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Coverage Disputes: A Search for Accountability and Sensibility

***445 TO PAY OR NOT TO PAY, THAT IS THE QUESTION: COVERAGE DISPUTES BETWEEN HEALTH PLANS AND MEMBERS**

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I. Introduction

It's not easy being a health plan [\[FN2\]](#) these days. Health plans are commonly blamed for virtually all of the ills in the health care system, including increasing costs, rising premiums, the growing uninsured population, and restrictions on access to life-saving drugs and procedures. During the political season, candidates ***446** portray health plans as greedy, unethical, self-serving entities that collect large premiums and then deny coverage for those in need. Not surprisingly, political cartoonists skewer health plans as the primary villains in the health care system, scheming to make sure that sick people do not get the health care they need and deserve. [\[FN3\]](#)

While health plans deserve criticism when they mishandle claims or make mistakes, the vast majority of claims are paid promptly and with no hassle for the members. [\[FN4\]](#) But when coverage disputes do arise, they can be extremely frustrating and stressful for the members involved. In such cases members are dealing not only with financial issues, but also with the health of themselves or others in their family. Given the nature of these issues and the high stakes involved, health plans should make every effort to resolve coverage disputes as promptly as possible and to reduce the hassle, frustration and stress for their members. Accordingly, this essay identifies the health plan's responsibilities in making coverage decisions and resolving disputes, as well the members' responsibilities when coverage issues arise.

II. Coverage Restrictions

As noted above, health plans frequently are vilified for failing to cover needed care in order to make bigger profits. [\[FN5\]](#) At ***447** the same time, health plans also are blamed for ever-rising costs and unaffordable premiums. [\[FN6\]](#) But if health plans paid for everything that members wanted or believed they needed without restriction, premiums would escalate even faster than they do today. In fact, rapidly increasing utilization--including inappropriate and excessive utilization--along with expensive new technologies and drugs, are major contributors to rising health care costs and health care premiums. [\[FN7\]](#) Another factor that drives cost increases is our "fee-for-service" payment system that rewards the volume of services and tests performed, rather than the qual-

ity of care provided.

In view of relentless increases in health costs and insurance premiums, those who pay the majority of the health care bill - employers - expect health plans to adopt reasonable measures to try to keep health care costs and premiums under control. Employers expect, rightly, that health plans will do this by enforcing the terms of policies that the employers purchase for their employees. Although members still have wide latitude to go to virtually any doctor they choose to see, and to get the tests, procedures and medications they need or want, there still are ***448** certain limits, restrictions and exclusions in the members' coverage documents. [FN8]

It is these limits, restrictions and exclusions in the members' coverage documents that often form the basis of the dispute between the health plan and the member. While coverage disputes cover a wide variety of issues, examples of some common types of disputes include the following:

A. Requests for coverage for procedures that the health plan considers “experimental.”

Health plan coverage documents typically have exclusions for “experimental” procedures and treatments. [FN9] In determining whether a particular procedure or treatment is experimental, a health plan typically has an internal committee, which includes physicians and other medically-trained individuals, that evaluates all of the relevant clinical and scientific evidence available to determine whether the procedures are still experimental, or if it has been proven to be safe and effective. The plan also may rely on input and advice from external, independent medical experts. Given the countless new technologies, devices and procedures that enter the market each year, this is an area that is ripe for ongoing coverage disputes between health plans and members.

***449** B. Requests for coverage for procedures that the health plan considers “cosmetic,” as opposed to “medically necessary.”

Coverage documents also have exclusions for procedures that are “cosmetic.” Minnesota law defines “cosmetic services” as “surgery and other services performed primarily to enhance or otherwise alter an enrollee's physical appearance without correcting or improving a physiological function.” [FN10] In determining whether a particular proposed procedure is “cosmetic,” a medial reviewer will review the member's medical records and the basis for the surgical request and, as appropriate, consult with the treating physician to discuss the member's condition.

C. Requests by members to go to “non-network” providers, but get covered at the “in-network” benefit level.

Typically, health plan coverage documents provide better benefits for members who are treated by “in-network,” as opposed to “non-network,” providers. This is because the health plan negotiates discounts with providers in its network, but does not have discounted rates with non-network providers. However, under certain circumstances, members may request to get in-network coverage for treatment by non-network providers. [FN11]

In considering whether to approve non-network services at the in-network coverage level, the health plan considers whether ***450** there is appropriate care available within the network for the member's medical needs. Although the member may prefer to see a particular specialist outside the network, the health plan will only approve in-network coverage for the non-network provider if it is determined that the member has some particular

condition that cannot be treated appropriately within the network. [FN12] Medical professionals employed by the health plan make these determinations based on the member's medical records and treatment needs.

