APPEAL TRAINING
COURSE 11

ERISA STRATEGIES

COURSE
HANDOUT

AppealTraining.com

ERISA

The Employee Retirement Income Security Act of 1974, also known as ERISA, is a federal law applicable to most employee benefit plans, excluding state and federal employees and religious organizations. In passing ERISA, Congress established federal jurisdiction over benefit plans so that companies operating in multiple states could avoid the undue burden of keeping abreast of the state-by-state variations in insurance regulations. ERISA allows companies to develop employee benefit plans through private insurers, develop self-insured plans, and/or customize their benefit packages to suit their specific needs. Because these benefit plans are exempt from certain insurance laws and state regulations, costly state coverage mandates do not apply to the benefit design. Medical providers attempting to cite state insurance mandates and consumer protections in group health plan appeals, and even in subsequent litigation, find their efforts thwarted by both the ERISA exemptions and the ERISA standing to sue requirements which allow only qualified parties, usually a plan beneficiary, to bring suit. The Oklahoma Supreme Court observed the following about this aspect of the federal legislation that affects millions of insured Americans:

> [ERISA] contains one of the broadest preemption clauses ever enacted by Congress. ERISA provisions supersede any and all state laws insofar as they now or hereafter relate to any employee benefit plan. Congress has expressed an exclusive federal interest in regulating employee benefit plans. The breadth of ERISA's preemption clause often results in plan beneficiaries or participants being left without a meaningful remedy. (Source: *Felix v. Lucent Technologies, Inc.*, 2007 OK Civ. App 33; 157 P.3d 769)

The court's reference to the lack of "meaningful remedy" under ERISA reflects the limited damages that can be sought by beneficiaries or providers bringing suit against an ERISA plan. State courts often have the option of leveling punitive damages against insurance companies for failure to pay claims according to state law. In particular, states that recognize "*bad faith*" in claim processing, a term meant to describe intentionally misleading or dishonest practices, might allow for treble damages in addition to claim payment. ERISA, by contrast, limits damages to the amount of the denied benefit. Although legal fees and lack of disclosure penalties can increase the judgment against a carrier, punitive damages are expressly prohibited.

A number of ERISA critics have raised concerns that the absence of punitive damages and penalties discourages litigation. Many health law experts point out that the potential for punitive damages deters insurance carriers from abusing the authority they have over claim processing. Without any such deterrent, carriers can unjustly deny claims, knowing that their liability for such poor decision-making is limited to the amount of the benefit in question. Furthermore, the ERISA protections extend to the appeal process itself. Any medical professional who has ever cited the state's prompt payment law, a mandatory coverage requirement, or newly passed state managed care reform in a group health plan appeal has often heard the following: "We don't have to abide by state law. We're under ERISA jurisdiction." Sometimes no response is provided at all because ERISA recognizes the provider's rights to appeal only in claims involving urgent care.

As a result of these issues, ERISA has been identified as the source of widespread irregularities in claim processing. Among healthcare billing professionals, ERISA became associated with several distinct reimbursement challenges including unanticipated limitations and exclusions, slow payment, and, most insidiously, heavily restricted access to remedies in the event of nonpayment.

Disclosure requirements and benefit claims procedure regulation

The one clear protection that medical providers have underutilized is the **ERISA disclosure requirement**. Because Congress allowed for broad flexibility in benefit design, strict protections were included to require employers to disseminate clear information on available benefits in the form of a **Summary Plan Description (SPD)** and to respond promptly to requests for benefit clarification. U.S. Code title 29, Chapter 18, Subchapter I requires the plan fiduciary to provide an SPD to each participant.

Providers' and beneficiaries' rights were extended even further under the 2002 ERISA **benefit claims procedure regulation**. Understanding how these two protections—ERISA disclosure requirements and the benefit claims procedure regulation—can assist providers with securing detailed claim information and fair reimbursement from ERISA employee benefit plans.

