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## **UNDERSTANDING ERISA**

### **MAXIMAL REIMBURSEMENT THROUGH COMPLIANCE**

### **Beyond and Above Coding & Billing + MCO Contracting**



Claims Recovery Company

Federal employee benefits law, ERISA, is the most important law for employer-sponsored health plan reimbursement, or private health insurance under managed care, but ERISA is least understood by health care providers and billing & coding professionals in USA.

ERISA stands for Employee Retirement Income Security Act of 1974. ERISA is the federal law governing and regulating any claim dispute and reimbursement from health insurance obtained through employment in private sectors. ERISA governs or controls more than 90% of non-Medicare claims but ERISA has been almost completely misunderstood by health care providers and reimbursement professionals.

According to US Supreme Court unanimous ruling in *Aetna v. Davila* on June 21, 2004, ERISA governs and regulates any money or benefits dispute with ERISA regulated employer sponsored plan, both self-insured or fully-insured through purchase of insurance, ERISA completely preempts and invalidates any and all state laws if your dispute is ultimately about money or reimbursement from health plans. State laws primarily regulate fairness of process in medical necessity determination, non-ERISA claim adjudication, and general insurance business with nonspecific claim dispute. Managed care contracts and managed care networks primary deal with provider discount, provider relationship, quality of care and provider access options with discounts. ERISA primarily and ultimately controls plan coverage, eligibility, plan/policy limit and level of reimbursement as well as participant or beneficiary right under the plan.

Successful reimbursement is defined as maximum reimbursement for what you are legally entitled to under applicable federal and state laws as well as individual plan provisions or insurance policy.

Managed care claim denials or delays nowadays are primarily due to 30% of billing and coding disputes + 70% of claim regulation and plan provision related disputes.

The most compliant and powerful solutions to managed care denials and delays are to be fully or sufficiently educated on ERISA claim regulation, and to establish an ERISA Appeal Department for providers and facilities, to seek and obtain maximal reimbursement in a compliant fashion for what you are legally entitled to under applicable federal and state laws, individual plan provisions and applicable managed-care contracts.

### **NO. 1 MISCONCEPTION ABOUT ERISA:**

#### **ONLY SELF-INSURED HEALTH PLANS ARE COVERED UNDER ERISA.**

ERISA covers every employer-sponsored health plans in private sector, not only self-insured but also fully-insured (through purchase of insurance) health plans.

Federal law, §29USC1002, defines an ERISA plan in part as the following:

"(1) The terms ``employee welfare benefit plan" and ``welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, **through the purchase of insurance or otherwise**, (A) medical, surgical, or hospital care or benefits, 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, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions)." (Emphasis added)

The simplest way for reimbursement professionals to understand or identify ERISA plan is only one sentence:

Health Insurance through Employment in Private Sector = ERISA.

ERISA does not govern any non-private governmental plans, Medicare, workers compensation, church plans, individual plans and personal injuries claims.

## **NO. 2 MISCONCEPTION ABOUT ERISA:**

### **STATE INSURANCE LAWS REGULATE YOUR CLAIM DISPUTE WITH AN ERISA PLAN**

On June 21, 2004, a unanimous US Supreme Court ruled that claim processing and denials of benefits under the employer-sponsored health plans, ERISA-regulated benefit plans, for both self-insured and fully-insured (through purchase of insurance) health plans, are completely governed by federal law ERISA, ERISA supersedes and invalidates state laws.

If you ever want any money/reimbursement from an employer sponsored health plan, ERISA completely controls your money problems and ERISA completely supersedes your state laws.

U.S. Supreme Court Unanimous Ruling in Aetna v. Davila on 06/21/04

"We hold that respondents' causes of action, brought to remedy only the denial of benefits under ERISA-regulated benefit plans, fall within the scope of, and are completely pre-empted by, ERISA §502(a)(1)(B), and thus removable to federal district court. The judgment of the Court of Appeals is reversed, and the cases are remanded for further proceedings consistent with this opinion. It is so ordered."