In addition to these three areas of coverage disputes, other examples of potential disputes involve such things as “pre-existing conditions,” requests for non-formulary medications, and “prior authorization” requirements. Further, as members have taken on greater financial liability in recent years through high deductible plans, there is the potential for an increasing number of disputes involving co-payments, co-insurance, and maximum out-of-pocket costs. Given the increasing complexity of plan designs, and the importance of these issues to members seeking health care coverage for themselves or their family members, health plans face a growing challenge in administering their plans while addressing and resolving member concerns.

III. Health Plan Coverage Decisions

Contrary to popular myth, it is not health plan “bean-counters” who are making coverage decisions. Rather, when the coverage concern involves an issue such as in-network care or an “experimental” procedure, medical professionals employed by the health plan, such as physicians and specially-trained nurses, typically review the medical records and, if necessary, consult with outside experts. The health plan also consults, as appropriate, with *451 the member's physician. The health plan then makes its determination based on the member's medical condition and treatment needs. If the member is dissatisfied with the plan's coverage decision, the member has the right to appeal, which usually include both internal and external appeals. [FN13] Members also have legal remedies available if their appeals are unsuccessful.

State and federal regulations dictate basic requirements for responding to member complaints and appeals. These regulations typically prescribe such issues as how promptly health plans must respond to member complaints and appeals, and the type of information that plans must provide to members in responding to complaints and appeals.

In addition to complying with regulatory requirements for responding to member complaints and appeals, health plans should adopt practices that will help avoid coverage disputes in the first place, or resolve them promptly and fairly once they do arise. Based on my experience in both a regulatory role and as a health plan attorney, [FN14] I believe that the guidelines below can be helpful in avoiding coverage disputes with members, and in resolving disputes when they do arise. [FN15]

A. Provide clear information.

As noted above, the starting point for addressing a coverage issue or dispute is the member's coverage document. This document describes the member's benefits, along with any *452 exclusions, restrictions, etc. Undoubtedly, some coverage disputes are caused by the language and terminology in the coverage document. It can be intimidating for an individual dealing with his or her own medical condition, or that of a spouse, child or other family member, to understand such terms as “co-pay,” “co-insurance” “deductible,” “out-of pocket maximum,” “lifetime maximum,” “in-network,” “non-network,” “pre-existing condition,” “prior authorization,” “coordination of benefits,” “experimental,” “medically necessary,” “cosmetic,” and numerous other terms used in coverage documents and other health plan communications.

Given the potential for member confusion, health plans should attempt to write coverage documents, and

other communications that describe the member's benefits, in the clearest possible manner that ordinary people will understand. In doing so, health plans should strive to make their documents as free of acronyms, industry-speak, and bureaucratic language as possible so that even members with little knowledge of the health care system will understand such documents. [FN16] Similarly, health plans should explain their coverage decisions in plain language that allows the member to understand the reason for the decision and to challenge the decision in an appeal.

B. Be as responsive as possible to members.

It probably goes without saying, but health plans should strive to make it as simple and user-friendly as possible for members to contact the plan to ask questions, seek information, resolve billing and coverage disputes, etc. Plans also should try to resolve questions and problems the first time the member contacts the plan. Nothing is more frustrating for members than getting no response at all, or getting transferred to multiple individuals who are unable to resolve the member's issue or answer the member's *453 question. If the customer service representative cannot answer the question the first time the member calls, the plan should ensure that someone returns the member's call as promptly as possible after doing further research on the issue. Even if the answer is not what the member hopes to hear, it is important to be as responsive as possible. A responsive, understanding and empathetic customer service representative can help defuse and avoid disputes, even if the answer is, for example, that a particular procedure is not covered under the member's policy. On the other hand, failing to provide answers, return calls or resolve member concerns in a timely manner is likely to lead to escalation of any conflict, such as letters to regulators, legislators, or board members seeking assistance.

