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Work Incentive Support Center

Policy and Practice Brief:

Expanding Health Insurance Options

**A Framework for Advising Social Security Beneficiaries of
Their Rights Under Private Insurance Contracts**

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This is one of a series of articles written for benefits specialists employed by Benefits Planning, Assistance and Outreach (BPA&O) projects and attorneys and advocates employed by Protection and Advocacy for Beneficiaries of Social Security (PABSS) programs. Materials contained within this policy brief have been reviewed for accuracy by the Social Security Administration (SSA), Office of Employment Support Programs. However, the thoughts and opinions expressed in these materials are those of the author and do not necessarily reflect the viewpoints or official policy positions of the SSA. The information, materials and technical assistance are intended solely as information guidance and are neither a determination of legal rights or responsibilities, nor binding on any agency with implementation and/or administrative responsibilities.

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Introduction

The need for adequate health care coverage has been cited by many as one of the major issues facing individuals with disabilities who are contemplating entry into the world of work. Faced with the regular need to obtain a range of high cost medically-related items and services, work is often not possible unless some third party payment source is available to pick up the majority of those health-related costs.

Social Security Disability Insurance (SSDI) and Supplementary Security Income (SSI) beneficiaries have come to rely upon Medicare and/or Medicaid as their primary health insurance plan or plans. Many beneficiaries look to special work incentives to continue Medicare or Medicaid eligibility to meet many of the health-related costs that continue when they go to work. These special work incentives include extended Medicare benefits,¹ section 1619(b) Medicaid benefits,² and the optional Medicaid buy-in program.³ A major role of benefits specialists, employed within Benefits Planning, Assistance and Outreach (BPA&O) projects, is to educate beneficiaries concerning their eligibility for extended Medicare, section 1619(b), and the Medicaid buy-in program.

Despite the tremendous work incentives, offered through extended Medicare, section 1619(b) Medicaid, and the Medicaid buy-in, beneficiaries often need to look to employer-funded private insurance contracts to meet all or part of their health insurance needs. This is true for a number of reasons:

- Medicare does not offer a prescription drug plan and has either no coverage or very limited coverage for many community-based services.
- A state's Medicaid program may not cover many of the optional services needed by some beneficiaries to enable them to continue working. For example, a prescription drug is an optional Medicaid service and is not required to be provided in every state.
- A former SSI beneficiary may not be eligible for 1619(b) Medicaid because they fail to meet one of the criteria for eligibility. For example, in states in which Medicaid is not automatic for SSI beneficiaries,⁴ an individual will not be eligible for 1619(b) if he or she was not eligible for Medicaid in the month prior to their loss of SSI due to wages.⁵
- A current 1619(b) recipient will face a loss of eligibility if he or she plans to save any money beyond SSI's \$2,000 limit for non-exempt resources.⁶
- A current 1619(b) recipient will face a loss of eligibility if he or she plans to marry an individual with significant income, earned or unearned, as income deemed from a spouse can make a person ineligible for 1619(b) Medicaid.
- The optional Medicaid buy-in may not be available in the individual's state or, if it is, he or she may not meet the eligibility criteria.

¹ See section 202 of the Ticket to Work and Work Incentives Improvement Act of 1999, 42 U.S.C. § 426(b), increasing the duration of continued Medicare eligibility for an SSDI recipient who goes to work from 39 to at least 93 months following the SSDI nine-month trial work period. *See also* Program Operations Manual Systems (POMS) HI 00820.025.

² Section 1619(b) offers continued Medicaid eligibility to certain former SSI beneficiaries who lose SSI because of wages from work activity. *See* 42 U.S.C. § 1383h; 20 C.F.R. § 416.268-.269; POMS SI 02302.030 et seq.

³ Ticket to Work and Work Incentives Improvement Act of 1999, § 202. These provisions are primarily codified as amendments to 42 U.S.C. §§ 1396a(a)(10)(A)(ii) and 1396o.

⁴ These states are known as section 209(b) states, 42 U.S.C. § 1396a(a)(10)(A)(i), and include the following 11 states: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. POMS SI 01715.020.

⁵ *See* 42 U.S.C. § 1382h(b)(3); POMS SI 02302.010 C.

⁶ A individual is allowed \$2,000 or an eligible couple is allowed \$3,000 in non-exempt resources under the SSI program. 20 C.F.R. § 416.1205.

This article will provide a basic primer on private insurance contracts, with an emphasis on issues facing individuals with disabilities.⁷ We will explain what private insurance is, the types of policies that are offered, and who is typically covered by the policy. We will also explain some of the special protections offered through the federal Health Insurance Portability Act of 1996, including protections against most preexisting conditions clauses, and the right to continued coverage under the federal Consolidated Omnibus Reconciliation Act (COBRA) provisions. We will then address what items are covered in the policy, when they can be approved for an individual, and what appeals may be available to challenge a denial of coverage. Finally, we will discuss the impact that the federal Employee Retirement Income Security Act (ERISA) has on the enforcement of certain health insurance plans.

Despite a variety of federal legislation enacted in recent years, private insurance contracts are often governed by state law. Except for those areas in which the federal law governs, any legal questions concerning the interpretation or enforcement of insurance contracts will be governed by state law, regulation, policy, and case law. For this reason, many of the principles summarized in this article must be viewed as general guidelines subject to state-by-state law, regulation, policy, and caselaw.

Some Basic Concepts

I. A Private Insurance Policy Is a Contract

An insurance policy is a legally-binding contract. It is important to distinguish between the actual policy or contract and any other document which describes its provisions. In the author's experience, many individuals possess a document which they refer to as their contract which is actually something else. Often the document is called by a name such as "Employee's Health Benefit Handbook." Most likely this document is not the insurance contract, but is a summary written in plain English for the employee's or beneficiary's convenience.

