Document #7505 **CMA Legal Department**
ERISA Plans **January 2013**

This document explains what ERISA plans are and how they work. It is designed to assist physicians in dealing with an ERISA plan and understanding ERISA plans' general payment obligations. For a discussion of ERISA preemption where an ERISA plan fails to authorize care, or is sued for a physician's alleged malpractice, *see* CMA ON-CALL document #7008, "Managed Care: Health Plan Liability." For a discussion of denials of medically necessary services, *see* CMA ON-CALL document #7152, "Denials of Necessary Medical Services."

"ERISA" stands for the Employee Retirement Income Security Act. It is the federal law that governs employee benefit plans, including plans through which employees receive health coverage. Getting paid or getting care authorized by an ERISA plan has traditionally raised unique problems for physicians because ERISA plans are governed by federal ERISA law, discussed below. However, in recent years, courts are increasingly finding that ERISA plans are subject to state law, particularly if they are not self-insured. Also discussed below is whether a physician may obtain attorneys' fees when suing an ERISA plans, and how the court's "standard of review" will impact a physician's claim.

ERISA PLANS – THE BASICS

ERISA Plan Defined

1. Why is ERISA even an issue?

Although it may be difficult for physicians to determine whether they are dealing with an ERISA plan, in most cases where the employer sponsors the plan and pays premiums on behalf of the employees, an ERISA plan exists. The reason why it matters that a plan is covered by ERISA is because federal law "supersedes," that is preempts, any state law which relates to an ERISA plan, unless it is "saved" from federal regulation because it regulates the business of insurance. Under these circumstances, as is discussed below, preemption is more likely to occur where the ERISA plan is an employer's "self-insured plan," as opposed to a health insurance plan purchased by an employer. As a result, aggrieved patients and/or their physicians may or may not have judicial recourse under state law or the ability to seek administrative relief from state regulators, depending on whether:

- An ERISA plan is involved;
- The dispute "relates to" the plan; and
- The plan was self-insured by the employer.

Although traditionally courts favored an expansive reading of the "relates to" language (and thus ruled that the state law was preempted), the courts have shifted the way they applied ERISA's preemption rules to a "presumption against preemption."

2. What is an ERISA plan?

An ERISA plan (sometimes called an "employee welfare benefit plan" or "welfare plan") is:

a) A plan, fund or program;

b) Established or maintained;

c) By an employer or by an employee organization (e.g., a union), or by both;

d) Through the purchase of insurance or otherwise;

e) For the purpose of providing medical, surgical, hospital care, or other benefits; or

f) Benefits to the employees or their beneficiaries.

(29 U.S.C. §1002(1).)

The crucial question is whether the employer "established or maintained the ERISA plan." Where an employer purchases a plan, contributes towards premiums and remits them to the insurer, and retains authority to terminate the policy or change its terms, an ERISA plan has been created. (Marshall v. Bankers Life & Casualty Co. (1992) 2 Cal.4th 1045, 10 Cal.Rptr.2d 72.) The employer need not process claims or administer the policy for an ERISA plan to be created. (*Id*.) There are instances where an ERISA plan is not established. For example, if the employer merely advertises a group insurance plan and arranges for deductions for premiums to be made from the employee's paycheck, no ERISA plan exists.

The Department of Labor promulgated a safe harbor regulation explaining when an employer may be involved with an employee welfare benefit plan without having "established or maintained" it. This regulation provides in pertinent part:

> An employee welfare benefit plan shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which: (1) the employer makes no contribution to the policy; (2) employee participation in the policy is completely voluntary; (3) the employer's sole functions are, without endorsing the policy, to permit the insurer to publicize the policy to employees, collect premiums through payroll deductions and remit them to the insurer; and (4) the employer receives no consideration in connection with the policy other than reasonable compensation for administrative services actually rendered in connection with payroll deduction.

(29 C.F.R. §2510.3-1(j).) It is only when all four of the "safe harbor" provisions are satisfied that an employer is not considered to have "established or maintained" the program or plan, thereby escaping ERISA's application. *See Kanne v. Conn. Gen. Life Ins. Co.* (9th Cir.1988) 867 F.2d 489. *See also Van Natta v. Sara Lee Corp.* (N.D. Iowa 2006) 439 F.Supp.2d 911 (employer maintained ERISA plan where it maintained "sole discretion" to adopt rules regarding the administration of the plan).

Also, no ERISA plan is established where health care coverage is through a federal, state or local government employer, pursuant to an express exception in the law. Also, plans maintained by church-related organizations, including church-related hospitals, schools and universities, and plans maintained solely to comply with state workers' compensation or temporary disability laws are also exempted from ERISA. (29 U.S.C. §1003.)

Finally, a plan "under which no employees are participants" does not constitute an ERISA employee benefit plan. (29 C.F.R. §2510.3-3(b).) Neither an owner of a business nor a partner in a partnership can constitute an "employee" for purposes of determining the existence of an ERISA plan. (29 C.F.R. §2510.3-3(c)(1), (2).) ERISA does not govern a plan whose only beneficiaries are a company's owners.

However, in *Peterson v. American Life & Health Insurance Company* (9th Cir. 1995) 48 F.3d 404, a patient maintained that his policy did not constitute an ERISA employee benefit plan because at the time of his bypass surgery it covered only him, a partner in his partnership. The court found that the fact that the policy covered only a partner *at the time of his surgery* was not determinative. It concluded that the policy, taken as a whole, did constitute an ERISA plan, in part because the patient's policy originally covered a non-partner employee in addition to the patient and his partner. Because the court found that the patient's policy was purchased by the patient for the purpose of providing benefits to its employees as well as its partners, the policy was found to be part of an ERISA plan and governed by ERISA.

3. What is a self-insured plan?

ERISA does not define "self-insured," but this term means ERISA plans (through their employers) that bear risk of paying benefits themselves rather than buying commercial products from insurers or HMOs. Many commercial insurers provide only administrative services to self-insured plans. Administrative services that commercial insurers perform for self-insured plans can include, but are not limited to, claims processing and claims management, coverage determinations, and eligibility decisions. The extent to which ERISA preempts state laws that regulate entities like commercial insurers performing administrative services to self-insured plans has not been settled by the courts. Recent cases suggest, however, that ERISA does not preempt state laws that regulate commercial insurers and other entities providing administrative-only services to self-insured ERISA plans. *See* e.g., *Kentucky Association of Health Plans, Inc. v. Miller* (2003) 538 U.S. 329, 155 L.Ed.2d 468 (U.S. Supreme Court suggesting that licensed health plans acting as third-party administrators are engaged in insurance activities and thus subject to state legislation). (*Id*. at 477, n.1.) The PBM cases discussed below also strongly support the argument that ERISA does not preempt a broadly-worded state law that applies to entities that provide administrative services-only to self-insured ERISA plans.

Identifying ERISA Plans

4. How can I find out if I am dealing with an ERISA plan?

All ERISA plans are required to file a 5500 form with the Internal Revenue Service (IRS). They are available for public viewing through a website, http://freeerisa.benefitspro.com/. Interested persons must register with the website in order to access the database, but access is otherwise free. Unfortunately, there is no easy way to find out if the plan is self-insured—often the best way to find out is to contact the employer directly.

ERISA Plan Operations

5. How do ERISA plans work?

Generally, all assets of an ERISA plan from which patients benefits are paid, are held in trust by one or more trustees. These trustees are either named in the trust instrument or in the plan instrument, or are appointed by a named fiduciary. The trustee has exclusive authority and discretion to manage and control the assets of the plan, except to the extent that the plan expressly provides that the trustee is subject to the direction of a named fiduciary, or the authority to manage or dispose of assets is delegated to an investment manager. An ERISA plan must provide for one or more named fiduciaries who have authority to control the operation and administration of the plan. The term "named fiduciary" means a person who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary by the employer or employee organization. (29 U.S.C. §1102.)

The person specifically designated by the terms of the plan to run the day-to-day operations of the plan is called the "plan administrator." The plan administrator is usually the one who makes decisions on whether to pay physician claims. If a plan administrator is not designated, the plan sponsor administrates the plan. The term "plan sponsor" means: (1) the employer in the case of an employee benefit plan maintained by a single employer; (2) the employee organization in the case of a plan maintained by an employee organization; or (3) in the case of a plan maintained by two or more employers or employee organizations, the group of representatives of the parties who establish or maintain the plan. (29 U.S.C. §1002(16)(B).)

If a plan administrator is also a "fiduciary," the plan administrator will have even more strict obligations to dispense plan assets properly. If a fiduciary breaches its fiduciary duty, it may be required to pay back to the plan, the patient or the physician, amounts resulting from its breach. (29 U.S.C. §1109(a).) Plan administrators will be considered fiduciaries when they have discretionary (as opposed to purely ministerial) authority over a) the management or administration of the plan, or b) the management or disposition of plan assets. (29 U.S.C. §1002(21); *IT Corporation v. General American Life Ins. Co.* (9th Cir. 1997) 107 F.3d 1415.)

ERISA PREEMPTION

Four Part Test

6. How do the general preemption rules work?

The starting point for ERISA preemption is section 514(a) of ERISA (29 U.S.C. §1144(a)), which provides, in part:

> Except as provided … [ERISA] shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan… (Emphasis supplied).

As a result of this provision, if preemption occurs, federal ERISA law, not state law, will supersede and govern the patient's and/or physician's claim. The reason that this is important is because ERISA law generally does not allow for claims of emotional distress or compensatory or punitive damages, but rather limits recovery to amounts due under the plan's terms, and potentially attorney fees.

To determine whether a state law is preempted, courts engage in a four-part analysis, as follows:

a) Does the law itself "relate" to an employee benefit plan? If not, the state law is not preempted. If so:

   i) Does the state law "regulate insurance"? If no, the law is preempted. If yes, the law is "saved" from preemption unless;

   ii) Does the state law purport to regulate insurance by "deeming" a plan to be an insurance company? If so, the savings clause does not apply and state law is preempted. Because of this "deemer" clause, self-insured plans are generally sheltered from state insurance regulation. *See, Metropolitan Life Ins. Co. v. Massachusetts* (1985) 471 U.S. 724, 747, 85 L.Ed.2d 728. If not, the savings clause applies and saves state law from preemption unless; or

   iii) Even if the state law would otherwise be "saved" as an insurance regulation, does the state law provide an alternative civil enforcement provision? If so, it may be preempted. (29 U.S.C. §1132(a).) *See* discussion below.

"Relates To"

The U.S. Supreme Court's analysis of ERISA changed dramatically in 1995. Cases interpreting the scope of ERISA preemption prior to the U.S. Supreme Court's opinion in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers* (1995) 514 U.S. 645, 131 L.Ed.2d 695 are of questionable precedential value particularly given the U.S. Supreme Court's continuing shift towards states' rights and away from federal preemption. *See* e.g., *Stevenson v. Bank of New York Co. Inc.* (2d Cir. 2010) 609 F.3d 56, 62 (stating that the broad reading of ERISA preemption in cases preceding Travelers had been "misguided.")