A simple interpretation of the phrases:

"Causes Of Action" = Lawsuit, Appeal, Dispute, "Pissed Off", Frustration, Dissatisfaction

"To Remedy Only The Denial Of Benefits" = Money, Money, And Ultimately Money

"ERISA Regulated Benefit Plans" = Employer Sponsored Health Plan In Private Sector, Both Self-insured And Fully-insured ("through the purchase of insurance or otherwise") More Than 80-90% Of Non-Medicare Claims.

"Fall Within The Scope Of" = Being Controlled, Governed And Regulated By

"Completely" = 100%

"Preempts" = Supersedes, Invalidates, Takes Precedence Over

A simple translation for US Supreme Court ruling is:

If you want the money/reimbursement from self-insured or fully insured health plans, federal law ERISA controls your money dispute, ERISA completely preempts or invalidates your state laws if your dispute is about money.

#### NO. 3 MISCONCEPTIONS ABOUT ERISA:

##### MY MANAGED-CARE PROVIDER OR NETWORK CONTRACT GOVERNS MY CLAIM DISPUTE

If your claim is simply about provider discount or provider relationship, your claim is not about ERISA, however if you want money/reimbursement from employer-sponsored health plans, it is almost always ultimately about ERISA instead of provider contract dispute or state insurance law problems.

Having signed managed care contract, as participating provider with insurance verification or precertification, most health care providers mistakenly believed that their disputes are no longer ERISA dispute.

In *PERALTA V HISPANIC BUSINESS*, the Ninth Circuit, federal appeals court, has explained that common law claims do not "relate to" an ERISA plan when

"the "adjudication of the claim required no interpretation of the plan",

“no distribution of benefits”, and

“no dispute regarding any benefits previously paid”.

Both federal and state laws are public policies, if your private contract is conflicting with public policies, your private contract will not be enforceable. Federal law preempts state laws, state laws govern your managed-care contracting, therefore federal law, ERISA, is the most important law regulating your money dispute with ERISA regulated employer sponsored health plans, not only self-insured but also fully-insured.

### **ERISA BASICS**

ERISA is federal law, ERISA claim regulation is enforced administratively by a federal agency, Department Of Labor, DOL. Any ERISA dispute will ultimately adjudicated or decided judicially in federal court instead of state court.

State government, Department of Insurance, and state court, do not have jurisdictions over ERISA claim dispute.

DOL has published numerous guidelines, interpretations and compliance assistance programs on DOL website, [www.dol.gov/ebsa/](http://www.dol.gov/ebsa/)

What You Should Know about Filing Your Health Benefits Claim (Claims Card)  
<<http://www.dol.gov/ebsa/publications/wyskfhbc.html>>

Filing A Claim For Your Health Or Disability Benefits (PDF)  
<<http://www.dol.gov/ebsa/publications/filingbenefitsclaim.html>>  
<http://www.dol.gov/ebsa/pdf/filingbenefitsclaim.pdf>

Patient's Rights Claims Procedure Regulation (Fact Sheet)  
<<http://www.dol.gov/ebsa/newsroom/fs112000.html>>

Benefit Claims Procedure Regulation (FAQ)  
<[http://www.dol.gov/ebsa/faqs/faq\\_claims\\_proc\\_reg.html](http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html)>

An insurance policy without ERISA compliance is referred to as "Phantom SPD" in the industry.

DOL claims guide, "Filing A Claim For Your Health Or Disability Benefits", provides the following about SPD:

### **"Reviewing The Summary Plan Description**

A key document related to your plan is the summary plan description (SPD). The SPD provides a detailed overview of the plan - how it works, what benefits it provides, and how to file a claim for benefits. It also describes your rights as well as your responsibilities under ERISA and your plan. For some single-employer collectively bargained plans, you should also check the collective bargaining agreement's claim filing, grievance, and appeal procedures as they may apply to claims for health and disability benefits.

Before you apply for health or disability benefits, review the SPD to make sure you meet the plan's requirements and understand the procedures for filing a claim. Sometimes claims procedures are contained in a separate booklet that is handed out with your SPD. If you do not have a copy of your plan's SPD or claims procedures, make a written request for one or both to your plan's administrator. Your plan administrator is required to provide you with a copy."

