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New Ways to Force Insurance Companies to Play by the Rules

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On Feb. 5, 2001, Theresa McElhaney, a suburban realtor, suffered a back injury when her car was rear-ended. Fortunately for her, after several months of treatment, Theresa's injuries healed and she gradually forgot her trauma.

Unfortunately for her physician, his trauma had just begun.

Today, health care providers need to be aware of all the nontraditional, as well as traditional, methods to force insurance companies to play fair. To control costs, insurance companies have instituted various systems including preferred provider groups, flat fee arrangements, heightened scrutiny of charges, rationing of services, bundling and down-coding, denials of coverage of treatments deemed "medically unnecessary," and other unsettling processes. Indeed, health care providers have found themselves increasingly trapped between the patients, to whom they provide care, and the insurance companies that pay for the services. Due to this environment, patients and providers have become

increasingly concerned with the effect insurance companies' decisions have on them.

Two recent court cases indicate, under the auspices of cost control, that patient and provider sway with insurance companies is in fact legally quite limited. In *Pegram vs. Herdrich*, the United States Supreme Court addressed whether insurance companies could be sued under federal law for the manner in which they control costs. The answer was an unequivocal "no." This decision was reiterated in preliminary rulings in the landmark class-action lawsuit brought on behalf of 600,000 physicians against the health care industry by national and state medical associations, known as *In re Managed Care Litigation*, currently pending in federal district court in Miami.

What has been learned from the *Pegram*, *Managed Care*, and other similar cases shows that bringing lawsuits against insurance companies based on the way they pay health care providers will be difficult. This is because various federal laws protect insurance companies from lawsuits in state courts under state insurance laws. Most notable among the laws that shield insurance companies is an arcane federal law meant to protect employee fringe benefits, the Employee Retirement Income Security Act of 1974 or "ERISA." The manner in which courts have interpreted this law often stands in the way of obtaining judicial redress against insurance companies. ERISA is so important because most people have health insurance coverage through their employers. When health insurance is employer-provided, it is usually subject to ERISA. Indeed, ERISA regulates and governs the vast majority of health care-related claims in the United States. Health care professionals and their organizations have tended to overlook ERISA as an impediment to obtaining prompt and fair payments of their claims.

Because of the current legal landscape, a major change will have to occur by legislation in Congress, such as the Patients' Bill of Rights, to fundamentally

reshape the health care industry. The big question thus becomes, how soon and how much protection will any new law provide?

This article does not answer this question. Instead, it addresses how health care providers may be able to employ the current law, ERISA, against insurance companies. It should be noted that the methods and strategies suggested below, while based on extensive research and practical experience are novel. Thus, judicial outcomes for each case will be different and unpredictable. Consequently, it is expected that litigation will be necessary to fully develop this aspect of ERISA law.

THE CURRENT LAW

ERISA is the federal law that regulates and governs most of the health care claims and health care-related matters in the United States. One of the biggest misconceptions among health care providers about ERISA is that it covers only self-insured big corporations, such as Fortune 500 companies, or managed care plans, such as HMOs or PPOs. However, as long as your patient is self-insured or your patient's employer paid for any part of a group insurance premium, your patient is most likely covered under an ERISA plan. Consequently, it is extremely important for health care providers to have a basic understanding of ERISA.

Because ERISA plans are governed by federal laws and regulations, ERISA-related claims are different from traditional state insurance laws and claims made under state laws.

Originally, ERISA was enacted by Congress in 1974 to protect employees' fringe benefits-like pensions, health care, and disability insurance. While ERISA may, however awkwardly, accomplish many of its protective goals, it has made suing the insurance companies that provide health care benefits to employees difficult. This is because ERISA "preempts" or trumps most state laws dealing with health care. Indeed, insurance companies view preemptions as a significant corollary

benefit for offering ERISA-qualified plans. Under ERISA, insurance companies are shielded from having to pay damage awards for pain and suffering or punitive damages, although a defeated insurance company would be liable to pay the prevailing attorneys' fees and costs. For this reason, the insurance companies know that even if they lose a case, their exposure from a lawsuit is very limited.

This is why lawsuits have sought to end-run ERISA's preemption power by invoking other federal laws, such as the Racketeer-Influenced Corrupt Organizations Act of "RICO," which are not pre-empted. For example, if a patient seeks a certain type of treatment and the provider renders the treatment but the insurance company later refuses to pay for it, under most circumstances the provider may bring a lawsuit in federal court only to obtain payment from the insurance company. Further, even if victorious, a successful plaintiff can recover only the cost of the treatment.

