EMPLOYMENT SERVICES ALERT

10/28/14

Increase in DOL Investigations of Health Care Benefit Denials

As a part of its health plan audits for Fiscal Year 2015, we expect the Department of Labor (DOL) Employee Benefit Security Administration (EBSA) to continue to focus on compliance, especially given the group health plan reform mandates of the Patient Protection & Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act (HCERA) (collectively "ACA"). It is our understanding, from discussions with sources within EBSA, that EBSA is actively seeking to investigate cases where plan administrators improperly deny participant's initial healthcare claims. These investigations into improper denials expand upon the comprehensive checklist for auditing ACA compliance by health plans that EBSA had begun implementing in 2012 as part of its ACA implementation activities.

As written, the claims processing regulations under The Employee Retirement Income Security Act of 1974 (ERISA) are intended to help ensure accurate and prompt initial decisions on healthcare claims. A violation of claims regulations under ERISA may result in an improper denial of a claim. The ERISA statute and DOL regulations require ERISA plans to establish and maintain claims procedures under which information can be requested by participants and beneficiaries, and disputes about benefit entitlements can be addressed. Plan administrators should know that the following basic steps are required in an internal claims and appeal procedure:

- a claim for benefits is made by a claimant or authorized representative;
- a benefit determination is made by the plan, with required notification mailed to the claimant;
- an appeal is made by the claimant or authorized representative of any adverse determination; and
- the determination on review by the plan, with required notice sent to the claimant.
- Additional notices are required when (a) a pre-service claim is incorrectly filed; and (b) an urgent care claim is filed but is incomplete.

Because the courts have held that failure to inform plan participants of their right of appeal is a violation of good faith, plan administrators must be well-versed in ACA's newly implemented appeals and review procedures.

Plan Administrator as Defined by ERISA

Due to the many ways that ERISA plans can be organized and administered, ERISA does not refer to one type of entity when imposing legal responsibilities and liabilities. Instead, the statute uses the general term "plan administrator" to describe who is responsible for most items of legal compliance. Every ERISA plan must have a plan administrator. The ERISA plan administrator has numerous statutory responsibilities and is liable for the statutory penalties that may be imposed for failure to properly discharge those responsibilities. In addition, the plan administrator is typically responsible for most of the plan's administrative functions. Although the plan administrator may delegate certain

responsibilities to others, it generally cannot avoid ultimate legal responsibility if the delegated responsibilities are not properly discharged.

Because increasing numbers of ERISA plans are self-funded, plan administrators should be conscious of their fiduciary status under 404(a)(1) of ERISA and the potential exposure to liability that they may be faced with if their denial of benefits was arrived at improperly. In a self-funded arrangement, the employer acts as the insurer and provides the health benefits to employees with its own funds. By doing so, the employer directly assumes the risk for the payment of benefits for any claims. Therefore, even if the claim administration process is handled by a third party administrator (TPA), it is important that the plan administrator remain cognizant of the fact that they remain the fiduciary on the health plan, and are thus liable for any incorrect denials, which is not the case in a fully-insured situation.

Specific Claim Denials That Raise a Red Flag to the DOL

It is our understanding that the DOL is closely examining denials with respect to experimental treatments and acute inpatient care. Insurance contracts often give the plan administrator the authority to use discretion over what are considered experimental treatments. In many instances, however, denying a treatment or therapy because it is considered experimental or investigational is often a more complex undertaking than it first appears because experimental treatment denials are often the source of participant complaints to the DOL and the trigger for a health plan investigation. The following tips, although not all inclusive, can help plan administrators make decisions about experimental medical treatments:

- Review referenced medical guidelines and confirms that the most current guidelines are being utilized.
- Review the proposed plan of treatment and find out if the protocols for treatment state explicitly or implicitly that it is experimental.
- Review patient consent forms to figure out if the procedure is considered experimental or investigational.
- Review the number of prestigious institutions that are performing the procedure in question. What could appear to be an experimental treatment in the community hospital may be considered the standard of care in academic or specialty hospitals.
- Review statistics referencing the chances for patient success. The greater the chance for patient success, the less likely the treatment will be deemed experimental by the courts.

Additionally, plan administrators can find themselves faced with potential liability in denying acute inpatient care, particularly care associated with the treatment of eating disorders. Plan administrators who are not well versed in the nuances of eating disorder treatments would be well served to confer with medical experts and the participant's caretakers to confirm that they receive an appropriate length of medical stay. In fact, just recently the U.S. Court of Appeals for the Ninth Circuit ruled that a claims administrator for an ERISA plan abused its discretion in refusing to pay for more than three weeks of inpatient hospital treatment for an insured's anorexia nervosa.

Employers should consider taking a serious look at their group health plans, not only for compliance with the PPACA and ERISA, but also with the long-standing mandates for group health plans such as HIPAA, COBRA and others laws.

Roetzel and Andress's attorneys are available to answer questions about this and other workplace developments.

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