
INSURANCE AND EMPLOYEE BENEFITS

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INSURANCE AND EMPLOYEE BENEFITS

by Irwin E. Keller¹

I. Introduction

Living successfully with HIV requires many things: positive attitude, good social and family support and, especially, access to quality medical care. In the U.S. today, the cost of medical services is so insanely high that, in reality, they are available only to individuals who are insured or are eligible for some form of public benefits. For many people with HIV, health insurance has become the most important factor in choosing, changing or leaving employment. And in some instances health or disability benefits are the specific site of HIV discrimination.

Insurance law, both in California and in other states, represents an ongoing struggle between the business goals of private enterprise on the one hand, and the health care and security needs of the public on the other.

An insurance contract is, in essence, an elaborate type of gamble. An insurance carrier wagers that you will not get sick, become disabled, or die. An insurer that collects premiums but doesn't end up having to pay claims has won the wager, and profited thereby. Insurers therefore have a goal of betting, when possible, only in instances where they know they will win. This is primarily accomplished through a preliminary fact-finding, or "handicapping" if you will, known as "medical underwriting." Through medical underwriting, an insurer investigates the medical history of a potential insured, to see if this is someone against whom they have good odds of winning the bet. It is also accomplished by attempting to limit the insurer's exposure: through pre-existing condition exclusions, coverage caps, and narrow definitions of medical necessity.

From the insured's point of view, however, an insurance contract is a means to realize some basic rights: the right to health care, and the right to subsist if unable to work. These goals of complete access to health care cannot be forced onto the insurance industry other than through political pressure and legislative reform. State laws restricting use of HIV status and other information in medical underwriting, limiting the duration of pre-existing condition exclusions, and mandating certain types of coverage and continuation of coverage are all examples of consumer-based legislative reform regulating the insurance industry's ability to establish the "house rules" of the gambling establishment.

The competing goals of the insurance industry and the public (especially the HIV community) result in the complicated set of laws under which the insurance industry now operates. Some laws seem to favor consumers; some seem to favor insurers. Nothing short of public entitlements guarantees HIV-positive individuals an absolute right to health care, or to disability income.

The kinds of insurance issues that HIV-positive clients bring to the AIDS Legal Referral Panel span a broad spectrum. Some individuals have insurance policies or employee benefits packages, and are trying to make sure those benefits will meet their needs. Others have a current problem:

¹This chapter was based on the work of many people. The 1995 Insurance chapter was written by Irwin E. Keller, Esq., former Executive Director of the AIDS Legal Referral Panel. Irwin thanked Emily Duskow, Esq. and Larry Mercer, Esq. for their assistance with legal content, and Betsy Johnsen, Esq.; Emily Duskow, Esq.; and Carol Wu, Esq. for their editorial assistance.

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- an insurance company has refused to pay for an innovative treatment that the client's doctor has strongly recommended and that the client wants to try;
- a client's employer has given faulty information about the terms of the group long-term disability policy, and the employee has gone out on disability only to find her disability claim denied based on a pre-existing condition exclusion;
- a large employer has reduced lifetime coverage for HIV-related medical claims to \$10,000, compared to \$500,000 for other care;
- an employer forgot to process the client's request to convert his life insurance to an individual policy, and so the policy lapsed after the employee goes out on disability;
- a client is quite sick and wants to go to live with his parents back East but his health insurance refuses to cover out-of-state health care claims.

In this chapter, we look at the laws that apply to many of these very common scenarios. In order to do so, we will explore the birth, life, and afterlife of insurance benefits; in other words, access to insurance, coverage under insurance contracts, and continuation of coverage. Some of it will involve HIV-specific statutes and case law. Other pieces of it, like federal ERISA law, though not HIV-specific, will still be crucial to preserving the rights and meeting the needs of individuals living with HIV and AIDS.

Much of this material will look daunting. But I encourage you to be brave. If you can get a grasp on just the material in this chapter, you will understand enough to help a client interpret his insurance policy, or to write letters to help resolve a coverage dispute. Even these simple advocacy steps can achieve results that are of immeasurable value to your client: health care and the security of disability income.

II. Threshold Issue: Who governs what?

In doing any sort of advocacy in the area of health, disability or life insurance, it is important to recognize that many insurance plans may look alike, but actually be different sorts of animals, regulated in very different ways.

Health insurance is coverage to pay for health care costs. Most health plans in California are no longer true "insurance," but are technically "health care service plans," or HMOs, regulated by the Health & Safety Code, and under the jurisdiction of the California Department of Corporations. Some provisions relating to all health coverage are still included in the Insurance Code as well, where health insurance is periodically (and confusingly) referred to as "disability insurance."

Disability insurance pays a monthly wage replacement to an individual who becomes too disabled to work. The California Department of Insurance regulates disability insurance through the Insurance Code, where it is sometimes referred to as "disability income insurance." Disability policies are available individually, or often through employers. They can be "long-term disability" policies, or "short-term disability" policies. Usually, disability policies have their own definition of disability, related to one's ability to engage in work. This functional definition is usually unrelated to how one's employer categorizes the employee's status (e.g., medical leave, sick leave, disability).

Life insurance, also regulated under the Insurance Code and under the Department of Insurance's jurisdiction, pays a set benefit amount to a beneficiary upon the death of the insured.

More and more frequently, people with disabling HIV or AIDS are using their life insurance policies (if they are lucky enough to have one) as a means of accessing cash during their lifetime.

Self-insured benefits plans are employer-provided plans that may look like insurance but are actually neither fish nor fowl. Specifically, they are offered by large employers that opt to create an internal fund to pay employees' health care costs (or disability or life insurance benefits), instead of buying an insurance policy or health care contract. These plans are known as self-funded or self-insured "welfare benefits" plans. To make matters worse, these self-funded plans are often disguised as true insurance: An insurance company is hired to act as the "third-party administrator" of the plan, and charged with making the coverage decisions. Employees are often under the impression that the insurance company is their insurance carrier, when in actuality there is no insurance policy at all, and the insurance company is only involved in an administrative capacity. Self-insured plans are governed almost exclusively by the federal law known as the Employee Retirement and Income Security Act of 1974, or "ERISA."² (See SECTION VI.C.1: ERISA PREEMPTION, *below*.) These plans may also be subject to the Americans with Disabilities Act, if they are used to discriminate. (See SECTION IV.B: COVERAGE CAPS FOR HIV CLAIMS, *below*.)

Most of this chapter will discuss actual insurance products and health plans that are regulated by the state. Where self-insured plans are discussed, it will be noted. Keep in mind that if your client is insured through a self-insured plan, all bets are off; don't presume that any of the rules based on state common or statutory law will apply. Other theories will probably have to be developed to attack unfair practices by self-insured plans.

III. Getting Insurance: Underwriting and Rescission

A. HIV status in underwriting

Many HIV-positive individuals have great concerns about their ability to obtain insurance coverage. Many feel they must hide their HIV status in order to obtain insurance. Many do not even try to obtain insurance. In actuality, California limits how insurers may use HIV information. The protections are strongest in the area of health insurance - especially in health insurance provided as an employee benefit.

1. Health insurance

(a) Individual policies. Health insurers in California are not permitted to require an HIV test of an individual as a prerequisite to providing insurance, or to ask about or use an applicant's HIV test result to determine insurability.³ In fact, health insurance applications must include the following language:⁴

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

This law, however, stops short of prohibiting a health insurer from inquiring whether the applicant has sought advice, been diagnosed with, or received treatment for HIV or AIDS. As a result,

²29 U.S.C. 1001 *et seq.*

³Cal. Health & Safety Code §1389.1.

⁴Cal. Ins. Code §10291.5(c)(2).

essentially the only people protected in underwriting are HIV-positive individuals who have received no treatment, care, or prophylaxis of any type. Any HIV-related medical record beyond a mere HIV test result can and will be used in medical underwriting for individual health insurance policies.

