10.0 HEALTH-CARE ISSUES

10.1 Overview

After a natural disaster, lawyers may face questions that range from simple requests about where to find the phone number for a particular state agency to more complex inquiries about health-care insurance or malpractice liability.

As a lawyer, you must differentiate between questions that raise genuine legal issues or those that require you to direct someone to an appropriate agency physician, or another health-care provider. For example, in the wake of Katrina, some legal hotlines reportedly received calls for advice on how to diagnose "Katrina Cough" and give first aid techniques. These are not questions you should answer.

On the other hand, there will be many questions that are well within the scope of a lawyer's expertise. You may be asked to suggest sources of information concerning public resources or benefits, as well as asked questions concerning payment for health-care services. This guide is designed to provide basic information to help you formulate your responses.

10.2 Most Common Issues/Questions

- I lost my job as a result of the disaster. What will happen to my health insurance?
- What if my employer drops health insurance coverage altogether?
- When I go to the doctor's office, I am usually asked to sign a "HIPAA" form. What is HIPAA?
- Can I request that my personal health information not be disclosed to anyone?
- What personal information of mine is covered by HIPAA?
- How can I find out if my PHI has been wrongfully used or disclosed?
- I lost my job, but my spouse is still employed. I used to be covered under my employer's plan. Can I switch to my spouse's plan?
- I lost all of my health insurance papers, and I need to file a claim. What should I do?
- How can I get my prescriptions filled?

10.3 Summary of the Law

Organization and financing of health care in the United States

In the United States, the delivery of health care involves a complicated network of providers, including, first responders (such as emergency medical technicians and paramedics), health-care practitioners, hospitals, out-patient clinics, ambulatory care centers, and emergency treatment centers. In many cities, including Houston, health-care providers enter into contractual relationships known as "integrated delivery systems." An integrated delivery system is an organization or group of related organizations in which hospitals and physicians pool their activities to deliver comprehensive health-care services to individuals. Such systems generally tie together a hospital or hospital system, professional practice groups of physicians and other providers, management systems, rehabilitation programs, and, in most instances, an insurance provider or health maintenance organization (HMO).

The sources of health-care financing are also wide-ranging. Most commonly, payment comes from a combination of sources, including a patient's co-payment and additional funds from private insurance (including employer-sponsored health benefits), government benefits (such as Medicaid or Medicare), or even funds set aside to cover charity care. In rare circumstances, patients may actually pay the entire cost of the medical services that they receive.

Some health-care financing arrangements still rely in part on a "fee-for-services" payment system, which is a system of health insurance payment in which a doctor or other health-care provider is paid a fee for each particular service rendered, but most methods of insuring or financing health care involve some degree of managed care. Managed care combines the delivery and financing of health care in order to create economies of scale. In a managed care system, a combination of contractual obligations and incentives is used to align the expectations of patients, providers, and payors with the goal of reducing the cost of health care delivery while maintaining a level of health care access that satisfies the patients' needs. HMOs, preferred provider organizations (PPOs), and integrated delivery systems are examples of the managed care strategy at work.

Provider/Patient Relationships

While health care providers are not subject to a common-law "duty to treat," such an obligatory duty may arise due to contractual obligations, statutory requirements, or a de facto relationship established by the parties' conduct. Lawyers should not assume that the "no duty to treat" principle is applicable in all cases.

Once a provider-patient relationship has been established, the provider assumes legal and ethical duties to the patient that, again, may be based on contract (such as may be required as a condition of the physician's participation in an HMO); common law theories of tort, fraud, and fiduciary standards; federal or state statutes; or professional ethics. In addition, both private accreditation systems and public quality control regulations play a part in defining the public's reasonable expectations of health care providers.

It is also important to note that hospitals and health-care systems owe certain duties to patients that are independent of any obligations that derive from the physician/patient relationship. These responsibilities typically include the duty to (1) select, supervise, and retain medical staff; (2) use reasonable care in the maintenance of facilities and equipment; (3) oversee all persons who

practice medicine within the facilities; and (4) formulate, adopt, and enforce adequate rules and policies to ensure quality care for patients.

