U.S. DEPARTMENT OF LABOR

ADVISORY COUNCIL ON EMPOYEE WELFARE AND BENEFIT PLANS

TESTIMONY OF KAREN L. HANDORF

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My name is Karen Handorf. I am Senior Counsel at the law firm of Berger Montague, PC where I represent plan participants and fiduciaries in litigation brought against third-party administrators of ERISA-covered health plans. Prior to entering private practice in 2007, I spent over twenty-five years at the Department of Labor in the Plan Benefits Security Division, Office of the Solicitor where I litigated a wide range of ERISA issues, including those relating to benefit claim denials.

Thank you for inviting me to testify concerning the low number of appeals of health benefit plan denials and the possible reasons for such low numbers. This is a complex question for which there are many possible answers, but I share with you my observations based on litigating cases brought by plan fiduciaries and participants against insurance companies acting as third-party administrators (TPAs) of self-funded health plans.

I. INTRODUCTION

It is my view that the small number of health care benefit appeals is due to several factors. TPAs control how claims are paid to both network and out-of-network providers with little or no transparency and yet escape fiduciary responsibility by claiming that they are just engaged in ministerial acts. This lack of transparency and accountability allows TPAs to manipulate the claims process to collect fees in addition to the per member per month fees they collect to administer plan claims. Participants often have no idea why their claims are being denied, do not have the resources to appeal the claim denial and have difficulty finding attorneys who are willing to take their cases, which do not involve large sums of money and are difficult to win because of the abuse of discretion standard. Moreover, attorneys are unable to collect fees for the critical internal appeals process where the record is developed. Providers, who have the knowledge and resources to bring the claims, are unable to bring them under ERISA because: (1) plan provisions often prohibit participants from assigning their claims to providers, and (2) most non-ERISA

claims are completely preempted by ERISA. Many ERISA plans do not establish a rate of payment, and courts have increasingly allowed providers to bring state contract or estoppel claims against TPAs alleging that they have not been paid enough for their services. Thus, the claims process is primarily controlled by TPAs and providers, neither of which is directly regulated by ERISA, and many benefit disputes are resolved under state law rather than ERISA.

For these reasons, I believe that any changes to the claim regulations will not meaningfully improve the rights of plan participants unless they reflect the reality that most ERISA health plans are network plans controlled by TPAs. Moreover, meaningful improvement cannot be made without other substantial changes to the statute. I recommend the following:

- The network agreements should be made public or, at the very least, available upon request.
- Anti-assignment clauses should be prohibited.
- TPAs should be required to report the amount of fees they are collecting when they adjudicate a claim, and the EOB should reflect how much is being paid in fees as part of the benefit cost.
- The ministerial exception should be rewritten to clarify that TPAs are plan fiduciaries unless all policies and procedures and network contracts are revealed to plan fiduciaries and claims data is readily available to them.
- Plan documents should be required to establish the payment rates for out-of-network providers so that participants have a basis upon which to challenge the rate of payment.
- Discretionary clauses should be banned in plan documents.
- Attorneys should be get compensated for work they put into the internal appeals phase, even if they are not required to file suit.

These conclusions are reached based on my own experience and research as outlined below.

II. DISCUSSION

A. The Administration of Self-funded Plans are Controlled by TPAs Who Control How Much is Paid to Providers

Most self-funded health plans contract with one of the major insurers (the Blues, United, Cigna and Aetna) for access to their network providers at reduced rates and for related claims services pursuant to administrative service agreements (ASAs).

Self-funded plans choosing this option are generally limited in choice of networks and TPAs because only one or two carriers offer networks in the geographic area where participants are located. This, in turn, limits a plan fiduciary's ability to negotiate the ASA's terms.