The health insurance contract is likely to be a much larger document and is likely to be written in more technical language. Typically, it will contain language on the title page describing it as the health insurance contract or policy. It is the contract and not some other summary of its provisions that will be the basis for determining whether the individual and his or her family members receive specific benefits through the health insurance policy. If an individual or the individual's attorney or advocate wants to determine the scope of the benefits under the insurance policy, it is important to obtain the actual contract. It is also important to obtain copies of any amendments, riders and supplemental policies for which the individual or employer is paying. The provisions covering some of the more expensive items will often appear in a major medical rider or supplement to the policy.

Readers should note that under the federal Employee Retirement Income Security Act (ERISA), which will cover most employer-funded health plans, the employer is required to provide the beneficiary with a "Summary Plan Description" (SPD) written in plain

⁷The author has, with permission, used materials previously published in the *AT Advocate* newsletter, a publication of the National Assistive Technology Advocacy Project, and a training outline prepared by attorney, Steve Elliot of the Minnesota Disability Law Center as a basis for some parts of this publication.

English.⁸ If this SPD is provided to employees pursuant to the mandates of ERISA or any similar state law, the employees will have a much stronger argument that the language of the SPD should be considered in interpreting ambiguous provisions in the insurance contract, as the purpose of the disclosure is to allow individuals to understand the coverage they are getting.

II. Individual Health Insurance Versus Group Health Insurance

Sometimes, the insurance contract is for individual coverage, i.e., it is between the individual and the insurance company. More often, the contract is for group coverage. Typically, a group policy is taken out by an employer for the benefit of employees and their families. Since the focus of this article is on persons with disabilities who go to work, this article will stress the issues related to group health plans provided by the employer.

Some large organizations, such as a local Chamber of Commerce, will contract with an insurance company to obtain group coverage for its members who wish to enroll. Self-employed individuals and small businesses will often take advantage of this type of group health plan. The advantage of group coverage over individual coverage is that the group's buying power usually allows it to obtain better coverage for a lower annual premium.

III. Types of Health Insurance Plans

When a job offers an employer-funded health insurance plan, it will likely fall into one of three categories: an indemnity or fee-for-service plan, a managed care plan, or a plan with a preferred provider organization. Some employers may offer two or more plans for an employee to choose from, sometimes allowing them to pick from among several competing plans in different categories.

The term “managed care” will often be used to describe all health plans other than the traditional fee-for-service plan, including the preferred provider organization plans described below. The term “health maintenance organization” (HMO) will also be used broadly to describe the entity which oversees any of the managed care or non-traditional plans. Sometimes the term “managed care organization” will be used interchangeably with the term HMO.

Choosing a health insurance plan is a challenge for anyone, but particularly for individuals who have disabilities or preexisting medical conditions. Individuals with disabilities should select a group health plan based on individual circumstances, after reviewing what each plan has to offer. Some key questions to be considered in choosing among competing plans include:

- Must the individual contribute to the monthly or quarterly premium and, if so, how much?
- Will the plan cover key, high-cost services that will be needed by the individual, such as medication, mental health services, inpatient or emergency room care, and durable medical equipment?

⁸ 29 U.S.C. § 1021(a). ERISA is discussed more fully later in this article.

- Will one of the plans offer lower co-payments or deductible for the key services identified?
- If established relationships with key medical providers is important, will the plan allow the individual to use his or her own doctors and therapists, or is he or she required to use providers either provided or approved by the plan?
- Does the company, which operates the plan have a good or bad reputation among coworkers or in the community?

A. Indemnity or Fee-For-Service Plan

In this system, the health care is provided, and then the provider submits a bill to the insurance company. The health care provider receives most of their reimbursement after providing the health care. This is the opposite of what we usually mean by “managed care,” and is the way most health care was traditionally provided. Controls are usually put on a fee-for-service system by requiring “prior authorization” of expensive or long-term services. This type of plan is usually provided by an insurance company, that takes the financial risk and responsibility for paying claims in exchange for the payment of premiums by the individual or group.

The advantage of this type of plan is that it offers the beneficiary the ability to go to any provider for treatment. The disadvantage is that payment rates may be lower than the cost of the care or co-payment requirements may make treatment more expensive. Some beneficiaries report that this type of plan is preferred over an HMO-type plan if an individual is likely to seek specialty treatment with physicians not enrolled with the HMO or if treatment will be sought outside the HMO's geographic area.

B. Managed Care Plans

These plans typically provide health care through a defined network of primary care physicians and hospitals. The plan is run by an HMO, sometimes called the managed care organization. In this system, decisions about paying for care are generally made at the front end, before the services are received. These decisions are made by the payer (health plan or employer), who bears the financial risk. The health plan or employer reimburses the health care providers in advance for services that are expected to be delivered. Generally, managed care systems control health care costs by discouraging unnecessary hospitalization and overuse of specialists. The managed care system may also seek to control costs by offering a range of preventative services to avoid the need for more expensive treatment later on.

C. Preferred Provider Organization (PPO)

The Preferred Provider Organization is a health plan that negotiates discounted fees with hospitals, doctors and other health care providers, then encourages enrolled members to use the preferred network by offering lower co-payments and other incentives. Enrolled members may choose to go to out-of-network providers at a higher cost. Many would describe the PPO plan as a form of managed care and would also describe the oversight entity as an HMO.

IV. Analysis of Insurance Policy Coverage: A Three-Part Test

To determine whether an individual is eligible for private insurance coverage for any particular item or service, we must address three issues:

1. Is the child or adult in question covered by the insurance policy?
2. Is the item being sought one that is covered by the policy?
3. Is the item being sought medically necessary?

The remainder of this article will address these issues. We will then turn to what an individual can do when insurance coverage is denied for any reason.

Who is Covered by the Policy?

This analysis is usually very easy. An individual policy covers one person, a family policy also covers the spouse and other dependents, typically the children. In many cases, however, we must look further to determine whether the particular individual, the medical condition, or the benefit sought is covered by the contract. Most of these issues will be resolved by reference to the contract language. Other issues will be resolved by reference to various state and federal laws.