(b) Employer-provided policies. A California law passed in 1993 creates a "guarantee issue" requirement for insurers that sell health insurance to small groups. What this means is that for employer-provided group insurance, if the employer has between three and 50 employees, the insurer cannot engage in medical underwriting. In other words, all employees eligible to participate (by working sufficient hours, etc.) will be covered. No individual employee may be excluded from the group due to his health condition.⁵ (Some limits on coverage based on pre-existing medical conditions may legally apply, however. *See* SECTION IV.A: PRE-EXISTING CONDITION EXCLUSIONS, *below*.)

Employees of small employers are nonetheless often asked to fill out a medical questionnaire as a prerequisite to obtaining insurance through the group. Although this gives the impression that medical underwriting is taking place, the carrier can only legally use the information to determine the appropriate premium for the employer to pay, and also to help determine whether a pre-existing condition exclusion is applicable to the employee. It cannot be used to deny coverage to an individual employee or to refuse the policy to the employer.

As in the case of applications for individual health policies, medical questionnaires for employer-provided insurance may not ask questions regarding HIV test results.

A side issue is raised by the effect of these medical questionnaires on an employee's right of privacy.⁶ Ideally, employers should ask employees to return questionnaires to them in sealed envelopes, which are then forwarded to the insurance company without being opened. This would prevent employees from having to constructively disclose an AIDS diagnosis to his employer when he is otherwise not ready to. Unfortunately, employers - especially small employers - do not regularly follow this practice.

Oddly, insurers offering health insurance to employers with over 50 employees *may* engage in medical underwriting. As a practical matter, however, employer groups that large usually involve no medical underwriting since the insurer's risk is spread more effectively in a large group. Instead, there is an open enrollment, where eligible employees may enroll in a health insurance plan, without having to demonstrate insurability.

(c) Major Risk Medical Insurance Program (MRMIP). Individuals with symptomatic HIV who do not have access to health insurance through employment may be eligible for enrollment in the special plan known as MRMIP. MRMIP (pronounced "Mister Mip") is a program of government subsidized, *private* health insurance for individuals who have been denied medical insurance in the past due to serious health conditions.⁷ Individuals can choose plans from a number of vendors, including Blue Cross, Blue Shield, and Kaiser Permanente. Premiums range up to several hundred dollars per month, generally out of range for indigent clients. A number of limitations, deductibles and co-payments apply.

The program is subsidized by California's cigarette tax, so availability of slots in the program varies. Individuals may apply by calling 1-800-289-6574.

⁵AB1672, codified at Cal. Ins. Code § 10705(g) – (h); Cal. Ins. Code § 10198.7 (amended 1997); Cal. Health & Safety Code § 1357.03; *See also* Cal. Ins. Code § 10700(w)(1) (for definitions).

⁶Improper disclosure of HIV information is prohibited by Article I, Section 1 of the California Constitution. *See Urbaniak v. Newton*, 226 Cal.App.3d 1128, 1140 (1991). There are some exceptions to the privacy rule which are mostly penal in nature. *See Heller v. Norcal Mutual Ins. Co.*, 8 Cal. 4th 30, 42 (1994); *People v. Hall*, 101 Cal. App. 4th 1009, 1022 (2002).

⁷Cal. Ins. Code § 12700 (a)-(f), § 12739.4.

2. Disability and life insurance

Unlike the case of health insurance, a disability or life insurer in California may require an HIV antibody test as a prerequisite to obtaining insurance, and may decline an application based on a positive test result.⁸ There are some restrictions, however. There must be written, informed consent on the part of the applicant. The insurer must bear the cost of the test and must follow specific guidelines in disclosing a positive test result to the applicant. And in order to preserve the HIV-testing prohibition for health insurance, no HIV test is permitted if the insurer is simultaneously reviewing the applicant for health insurance. If the insurer reports test results to the Medical Information Bureau, which insurers use to pool information, it may only use a "generic blood test code" that doesn't specify HIV. (In practice, however, the "abnormal blood test" code is likely read by other insurers to mean HIV positive.)

In addition, the decision to require an HIV test cannot be made in a discriminatory fashion. For instance, HIV testing cannot be the *only* medical inquiry the insurer makes. In addition, HIV testing may not be required only of single people or those presumed to be gay or bisexual.

Although it may require a test, an insurer may not ask about prior HIV tests, unless the question is limited to prior tests undertaken *for the sole purpose of obtaining insurance*.

B. Sexual orientation & other substitute indicators of HIV status

Sexual orientation may not be taken into consideration in determining insurability or premium rate in California, regardless of the type of insurance at issue.⁹ In addition, factors such as marital status, living arrangements, occupation, beneficiary designation or zip codes may not be used to determine sexual orientation, to determine whether an HIV test will be required (for life or disability income insurance), or to determine terms of coverage in an HMO plan.

Also, if an individual participated in an AIDS-related research study, and that fact is disclosed to the insurer, that information may not be used to determine insurability. This rule applies to all types of insurance.¹⁰

C. Misrepresentations in insurance applications

Many people with HIV are concerned that if their insurer learns of their HIV status while they are covered by a policy, the policy will be cancelled. This is generally not likely. However, if an individual misrepresented facts when applying for insurance, the insurance carrier generally can rescind the policy as long as the policy is "contestable".

1. Rescission

(a) What is rescission? If an individual makes material misrepresentations in his application for insurance coverage, the carrier may rescind the policy; i.e., void the insurance contract as if it had never been entered into. The contract would be voided back to the original effective date, and all premiums paid would be refunded to the insured. An insurer may do this only if the misrepresentation is material, and if the rescission is within the contestability period of the policy.

⁸ Cal. Ins. Code § 799.10. An insurer's violation of these statutes probably gives rise to a private cause of action but a party to a contract generally cannot be liable in tort. *See Wetherton v. Growers Farm Labor Ass'n*, 275 Cal.App.2d 168, 174 (1969); *compare with Applied Equipment Corp. v. Litton Saudi Arabia Ltd.*, 7 Cal.4th 503, 521 (1994); *see also Webber v. Inland Empire Invs.*, 74 Cal. App. 4th 884, 898 (1999) (for clarification).

⁹ Cal. Ins. Code § 10140 (insurance); Cal. Health & Safety Code § 1365.5 (HMOs).

¹⁰ Cal. Health & Safety Code § 12115.

(b) What misrepresentations are "material"? Although some case law suggests that the very fact that an insurer asks a question makes the question material,¹¹ statutory law as well as the weight of precedent suggest that materiality is a question of fact.¹² The insurer has the burden of proving that the true facts, if known, would have made the contract less desirable to the insurer. In other words, it would have to demonstrate that according to its underwriting guidelines, the policy would not have been issued or would have entailed significantly higher premiums.

The misrepresentation in question must be attributable to the insured in order to give rise to rescission. If the insurer's agent made the misstatement, it waives its right to rescind based on that misstatement. Note, though, that an insurance *broker* is the insured's agent, not the insurer's. The relevance of the insured's state of mind is unclear. A specific intent to deceive is not necessary.¹³ However, in the case of disability or health insurance, an insurer can rescind if the misstatement was made with intent to deceive, even if the misrepresentation itself was not material.¹⁴ In contrast, if the applicant for insurance had no present knowledge of the facts sought, or failed to appreciate the significance of information related to him, his incorrect or incomplete responses would not constitute grounds for rescission.¹⁵

2. Incontestability and "post-claims underwriting"

An insurer's right to rescind an insurance policy is limited by law to a period of time after the effective date of the policy known as the "contestability" period. Of course insurers may choose to provide shorter contestability periods through the policy language, but the law provides the outside limits.

An insurer may not rescind a group life insurance policy after it has been in force for two years.¹⁶ An individual life insurance policy only becomes incontestable after it has been in force for two years during the life of the insured.¹⁷ If an individual policy lapses for non-payment of premiums and is reinstated, a new contestability period applies with respect to any misrepresentations made by the insured that are material to the reinstatement.

