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Believe It or Not, Sometimes Lawyers *Are* the Good Guys!

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Introduction

The title of this paper reflects the tremendous cynicism faced by all attorneys in this country. If you don't believe that there is a lack of confidence and respect for legal professionals, just ask the average person on the street for their opinion of the attorneys on both sides of the 'O.J. trial'. Lawyers are seldom, if ever, considered by anyone to be the 'good guy'.

However, lawyers are getting some company. Sadly, the cynicism and erosion of confidence long suffered by attorneys is now spilling over to the medical profession. While the providers themselves are not necessarily immune from criticism, the primary focus of public venom is on the 'health care system' in general. There is tremendous frustration concerning health care reform and the inability to legislate appropriate reform measures. In fact, there is little, if any, agreement as to what are the best reform measures. This paralysis and inaction has resulted in skepticism on the part of the general public with respect to the health care 'system' and its ability to provide quality care at an affordable cost.

In short, we, as a medical/legal 'team', working on behalf of our patient/client, face tremendous public pressure, simply based on the nature of our professions. However, we have all chosen to make our collective professional lives even more difficult: we work on behalf of the single most downtrodden group in America (and international society): the morbidly obese person. As a 'recovering' obese person, I can personally attest to the discrimination and hostility directed by the non-obese public toward this segment of society. Discriminating against the obese is the last bastion of socially-acceptable discrimination. It is treated as a character defect rather than a medical condition. This is not likely to change anytime in the near future.

What a formula!:

Lawyers (whom nobody likes)
+ Medical Professionals (with whom everyone is frustrated)
+ Morbidly Obese Persons (who are 'defective' persons unable to care for themselves)
= *A Group Without Any Popular Support!!!*

This formula provides the backdrop, both theoretical and pragmatic, which we all face in trying to do our jobs. And precisely what is that job? Making available a proven and effective treatment of morbid obesity . . . bariatric surgery. What is the single largest obstacle to making that procedure available to those in need? Insurance companies who don't like paying claims in general and specifically despise paying for this type of procedure. Moreover, because of a lack of popular support there is no public outcry against what insurers are doing in this arena.

As a consequence, we must work together against great odds to advocate on behalf of our patient/clients. Nobody else is going to help. And despite this pressure, we all press forward in an effort to get bariatric procedures approved.

The purpose of this paper is to provide information which may assist medical providers and their staffs in getting more procedures approved. These are 'nuts and bolts' which may lead to more insurers accepting coverage in individual cases. However, until public education and international consciousness is raised both about the plight of morbidly obese persons and the efficacy of this treatment modality, it is naive to think that our jobs will get any easier in the foreseeable future.

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As a caveat, this paper is not intended to provide universal 'legal advice' applicable to all cases. While the general concepts discussed conform to the laws in most jurisdictions, consulting a legal professional in your particular state is always preferred when dealing with a specific fact situation.

Nuts and Bolts: Some Basics in Insurance Law

Health insurance policies have become more and more complicated (some would say incomprehensible) over the years. However, for purposes of this discussion, most, if not all, policies contain these essential parts:

1. An 'Insuring Agreement' which defines the scope of coverage;
2. A 'Definitions' section which sets forth the essential terms of the policy;
3. A lengthy section entitled 'Exclusions' or 'Limitations' or such similar designation which defines what the policy will not cover;
4. A 'pre-authorization' protocol; and
5. An 'appeal' procedure for denials.

Of course, policies have many more parts dealing with subjects such as conditions for enrollment, conversion privileges, coordination of benefits, etc. However, while some of these sections may impact the occasional request for bariatric surgery coverage, they are less likely to come into play than items 1–5.

The 'scope of coverage' of health insurance policies is generally not an issue. They specifically cover medical treatment necessitated by 'accident' or 'illness' which takes place during the policy period.

The 'definitions' section of a policy lends itself to greater challenges. There you will find how the insurer defines critical concepts such as 'medical necessity', 'experimental treatment', 'reasonable and customary charges', 'cosmetic' and such other matters. However, insurers will often attempt to define terms in an exclusionary manner. In other words, besides defining the term, it will attempt in one way or another to limit coverage through that definition. Depending on the situation, as will be discussed below, that attempt by the insurer may or may not be valid.