At what age does the coverage of a child end? This will vary from policy to policy and could be governed by your state's insurance laws. Typical provisions for family coverage provide that a child is covered until age 18 or 19, or through age 22 or even age 25 if the child is a full-time college student. Often, coverage is extended indefinitely if the adult child has a disability. Disability is often defined in terms similar to the definition of disability in the SSI or SSDI programs. Some private insurance plans may impose an income test for adult children with disabilities, not covering the adult child whose income is above a certain threshold. Because few people thoroughly review their health insurance policies, many are unaware that potential insurance policy coverage may exist for an adult child with a disability who is well into his or her 20s or 30s.

Preexisting Condition Clauses and the Health Insurance Portability Act of 1996

I. Use of Preexisting Conditions Clauses

Many policies contain provisions which, as a practical matter, result in certain individuals being uninsured for all purposes or with respect to certain conditions or items covered by the policy. Unless otherwise limited by law, these provisions are legal and will serve to limit who and what is covered. You must read the policy carefully to determine whether these limitations exist. Since persons who need expensive services, such as prescription drugs, mental health treatment, physical therapy, or durable medical equipment often have long-standing disabilities; a preexisting conditions clause can present a major barrier to obtaining those services.

One provision, found in many policies, creates a 10 or 12 month waiting period for coverage of conditions which existed prior to the first month of coverage. The purpose of such a provision may be to eliminate coverage for a preexisting pregnancy. Other provisions may totally exclude coverage for any preexisting condition. Here, the purpose is to avoid high-cost beneficiaries in general.

A preexisting condition clause will create a major barrier to employment for many SSI and SSDI beneficiaries. These individuals, who have continuing and severe disabilities, will often face high-cost medical expenses. If they are uncertain of their ability to have an existing condition covered by a private insurance policy, they may choose not to take a job that offers that policy. Any significant preexisting condition exclusion, even if limited in time, could cost the person hundreds or thousands of dollars. Although some of these provisions are still legal, as explained below their use in group health insurance plans has been limited by the federal Health Insurance Portability and Accountability Act (HIPAA).

II. HIPAA: Governing Law and Regulations

The Health Insurance Portability and Accountability Act of 1996 applies to plan years beginning after June 30, 1997. The law appears in two places with nearly identical language.⁹ Implementing interim regulations appear in three places with nearly identical language.¹⁰ Unless otherwise noted, all references are to the Labor Law or the Department of Labor regulations. HIPAA applies to group health plans and health insurance issuers offering group plans.¹¹ Its major impact is the elimination of most preexisting condition exclusions in group health insurance plans.

III. Preexisting Condition Exclusions, Waiting Periods, Affiliation Periods

A. The Basic Rules

It is important to distinguish a period of exclusion due to a preexisting condition and a waiting period or affiliation period. A preexisting condition exclusion “means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage....”¹² A waiting period is “the period that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan.”¹³ If a waiting period applies equally to all potential beneficiaries, it is permitted under HIPAA. An affiliation period is “a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.”¹⁴ An affiliation period is legal under HIPAA as an alternative to a preexisting condition exclusion.¹⁵

B. How the Rules Would Apply to an SSI or SSDI Beneficiary Who Goes To Work and is Covered by a Group Health Plan

The distinction between a waiting period and preexisting condition exclusion is best illustrated by two examples. The first involves a waiting period which is permitted under HIPAA.

⁹ See 29 U.S.C. §§ 1181 *et seq.* (Labor Law provisions); 26 U.S.C. §§ 9801 *et seq.* (Internal Revenue Code provisions).

¹⁰ See 26 C.F.R. §§ 54.9801-1T *et seq.* (IRS regulations); 29 C.F.R. §§ 2590.701-1 *et seq.* (Dept. of Labor regulations); 45 C.F.R. §§ 144.01 *et seq.* (Health Care Financing Administration regulations).

¹¹ 29 C.F.R. § 2590.701-1.

¹² *Id.* § 2590.701-2.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.* § 2590.701-7.

Example 1. Janice is an SSDI beneficiary who goes to work despite severe multiple sclerosis. She goes to work in a job, which is covered by an employer-funded group health insurance plan that would cover her \$1,200 per month in medication expenses with \$40 in monthly co-payments. Under the terms of the plan, however, Janice must be employed for nine months before she can enroll in the plan. The same waiting period applies to all new employees.

Since the nine-month period would apply to all new employees, it is a waiting period, which is permitted by HIPAA. Janice must look to options other than the health insurance plan to cover medication expenses during the first nine months of her employment. (For example, if her state offers the optional Medicaid buy-in program with little or no monthly premium to be paid, that program may be able to cover her prescription drug costs.)

The second example involves a preexisting condition exclusion and will be subject to the limitations imposed by HIPAA.

Example 2. Same facts as example 1, except that the employer's health plan takes effect on Janice's first day of employment. Under the terms of the plan, Janice must be employed for nine months before it covers treatment for any condition that existed before she started employment. This rule would apply to any new employees.

This would meet HIPAA's definition of a preexisting condition and be subject to the rules discussed below.

IV. HIPAA's "Six-Month Look-Back Rule"

A. The Basic Rule, With Examples From HIPAA Regulations

"A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending with the enrollment date."¹⁶ If there is no advice, diagnosis, care or treatment recommended or received within the 6-month look-back period, the preexisting exclusion will not be legal. The applicability of this rule is best understood by looking at the four examples contained in the DOL regulations,¹⁷ three of which are reproduced here verbatim:

"Example 1. (i) Individual A is treated for a medical condition 7 months before the enrollment date in Employer R's group health plan. As part of such treatment, A's physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, A does not receive a follow-up examination and no other medical advice, diagnosis, care, or treatment for that condition is recommended to A or received by A during the 6-month period ending on A's enrollment date in Employer R's plan.