10.4 Useful Websites

- For information concerning disaster assistance services being offered in surrounding states, visit the Texas Department of State Health Services' website: http://www.dshs.state.tx.us/preparedness/disasters.shtm.

- Specific DSHS announcements are located as follows:

  DSHS Reminds Public of Carbon Monoxide Dangers
  http://www.dshs.state.tx.us/preparedness/factsheet_co2-generators.shtm

  DSHS Issues Health-Related Precautions
  http://www.dshs.state.tx.us/news/releases/20080914.shtm (DSHS issued health-related precautions specific to Disaster Ike, but the release contains generally helpful information.)

- Other helpful websites:

  Texas Health and Human Services Commission

  Finding Help in Texas (FAQs)
  https://211texas.hhsc.state.tx.us/211/faq.do

  Temporary Assistance for needy families (TANF)
  http://yourtexasbenefits.hhsc.texas.gov/programs/tanf/

  Medicaid Texas
  http://yourtexasbenefits.hhsc.texas.gov/programs/health/

  Texas Department of Insurance
  http://www.tdi.state.tx.us/CONSUMER/storms/

  Harris County Health Department
  http://www.hcphes.org/

  Red Cross
  http://www.redcross.org/

10.5 FAQs—COBRA Health Insurance Continuation

Q. 10-1 I lost my job as a result of the disaster. What will happen to my health insurance?

If you have lost your job due to a natural disaster, you may be eligible to extend your employer-based medical plan coverage for a limited period of time.

COBRA or the "Consolidated Omnibus Budget Reconciliation Act" is a federal law that may let employees and some retired employees keep their employer group health plan coverage between eighteen and thirty-six months if—

1. the employment ends (unless the employee is fired for gross misconduct) or
2. the person loses coverage as a dependent of the covered employee.

This is called continuation coverage. This coverage applies to employer-sponsored dental and vision plans, as well.

Generally, COBRA only applies to employers with twenty or more employees. It does not apply to plans sponsored by the federal government and some church-related organizations.

Texas requires insurers covering employers with two or more employees to keep coverage for up to six months after COBRA ends if the coverage was through an insurance company or HMO subject to Texas insurance laws and rules. If the employee was fired, he may not be eligible. Additionally, the employee must have been covered for at least three consecutive months immediately before the end of his employment.

The cost of COBRA is more expensive than what the employee is used to paying, because it can include the portion of the premium that the employer had been paying. However, the cost may not be more than 102 percent of the total premium amount.

If you lose your job, the employer must tell the plan administrator of your right to COBRA within thirty days. The plan administrator then has fourteen days to notify you of your ability to accept or reject the coverage. You then have sixty days to tell the plan administrator if you accept or reject the coverage, and payment for the first period of coverage must be made in full within forty-five days.

You should call your employer's benefits administrator for questions about your specific COBRA options. If you have questions about Medicare and COBRA, you should call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY: 1-855-797-2627). If your group health plan coverage was from a private employer, contact the Department of Labor at 866-444-3272 or 972-850-4500. If your group health plan coverage was from a state or local government employer, call the Centers for Medicare & Medicaid Services (CMS) at 1-877-267-2323, extension 61565. You may also contact the Texas Department of Insurance regarding continuation of benefits in Texas at 800-252-3439. If your coverage was with a federal government employer, visit the Office of Personnel Management at www.opm.gov.

Q. 10-2 What if my employer drops health insurance coverage altogether?

If your employer goes out of business or otherwise cancels its group health plan coverage, neither federal COBRA nor state continuation will be available to you or your family members.

However, you and your family members may be able to obtain individual insurance policies. You should contact an insurance broker to purchase such a policy. If you do not know of one, you can contact the Texas Department of Insurance at 800-252-3439 to find a broker in your area.

Previously, if you were turned down for coverage from two separate insurers due to a pre-existing health condition, you may still have been able to obtain major medical insurance coverage from the Texas Health Insurance Risk Pool (www.txhealthpool.org), commonly referred to as the Risk Pool. However, as a result of the Affordable Care Act, the Risk Pool no longer exists.