1. Network Provider Payment Terms Are Not Disclosed to Plans.

ASAs are usually vague as to how network providers will be paid. Some ASAs provide that claims will be paid at the discount the TPA has negotiated with the medical providers in its network, but the plan is not informed what the discount is. ASAs sometimes state that the TPA will pay network benefits under the plan pursuant to other provisions in medical provider contracts without revealing what those provisions are or to whom they apply. ASAs sometimes state that in some cases providers may be paid more than the billed amount but do not explain the circumstances under which that occurs. Requests for clarification of those terms before the ASA is signed by plans are usually met with the response that the internal methods of the TPA and its contracts with network medical providers are proprietary.

The following language, for example, is from an ASA between Anthem and a self-funded plan defining the payment method for network claims:

> Provider and Vendor Claims. Except as otherwise provided in this Agreement, Paid Claims shall mean the amount Anthem actually pays the Provider or Vendor without regard to: (i) whether Anthem reimburses such Provider or Vendor on a percentage of charges basis, a fixed payment basis, a global fee basis, single case rate, or other reimbursement methodology; (ii) whether such amount is more or less than the Provider's or Vendor's actual Billed Charges for a particular service or supply; or (iii) whether such payments are increased or decreased by the Provider's or Vendor's achievement of, or failure to achieve, certain specified goals, outcomes or standards adopted by Anthem.

The SPD provided to participants for this plan does not state how network claims are priced. Instead, it states that the plan receives discounted fees and rates from physicians in the provider network, that using network providers will lower out of pocket costs, and that the provider will submit claims forms directly to Anthem. This is not unique. An SPD provided to participants of a United administered plan states that "when covered health services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider" with no further explanation.

2. TPAs Have Almost Complete Discretion Over Payments to Out-of-Network Providers.

ASAs are often vague about the terms under which out-of-network providers will be paid. The following language, for example, is contained in a United ASA: "United offers out of network programs that strive to increase savings to Customer by accessing discounts or negotiating reductions of out-of-network claims. United offers a mix of out of network programs that offer varying degrees of discounts, consumer advocacy, and cost controls."

Similarly, an SPD from a plan that uses United as its TPA is vague about the way out-of-network claims are priced:

"When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

> Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
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> If the rates have not been negotiated, then one of the following amounts:
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> > For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area."

As discussed below, this gives the TPA complete discretion to determine how much to pay on out-of-network claims and to collect fees in the process. The participant, however, ends up responsible for the balance of the bill with no real ability to dispute the payment made by the plan to the provider.

B. TPAs Control the Relationships with Providers and Do Not Provide Information Necessary for Plan Fiduciaries to Monitor Them.

TPAs guard their relationships with network providers by prohibiting the plan from directly contacting network providers. The network provider seeks pre-authorization directly from the TPA, submits claims directly to the TPA, handles all claims disputes directly with the TPA, and receives payment directly from the TPA. If the TPA or the plan determines that overpayments have been made to a provider, the TPA controls how those overpayments will be collected and what amount will be collected.

It is almost impossible for plan fiduciaries to determine how a TPA administers network and out-of-network claims. TPAs consider their processes and procedures for administering claims to be proprietary and will not share them with plan fiduciaries. When plan fiduciaries seek claims data from a TPA, the TPA almost always points to limiting provisions in the ASA, insists on limitations on the number of claims that can be audited and restricts review to its own chosen vendors. TPAs generally require a non-disclosure agreement limiting the use of the data, including prohibiting plans from performing analytical procedures on claims data. When plans respond that ASA provisions restricting access to claims data violate the gag clause prohibitions of the Consolidated Appropriations Act (CAA), 29 U.S.C. § 1185m.[1] TPAs respond that the CAA does not require them to produce the data; it only prohibits plan fiduciaries from entering contracts that contain gag clauses.

Even if plan fiduciaries obtain claims data, they often find it difficult to analyze the data without access to the contracts between the TPA and the network medical providers. As noted above, the ASAs are generally vaguely worded to give the TPA maximum flexibility in negotiating reimbursement arrangements with network providers, resulting in contract terms that allow fee-for-service payments at a discounted rate, value-based payments, and diagnosis related group ("DRG") payments, and give the TPA permission to pay more than the billed amount without explaining the circumstances. In addition, the TPA may have revenue neutrality agreements with providers guaranteeing the providers a certain amount per year, which may cause the TPA to pay more for some plan claims than the agreed upon rate to make up a shortfall.