C. Resolve mistakes in member's favor.

On occasion, a health plan may contribute to a member's confusion or misunderstanding about the member's benefits, or may even provide information that is simply wrong. This may occur, for example, when the member calls the health plan to ask a question about the member's benefits. If the member then relies on incorrect information provided by the health plan representative, the plan generally should resolve the coverage dispute in the member's favor. A simple illustration of this involves a member who inquires as to whether a particular provider is in the health plan's network. If the plan representative mistakenly tells the member that the provider is in the network and the member relies on that information in being treated by a non-network provider, then the plan should cover the member's treatment by the non-network provider at the in-network coverage level. [FN17]

*454 D. Treat members in consistent manner.

Health plans should strive to ensure that similarly situated members are treated in an even-handed and consistent manner. If one member, for example, is granted coverage for a procedure on the ground that it is deemed to be "medically necessary," it would be unfair to other members with the same condition to deny coverage for the procedure on the ground that it is considered "cosmetic." Different coverage decisions for similarly situated members could potentially lead to lawsuits by members or actions by regulators, who may allege that the plan engaged in unfair claims practices and/or violated non-discrimination provisions of the Employee Retirement Income Security Act. [FN18] The employer could also contend that the plan's coverage decisions violated the plan's contract with the employer by allowing coverage for some members for procedures or treatments that should not be covered for any members under the group's coverage documents.

E. Account for member's individual circumstances.

While health plans should strive to treat similarly situated members in the same manner, plans also should take into account each member's individual circumstances, medical condition and treatment needs. Necessarily, there are variations from member to member with the same or similar medical conditions that may lead to different coverage decisions. Thus, the health plan must take each member's unique medical situation into account in deciding, for example, whether appropriate care is available for that member within the network. Even if two members have the same medical diagnosis, one may have a complicating factor that requires that member to be treated by a non-network specialist. These individual decisions must be based, to the extent possible, on objective factors in order to reduce the likelihood that the plan will be accused of treating similarly situated members in an *455 inconsistent manner. Treating members in a consistent manner, while at the same time accounting for individual differences among members, is one of the most challenging issues for health plans in resolving coverage issues and disputes.

IV. External Factors in Coverage Decisions

While the health plan makes individual coverage decisions based on each member's coverage document, the health plan may at times also be affected by “external” factors that influence coverage decisions. In other words, coverage decisions are not made in a total vacuum. Rather, they sometimes are made in a highly charged political environment and can be the subject of intense scrutiny. These factors include:

A. Regulatory interest.

Health plans are extensively regulated on the state level and are subjected to detailed laws and regulations that cover virtually every aspect of their business. In every state, regulators have significant authority to conduct investigations, review health plan records, conduct audits, issue cease and desist orders, and impose fines for violations of state insurance laws. Accordingly, health plans generally should strive to stay in good graces with their regulators and naturally are susceptible to influence from regulators regarding coverage decisions.

This is not to suggest that health plans should routinely “roll over” when a regulator calls on behalf of a particular member. The health plan must, however, factor the regulator's position into its decision-making process. If the health plan believes it has a solid basis for its coverage decision and can explain and justify its decision to the regulator, the plan may decide to stand by its decision even if the regulator disagrees with the plan's decision.

In deciding whether to defer to the regulator's position, the plan should consider a variety of factors, including: the importance of the issue to the regulator; the potential impact of the plan's *456 coverage decision on the ongoing relationship with the regulator; the likelihood that the regulator would prevail in any legal or regulatory action against the plan; and whether the issue involves an isolated situation or a large number of members, which would have a far broader impact on the plan and its employers and members who pay for coverage. For example, a regulator may want the health plan to cover a procedure that the health plan considers to be “experimental.” A reversal on such an issue could lead to significant costs for the plan--and its employers and members--for a procedure that the plan believes, based on the totality of the scientific evidence, has not been proven to be beneficial. These factors need to be considered in totality in deciding whether to revise a coverage decision when facing regulatory pressures.

B. Media interest.

Health plans generally operate in a “fish bowl” and their actions are subjected to scrutiny, criticism and second-guessing by the media and the public. A recent example involves the highly-publicized case noted above involving the seventeen year-old girl who died after her health plan denied her request for coverage for a liver transplant. Following significant media attention and even public rallies on the girl's behalf, the plan reversed its decision and granted the request to cover the liver transplant, but the girl died before the transplant took place. The health plan took a public beating for weeks following this episode, even though the plan had consulted with an independent oncologist and transplant surgeon who concluded that the proposed transplant was experimental, exceeded appropriate risk-taking standards and would not have saved the girl's life. [FN19] In these types of high-profile cases, health *457 plans should be confident that their decisions are based on the best available medical and scientific studies, and then do their best to explain the reasons behind their decisions to the best possible extent. [FN20] However, even if the plan is confident that it made the right decision, it still may be impossible to avoid public criticism for its decision.