Whether your employer must offer you health insurance depends on the size of your employer. Under the Affordable Care Act, if your employer has fifty or more full-time employees, it is required to provide health insurance to employees or pay a penalty. If your employer is a small business, it does not have to pay a penalty if it does not provide health insurance.

The ACA counts you as full-time if you average more than thirty hours per week at your job. If your average hours are less than thirty hours per week, the law does not require your employer to provide insurance. The company is free to cancel any coverage it does provide. If you are a full-time worker, it can cut your hours until you no longer qualify for full-time and, therefore, insurance. The Employee Retirement Income Security Act (ERISA) says your employer must notify you about any major changes to your insurance plan. You must also be notified about your ability to continue coverage under COBRA or the Texas law. If your employer cancels your group health-care coverage but continues to employ you, you may be able to convert to individual coverage for six to nine months until you can find a better insurance deal or a job with better health insurance benefits.

For insurance questions or for help with an insurance-related complaint, call the Texas Department of Insurance (TDI) Consumer Help Line at 1-800-252-3439.

In addition, some low-income individuals may qualify for Medicaid programs in Texas. Medicaid provides health-care coverage for some low-income individuals, families and children, pregnant women, the elderly, and people with disabilities. Medicaid in Texas is dependent on various factor (including an individual's income and family size), so one's eligibility for Medicaid will be determined on a case-by-case basis. If you have lost your employer-provided insurance and qualify as a low-income individual or household in Texas, you and/or your children may qualify for Medicaid. To apply, call 2-1-1 or visit your nearest Texas Health and Human Services Commission (TxHHSC) office.

10.6 FAQs—HIPAA, Privacy, and Special Enrollment Rights

Q. 10-3 When I go to the doctor's office, I am usually asked to sign a "HIPAA" form. What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established fairly strict privacy and disclosure requirements for health-care providers and health-care plans.

However, there are certain exceptions to such requirements in the event of a disaster. A bulletin authored by the U.S. Department of Health and Human Services provides a summary of what patient information can be shared in order to assist in disaster relief efforts. It was published for Katrina victims in 2005, but the information contained there is still accurate today. Go to http://www.hhs.gov/sites/default/files/katrinanhipaa.pdf.

Here is a brief look at the issue:

- TREATMENT. Health-care providers as well as your health plan can share patient information as reasonably necessary to provide treatment, coordinate care, and arrange for payment. You may request reasonable restrictions on the use of your data, even for these purposes.

- NOTIFICATION. Health-care providers and health plans can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care, of the individual's location, general condition, or death.

- IMMINENT DANGER. Health-care providers and health plans can share patient information with anyone as reasonably necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public consistent with applicable law and standards of ethical conduct.

- FACILITY DIRECTORY. Health-care facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and general condition.

Q. 10-4 Can I request that my personal health information not be disclosed to anyone?

Under HIPAA, a Request for Confidential Communications is a request that your health information or identity be disclosed only to you because you believe that if it were revealed to others, your life and/or health would be in immediate danger. This request must be reasonable and may not adversely impact your care. You must immediately notify your health-care provider and/or health plan and tell them how and where you wish to be contacted. They may deny your request if it presents a threat to public health or safety.

A Request for Restriction is different than a Request for Confidential Communication. A Request for Restriction is your right to ask that a restriction or limitation be placed on what medical information will be used or disclosed about you. It can be made for any reason. Your health-care provider or health plan do not have to agree to the request, but if it is reasonable, they will usually honor it.

Make any special privacy requests in writing and keep a signed copy if the provider or health plan agrees to follow it.

Q. 10-5 What personal information of mine is covered by HIPAA?

HIPAA applies to individually identifiable health information used by health-care providers and health plans in their treatment, payment, and health-care-operation functions. Under HIPAA, this information is known as "Protected Health Information" or "PHI." Note, PHI does not include information used or disclosed by your employer for employment-related reasons, nor by health care providers when they are performing employment-related functions (such as drug testing and fitness for work).