In one case, a plan was able to obtain claims data from a source other than the TPA and compared the amount the plan paid for claims with the amount it should have paid had the hospital's published negotiated rates been applied. The plan discovered

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[1] The CAA prohibits, among other things, group health plans from entering into an agreement with a third-party administrator or other service provider offering access to a network of providers that would directly or indirectly restrict a plan from electronically accessing de-identified claims and encounter information or data, including, on a per claim basis: (1) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract, (2) provider information, including name and clinical designation, (3) service codes, or (4) any other data element included in a claim or encounter transaction.

that none of its payments were consistent with the published discounts. The plan paid more than the published discounted rate in most instances, and, in some cases, it paid more than the billed amount.

It is even more difficult for plan fiduciaries to monitor claims payments to out-of-network providers. As noted above, many ASAs do not define how the price paid to out-of-network providers will be determined or give the TPA broad discretion to choose among payment options.

C. Despite their Substantial Control Over Plan Administration, TPAs Assert That They are Not Fiduciaries.

When TPA are sued for self-dealing or other fiduciary breaches, they deny that they are fiduciaries based on an old DOL interpretive bulletin carving out those who perform certain "ministerial functions" from ERISA's otherwise broad functional fiduciary reach. 29 C.F.R. § 2509.75-8. The interpretive bulletin was designed to ensure that lower-level employees assigned administrative tasks with respect to a plan could do their jobs without concern about possible fiduciary liability. The bulletin states that persons who perform "purely ministerial functions" are not fiduciaries to the extent that they have "no power to make any decisions as to plan policy, interpretations, practices or procedures" and perform their functions "within a framework of policies, interpretations, rules, practices and procedures made by other persons." *Id*. When the person performing ministerial functions is subject to another person's rules, the person "is not a fiduciary because such person does not have discretionary authority or discretionary control respecting management of the plan [and] does not exercise any authority or control respecting management and disposition of assets of the plan." *Id*.

This interpretive bulletin is routinely cited by TPAs to avoid fiduciary liability when the plan fiduciaries retain ultimate authority to decide a benefit claim although few, if any, of the claim decisions ever reach that level of review. Instead, the TPA makes the final claims decision in almost all instances. TPAs also routinely rely upon this interpretive bulletin to argue that the TPA is not a fiduciary because the plan adopted the TPA's internal practices and procedures when it signed the ASA. Thus, the TPA argues, it has no discretion because it is performing its functions "within a framework of policies, interpretations, rules, practices and procedures" made by the plan itself. The plan, however, has never seen the TPA's policies, interpretations, rules, practices, and procedures because the TPA considers them to be proprietary.

Courts have adapted this analysis in dismissing claims against TPAs brought by plan fiduciaries alleging fiduciary breaches.[2]

III. TPAs Engage in Practices That Negatively Impact Participants.

Vague contract terms and lack of transparency allow TPAs to exercise broad discretion with respect to claims payment and recovery of overpayments without review. Recent cases and articles in the press have revealed some practices that are questionable, allow TPAs to collect unreasonable or hidden fees, and engage in a practice called cross-plan offsetting which the Department of Labor asserts, and some courts have held, is self-dealing and violates prohibited transaction rules. These practices may explain some of the reasons there are limited appeals of benefit denials.

A. Participants are Harmed by Auto-adjudication of Claims.

ProPublica reported that Cigna doctors responsible for reviewing claims rejected patient's claims without opening their files. See https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims. Instead of having a doctor review the patients' records and use their expertise, a Cigna algorithm flags mismatches between diagnoses and what Cigna considers to be acceptable tests and procedures for the medical condition. According to one Cigna doctor, he literally clicked and submitted claims, which allowed him to take 10 seconds to review 50 claims at a time. According to insurance executives, similar systems exist throughout the industry. A former Cigna executive explained, "Why not just deny them all and see which ones come back on appeal? From a cost perspective, it makes sense."