V. Member Responsibilities

Thus far, I have discussed how health plans should address coverage disputes. At the same time, members also have certain responsibilities with regard to coverage issues and disputes:

A. Choose a plan carefully.

First, members need to be as thoughtful as possible when choosing coverage and need to consider the type of plan that best suits their needs. More and more employers are offering multiple insurance plans side-by-side in order to provide a greater range of choices to their employees. Some of these plans have lower premiums but more limited benefits or networks. Other plans have higher premiums with broader coverage and larger networks. If a member chooses a lower cost plan with limited benefits or a narrower network, the member needs to accept those limitations when health care needs arise. Unfortunately, some members choose lower cost plans, and then are dissatisfied with their coverage when they need care.

B. Read the coverage document before seeking care.

Admittedly, coverage documents, with all their specialized terminology, can be challenging to read and understand. Nevertheless, those coverage documents are extremely important *458 in that they describe the member's benefits, including any restrictions and limitations on coverage. Therefore, it is critical that members read such coverage documents when they need to seek medical care. [FN21] Once the member has obtained care, it may be too late to resolve the coverage issue if the member has, for example, gone to a non-network provider or failed to obtain prior authorization for a particular procedure that required it.

C. Contact the health plan with questions before obtaining care.

Just as members should read the coverage document before seeking care, they also should contact the plan with questions before obtaining care and incurring expenses. If the coverage document has restrictions that the member has not complied with, it is unlikely that the plan will make an exception for the member after the care

is received.

VI. The Coverage Dilemma

At the heart of the coverage disputes discussed above - experimental procedures, non-network providers, etc. - is the trade-off between coverage and cost. It is of course understandable that individuals and their families in life-threatening situations want to try any and all new treatments and devices to try to find a cure or save a life--regardless of cost--even if those treatments or devices are new to the market and are still experimental. In each individual case, the public's sympathy is usually with the family that is seeking the care at issue--not the health plan that has determined that a particular procedure is experimental. But the cumulative financial impact of paying for *459 care that is experimental, unproven and even potentially harmful is significant and contributes to rising costs for all members.

Given the scrutiny of health plan coverage decisions, it is not surprising that health plans have been required in some cases to cover procedures that ultimately turned out to be ineffective, or even harmful. One example from Minnesota provides an interesting case study. In the mid-1990's, Minnesota health plans faced a series of lawsuits and public criticism for failing to cover expensive bone marrow transplants for women with advanced breast cancer. At the time, the plans considered this procedure to be experimental and, based on the available medical literature, even potentially harmful to those who received it. Nevertheless, due to the intense public pressure to cover such procedures, the health plans reversed their policies and the Minnesota Legislature even passed a mandate in 1995 requiring this procedure to be covered. [FN22]

Nine years later, following publication of additional medical studies that concluded that the procedure was in fact ineffective and even potentially harmful, the legislature repealed the mandate and the procedure no longer is covered in Minnesota. [FN23] In an article in Discover magazine, a medical writer summed up the bone marrow transplant controversy as follows:

For more than a decade, physicians convinced breast cancer patients that bone marrow transplants were their best hope of salvation. But the insurance companies who resisted paying for the procedures were right all along: It was experimental medicine and most women were a lot better off without it. *460 How could so many oncologists ignore basic principles of science? [FN24]

While the bone marrow transplant issue involved life and death situations and therefore received a great deal of public attention, health plans face less publicized issues all the time. Each year, countless new treatments and devices are introduced into the market to address a wide range of health conditions. Some of these treatments and devices turn out to be highly effective and become widely accepted and utilized. Others are found to be ineffective and/or even potentially dangerous. As more and more new treatments and devices enter the market, health plans will face a growing challenge in ensuring that all members receive appropriate care, while at the same time enforcing coverage restrictions and controlling costs and rising premiums for their members. Due to the ongoing dilemma and trade-offs involving coverage and cost, there is no doubt that health plans and members will continue to face coverage disputes over these issues.