ERISA disclosure requirements

ERISA benefit plans must operate according to a written plan and the terms of the benefits must be communicated to beneficiaries in the SPD. The SPD is defined by the U.S. Department of Labor health benefits advisor as "an important document that the plan administrator must automatically provide to

participants [that] explains what coverage the plan offers, how the plan must operate and the rights and responsibilities of participants and beneficiaries. [An] SPD also must be given to participants and beneficiaries upon request." (Source: *www.dol.gov/elaws/ebsa/health/glossary.htm?wd=Summary_Plan_Description*)

To ensure compliance with the required disclosure of the SPD when requested, ERISA 502 (29 U.S.C. 1132) provides for a penalty of up to $110 per day when a participant requests an SPD and is not provided with the document within 30 days of the request. Further, the SPD must contain a number of items of particular interest to providers, including the following:

- Assignment provisions. Providers' ability to pursue litigation can be affected by an anti-assignment clause in the SPD.
- Benefit information including Newborns' and Mothers' Health Protection Act of 1996, Women's Health and Cancer Rights Act, and U.S. Mental Health Parity Act mandatory coverage notices.
- Preexisting condition exclusions/limitations.
- Procedures governing submitting claims and appeals.
- Name, address, and business telephone number of the plan administration. The plan administrator often has final authority over benefit decisions and would also be able to provide information regarding whether an appeal committee has been established to review appeals not resolved at the carrier level.

If these details are not spelled out in easy-to-understand terms or if your claims do not appear to have been processed according to the benefit availability described in the SPD, subsequent appeals can reference information directly from the SPD. This can be very effective because the employer or carrier has a fiduciary duty to process claims according to the SPD terms. Further, carriers may not be aware of the exact information in the SPD and may be processing claims according to their own processes and procedures. According to Attorney Joseph Lazzarotti in the article "ERISA Basics—What Is a Summary Plan Description?", SPDs do not always include the required benefit information:

> "A significant area of non-compliance with the summary plan description content requirements is with group insurance plans, e.g., group health, life and long-term

> disability insurance arrangements. While much of the information described above is included in the certificates of insurance or other benefit booklets that plan sponsors obtain from their carrier, there is often a gap between what is communicated in those certificates/booklets to employees that are covered under such plans and what ERISA and other laws require to be communicated. It is likely that this gap exists for a number of reasons, including the fact that insurance companies prepare their documents to comply with state insurance laws, and, when issuing insurance, are not acting as plan sponsors subject to the disclosure requirements under ERISA."
> (Source: *www.jacksonlewis.com/articles/1005_Bender.pdf*)

Failure to include the required information can make it difficult for a plan to defend denials. For example, if a claim is denied as preexisting but no preexisting limitation or exclusions are named in the SPD, the court can rule that the plan was ambiguous and, as such, cannot enforce a provision not clearly included in the SPD. Obtaining the SPD will allow the provider to review the plan for any deficiencies potentially affecting the claim. Furthermore, appeals can provide a description of any potentially applicable deficiencies in an attempt to obtain claim payment in accordance with the actual language of the controlling document.

How to use ERISA to get accurate information during Verification Of Benefits

Chapter 2 discussed using a Pretreatment Disclosure Request to ensure that accurate, complete coverage information is obtained prior to treatment. Often it is crucial to cite regulatory information in order to obtain the detailed information requested. Such requests are even more effective if there is a potential for sanctions to be assessed against noncompliant carriers.

ERISA disclosure requirements are among the most stringent due to the $110-per-day fine which can be assessed by federal courts against noncompliant employee benefit plans. It is therefore important to cite this sanction when requesting disclosure from a carrier administering an ERISA employee benefit plan. Although employees and named beneficiaries have typically been awarded such fines after ERISA violations, the courts have awarded fines to third-party assignees who have successfully established beneficiary status by presenting a valid ERISA-compliant assignment of benefits during litigation.