According to the ProPublica report, Cigna executives stated that they knew that many patients would pay the bills rather than deal with the hassle of appealing a rejection. Cigna's program focused on tests and treatments that typically cost a few hundred dollars each and, according to a Cigna executive, "[i]nsurers are very good at knowing when they can deny a claim and patients will grumble but still write a

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[2] *See e.g.Mass. Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Mass.*, 66 F.4th 307 (1st Cir. 2023); *Tiara Yachts, Inc. v. Blue Cross Blue Shield of Michigan*, No. 1:22-cv-603 (W.D. Mich.) (dismissed Feb. 27, 2023) (appeal pending); *Trustees of Intern'l Union of Bricklayers and Allied Craftworkers Local 1 v. Elevance*, 2024 WL 1707223 (D. Conn. Apr. 22, 2024).

check." Cigna points out that doctors and their patients can appeal the decision, but Cigna does not expect many appeals, estimating that only 5% of people would appeal a denial. Cigna acknowledged that the denials would "create a negative customer experience" and a "potential for increased out of pocket costs," but with respect to one procedure alone, Cigna saved roughly $2.4 million a year.

B. Participants are Harmed by Shared Savings Programs.

A recent New York Times article described the use of MultiPlan and Data iSight (referred to as "repricers") by the major insurers, acting as TPAs for self-funded health plans, to price out-of-network claims at low rates and take a percentage of the difference between the billed rate and the sum actually paid as a "savings" fee. https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills.html. This program incentivizes low payments to out-of-network providers to maximize the savings fee and often results in the plan participant being financially obligated to pay the balance of the bill.

Because the "savings" fee is often disguised as part of the benefit payment and not reported separately to the plan,[3] it is difficult to determine how widespread these arrangements are, although they have been the subject of recent lawsuits. As the NYT article states, MultiPlan and Data iSight are used by the largest TPAs: UnitedHealth, Cigna, Aetna, Kaiser Permanente, Humana and some of the Blues. A recently filed lawsuit filed by W.W. Grainger against Aetna claims that Aetna uses Zelis Healthcare Corp. and Global Claims Services in addition to MulitPlan to reprice claims.[4]

According to one complaint, Aetna takes money from a self-funded plan to pay a claim and then sends the claim to repricers to negotiate it down. According to the complaint, "[t]he repricing companies have one job: to delay payment until the provider's biller relents and agrees to accept an amount well below the billed amount and well below what Aetna wrongfully obtained from the Plans. If one repricing company is not making headway with a provider, then Aetna shifted the claim to

[3] For example, a repricer could pay a provider $1500 for a procedure that was billed at $100,000 but charge the plan $26,150 ($25,000 for the "savings" fee plus $1500 for payment to the provider) without stating how much of the $26,500 was for the "savings" fee and how much was to compensate the provider.

[4] *W.W. Grainger, Inc. et al. v. Aetna Life Ins. Co.*, No. 2:24-cv-00352 (E.D. Tex., filed May 10, 2024).

another repricing company, and then another, and then another."[5] It is in the TPA's best interest to pay the least amount because the larger the margin between the billed amount and the paid amount, the larger the percentage of savings collected as a savings fee by the TPA and the repricer.[6]

Because the out-of-network provider has not agreed to accept whatever the TPA is willing to pay, the participant remains responsible for the difference between the billed amount and the so-called negotiated amount.[7] According to the NYT, participants received EOBs outlining the thousands of dollars the participant "saved" or the "discount" they received when, in fact, they were liable to their doctors for that amount. One participant was shocked to discover that she owed more than $100,000 to her provider who had only been paid $5,449.27 by United for a complicated heart surgery. Assuming the SPD contained the language outlined above, it is difficult to see that she has a claim for additional payment when the SPD gives United complete discretion to pay an out-of-network provider whatever amount the provider can be forced to accept. The NYT found that patients hit with unexpectedly large bills complain that appeals are fruitless.