¹⁶ *Id.* B 2590.701-3(a)(1)(i).

¹⁷ The examples appear following B 2590.701-3(a)(1)(i)(c).

(ii) In this Example 1, Employer R's plan may not impose a preexisting condition exclusion period with respect to the condition for which A received treatment 7 months prior to the enrollment date.

Example 2. (i) Same facts as Example 1, except that Employer R's plan learns of the condition and attaches a rider to A's policy excluding coverage for the condition. Three months after enrollment, A's condition recurs, and Employer R's plan denies payment under the rider.

(ii) In this Example 2, the rider is a preexisting condition exclusion and Employer R's plan may not impose a preexisting condition exclusion with respect to the condition for which A received treatment 7 months prior to the enrollment date.

Example 3. (i) Individual B has asthma and is treated for that condition several times during the 6-month period before B's enrollment date in Employer S's plan. The plan imposes a 12-month preexisting condition exclusion. B has no prior creditable coverage to reduce the exclusion period. Three months after the enrollment date, B begins coverage under Employer S's plan. Two months later, B is hospitalized for asthma.

(ii) In this Example 3, Employer S's plan may exclude payment for the hospital stay and the physician services associated with this illness because the care is related to a medical condition for which treatment was received by B during the 6-month period before the enrollment date."

B. How the Rules Would Apply to an SSI or SSDI Beneficiary Who Goes to Work and Is Covered by a Group Health Plan

Let us go back to Janice's example to consider the application of these rules to the beneficiary who goes to work.

Example 1. In the six months before she starts work, Janice sees her neurologist twice and takes daily medication to treat her multiple sclerosis condition. She is immediately covered by the health insurance plan when she starts work, but the plan has a nine-month preexisting conditions exclusion and will not cover treatment related to her multiple sclerosis condition during her first nine months of work.

Since Janice received care and treatment for this condition during the six months preceding her enrollment in the plan, HIPAA would allow this provision subject to the rules discussed below.

Now, let us add a few facts to give us a different result when Janice seeks treatment for a new condition.

Example 2. Shortly after she starts working, Janice seeks treatment for depression. She visits a psychiatrist and begins taking anti-depressant medication. Janice received treatment for depression more than ten years earlier

when she was first diagnosed with multiple sclerosis, but did not receive nor have treatment recommended during the six months before she started work and enrolled in the group health plan. She is told that the preexisting conditions clause means she will not be eligible for mental health treatment until she has been employed for nine months.

Under the HIPAA regulations, this would not be a legal preexisting conditions exclusion. Since Janice did not receive mental health treatment and no treatment was recommended in the six months preceding her enrollment in the plan, this exclusion is not legal.

V. Maximum Length of Preexisting Condition Exclusion: the “12-Month Look-Forward Rule;” Reduction of Period Through “Creditable Coverage”

A. The Basic Rule, With Examples From HIPAA Regulations

“A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date.”¹⁸ For example, using an enrollment date of August 1, 2002, the maximum preexisting exclusion under the 12-month look-forward rule would be through July 31, 2003. A “late enrollee” is a person who either enrolls after the earliest date on which coverage can become effective or after a special enrollment date established for that individual.¹⁹

“The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date....”²⁰ The “enrollment date” is the “first day of coverage or, if there is a waiting period, the first day of the waiting period.”²¹

What qualifies as “creditable coverage?” It includes a very wide range of public and privately funded health coverage, including any of the following:²²

- A group health insurance plan
- An individual health insurance plan
- Medicare
- Medicaid
- Certain health insurance plans offered to federal employees, members of the armed forces, and members of the Peace Corps

In order to count past coverage as creditable coverage, there must be no “significant break” in coverage. This is defined as a break of 63 consecutive days.²³ Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. The applicability of this rule is best understood by looking at the eight examples contained in the DOL regulations,²⁴ several of which are reproduced here verbatim:



¹⁸ *Id.* B 2590.701-3(a)(1)(ii).

¹⁹ *Id.* B 2590.701-3(a)(2)(iii).

²⁰ *Id.* B 2590.701-3(a)(1)(iii).

²¹ *Id.* B 2590.701-3(a)(2).

²² *Id.* B 2590.701-4(a)(1).

²³ 29 C.F.R. B 2590.701-4(b)(2).

²⁴ These appear following B 2590.701-4(b)(2)(iv).

“Example 1. (i) Individual A works for Employer P and has creditable coverage under Employer P’s plan for 18 months before A’s employment terminates. A is hired by Employer Q, and enrolls in Employer Q’s group health plan, 64 days after the last date of coverage under Employer P’s plan. Employer Q’s plan has a 12-month preexisting condition exclusion period.

(ii) In this Example 1, because A had a break in coverage of 63 days, Employer Q’s plan may disregard A’s prior coverage and A may be subject to a 12-month preexisting condition exclusion period.

Example 2. (i) Same facts as Example 1, except that A is hired by Employer Q, and enrolls in Employer Q’s plan, on the 63rd day after the last date of coverage under Employer P’s plan.

(ii) In this Example 2, A has a break in coverage of 62 days. Because A’s break in coverage is not a significant break in coverage, Employer Q’s plan must count A’s prior creditable coverage for purposes of reducing the plan’s preexisting condition exclusion period as it applies to A.

Example 3. (i) Same facts as Example 1, except that Employer Q’s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) In this Example 3, the issuer that provides group health insurance to Employer Q’s plan must count A’s period of creditable coverage prior to the 63-day break.

Example 4. (i) Same facts as Example 3, except that Employer Q’s plan is a self-insured plan, and, thus, is not subject to State insurance laws.

(ii) In this Example 4, the plan is not governed by the longer break rules under State insurance law and A’s previous coverage may be disregarded.

Example 5. (i) Individual B begins employment with Employer R 45 days after terminating coverage under a prior group health plan. Employer R’s plan has a 30-day waiting period before coverage begins. B enrolls in Employer R’s plan when first eligible.