Disability and health insurers must restrict their right to rescind by choosing one of two contestability provisions for the policy. The provisions are set forth by statute.¹⁸ For noncancellable policies they must use Form A. For all other policies they may choose either Form A or Form B. Under Form A, the policy becomes incontestable after two years, except in the case of fraudulent misstatements. Under Form B, a policy becomes incontestable after a period of two years, but the period is suspended during any time that the insured is sick or disabled. This limit applies even to fraudulent misstatements.

The law also attempts to discourage insurers from engaging in the practice known as "post-claim underwriting." Post-claim underwriting is the practice of only beginning an investigation to rescind after a claim has been made against the policy. An insurer waives its right to rescind a policy if it neglects to make inquiries as to [material] facts, where they are distinctly implied in other facts

¹¹*Cohen v. Penn. Mutual Life Ins. Co.*, 48 Cal.2d 720, 726 (1957).

¹²Cal. Ins. Code § 334; Cal. Ins. Code § 10380; *Thompson v. Occidental Life Ins. Co.* (1973) 9 Cal.3d 904, 916; *Ransom v. Penn. Mutual Life Ins. Co.* (1954) 43 Cal.2d 420, 427; *Burns v. Prudential Ins. Co. of America* 201 Cal.App.2d 868, 871 – 873 (1962); *Miller v. Republic National Life* 789 F.2d 1336, 1340 (9th Cir. 1986).

¹³Cal. Ins. Code § 331, § 359.

¹⁴Cal. Ins. Code § 10380.

¹⁵*Thompson v. Occidental Life Ins. Co. of Calif.*, 9 Cal.3d 904, 916 (1973).

¹⁶Cal. Ins. Code § 10206 (note that b indicates a small exception if the insured used is an imposter).

¹⁷Cal. Ins. Code § 10113.5.

¹⁸Cal. Ins. Code § 10350.2, as amended October 1993.

of which information is communicated.¹⁹ In other words, if the insurer has notice that an insured's representations about his health are or may be untrue, it has a duty to investigate. If it issues the policy notwithstanding, it cannot sit back, collect premiums, and then attempt to rescind after a claim is made. Statutory law also requires health insurers to investigate facts in an application before issuing the policy, and prohibits them from later rescinding for failure to have completed medical underwriting.²⁰

IV. Using Insurance: Coverage Issues

Once an individual legitimately obtains insurance coverage, he should be able to make claims against the policy, subject to the limitations of the policy. The limitations can include annual and lifetime caps, exclusions for certain kinds of claims, and some exclusions for claims based on certain medical conditions that arose before the policy was issued.

A. Pre-existing condition exclusions

Many laypeople confuse "pre-existing condition exclusions" with an insurer's right to deny insurance based on medical conditions. In fact, pre-existing condition exclusions do not have to do with obtaining insurance at all, but rather with the ability to get certain types of claims covered.

A pre-existing condition exclusion is a finite period of time during which claims (for health care, disability or death) will not be paid if the basis for the claim is a "pre-existing condition" as defined in the policy. A "pre-existing condition" is usually defined as a condition for which medical care was sought or received during a specified period of time before the effective date of the policy. The period during which claims will not be paid is referred to as the exclusion period, and the period that defines the pre-existing condition is referred to as the "lookback period."

Where pre-existing condition exclusions exist, an insurance policy must say so. In some instances, the law limits the pre-existing condition exclusions that might otherwise be legitimately used in insurance policies, as follows.

1. Health insurance

Under California law, pre-existing condition exclusion periods in group health plans may not last more than six months. Pre-existing condition exclusions in individual health insurance policies may not exceed one year. The only medical conditions that can trigger the exclusion are those for which medical advice, diagnosis, care, or treatment, including the use of prescription medications, was recommended by or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage, or twelve months in the case of individual coverage.²¹ See FIGURE 1.

¹⁹Cal. Ins. Code § 336 (careful not to extend too far as some knowledge is required).

²⁰Cal. Ins. Code § 10384; Cal. Health & Safety Code § 1389.3.

²¹ Cal. Ins. Code § 10708(a); Cal. Health & Safety Code § 1357.51.

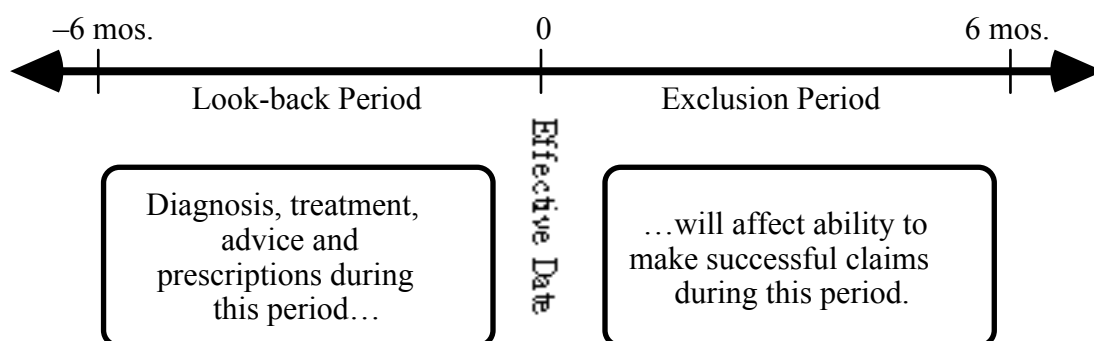


Figure 1: Pre-existing Condition Exclusion in Group Health Insurance

However, if an individual was previously covered by health insurance, and no more than 180 days have elapsed between the termination of the old coverage and the effective date of the new coverage,²² the length of the previous coverage is credited against the pre-existing condition exclusion of the new coverage. If the individual had been covered for more than six months, and the new coverage has a six month exclusion, that exclusion is, in effect, waived for this individual. In other words, with more or less continuous employment-related or individual health coverage, an individual will be subject to a pre-existing condition exclusion only once, and the exclusion is then waived in future health insurance.²³ This ability to move from employer to employer without being subject to a new pre-existing condition exclusion is known as the "portability" feature of California's health insurance reform of 1993.

2. Disability or life insurance

Many disability and life policies have pre-existing condition exclusions worded similarly to those of health insurance. If, within the exclusion period, an individual becomes disabled by, or dies from, a condition that originated during the lookback period (as defined in the policy), the claim will not be honored. Note that this is not a waiting period before benefits begin. Rather, if the excluded disability began during the exclusion period, the claim will not be paid — ever.

Some disability policies attempt to formulate a pre-existing condition exclusion by stating that disabilities will only be covered by the policy if the disabling illness originated while the policy was in effect. However, case law indicates that the crucial test of when a disability originated is not when, say, transmission of a pathogen occurred, but rather when the illness became manifested: [The insured's illness will have] originated under the terms of [the] policy when it manifested itself by distinctive symptoms sufficient to interfere with his regular employment or from which a reasonably accurate medical diagnosis could be made.²⁴

This analysis raises odd questions when applied to HIV. At what point is an HIV infection no longer a mere pathogen, but rather a manifestation? If an individual is asymptomatic, can an HIV infection itself, or even lowered T-cells, ever be considered a pre-existing condition? If so, for what — AIDS? For any or all opportunistic infections? If an individual is experiencing symptoms of some type of HIV-related condition, does that become a pre-existing condition for all other HIV-related opportunistic infections, even if the only connection between the two conditions is that both appear

²²This is if one's previous coverage and one's new coverage are both employment-related. If instead one of the coverage periods was through an individual policy, the lapse may not exceed 30 days.

²³Cal. Ins. Code § 10708(c); Cal. Health & Safety Code § 1357.51.

²⁴*Bower v. Roy-Al Corp.*, 33 Cal.App.3d 1027, 1041 (1973).

in HIV-positive individuals? These questions have not yet been answered under the law. Caution, however, argues that whenever making a claim, the disabling condition or the condition causing death should be named as precisely and narrowly as possible if the claim is made during the exclusion period.