In 1995, in the *Travelers* case, the Supreme Court began its preemption analysis with the presumption that Congress did not intend to supplant state laws. There, commercial insurers attacked a New York state statute requiring surcharges to be added to hospital bills of patients with commercial insurance, but not to bills of those covered by Blue Cross. The commercial insurers argued that ERISA should preempt the statute because the surcharge exemption for Blue Cross increased the costs that employee benefit plans would pay if they had obtained commercial insurance from insurers other than Blue Cross. The court had no trouble concluding that the statute "cannot be said to make 'reference to' employee benefit plans in any manner." Nor was there an impermissible "connection" to employee benefit plans. According to the court, the "indirect economic effect" of the surcharges was not enough to create a "connection with" employee benefit plans that would justify preemption. *Travelers* went on note that nothing in ERISA indicates that Congress intended to displace general health care regulation, which traditionally has been a matter of local concern, simply because such laws have an indirect economic effect on employee benefit plans.

Following *Travelers*, the Supreme Court in *DeBuono v. NYSA-ILA Medical and Clinical Services Fund* (1997) 520 U.S. 806, 138 L.Ed.2d 21, upheld a New York gross receipts tax on the income of medical centers owned by a self-insured employee benefit plan. It made no difference to the Supreme Court that the tax was assessed directly against the medical centers (whereas in *Travelers*, the tax was indirect) since there is a presumption against preemption of state regulation of health and safety, including health care regulation and taxation. *See also Hattem v. Schwarzenegger* (2d Cir. 2006) 449 F.3d 423 (California's tax on unrelated business taxable income not preempted and thus applied to ERISA trust).

On the other hand, in *Rush Prudential HMO, Inc. v. Moran* (2002) 536 U.S. 355, 122 S.Ct. 2151, 153 L.Ed.2d 375, the court concluded that it was "beyond serious dispute" that a state law requiring external review of all HMO medical necessity disputes "related to" employer benefit plans. The court noted that the external review law bore "indirectly but substantially on all insured benefit plans . . . by requiring them to submit to an extra layer of review for certain benefit denials if they purchase medical coverage from any of the common types of health care organizations covered by the state law's definition of HMO." (*Id*. at 389.) Nevertheless, the Supreme Court held that ERISA did not preempt the state external review law because that law was "saved" from preemption by ERISA's insurance Savings Clause (*see* the discussion of ERISA's savings clause below).

"Relates To" and State "Pay or Play" Laws

An emerging issue in ERISA preemption litigation concerns whether or not so-called "pay or play" laws "relate to" ERISA plans. This issue has drawn a significant deal of attention in courts and the press over the past couple of years, and courts have differed on the issue.

A couple of recent cases have ruled that state "pay or play" laws do relate to ERISA plans. In *Retail Industry Leaders Ass'n v. Fielder* (4th Cir. 2007) 435 F.Supp.2d 481, the court considered whether ERISA preempted Maryland's Fair Share Health Care Fund Act (FSHCFA). The FSHCFA required employers with 10,000 or more Maryland employees to spend at least eight (8) percent of their total payrolls on employees' health insurance costs or pay the difference between what the employers spent and the eight percent to the State of Maryland. The FSHCFA was written in such a manner that it only applied to Wal-Mart Stores, Inc. The Fourth Circuit ruled that the FSHCA related to ERISA plans for purposes of ERISA preemption because the FSHCA interfered with ERISA's legislative purpose, i.e., to ensure uniform administration of employee benefit plans on a nationwide basis. (*Id*. at 194.) In the court's view, this interference existed because: (1) the FSHCFA would force Wal-Mart to provide a greater level of health benefits in Maryland than Wal-Mart would have to provide in other states; (2) the FSHCFA imposed record-keeping requirements not mandated by other states; and (3) because the vast majority of Wal-Mart's health care spending occurred via ERISA plans, Wal-Mart would not be able to use non-ERISA health plan spending options to satisfy the FSHCFA without having to alter its existing ERISA plans. (*Id*. at 197.) Relying heavily on the *Fiedler* court's rationale, a New York federal district court in *Retail Industry Leaders Ass'n v. Suffolk County* (E.D. N.Y. 2007) 497 F. Supp. 2d 403, ruled that ERISA preempted the Suffolk County Fair Share for Health Care Act, a law which in the court's view was "substantially similar" to the FSHCFA. (*Id*. at 416.)

On the other hand, the Ninth Circuit recently reached a different conclusion. In *Golden Gate Restaurant Ass'n, v. City and County of San Francisco* (9th Cir. 2008) 512 F.3d 1112, the court ruled that it was likely that ERISA would not preempt the San Francisco Health Security Ordinance (Ordinance), which required employers to make "health care expenditures" on behalf of their employees at a rate of either $1.17 or $1.76 per hour, depending on the employer's size. Under the Ordinance, "health care expenditures" included, but were not limited to: (1) contributions by an employer on behalf of its employees into a health savings account; (2) payments made by an employer to a third party for the purpose of providing health care services for its employees; and (3) an employer reimbursing employees for expenses incurred in purchasing health care services. If an employer did not make the required health care expenditures, the employer was required to make equivalent payments to the City of San Francisco. In ruling that ERISA preemption was unlikely, the court found that the Ordinance did not interfere with ERISA's "uniform regulatory regime" because the Ordinance: (1) did not require any employer to adopt an ERISA plan or other health plan; (2) did not require any employer to provide specific benefits through an existing ERISA or other health plan; and (3) imposed administrative burdens on an employer regardless of whether or not the employer had an ERISA plan.

Savings Clause

If it is determined that a law relates to an employee benefit plan, the question is whether the law "regulates insurance" and thus is "saved" from preemption. In 1999, the Supreme Court in *UNUM Life Ins. Co. v. Ward* (1999) 526 U.S. 358, 143 L.Ed.2d 462, again liberalized what "regulates insurance" for the purposes of the savings clause. At issue there was whether California could compel an ERISA plan to honor claims filed after the policy mandated deadline, since California law prohibits an insurer from denying a claim on the basis of lateness unless the insurer can prove it was prejudiced by the delay. According to the Supreme Court, this rule appeared to satisfy the "common sense view of a regulation that hones in on the insurance industry" and thus was "saved" from preemption. Interestingly, the court also rejected the assertion that the notice-prejudice rule conflicted with the substantive provisions of ERISA and specifically the rule that requires plans to provide notice and the opportunity for a review of denied claims. *See* 29 U.S.C. §1133. According to the court:

> By allowing a longer period to file than the *minimum* filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulations.

(*Id*. at 478.)

As will be discussed more fully below, the U.S. Supreme Court more recently established a new test for determining whether a state law is "saved" as a regulation of insurance. A state law will be "saved" if it meets the following two tests:

1. It is specifically directed toward entities engaged in insurance; and

2. It substantially affects the risk pooling arrangements between the insurer and the insured.

See Kentucky Association of Health Plans, Inc. v. Miller (2003) 538 U.S. 329, 155 L.Ed.2d 468. Moreover, the court has at least suggested that, pursuant to this analysis, state laws may regulate health plans providing only third party administrative (TPA) services to self-insured ERISA plans. (155 L.Ed.2d at 477, n.1.)

ERISA's Enforcement Provisions

Even if a law is "saved" by virtue of the fact that it regulates insurance, it may still be preempted if it conflicts with ERISA's civil enforcement scheme.

ERISA's civil enforcement provisions authorize six specific types of relief. (29 U.S.C. §1132(a).) In enacting this provision "Congress intended a federal common law of rights and obligations to develop under ERISA, without embellishment by independent state remedies." (*Pilot Life Insurance v. Dedeaux* (1987) 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (state laws which allow for extra contractual and punitive damages incompatible with ERISA's civil enforcement provisions are preempted).) Thus, to the extent the state law provides a new cause of action or new form of relief, it may be preempted by ERISA's civil enforcement scheme, even if it regulates insurance and would otherwise be "saved" from preemption as discussed above. *See* e.g., *Spellman v. United Parcel Service* (D.ME 2008) 540 F.Supp.2d 237 (holding that although a Maine statute requiring disability insurers to pay employees benefits under certain conditions would otherwise have been saved from preemption as a regulation of insurance under the Kentucky Association of Health Plans' test, ERISA's civil enforcement provisions nevertheless preempted an insured's efforts to enforce the law in an effort to collect benefits from an ERISA plan).

In 2004, in *Aetna Health Inc. v. Davila* 542 U.S. 200 (2004), the U.S. Supreme Court made defined more clearly when a state law-based claim conflicts with ERISA's civil enforcement scheme. Under *Davila*, a state law-based claim conflicts with ERISA's civil enforcement scheme if: (1) the plaintiff, at some point in time, could have brought his or her claim under one of ERISA's civil enforcement provisions; and (2) the plaintiff's claims are not based on a legal duty that is independent of ERISA or an ERISA plan's terms. (*Id.* at 211.) A claim is not based on an independent legal duty: (a) if the interpretation of the applicable ERISA plan terms forms an essential part of the plaintiff's claims; (b) when the plaintiff's cause of action exists only because of the administration of an ERISA plan; or (c) derives entirely from "the particular rights and obligations established by the benefit plans." (*Id*. at 213.)

To the extent the state law claim does not provide a new cause of action or expose the plan to greater liability than is available under ERISA, the state law claim should survive preemption from ERISA's civil enforcement provisions. In *Rush Prudential HMO, Inc. v. Moran* (2002) 536 U.S. 355, 122 S.Ct. 2151, 153 L.Ed.2d 375, the U.S. Supreme Court concluded that Illinois' external review law "was not an alternative remedy barred by ERISA since it imposed no new obligation or remedy in conflict with ERISA." The court rejected the HMO's argument that the Illinois Act interferes with Congress' attempt to provide a unified federal regime of rights and remedies under ERISA, but acknowledged that a state might provide for an independent review that was so close to adjudication that it would be barred as an "alternative remedy." The court noted that the external review law set up something significantly different from common arbitration. Although the independent review considers disputes about HMO contracts and "receives" evidence like medical records, the law did not give the reviewer "free ranging power to construe contract terms"—but rather only the power to render a professional judgment. Thus, according to the court, the procedure most resembled getting a second medical opinion—something far removed from an enforcement scheme. *See also Bacon v. Stiefel Laboratories, Inc.* (S.D.Fla. 2010) 677 F.Supp.2d 1331, 1347-1348 (stating that "…as indicated in *Rush*, a law is not preempted if it merely creates other procedural rights (such as the right to an independent medical review), but does not conflict with ERISA's remedies or provide for greater remedies than those authorized by ERISA.") On the other hand, if a state's external review law resembles an arbitration, it may be seen as conflicting with ERISA's remedial scheme and be preempted. *See* e.g., *Hawaii Management Alliance Association v. Insurance Commissioner of Hawaii* (Hawaii 2004) 100 P.3d 952 (holding that even though Hawaii's external review statute fell within the scope of ERISA's Savings Clause, ERISA nevertheless preempted the Hawaii law because it provided a remedial process akin to a formal arbitration proceeding).