Q. 10-6 How can I find out if my PHI has been wrongfully used or disclosed?

If you believe that your private medical information has been exposed or wrongfully shared, you should contact the person or entity responsible for the disclosure and ask them to retrieve the disclosed records, and request that whoever received them destroy their copies. The responsible party will probably be willing to help you if an error did occur. If you are not sure, you have the right to request a prompt accounting of all disclosures that may have been made in error by a health-care provider or health plan in the prior six years. You also have a right to review and receive a copy of all PHI in the possession of your health-care providers and health plans. They are allowed to charge a "reasonable, cost-based fee." They can charge for supplies, staff time for copying and processing, and mailing (if applicable). However, they may not charge for the time a staff member spends searching for the record.

You should then contact the United States Department of Health and Human Services (HHS) to describe the alleged incident and request an investigation. If any HIPAA violations are found, the agency may warn or discipline the person responsible for the disclosure, or refer the matter to the Department of Justice for prosecution.

You may contact HHS by calling 1-877-696-6775 or filling out a "Health Information Privacy Complaint" (PDF) form at www.hhs.gov/sites/default/files/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf.

Q. 10-7 I lost my job, but my spouse is still employed. I used to be covered under my employer's plan. Can I switch to my spouse's plan?

Under certain circumstances, you may qualify to switch to your spouse's health insurance during a special enrollment period. Special enrollment periods are triggered by certain life events, including marriage, the birth or adoption of a child, or when the spouse is no longer eligible for coverage under their own company's health insurance plan, which typically occurs when there is a job loss. This can also occur when a spouse loses Medicaid or CHIP eligibility.

If you qualify, you'll probably have to show proof of the change in circumstances before the company will let you enroll. Usually you have to enroll within a certain time frame, which is normally thirty days, in order to qualify.

This question and answer subsection uses information provided by the U.S. Department of Labor at http://www.dol.gov/ebsa/faqs/faq_compliance_hipaa.html.

10.7 FAQs—Health Insurance Claims

Q. 10-8 I lost all of my health insurance papers and I need to file a claim. What should I do?

If you have to file your health insurance claim yourself, you will need to contact your insurance company to obtain a health insurance claim form, or you may be able to download a copy from their website. Your claim form will also give you additional instructions about what other information you will need from your doctor or health-care facility.

If you are able to use a computer, many insurances companies now offer the ability to log onto your health and medical benefits plan online. You can ask your insurer to find out if they have online access. Many times, they will also have someone who will walk you through how to set it up if you do not know how.

You may then be able to file your claim online or at least be able to start your claim. If you have to mail it or any supporting documents, be sure to make copies of everything before you mail them.

When you access your plan online or contact your insurer, be sure to ask how long it will take to process your claim.

You should make sure that you are aware of that date so that you can watch for your claims award or file an appeal of the claim if you receive a denial notice.

If your claim is denied, the plan administrator must send you a notice, either in writing or electronically, with a detailed explanation of why your claim was denied and a description of the appeal process. In addition, the notice must include the plan rules, guidelines, protocols, or exclusions (such as medical necessity or experimental treatment) used in the decision or provide you with instructions on how you can request a copy from the plan. The notice may also include a specific request for you to provide the plan with additional information in case you wish to appeal your denial.

Claims are denied for various reasons. Perhaps the services you received are not covered by your plan. Or, perhaps the plan simply needs more information about your claim. You should check with your plan to make sure of your appeal deadline. Some private insurers allow up to 180 days to file an appeal of a claim, but others, such as managed-care plans, only allow a very short timeframe.

Use the information in your claim denial notice in preparing your appeal. You should also be aware that the plan must provide to claimants, on request and free of charge, copies of documents, records, and other information relevant to the claim for benefits. Further, the plan must also identify, on your request, any medical or vocational expert whose advice was obtained by the plan. Be sure to include in your appeal all information related to your claim, particularly

any additional information or evidence that you want the plan to consider, and get it to the person specified in the denial notice before the end of the appeal deadline.

On appeal, your claim must be reviewed by someone new who must look at all of the information submitted and consult with qualified medical professionals if a medical judgment is involved. This reviewer cannot be a subordinate of the person who made the initial decision and must not give any consideration to the prior decision.

In addition, plans have specific periods of time within which to review your appeal, depending on the type of claim. Be sure to check with your insurance plan to find out what the deadlines are.