According to the NYT, United has reaped an annual windfall of about $1 billion in fees in the last few years from its Shared Savings program. MultiPlan informed investigators that it identified $23 billion in bills from various insurers that it recommended not be paid.[8]

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[5] *Id.*

[6] It is unclear whether TPAs report the amount they receive in "savings" and other fees to ERISA-covered plans. The CAA amended Section 408(b)(2) of ERISA, 29 U.S.C. § 1108(b)(2), to require disclosure of all direct and indirect compensation received by "consultants" and "brokers" to ERISA-covered health plans, but TPAs claim they are not covered by these provisions because they are neither consultants nor brokers.

[7] *See Popovchak v. UnitedHealth Group*, 2023 WL 6125540 *4-6 (S.D.N.Y. Sept. 23, 2023).

[8] Shared savings programs are also applied to overpayment recoveries. There is some suspicion that TPAs sometimes shut off algorithms so that they can obtain a "savings" fee when they collect the overpayment. It is not clear that the participant would be financially impacted by the practice although it might impact the co-insurance payments.

C. Participants are Harmed by Cross-plan Offsetting.

TPAs also engage in a practice called cross-plan offsetting through which a TPA recovers an overpayment to a health care provider under one health plan that it administers by underpaying or "offsetting" an amount owed to the same provider under a different health plan it administers. Often the TPA takes money from self-funded plans to reimburse itself for overpayments it made to the provider in its insured plans, thus putting self-funded plan assets in its corporate accounts with no third party involved. Along the way, the TPA may collect "savings" fees from self-funded plans for collecting the overpayments it made in the first place.

A complaint filed against United challenging cross-plan offsetting explains the process. The participant received healthcare from an out-of-network provider, and the provider submitted a benefit claim on the participant's behalf for a total of $34,000. In a Payment Remittance Advice (PRA), United informed the provider that the allowed amount was $14,040 and, after applying certain deductions and co-insurance, the "Payment Amount" was $8,015.88. United reported in the EOB to the participant that $8,015.88 was the total benefit paid under her Plan. The provider, however, received nothing for his services because the entire amount paid by the participant's plan was used by United to pay itself back for overpayments it allegedly made to the provider for medical services provided to a different patient under a different plan that was insured by United. The provider was informed of the reason for the offset and was directed by United to adjust the participant's account balance based on this information. The provider, however, had no obligation to adjust the participant's account balance, and the participant continued to owe the remaining amount.[9]

The participant, however, has little recourse. The participant cannot challenge the original amount paid to the provider because the plan contains no specific reimbursement rate for out-of-network providers. The participant is not given an opportunity to appeal United's decision to take the offset nor would she have had the information necessary to show that her provider had not been overpaid for a claim of a different participant in a different plan. If she is lucky, her provider will not balance bill her. But even if the provider does not balance bill the participant, the provider has provided medical services to the participant for which he has not

[9] *See Smith v. UnitedHealth Group, Inc.*, No. 0:2022 cv 01658 (D. Minn.).

been fully compensated, upsetting the doctor-patient relationship and inhibiting the participant from seeking further medical care.[10]

As discussed below, the provider does not have standing under ERISA to pursue the claim on behalf of the participant, and often cannot be assigned the participant's claim because of plan anti-assignment provisions. As one court stated, in effectuating cross-plan offsets, the TPA acts as "judge, jury and executioner."[11] Thus, the TPA's use of cross-plan offsetting becomes almost immune from challenge.

DOL has stated that cross-plan offsetting violates ERISA's rule under 29 U.S.C. § 1104(a) that a plan fiduciary shall discharge its duties with respect to a plan solely in the interest of the participants and beneficiaries. DOL also asserts that a fiduciary engaging in cross-plan offsetting is acting on both sides of a transaction in violation of 29 U.S.C. § 1106(b)(2) and, where the offset amount benefits the TPA's insured plans, is dealing with plan assets in its own interest or for its own account in violation of 29 U.S.C. § 1106(b)(1).[12] DOL recently settled a lawsuit against EmblemHealth requiring it to cease the practice. [13]At least one court has held the practice to be illegal, and another has held that the practice, if not illegal, is in serious tension with ERISA and questionable.[14] The practice, however, continues with substantial numbers of recoveries through offsets likely used to reimburse TPAs for alleged over-payments made in insured plans.