The 'Exclusions' or 'Limitations' portion of the policy often provides the single most substantial hurdle in obtaining approval for bariatric procedures. These Exclusions run the gamut from the extremely clear and succinct to the extremely broad and ambiguous. As discussed below, the better the exclusion is drafted with respect to bariatric surgical procedures, the less likely you will successfully obtain coverage for your patient. Conversely, poorly drafted exclusions, which are quite prevalent, lend hope to your patients that the insurer will be required to provide coverage.

All of you are familiar with the pre-authorization procedures universally required for 'elective procedures', of which bariatric surgery is among.[1] These pre-certification requirements have not only been upheld by courts as being acceptable, they are generally embraced by courts as being positive features in an insurance policy. With pre-authorization comes territory that the insured is almost always unaware of when the policy is first read: the 'secret' guidelines and protocols that govern the acceptance or rejection of various procedures, including bariatric surgery, utilized by the insurer.

Under the guise of determining 'medical necessity', an insurer has the ability to establish guidelines or protocols which govern whether or not specific procedures should be authorized. As a general proposition, this process has also been embraced by the courts. Policies now contain lengthy and complicated definitions of 'medical necessity', which attempt to usurp the decision-making authority from the treating physician and vest it in the insurance company or its designated reviewing entity, physician, utilization review department, etc.

Overcoming the hurdles established by an insurer with respect to bariatric surgical procedures may be the single greatest frustration encountered by both the patient and you as his or her advocate. While courts allow such procedures, it is important to realize that they cannot be utilized with impunity to the detriment of the patient. While a treating physician's determination of 'medical necessity' does not automatically carry the day, an insurer cannot arbitrarily establish a definition of medical necessity solely designed to eliminate otherwise necessary medical treatment or deny a claim. The standards which are established should be no more or less narrow than the prevailing community standard or generally accepted medical practice for that same treatment. While this is a positive in the abstract, there are practical difficulties in applying this concept because of the wide divergence of opinions in the medical community with respect to the propriety and efficacy of bariatric surgery or whether other, less 'drastic' treatments are more appropriate.

[1] In addition, most policies also allow for 'retrospective review' of a procedure which has already been performed. However, this is rarely an occurrence with bariatric procedures, since almost all providers known to this author secure affirmation or denial of coverage prior to scheduling a surgery date and performing the procedure.

Lastly, you should also be cognizant of the various 'appeal' procedures which a patient confronts in the event a requested procedure is denied. These procedures, and the impact your work can have on their success or failure, are of critical importance to your patient's success in overturning an erroneous or unreasonable denial of benefits. Moreover, there are also time constraints often spelled out in the policies which are generally enforceable. Accordingly, to the extent you are able, you should not let a patient 'sit on his/her rights' with respect to pursuing an appeal. It is also at this critical stage, if not earlier if you sense a declination is forthcoming, that the advice of counsel should be sought by the patient. '. . . sometimes lawyers *are* the good guys . . .', remember?

'Advanced' Insurance Law: Some Ammunition for the Fight

There are some legal concepts which may assist you in dealing with insurance companies on behalf of your patients. First, insurance policies are generally considered 'adhesion' contracts. That simply means that they are form contracts written by one party (the insurance company) which possesses *substantially* greater bargaining power than the other party (the insured). Only the insurer *really* knows what is contained in its policy.[2] As such, certain general rules apply to interpreting these contracts which may help you get approvals.

A. Exclusions Are Strictly Construed Against the Insurance Company

As a general proposition, courts require that an insurance company draft its exclusions clearly, conspicuously and unambiguously. Because the insurance company drafts the contract, it is generally held responsible to provide coverage for the insured if the contract is not clear or is otherwise ambiguous. While such a doctrine (the 'contra-insurer' rule) is not universally applied,[3] if you believe that a particular exclusion is not clear or is reasonably susceptible to two or more meanings (the generally-accepted legal definition of 'ambiguous'), you and your patient have a basis to fight application for that exclusion.

Let's illustrate with an example. Assume your patient has a policy with the following Exclusion (taken from an actual insurance policy):

> In general, the [company name] Medical Plan does not pay for the following procedures and services.
>
> **Specific procedures and equipment not covered**
> - **Weight Control** medicines, tests, exams, plans, and programs

The question most of you will appropriately ask is: 'Does our procedure fall within this exclusionary language?' The answer you will all likely reach is a resounding 'NO!!!' The surgical treatment of the **disease** of morbid obesity is *not* a 'weight control' program similar to Weight Watchers, Jenny Craig, or the other commercial diet outfits. Accordingly, you and your patient have a contractual basis upon which to fight any denial based on this type of exclusion. You can argue that it is 'ambiguous'.