Preemption Analysis Applied to Managed Care

Applying this analysis, courts have come to the following conclusions:

Physician Contract Disputes. A physician's claim against a contracting health plan will typically not be preempted if the claim concerns allegations that the plan underpaid the physician for providing covered services, as opposed to refusing to pay the physician because services were not medically necessary or a covered benefit under the applicable health benefit plan. One of the leading cases on this issue is *Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc., et al.* (9th Cir. 1999) 187 F.3d 1045. In *Anesthesia Care,* the Ninth Circuit refused to preempt CMA's class action on behalf of physicians asserting that Blue Cross breached its provider contracts regarding fee schedules and the procedures for setting them. Significantly, the court refused to find that the economic impact of the breach of contract claims would be so acute as to force an ERISA plan to adopt a certain scheme of substantive coverage. As the court noted, the dispute was not over the right to payment (i.e., whether the terms of the plan covered the services) which might be said to depend on the patient's assignment to providers, but the amount or level of payment, which depended on the terms of the physician-plan contract.[1]

Post-*Davila* cases have followed *Anesthesia Care*. One of the leading post-*Davila* cases is *Pascack Valley Hospital, Inc. v. Local 464A UFCW Welfare Reimbursement Plan* (3d Cir. 2004) 388 F.3d 393. In *Pascack Valley,* a hospital filed a breach of contract action against an ERISA plan for amounts owed. The court found that ERISA did not preempt the hospital's claim in part because the allegations concerned the amount, or level, of payment, but not the right to payment. (*Id*. at 403-404.) The court analyzed the hospital's allegations using the Davila two-step process. First, the court ruled that the hospital, at some point in time, could not have brought its claim under one of ERISA's civil enforcement provisions because there was not sufficient evidence that the hospital had taken assignment from the patient. Second, the court ruled that the hospital's claims were based on a legal duty independent of ERISA or an ERISA plan's terms because, following the *Anesthesia Care* court's rationale, those claims concerned amounts that the plan was obligated to pay pursuant to a contract between the hospital and plan, and not the right to payment, which would have implicated the coverage or eligibility provisions of the ERISA plan.

The fact that a physician or health care provider has accepted assignment from a patient has not in most cases been sufficient to trigger ERISA preemption. This is because the courts have recognized that a plaintiff is "master" of his or her claim. (*Caterpillar, Inc., v. Williams* (1987) 482 U.S. 386.) For example, a physician who has accepted an assignment will, depending on the assignment's wording, be able to "stand in the shoes" of the patient and bring whatever claims the patient/participant would have been able to assert against the ERISA plan. These types of claims would be federal ERISA claims, and ERISA limits the types of remedies that are available to an ERISA participant remedies for such claims. But if a physician has a contract with an ERISA plan, e.g., a fully-insured plan offered by a health insurer, the physician may also be able to raise breach of contract claims against the plan. Because the physician is "master of his or her claim" under *Caterpillar*, the physician is free to choose whether he or she wants to pursue an ERISA claim based on the assignment, or whether the physician wants to maintain a breach of contract lawsuit that does not rely on a patient assignment. A good example here is *Franciscan Skemp Healthcare, Inc. v. Central States Joint Board Health and Welfare Trust Fund* (7th Cir. 2008) 538 F.3d 594. In this case, the hospital filed suit in state court alleging allegations of negligent misrepresentation. The court ruled that ERISA preemption under *Davila* did not apply because even though the plaintiff hospital accepted assignment, the hospital did not sue Central States as the patient's assignee, but under a legal

[1]This case resulted from CMA's class action lawsuit brought against Blue Cross challenging its retroactive fee reductions in 1993, and subsequent reductions in 1994 and 1995, on the grounds that the reductions were not made in accordance with the Blue Cross Prudent Buyer agreement. This decision resulted when Blue Cross sued CMA's class plaintiffs individually in federal court on the grounds that the case was preempted by ERISA, which the Ninth Circuit rejected.

theory independent of assignment (negligent misrepresentation). In reaching this conclusion, the court stated that "Franciscan Skemp could bring ERISA claims in [the beneficiary's] shoes as a beneficiary for the denial of benefits under the plan; but it has not .... Franciscan Skemp is basing its claims on a conversation to which [the beneficiary] was not even a party." (*Id*. at 598.)

Complexities in some recent cases based on the distinction between the "right to payment" versus the "amount of payment."

As already noted, courts like those deciding *Anesthesia Care Associates Medical Group* and *Pascack Valley* make use of the distinction between a provider pursuing "amounts of payment" in which case preemption would not apply, as opposed to the "right to payment," which are preempted. Some recent litigation using this distinction has resulted in some confusion, and has resulted in some plaintiffs lawsuits being removed to federal court even though ERISA did not preempt all of the plaintiffs' allegations. This can be important if state law court is a more favorable venue for the physician than federal court. One example here is *Connecticut State Dental Association v. Anthem Health Plans, Inc.* (11th Cir 2009)591 F.3d 1337. In *Connecticut Dental*, dentists sued Anthem in state court for breach of contract and other state law-based claims. The court removed the entire lawsuit to federal court. In reaching this result, the court noted that while some of the plaintiff's claims concerned amounts of payment, other claims concerned the right of payment. For example, the court noted that the plaintiffs' lawsuit alleged that Anthem breached its contractual obligations by…"systematically denying and/or reducing Dentists' reimbursement for medically necessary services through improper denials." (*Id*. at 1350-1351.) The court read this language as a dispute over coverage that brought such claims within ERISA's preemptive scope. But because the court had jurisdiction over the ERISA-preempted claims, it assumed jurisdiction over the state law claims as well. Thus, while the purely state law claims focusing on payment amounts were not preempted by ERISA, the federal court, for the sake of efficiency, decided that it would resolve those state law disputes along with the ERISA claims. *See also Borrero v. United Healthcare of New York* (11th Cir. 2010) 610 F.3d 1296 (where the court exercised jurisdiction over plaintiff physicians' non-preempted breach of contract claims because the plaintiffs also alleged that United did not pay physicians due to inappropriate coverage determinations. *See also Lone Star OB/GYN Associates v. Aetna Health Inc.* (5th Cir. 2009) 579 F.3d 525. ERISA plaintiffs could avoid these kinds of results by ensuring that their allegations avoided any language that could be construed as implicating coverage, medical necessity, and/ or eligibility determinations, although this strategy might not be the most efficient from a class action perspective.

Provider Anti-discrimination Provisions Not Preempted. Courts governing California similarly refuse to find ERISA preemption where the connection is not so direct that it affects an ERISA plan's operation in a meaningful and substantive way. *See Dishman v. UNUM Life Insurance Co. of America* (9th Cir. 2001) 269 F.3d 974 (ERISA does not preempt state law claim for tortious invasion of privacy). For example, in *Washington Physicians' Association v. Gregoire* (9th Cir. 1998) 147 F.3d 1039, the court refused to preempt Washington's "alternative provider statute" which prohibited HMOs and other health carriers from excluding certain classes of providers (acupuncturists, chiropractors, etc.) from the health plans which they arrange. Under the law, self-insured employee benefit plans were specifically excluded from coverage. The Ninth Circuit did not find anything which impermissibly "related" to employee benefit plans. Rather, the court concluded that the statute regulated health insurance in a broad and neutral way, and only when the insurance is not provided by the employee benefit plan itself. Put another way, the fact that an employer-sponsored plan contracts with an HMO or carrier to provide the ERISA plan does not mean that the HMO or health insurer can escape state regulation on the grounds that the regulation relates to the plan. As the court stated:

> We read the Act to operate only on health carriers that are distinct from ERISA plans, and with such a reading, it is simply false to say that the Act imposes an administrative burden on the plan, or that it

> dictates certain benefit structures. The Act does not require employers to provide any particular welfare benefit to employees, and it does not impose any burden on the plan in administering any benefits it chooses to provide. All of these burdens fall on the health carrier.

Rather than directly regulating the employee benefit plan, the statute regulated products which the employee benefit plan purchased. As the court stated:

> The mere fact that many employee benefit plans choose to buy health insurance for their plan members does not cause a regulation of health insurance automatically to 'relate to' an employee benefit plan…just as a plan's decision to buy an apple a day for every employee, or to offer employees a gym membership, does not cause all state regulation of apples and gyms to 'relate to' employee benefit plans. After *Travelers*, employee benefit plans no longer have a 'Midas touch' that allows them to deregulate every product they choose to buy as part of their employee benefit plan.

(*Id*. at 652.)

The U.S. Supreme Court confirmed this result, although not the analysis, in *Kentucky Association of Health Plans, Inc. v. Miller* (2003) 538 U.S. 329, 155 L.Ed.2d 468, where it upheld against a preemption challenge Kentucky's any willing provider (AWP) law. In defending Kentucky's AWP law from ERISA preemption, the State of Kentucky chose not to argue that the AWP law did not "relate to" an ERISA plan. Consequently, the court only examined whether the law was "saved" from preemption as a regulation of insurance. The court ruled that the AWP law was saved. In so ruling, the court changed the test for determining whether a state law regulates insurance for purposes of the ERISA "savings" clause. The new test requires that the following two factors be present for a state law to regulate insurance:

1. It must be specifically directed toward entities engaged in insurance; and

2. It must substantially affect the risk pooling arrangement between the insurer and the insured.

Because the AWP law at issue in the *Kentucky Association of Health Plans* had the effect of prohibiting insureds from seeking lower cost insurance from companies with closed panels, it "substantially affected the type of risk pooling arrangements" insurers could offer." (538 U.S. at 339.) A number of courts have recognized that *Kentucky Association of Health Plans* new two-part test is more generous than the one required by prior Supreme Court cases. *See* e.g., *American Council of Life Insurers v. Watters* (W.D. Mich. 2008) 536 F.Supp. 2d 811, 822 ("As apparent from the new test articulated in *Kentucky Ass'n*, the standards have been unmistakably relaxed for deciding when a state law "regulates insurance….")