Under ERISA, the plan or insurance company cannot keep secret away from the plan participant and beneficiary, or your patient. The plan administrator is required under the ERISA law to disclose the plan SPD within 30 days to the claimant upon specific written request, the failure to do so by the plan administrator may be sued and could be punished for up to \$110 per day as statutory penalty (SPD penalty) determined by a federal judge.

The specific plan SPD is the most important governing and controlling document for almost all of your claim disputes, including policy coverage, specific policy limit, specific policy exclusion, medical necessity, usual, customary and reasonable, pre-existing condition, precertification or prior authorization, network access, specialist referral, bundling and downcoding, and overpayment refund dispute. More importantly, the specific plan SPD provides for specific appeal procedures, legal entities who are responsible for appeal decisions, and defending potential lawsuit under ERISA.

Most appeals filed by health care providers and reimbursement professionals with an insurance company, managed-care network or a TPA (Third-Party Administrator) are generally considered

to be a provider inquiry or grievance over provide a contract dispute, instead of sufficient and qualified ERISA appeal with plan fiduciary and the administrator over "denial of benefits", therefore most of them are simply wasting time and money.

## **YOUR TRADITIONAL ASSIGNMENT OF BENEFIT IS NO GOOD FOR APPEALS**

Under ERISA, the providers do not have automatic appeal rights, regardless of PPO/HMO/MCO participation status, to challenge the plan's delay or denial of your claims. However, if you have ERISA compliant legal assignment of benefit, your appeals right will be as good as that of your patients. the "real tricks" or compliant assignment, are to have ERISA compliant "Assignment of Benefits Form" signed by patients and timely to put the plan administrator on sufficient notice so that the plan would have sufficient time to verify your assignment for benefits as provided by ERISA claim regulation.

Under ERISA, the plan participant can freely name or designate a healthcare provider as his/her "authorized representative". A health plan may not interfere or restrict the participant designation of authorized representative, but the health plan may establish reasonable claim procedure to verify the validity of participant's designation of authorized representative. Regardless of PPO/HMO/MCO participation, the federal law, ERISA, governs and regulates assignment of benefits practice or authorized representative designation, the managed-care contract or even any state laws are completely preempted by ERISA if state laws or PPO contract are conflicted with ERISA claim regulation. A managed-care contract is a third-party contract independent from ERISA plan, and therefore is only relevant for provider grievance in connection with network participation for provider discount.

DOL, through Frequent Asked Questions, FAQ, explains the relationship between your traditional assignment of benefit and "legal assignment of benefits" for authorized representative.

In a simplified explanation, FAQ B2 basically says that your traditional assignment of benefit is "no good" for appeals and requesting for documents, but only for a healthcare provider to receive benefits payment directly from the plan, if the payment is coming. If the reimbursement payment is delayed or the claim is denied, a provider will have no right to appeal with your traditional assignment of benefit.

FAQ B3 basically explains that if you have ERISA compliant assignment of benefits, "legal assignment of benefit", your appeals right will be as good as that of your patient, as you're an authorized representative to appeal on behalf of your patient.

DOL Benefit Claims Procedure Regulation (FAQ)  
<[http://www.dol.gov/ebsa/faqs/faq\\_claims\\_proc\\_reg.html](http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html)>

**“B-2: Does an assignment of benefits by a claimant to a health care provider constitute the designation of an authorized representative?”**

No. An assignment of benefits by a claimant is generally limited to assignment of the claimant’s right to receive a benefit payment under the terms of the plan. 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. In addition, the validity of a designation of an authorized representative will depend on whether the designation has been made in accordance with the procedures established by the plan, if any.

**B-3: When a claimant has properly authorized a representative to act on his or her behalf, is the plan required to provide benefit determinations and other notifications to the authorized representative, the claimant, or both?**

Nothing in the regulation precludes a plan from communicating with both the claimant and the claimant’s authorized representative. However, it is the view of the department that, for purposes of the claims procedure rules, when a claimant clearly designates an authorized representative to act and receive notices on his or her behalf with respect to a claim, the plan should, in the absence of a contrary direction from the claimant, direct all information and notifications to which the claimant is otherwise entitled to the representative authorized to act on the claimant’s behalf with respect to that aspect of the claim (e.g., initial determination, request for documents, appeal, etc.). In this regard, it is important that both claimants and plans understand and make clear the extent to which an authorized representative will be acting on behalf of the claimant.”