Sample Letter W, "Pretreatment Request for Summary Plan Description," is a Pretreatment Disclosure Request for requesting information regarding an ERISA employee benefit plan. It clarifies the provider's rights as a third-party assignee and references the ERISA penalty for disclosure violations. This letter can be substituted for Sample Letter A, "Pretreatment Request for Benefit Disclosure," when dealing with group health benefit plans that fall under ERISA.

ERISA claims procedure regulation

The U.S. Department of Labor published the ERISA claims procedure regulation in November 2000. The regulations, which went into full effect January 1, 2003, set new, shorter time frames, additional disclosure requirements, and new standards for making claim decisions on group health plans. Applicable time frames to medical claims are explained at the U.S. Department of Labor's "How to File a Health Claim" instruction page:

- **Urgent care claims** must be decided as soon as possible, taking into account the medical needs of the patient, but no later than *72 hours* after the plan receives the claim. The plan must tell you within 24 hours if more information is needed; you will have no less than 48 hours to respond. Then the plan must decide the claim within 48 hours after the missing information is supplied or the time to supply it has elapsed. The plan cannot extend the time to make the initial decision without your consent. The plan must give you notice that your claim has been granted or denied before the end of the time allotted for the decision. The plan can notify you orally of the benefit determination as long as a written notification is furnished to you no later than three days after the oral notification.

- **Preservice claims** must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than *15 days* after the plan has received the claim. The plan may extend the time period up to an additional 15 days if, for reasons beyond the plan's control, the decision cannot be made within the first 15 days. The plan administrator must notify you prior to the expiration of the first 15-day period, explaining the reason for the delay, requesting any additional information, and advising you when the plan expects to make the decision. If more information is requested, you have at least 45 days to supply it.

The plan then must decide the claim no later than 15 days after you supply the additional information or after the period of time allowed to supply it ends, whichever comes first. If the plan wants more time, the plan needs your consent. The plan must give you written notice that your claim has been granted or denied before the end of the time allotted for the decision.

- **Post-service health claims** must be decided within a reasonable period of time, but not later than *30 days* after the plan has received the claim. If, because of reasons beyond the plan's control, more time is needed to review your request, the plan may extend the time period up to an additional 15 days. However, the plan administrator has to let you know before the end of the first 30-day period, explaining the reason for the delay, requesting any additional information needed, and advising you when a final decision is expected. If more information is requested, you have at least 45 days to supply it. The claim then must be decided no later than 15 days after you supply the additional information or the period of time given by the plan to do so ends, whichever comes first. The plan needs your consent if it wants more time after its first extension. The plan must give you notice that your claim has been denied in whole or in part (paying less than 100% of the claim) before the end of the time allotted for the decision.

(Source: *www.dol.gov/ebsa/publications/filingbenefitsclaim.html*)

These protections can be cited in both preservice and post-service appeals in order to demand full, timely disclosure of the denial basis. See Sample Appeal Letter X, "Lack of Precertification of ERISA Urgent Care Claims." Further, the regulations are available online at *www.dol.gov/dol/allcfr/ebsa/Title_29/Part_2560/29CFR2560.503-1.htm* and you should read them in their entirety to better understand how the time frame mentioned may be applied and how the disclosure and expert review requirements are worded.

How to use ERISA claims procedure regulation to get a full and fair appeal review

As discussed in earlier chapters, claim denials expose many areas of disagreement among all involved parties regarding what should be covered under a health plan and what should not. Because of the

diverse and meaningful arguments on both sides, courts often look at carriers processes for reaching decision in an effort to determine if a fair coverage decision has been reached.

Under the ERISA claim procedure regulation, a claim must be decided anew upon appeal. The fact that a denial was reached by prior reviewers is to have no weight in appeal review. Further, states that an appeal of an adverse benefit determination must provide "full and fair review." Full and fair review is defined by the regulation to include the following:

> ... (iv) provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination...