(ii) In this Example 5, B does not have a significant break in coverage for purposes of determining whether B’s prior coverage must be counted by Employer R’s plan. B has only a 44-day break in coverage because the 30-day waiting period is not taken into account in determining a significant break in coverage.”

B. How the Rules Would Apply to SSI or SSDI Beneficiary Who Goes to Work and Is Covered by a Group Health Plan

Once again, let us go back to the example of Janice to consider how these rules might apply to a beneficiary who goes to work.

Example 1. Janice was receiving SSDI benefits and was covered by Medicare during the five years immediately before starting a job with employer ABC. She was also covered by Medicaid, during the past five years, through her state's medically needy or spend down program. The Medicaid program has covered her prescription drugs which cost about \$1,200 per month. After starting the job with ABC, she will lose her right to continue on the Medicaid spend down program and her state does not offer the optional Medicaid buy-in program. Medicare does not cover prescription drugs.

The employer provides a health insurance plan and that plan will cover the prescription drugs Janice uses, subject to a \$10 per prescription co-payment. However, the group health plan offered by the employer includes a 12-month preexisting condition exclusion period. Is the preexisting condition exclusion legal and enforceable?

The preexisting condition exclusion in ABC's group health plan is legal under HIPAA, as it is limited to a 12-month period. In Janice's case, however, this period of exclusion is reduced by the period of "creditable coverage" which she had as of her enrollment date for the group health plan. In her case either the continuous Medicare or Medicaid coverage will meet the creditable coverage requirements. Since she was continuously covered by Medicare and Medicaid for 12 consecutive months prior to the enrollment date, with no significant break in coverage, the exclusion period will be eliminated (i.e., reduced to zero) and Janice will be immediately covered by the group health plan. Importantly, this allows Janice to immediately take advantage of the group health plan's prescription drug coverage.

VI. Preexisting Condition Exclusions Barred for Newborns, Adopted Children and Pregnancy

HIPAA disallows preexisting condition exclusions in three instances:²⁵

Newborns: It prohibits exclusion of newborns, who would otherwise be covered by the policy, so long as the child is covered by some form of creditable coverage within 30 days of birth.

Adopted children: It prohibits the exclusion of an adopted child (i.e., one adopted or placed for adoption before age 18) who is covered under creditable coverage within 30 days of the adoption or placement for adoption.

Pregnancy: Neither a group health plan nor a health insurance issuer offering group health insurance may impose a preexisting condition exclusion relating to pregnancy.

VII. The "Certificate of Creditable Coverage"

The HIPAA regulations envision that a person will establish past creditable coverage by producing a certificate or certificates. Generally, the entity providing the past creditable coverage has an obligation to provide a "certificate of creditable coverage."²⁶



²⁵ 29 C.F.R. § 2590.701-3(b).

²⁶ See 29 C.F.R. § 2590.701-5(a)(1)(i), regarding obligations of group health plans and health insurance issuers offering group health insurance. See *id.* § 2590.701-5(a)(6)(i) & (ii), regarding other entities referred to above (e.g., Medicare, Medicaid, etc).

VIII. HIPAA's Anti-Discrimination Provisions

Under HIPAA, a health insurance issuer offering group health insurance coverage is prohibited from discriminating. It may not establish rules for plan eligibility based on any of the following health status factors in relation to the individual or a dependent:²⁷

- Health status
- Medical condition (physical or mental illnesses)
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability (including conditions arising out of acts of domestic violence)
- Disability

COBRA: The Right to Continued Coverage After a Layoff or Job Termination

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)²⁸ applies to employers who customarily employed 20 or more employees on a typical business day in the preceding calendar year. COBRA provides an option for continuing insurance coverage for employees and their dependents after a lay off or job termination.

Under COBRA, the employee or dependent has a minimum of 60 days to elect continued coverage.²⁹ The employee or dependent is generally entitled to continued coverage, at their own expense, for a period of 18 months following the termination.³⁰ In some cases, COBRA coverage can extend for a longer period of time. For example, an individual who is found disabled under the SSI or SSDI program rules within the first 60 days of continued coverage will be eligible for continued coverage for 29 months. To extend coverage to 29 months, the employee must provide notice of his or her disability before the 18 month continuation period expires.³¹ COBRA limits the premium to 102 per cent of the group rate paid by the former employer and permits payment in monthly installments.³² COBRA does not, however, apply to employees who are terminated as a result of gross misconduct.³³

COBRA protects individuals during the period they are between jobs or awaiting Medicare eligibility. It protects an employee's spouse and dependent children when they lose eligibility under the group health plan as a result of the employee's death, entitlement to Medicare, termination of employment or reduction of work hours.³⁴ COBRA also protects a spouse in the event of divorce or legal separation and protects dependent children who lose their right to coverage as dependents because they get older or marry.³⁵

²⁷ *Id.* B 2590.702.

²⁸ 29 U.S.C. §§ 1161 *et seq.*

²⁹ *Id.* B 1165.

³⁰ *Id.* B 1162(2).

³¹ *Id.* B 1162(2)(A)(v).

³² *Id.* §§ 1162(3)(A) and (B).

³³ *Id.* B 1163(2).

³⁴ *Id.* §§ 1163, 1167(3).

³⁵ *Id.* §§ 1163(3) & (5).

Coverage of Specific Services Under the Insurance Contract

As stated above, analysis of whether an individual is eligible for coverage of particular services under an insurance policy turns on three issues: first, whether the individual is covered by the policy; second, whether the item or service is covered by the policy; and third, whether the item or service sought is medically necessary for the individual. If the answer to each question is yes, the insurance policy will pay for the item or service, subject to any policy limits, co-payments, or deductibles. The previous sections addressed issue one; we now turn our attention to issues two and three.