D. Participants are Harmed by Other TPA Practices.

A review of complaints filed in courts over the past several years reveals other undisclosed TPA practices that may impact the amount participants pay:

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[10] Because the participant was not balance billed, the court held that she had not suffered an injury in fact sufficient to give her Article III standing. *See Smith v. UnitedHealth Group, Inc.*, No. 0:2022 cv 01658,2023 WL 3855425 (D. Minn. May 4, 2023) (appeal pending).

[11] *Peterson v. UnitedHealth Grp.*, 242 F. Supp. 3d 834, 838 (D. Minn. 2017).

[12] *See* DOL Amicus Brief in Support of Plaintiffs*, Peterson v. UnitedHealth Grp.*, 2017 WL 3994970 (8th Cir. Sept. 7, 2017).

[13] https://www.dol.gov/newsroom/releases/ebsa/ebsa20231005.

[14] *Lutz Surgical Partners PLLC v. Aetna*, No. 3:15-cv-02595, 2021 WL 2549343 (D.N.J. June 21, 2021); *Peterson v. UnitedHealth Grp.*, 913 F.3d 769, 777 (8th Cir. 2019).

• TPAs using subcontractors to provide services and pay the additional fee to them from plan assets without the plans' knowledge and contrary to contract terms by using "dummy codes" which resulted in participants paying more in co-insurance. [15]

• TPAs employing "exclusion lists" to induce medical providers to join their network by promising that they will provide no scrutiny or limited scrutiny to their claims without informing plans of such exclusion lists. [16]

III. Substantial Barriers Stand in the Way of Benefit Claim Appeals.

A. Providers do not have ERISA Standing, and Anti-assignment Provisions Limit their Ability to Act on Behalf of Participants.

Usually, the plan participant is not involved in the payment or negotiation process. Instead, the participant usually assigns their benefit claims to the provider or authorizes the provider to represent the participant during the claims process. It is generally the provider who obtains pre-certification, requests payment of benefits, and negotiates with the TPA with respect to the amount the provider will be paid. The TPA will generally pay the participant's benefits directly to the provider. Thus, the providers, who are not ERISA regulated parties, and the TPAs, who are minimally regulated by ERISA (absent clarification of the ministerial exception to fiduciary status), determine the reimbursement rate for millions of dollars of claims without input from the plans, their fiduciaries, or their participants.

The provider, however, does not have standing under ERISA to file a benefit claim in federal court unless the participant assigns the benefit claim to the provider. Courts have consistently held that providers have standing if the participant has assigned the benefit claim to the provider.[17] Many plans, however, contain anti-assignment provisions, and courts have also consistently held that a provider does

[15] *Peters v. Aetna Inc.*, 2 F.4th 199 (4th Cir. 2021).
[16] *W.W. Grainger, Inc. et al. v. Aetna Life Ins. Co.*, No. 2:24-cv-00352 (E.D. Tex., filed May 10, 2024).
[17] *North Jersey Brain & Spine Center v. Aetna*, 801 F.3d 369, 373-3 (3d Cir. 2015); *Tango Transp. V. Healthcare Fin, Servs., LLC*, 322 F.3d 888, 889 (5th Cir. 2003); *I.V. Servs. Of Am. V. Inn Dev. & Mgmt.*, 182 F.3d 51, 54 (1st Cir. 1999); *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1352 (11th Cir. 2009).

not have standing if the plan contains an anti-assignment clause.[18] It is the provider, however, who has the knowledge and resources to pursue the claim on behalf of the participant. By requiring plans to include anti-assignment provisions in plan documents, TPAs significantly reduce the number of benefit challenges.