3. Credit insurance

Insurance policies that promise to pay money against a debt, such as a credit card or a mortgage in case of disability or death, often contain pre-existing condition exclusions. Some of these exclusions are constructed in a way that creates an independent lookback period for each credit card purchase, making the policy meaningless for anyone who has a serious medical condition, except for purchases made before the condition arose.

In other credit insurance policies, the existence of a pre-existing condition may have the effect of simply voiding the policy. If the policy has such a limitation, it must be stated in bold capital letters on the application, the certificate, and the policy.²⁵

B. Coverage caps for HIV claims

Some providers of health care benefits have attempted to reduce their risks by placing specific dollar caps on what will be paid for HIV-related claims. These caps are probably illegal whenever they arise. Nonetheless, among large, self-insured corporations, they are still quite common.

1. In insurance plans

An insurer may not dump, refuse to insure, charge a different premium rate, or limit coverage available to an individual solely because of a physical or mental impairment, except where the refusal, limitation or rate differential is based on sound actuarial principles or is related to actual and reasonably anticipated experience.²⁶

This law would probably prevent the institution of HIV-specific caps in insurance policies, at least if it were the only disability for which coverage was capped. Also, insurers may not limit coverage for AIDS-related claims, unless the insurer could have denied insurance at the application phase based on the HIV condition.²⁷ So, for instance, if an enrollee or applicant is HIV positive and asymptomatic, he could not be denied the insurance. No cap may apply to this person. Or if the insurance was offered through a small employer such that issue of the policy was guaranteed, no cap may apply.

2. In employer-provided self-insured plans

The practice of "capping" HIV-related health care benefits has gained popularity over recent years among self-insuring employers, unions and multi-employer benefits plans.²⁸ Federal courts have held that nothing in ERISA, even its non-discrimination provision, prohibits this practice.²⁹

²⁵Cal. Ins. Code § 10127.5.

²⁶Cal. Ins. Code § 10144.

²⁷Cal. Ins. Code § 799.08; See also Cal. Ins. Code § 799.02.

²⁸See generally ALRP Policy Publication: "Capping Justice: Discriminatory Limits on HIV/AIDS Health Care Benefits," Di Donato & Johnsen, eds. (1993).

²⁹*McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991), *cert. denied sub nom.*; compare with *Stephen Allen Lynn, P.C. Employee Profit Sharing Plan & Trust v. Stephen Allen Lynn, P.C.*, 25 F.3d 280, 283-87 (5th Cir. Tex. 1994); *Owens v. Storehouse*, 984 F.2d 394 (11th Cir. 1993).

Since the passage of the Americans with Disabilities Act (ADA), the federal EEOC has taken the position that these caps probably violate the Act. Under the EEOC's 1993 guidelines on the topic, employers must demonstrate that any disability-based distinctions in health benefits are cost or actuarially justified, and are not a subterfuge to evade the purposes of the Act.

As of this writing, no federal court has specifically held that HIV caps are illegal as a matter of law. However, the case law has clarified various aspects of such claims. For instance, courts have held that union benefit plans are subject to the ADA,³⁰ and that multi-employer welfare arrangements might, in some circumstances, stand in the shoes of an employer for ADA purposes.³¹

C. Experimental and "off-label" treatments

Health insurance policy language often excludes coverage for experimental or investigational treatments. If coverage for an experimental treatment is denied for an individual who is terminally ill, the insurer must give written notice of the medical and scientific grounds for the denial, a description of alternative procedures or treatments that are covered by the policy, and instructions on how to appeal the decision.³²

Even if the policy does not explicitly exclude coverage for experimental treatments, an insurer may attempt to deny coverage for innovative care, claiming that it is not "medically necessary," as defined in the policy. The only way to respond to this type of denial is to challenge the insurer's decision using evidence that the treatment meets the standard of care in the community. In the San Francisco Bay Area, where HIV care is cutting edge, it might be somewhat easier to mount an argument that there is a consensus among physicians in the community as to the effectiveness of the procedure in question, and that it is not experimental as defined in the policy. Evidence that other treatments for the same condition have little or no effect, or have severe side effects, can contribute to a successful argument that the innovative treatment is indeed medically necessary.

In doing this advocacy, it may be worthwhile to remind the insurance carrier, that under California common law, insurance contracts are construed in favor of coverage and require that a physician's judgment govern unless it is plainly unreasonable.³³

"Off-label treatment" refers to use of an FDA-approved prescription drug for indications other than those stated on the marketing label. Under California law, health plans that cover pharmaceuticals must cover off-label uses of pharmaceuticals if prescribed by a physician in accordance with standards of medical practice.³⁴ Certain conditions must be met to prove that the off-label use reflects those standards; for instance it must be FDA-approved, prescribed for treatment of a life-threatening condition, and recognized for the off-label use by certain medical bodies or by two articles from major peer-reviewed medical journals.

³⁰*Mason Tenders District Council Welfare Fund v. Donaghey*, No. 93 Civ. 1154 (S.D.N.Y. 1993); see also *Legal Guide to Human Resources* § 17:65 Steven C. Kahn & Barbara Berish Brown (updated 2003).

³¹*Carparts Distrib. Ctr., Inc. v. Automotive Wholesaler's Ass'n of New England*, 37 F.3d 12 (1st Cir. 1994); *Carparts Distrib. Ctr. v. Automotive Wholesaler's Ass'n of New England*, 987 F.Supp. 77 (D.N.H. 1997) (on remand).

³²Cal. Ins. Code § 10144.1.

³³*Sarchett v. Blue Shield of California*, 43 Cal.3d 1, 7 (1987); but see *Becker v. State Farm Fire & Casualty Co.*, 64 F.Supp. 460 (N.D. Cal. 1987); see also *Chase v. Blue Cross of California*, 42 Cal. App. 4th 1142 (Cal. App. 1st Dist. 1996); *McLaughlin v. Conn. Gen. Life Ins. Co.*, 565 F.Supp. 434, 450-451 (N.D.Cal. 1983) (treatment is deemed necessary if it is "in some degree beneficial to the patient," regardless of whether the FDA has approved it); see also *Reshamwella v. State Farm Fire & Casualty, Co.*, 72 Fed. Appx. 543, 545 (2003); *Hughes v. Blue Cross of No. Calif.*, 215 Cal.App.3d 832, 845 – 846 (1989) (utilizing an overly-restrictive standard of "medical necessity" may constitute bad faith by the insurer, yet this may be difficult to show in most cases)(*cert. dismissed*).

³⁴Cal. Health & Safety Code § 1367.21 (health care service plans) (amended 2000); Cal. Ins. Code § 10123.195 (group or individual health insurance policies); Cal. Ins. Code § 11512.182 (group or individual nonprofit hospital service plans).

V. Holding on to Insurance: Continuation Coverage

Since the majority of Americans get their insurance coverage through their employment, it is particularly important that people with HIV be able to continue their coverage in case they become too disabled to work. That is when their insurance is most valuable. A number of legal mechanisms permit individuals to maintain their insurance coverage.

A. Conversion

1. Health insurance

If an individual is part of a group health policy and becomes ineligible for coverage under the policy (for instance, he stops working), the insurer must offer him an individual policy without his having to provide evidence of insurability.³⁵ The "conversion policy" the individual receives will not be of the same quality as the group coverage.³⁶ It generally entails a higher premium and usually excludes outpatient pharmaceutical coverage. If the employer that sponsored the group plan is subject to COBRA (*see below*), the conversion option will be available to the former employee at the conclusion of the COBRA period.

The insurer is not required to offer a conversion policy if, at the time of conversion, the individual is entitled to be covered by Medicare.³⁷ A few group plans, however, will offer conversion to a Medicare supplemental policy, even though the law does not require them to do so.

