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Benefits Alert

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Fiduciary governance: Handling participant claims and appeals and provider disputes

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Understanding claims and appeals procedures can hel

Understanding claims
avoid costly mistakes.

What's the impact?

- Plan and claims administrators should follow the plan's claims and appeals provisions to avoid inadvertently triggering complainant-friendly review standards.
- Minimize risk in disputes by understanding how healthcare providers can assert ERISA rights against a plan.
- Exercise caution when handling document requests and/or disputing plan reimbursements—failure to properly handle these requests can result in liability.

As we near the end of our Health and Welfare Plan Fiduciary Governance Series, we turn to a basic fiduciary function—handling participant claims and appeals and healthcare provider disputes. Although this is a basic fiduciary function that is guided by regulatory claims and appeals procedures, even the slightest missteps can prove costly. Additionally, healthcare providers (to whom plan participants often assign their rights or delegate as representatives) are

increasingly disputing health plan reimbursements and administrative practices. When claims and appeals are filed, or providers acting on behalf of participants request information or dispute payment, health plan fiduciaries must be ready to act within defined timeframes set by Department of Labor (DOL) regulations.

Background on Claims and Appeals and Fiduciary Status

Section 503 of the Employee Retirement Income Security Act of 1974 (ERISA) states that plans must notify plan participants of claim denials and provide a right to appeal those denials subject to procedures established by the DOL. Those procedures (found in 29 C.F.R. § 2560.503-1) are comprehensive and contain detailed rules related to (i) when claims and appeals must be filed, (ii) when claims administrators must respond to claims and appeals, (iii) the content of the notice of claims or appeals denials, (iv) rights related to external review, and (v) when plan participants are able to bring legal action in court. For group health plans not grandfathered from the market reforms of the Affordable Care Act, the agencies added substantial additional requirements to the internal claims and appeals process.

These claims and appeals provisions are generally referred to as "internal" because they are procedures that must be embedded within employee benefit plans and do not involve courts or arbitration. Importantly, plan participants must fully complete (or "exhaust") the internal claims and appeals before bringing legal action under ERISA. It is important that claims administrators comply with the regulatory claims and appeals procedures because failure to do so can have the following negative impacts:

DEEMED EXHAUSTION

As noted above, plan participants must exhaust their internal claims and appeals procedures before bringing action in court. However, if a claims administrator fails to follow the plan's claims and appeals provisions, the plan participant can seek to bring litigation prior to exhaustion by arguing that the claims administrator's failure to follow the rules amounts to "deemed exhaustion." Whether or not a deemed exhaustion argument carries the day depends on the facts and circumstances, but claims administrators should strive to avoid these issues by following the plan's claims and appeals procedures.

DE NOVO STANDARD OF REVIEW

If a claims administrator follows the procedures and a participant exhausts the internal process, any litigation seeking payment of benefits brought by the participant would be subject to a plan-friendly "arbitrary and capricious" standard of review. Under this standard of review, the plaintiff would need to show that the claims administrator acted arbitrarily and capriciously when denying a claim and/or subsequent appeal. Importantly, the court's review would be limited solely to the materials contained within the internal claims and appeals administrative record.

However, if a claims administrator fails to follow the claims and appeals procedures, a court could disregard the claims administrator's determination and the administrative record and, instead, conduct a fresh (or de novo) review of the claim and appeal, including any additional information that may not have been considered by the claims administrator.

Following the claims and appeals procedures can seem straightforward, but there are several claims and appeals-related issues that claims administrators might face. A few of those issues are described below.

Claims Administrator as an ERISA Fiduciary

In the health and welfare plan context, claims administration is almost always delegated to a third party. For fully insured plans, the insurance carrier will be the claims administrator. For self-funded plans, claims administration is generally delegated to the third-party administrator (TPA). Occasionally, TPAs delegated claims and appeals authority will seek to disclaim or minimize their fiduciary status through the services agreement. TPAs seeking to disclaim fiduciary status typically argue that their functions are ministerial in nature—they are simply applying the coverage rules set forth in the plan and are not exercising any discretion. After all, the hallmark of ERISA fiduciary status is discretionary authority or responsibility.

Long-standing guidance and case law have made clear that whether a person or entity is an ERISA fiduciary is not determined via contract or by some written delegation (except, perhaps, fiduciaries specifically identified as fiduciaries in plan documents (e.g., named fiduciaries). Rather, a person or entity will be considered a fiduciary if the person or entity functions as one. In other words, if a TPA is exercising discretion when administering claims and appeals, the TPA is an ERISA fiduciary. Given the complexity of health and welfare plan coverage rules, especially with medical and prescription drug benefits, it is very unlikely that a TPA can administer claims without exercising some discretion. Thus, in most cases, the TPA claims administrator would be considered a functional ERISA fiduciary despite any agreement provisions to the contrary.

From time to time, a claims administrator will even leave the responsibility for handling final decisions on appeal with the employer. An employer typically does not have the expertise to review claims, nor does it want to access the sensitive health information of its employees. In practice, the claims administrator would be processing appeals but shifting the liability to the employer. Employers should carefully review their agreements with claims administrators to avoid assuming responsibility for handling final appeals decisions.

The fact that a claims administrator is likely an ERISA fiduciary does not absolve the plan administrator of fiduciary responsibility for claims and appeals. Yes, the actual administration of the claims and appeals can be delegated to a TPA claims administrator, but plan administrators still have a fiduciary obligation to monitor service providers. Thus, plan administrators need to

know and understand the claims and appeals process employed by their vendors, including the content of explanation of benefits provided to participants on claims denied in whole or in part.