Providers may be able to get around the anti-assignment clauses and directly sue TPAs under state law if they claim that they were promised a certain payment by the TPA and have been underpaid. Some courts hold that where the claims have been approved but underpaid, the provider has an independent right to assert state law estoppel or contract claims. Most courts hold that if the claims involve the "rate of payment" based on state law, not the "right to payment" based on plan terms, they are not completely preempted by ERISA.[19] Some courts rely on the absence of plan language setting a rate of payment. [20] In these cases, the providers have a cause of action even when the participant does not. Other courts have limited providers' ability to pursue state law claims on the ground that those claims are completely preempted by ERISA.

Many providers, however, do not have the financial resources to challenge reimbursement denials. A group of small hospitals in Southern Ohio informed me that many of their claims are not paid or paid for far less than the negotiated rate, but they do not have the resources to pursue cases in the courts. Single practitioners are often targeted, most likely because they do not have the resources to challenge payment denials. When the TPA claims that it has overpaid them, the TPA simply collects the payment by a cross-plan offset or refuses to pay for additional treatment until the overpayment is collected.

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[18] *See, e.g.*, *American Orthopedic & Sports Medicine v. Independence Blue Cross Blue Shield*, 890 F. 3d 445, 453 (3d Cir. 2018); *McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc.*, 857 F.3d 141, 147 (2d Cir. 2017); *Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1295-96 (11th Cir. 2004); *LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores*, 298 F.3d 348, 352 (5th Cir. 2002); *City of Hope Nat'l Med. Ctr. v. HealthPlus, Inc.*, 156 F.3d 223, 228-29 (1st Cir. 1998); *St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc.*, 49 F.3d 1460, 1465 (10th Cir. 1995)

[19] *See McCulloch Orthopaedical Surgical Servics, PLLC v. Aetna, Inc.*, 857 F. 3d 141, 145-6 (2d Cir. 2017) (citing cases).

[20] *Jenkins v. Aetna Health Inc.*, 2024 WL 1795488 (S.D.N.Y. Apr. 25, 2024).

B. Participants attempting to challenge claims denials face numerous obstacles.

Participants who are denied a benefit or who wish to challenge a benefit underpayment face significant obstacles in doing so.

1. There are no incentives for insurers to administer claims properly.

Insurers have no incentive to ensure proper claims administration because all that is likely to happen even if they are determined to have wrongfully denied a claim is that they will be forced to pay the claim. There are, of course, no punitive damages allowed under ERISA, and while there was some hope that the Supreme Court's decision in *Cigna v. Amara,* 563 U.S. 421 (2011), would provide compensatory relief for claims mismanagement, a recent case puts that in doubt. In *Rose v. PSA Airlines*, 80 F.4th 488 (4th Cir. 2023), doctors for a 27-year-old flight attendant named Kyree attempted to obtain prior authorization from a self-funded plan for an immediate heart transplant necessary to save Kyree's life. Pre-approval was denied because Kyree did not meet certain alcohol-abuse criteria allegedly required by the plan. Kyree's doctors sought an expedited external claim review required by law to be completed within seventy-two hours. The external reviewer, however, treated the request as a standard review to be completed within 45 days despite the urgency of the request. Kyree died a little over a week after submitting the external review application—five days after a decision should have been rendered. Eventually, the external reviewer overturned the previous claims denials, finding that the plan document did not contain the alcohol abuse exception, but by that time Kyree had been dead for almost a month.

The administrator of Kyree's estate sued seeking equitable relief for disgorgement of the amount the defendants saved by mismanaging Kyree's claim under ERISA's equitable relief provision,[21] but the district court and the Fourth Circuit determined that ERISA did not provide for such relief, despite two previous Fourth Circuit decisions holding that such relief was available. Thus, those who administered the plan escaped any liability for using false criteria to deny the claim and for negligently failing to expedite review of the claim.

[21] Damages for wrongful death are not allowed under ERISA.