The language quoted above is, in this author's opinion, reasonably susceptible to two meanings: (1) a denial of benefits for all weight-related treatment, including bariatric surgery (the position advanced by the insurer); or (2) a denial of payment for an insured's attempt to lose small to medium amounts of weight under the supervision (with the concurrent expense) of one of the commercial ventures outlined above. These two reasonable interpretations of the language render the exclusion 'ambiguous'. In most jurisdictions, the insurer will be held to provide coverage because it was responsible for drafting the policy language. However, it is important to remember that the alternative interpretations of the language must be 'reasonable'. Courts will generally not find an ambiguity if the interpretation offered by the insured is strained, or patently unreasonable.

It is also important to remember that 'ambiguity' is not solely found in the wording of the language at issue itself. The *context* of the offending language, when reading the policy as a whole, may create an ambiguity. There may be times where the wording of the coverage provisions, definitions and certain exclusions, when read together, conflict in some way so as to render the impact of any particular policy term or provision unclear. This circumstance can also lead to a finding of 'ambiguity'.

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[2]In fact, you may be surprised to know that many times the insured/patient never gets the actual 'policy'. In the context of group insurance policies obtained as a benefit of employment, which is the way most people obtain their insurance coverage, the 'master policy' is retained by the employer and the insurer. The employee receives a coverage 'certificate' which summarizes, often incompletely or inaccurately, the benefits contained in the policy. Discrepancies often exist between the 'policy' and the 'certificate', which can often lead to confusion when a denial is being challenged.

[3]For instance, my home state of California and its Supreme Court has recently adopted a fairly onerous set of rules governing the interpretation of insurance contracts which has several steps which must be followed before invoking the 'contra-insurer' rule, but many jurisdictions start and end with that analysis which is, in my opinion, much more beneficial to policyholders.

In the cases involving bariatric surgery, this may prove to be a powerful tool to fight an otherwise well-drafted exclusion eliminating such procedures.[4] In that instance, you may wish to carefully determine whether other physical conditions which that patient has (e.g., hypertension, sleep apnea, diabetes, depression, arthritis, etc.) directly benefit from the treatment of the underlying condition of obesity. In such cases, you can 'build' a case for coverage based not on the treatment *solely* for morbid obesity, but also as treatment for the related 'co-morbid' conditions.

B. Policy Language Must Be Conspicuous, Plain and Clear

A separate, but related concept, is whether the language is 'conspicuous, plain and clear'. 'Plain and clear' means that is must be *understandable to a lay reader.* This can arise in several different contexts. In our hypothetical example recited above, the exclusion does not specifically address the *medical condition* known as 'morbid obesity'. At present, the concept of 'morbid obesity' is not new, nor is the concept of surgical intervention to treat this condition. As the argument goes, if excluding treatment for 'morbid obesity' is what the insurer intended, that is what the insurer should have *plainly and clearly stated.* Since that was not stated, and it could have been stated that way, the patient should win.

The other issue is whether the language is 'conspicuous'. As stated earlier, insurers often attempt to 'bury' exclusionary language under the guise of a 'definition' or place limiting provisions in other parts of the policy. Courts have held that this may not be a valid limitation on coverage. Unless the exclusionary language is 'conspicuous', meaning that the insured's attention is likely to be drawn to that particular limiting provision, the language may not be relied upon by the insurer. Examples include:

- Not including it in the 'Exclusions' portion of the policy;
- Burying it in a 'General Limitations' section with dense, hard to read print;
- Placing the 'exclusion' in the 'Covered Services' portion of the policy.

[4]Aggressive health insurers are re-defining the scope of their exclusions to eliminate coverage for the 'surgical treatment of morbid obesity'. These are by far the toughest cases which practitioners, both legal and medical, face in this environment. However, dissecting the language of the policy *as a whole* may assist in finding other conditions for which the surgery is a proven benefit.