THE OTHER WAY TO GET PAID

Rather than fight the insurance companies by trying to find a way around ERISA, health care providers may be able to use ERISA against the insurance companies ERISA contains provisions requiring insurance companies to disclose and report certain types of information. If these rules are not followed, ERISA imposes a statutory penalty.

One such obscure ERISA provision requires insurance companies to provide certain types of information, or be exposed to a \$110-per-day fine after the passage of 30 days. This information includes summary plan descriptions ("SPDs") and the specific reasons, with supporting documentation, as to why a claim for benefits has been denied. SPDs are booklets describing the terms of an ERISA plan, including coverage and exclusion information, plan-appeal processes and specific rights under ERISA, and who is in charge of making the decisions on claims (the identity of the "plan administrator").

If the insurance company fails to provide the SPD and other information requested within 30 days of a properly made request, it is subject to the \$110-per-day fine. SPDs are of particular importance to health care providers because they explain the basic information that a provider needs to properly demand payment of bills. Without an SPD, a health care provider does not have all of the information needed to ensure compensation for services rendered. Most insurance denials such as policy exclusion (not covered or excluded by policy) and medical necessity denials, as well as usual, customary, and reasonable (UCR) denials, can be effectively challenged and appealed by healthcare providers within the existing ERISA framework and claim procedure.

Assume the following scenario: A patient, insured by or thought ABC Insurance Co., comes to your office seeking treatment. You provide the treatment and forward the bill to the insurance company. ABC denies coverage, stating that the treatment was “not medically necessary.” You then have a choice. You can writher off the bill, charge back the patient, or fight the denial.

Writing off the bill is not a good business decision. Charging back the patient, while a common custom, places a wedge between you and your patient. Taking on an insurance company will be a time-consuming and frustrating process. By following certain techniques, however, you can increase the likelihood of success in collecting payment from insurance companies.

STEP ONE: THE LEGAL ASSIGNMENT

The first necessary step to this strategy is to obtain legal assignment form your patient. General health care providers’ assignment of benefits (authorization for payments to heather care providers) may not satisfy requirements to legally assign the benefits a patient deserves from his health insurance play. The legal assignment of benefits is a declaration by the patient that you are entitled to be reimbursed directly by the issuer for services rendered and may pursue such reimbursement if wrongfully denied.

Traditionally, health care providers have not required pre-payment for services.

Accordingly, it is expected that courts will honor these assignments as they complement the classic doctor-patient relationship. The assignment should be a legal document containing all of the necessary information to constitute a legal assignment. It need not be complex. But to be effective, it should contain a description of what is being assigned (right of reimbursement for services rendered and cause of actions, as well as remedies in pursuing such reimbursement), why it is being assigned (for the provider who agrees to provide healthcare-related services), and the patient's signature (notarized, if required by state law). As soon as you obtain the assignment, send it to the insurance company, with a descriptive cover letter, so that the insurance company is "put on notice" of the assignment.

STEP TWO: DEMAND PAYMENT AND APPEAL ANY DENIALS IN A TIMELY FASHION

Following a denial of coverage, the second step is to make a timely written demand or appeal. This appeal should also include a request for the following:

- payment of bills
- an explanation in detail of why the insurance company denied payment
- copies of the documents supporting the insurance company's decision to deny payment, and
- a copy of the plan's SPD.

ERISA provides 60 days within which an appeal can be filed. Failure to appeal a denial within the 60 day period can result in the forfeiture of your right to reimbursement and even access to court. You may have to complete two or more levels of appeals before you can file a lawsuit in federal court to pursue your legal right to reimbursement.

Under ERISA, the appeal must be made to the plan administrator. The plan administrator is the official decision-maker named by the insurance plan. In a health care context, the plan administrator is typically either the insurance provider (i.e. Blue Cross) or, if the plan is self-funded, the company funding the plan.

Unfortunately, all you have is your patient's insurance card. Frequently, the insurer listed on the card is on the plan administrator but rather a so-called third-party administrator ("TPA"). A TPA is an insurance company hired by the plan administrator to process claims. Thus, along with your written demand, you should also include a detailed instruction sheet asking for the identity of the company to which you sent the demand. For example, "Are you the plan administrator? If you are the TPA, who is the plan administrator?" etcetera. Ask that the sheet be returned to you in a enclosed self-addressed, stamped envelope. That way you can send your demand for payment directly to the plan administrator.