2. Life insurance

If an individual's employment ends for any reason, he has, within 31 days of losing coverage, a right to request conversion to an individual life insurance policy.³⁸ The conversion will generally be to a whole life rather than a term policy. The conversion is guaranteed regardless of the individual's health status. Although this conversion option should be included in the summary plan description, employers rarely remind employees of this right when their employment ends. For that reason, many individuals irrevocably lose their life insurance when they stop working.

B. COBRA

1. COBRA continuation coverage

COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986) is a body of law that provides for continuation of group health coverage for employees and other "qualified beneficiaries" who would otherwise lose their coverage under the terms of the policy. This could be due to a reduction in work hours, termination or layoff, or (in the case of dependent coverage) loss of relationship with an employee (such as divorce from or death of an employee).³⁹

³⁵Cal. Ins. Code § 12670 (amended 2002); Cal. Health & Safety Code § 1373.6.

³⁶29 USC §1162(5).

³⁷Cal. Ins. Code § 12677.

³⁸Cal. Ins. Code § 10209(b).

³⁹29 U.S.C. § 1161 *et seq.*; 26 U.S.C. § 4980B(5)f(6).

Not all employers are subject to COBRA. Only employers that are not churches and have 20 or more employees are obligated to provide COBRA coverage.⁴⁰

All employees of COBRA employers may become eligible for COBRA continuation unless they were terminated for gross misconduct. For all other employees, the plan administrator is required to give notice of the right to elect COBRA coverage within 44 days after the employee's "qualifying event date" (that is, the date of termination, reduction in hours, etc.). If the employer administers its own health plan, notice must be given within 14 days.

The employee then has 60 days to elect coverage and to begin paying current premiums. (Note, however, that the employee has an additional 45 days from his election to pay whatever premiums became due before he elected.) Employees may be required to pay up to 102% of the amount that it cost their employer to retain them on the group insurance. Generally, for employees whose employment ends, COBRA coverage lasts for eighteen months from the qualifying date.

Employees insured under COBRA have exactly the same rights as active employees under the group health plan. Their coverage must be identical. Changes to — or cancellation of — the policy affect both groups equally.

2. 29-month continuation for disability

If an employee is disabled at the time of his COBRA qualifying event, he may extend his COBRA coverage for an additional eleven months, bringing the full COBRA coverage up to a total of 29 months.⁴¹ He may be required to pay 150% of the premium cost for those eleven months.

In order to get this additional period of coverage, the employee is responsible for notifying the employer within 60 days of a determination of disability by the Social Security Administration that he wants to extend his coverage for the additional eleven months. This notification by the employee must occur before the end of the initial 18 months of COBRA. The SSA award letter must reflect that disability began at or before the COBRA qualifying event. The eleven-month extension ideally will give the former employee coverage until he becomes Medicare eligible.

C. Vested benefits: 12-month extension for disability

In general, the rights of an insured are deemed to vest when a claim or loss arises. Therefore, subsequent termination or modification of a health insurance policy does not affect the insured's right to be reimbursed for ongoing medical expenses up to the policy limits in effect at the time of the loss. This is known as the vested benefits rule.⁴²

In a further development of this principle, California statutory law mandates that when a group health plan is terminated, insureds who are totally disabled must be provided at least 12 months of continued benefits, at least for the disabling condition.⁴³ In other words, a health insurer cannot escape paying a disabled person's claims by canceling the entire group policy.

The law does not explicitly require the extension to be provided to individual insureds who leave the group, if there is no cancellation of the group policy as a whole. Nonetheless, some

⁴⁰The counting of employees is rather technical. It can include part-timers and temps, even if those individuals are not themselves eligible to participate in the group plan. Also, multiple employer welfare arrangements (through, e.g., trade associations) and plans that are collectively bargained through unions are subject to COBRA.

⁴¹29 U.S.C. § 1162(2)(a)(v).

⁴²*Silberg v. Calif. Life Ins. Co.*, 11 Cal.3d 452, 465 (1974) [applies the rule without comment]; *Fields v. Blue Shield of Calif.*, 163 Cal.App.3d 570, 589 (1985); see also *Williams v. California Physicians' Service*, 72 Cal. App. 4th 722 (Cal. App. 3d Dist. 1999), Cal. Ins. Code § 10291.5(b)(4).

⁴³Cal. Health and Safety Code § 1399.62(b); Cal. Ins. Code § 10128.2.

insurers voluntarily extend benefits for 12 months (or some shorter period) to disabled insureds who leave the group. Consult the policy language to determine if such an extension is applicable.

This limited coverage is distinct from the COBRA extension for disability, discussed above. The two laws would interact in, for example, a scenario where someone has gone out on disability, remains in the group health plan through COBRA, and the employer cancels its insurance coverage for all plan members — both active employees and former employees on COBRA. Disabled COBRA participants should then have access to the 12-month extension of benefits discussed above.

D. Waiver of premium

In many employer-provided life insurance plans, an individual who leaves work due to disability often has the right to remain within the group plan by requesting a "waiver of premium" under the terms of the policy. Most individual life insurance policies offer a waiver of premium as well. Under a waiver of premium, if the insured becomes disabled, no premiums will have to be paid, and the policy will stay in effect indefinitely.⁴⁴ In order to trigger the waiver of premium, the individual should contact the insurance carrier and request it. A doctor's verification of disability may be required.

E. Viatical settlements and accelerated benefits

For many individuals with HIV, continuation of life insurance is particularly important as a potential means of obtaining cash in a time of need. This is often accomplished by selling a life insurance policy in a transaction known as a "viatical settlement." In such a transaction, a private investor is irrevocably named as the policy's beneficiary in exchange for a cash payment representing a percentage of the policy's death benefit.⁴⁵ Viatical settlement companies prefer to purchase individual policies with a waiver of premium, since otherwise they will become responsible for paying premiums. It might therefore be beneficial for an employee going out on disability to convert the employer's group life insurance to an individual policy, *as long as the individual policy includes a waiver of premium provision*.

Many life insurance companies offer what are known as "accelerated benefits" or "living benefits." In those instances, the insurance carrier will pay a portion of the death benefit to the insured, if his life expectancy is under two years, and the remainder to the designated beneficiary when the insured dies.

The proceeds of both viatical settlements and accelerated benefits are often excluded from taxable income on one's federal tax return.⁴⁶ Both, however, are non-taxable on the California return.⁴⁷ Receiving a large influx of cash can also be a problem for individuals who rely on need-based public benefits such as SSI or Medi-Cal. It is important to consult with a public benefits specialist before receiving such a sum.

⁴⁴Cal. Ins. Code § 10128.2.

⁴⁵See Cal. Ins. Code §§ 10113.1- 10113.2.

⁴⁶26 USC § 101; See 33 Am. Jur.2d Federal Taxation ¶ 12825.

⁴⁷Fed. Rev. & Tax. Code § 17131.5.

VI. Remedies and Procedure

A. Statutory violations

Insurers, by statute, are held to certain standards of conduct in carrying out their business. Some statutory requirements, such as regulations on the use of HIV status in underwriting, may give rise to a private right of action.⁴⁸

Insurers are also bound by a statutory duty of good faith, including specific standards for handling HIV-related claims. For instance, it is unlawful for an insurance company to delay paying AIDS-related health care claims for more than 60 days, if the delay is for the purpose of investigating whether the condition pre-existed the coverage.⁴⁹

Other unfair practices prohibited by statute include misrepresenting pertinent facts or policy provisions, unreasonably delaying claims resolution, not acting in good faith to settle claims promptly and fairly, forcing an insured to initiate litigation by offering an unreasonably low sum, discouraging an insured from obtaining services of an attorney, and misleading an insured as to the applicable statute of limitations.⁵⁰ The statute prohibiting these practices is essentially a codification of the tort of breach of implied covenant of good faith and fair dealing ("bad faith"), as it has been interpreted in case law.⁵¹

Although the unfair practices statute at one time supported a private right of action for both insureds ("first parties") and claimants ("third parties"),⁵² the California Supreme Court subsequently revoked that right in *Moradi-Shalal v. Fireman's Fund*.⁵³ Since that ruling, the Commissioner of the Department of Insurance is the only party with standing to enforce the provisions of the statute. The remedies are generally limited to injunctive relief and restitution. In other words, the remedy would probably be restricted to payment of the claim.

