to their employees the option to elect coverage for same-gender domestic partners of covered persons if the policy permitted coverage for eligible dependents and was issued or renewed after July 10, 2004.
 2. The Civil Union Act, which went into effect on February 19, 2007, supersedes the Domestic Partnership Act. It provides that “civil union couples shall have all of the same benefits, protections and responsibilities under law . . . as are granted to spouses in a marriage.” Plans that include dependent coverage *must* provide coverage to civil union couples, if the couple so elects, as of Feb. 19, 2007. Employers can’t opt out of offering such coverage. Don’t have to wait for renewal date of policy.
 3. Same-sex marriages established under valid law (Massachusetts, Canada, Netherlands, South Africa, and Spain) must be treated the same as civil union in NJ.
- F. **Access to Medical Records**
1. Under NJ law, patients have the right of access to their medical records that are in the possession of HMOs, other insurance entities, and hospitals.
 2. They can charge a reasonable copying fee. For hospitals, that fee can’t exceed \$1.00 per page or \$100 per record for the first 100 pages, \$0.25 per page for over 100 pages, with a \$200 maximum; a search fee of up to \$10 per patient request and postage fees of up to \$5 are also allowed. *NJAC 8:43A-13.5*.
 3. Insurers have to respond to request for records within 30 business days, informing person of nature and substance of records that it possesses and permitting them to see and copy the information in person or obtain a copy of it by mail, whichever they prefer.
 4. Generally an insurer can’t disclose medical information about a member without the person’s written authorization, unless ordered by a court or required by statute, or if there’s litigation between the person and insurer.
 5. For violations by insurer, can file complaint with DOBI or file a civil action seeking equitable relief. For violation by hospital, can file a complaint with hospital or with Dept. of Health & Senior Services.
 6. *Parents’ Access to Minors’ Medical Records:*
HIPAA defers to state law if there is explicit state law that permits or precludes disclosure of PHI about a minor to a parent, guardian, or other person acting in loco parentis. Under NJ law, a parent or guardian has authority to consent to authorize release of child’s records when child is 14 or younger. But when a minor is over 14, both the minor and parent have to consent to disclosure of medical records.

Under *NJAC 13:42-8.6*, a medical provider doesn't have to release medical information to parent if child doesn't consent and, in the provider's professional judgment, the release may adversely affect the minor's health or welfare. Also if the information relates to the minor's sexually transmitted disease, termination of pregnancy, or substance abuse.

G. Hospital Discharge Policies, NJAC 8:43G-4.1

1. Hospital patients have the right not to be transferred to another facility except for the following reasons:
 - The hospital can't provide the type or level of medical care appropriate for the patient's needs, or
 - The transfer is requested by the patient, or by the next of kin or guardian if patient is mentally incapacitated or incompetent.
2. Hospital patients have the right to be informed of any hospital discharge appeal process.
3. They have the right to receive from physician an explanation of reasons for transfer, information about alternatives to transfer, verification of acceptance from receiving facility, and assurance that transfer will not subject patient to substantial unnecessary risk of deterioration of medical condition. Explanation must be given in advance to patient, next of kin or guardian, except in life-threatening situation where immediate transfer is necessary.
4. Medicaid recipients must consent to or request transfer. Otherwise it's an involuntary transfer, and Medicaid must approve it. Patient who opposes transfer has right to a hearing. *NJAC 10:63-1.10*.

III. FEDERAL AND STATE LAWS ON SAME SUBJECT

A. Mental Health Parity Act, NJSA 17B:27-461v (P.L. 1999, c. 106) & 29 USCA §1185a.

NJ law is more protective of insureds' rights than federal law. Self-funded plans have protection of federal law, but not state law.

1. *New Jersey Law*
 - a. NJ Mental Health Parity Act requires group policies delivered, issued, executed or renewed in NJ to provide benefits for "biologically based mental illness" under the same terms and conditions as provided for any other sickness under the policy. That means same co-pays, deductibles, caps on number of visits or payments as applied to other medical or surgical benefits.
 - b. Biologically based mental illness includes but is not limited to schizophrenia, schizoaffective disorder, major depressive disorder,

bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism. Doesn't include anorexia or substance abuse disorders. (Recently, there have been lawsuits on anorexia exclusion by insurers.)

- c. Legislature is considering a bill in Senate and Assembly that would expand the parity requirement for most mental disorders, including anorexia, post-traumatic stress disorder, and substance abuse.

2. *Federal Law*

- a. Requires same aggregate lifetime limits and annual limits for mental illness and for physical illness, but doesn't require the same terms and conditions relating to amount, duration or scope of benefits.
- b. Small employers (2-50 employees) exempt.
- c. Doesn't limit application to "biologically based mental illness," but excludes treatment of substance abuse or chemical dependency.

B. U.S. Family and Medical Leave Act (FMLA), 29 USC §2612, & NJ Family Leave Act, NJSA 34:11B-1 to -16

1. *NJ Family Leave Act*

- a. Employers with 50 or more employees anywhere worldwide must comply with law for their NJ employees.
- b. Requires employers to grant eligible employees up to 12 weeks unpaid leave of absence in a 24-month period for birth or adoption of child or the serious illness of a parent, child or spouse. *Not for one's own serious illness.*
- c. Employee must have been employed for at least 12 months for the employer and must have worked 1,000 base hours in the preceding 12 months in order to be eligible.
- d. Can be consecutive or intermittent leave. Must tell employer you're taking family leave, not sick days.
- e. Employer can require employees to certify that they are needed to care for sick family member and can require certification of family member's condition.

2. *Federal Family and Medical Leave Act*

- a. Provides up to 12 weeks unpaid leave in a 12-month period.
- b. In addition to providing for leave for birth or adoption of child, or serious illness of a parent, child, or spouse, *also provides for leave due to an employee's own disability.*

- c. Must request leave in writing 30 days in advance if possible or as soon as is practicable.
- d. Employer can require medical certification of serious illness and can require certification of fitness for work before returning to work.
- e. If you get short-term disability, it will pay for your time off for 26 weeks, but the weeks taken will count toward your FMLA weeks. FMLA prohibits firing you during your leave.