2. Participants cannot find representation.

As noted above, insurers are aware that participants are unlikely to bring benefit claims because of the small dollar amount involved and the lack of transparency as to how the benefit was determined. Other factors, described below, discourage attorneys from bringing benefit claims:

a. Abuse of Discretion Standard

Since the Supreme Court's decision in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989), most employee benefit plans grant insurance companies and others deciding benefit claims broad discretion to determine eligibility for benefits and to interpret the terms of the plan. Instead of courts interpreting ambiguous plan language or application of plan language to the specific facts of the case *de novo*, courts defer to the decision of the plan fiduciary/claims reviewer unless they find that decision to be arbitrary and capricious. This standard also severely limits the scope of discovery in a benefit suit. The standard thus makes it extremely difficult for health plan participants to obtain promised benefits even when the court determines that it would decide the matter differently under a *de novo* standard. This unfairly disadvantages sick, retired, and disabled individuals challenging benefit denials, but it also discourages attorneys from representing those denied benefits.

b. No attorney fees for pre-filing work

In many disputes over benefits, the participant must retain legal counsel and other experts to analyze the difficult legal, medical, and contractual issues that arise during the plan's internal claims process. Because claimants generally are forbidden from supplementing the plan's claims procedure file with additional pertinent evidence during a subsequent lawsuit, it is essential that the administrative record contains complete information necessary to establish the claim. However, courts have interpreted ERISA section 502(g), 29 U.S.C. § 1132(g), which authorizes a court to award reasonable attorney's fees and costs, to exclude fees for that portion of the attorney's work and fees incurred in the pre-judicial claims process.[22] This makes it more difficult for claimants to retain legal counsel, particularly in cases with relatively small claims, and results in unfair claims denials. In addition, some courts do not allow a prevailing party's expert witness fees incurred in the court action to be included as a cost under Section 502(g).

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[22] *See Cann v. Carpenters 'Pension Trust for N. Calif.*, 989 F.2d 313, 317 (9th Cir. 1993); *Anderson v. Procter & Gamble Co.*, 220 F.3d 449 (6th Cir. 2000).

c. Venue Provisions

Section 502(e)(2) of ERISA, 29 U.S.C. §1132(e)(2), allows ERISA suits to be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found. Some employee benefit plans require that participants bring any such suits in a particular federal district, such as where the plan is administered, and courts have upheld these plan provisions.[23] In effect, this requires participants to bring ERISA claims in courts that may be hundreds or even thousands of miles from where they live or work, making it inconvenient and expensive for the participant to find legal representation.

IV. CONCLUSION

While it is essential that we remove barriers preventing participants and beneficiaries from asserting their rights, it is also essential to control the rising cost. The cost of employer-sponsored health care has risen dramatically in the past years with a negative impact on the physical and financial health of American workers and their families. According to a recent survey by the Kaiser Family Foundation, the average annual premium for employer-sponsored health insurance in 2023 was $23,968 for family coverage – an increase of 7 percent over the previous year and an increase of 22 percent over the last five years.[24] Deductibles have risen as well. A 2019 survey found that 33 percent of people with employer-sponsored insurance put off or postponed needed care due to costs, and 18 percent did not fill prescriptions, rationed doses, or skipped doses of medicine.[25] Significant numbers of employees with employer sponsored health care carry substantial amounts of medical debt.[26] It will do these employees no good if we improve the claims appeal process, but they and their families cannot afford to seek medical care.

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[23] *See Smith v. Aegon Cos. Pension Plan*, 769 F.3d 922 (6th Cir. 2014); *In re Mathias*, 867 F.3d 727 (7th Cir. 2017).

[24] https://www.kff.org/report-section/ehbs-2023-summary-of-findings/#:%7E:text=HEALTH%20INSURANCE%20PREMIUMS%20AND%20WORKER,and%20%2423%2C968%20for%20family%20coverage.

[25] https://www.americanprogress.org/article/health-insurance-costs-are-squeezing-workers-and-employers.

[26] https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey.

The extent to which TPA practices increase costs is unclear, but it is essential that we examine TPA practices and procedures as well as the claims appeal process to fully understand the health care issues facing American workers and their families.