I. What Services are Covered Under the Insurance Contract?

Analysis of what is covered starts with reviewing the provisions of the insurance policy or contract. Again, the individual or advocate must make sure to obtain the actual contract and not just some summary or handbook that describes its provisions. Where possible, you should obtain both the contract and the separate handbook (or Summary Plan Description (SPD) for policies covered by ERISA), as the handbook may be an easier document to read. In a legal challenge, however, the contract itself is the best evidence of the scope of insurance coverage, with the handbook or SPD available to clarify ambiguities in the contract. We stress again that it is important to obtain copies of any amendments, riders, and supplemental policies for which the individual or employer is paying.

During this stage of our analysis we are reviewing the policy to determine whether an item or service is “potentially” available for an individual. The most common services, like doctor visits and medication are usually straightforward. However, the issue may be when a specialist is covered. In the managed care context, the policy is likely to delegate that decision to a primary care physician who some have described as serving a gatekeeper role for the HMO. With prescription drugs, the issue is now often a two-tiered analysis. The first issue is whether medication is covered and second, whether the policy provides different coverage for brand name and generic drugs. Since brand name drugs tend to be more expensive, a growing trend is to require higher co-payments for them.

For persons with some chronic conditions, trips to a hospital's emergency room may occur each year. Here again, because emergency room treatment is expensive, expect that the insurance policy will regulate when it can be used and may impose significant co-payments. Since some form of HMO-type coverage is becoming the norm, the primary care physician or an on-call physician may need to pre-approve this treatment before it is sought if only through a phone conversation. Individuals who expect to use the emergency room with any frequency must become aware of the steps needed to ensure coverage for this type of care.

Specialized equipment or what is now commonly referred to as “assistive technology” (AT) is important to many individuals with severe disabilities. Coverage for items such as custom and power wheelchairs, augmentative and alternative communication devices, specialized braces, hearing aids, powered hydraulic lifts, and bath equipment can often prove to be very expensive. In private health insurance policies, these items are commonly referred to as durable medical equipment (DME).

DME is usually not available in a “basic” plan, the least costly of group plans. DME may be provided in a “major medical” plan, which is often an adjunct or a rider to a basic plan. Major medical riders often cover items such as hospital stays, diagnostic testing, and DME. In addition to the DME clause, AT might be covered by a clause which addresses prosthetics, orthopedic appliances, medical supplies, or vision services and equipment. One should review the entire policy and all the riders in search of any language that can be relied upon to fund AT.

You also need to look for “exclusions,” i.e., provisions that specifically mention items that are not covered. In general, policy exclusions are legal unless they are specifically made illegal by state or federal law, or are successfully challenged under a non-discrimination law like the Americans with Disabilities Act (ADA). The ADA and any similar federal or state laws are beyond the scope of this article and will not be discussed. A policy may list various types of DME or other AT categories that the insurer will not cover. Examples of items which are commonly excluded from coverage are:

- Air conditioners
- Hearing aids
- Augmentative and alternative communication devices
- Humidifiers
- Items characterized as athletic or exercise equipment
- Orthotics - shoe inserts
- Eyeglasses
- Equipment characterized as experimental

Even if a DME clause or a similar clause would appear to cover an item, the policy may specifically limit the funding that is available. Some policies contain provisions that place a dollar limit on what will be spent on a particular item or within a category of coverage. For example, one policy we reviewed had a limit of 20 visits per year for mental health counseling; another had a \$1,000 annual limit on DME coverage. Insurers may also require a co-payment for certain services (e.g., one major New York provider sets the DME co-payment at 20 percent, while another sets it at 50 percent). An insurer with a 50 percent co-payment would pay \$5,000 towards the purchase of a \$10,000 power wheelchair while the insured or beneficiary would be responsible for payment of the remaining \$5,000. If a person is covered by both private insurance and Medicaid, Medicaid may be able to pick up the remaining \$5,000 co-payment as a secondary payer.

Each policy will contain its own definition of DME which may be similar to the following four-part definition which comes from the Medicare program:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to an individual in the absence of illness or injury;
and
4. Is appropriate for use in the home.

Some policies may not include part four of the definition, i.e., that the item is “appropriate for use in the home.” Other policies may include, as part of the definition, a requirement that the item “is able to withstand use by more than one person.” Any part of this definition, or any alternative definitions, can give rise to disputes over what is covered. For example, many insurers interpret the statement, “is able to withstand use by more than one person,” to exclude anything but standard equipment. Therefore, some insurers have refused to fund customized wheelchairs by invoking that clause. They may limit payment to the normal cost for a standard wheelchair, which is usually far less than the cost of the customized wheelchair. That coupled with the co-payment requirement may make the particular wheelchair or other piece of DME unaffordable.

II. Is the Requested Item or Service Medically Necessary?

Like Medicaid and Medicare, private insurance policies will only pay for a health-related item that is “medically necessary.” The policy may or may not use that actual term. How that term (or any similar term) is defined is determined by the individual insurance contract. Some policies will use the term medically necessary with no further explanation. Many policies will use language such as the following in defining medical necessity:

- Is consistent with the symptoms or diagnosis and treatment of a condition, disease, ailment, or injury;
- Is in accordance with standards of good medical practice;
- Is the least costly appropriate alternative; and
- Is not for the insured’s convenience.

In cases involving inexpensive DME, such as crutches or a walker, the policy may allow coverage based on a doctor’s prescription. The prescription alone is enough to establish medical necessity. Similarly, for most medications, the prescription is probably sufficient with no requirement for any type of prior approval process.

When the item is more expensive, the policy may require that a determination of coverage and medical necessity be made through a prior approval process. Determinations of medical necessity are usually made by an employee of the insurance company or HMO, such as a doctor or utilization review agent. Your state law may dictate the level of qualifications required of this decision maker. This process of determining both coverage under the policy and medical necessity is probably similar to the prior approval process used by Medicaid agencies in most states to rule on applications for DME funding and approval of other expensive items, such as out-of-state treatment.