Health care service plans, including HMOs, are also subject to statutory restrictions on their conduct. Violations include committing fraud, issuing descriptions of coverage that do not comply with the law, and engaging in false advertising.⁵⁴ They are also required to pay claims within certain time limits.⁵⁵ There is no private right of action to enforce these statutory provisions. Instead, an enforcement action must be brought by the director of the Department of Corporations.⁵⁶ A health plan that violates the statute may be liable for penalties, or may have its license suspended or revoked.

B. Common law actions

In recent years, an insured's right to bring state common law tort or contract actions against an insurer has been eroded in a number of ways. If an insured's coverage is employer-provided, the

⁴⁸Under *Wetherton v. Growers Farm Labor Ass'n.*, 275 Cal.App.2d 168, 174 (1969) (when a statute embodying public policy has no specific remedy, an injured party may bring a private action); *Michael R. v. Jeffery B.*, 158 Cal. App. 3d 1059, 1066-67 (Cal. Ct. App., August 2, 1984).

⁴⁹Cal. Ins. Code § 790.03(h)(16).

⁵⁰Cal. Ins. Code § 790.03(h).

⁵¹Cal. Ins. Code § 790 *et seq.*; see, e.g., *Richardson v. GAB Services, Inc.*, 161 Cal.App.3d 519, 524 (1984).

⁵²*Royal Globe Ins. Co. v. Superior Court*, 23 Cal.3d 880 (1979).

⁵³*Moradi-Shalal v. Fireman's Fund Ins. Cos.*, 36 Cal.3d 287 (1988).

⁵⁴Cal. Health & Safety Code § 1386; Cal. Bus. & Prof. Code § 17200 & § 17500 *et seq.*

⁵⁵Cal. Health & Safety Code § 1371.

⁵⁶Cal. Health & Safety Code § 1386.

federal law known as ERISA will preempt all common law actions.⁵⁷ Of course, an insured's statutory bad faith claims have also been eliminated, as discussed above.

An insured with *individual* (not employer-provided) coverage still has available a private right of action against an insurer based on a number of common law theories. That insured has the right to sue for breach of contract, fraud, intentional infliction of emotional distress, and - most significantly - breach of the implied covenant of good faith and fair dealing. Despite the *Moradi-Shalal* case, which eliminated private right of actions based on *statutory* bad faith, the *common law* version still exists in "first party" cases (i.e., an action by the insured).⁵⁸ The insurer's violation of the statute of the unfair practices statute, though not directly actionable by the insured, may still be evidence in a common law bad faith action.⁵⁹

Attorney fees may not be recovered in a breach of contract action, except as specifically provided for by statute or under the contract.⁶⁰ If the insured brings a tort action, such as a bad faith action, he may recover attorney fees reasonably incurred in order to compel payment of benefits due (but not the fees incurred in proving "bad faith").⁶¹

In any sort of action based on an insurance policy, the court will construe ambiguities in the plan in favor of greater coverage for the insured. This common law principle is based on the fact that the contract was drafted by the insurer, which had ample opportunity to make the contract clear and unambiguous. This principle is known as the "contra insurer" doctrine.

What's more, courts will not enforce exclusions to or limitations on full coverage unless the exclusionary clauses are "conspicuous, plain, and clear" and are placed "in such a fashion as to make obvious their relationship to other policy terms, and . . . such provisions [are brought] to the attention of the insured."⁶² This rule of interpretation, called the "reasonable expectations" rule, is applicable even in ERISA cases.

C. Employer-provided plans

The majority of Californians who have health insurance get it through employment, either theirs or a family member's. The federal law known as ERISA will therefore come into play in any dispute over benefits. Although an insurance policy is still an enforceable contract, the means of enforcing it are different under ERISA. Moreover, certain claims (like bad faith) are eliminated and damages are limited. An insurance advocate should have some understanding of these constraints before opening dialogue with an employer or an insurer regarding a benefits claim.

1. ERISA Preemption

The Employee Retirement and Income Security Act of 1974 (ERISA)⁶³ is the federal law governing employers' duties with respect to benefits plans - including health, disability and life insurance, pension and retirement. ERISA primarily focuses on pension and retirement plans, and

⁵⁷*Pilot Life v. Dedeaux*, 481 U.S. 41 (1987); for clarification see *K.Y. Ass'n of Health Plans, Inc. v. Miller*, 123 S.Ct. 1471 (2003), and *Varr v. Olimpia*, 45 Cal. App. 4th 675 (May 17, 1996).

⁵⁸*Zephyr Park Ltd. v. Superior Court*, 213 Cal.App.3d 833, 837-838 (1989); *Cooper v. Equity Gen. Ins.*, 219 Cal. App. 3d 1252, 1257 (1990).

⁵⁹*Vesely v. Sager*, 5 Cal.3d 153, 164 (1971); but see *Strang v. Cabrol*, 37 Cal.3d 720, 724 (1984).

⁶⁰Cal. Code Civ. Proc. § 1021 (amended 1993).

⁶¹*Burnaby v. Standard Fire Ins. Co.*, 40 Cal. App. 4th 787, 790 (November 30, 1995); *United Services Automobile Ass'n v. Superior Court*, 93 Cal. App. 4th 633, 645 (November 1, 2001).

⁶²*Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382, 386 (9th Cir. 1994). In this case, the court refused to enforce a pre-existing condition exclusion that was buried in the definitions section of a health insurance policy.

⁶³29 U.S.C. 1001 *et seq.*

provides virtually no substantive requirements for health and disability benefits. ERISA does not require an employer to provide health coverage nor does it dictate the contents of any coverage an employer chooses to provide. ERISA does, however, provide procedural requirements such as requiring employers to disclose the terms of their health plan (if any) to their employees by means of a "summary plan description" (SPD).⁶⁴

The most significant characteristic of ERISA is its sweeping preemptive effect on state law regulating benefits plans. Under the statute, ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."⁶⁵ It preempts state statutes as well as causes of action arising out of them, even if the state statutes' purposes and requirements are consistent with ERISA.⁶⁶ It also preempts common law causes of action, such as bad faith, when insurance is employer-provided.⁶⁷

There is an important exception to ERISA's preemptive force. Under ERISA's "savings clause," states may still regulate the business of insurance itself.⁶⁸ To be saved from preemption, a regulation would have to spread policyholder risk, address the relationship between insurer and insured, and apply explicitly and exclusively to entities within the insurance industry.⁶⁹ So industry-wide regulation, such as on the use of HIV status in underwriting, or even regulation dictating the substantive content of group insurance policies, would be saved from ERISA preemption. In contrast, a common law contract or tort action against a group insurer would be preempted since contract and tort law do not explicitly regulate the insurance industry.⁷⁰

Under ERISA's "deemer" clause, an explicit distinction is drawn between insurance companies on one hand and benefits plans on the other. Specifically, ERISA provides that no employee benefit plan "shall be deemed to be an insurance company" for the purposes of being subject to state insurance regulation.⁷¹ In the case of self-funded plans, where there is no insurance product but only an employee benefit plan, the effect of the "deemer" clause is most profound. All state attempts to regulate or control the content of those plans will probably be preempted.⁷²

Note, however, that other federal laws may affect the rights and responsibilities of employers that provide employee benefits. The Americans with Disabilities Act, for example, may prohibit certain types of disability-based discrimination in the establishment and administration of employee benefits plans. (See SECTION IV.B.2., *supra*.)

2. Procedural requirements

Whenever an insured attempts to enforce his rights under an employer-provided plan, he must first exhaust whatever administrative remedies are available to him under the terms of the plan as

⁶⁴29 U.S.C. 1022.