Source: This question and answer subsection utilizes information provided by the U.S. Department of Labor at: http://www.dol.gov/ebsa/publications/filingbenefitsclaim.html.

Q. 10-9 I'm enrolled in Medicare Part C (Medicare Advantage), but I can't access any of my usual providers. What do I do?

If you need medical attention and cannot access your regular provider during a disaster or emergency, if you are enrolled in original Medicare, call 1-800-MEDICARE (1-800-633-4227) to get more information about where to see a doctor.

If you have a Medicare Advantage or other Medicare health plan, call them at 1-800-MEDICARE or check their Internet website (https://www.medicare.gov/find-a-plan/questions/home.aspx) to find out any temporary changes to rules and timelines. You will also be told if you are allowed to see doctors or go to hospitals outside of your provider network during an emergency.

Your plan may also be able to apply the in-network rate to services you receive out-of-network during this period. Save your receipts in case you need to provide it and ask for a refund.

10.8 FAQs—Prescriptions

Q. 10-10 How can I get my prescriptions filled?

For information on how to get your prescriptions filled, contact the Texas Department of State Health Services at (512) 776-2150, 1-888-963-7111, or 1-800-735-2989. Also, visit their website at http://www.dshs.texas.gov/preparedness/e-prep_public.shtm.

Any evacuee who needs a prescription filled generally must have ***one*** of the following:

1. a written prescription from a licensed health care provider;

2. a prescription phoned or faxed in from a licensed health care provider to a licensed pharmacy in Texas;

3. a current prescription bottle indicating a remaining refill; or

4. other proof of an existing prescription.

Evacuees in shelter should check with shelter staff for prescription assistance.

Those eligible for the federal Emergency Prescription Assistance Program (EPAP) can receive a one-time fill up to a thirty-day supply of medication. There is no charge or co-pay to the eligible person. EPAP is a joint program of the U.S. Federal Emergency Management Agency and the U.S. Department of Health and Human Services.

During a disaster, individuals with prescription questions regarding EPAP eligibility, covered drugs and durable medical equipment, and claim submission may call 1-855-793-7470. This number is only active during a declared disaster in which EPAP has been activated. The EPAP-covered prescriptions can be filled at almost any pharmacy in Texas. The pharmacy is responsible for verifying eligibility for the EPAP program.

Eligibility for the Emergency Prescription Assistance Program: The person applying—

1. must be from a county declared as a disaster area. Recipients must demonstrate residence within the covered area. Zip codes of areas determined eligible for EPAP will be posted to the EPAP website (http://www.phe.gov/preparedness) just prior to or during the activation. Identification can be a driver's license, state issued identification card, current lease, utility bill, or other credible attestation of residence; and

2. must have no prescription insurance coverage.

Q. 10-11 I'm enrolled in a Medicare Part D Prescription Drug Plan. How can Medicare help me with my prescriptions?

If you had to leave your home without your medicine, or your medicine was damaged or lost due to the disaster or emergency, try to refill it at your usual network pharmacy. Pharmacies are expected to suspend "refill too soon" restrictions to allow enrollees to get necessary medications. If you are unable to go to your local pharmacy, contact your Medicare Advantage or Part D plan at 1-800-MEDICARE (1-800-633-4227) and they can help you find another nearby network pharmacy to get your medication.

If you are unable to get your prescription at an in-network pharmacy, your plan can help you get it at an out-of-network pharmacy, but you may pay more out-of-pocket. If you paid full cost, you may be able to get a refund. You will just need to keep your receipts and ask your plan where to submit those along with a paper claim form.

You might also ask your plan if you can get an extended day supply in case you are unable to return home for a while.

Additionally, pharmacies are also permitted to waive co-pays if they determine a person cannot pay; however, that is a decision that is up to the pharmacy.

For more information, see: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_093011.pdf. Other helpful links can found at http://www.phe.gov/coi/Pages/links.aspx.

10.9 Medicaid

If you are on Medicaid and had to leave home and need a new main doctor, call your health plan for assistance in finding another doctor. If you don't have your health plan's number, call 800-964-2777.