The regulations also specify that the information submitted be reviewed by an appropriate named fiduciary who did not make the initial adverse determination (and is not the subordinate of the individual who made that determination). In addition, if the appeal involves medical judgment, including a determination of medical necessity or whether a procedure is experimental, the regulations require the fiduciary on review to consult with an independent health professional with the appropriate training and experience and the professionals consulted in connection with an adverse benefit determination must be identified.

Your appeal letters can demand that the insurance carrier confirm compliance with these requirements. Further, if you are submitting voluminous medical information to support the treatment and suspect that it was not carefully reviewed as required, you can demand that the appeal response directly respond to the information in a point-by-point manner so that there is some assurance that the submitted information was reviewed as required by the full and fair review specifications.

The Department of Labor has posted extensive interpretive information about the regulation at **http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html** and the regulation can be accessed at **www.dol.gov/dol/allcfr/ebsa/Title_29/Part_2560/29CFR2560.503-1.htm.**

Contract Renegotiation

The main difficulty in citing ERISA protections in provider appeals is that carriers will routinely state that the protections apply to the beneficiary, not the provider. While providers can secure protection under many ERISA plans by obtaining an assignment of benefits, getting the carrier to fully recognize

your rights as an assignee is a time consuming process.

A source of confusion is that carriers routinely look at managed care contractual agreements as the primary source of their obligation to the provider. Providers will likely find carriers much more compliant with the claim processing protections which are specifically enumerated in the managed care contract. Therefore, next time the contract is up for negotiation, review the contractual protections related to the providers rights to denial disclosure, full and fair claim and appeal review and penalty for failure to provide requested benefit information and timely precertifications. If no protection or inadequate, ambiguous terms are used to reference these items, you can use the ERISA regulation as the basis for attempting to negotiate more clear protections which arguable the carrier should be providing anyway on ERISA claims.

Your negotiation tactic should center on the fact that the ERISA law and regulation are meant to protect beneficiaries and assure quality decision-making. Because it is a federal mandate, it would be more widely applicable than trying to get the carrier to incorporate state consumer protections. Further, the point can be explained that the ERISA regulation may be applicable to any provider that obtains assignment. The contract just clarifies and formalizes the duties of the carrier.

Tracking ERISA claim processing violations on a per-carrier basis can be very helpful during contract renegotiations. Contract negotiation meetings are an excellent time to explain your need for disclosure of benefit information and to negotiate for contract protections and penalties that mimic those specifically extended to beneficiaries. An ERISA Benefit Claims Processing Compliance Report, such as the one shown in Table 10.1, lists various types of disclosure requests which may be made and the applicable time frames for carrier response. Different types of requests have different deadlines depending on whether the disclosure request relates to an urgent care claim, a preservice claim, or a post-service claim. The time frames listed beneath each notification type list deadlines specific to urgent care, preservice claims, and post-service claims, in that order. For example, under the Notification Type “Untimely Initial Determination,” the applicable deadlines are “Beyond 72 hours/15-day/30-day deadline,” which means plans must provide a written, initial determination for urgent care claims in 72 hours, for preservice claims in 15 days, or for post-service claims within 30 days.

ERISA Benefit Claim Processing Compliance Report

Carrier:

Date Span:

Notification Type	**Urgent Care Claims**	**Pre-service Claims**	**Post-Service Claims**
Request for Summary Plan Description (Beyond 30 days)			
Untimely Initial Determinations (Beyond 72 hours/15-day/30-day deadline)			
Untimely Notification of Improperly Filed Claims (Beyond 24 hours/5-day/30-day deadline)			
Untimely Appeal Decisions (Beyond 72 hours/30-day/60-day deadline)			