⁶⁵29 U.S.C. 1144(a).

⁶⁶*Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); *but see Ky. Ass'n of Health Plans, Inc. v. Miller*, 123 S.Ct. 1471, 1479 (2003).

⁶⁷*Pilot Life v. Dedeaux*, 481 U.S. 41, 50-51 (1987); *but see Ky. Ass'n of Health Plans, Inc. v. Miller*, 123 S.Ct. 1471, 1479 (2003).

⁶⁸29 U.S.C. 1144(b)(2)(A); *Metropolitan Life, supra*, 471 U.S. at 739, *but see Ky. Ass'n of Health Plans, Inc. v. Miller*, 123 S.Ct. 1471, 1479 (2003).

⁶⁹*Metropolitan Life, supra*, 471 U.S. at 739; *Pilot Life v. Dedeaux, supra*, 481 U.S. at 48-49; *but see Ky. Ass'n of Health Plans, Inc. v. Miller*, 123 S.Ct. 1471, 1479 (2003).

⁷⁰*Kanne v. Conn. Gen. Life Ins. Co.*, 867 F.2d 489,491 (9th Cir. Cal. 1988) (contract action preempted). *See also Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131-132 (9th Cir. 1993) (a wrongful death action brought against insurer for unlawful denial of a claim for a bone marrow transplant held preempted by ERISA).

⁷¹29 U.S.C. § 1144(b)(2)(B).

⁷²*FMC Corp. v. Holliday*, 498 U.S. 52 (1990); *see also New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 US 645 (1995).

laid out in the summary plan description.⁷³ Then he may file an action under ERISA. Since ERISA will provide the sole remedy for an action regarding an employee benefits plan, the action will be considered to "arise out of" federal law. It is therefore a federal claim, subject to federal jurisdiction. Some procedural aspects of ERISA vary depending on whether the claim is for breach of fiduciary duty under ERISA § 409(a)⁷⁴ or to recover benefits under ERISA § 502(a)(1).⁷⁵ A claim against the employer for violating the fiduciary duties imposed by ERISA will be subject to ERISA's own statute of limitations: six years from the breach, three years from discovery of the breach, or six years from the discovery of the breach in the case of fraud or concealment.⁷⁶ State court will have no jurisdiction, and the action must be brought in federal court.⁷⁷

If the claim is only for payment of benefits under the plan, ERISA will not impose a statute of limitations. Instead, the court will incorporate the most analogous state statute of limitations, such as California's four-year statute for breach of a written contract.⁷⁸ There will be concurrent state and federal jurisdiction.⁷⁹ If the claim is filed in state court, the defendant may — but is not required to — remove it to federal court.⁸⁰ The proper defendant would be the plan administrator. That would mean either the employer or a third party administrator in the case of self-funded plans or, when the employer purchased insurance, the insurance company as plan administrator.

ERISA also controls the remedies available to plan participants. In claims disputes, ERISA authorizes payment of the benefits, enforcement of rights under the plan, and clarification of future benefits. In breach of fiduciary duty cases, ERISA authorizes restitution as well as other "equitable or remedial relief."⁸¹ Punitive damages are not available under ERISA.⁸² Attorney fees may be awarded to either party, at the discretion of the court.⁸³

Many HIV-positive clients report problems with their insurance as a result of misinformation given to them by their employer or by the insurer; for instance, regarding the applicability of a pre-existing condition exclusion. ERISA limits the availability of estoppel claims to enforce these misrepresentations. If the language of the plan is unambiguous and payment of the claim would conflict with the plain language of the plan, no equitable estoppel claim against a benefits plan may be maintained.⁸⁴ However, if the plan language is ambiguous such that reasonable persons could disagree as to its meaning or effect, the plan administrator's oral representations may be binding.⁸⁵ If the plan administrator (employer or insurer) made the representations with an intention to mislead, an estoppel claim may be maintained - not against the policy or plan, but against the party that made

⁷³29 U.S.C. 1133 (requiring plans to establish internal procedures for "full and fair review" of claims disputes); 29 C.F.R. 2560.503-1 (establishing the minimum requirements for those procedures); *Amato v. Bernard*, 618 F.2d 559, 567-568 (9th Cir. 1980) (requiring exhaustion of those remedies prior to filing a court action, unless they are inadequate or futile).

⁷⁴29 U.S.C. 1109(a).

⁷⁵29 U.S.C. 1132(a)(1)(B).

⁷⁶29 U.S.C. 1113.

⁷⁷29 U.S.C. 1132(e)(1).

⁷⁸Cal. Code Civ. Proc. § 337.

⁷⁹29 U.S.C. 1132(e)(1).

⁸⁰*Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *Hughes v. Blue Cross of No. Calif.*, 215 Cal.App.3d 832 (1989).

⁸¹29 U.S.C. 1109(a), 1132(a)(2).

⁸²*Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151, 2165 (June 20, 2002); *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 139 (1985).

⁸³29 U.S.C. 1132(g); *Massachusetts Mutual*, *supra*, 473 U.S. at 147; *Watkins v. Westinghouse Hanford Co.*, 12 F.3d 1517, 1528 (9th Cir. 1994).

⁸⁴*Davidian v. So. Calif. Meat Cutters Union*, 859 F.2d 134, 136-137 (9th Cir. 1988); *Kessler v. ADT Sec. Servs., Inc.*, 33 Fed. Appx. 850, 852 (2002).

⁸⁵*Kaiser Permanente Employees Pension Plan v. Bertozzi*, 849 F.Supp. 692, 697 (N.D.Cal. 1994); *but see Lancaster v. United States Shoe Corp.*, 934 F.Supp. 1137, 1154 (N.D. Cal. 1996).

the misrepresentation.⁸⁶ Finally, an administrator's failure to give complete and accurate information regarding the content of the plan may be actionable as a breach of fiduciary duty under ERISA.⁸⁷

3. Standard of review in ERISA plans

When a claim is made for benefits under an employer-sponsored insurance contract, the court may interpret the contract *de novo* if the terms of the contract are ambiguous, and need not defer to the claims decision of the insurance company. In reviewing the contract, the court will interpret ambiguities in favor of the insured.⁸⁸

When a claim is made for benefits under a self-funded plan, the standard of review will depend upon whether the language of the plan explicitly vests in the plan administrator discretion in making claims decisions. If it does not, the court may perform a *de novo* review of the claims decision, and may incorporate factors extrinsic to the language of the plan, including other disclosures to employees. If the plan document does grant that discretion, the court will only review the claim decision for abuse of discretion, or for arbitrary and capricious action.⁸⁹ This is a standard that is nearly impossible for an insured to meet if no new evidence has been used as the basis of denial of the benefits.⁹⁰

The court also has the discretion to apply a heightened level of scrutiny in reviewing a plan administrator's decision if there is a conflict of interest, or even a suspicion of partiality.⁹¹ However, it should be noted that broad deference is given to the discretion of an administrator of a plan, unless the beneficiary fulfills the burden of bringing forth evidence that the administrator acted in its own best interest to the extent of breaching its duty to the beneficiary.⁹² If the employee prevails and the administrator is found to have breached its duty of good faith and fair dealings, then the employee may be entitled to attorney fees, at the court's discretion, as determined by the reasonable hourly attorney fee times the hours spent on the case.⁹³

D. Long-Term Disability Benefits

The long-term disability (LTD) plans often included in employer-provided benefit plans are one of the primary focuses of ERISA. This is an area of the law that affects many AIDS patients and is an area that many attorneys can provide the assistance which is so urgently needed. If the attorney can be involved in the administrative appeals process that an employee is going through with his or her insurance company, there is a good chance that the LTD benefits will be provided even though they often fall under ERISA.

⁸⁶ *Carver v. Westinghouse Hanford Co.*, 951 F.2d 1083, 1087-1088 (9th Cir. 1991); *see also Lix v. Edwards*, 82 Cal. App. 3d 573, 580 (Cal. App. 2d Dist. 1978).