If you face an insurer attempting to deny coverage, be sure to get the whole policy to determine where the language is in the policy being relied upon by the insurer. If it is not 'conspicuous' or 'plain and clear', you have arguments to present which may sway the insurer toward saying 'yes' instead of 'no'.

C. Clarity in Language Usage is Your Patient's Greatest Ally

The best weapon that patients have against insurance companies is the use of *language* with respect to 'morbid obesity'. However, that also requires you as the patient advocate to be equally careful about your own use of language when dealing with both your patients and their insurers. Because insurance contracts are 'adhesion' contracts, the insurer, as stated before, is generally 'stuck' with the language it drafted. If the insurer was not as precise as it should have been in its usage of that language, you should use that lack of precision as a sword in your fight for coverage. However, be sure to use it as a shield as well.

For example, we all loosely refer to patients as 'obese' when we usually mean 'morbidly obese' or suffering from 'clinically severe obesity'. However, we all know that these are two different conditions with vastly different health consequences.

It is important that we all be careful in our use of medical 'terms of art' if we are to hold the insurance industry accountable for its failure to do so. For instance, be sure to utilize the appropriate diagnosis codes for 'morbid obesity' rather than just 'obesity'. This assists you when confronting an exclusion related to 'obesity' (i.e. >20% over ideal body weight) as opposed to an exclusion for 'morbid obesity' (i.e. >100 lb over ideal body weight or 200% of ideal body weight). Again, if the insurer intended to exclude treatment for 'morbid obesity', an exclusion related solely to 'obesity' may not do the trick.

And Now For the Bad News . . .

We all know that the practice of medicine is changing rapidly. 'Managed (or is it 'mismanaged') care' continues to plague providers of medical services, with insurance companies controlling, in part, how medicine is practiced based on their holding the purse strings. Under the guise of 'cost control', insurers are vested with tremendous power in denying clearly covered benefits, often unreasonably. Not so rhetorically we all ask: how can they get away with it?!?

There is a simple answer: **ERISA**. Let me explain.

In the United States, employee benefit plans are exclusively controlled by a massive, often incomprehensible, federal statute called the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. §§ 1001–1461). In 1987, the United States Supreme Court rendered a decision called *Pilot Life Ins. Co. V. Dedeaux* (1987) 481 U.S. 41. In that decision, one of the most broadly sweeping and anti-consumer opinions in the history of the high court, it was determined that ERISA 'preempts' all state laws with respect to employee benefit programs, which includes group health policies. What does that mean? Many of you are familiar with the term 'bad faith' with respect to insurance companies denying claims. If they act unreasonably, they can be held liable for damages, possibly even punitive damages if their conduct is reprehensible enough in the handling of a given claim. However, since *Pilot Life*, policyholders no longer have a 'bad faith hammer' to hit an insurance company over the head. That decision states that ERISA governs all rights and remedies in the group health context. Those remedies do not include damages for bad faith or punitive damages. In short, under ERISA, the only thing you can get are the benefits due to you. Sometimes you can get your attorney's fees. That's it.

How does this impact you everyday? Most of your patients have obtained their insurance as a benefit of their employment. That means that their rights against the insurance company are strictly limited. Insurers know this and therefore act much more unreasonably in claims handling, knowing that the most that they can be held accountable for are the benefits themselves. They face little other exposure. Insurers know many patients won't contest a denial of benefits. They just go away. Insurers also know that attorneys are less likely to become involved in ERISA cases because there isn't the specter of large damage awards to making handling the case on a contingent fee basis worthwhile to either the patient/client or the lawyer. So insurers become tenacious in denying valid claims, knowing that they can't be held accountable. That's the primary reason why we have the difficulties we do in getting these procedures approved.

To enhance your chances of successfully getting procedures approved, be aware that you have much more leverage if the patient has an 'individual' policy purchased by his or her self rather than an employment-provided policy. Those patients retain their 'bad faith' rights, to the extent such rights exist in your individual jurisdictions, and thus you have a better chance of swaying an insurer to provide coverage. Alternatively, your patient has a better chance of securing the services of counsel to represent him or her against the insurance company in the event of an unreasonable denial of a claim for benefits. These are the cases to push as hard as you can. They pose your best chance of success.

What Can You Do To Help Your Patient's Lawyer?