VII. Impact of Health Care Reform on Coverage Disputes

In this essay I have explained in general terms, how health plans tend to approach coverage disputes. The types of coverage disputes identified in the essay typically arise under the "fee-for-service" payment system,

which pays providers based on the number of tests and procedures performed on a member. In short, more tests and procedures lead to higher reimbursement payments to providers. By restricting coverage for certain types of procedures, health plans are attempting to ensure that the care provided is appropriate, while at the same time controlling escalating costs.

***461** It is quite possible, however, that over the next several years there will be a gradual shift away from fee-for-service toward very different payment models. In Minnesota, for example, a health care task force appointed in 2007 by the Governor, Tim Pawlenty, is considering the development of a payment model that would hold providers accountable for the “total cost of care” for their patients - meaning that providers would be paid a specified amount to care for patients, based on the nature of their medical conditions. Under this payment system, providers no longer would be paid on a fee-for-service basis. The task force also is considering establishment of some type of independent agency that would evaluate the effectiveness of new technologies, services and medications while determining whether these should be covered by health plans.

These and other proposals will be under discussion during the 2008 Minnesota legislative session. Undoubtedly, reform proposals also will be considered in other states around the country and even at the federal level as health care costs continue to rise, along with the number of uninsured Americans. While it is too early to tell whether these reform proposals will be enacted, let alone have the desired impact, it is likely that significant health care reform is on the horizon over the next several years. Indeed, certain reforms, such as the way providers are paid, are starting to occur in the private market even without government action.

If significant reform occurs through government action, private market forces, or a combination of both, the nature of coverage disputes also will change. For example, if providers become accountable for the “total cost of care” for their patients, then there may be fewer disputes between health plans and members about whether certain procedures are covered. Under this type of payment scheme, the providers would be financially accountable for the care their members receive, so there may be increasing disputes between providers and members regarding the care provided. Or if an independent agency is created to determine whether new technologies, services and medications should be covered by health plans, then the nature of disputes about these ***462** issues likely would change. Under such a scenario, the health plan may have a far more limited role in determining which new treatments to cover.

VIII. Conclusion

For now, under our current fee-for service system, coverage disputes will continue to occur between health plans and their members. As outlined above, there are certain responsibilities on both sides in avoiding and resolving coverage disputes between health plans and members. As pressures continue to mount on health plans to control costs and keep premiums affordable, the number of disputes is likely to grow, at least until significant reform takes hold that changes the nature of provider payments, and coverage disputes, altogether.

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and his former role as a regulator. The views expressed in this essay are those of the author and are not submitted on behalf of Medica.

[FN2]. I use the term “health plan” in this essay to refer both to health maintenance organizations (HMOs) and health insurance companies. HMOs and health insurance companies are regulated primarily at the state level, so each state has its own laws that govern such entities. In Minnesota, for example, HMOs are required to operate as nonprofit corporations. [Minn. Stat. § 62D.02\(4\)](#) (2006). However, there is no similar requirement for health insurance companies operating in Minnesota. See [Minn. Stat. § 62A](#) (2006). Nevertheless, the differences between the way HMOs and insurance companies operate in Minnesota are relatively minor: both provide health insurance to employers and individuals through a wide network of providers and typically impose few restrictions on access to specialists. In contrast, in the 1970's, 1980's and early 1990's, Minnesota HMOs often employed a “gatekeeper” model that limited access to specialists and imposed other restrictions on members in an attempt to keep costs low. Also, HMOs often paid providers on a capitated, rather than fee-for service, basis. Due to member dissatisfaction and frustration with HMOs, they have evolved in Minnesota over the past decade to operate far more like traditional indemnity insurance companies that pay on a fee-for service basis and have open provider networks and few restrictions on members.

[FN3]. Typing the term “health care political cartoons” into a search engine, such as Google, instantly produces links to websites with hundreds of cartoons, many of which poke fun at health plans.

[FN4]. For example, in 2007, Medica processed approximately 11 million medical claims, and eighty-five percent of those claims were paid in less than ten days. Mary Quist, Claims Statistics, Mar. 14, 2008 (Internal Medica memo on file with author).