If you are on Medicaid or CHIP and live in a county declared a federal disaster, you may be able to see out-of-network providers for emergency and nonemergency services until the disaster declaration ends. Medicaid clients and legally authorized representatives can access Medicaid health records at yourtexasbenefits.com.

Sometimes in a disaster, your co-pay and enrollment fee for CHIP may be waived if you live in a county declared a federal disaster. If you are unsure of your benefits, call 800-964-2777 to check.

If you have an appeal pending or have a hearing scheduled and have questions about your fair hearing, you should call the Fair and Fraud Hearings Section at 512-231-5701.

If you have a claim pending with the Medicaid Estate Recovery Program and were affected, you might be able to get deadlines extended for responses and materials needed. You should call 800-641-9356 for more information.

D-SNAP and WIC

If you enrolled in D-SNAP and you are pregnant or have a child younger than five, you will also be eligible for WIC, which allows you to get fruit and vegetables, cereal, bread, and milk, as well as infant formula. If you need more information, you should visit TexasWIC.org or call 800-942-3678 for more information.

If you lost your Lone Star Card in the disaster and need a new one, you should call 1-800-777-7328 (toll-free) for a replacement. You may also be able to buy replacement food you may have lost in the disaster. You will need to file a Form H1855, Affidavit for Nonreceipt or Destroyed Food Stamp Benefits, with your nearest Texas Health and Human Services Office.

Q. 10-12 What if I need extra food stamp assistance?

The Disaster Supplemental Nutrition Assistance Program (D-SNAP) offers short-term food assistance benefits to families recovering from a disaster.

To be eligible, you must—

1. be from a county that has been declared a federal disaster area;
2. have experienced a loss of income, destruction of your home or a disaster-related expense, such as temporary shelter or home repairs;
3. not have been getting regular SNAP food benefits at the time of the disaster; and
4. meet certain income limits.

D-SNAP benefits are issued through the Lone Star card that can be used at most grocery stores. To apply, you should watch for bulletins regarding how and when to apply for D-SNAP, call 877-541-7905 or call 2-1-1 and after picking a language, choose option 2, or visit yourtexasbenefits.com. See https://hhs.texas.gov/services/financial/disaster-assistance for more info.

- If you forgot or your medication or lost it during the evacuation, you can get it replaced, if your pharmacist approves.
- If you are on dialysis and need help finding a provider, call 866.407.ESRD for help.
- Pregnant women, women and girls ages 10 to 55, and men and boys 14 and older can get one bottle of mosquito repellent per month from a participating pharmacy if they are in the following programs:
    - Medicaid
    - Children's Health Insurance Program
    - CHIP-Perinatal
    - Healthy Texas Women
    - Children with Special Health Care Needs Services Program
    - Family Planning Program

https://hhs.texas.gov/about-hhs/communications-events/news/2017/08/hhs-works-approval-emergency-benefits.

Q. 10-13 What happens if I get Medicaid, SNAP, TANF, or SNAP and because of the disaster, I had to change my address or move-in with family?

If you receive any of the above, you must report any change in your address, household makeup, including number of people, or income, to Texas Health and Human Services within ten days of the change. You can report changes online at www.YourTexasBenefits.com or by going to the nearest Texas Health and Human Services Offices and completing Form H1019 or by calling 2-1-1. Make sure when you report the change you keep a log of the date you reported the change, how you reported it and if you spoke with someone, the name of whom you spoke with.

Q. 10-14 How can I get help with funeral assistance if someone I loved died in the disaster?

You should first check and see if he or she had a private life insurance policy. If so, you should file a claim with the life insurance policy and provide the appropriate documentation.

You may also submit a signed statement to FEMA from a licensed medical official that the cause of death was caused by the disaster. You must then also submit estimates of the funeral costs and other funeral assistance, which can be verified by FEMA, and confirmation that the expenses have not been paid for by other resources, such as Social Security or a Veterans Affairs pension.

If you qualify, certain funeral costs may be paid by FEMA through the Other Needs Assistance (ONA) provision of the Individuals' and Households Program (IHP). Costs may include price of a casket, burial plot, monument and/or internment or cremation fees.

If the person who died was a veteran, you may call the Veteran's Administration at 1-800-827-1000 to find out what other benefits might be available.