III. What if the Policy's Language is Unclear?

Where the policy language is clear, that language determines what is available under the policy. What if a particular provision is unclear or ambiguous?

We have not attempted to review the laws, regulations, and case law of the 50 states to look for rules governing the interpretation of health insurance contracts. However, you need to become familiar with your relevant state law and case law as it may provide guidance for interpretation of ambiguous contract provisions.

A good starting point for analysis is the *Restatement of Contracts, 2nd*. Although the *Restatement* is not law, it has been regularly cited with approval by the courts. Under the *Restatement*, the general rule is that insurance contracts must be liberally construed, with ambiguities in the policy language resolved in favor of the insured (i.e., the beneficiary).³⁶

This general rule for interpreting insurance contracts has been adopted by both the federal and state courts from New York.³⁷ If it is adopted by the courts in your state, this general rule should be helpful to attorneys pursuing insurance-related court appeals. Since insurance policy provisions governing coverage categories and medical necessity are often written in very general language, it would be most helpful to know that those terms will be interpreted in favor of the person seeking the item in question.

Appeals Rights

There are three potential ways to appeal an adverse determination:

- through an insurance company's internal appeal process;
- through a complaint process available through your state's insurance department or a similar agency; and
- through a court appeal.

The availability of any of these three remedies may depend on the policy or the state or federal laws, which govern the policy.

Many readers who work for Protection and Advocacy (P&A) agencies have taken on insurance appeals as part of your work. Attorneys and advocates who work under the new, P&A for Beneficiaries of Social Security (PABSS) grants could handle insurance appeals if doing so will help overcome a barrier to work. You may also be able to identify other attorneys/advocates who work within the P&A agency, a Legal Services or Legal Aid agency, or *pro bono* private attorneys who will handle some insurance-related appeals, without charge.

I. Appeals Directly to Insurance Company

Here again, check state law to determine what, if anything, is required as an insurance company appeal process. One should also check the policy in question which will

³⁶ *Restatement of Contracts, 2nd*, § 206 & comment a.

³⁷ *See, Westchester Resco Co., L.P. v. New England Reinsurance Corp.*, 818 F.2d 2, 3 (2nd Cir. 1987); *Stainless, Inc. v. Employer's Fire Insurance Co.*, 418 N.Y.S. 2d 76, 79 (Appellate Div., 1st Dept. 1979), affirmed 428 N.Y.S. 2d 675; *Government Employees Ins. Co. v. Kligler*, 42 N.Y. 2d 863, 397 N.Y.S. 2d 777 (1977) (a decision from New York's Court of Appeals).

probably describe how one appeals an adverse decision. If the group health plan is covered by ERISA (see discussion below), that law requires specific appeal processes.

It is important to determine both the method of filing an appeal and any time limits for doing so. Sometimes a telephone call to the insurer initiates the appeal. Other policies may require that an appeal be in writing. We always recommend that a person file a written letter to appeal and follow up that letter with a phone call.

Since there will nearly always be a time limit imposed for filing an appeal or grievance, it is important to find out what the time limit is and file any appeal within the time frame imposed. Since information about how to appeal is not always readily available, we suggest filing an appeal letter with the insurance company or HMO as soon as possible after an adverse decision is received.

In almost all cases we recommend using the appeal or grievance procedure established in the insurance contract before proceeding further. In our experience, a significant percentage of insurance appeals can be favorably resolved in this manner. During the past several years, the author's advocacy program has successfully resolved several cases involving private insurance funding of augmentative communication devices, power wheelchairs, and inpatient mental health treatment. One large HMO agreed to pay for a power wheelchair with power tilt and space after we intervened, conceding that our client's was the first such wheelchair they had approved. One former client obtained a standing wheelchair after she wrote a very strong and well-reasoned appeal letter.

Sometimes a purpose of the correspondence with the insurance company or HMO is to provide supplemental medical documentation to support the claim. In other cases, the purpose is to educate the decision maker who will decide the claim concerning how the item or service in question will treat the medical condition or overcome the effects of the disability.

II. Filing a Complaint with a State Insurance Agency

An individual may also have a right to file a complaint with your state agency which oversees health insurance. If an agency of state government accepts complaints, you need to determine what procedure must be followed. For example, your state's agency may or may not require that complaints be in writing or submitted on an approved form.

It is important that you determine the authority of your state insurance agency to act on complaints. For example, you may be more likely to file a complaint with them if they have authority to order an insurance company to fund items or services in an individual case. If their authority is limited to an investigation of the complaint and some attempt at mediation, you may be less likely to turn to them. If an individual pursues a complaint before your state insurance agency, it is critical to know if that complaint tolls or stops the running of the statute of limitations for filing a lawsuit or pursuing other remedies under the policy.

III. Court Appeals

The third option for appeal is a lawsuit in a court of competent jurisdiction. Subject to the provisions of ERISA, discussed below, most appeals will be filed in your state courts. This method of appeal may be very costly, however, because of filing fees and attorney fees (in those cases in which free legal services are not available).

Insurance appeals may be filed under your state's common law of contracts. There may also be claims that arise under state law provisions which govern health insurance. It is important that you determine the statute of limitations governing a court appeal under the health insurance policy in question. In New York, for example, the usual statute of limitations for suing under a contract is six years. However, if the claim arises under a health insurance contract, the statute of limitations is three years. New York law also permits parties to a contract to agree on a shorter statute of limitations. One major insurer has a one year statute of limitations in its standard policy. If your state law also allows parties to provide a shorter statute of limitations by contract, you must read the contract provisions to learn what the statute of limitations is for any particular insurance policy.

If an individual pursues an appeal or grievance through the insurance provider it is critical to know if that grievance tolls or stops the running of the statute of limitations for filing a lawsuit. When a lawsuit is likely, it is important to research the law and the particular contract involved to ensure that the statute of limitations does not expire.