Assignment of ERISA Rights and Designation of Authorized Representative

ERISA establishes several participant and beneficiary rights—for example, the right to request certain plan-related documents and the right to bring legal action to recover benefits. Those rights do not extend to healthcare providers owed payment from the health plan. However, there are two key avenues through which a provider can assert ERISA rights against a plan—through assignment and through designation as an authorized representative.

First, a plan participant may wish to assign ERISA rights to a third party. In particular, a provider who is disputing payment may ask a participant to assign the right to request plan documents or the right to bring legal action against a plan or plan administrator.

Second, ERISA allows plan participants to designate an authorized representative to act on the participant's behalf. Once a designation is made, the authorized representative will be able to assert all ERISA rights available to the participant. Unlike in the case of assignment, the rights must be asserted on the participant's behalf. For example, a provider assigned ERISA rights can file litigation as the plaintiff. In contrast, as an authorized representative, the provider would need to file any lawsuit in the name of the plaintiff. However, if a provider waived the individual's obligation to pay any outstanding claim payments, the provider would have no claim on behalf of the individual.

These two avenues may seem functionally equivalent; a provider can eventually achieve their aim either as an assignee or as an authorized representative. There is one key difference—plans can expressly prohibit the assignment of ERISA rights. Anti-assignment clauses in health and welfare plans are common and have been judicially upheld as enforceable. The ability to designate an authorized representative, however, cannot be restricted. Remember, however, that the participant must himself or herself have a claim; otherwise, the provider does not have the shoes in which to step. At the very least, plan administrators should review their plans and consider whether to add or enhance anti-assignment language. Legal counsel needs to be consulting on the enhanced contractual provisions.

Plan Overrides

From time to time, participants who have had a claim or appeal denied by the claim administrator will reach out to the plan administrator to ask for an exception or for some help in getting the claim administrator to reconsider. Although TPAs, particularly of self-insured plans, will typically permit the plan administrator to override a claim or appeal determination (albeit

occasionally with the agreement from the plan administrator to hold the TPA harmless), there are risks in doing so.

First, plan administrators have a fiduciary obligation to follow the terms of the plan documents. If the plan's terms and conditions are clearly inconsistent with the override, the overriding plan administrator could later be found to have violated ERISA's fiduciary requirements. Where the plan's terms are ambiguous, the override may not actually conflict with the plan documents (and, thus, the risk of a fiduciary breach is lower). Depending on the underlying issue, plan administrators could avoid the fiduciary risk by amending the plan going forward to align with the override.

Second, as with any ad hoc exceptions to a general rule, overrides set precedents and risk inconsistent application. Plan administrators need to be mindful of the reasons for granting an override because similar reasons may also apply in a future override request. If an override request were granted but then another similar request is later denied, the participant that is denied could claim that the plan administrator is acting arbitrarily with respect to plan interpretation and administration.

Although having the contractual right to override a claims administrator's determination is preferred, the best practice is for plan administrators to utilize that right sparingly and only when the plan administrator either disagrees with the claim administrator's interpretation of an ambiguous term or is prepared to amend the plan.

Provider Document Requests and Payment Disputes

Finally, over the past five years or so, providers (either directly or through third-party services) have been sending letters to plan administrators seeking copies of plan documents or disputing plan reimbursements. These letters are almost always from out-of-network providers, ranging from simple document requests under ERISA § 104(b)(4) to 20–30 page-long allegations of illegal activity. Whatever the nature of the letter, plan administrators need to treat them seriously, as failure to properly handle these requests could result in liability. Set forth below are key steps to take when handling these letters, and we recommend that any plan administrator consult with legal advisors when responding.

STEP 1

When the letter from a provider comes in, confirm whether there has been an assignment of ERISA rights (if permitted under the plan) or a properly signed designation from the participant that the provider is acting as an authorized representative. If there is no indication of either, the plan administrator can simply respond to the provider by stating that in the absence of an assignment (if permitted under the plan) or a signed authorization to act on behalf of the participant, the plan administrator will not substantively respond to the letter.

STEP 2

If the provider letter reflects an appropriate assignment or designation, the plan administrator should review the letter closely and determine what actions are necessary. If the letter requests documents, the plan administrator should work with counsel to produce only those documents required under ERISA § 104(b)(4). If claims-related information is requested, it is unlikely that the plan administrator will have access to that information. In that case, the claims-related request would be forwarded to the claims administrator, who would then send the information directly to the provider. Plan administrators have 30 days to respond to ERISA § 104(b)(4) requests and failure to do so can result in a $110 per day penalty.

If the letter does not request documentation but, instead, simply disputes payment or administrative practices, the plan administrator should forward the letter to the claims administrator and request confirmation that the claim was handled properly or, if it was not handled properly, ascertain how and when it will be corrected. An important question to ask the claims administrator is whether the provider (as assignee or authorized representative) has exhausted the plan's internal claims and appeals procedures. Oftentimes, providers dispute initial claims denials without following the plan's claims and appeals procedures. If the claims administrator confirms that the claim was handled in accordance with plan terms, the plan administrator should work with counsel to determine how best to respond. In many cases, the best response may be to simply refer the provider to the claims administrator as the party with claims and appeals responsibility.

Takeaways

Plan sponsors should be sure their plan documents and service agreements contain provisions that properly protect the plan sponsor with regard to claims and appeals determinations. And although actual claims and appeal determinations are usually managed by third-party claims administrators, plan administrators still play an important role. Whether evaluating plan document disclosure requests or considering an override request, plan administrators should follow their fiduciary obligations when handling those issues. Despite delegations to third-party service providers, plan administrators are still responsible for the plan's overall compliance.

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