In handling any type of medical claim, especially bariatric surgical procedures, the provider and the lawyer are, or should be, close partners in reaching the ultimate goal of getting the patient the surgery needed. You can help in a number of ways.

1. Documentation: Document all your dealings with the insurance company. Attempt to confirm important telephone conversations in writing. Keep notes of all your conversations. If you feel your patient's claim is being handled unjustly, use words like 'unreasonable', 'arbitrary', 'indifferent', and 'contrary to the patient's reasonable expectations' in your correspondence. These are 'magic' words in the realm of insurance coverage and may assist the lawyer in proving the case years later when you cannot recall what was said or how you felt.
2. Keep the patient informed: It is critical that the patient be aware of your dealings with the insurer. Sometimes patients have access to other resources which can get an insurer to change its mind. Unions have liaisons which interact directly with carriers; large employers often have the same thing. Use whatever resources are available. The insurance industry is a powerful monolith carrying most of the ammunition; fight back with whatever is available. Most importantly, don't be afraid to share the 'bad news' with your patients. Don't paint too rosy a picture . . . yet still give them hope. Remember, your patient is extraordinarily fragile and the insurance company is counting on the fact that the vast majority of patients aren't willing to put up a fight.
3. Be complete: As discussed above, include all of the patient's relevant medical history. Educate the attorney about your surgical procedures. Provide data, if available, showing the efficacy of the treatment. Don't expect the attorney to know everything about the medical aspects of the case; educate them.
4. Secure the support and involvement of your physicians: Get the doctor to speak to the lawyer. You and the doctors should be open and available to testify at any hearings relative to court proceedings or appeal procedures.
5. Provide comparison data: Most, if not all of you, have insurers that 'routinely' approve procedures and others that never do. Make the attorney

aware of who is saying 'yes' and who is saying 'no'. He or she may be able to establish a pattern of practice against particular insurers which could lend vital assistance to the success of any individual claim.

While all of this may be common sense, it is vitally important to the success of any lawyer in handling an appeal or litigation against the insurer. Besides the patient, you are the key witnesses to conduct which is likely to be at best unreasonable and, at worst, reprehensible, discriminatory and evil.

Conclusion

We have selected a profession fraught with challenges. We have an industry as an opponent with virtually unlimited resources. We have an unpopular cause . . . remember that the perception of the public and much of the legal and medical professions is that fat people are flawed and just need to push away from the table and walk around the block 3 times a week and everything will be alright. We know that that is not the case. It is our job to advocate on behalf of our clients and patients. We are the front-line troops battling an evil and insidious disease which robs people of their spirit and their dignity. Don't ever lose sight of the good that comes out of each approval you obtain . . . lives are changed in ways you can never fully appreciate unless you've been there. The job, although difficult, is rewarding. Hopefully this paper provides each of you with additional ammunition in the fight to get just one more approval than you otherwise might have. If that happens, something glorious has occurred.

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Editor's Note

Walter Lindstrom, Jr established the Obesity Law and Advocacy Center. He has practiced law for over 9 years in the area of insurance coverage and litigation. His experience includes prosecuting and defending declaratory relief and bad faith cases, preparing coverage opinions on behalf of both insurers and policyholders, and generally advising individuals and businesses with respect to all areas of insurance law. He has also lectured on various insurance-related topics to other attorneys and insurance industry professionals. Mr Lindstrom was admitted to the state bar of California in 1987 and was admitted to practice in the state of Arizona in 1995.

Mr Lindstrom graduated *Cum Laude* from the University of San Diego School of Law in December 1986, where he participated in a number of extracurricular activities, concentrating primarily on advocacy and moot court competitions. He won 'Best Brief' and 'Best Oralist' in the 1985 USD Law & Motion competition. He received his undergraduate degree in both Philosophy and History from Loyola Marymount University, again with *Cum Laude* honors.

Walter brings a unique perspective to his representation of morbidly obese persons. A divided gastric bypass (Roux-en Y) has helped him to lose 160 + lb over the last 2 years. He carries an empathy and passion to his representation that no other lawyer can share with regard to a morbidly obese client. His personal battle to obtain insurance coverage for his treatment, combined with his extensive experience as an insurance law expert, make him a passionate advocate for those persons suffering from the extreme and debilitating disease of 'morbid obesity'. He is the first attorney member of the ASBS and has been appointed to the ASBS Insurance Committee.