The Impact of ERISA

The federal Employee Retirement Income Security Act (ERISA) applies to a wide range of employee benefit plans, covering such things as pensions, disability benefits, death benefits, and health insurance.³⁸ This section will discuss its application to employer funded health insurance. Although the law is complicated and has been widely interpreted by the courts, we will present a short, practical summary of when it applies and how it can be enforced.

I. What Kind of Plans Are Covered Under ERISA?

ERISA applies, with specified exceptions, to any "employee benefit plan" established or maintained by employers "engaged in commerce or in any industry or activity affecting commerce," as well as to plans established by labor organizations "representing employees engaged in commerce or in any industry or activity affecting commerce"³⁹ Nearly all employers would meet this test. Health insurance plans offered by government agencies to public employees are not covered by ERISA.

II. The ERISA Preemption of State Laws

ERISA preempts all state laws "insofar as they may now or hereafter relate to any employee benefit plan"⁴⁰ Preempted State law includes not merely statutes, but also "all laws, decisions, rules, regulations or other state action having the effect of law"⁴¹ Where preemption applies, ERISA fully takes the place of the state law, regulation, or policy and only ERISA is enforceable in the courts.

³⁸ 29 U.S.C. §§ 1001 *et seq.*

³⁹ *Id.* § 1003(a)(1) & (2).

⁴⁰ *Id.* § 1144(a).

⁴¹ *Id.* § 1144(c)(1). *See, e.g., Anshultz v. Connecticut General Life Insurance Co.*, 850 F.2d 1467 (11th Cir. 1988).

In some states, a body of common law or case law has created a right to sue an insurance company that denies claims in bad faith. This could give rise to punitive damages to punish a defendant for particularly outrageous behavior. The U.S. Supreme Court has held that this kind of claim is preempted by ERISA and not available to the individual.⁴²

There is an exception to this preemption of state law, which includes “any law of any state which regulates insurance.”⁴³ If an individual’s claims are directly against the insurance company or HMO, which operates the health benefit plan, state insurance law will apply.

When a self-funded employee benefit plan is involved, the exception just described does not apply and any relevant state law is preempted. This means that self-funded employee benefit plans are not governed by state laws at all, including the state’s insurance laws. Self-funded plans are those in which the employer directly pays for claims made under the plan and includes plans that are administered directly by the employer and those that are administered by a third party such as an insurance company. Because administration of self-funded plans is very common and occurs with many large employers, employees are often not aware that they are in a self-funded plan.

Despite this added complication created by the preemption of state laws, the provisions of the health insurance plan remain enforceable in the courts within the framework described in section IV, below. It is also important to note that any of the rights to resolve disputes through informal channels remain intact as described in section III, below. Finally, except in the case of self-funded plans, any rights created by your state’s insurance laws should still be enforceable.

III. ERISA Procedural Protections

Under ERISA, the plan administrator must furnish copies of plan documents and relevant claims information to a requesting participant within 30 days of receiving the request.⁴⁴ If a plan administrator fails or refuses to produce the requested documents within 30 days, a court may require the administrator to pay the requesting participant up to \$100.00 per day until the administrator complies with the request.⁴⁵ Concealing exclusions or writing plans ambiguously violates ERISA, which requires that SPDs “be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise [claimants] of their rights and obligations under the plan.”⁴⁶

When a claim has been denied, ERISA requires that claimants be clearly informed of the denial, the specific basis for it, and the procedure for a review that must be “full and fair.”⁴⁷ Department of Labor regulations set out the minimum requirements for employee benefit plan procedures and the specifics of the denial notice.⁴⁸ Some courts have held that a plan administrator’s failure to provide adequate notice may result in an extension of time for plan participants to assert their rights under ERISA.⁴⁹



⁴² *Pilot Life Ins. Co. v. Dedaux*, 481 U.S. 41, 47 (1987).

⁴³ 29 U.S.C. § 1144(b)(2)(A).

⁴⁴ 29 U.S.C. § 1021.

⁴⁵ *Id.* § 1132(c).

⁴⁶ *Id.* § 1022(a).

⁴⁷ 29 U.S.C. § 1133.

⁴⁸ 29 C.F.R. § 2560.503-1(f) & (g).

⁴⁹ *See, e.g., White v. Jacobs Engineering Group Long Term Disability Benefit*, 896 F.2d 344 (9th Cir. 1989). In *White*, the court held that because the notice was inadequate, the plaintiff’s claim was not barred by a 60-day time limitation for administratively appealing a denial.

IV. Judicial Review of ERISA Claims

The ERISA law provides for a right to go into either state or federal court to recover benefits denied under the plan and/or seek an order to enjoin (or stop) any practice of the plan administrator that violates the provisions of ERISA. When a plaintiff files in state court on a claim governed by ERISA, the defendant may move to have the matter removed to federal court. The U.S. Secretary of Labor also has authority to start a court action to enforce ERISA. When a plaintiff wins his or her ERISA case, the court may award costs and reasonable attorney's fees to a prevailing plaintiff.⁵⁰

If the plan administrator is explicitly given discretion to make coverage determinations, then the court will reverse the plan administrator's decision if it was arbitrary and capricious or not supported by substantial evidence. This "arbitrary and capricious" standard means that the court will give considerable deference to the decision of the plan administrator and will not disturb that decision if it was reasonable (even if the court might have rendered a different decision on the same facts). If the plan administrator was not given discretion to make coverage determinations, then the court conducts a *de novo* review of the coverage decision, without giving any special deference to the plan administrator.⁵¹ The court's review is limited to the record created in the administrative proceedings conducted under the plan.

Conclusion

The issues surrounding private health insurance plans will increase in importance to BPA&O projects, PABSS projects, and other disability advocacy programs as more SSI and SSDI beneficiaries go to work with employers who offer health insurance. This article has provided a general framework within which to advise those beneficiaries of their rights under their private insurance plans and some of the special federal laws that apply to them.

⁵⁰ 29 U.S.C. § 1132.

⁵¹ *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

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