**ERISA DEFINITION OF A DENIAL - ANY PAYMENT LESS THAN 100 PERCENT CLAIMED.**

DOL FAQ C12 illustrated ERISA definition for a denial, "Adverse Benefit Determination": any payment less than 100% claimed. A denial may or may not be an incorrect denial, but a denial triggers appeal process for claimant to understand the reasons for denial and to challenge a denial if he/she disagrees with the benefit determination by the plan.

Benefit Claims Procedure Regulation (FAQ)  
<[http://www.dol.gov/ebsa/faqs/faq\\_claims\\_proc\\_reg.html](http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html)>

**“C-12: If a claimant submits medical bills to a plan for reimbursement or payment, and the plan, applying the plan’s limits on co-payment, deductibles, etc., pays less than 100% of the medical bills, must the plan treat its decision as an adverse benefit determination?”**

Under the regulation, an adverse benefit determination generally includes any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. In any instance where the plan pays less than the total amount of expenses submitted with regard to a claim, while the plan is paying out the benefits to which the claimant is entitled under its terms, the claimant is nonetheless receiving less than full reimbursement of the submitted expenses. Therefore, in order to permit the claimant to challenge the plan’s calculation of how much it is required to pay, the decision is treated as an adverse benefit determination under the regulation. Providing the claimant with the required notification of adverse benefit determination will give the claimant the information necessary to understand why the plan has not paid the unpaid portion of the expenses and to decide whether to challenge the denial, e.g., the failure to pay in full. This approach permits claimants to challenge whether, for example, the plan applied the wrong co-payment requirement or deductible amount. The fact that the plan believes that a claimant’s appeal will prove to be without merit does not mean that the claimant is not entitled to the procedural protections of the rule. This approach to informing claimants of their benefit entitlements with respect to specific claims, further, is consistent with current practice, in which Explanation of Benefits forms routinely describe both payable and non-payable portions of claim-related expenses. See § 2560.503-1(m)(4).”

**ERISA REGULATION GUARANTEES A FULL AND FAIR REVIEW, MUCH BETTER THAN ANY STATE INSURANCE LAWS**

As stated above, ERISA defines a denial as any payment less than 100% claimed, claim denied in part or in whole, or claim delayed, and a denial triggers ERISA appeal process, the plan administrator under ERISA must provide a claimant with a “Full and Fair Review”, not “Fool and Fear Review” to guarantee:

1. Disclosing plan document and evidence based on which a denial was made.
2. Affording the claimant an opportunity to reasonably access the accuracy and reliability of that evidence.
3. Requiring the decision maker, fiduciary, to consider the evidence presented by both parties before reaching and rendering decision.

ERISA full and fair review is much better than any state insurance laws, because ERISA mandates the plan administrator to resolve claim dispute as a fiduciary who shall discharge his/her duties with respect to a plan "solely in the interest of the participants and beneficiaries" 29 U. S. C. 1104(a)(1), while state insurance laws only require an insurance company to show fair dealing and good faith but work for its own best interest in resolving your claim dispute.

Under ERISA, the plan administrator cannot withhold any secret from a participant or beneficiary, such as insurance policy or SPD, policy conditions and limitations, treatment guidelines, medical policies, identities of medical reviewers, legal advice from attorneys, fee schedules and even the plan service agreement with TPAs.

Theoretically speaking, unless you practice ERISA appeals to make it a reality, ERISA claim regulation might be the best "insurance law" in USA, however, due to the lack of understanding by health care providers and reimbursement professionals, ERISA has never been complied and enforced as intended by Congress in 1974, to protect average American workers and their families.

Again, citing DOL federal guidelines in ERISA Claim Guides, "Filing A Claim For Your Health Or Disability Benefits", I will summarize ERISA appeal process from DOL publication, for more specific appeal instructions for your specific reasons of denials, please refer to ERISAclaim.com, or contact me at ERISAclaim.com for further educational assistance programs.