Although *Kentucky Association of Health Plans* liberalized the test used to determine when a state law is saved from preemption as an insurance regulation, not all state laws or regulations that govern health plans can be expected to satisfy the two part test set out in *Kentucky Association of Health Plans*. A recent example of a regulation not satisfying the two-part test is the regulation at issue in *Sgro v. Danone Waters of North America, Inc.* (9th Cir. 2008) 532 F.3d 940. One issue in that case was whether ERISA preempted a California regulation that required health plans to pay their beneficiaries for the costs beneficiaries incurred in making copies of records requested by health plans. The *Sgro* court concluded that the California regulation met the first prong of the *Kentucky Association of Health Plans* test because the regulation only applied to insurers. (*Sgro*, 532 F.3d at 943.) Nevertheless, the court held that ERISA preempted the regulation because the regulation failed to "substantially affect" the risk pooling arrangement between the insurer and the insured as required under the second part of the *Kentucky Association of Health Plans* test. (*Sgro*, 532 F.3d at 943-944.) The court acknowledged that the regulation could affect insurers' risks because, by requiring insurers to pay copying costs, the regulation might make it slightly easier for insureds to file claims, which in turn would probably cause insurers to pay more benefits

than they otherwise would absent the regulation. Yet the court found that such risk was too remote and speculative to "substantially" affect the risk pooling arrangement between insurers and their insureds because "Few, if any, claimants will forgo a meritorious claim because of the relatively small expense of copying—so few, in fact, that they are unlikely to substantially affect the risk pool." (*Id*. at 944.)

State Payment Standards Not Preempted. A U.S. District Court ruled that ERISA does not preempt claims by a group of physicians alleging a health plan violated a Maryland law requiring HMOs to pay non-contracting physicians pursuant to state mandated formulas. *See Medical and Chirugical Faculty v. Aetna U.S. Healthcare* (D.Md 2002) 221 F.Supp.2d 618. In so ruling, the court noted the unanimity of courts finding that physicians' independent state law claims are not preempted by ERISA and that the action concerned the right to receive payments consistent with statutory formulas, not the right to any benefits due plan participants. Even if the claims "related" to an ERISA plan, the court concluded, the claims were nevertheless "saved" from preemption because the claims involved a state law that regulated insurance. *See also Foley v. Southwest Texas HMO, Inc.* (E.D.Tex. 2002) 226 F.Supp.2d 886 (ERISA did not preempt Texas prompt pay statute) and *South Texas Spinal Clinic P.A. v Aetna Healthcare, Inc.*, (W.D.Tex. 2004) 2004 U.S.Dist. Lexis 8911 (prompt payment statutes independent of enrollee's rights under ERISA and therefore not preempted.); but *see Baptist Hospital v. United Healthcare* (E.D.Tex. 2002) 216 F.Supp.2d 625 (prompt pay statute was used as an alternative to ERISA's civil enforcement provisions, and thus preempted where provider did not sue independently, but as an assignee of plan participant); *Lone Star OB/GYN Associates v. Aetna Health Inc.* (W.D.Tex. 2008) 557 F. Supp. 2d 789 (ERISA did not preempt Texas' prompt pay laws applicable to HMOs and PPOs). In reaching its conclusion that ERISA did not preempt Texas' prompt payment laws, the *Lone Star* court stated that, based on its legal research and analysis, "the court agrees with the overwhelming majority of cases holding that claims such as those asserted by Lone Star's Amended Petition [alleging violations of Texas' prompt pay laws] are not completely preempted by ERISA…." (*Id*. at 808.)

Assignment Laws Not Preempted. Although the Federal Circuit Court governing California, the Ninth Circuit, has already concluded that ERISA does not prohibit assignment (see below), a recent Fifth Circuit court is instructive relative as to when a state payment law is preempted by ERISA. In *Louisiana Health Service of Indemnity Co. v. Rapides HealthCare* (5th Cir. 2006) 461 F.3d 529, the court ruled that the state assignment statute did not have an impermissible connection with ERISA and thus was not preempted. According to the court, the burden on plan administrators was minimal (especially since pursuant to Louisiana law, all claims were required to be submitted on a uniform claim form) because the statute did not create any additional paperwork for insurers, and insurers would pay benefits only one time.

External Review Not Preempted. In *Rush Prudential HMO, Inc. v. Moran* (2002) 536 U.S. 355, 122 S.Ct. 2151, 153 L.Ed.2d 375, the U.S. Supreme Court ruled that a state law mandating an external review system whereby a neutral third party decides disputes between treating physicians and health plans over medical necessity is "saved" as insurance regulations, and does not provide an additional remedy "consistent with ERISA's exclusive remedial scheme."

Wrongful Denial of Services Preempted? Unfortunately, the U.S. Supreme Court ruled unanimously that ERISA preempts all state laws which attempt to hold managed care organizations liable for wrongly denying medically necessary care. (*Aetna Health, Inc. v. Davila* (2004) 542 U.S. 200, 159 L.Ed.2d 312.) As a result, the Ninth Circuit concluded that ERISA preempted an enrollee's claim that the plan violated Health & Safety Code §1371.4, by refusing to cover emergency treatment wherever the insured "reasonably believes that an emergency exists." *See Cleghorn v. Blue Shield* (9th Cir. 2005) 408 F.3d 1222. For a more detailed discussion of preemption of claims against plans for negligence or other claims involving quality of care, *see* CMA ON-CALL document #7008, "Managed Care: Health Plan Liability."

Negligent Representation of Eligibility Not Preempted. A number of courts have held that ERISA does not preempt a health care provider's state law claims against a health plan when the plan refuses to pay because the patient turned out to be ineligible for coverage. A recent example is *Franciscan Skemp Healthcare, Inc. v. Central States Joint Board Health and Welfare Trust Fund* (7th Cir. 2008) 538 F.3d 594. Prior to furnishing services to Central States' beneficiary, the plaintiff hospital called Central States to verify the beneficiary's eligibility and coverage of proposed health care services. During the phone conversation, a Central States representative told the hospital that the beneficiary was eligible and that the proposed health care services were covered. Based on this conversation, the hospital treated the beneficiary. Central States subsequently denied payment because, at the time the services were provided, the patient was not eligible for coverage due to a failure to pay plan premiums. Franciscan Skemp sued for payment, alleging that Central States had negligently misrepresented the patient's eligibility. The court ruled that ERISA did not preempt the hospital's claim because that claim did not satisfy the *Davila* two part test. The claim did not satisfy the first part of the *Davila* test because the hospital was not suing to recover benefits due to the patient under the terms of Central States' plan. Rather, the hospital was seeking damages arising from alleged misrepresentations made by Central States to the hospital. *Franciscan Skemp Healthcare,* at 598. The second prong of the *Davila* test did not apply because the hospital's negligent misrepresentation claim "derive[d] from duties imposed apart from ERISA and/or the plan terms; Wisconsin state law defines those duties." (*Id.*)

Anti-discretionary Clauses Not Preempted. Notwithstanding the result of *Davila*, there is a growing body of case law indicating that ERISA does not preempt state laws or regulations that ban health plans' use of discretionary clauses. A recent example is *American Council of Life Insurers v. Ross* (6th Cir. 2009) 558 F.3d 600. The issue in *American Council of Life Insurers* concerned whether ERISA preempted a Michigan insurance regulation that prohibited health insurers' use of discretionary clauses. The regulation defined "discretionary clause" as follows:

> "Discretionary clause" is a provision in a form that purports to bind the claimant to or grant deference in subsequent proceedings to the insurer's decision, denial, or interpretation on terms, coverage, or eligibility for benefits including, but not limited to, a form provision that does any of the following:
>
> 1. Provides that a policyholder or other claimant may not appeal a denial of a claim.
>
> 2. Provides that the insurer's decision to deny policy coverage is binding upon a policyholder or other claimant.
>
> 3. Provides that on appeal the insurer's decision-making power as to policy coverage is binding.
>
> 4. Provides that the insurer's interpretation of the terms of a form is binding upon a policyholder or other claimant.
>
> 5. Provides that on appeal the insurer's interpretation of the terms of a form is binding.
>
> 6. Provides that or gives rise to a standard of review on appeal that gives deference to the original claim decision.
>
> 7. Provides that or gives rise to a standard of review on appeal other than a de novo review.

Insurers and their association, America's Health Insurance Plans, argued that ERISA preempted the Michigan regulation. The court held that the Michigan regulation met *Kentucky Association of Health Plans*' two part test and was consequently saved from preemption. The regulation satisfied the first prong because there was "no serious dispute" that the regulation was "directed toward entities engaged in insurance." The regulation satisfied the second prong because the regulation would "dictate to the insurance company the conditions under which it must pay for the risk it has assumed." The court also determined that the regulation did not conflict with ERISA's comprehensive remedial scheme, because, at most, the regulation would only affect the standard of review a court would apply when evaluating an ERISA plan's benefit determination. The regulation did not, for example, authorize any form of relief in state courts or grant a plan participant the ability to enforce his or her rights under an ERISA plan. *See also Standard Insurance Company v. Morrison* (9th Cir. 2009) 584 F.3d 837 (holding that a state law prohibiting insurers' use of discretionary clauses was saved from preemption under *Kentucky Association of Health Plans* because the law was a regulation of insurance).

Subrogation/"Make Whole" Regulations Not Preempted. The *Benefit Recovery, Inc. v. Donelon*, (5th Cir. 2008) 521 F.3d 326 case centered on a "directive" developed by the Louisiana Commissioner of Insurance ("Commissioner"). The directive required insurance companies to insert in their contracts with insureds a clause that would prevent the insurer from enforcing its subrogation rights against the insured until the insured had been fully compensated for his or her injuries. Benefit Recovery sued the Commissioner, arguing that ERISA preempted the directive. The court ruled that the directive was saved from preemption under the two-part *Kentucky Association of Health Plans* test. The directive met the first part of the test "because [the directive] specifically requires insurance companies to include certain terms in their contracts." (*Id.* at 331.) The directive met the second part of the test because the directive altered the permissible bargains between insurers and insureds "by telling them what bargains are acceptable." (*Id.*)

Pharmacy Benefit Managers (PBMs)

It is unclear whether ERISA preempts state requirements applicable to PBMs, particularly when the regulated PBMs provide administrative services to ERISA self-funded plans. At least one federal circuit court has concluded that ERISA does not preempt such requirements. For example, in *Pharmaceutical Care Management Association v. Rowe* (1st Cir. 2005) 429 F.3d 294, an association of PBMs sought to enjoin enforcement of the Maine Unfair Prescription Drug Practices Act on ERISA preemption grounds. That Act was broadly written so that it imposed a number of requirements on PBMs that provided administrative services to a wide range of entities, including, but not limited to, employee benefit plans. For example, the Act required PBMs to act as fiduciaries for their clients, disgorge profits from self dealing, and disclose certain financial relationships with third parties. The court concluded that while the PBMs may be fiduciaries under state law, they would not be under the definition of ERISA as the state law did not require them to exercise "discretionary authority or control in the management of the plan." For example, provisions requiring disclosure of conflicts of interest and payments from drug manufacturers are administrative provisions that involve no PBM discretion. Further, the court found the law had "no connection" to ERISA plans and thus was not "preempted," as the Maine law did not preclude plan administrators from administrating their plans in a uniform fashion and the existence of ERISA plans was not essential to the state law's operations. *See also Mulder v. PCS* (D.N.J. 2006) 432 F.Supp.2d 450 (in an action alleging PBMs received kickbacks and rebates from drug manufacturers in violation of their fiduciary duties under ERISA, the court concluded that the PBM did not acquire "fiduciary" status under ERISA as its drug utilization review program involved only the administration of the benefit, not the provision of it). However, in 2010, the District of Columbia Court of Appeals reach the oppose conclusion concerning a D.C. law that was virtually identical to the Maine statute at issue in *Rowe*. *Pharmaceutical Care Management Ass'n v. District of Columbia* (D.C.Cir. 2010) 613 F.3d 179.