[FN5]. As noted in footnote 2 above, Minnesota law requires that HMOs be organized as nonprofit companies. Insurance companies, on the other hand, are permitted to be for-profit entities and several national for-profit insurers have small segments of the Minnesota insurance market. However, the nonprofit environment makes it difficult for for-profit insurance companies to compete in Minnesota since the Minnesota HMOs and their related insurance companies typically have smaller operating margins than for-profit insurers. In recent years, Minnesota's nonprofit HMOs and their related insurance companies actually have sustained significant operating losses. According to public filings, Minnesota's three largest HMOs and their related insurance companies had operating losses in 2006 of more than \$60 million. Mary Quist, 2006 Competitor Analysis, Jan. 22, 2008 (Internal Medica memo on file with author).

[FN6]. The reasons for ever-increasing costs include such factors as: the aging population, an increase in obesity and diabetes, new drugs and technologies, the “medical arms race”, increasing (and often excessive and inappropriate) utilization, and higher reimbursement rates to providers. For a detailed analysis of the factors driving increasing health care costs, see PricewaterhouseCoopers, *The Factors Fueling Rising Healthcare Costs 2006* (Jan. 2006), www.ahip.org/redirect/PwCCostOfHC2006.pdf.

[FN7]. A highly publicized book released in 2007 makes the case that overutilization is a major driver of health care cost increases. See Shannon Brownlee, *Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer* (Bloomsbury Publishing Plc. 2007).

[FN8]. The term “coverage documents” as used in this essay refers to the documents provided to members that describe the benefits they receive under their health insurance policies. These coverage documents may have different names--such as Certificate of Coverage, Evidence of Coverage, Policy of Coverage--depending on the

health plan that issues them and the type of policy the member has.

[FN9]. In Minnesota, this term is defined in administrative rules issued by the Minnesota Department of Health. [Minn. R. 4685.0100\(6\)\(a\) \(2006\)](#).

[FN10]. [Minn. R. 4685.0100\(5\)\(a\) \(2006\)](#).

[FN11]. If the health plan grants approval, the plan typically must pay full “billed charges” to the non-network provider in order for the member to receive coverage as though the provider were in-network. This amount usually is substantially more than the contracted rate for the same services performed by an in-network provider. Therefore, approving in-network coverage for members who are treated by non-network providers contributes to higher health care costs.

[FN12]. If the member has a non-network benefit, the member still may choose to be treated by the non-network provider at the non-network coverage level-- meaning that the member has greater financial liability than he or she would have if the plan covered the non-network provider at the in-network benefit level.

[FN13]. Appeal rights are governed both by state and federal law. This essay does not address the appeal process.

[FN14]. As noted in footnote 1, before joining Medica, I served for thirteen years as an Assistant Attorney General in the Minnesota Attorney General's Office. One of my assignments in that office involved representing the Minnesota Department of Commerce on insurance regulation matters.

[FN15]. This essay discusses health plan coverage issues in the context of fully-insured members. Health plans may also serve as third-party administrators for self-funded employers. Coverage disputes involving members who are covered under self-funded plans may involve a different set of considerations, since the employer itself directly funds the health care of its employers.

[FN16]. One challenge for health plans is that regulatory requirements sometimes require health plans to use specific terminology in coverage documents, appeal letters and other communications.

[FN17]. In this example, the health plan should have the opportunity to correct the mistake by transitioning the member to an in-network provider as quickly as possible after the initial treatment by the non-network provider.

[FN18]. [29 U.S.C. §1104\(a\)\(1\)\(D\) \(2006\)](#).

[FN19]. See Scott Gottlieb, *Edwards and Organ Transplants*, *Wall St. J.*, Jan. 11, 2008, at A11. In this case, the health plan administered coverage for the self-funded employer. *Id.* Therefore, the health plan did not stand to save any money or gain financially by its coverage decision--as implied by the plan's critics. *Id.*

[FN20]. Depending on the issue, privacy laws may limit the type of response the plan is permitted to make.

[FN21]. In an emergency, the member likely will not have time to read the coverage document and would not be expected to do so. Health plans generally have broad coverage for emergencies, even when the member is out of town and goes to a non-network provider.

[FN22]. Patricia Lopez Baden, *Bill on Marrow Transplants for Breast Cancer Clears House*, *Star Tribune*, May

4, 1995, at 1A.

[FN23]. Rachel E. Stassen-Berger, If You Are A...How This Legislative Session Affected the Average Person (Or Mourning Dove), St. Paul Pioneer Press, May 23, 2004, at C1.

[FN24]. Shannon Brownlee, Bad Science and Breast Cancer, Discover, Aug. 1, 2002, available at <http://discovermagazine.com/2002/aug/featbad>.

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