Filing A Claim For Your Health Or Disability Benefits (PDF)  
<<http://www.dol.gov/ebsa/publications/filingbenefitsclaim.html>>  
<http://www.dol.gov/ebsa/pdf/filingbenefitsclaim.pdf>

### **“Filing a Claim – Summary**

- Check your plan’s benefits and claims procedure before filing a claim. Read your SPD and contact your plan administrator if you have questions.
- Once your claim is filed, the maximum allowable waiting period for a decision varies by the type of claim, ranging from 72 hours to 45 days. However, your plan can extend certain time periods but must notify you before doing so. Usually, you will receive a decision within this timeframe.
- If your claim is denied, you must receive a written notice, including specific information about why your claim was denied and how to file an appeal.
- You have at least 180 days to request a full and fair review of your denied claim. Use your plan’s appeals procedure and be aware that you may need to gather and submit new evidence or information to help the plan in reviewing the claim.

- Reviewing your appeal can take between 72 hours and 60 days depending on the type of claim. The law and the Department's rules allow a disability plan additional time if the plan's administrator has notified you beforehand of the need for an extension. For an appeal of a health claim, the plan needs your permission for an extension. The plan must send you a written notice, telling you whether the appeal was granted or denied.
- If the appeal is denied, the written notice must tell you the reason it was denied, describe any additional appeal levels or voluntary appeal procedures offered by the plan, and contain a statement regarding your rights to seek judicial review of the plan's decision.
- You may decide to seek legal advice if your claim's appeal is denied or if the plan failed to establish or follow reasonable claims procedures. If you believe the plan failed to follow ERISA's requirements, you also may want to contact the nearest EBSA office concerning your rights under ERISA.

Again, federal law, ERISA, governs and controls 100% reimbursement from the ERISA regulated employer sponsored health plans in private sector, ERISA preempts, supersedes and invalidates any and all state laws when you dispute is "denial of benefits"

ERISA always and ultimately regulates, governs or controls any managed care contract, HMO, PPO, POS and P4P. No provider contract can supersede, alter or limit ERISA rights and benefits as well as remedies, as clearly stated recently in almost every provider class-action lawsuit against insurance companies and managed care organizations, such as in Aetna class-action settlement agreement with 900,000 physicians:

"Nothing contained in this § 7.10 is intended, or shall be construed, to supercede, alter or limit the rights or remedies otherwise available to any Person under § 502(a) of ERISA or to supercede in any respect the claims procedures of § 503 of ERISA"  
<<http://www.aetna.com/provider/data/settlement.pdf>>

If you want to get paid from an employer-sponsored health plan, you must understand ERISA and file ERISA appeals if your claim is denied in part or in whole, unless the claim reduction is 100% pure PPO percentage discount or contract discount.

If you want to determine specific insurance coverage, limitation, restrictions and any secrets before rendering healthcare services, you need to obtain and review the individual plan's SPD, Summary Plan Description, in addition to telephone verification, because you all know that telephone verification is not guarantee of anything, but the plan's SPD is the governing plan document for all of your claim dispute.

New Federal Claim Regulation (Final Rule)  
<<http://www.dol.gov/ebsa/regs/fedreg/final/2000029766.htm>>

Amendments to Summary Plan Description Regulations (Final Rule)  
<<http://www.dol.gov/ebsa/regs/fedreg/final/2000029765.htm>>

By visiting DOL website and reading federal government official publications and guidelines, you will be able to understand more about ERISA, most important law about your money from employer-sponsored health plans.

### **ERISA VERSION OF INSURANCE POLICY: SPD**

As we all know, insurance policy decides insurance coverage. Under ERISA, for a self-insured plan, there is no insurance policy from insurance company but employee benefits plan. For a fully-insured plan, a group plan, an employer purchases an insurance policy for the entire group from an insurance company. Under ERISA, the insurance policy equivalent document is called SPD, Summary Plan Description, or ERISA version of insurance policy, for the convenience of learning process, we call self-insured plan document as an insurance policy, even though it was not an insurance policy.

SPD, Summary Plan Description, ERISA version of insurance policy, controls policy coverage, eligibility, limitation and everything about money, your reimbursement rights.

SPD in general has three basic components:

1. Legal information about plan sponsor, plan administrator, claim fiduciary and legal entity handling appeals and lawsuit;
2. The plan's appeal process or procedure;
3. A summary of benefits.