Potential ERISA Remedy for Claims Against Insolvent IPAs/Medical Group

7. It seems very unfair that my patient is left on the hook for emergency services when an IPA goes bankrupt. Does my patient have any remedy?

Perhaps, if the patient receives his or her health coverage from the patient's employer. Under these circumstances, ERISA would apply. ERISA contains a number of protections that might apply to protect the patient from the unfair result. First, final benefit decisions must be made by a "named fiduciary." (29 U.S.C. §1133; 29 C.F.R. §2506.503-1(h).) Moreover, a "named fiduciary" of the ERISA plan generally remains responsible for the ultimate payment obligations, regardless of how the ministerial aspects of the ERISA plan are handled. (29 U.S.C. §§1104 and 1105, 29 C.F.R. §2509.75-8.) In most cases, either the employer or the health plan will be the named fiduciary, not the medical group or IPA. Even assuming a bankrupt medical group or IPA had been a fiduciary under the plan, it is still possible that the employer or health plan may remain liable for the benefits not paid. Employers and health plans in California are both well aware of the tremendous disruption in care which has resulted from the numerous health plan intermediary bankruptcies in this state, and may well have an affirmative duty to ensure this does not occur. (Cf. *Bussian v. RJR Nabisco, Inc.* (5th Cir. 2000) 223 F.3d 286 (company may have breached its fiduciary duty by choosing the cheapest annuity provider rather than acting prudently and for the exclusive benefit of plan participants by basing its decision on criteria other than what was best for the beneficiaries and participants).) Thus a patient covered by an employer-sponsored health plan will likely retain the right to payment of the benefit by the employer or the health plan if the intermediary goes bankrupt. By extension, a physician who has an assignment and exhausts the plan's internal remedies will be able to enforce that right in federal court on the patient's behalf. Note that under an Interim Final Rule adopted in 2010 by the Internal Revenue Service, the DOL, and the U.S. Department of Health and Human Services, if an ERISA plan fails to strictly adhere to all of the requirements of its internal claims and appeals process with respect to a claim, the claimant, e.g., a physician who has taken assignment, will be deemed to have exhausted the internal claims and appeals process. *See* below for more information.

ERISA ENFORCEMENT

Private Right of Action Available

As noted above, ERISA contains its own federal enforcement provisions. ***These apply to all ERISA plans, regardless whether the employer provides health coverage through an insured or self-insured plan.*** Patients covered by ERISA plans are entitled to file a lawsuit in federal court as follows:

a) to obtain information from the plan administrator to which they are entitled;

b) to recover benefits, enforce rights, or clarify rights to future benefits to which they are entitled;

c) to redress breaches of fiduciary duty by plan fiduciaries; or

d) to stop any act or practice which violates ERISA or the terms of the plan or obtain other appropriate equitable relief.

(29 U.S.C. §1132(a)(1)-(3).)

CLAIMS PROCEDURE REGULATIONS

All ERISA Plans Must Comply

The Department of Labor (DOL) has issued a regulation designed to increase the likelihood that all patients covered by ERISA plans receive the health benefits to which they are entitled. This regulation is intended to ensure more timely benefit determinations, to improve access to information on which a benefit determination is made, and to ensure that participants will be afforded a full and fair review of denied claims. (29 C.F.R. §2560.503-1.) **This regulation establishes a *floor,* applicable to all ERISA plans whether insured or self-insured.** Subsection (k) of the regulation clarifies the nature and extent of ERISA preemption over these issues stating:

> Nothing in this section shall be construed to supersede any provision of state law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

The DOL explained in its comments to the rule that where both the state law and the ERISA regulation can be complied with, the state law is not preempted. As the DOL stated:

> Sub-paragraph (k)(1) states that the regulatory standards should not be read to supersede state law regulating insurance (even when such state law prescribes standards for claims processes and internal review of claims) unless such state law prevents the application of a requirement of the regulation. For example, a state may have a law requiring insurers to allow oral appeals of all claims or to decide claims within shorter periods of time. These laws would not prevent the application of the regulation because plans could comply with both the regulation and the state laws. (65 Fed.Reg. 70246, 70254, November 21, 2000.)

Changes Required by the Patient Protection and Affordable Care Act of 2010 (ACA)

According to the United States Department of Labor, Bureau of Labor Statistics, in 2010, 55.3% of all Americans had employment based health care coverage. *See* www.bls.gov/opub/cwc/cm20120125ar01p1.htm. The Patient Protection and Affordable Care Act (ACA), has had a broad impact on employment-related health insurance plans. Prior to enactment of the ACA, there was no federal requirement that employers offer health insurance coverage. Employer coverage was voluntary, and employees could choose whether to enroll in that coverage. Some of the major impacts of the ACA on employment based health care coverage include changes to plan provisions—such as the elimination of lifetime dollar limits on coverage and designating a set of "essential benefits"—and changes to plan administration requirements. (*Id.*) Beginning in 2014, employers that employed an average of 50 full-time employees during the previous calendar year must offer health coverage that meets minimum essential coverage requirements or pay a fine. The one exception is for firms with more than 50 employees that have no employees receiving a tax credit for health insurance. *See* www.uschamber.com/sites/default/files/100426_critical_employer_issues_ppaca.pdf.

Section 1001 of the ACA states that ERISA plans must comply with claim procedures adopted by the Secretary of the U.S. Department of Health and Human Services. *See* 42 U.S.C.A. §300gg-19. Pursuant to section 1001, on July 23, 2010, the Internal Revenue Service, DOL, and the Department of Health and Human Services issued an Interim Final Rule (IFR) adding six new requirements to the ERISA claims procedure regulations. The IFR can be accessed at www.gpo.gov/fdsys/pkg/FR-2010-07-23/pdf/2010-18043.pdf. These new requirements will be noted where relevant in the following discussion. The U.S. Department of Health and Human Services' web site contains a wealth of information concerning these requirements. *See* http://cciio.cms.gov/. These new requirements do not apply to grandfathered ERISA plans.

Reasonable Claims Procedures Required

ERISA plans are required to establish and maintain reasonable claims procedures governing the filing of benefit claims, notifications of benefit determinations and appeal of adverse benefit determinations. (29 C.F.R. §2560.503-1.) The IFR expanded the definition of "adverse benefit determination" to include rescissions of coverage. Before the IFR, "adverse benefit determination" meant a denial, reduction, or termination of, or failure to pay for, a benefit. Under the IFR, "adverse benefit determination" now includes a rescission of coverage, regardless of whether or not the rescission has an adverse effect on a particular benefit. Under this expanded definition, ERISA plan beneficiaries may now appeal rescissions of coverage just as they can payment or benefit denials.

Failure to maintain such reasonable claims procedures eliminates the requirement that a plan participant or beneficiary exhaust the plan's internal remedies before going to federal court to seek an order mandating the provision of or payment for contested medical services. And, even if the ERISA plan adopts reasonable claims procedures, under the IFR, if an ERISA plan fails to strictly adhere to all of the requirements of its internal claims and appeals process with respect to a claim, the claimant will be deemed to have exhausted the internal claims and appeals process. See below for further information.

The claims procedures for a group health plan will be deemed reasonable if:

- A description of all claims procedures, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as prior authorization procedures or U.R. procedures, and the applicable time frames are included as part of a summary plan description;

- The claim procedures do not contain any provision, and are not administered in a way that unduly inhibits or hampers the initiation or processing of claims for benefits (in particular, no fee may be imposed as a condition of making a claim or an appeal, and no prior authorization requirement may be imposed where it could seriously jeopardize the life or health of the patient);

- The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination (and a physician with knowledge of a patient's medical condition must be permitted to act as the authorized representative with respect to claims for urgent care);

- The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants;

- The claims procedures ensure that a claimant or representative is notified of any failure to obtain prior authorization and of the proper procedures to be followed as soon as possible but not later than five (5) days (twenty-four (24) hours for urgent care) after the failure. Oral notice is okay unless written notification is requested. This applies only where a communication naming a specific claimant, a specific medical condition or symptom and a specific treatment, service or product for which approval is requested is received by someone customarily responsible for handling benefit matters;

- The claims procedures do not require more than two levels of appeals before the claimant can file a federal ERISA lawsuit challenging the benefit denial;

- If any additional levels of voluntary appeal are offered which are not mandated by state law, the plan must waive any right to require exhaustion of these additional appeals, must agree that the statute of limitations is tolled during the pendency of those appeals, must require that the mandatory internal appeals be exhausted first, must provide extensive, or specified information about the voluntary appeal to enable the claimant to make an informed judgment about whether to use it, and it must be free; and

- The claims procedures must not contain a mandatory arbitration provision which would preclude the claimant from filing a lawsuit challenging the determination under ERISA or other applicable law.

(29 C.F.R. §2560.503-1(b)(1)-(5) and (c)(1)-(4).)

The Department of Labor issued a lengthy question and answer guidance (DOL FAQ) clarifying these claims procedure requirements which can be viewed on the Department's website at www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html.

ERISA Timelines for Approval/Denial Must Be Followed

- **Urgent Claims.** Under the IFR, urgent claims must be decided within twenty-four (24) hours, unless the claimant fails to provide sufficient information to determine whether and to what extent benefits are payable under the plan.[2] (Prior to the IFR, the deadline to decide an urgent claim was seventy-two (72) hours.) Appeals must be resolved within seventy-two (72) hours. A claim involving urgent care means a claim for which non-urgent care time frames either:

  - Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

  - In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim.

  The determination of whether a claim involves urgent care is usually made by an individual acting on behalf of the plan and applying the standard of using the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of a claimant's medical condition determines that a claim involves urgent care, then the claim is treated as such for purposes of these rules.

