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## QUICK TIPS:

- Have patient sign Assignment of Benefits before treatment.
- Obtain ERISA rights to become an authorized representative to act on a claimant's behalf in pursuing and appealing a benefit determination under a plan.
- Send appeals and information via certified mail, so that time guidelines can be accurately monitored.
- Notify patient and employer that handling of claim is not consistent with ERISA standards.
- If plan accessed PPO network for discount, review contract for any mandatory provisions.

\*This Material is provided for informational purposes only, and should not be construed as legal advice on any matter.\*

## In General:

The Employee Retirement Income Security Act of 1974 (ERISA) establishes federal standards for benefits offered through private-sector employers. While the original intent of ERISA was to protect the pension benefits of private-sector employees, it now also regulates health benefit plans offered by private-sector employers.

In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws. However, since most Americans obtain health insurance through their employer, the vast majority of health plans in America can be considered ERISA plans.

An "employee welfare benefit plan" that falls under ERISA may be broadly defined as a plan, fund or program that is established or maintained by an employer or an employee organization; for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital care, or benefits in the event of sickness, accident, disability, death or unemployment or vacation benefits, apprenticeship or other training programs or day care centers, scholarship funds or prepaid legal services.

*An employer has not "established or maintained" an ERISA-covered plan if "the sole functions of the employer are, without endorsing the program, to permit an insurer to publicize a program to employees, to collect premiums through payroll deductions, and to remit the premiums to the insurer, and the employer does not contribute premiums to the insurer or make a profit from the program." Donovan v. Dillingham, 688 F.2d*

## Self-funded Vs. Fully-Insured:

There are two general categories into which an "employee welfare benefit plan" can be divided: **self-funded or fully-insured**. The distinction between the two categories is very important, as it may determine whether the plan will be subject to state insurance laws, or whether state law will be pre-empted by ERISA.

**Self-funded Health Plans** – Health costs incurred under self-funded plans are reimbursed directly by the employer (even if the plan is administered by an insurance company). Self-funded health plans are regulated solely by the U.S. Department of Labor under ERISA, and as such, are exempt from state insurance laws.

**Fully-insured Health Plans** – Under a fully-insured health plan, an employer purchases insurance to cover health costs. Fully-insured health plans are subject to state insurance laws and regulations.\*

\* The regulatory distinction between self-funded and fully-insured plans does not apply to the remedies available to ERISA plan participants who have been denied benefits or payments. In this area, the available remedial measures must comply with ERISA standards.

## Disputing an ERISA Denial:

When disputing or questioning the denial of a claim by an ERISA health plan, the first step should be determining if the plan is self-funded or fully-insured. If fully-insured, the plan should comply with the applicable state laws regarding the processing of health claims. If the plan is self-funded, a provider disputing a denied claim should follow these additional steps:

1. **Written information request** – After receiving notice of a claim’s denial, the provider of service should immediately respond with a letter requesting the exact reason for the denial, any documentation which supports the denial, and the appeal process utilized by the plan to overturn denials.  
  
The plan must also provide, if requested, a copy of the Summary Plan Description (SPD). The SPD outlines the patient’s rights under ERISA and provides a description of the benefits offered under the plan. If the plan fails to provide a copy of the SPD or additional requested documentation within 30 days, the provider may avoid the administrative appeals process altogether, and proceed directly to court, if warranted.
2. **Appeal** – Submit timely appeals. Supporting documentation, such as medical records, itemized statements, invoices, etc., should be sent with appeal. It is advisable to send this information via certified mail, to both the plan administrator and the third party administrator.
3. **Notify Department of Labor** – If a plan is not complying with ERISA claim handling guidelines, notify the Department of Labor (DOL). If it is found that a plan has breached their fiduciary responsibility, the DOL is permitted to levy penalties against the plan.
4. **Litigation** – If necessary, once the administrative appeals process has been exhausted, it is possible to file a lawsuit to overturn the denial. A court will only review the administrative record as it existed at time of billing and appeal – underscoring the importance of submitting all relevant documentation during the appeals process.

## ERISA Timeliness Requirements:

Claims handling guidelines for Group Health Plans (post-service):

- Plan has 30 days from the date of the claim to issue benefit decision; plan may seek a 15 day extension, for reasons beyond its control, if it notifies the claimant of the need for the extension before the end of the 15 days.
- Claimant has 45 days from the date of notice to forward requested documentation.
- Claimant has 180 days from notice of adverse determination to appeal claim denial.
- Plan must issue decision on first appeal within 60 days and second appeal within 30 days

## ERISA Determinations - Review Standards:

- Courts give deference to a plan administrator’s determination regarding benefits.
- The court will only overturn a plan administrator’s determination if it is found to be **arbitrary and capricious**.
- The above standard (arbitrary and capricious) will not apply if a plan fails to comply with ERISA claim handling guidelines, and as a result, the court is free to review the claim as if a determination had never been made by the plan administrator.