STEP THREE: FIGHT BACK!

The third step is to fight back if the plan administrator refuses or fails to provide requested information. The plan administrator has 30 days to respond. If there is no response in 30 days, the \$110-per-day statutory penalty begins to accrue. Finally, you should send another demand letter, certified mail, on day 30, making sure to identify the first letter you sent. If no response is received by day 60, send a third letter, certified mail. In addition to the information contained in the initial demand letter, this letter should state that if you do not receive a response within two weeks you will initiate a lawsuit.

If the insurance company identifies itself as a TPA, redirect your correspondence to the plan administrator. If you do get a response within the 30 day time frame, you will have all of the information you need to evaluate your strategy for

pursuing a claim for payment of your bill and what treatments you may not be able to provide to a patient in the future without pre-payment.

If you believe further information is required for the insurance company to justify its denial of payment, ask for it. You should always appeal the denial of payments if you believe the insurance company should have paid you and you intend to file a lawsuit over the matter. Under ERISA, you must exhaust any internal administrative appeals under the terms of the insurance plan before filing a lawsuit. Employing this strategy will assist in ensuring that insurance companies adhere to the letter of the law in their attempts to deny payment for services you render.

It should be noted that historically, most health care providers have failed to complete such internal appeals in a timely fashion as required by ERISA and, this, have forfeited their rights to reimbursement for ERISA plans. This is one reason why health care lawsuits under ERISA by patients and health care providers often fail.

Additional Legal Issues

Because the timely appeals required by ERISA have rarely been made, insurance companies and managed care organizations have had the upper hand in litigation for health care providers' claims for payment. By following ERISA's claims procedures, it is hoped that the threat of the statutory fine will encourage insurance companies to supply health care providers with timely payment or, at a minimum, a detailed explanation, supported by documentation, as to why payment is being denied. Armed with this information, health care providers can better manage their businesses and patient relationships. For the strategy outlined above to work, three significant legal issues must be favorably resolved:

- 1.) Will courts honor the legal assignments?

The expected answer is yes.

Traditionally, health care providers do not require patients to pre-pay for treatment based on the right of the provider to submit his bill to the patient's insurance company for payment. It is expected that courts will not expose this tradition to change by refusing to honor the assignments, as long as such legal assignment is properly drafted and served on insurance companies in a timely fashion.

2.) Will courts allow health care providers to collect the statutory fine?

The answer to this question is uncertain. The SPD statutory penalty is frequently awarded to plaintiff-patients by courts. Since the point of the fine and any lawsuit would be deterrence, there is a strong argument to be made that the health care provider who brings the suit should be entitled to the amount recovered.

3.) What happens if it cannot be determined who the plan administrator is and a TPA is sued?

This is a complex question. Under the precise letter of ERISA, a lawsuit claiming statutory fines for failing to provide an SPD must be filed against the plan administrator. However, there is strong argument to be made that if the TPA refuses to reveal the plan administrator, this constitutes a violation of ERISA, as well.

Conclusions

ERISA regulates the majority of health care claims made in the United States. Given ERISA's impact, it is essential that health care providers have at least a basic understanding of ERISA to level the playing field against insurance companies when seeking payment for claims. Indeed, health care providers have rarely used ERISA's provisions designed to ensure they have access to important claims-related information. On the other hand, insurance companies

and managed care organizations have successfully taken advantage of ERISA to limit their exposure to lawsuits and unreasonably deny providers payments for services rendered.

This article suggests one approach for attempting to turn the tables on insurance companies within the ERISA context. Obviously, with any new legal strategy, there is the risk that courts will not rule favorably. Each case will be different, and judicial outcomes will be unpredictable. However, with careful attention to detail and well-framed arguments, it is believed that courts will look favorably on arguments that track the language of ERISA.

Clearly, this strategy is not a quick fix. Depending on the outcome, the heavily debated Patients' Dill of Rights in Congress and the large-scale litigation currently pending in federal district court in Miami will dramatically change how insurance companies do business. In the meantime, this strategy enables individual health care providers to take matters into their own hands. Also, these individual actions will serve as a hedge should the health care industry prevail in the large scale litigation. It is time that the insurance industry be made to comply with the very law, ERISA, that it has relied on as a shield from liability.