- **Concurrent Care Decisions.** Once a plan has approved an ongoing course of treatment, any reduction or termination before the approved course is completed is an adverse benefit determination. The claimant must be notified sufficiently in advance of the reduction or termination to permit appeal and determination on review before the benefit is reduced or terminated. A request by a claimant to extend a course of treatment involving urgent care must be decided as soon as possible, and the claimant must be notified of the decision within twenty-four (24) hours of the plan's receipt of the request, provided the request is made at least twenty-four (24) hours before the existing authorization lapses.

[2]Within twenty-four (24) hours, the claimant must be notified of this failure and be provided with at least forty-eight (48) hours to supply the required information.

- **Non-Urgent Pre-Service Claims** must be decided within fifteen (15) days, with a 15-day extension allowed in limited circumstances beyond the control of the plan. A "pre-service claim" means any claim for a benefit under a group health plan with respect to which the terms of the plan require prior authorization for obtaining medical care. (29 C.F.R. §2560.503-1(m)(iii).)

- **Post-Service Claims (involving purely the payment or reimbursement of costs for medical care that has already been provided).** Must be decided within thirty (30) days (with a 15-day extension allowed in limited circumstances beyond the control of the plan).

These time frames start running when the claim is filed pursuant to the plan's reasonable requirements, without regard to whether all information necessary to make the benefit determination accompanies the filing. If the plan notifies the claimant of the need for additional information, the time frames are tolled from the date this notification is sent until the claimant responds. With respect to pre-service and post-service claims, claimants must be given at least forty-five (45) days to provide the additional information before the claim is denied.

(29 C.F.R. §2560.503-1(f).)

ERISA Plan Must Provide Reasons and Criteria Supporting Adverse Benefit Determination

A plan administrator must provide electronic or written notification of an adverse benefit determination in a manner calculated to be understood by the claimant. This notification must set forth for all plans:

- The specific reason or reasons for the adverse determination;

- Reference to the specific plan provision that the determination is based upon;

- A description of any additional information or materials necessary to resolve the claim and an explanation as to why that additional information/material is necessary;

- A description of the plan's review procedures (and applicable time limits) and the right of a claimant to obtain judicial review;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making an adverse determination, the health plan must disclose either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the health plan must disclose either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge to the claimant upon request; and

- For claims involving urgent care claims, the plan must provide a description of the expedited review process applicable to the claim. (Note also that, in the case of an adverse benefit determination by a group health plan concerning a claim for urgent care, the information listed above may be provided orally so long as it is followed up electronically or in writing no later than three (3) days after oral notification.)

(29 C.F.R. §2560.503-1(g).)

ERISA PLANS MUST PROVIDE A FULL AND FAIR APPEAL OF ADVERSE BENEFIT DETERMINATIONS

Claimants must be provided with a reasonable opportunity for a full and fair appeal of an adverse benefit determination. To provide a full and fair review, the claims procedures for health plans must:

- Provide a claimant at least 180 days following receipt of notification of an adverse benefit determination within which to appeal the determination;
- Provide claimants with the opportunity to submit written comments, documents, records or other information relating to the claim for benefits;
- Provide that the claimant shall be provided upon request and free of charge reasonable access to copies of all documents, records, or other information relevant to the claimant's claim for benefits;[3]
- Provide for a review that takes into account all comments, documents, records and other information submitted by the claimant relating to that claim, without regard to whether this information was submitted or considered in the initial benefit determination;
- Pursuant to the IFR, provide the claimant, without charge, any new or additional information that the plan considered, relied on, or generated in connection with the claim, and such information must be provided to the claimant as soon as possible and sufficiently in advance of when the plan makes any final adverse benefit determination so that the claimant will have a reasonable opportunity to respond prior to the date on which the plan makes a final adverse benefit decision; and
- Pursuant to the IFR, and before the plan can make a final adverse benefit determination based on a new or additional rationale, the plan must provide the claimant with that new or additional rationale, without charge, and the rationale must be provided as soon as possible with sufficient advance notice of the date on which the plan must make a final adverse determination so that the claimant will have a reasonable opportunity to respond prior to that date.

No Deference. The review may not afford deference to the initial adverse benefit determination.

Reviewing Party. The party who reviews the claim must be a ***named fiduciary of the plan*** who is neither:

- The party who made the adverse benefit determination that is being appealed; or
- The subordinate of that party.

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[3]Information is "relevant" if: 1) it was relied upon in making the determination; 2) it was submitted, considered or generated in the course of making the determination, whether or not it was relied upon; 3) it demonstrates compliance with the administrative processes and safeguards designed to ensure that determinations are made in accordance with governing plan documents and applied consistently with respect to similarly situated claimants; or 4) it is a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether it was relied upon.

According to the DOL FAQ, "relevant documents" does not include access to the files of other claimants nor, with respect to the requirement to disclose the processes and safeguards to ensure consistent decision making, does the regulation require the generation of new documents solely to comply with this requirement. Instead, the regulation requires disclosure of, "plan rules or guidelines governing the application of specific protocols, criteria, rate tables, fee schedules, etc., to claims like the claim at issue, or the specific checklist or cross-checking document that served to affirm that the plan rules or guidelines were appropriately applied to the claimant's claim." (DOL FAQ B-5 and D-12.)

Medical Consultation. If an appeal of an adverse benefit determination involves medical judgment (e.g., whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the appropriate named fiduciary must consult with a healthcare professional who has appropriate training and experience in that field (who is independent from the healthcare professional who participated in the initial adverse benefit determination). The U.S. Department of Labor takes the position that the regulations do not require that this consulting health care professional be licensed, accredited, or certified in the state where the services were rendered or in the state where the claimant resides. *See* DOL/EBSA Advisory Opinion 2005-16A at www.dol.gov/ebsa/regs/aos/ao2005-16a.html.

Identification of Experts. The plan's procedures must provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with an adverse benefit determination, regardless if the advice was relied upon in making the determination. Note that the DOL interprets this regulation as requiring this disclosure only when requested by the claimant. (DOL FAQ, D-9.)

Generally speaking, requests for review of adverse benefit determinations must be in writing unless the case involves urgent care, in which case a request for an expedited appeal may be submitted orally or in writing.

(29 C.F.R. §2560.503-1(h).)

ERISA Plans Must Follow Benefit Determination Timelines on Appeal

Claimants must also receive a timely decision on appeal of an adverse benefit determination.

- **Urgent Claims.** On review, urgent claims must be decided within seventy-two (72) hours.

- **Non-Urgent Pre-Service Claims.** Where the group plan provides for one appeal of an adverse benefit determination, the notification must be provided not later than thirty (30) days after receipt by the plan of the claimant's request for review. Where the plan provides for two levels of appeal, notification must be provided with respect to any one of the two appeals, no later than fifteen (15) days after receipt by the plan of the request for review.

- **Post-Service Claims.** Where only one level of appeal is provided, notification must be provided within sixty (60) days after receipt of the request for review. Where there are two appeals of an adverse determination, the notification must be provided with respect to any one of the appeals not later than thirty (30) days after receipt of the request for review.

(29 C.F.R. §2560.503-1(i).)

ERISA Plans Must Follow Disclosure Rules on Appeal

The notification on review must be made in a manner calculated to be understood by the claimant. It must include:

- The specific reason or reasons for the adverse determination;

- Reference to the specific plan provisions on which the benefit determination is based;

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

- A statement describing any voluntary appeal procedures;

- A statement about the claimant's right to judicial review;

- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, the health plan must disclose either the specific rule, guideline, protocol or other similar criterion, or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request;

- If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the health plan must disclose either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation, will be provided free of charge upon request; and

- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency." Note, however, the DOL has stated that pending further review, it is not enforcing this requirement. (DOL FAQ D-13.)

Additional Notice Requirements Added by the IFR

The IFR imposes new beneficiary notice requirements that ERISA plans must satisfy. A notice of an adverse benefit determination must be written in a culturally and linguistically appropriate manner.

Notices must now include information sufficient to identify the claim involved. Such information must include: (1) the date of service; (2) the health care provider involved; (3) the claim amount (if applicable); (4) the diagnosis code (such as an ICD–9 code, ICD–10 code, or DSM–IV code); (5) the treatment code (such as a CPT code); (6) the corresponding meanings of these diagnostic and treatment codes; (7) the reason or reasons for an initial adverse benefit determination or final internal adverse benefit determination, which must include the relevant denial code, e.g., the claims adjustment reason code and/or the remittance advice remark code; (8) the corresponding meaning applicable to the relevant denial code; (9) a description of the ERISA plan's standard, if any, that was used in denying the claim (e.g., if a plan applied a medical necessity standard in denying a claim, the notice must include a description of the medical necessity standard); (10) a description of available internal appeals and external review processes, including information concerning how to initiate an appeal of an adverse determination; and (11) a disclosure concerning the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist beneficiaries with the internal claims and appeals and external review processes. Model notices for initial adverse benefit determinations and final adverse benefit determinations can be obtained at http://cciio.cms.gov/.

New Limitations on Conflicts of Interest Imposed by the IFR

The IFR also added new conflicts of interest restrictions on those performing adverse benefit determinations. More specifically, the ERISA plan must now ensure the independence and impartiality of the persons, e.g. claims adjudicators or medical experts, involved in making adverse determinations,. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual making a benefit determination must not be made based upon the likelihood that the individual will support a denial of benefits. For example, an ERISA plan cannot provide bonuses based on the number of denials made by a claims adjudicator. Similarly, a plan cannot contract with a medical expert based on the expert's reputation for outcomes in contested cases, rather than based on the expert's professional qualifications.

Deemed Exhaustion If the ERISA Plan Fails to Strictly Adhere to All Claims Procedure Requirements

The IFR states that if an ERISA plan fails to strictly adhere to all of the requirements of the internal claims and appeals process with respect to a claim, the claimant will be deemed to have exhausted the internal claims and appeals process, regardless of whether the ERISA plan asserts that it substantially complied with the claim procedure requirements or that any error it committed was de minimis.

Accordingly, upon such a failure, the claimant may initiate an external review under state or federal law, and pursue any available remedies, such as judicial review.

Continued Coverage Required

The IFR requires an ERISA plan provide continued coverage pending the outcome of an internal appeal. Under the IFR, an ERISA plan is generally prohibited from reducing or terminating an ongoing course of treatment without providing advance notice and affording the beneficiary an opportunity for review of the decision to reduce or terminate treatment prior to the reduction or termination occurring. Additionally, individuals in urgent care situations and individuals receiving an ongoing course of treatment may be allowed to proceed with expedited external review at the same time as the internal appeals process, under either a State external review process or the Federal external review process.