ERISA benefit assignability

As discussed in Chapter 1, two frequently asked questions, FAQs B-2 and B-3, address limitations providers face under the regulation. Specifically, FAQ B-2 states that "*Typically*, assignments are not a grant of authority to act on a claimant's behalf in pursuing and appealing a benefit determination under a plan [emphasis added]." However, assignments can more clearly spell out a provider's rights to pursue appeals and even litigate on behalf of the patient/beneficiary. Although no standard assignment of benefits wording is recognized by case law, an Illinois federal judge ruled an assignment of benefits valid based on confirmation of the following:

- The assignment form contained the words "Assignment of Benefits"
- The assignment form stipulated that the patient would be liable only for amounts not paid

by the insurer

- The provider specifically alleged in litigation that the assignment was in consideration for medical services

(Source: *Surgicore, Inc. v. Principal Life Insurance Co.*, No. 01-C-9387, N.D. Ill., Eastern Div.; 2002 U.S. Dist. LEXIS 9122)

Some SPDs specifically state that the health benefits are not assignable. Such limitations can be very damaging to provider rights because they may limit the provider's ability to claim the right to disclosure of denial detail, pursue appeals, or litigate as an assignee. Insurance carriers have a legal obligation to divulge the anti-assignment provisions and any failure to disclose anti-assignment provisions may compromise a carrier's ability to rely on such provisions in claims processing and any subsequent litigation. Therefore, carriers that cite anti-assignment provisions in denial letters should be willing to cite the exact wording of such provisions and where it is located in the SPD.

If your appeals or disclosure requests are being denied due to anti-assignment provisions, your first action should be to request and review the exact wording of the anti-assignment provisions. The U.S. District Court for the District of Arizona ignored an anti-assignment clause in an ERISA employee benefit plan because it was "hidden" in unrelated terms. In *Schaum v. Honeywell Retiree Medical Plan Number 507* (D. Ariz.; 2006), the court found that the restrictions on assignment appeared in a section titled "ERISA" and in the subsection "Plan Administration." Because the anti-assignment provisions were not located near the benefit description section, they were ruled invalid.

Another limitation to carriers' reliance on such provisions is whether state assignment laws are applicable. Many state laws prohibit anti-assignment provisions. The effect of these laws is in question in many states because of the broad exemption ERISA plans have from state laws. However, the U.S. Court of Appeals for the 5th Circuit upheld the Louisiana anti-assignment in a critical judgment against Blue Cross Blue Shield's (BCBS's) efforts to pay members directly for out-of-network care. The BCBS practice of mailing direct payment of out-of-network benefits to patients instead of to assignment-holding providers was found to be a violation of Louisiana law in 2006.

BCBS has been on the forefront of an insurance industry strategy of using anti-assignment provisions to force medical providers to become in-network providers. Such provisions restrict direct payment of

benefits to only patients and in-network providers.

The Louisiana Department of Insurance determined that BCBS was in violation of the Louisiana Assignment Statute and enlisted the Louisiana Attorney General for enforcement assistance. Once advised of the state's position regarding applicability of the law, BCBS responded with a federal lawsuit claiming that the state law was preempted under ERISA's preemption rule.

The U.S. Court of Appeals for the 5th Circuit ruled that the Louisiana law was not preempted by ERISA, paving the way for medical providers in Louisiana, Mississippi, and Texas to seek payment for out-of-network claims erroneously mailed to patients in violation of state assignment protections. This ruling applies to insurance carriers and not self-funded ERISA plans.

References

Department of Labor Health Benefits Advisor, Summary Plan Description, *www.dol.gov/elaws/ebsa/health/glossary.htm?wd=Summary_Plan_Description*.

Lazzarotti, J. "ERISA Basics—What Is a Summary Plan Description?", *www.jacksonlewis.com/articles/1005_Bender.pdf*.

Schaum v. Honeywell Retiree Medical Plan Number 507, D. Ariz.; 2006.

Surgicore, Inc. v. Principal Life Insurance Co., No. 01-C-9387, N.D. Ill., Eastern Div.; 2002 U.S. Dist. LEXIS 9122.