⁸⁷ 29 U.S.C. 1104(a)(1). *See also Eddy v. Colonial Life Ins. Co.*, 919 F.2d 747, 750-752 (D.C. Cir. 1990) (HIV-positive employee given incomplete information regarding his conversion rights and lost his insurance as a result; plan administrator found to have "a duty upon inquiry to convey to a lay beneficiary . . . correct and complete material information. . . ." *Id.*, at 750.); *see also Varity Corp. v. Howe*, 516 US 489, 492 (1996).

⁸⁸ *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir. 1990); *see also Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382, 387 (9th Cir. 1994).

⁸⁹ *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101 (1989); *Taft v. Equitable Life Assurance Society*, 9 F.3d 1469, 1471 (9th Cir. 1993).

⁹⁰ *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech.*, 125 F.3d 794, 797 (9th Cir. 1997).

⁹¹ *Dockray v. Phelps Dodge Corp.*, 801 F.2d 1149 (9th Cir. 1986).

⁹² *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1322 (9th Cir. 1995); *see also Snow v. Standard Ins. Co.*, 87 F.3d 327, 331 (9th Cir. 1996).

⁹³ 29 USC §1132(g); *see also Van Gerwen v. Guarantee Mutual Life*, 214 F.3d 1041 (9th Cir. 2000).

1. How This Works

A LTD plan provides monthly benefits to an employee who is unable to work due to illness or injury but will not be paid while the employee is still employed. So the first step to gaining LTD benefits is usually to establish that the individual was terminated after all vacation time, sick time, and short-term disability (usually 3-6 months) has been exhausted. Upon termination the employee should become eligible for COBRA (for 18 - 29 months), possibly social security compensation and LTD benefits.

The length of time that one is eligible for LTD benefits varies due to differing plans and the disability suffered. There are some limits on most LTD's, including a 24-month cap for most insureds suffering from mental or nervous illnesses, and most LTD benefits cease at age 65 for any other illness or disability. Most LTDs also have "own-occupation" and "any occupation" requirement periods. This means that insureds will get initial LTD benefits if they are unable to perform the duties of their own occupation because of an injury or sickness occurring while under the policy usually for a specified amount of time, e.g., 24 months. After this "own occupation" period, the insureds will only receive continued coverage if they are totally disabled for "any occupation" for which they are or may become suited by education, training or experience.⁹⁴

2. LTD Benefits and ERISA

Another disheartening side of LTD benefits is that, for the most part, if the benefits were received as part of an employment package then it would fall under ERISA, which basically limits the amount of recovery that is possible for an insured. Under ERISA, the most an insurance company is required to pay is compensatory, i.e., the benefits that they would have paid but for the carrier's wrongful denial of benefits. ERISA bars claims for increased damages for pain and suffering, bad faith, and other punitive damages. If the insured can show that the insurer breached the implied covenant of good faith and fair dealing, then the insurer will be liable for tort damages only if the LTD does not fall under ERISA.⁹⁵ This illustrates the importance of an attorney being involved in the administrative appeals process with the insurance company as soon as possible. However, if an attorney does not get in at the ground level all is not lost.

There are a few LTD plans that do not fall under ERISA – specifically, governmental and church plans⁹⁶, conversion disability coverage, or any plan that meets the safe harbor four-part test. The term "governmental" plan refers to a plan maintained or established by the federal or state government or any agency or instrumentality of the federal or state government.⁹⁷ Conversion disability coverage or a conversion plan is available to certain employees if the employer opted for this benefit under its group plan. A conversion plan is available to these employees who have been covered by the group plan for at least twelve months and is available when an employee's LTD insurance is terminated because his or her eligibility period ends.⁹⁸ A plan will be excluded from ERISA, due to safe harbor regulations issued by the Department of Labor, if it meets all four requirements: (1) no contributions are made by the employer; (2) employee participation is voluntary; (3) the employer is merely the conduit to publicize the program to employees and collect premium payments (through payroll deductions, etc.); and (4) and the employer does not receive consideration for its involvement (other than reasonable compensation).⁹⁹

⁹⁴ See, e.g., *Shipp v. Provident*, 14 F. Supp. 2d 1241 (2002).

⁹⁵ See, e.g., *Ackerman v. Fortis Benefits Ins. Co.*, 254 F.Supp. 2d 792 (S.D. Ohio 2003).

⁹⁶ 29 USC § 1003 (b).

⁹⁷ 29 USC § 1002 (32).

⁹⁸ See *Waks v. Empire Blue Cross*, 263 F.3d 872 (9th Cir. 2001).

⁹⁹ 29 C.F.R. § 2510.3-1 (j); see also 29 USC § 1002 (1), and *Qualls v. Blue Cross of California*, 22 F.3d 839 (1994).

3. LTD Benefits and Incontestability Clauses

In recent years and in order to save money, a common practice of insurance companies has been to deny LTD benefits to those policyholders diagnosed with AIDS. This procedure is often illegal and has been banned in California.¹⁰⁰ This practice is outlawed because incontestability clauses are now required in insurance policies in California. These incontestability clauses should preclude insurers from denying LTD benefits after the policy has been in effect for two years.¹⁰¹

Generally, incontestability clauses in insurance policies are preferential and construed in favor of the insured. However, as long as an insurer is not acting in bad faith (measured under a standard of reasonableness) as to deny an insured's claim of benefits, they may still be allowed to discontinue or deny benefits. There were few California cases that allowed insurers to discontinue or deny benefits even after the two-year period, but since incontestability clauses are becoming settled case law as well as statutory law, this is no longer likely to be allowed.¹⁰² These issues usually arise in cases involving insureds diagnosed with AIDS, when an insurance company tries to deny insureds' LTD benefits by stating that a positive HIV test result is the pre-manifestation of AIDS. Denial of benefits on this basis is usually deemed an action made in bad faith if the insured has had the policy for at least two years, excluding any time that the employee was disabled.¹⁰³

4. Looking Toward the Future

LTD benefits are often the last means of support for someone diagnosed with AIDS, and thus the importance of having an attorney involved if the benefits could be lost is tremendous. Often the problems that arise are administrative and procedural which can be easily handled if a lawyer is involved with the insurance company and the client at an early stage. The difficult cases deal with discrimination, which can sometimes be resolved by looking at the incontestability period, but sometimes involve an area of the law that is still quite unclear. Some of these issues are covered in Chapters 4 and 5 of this manual, yet others are still emerging law in the area of insurance benefit discrimination.

In a case involving an employee's challenge to a health insurance policy sponsored by an employer, the First Circuit held that Title III of the ADA governs some employee-employer provision of services issues.¹⁰⁴ However, although this court held that the employer who provides insurance could be held liable under Title III of the ADA, the Seventh Circuit held that insurance benefit caps for AIDS or AIDS-related conditions do not violate Title III.¹⁰⁵ Title III is described in depth in Chapter 5 of this manual and the brief synopsis of the cases involving insurance and ADA, offered above, is mainly to illustrate an area of law that may become important to AIDS patients in the context of LTD benefits. At the time this manual went to print, the Ninth Circuit has not ruled on these issues and the way in which Title III of the ADA may affect LTD's is still unclear.

¹⁰⁰ Cal. Ins. Code § 10350.2

¹⁰¹ *Galanty v. Paul Revere Life Ins. Co.*, 23 Cal. 4th 368 (2000).

¹⁰² *Morris v. Paul Revere Life Ins. Co.*, 135 Cal. Rptr. 2d 718 (Cal. App. 4th Dist. 2003).

¹⁰³ CA Ins. Code § 10350.2

¹⁰⁴ *Carparts Distrib. Ctr. v. Automotive Wholesaler's Ass'n*, 37 F.3d 12 (1st Cir. 1994).

¹⁰⁵ *Doe v. Mutual of Omaha Insurance*, 179 F.3d 557 (7th Cir. 1999).