GETTING PAID BY AN ERISA PLAN

8. What steps do I follow in order to get paid by an ERISA plan?

Contracting Physicians

As mentioned above, the Ninth Circuit ruled in *Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.*, *supra*, that claims regarding a contract between a physician and a health plan that contracts with an employer to provide benefits pursuant to an employee benefit plan is governed by state law. Thus, so long as the dispute does not deal with the right to payment (which might depend on the patient's rights to obtain benefits), but rather the amount or level of payment under the physician's contract, state law is applicable. In its Frequently Asked Questions about the Benefit Claims Procedure Regulation, the DOL suggests that ERISA has no application "where the provider has no recourse for amounts, in whole or in part, not paid by the insurer or managed care organization." (FAQ A-8.)

Non-Contracting Physicians

As noted above, ERISA plans are required to establish and maintain reasonable claims procedures governing the filing of benefit claims, notification of benefit determinations and appeal of adverse benefit determinations. (29 C.F.R. §2560.503-1.) As is discussed more fully above, state law is not preempted by these regulations except to the extent the state law prevents their application. Thus, state laws mandating claims be determined within a shorter period of time than that required by ERISA would not be preempted. These rules protect all patients covered by ERISA plans, regardless of whether the physician who provides services contracts with the plan. As is discussed below, a non-contracting physician who obtains the patient's authorization to do so may enforce these rules on the patient's behalf, even in the absence of an assignment of benefits.

While the courts have not required plans to pay billed charges, *see Webb v. Cariten Ins. Co* (6th Cir. 2006) 188 F.App. 391, they do recognize that "UCR" does not mean discounted rates. *See Geddes v. United Staffing Alliance Employee Medical Plan* (10th Cir. 2006) 469 F.3d 919 (stating that the ERISA health plan administrator arbitrarily and capriciously interpreted its plan coverage for a "usual and customary" fee charged by an out-of-network provider to be synonymous with the lower, negotiated contractual fee charged by an insurer's in-network physicians. The court ruled that the interpretation departed from industry custom of relying on average treatment charges in given geographic region and had the deleterious effect on plan beneficiaries by effectively denying medical coverage when plan members were forced to use out-of-network provider).

9. Can I bring a suit for non-payment of benefits?

ERISA law enables physicians to bring suit for non-payment of benefits in certain circumstances. Among the prerequisites to suit are: a) the physician must obtain an assignment of benefits from a participant (patient); and b) the plan's internal review procedures must be exhausted prior to initiating suit. These prerequisites are discussed below.

The Physician Must Obtain an Assignment of Benefits. The Ninth Circuit has ruled that an assignment to a physician is valid **where the ERISA plan language does not prohibit assignment. Notwithstanding other decisions from other jurisdictions to the contrary, this is the current rule applicable to California. ERISA plan payments are *not* assignable in the face of an express non-assignment clause in the plan documents.** (*Davidowitz v. Delta Dental Plan of California* (9th Cir. 1991) 946 F.2d 1476.) In *Davidowitz,* the non-assignment clause in the plan document read "Payment for services provided by a dentist who is not a participating dentist shall be made to an eligible person, and shall not be assignable" (*Davidowitz* at p. 1477, n.2) and was enforced by the court. Therefore, the physician and/or his or her lawyer will have to check the plan documents to determine whether benefits may be assigned. If not, the patient must pay the physician and obtain reimbursement from the plan. Note, however, that where there is an assignment, the provider could be bound by the statute of limitations set forth by the plan. *See Dallas County Hosp. Dist. v. Blue Cross Blue Shield of Texas* (N.D. Tex. 2006) 2006 WL 680473 (provider time-barred by a plan's two year statute of limitations from pursuing non-payment claim).

Another option which physicians may wish to try would be to send a letter to the plan administrator stating the reasons why they believe the care is medically necessary, and further delay will jeopardize the patient's welfare. Ask the plan to authorize you to take assignment, notwithstanding the purported anti-assignment clause in the contract. Hopefully, the plan will agree to make an exception. If so, get it in writing or at the very least, document such agreement very carefully. However, note that there are no reported cases where this approach has been tried. A court may find that a plan contract must be implemented the same for everyone, and may not allow the plan to waive the assignment prohibition under certain circumstances.

On a bright note, courts may be willing to interpret non-assignment clauses in favor of the physician. For example, in *Lutheran Medical Center of Omaha Nebraska v. Contractors, Laborers, Teamsters and Engineers, Health & Welfare Plan* (8th Cir. 1994) 25 F.3d 616, the ERISA plan contended that the language of the benefit agreement precluded a hospital and physician from bringing an action for payment as assignees. The plan agreement provided:

> No employee shall at any time, ... in any manner, have any right to assign his rights or benefits under such plan or this trust, or to receive a cash consideration in lieu of such benefits.

The *Lutheran* court held that this purported anti-assignment clause did *not* prevent a physician from suing the plan to enforce an assignment of benefits. This contract provision, the court found, prohibits assignment of "rights or benefits" under the plan, but did not prohibit assignment of causes of action arising after the denial of benefits. Here, the patients were held to have assigned their causes of action, *not* the right to receive benefits under the plan. However, this case was decided by the Eighth Circuit of the Federal Courts of Appeal and California is governed by the Ninth Circuit. Although the Eighth Circuit indicates this willingness to scrutinize alleged anti-assignment clauses and interpret them very narrowly, thus allowing physicians to recover payment, it is unclear whether the Ninth Circuit in California will follow suit.

Finally, Aetna, CIGNA and Health Net have agreed to accept assignments pursuant to their RICO settlements. For more information, *see* CMA ON-CALL document #7500, "Assignment of Benefits."

Before Suing, the Internal Review Procedures Must Be Exhausted. A physician (as well as a plan participant or beneficiary (patient)) is generally required to exhaust the plan's internal review procedures before bringing a lawsuit or arbitration action for payment. This means that before bringing a lawsuit, the physician must give the plan a chance to change its payment denial through internal appeal procedures. (This is generally true with non-ERISA plans also.) Failure to exhaust internal review procedures afforded by a plan may result in dismissal of a lawsuit brought later. *See Tilton v. United Healthcare of Louisiana, Inc.* (ED. LA 2002) 2002 WL 31016567 (physician failed to exhaust remedies where physician did not perfect appeal rights before plan). Exhaustion is not required, however, where internal review by the plan would be futile or inadequate. *See*, e.g., *Kennedy v. Empire Blue Cross & Blue Shield* (2d Cir. 1993) 989 F.2d 588.

Patient Authorization Required. Under the Department of Labor's Claim Procedure Regulation, discussed above, a physician is generally prohibited from exhausting the plan's internal remedies unless the patient has specifically authorized the physician to act as the patient's authorized representative. An exception applies for claims involving urgent care, that is, cases where a delay of fifteen days either "could seriously jeopardize the life or health of the claimant, or the claimant's ability to regain maximum function" or "would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim." (29 C.F.R. §2560.503-1(m)(1).) In such cases, a physician with knowledge of a claimant's medical condition must be permitted to act as the patient's authorized representative, regardless of whether the patient has affirmatively so designated them. (29 C.F.R. §2560.503-1(b)(4).)

According to the DOL, an assignment of benefits is not sufficient, standing alone, to constitute such an authorization. Moreover, plans can require that patients follow the plan's reasonable procedure for identifying the physician as the patient's authorized representative. *See* DOL FAQ B-1 and B-2. Consequently, physicians should ensure that patients file the appropriate paperwork with the plan designating the physician as the patient's authorized representative, and that they obtain a copy of that authorization to pursue the benefit claim and appeal as well as an assignment of benefits, or the assignment of benefits may be worthless, as there will be no way the physician can ensure that the internal remedies are exhausted as is generally required to pursue a claim in court.

The Claims Procedure Regulation provides for an exception to the exhaustion requirement where an ERISA plan fails to establish or follow claims procedures consistent with its requirements. (29 C.F.R. §2560.503-1(l). However, according to the DOL's FAQ, the claimant bears the burden of establishing the regulatory violation, the violation must not be an "inadvertent deviation" which can be corrected without prejudice to the claimant, and there is no tolling of internal plan deadlines should the claimant be wrong. (DOL FAQ F-2.) Thus, the internal process should rarely be abandoned, even if an ERISA lawsuit is filed before it is completed on the premise that exhaustion is not required.

Attorney Fees

10. Can physicians get attorney fees when suing an ERISA plan?

This is unclear. Courts which govern California look to the "Hummell" factors in order to decide whether to award attorney's fees in ERISA cases (from the case called *Hummell v. S.E. Rykoff & Co.* (9th Cir. 1980) 634 F.2d 446, 452). These factors are: a) the degree of the opposing party's culpability or bad faith; b) the ability of the opposing party to satisfy an award of fees; c) whether an award of fees against the opposing party would deter others from acting in similar circumstances; d) whether the party requesting fees sought to benefit all participants and beneficiaries of an ERISA Plan or to resolve a significant legal question regarding ERISA; and e) the relative merits of the parties' positions.

ERISA law (29 U.S.C. §1132(g)(1)) gives the federal courts discretion to award attorney's fees and costs to either party in any action under ERISA **brought by a "participant, beneficiary, or fiduciary."** The express language of the statute authorizes an award of attorney's fees when the action is brought by one of the parties enumerated. (*M & R Investment Co. v. Fitzsimons* (9th Cir. 1982) 685 F.2d 283, 288.) Where one of the above enumerated parties—participant, beneficiary, or fiduciary—brings an action, the district court has discretion to award attorney's fees to *either* plaintiffs or defendants. (*Carpenters Southern California Administrative Corp. v. Russell* (9th Cir. 1984) 726 F.2d 1410.)

The Ninth Circuit has refused to award attorney's fees in ERISA actions not brought by one of the enumerated parties. *See*, e.g., *Downey Community Hospital v. Wilson* (9th Cir. 1992) 977 F.2d 470, (reversing an award of attorney's fees because the action, by an insurance company, was not an action brought by an ERISA participant, beneficiary, or fiduciary); *M & R Investment* (9th Cir. 1982) 685 F.2d at 288, above (affirming a denial of attorney's fees because the action, by an investment company, was not brought by an ERISA plan participant, beneficiary, or fiduciary. However, when the *Hummel* factors (*see* discussion above) are met and the physician stands in the shoes of the patient because the physician has accepted an assignment, a court could very well award attorney's fees to the physician; *Kayes v. Pacific Lumber Co.* (9th Cir. 1995) 51 F.3d 1449. *See also Misic v. The Building Service Employees' Health and Welfare Trust* (9th Cir. 1986) 789 F.2d 1374, holding that a dentist, as assignee of beneficiaries pursuant to assignment, had standing to assert claims of assignors, but declined to award attorney fees in the case before it because "the question of assignability and standing are novel, and each side acted in good faith."

Contracting or Non-Contracting Physicians May Challenge Denial After Verification of Eligibility

11. What if an ERISA plan denies my claim after verifying the patient's eligibility?

You may be faced with a problem where a plan verified coverage for one of your patients, but after you provided services, the plan refused to pay, claiming the enrollee was ineligible. For information on a claim denial after verification of eligibility, *see* CMA ON-CALL document #7510, "Payment Denial After Treatment Authorization or Verification of Eligibility."

DECISIONS OF PLAN ADMINISTRATORS: STANDARD OF REVIEW

12. What is the "Standard of Review"?

ERISA benefits disputes are subject to one of two "standards of review." These are (1) "arbitrary and capricious review" where substantial deference is given to the decision of the plan administrator; and (2) "de novo review" where no substantial deference is given. In other words, the court may consider the plan's reasons for withholding payment, but the court does not have to do so. *This is best for the physician.* The determination of which standard of review applies can have a significant impact on the outcome of a physician's case.

Deference to Administrator

If the plan by its own terms "gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," (which is generally the case) a deferential standard of review is applied. (*Firestone Tire & Rubber Co. v. Brusch* (1989) 489 U.S. 101, 115, 103 L.Ed.2d 80.) Usually, courts call this an "arbitrary and capricious" or "abuse of discretion" standard. Under this standard, a decision which is consistent with the evidence, will generally be upheld, even if the evidence would also support a different conclusion. However, a decision will not pass muster when the evidence demonstrates that the trustees a) failed to consider an important aspect of the problem, b) offered an explanation for their decision that runs counter to the evidence, or c) is so implausible that it could not be ascribed to a difference in view or the product of their expertise. *See*, e.g., *Booton v. Lockheed Medical Benefit Plan* (9th Cir. 1997) 110 F.3d 1461 (denial of claim for medical benefits without explanation and without obtaining relevant information is abuse; no deference afforded plan administrator). Note that under the DOL's Claims Procedure Regulation, a named plan fiduciary must make the final decision on appeal, de novo, and in consultation with "a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment." (29 C.F.R. §2560.503-1(h)(3).) If plan documents do not confer discretionary authority to the plan administrator, then a reviewing court applies de novo review to the administrator's benefit decision. *See* e.g., *Woods v. Prudential Insurance Company of America* (4th Cir. 2008) 528 F.3d 320, 323-324 (holding that Prudential's decision to deny benefits was not subject to a deferential standard of review because the relevant plan document did not confer discretion on Prudential—the plan document merely stated that Prudential would make "eligibility determinations."

Deference to an ERISA plan administrator's decision is not forfeited if the administrator makes a "single honest mistake" when interpreting plan language. (*Conkright v. Frommert* (2010) 130 S.Ct. 1640.) Although *Conkright* addressed pension benefits, its holding will likely extend to determinations regarding health benefit plans. The dispute in *Conkright* concerned the method by which the ERISA plan administrator calculated pension benefit distributions. Initially, based on its interpretation of plan language, the plan administrator used one method (Method X) to calculate the distributions. Method X resulted in distributions lower than what participants had expected. After the participants sued the administrator, the court, under a deferential standard of review, ruled that the administrator's use of Method X was not a reasonable interpretation of ERISA plan language. The administrator then suggested a different method (Method Y) to calculate benefits. On this second time around the court did not afford the administrator any deference with respect to the administrator's interpretation of the plan, and the court accept the administrator's second interpretation giving rise to Method Y. The Supreme Court held that the lower court erred by not affording the administrator deference when the court evaluated the administrator's second interpretation (resulting in the use of Method Y). In reaching this conclusion, the Supreme Court noted that ERISA's interests in "efficiency, predictability, and uniformity in the manner in which they are promoted by deference to reasonable plan construction by administrators, do not suddenly disappear because a plan administrator made a single honest mistake."

It is too early to assess what, if any, effect *Conkright* may have on ERISA litigation between physicians and ERISA plans. *Conkright* will not, however, afford any protection to ERISA plans when the plan's internal review process suffers "significant procedural irregularities." (*Lafferty v. Providence Health Plans* (D. Or. 2010) 720 F.Supp.2d 1239.)

No Deference to Administrator

An ERISA fiduciary may lose its right to the above deferential standard of review. In *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Technology, Inc.* (9th Cir. 1997) 125 F.3d 794, a patient sued under ERISA claiming that an ERISA fiduciary (Standard Insurance Company) wrongfully denied medical coverage. The patient argued that the Plan was ambiguous regarding coverage and that Standard's determination was tainted by self-interest.

Given Standard's dual role as both the funding source and the administrator of the ERISA Plan, the court said that an "inherent conflict of interest" existed. Because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, "its fiduciary role is in conflict with its profit-making role." *A court will still review the decisions of an apparently conflicted fiduciary under the traditional abuse of discretion standard unless it appears that the conflict may have influenced the fiduciary's decision.* To make such a showing, it must be shown that the fiduciary's self interest caused a breach of its fiduciary obligations. Once evidence that the fiduciary may have acted in its own self-interest is provided, a more careful review must be undertaken by the court. The plan bears the burden of producing evidence showing that the conflict of interest did not affect its decision to deny or terminate benefits. The plan might be able to meet this burden, for example, by showing how its decision in fact benefited the beneficiaries under the plan as a whole. If the plan fails to carry its burden, however, the court's review becomes "de novo," i.e., without deference to the administrator. In the *Lang* case, the insurance company offered no explanation that its decision was made for the benefit of other plan beneficiaries. The court therefore concluded that Standard's decision to limit benefits was not entitled to deference and was subject to "de novo" review.

In 2008 the U.S. Supreme Court in *Metropolitan Life Insurance Company v. Glenn* (2008) 128 S. Ct. 2343, 171 L. Ed. 2d 299 adopted an approach to conflicts of interest similar to that taken by the Ninth Circuit in the *Lang* decision. In *Metropolitan Life*, the Supreme Court reiterated the *Firestone* court's statement that if "a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.'" (*Id*. at 2348.) The *Firestone* court did not, however, provide much guidance concerning what constituted a conflict of interest. The *Metropolitan Life* court provided significant guidance concerning conflicts of interest, stating that a conflict exists when "a plan administrator both evaluates claims for benefits and pays benefits claims…." (*Id.*) Importantly, this conflict of interest exists regardless of whether the administrator is a self-funded ERISA plan or an insurance company or managed care organization that is insuring an ERISA plan. (*Id*. at 2349-2350.)

Under *Metropolitan Life*, because the presence of a conflict of interest is just one factor that courts must weigh in determining whether or not a benefits decision constitutes an abuse of discretion [assuming that plan documents confer discretion on the party making the benefits decision], the extent to which that conflict impacts a court's review of that decision will depend on the facts of each case. The *Metropolitan Life* court did describe circumstances which may enable one to anticipate how courts will weigh the conflict when reviewing a benefits decision:

> The conflict of interest at issue here [i.e., where the administrator making benefit decisions is also paying claims]…should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration. It should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decision making irrespective of whom the inaccuracy benefits.

(*Id*. at 2351.) As noted in the discussion of the *Lang* decision above, an administrator's benefit decision will generally still be subject to deferential review at the judicial level even if a conflict exists, so long as the relevant plan documents confer the requisite discretion on the administrator. What *Metropolitan Life* may mean, however, is that courts may be more cognizant of conflicts of interest when reviewing benefits decisions, which may, in turn, encourage courts to set aside benefit denials more frequently than occurred prior to *Metropolitan Life*.

In *Pegram v. Herdrich* (2000) 530 U.S. 211, 147 L.Ed.2d 164, the U.S. Supreme Court further noted the potential conflict of interest between the plan and patient when the HMO makes decisions about appropriate medical treatment. In *Rush v. Moran*, *supra*, the court, relying on *Pegram*, rejected the argument that external review statute's de novo review of benefit denials deprived plan fiduciaries of their deferential standard since ERISA does not require a "lenient standard for judicial review of benefit denials." (153 L.Ed.2d at 401-402.) While eligibility determinations are administrative in nature, and subject to ERISA's fiduciary requirements, treatment decisions or mixed eligibility decisions (e.g., physician conclusions when to use diagnostic tests) are medical decisions which are not subject to ERISA's fiduciary requirements. *See Pegram v. Herdrich, supra*. For more information on the *Pegram* case, *see* CMA ON-CALL document #7008, "Managed Care: Health Plan Liability."

Further, de novo review is appropriate where an administrator engages in blatant violations of the procedural requirements of ERISA. *See Abatie v. Alta Health and Life Ins. Co.* (9th Cir. 2006) 458 F.3d 955 (wholesale violations of Act is grounds to review decision de novo); *Tinker v. Versata* (E.D.Cal. 2008) 566 F. Supp. 2d 1158 (applying de novo review because the defendant insurer failed to adhere to the procedural requirements of ERISA and the express terms of the plaintiff's benefit plan).

Construing Ambiguous Plan Language in Favor of the Plan Participant

Insurance policies sometimes contain ambiguous language, i.e., language that may be subject to two different, but reasonable, interpretations. Prior to the enactment of ERISA, courts had developed a doctrine often referred to as "contra proferentem" to resolve such ambiguities. Under this doctrine, ambiguity is construed against the insurer in favor of the insured, and courts are required to adopt the reasonable interpretation of a policy provision advanced by the insured. (*McClure v. Life Ins. Co. of North America* (9th Cir.1996) 84 F.3d 1129, 1134, *Lang*, 125 F.3d at 799.

Several courts have adopted the contra proferentem doctrine when it comes to interpreting ambiguous language in ERISA plans. One example here is *Billings v. Unum Life Ins. Co. of America* (11th Cir. 2006) 459 F.3d 1088. In *Billings*, an employee sued his ERISA plan for wrongful denial of disability benefits he felt he was due because he had obsessive compulsive disorder (OCD). The disability policy contained coverage limitations with respect to "mental illness." The court found the "mental illness" limitation was ambiguous--Unum provided a reasonable interpretation concerning why OCD fell under the "mental illness" limitation, but Billings likewise offered a reasonable interpretation as to why OCD was not subject to the limitation. Using the doctrine of contra proferentem, the court adopted Billing's interpretation. The Seventh and Ninth Circuit Courts utilize the contra proferentem doctrine to resolve ambiguities in ERISA plan provisions. *See* e.g., *Phillips v. Lincoln National Life Insurance Company* (7th Cir. 1992) 978 F.2d 302; *Patterson v. Hughes Aircraft Co.* (9th Cir. 1993) 11 F.3d 948. However, the Fifth and Eighth Circuit Courts do not. *See* e.g., *Brewer v. Lincoln National Life Insurance Company* (8th Cir. 1990) 921 F.2d 150; *Lynd v. Reliance Standard Life Ins. Co.* (5th Cir. 1996) 94 F.3d 979.

We hope this information is helpful to you. CMA is unable to provide specific legal advice to each of its more than 37,000 members. For a legal opinion concerning a specific situation, consult your personal attorney.

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