What Every Dentist Needs To Know About ERISA

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Introduction

ERISA is an acronym for the Employee Retirement Income Security Act of 1974,[1] a law affecting all privately sponsored employee benefits in the United States, excluding only benefits provided by federal, state, county or municipal employers, and, in some cases, benefits provided by a religious organization. Although the law was primarily designed to address retirement benefits, shortly before its passage, ERISA was expanded to encompass employer-sponsored "welfare" benefits which the statute defines to include:

- any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise,

- (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services.[2]

Because of the inclusion of health and disability insurance benefits under ERISA's umbrella, that law has had a marked impact on insurance claims in myriad ways. For example, when ERISA applies, it eliminates remedies traditionally available under state law, such as the right of the policyholder to sue for damages in the event of wrongful denial of benefits. Most courts have also interpreted the ERISA law to preclude jury trials of claims; and the evidence admitted in court is also, in most cases, drastically limited to the claim record made prior to suit being filed. But an even larger issue is that insurers of benefits subject to ERISA enjoy a privileged position unequalled by any other insurer. In a watershed 1989 ruling, the United States Supreme Court determined that both self-insured and insured disability plans may incorporate language that grants discretion to both interpret the policy and to decide whether claimants are entitled to benefits.[3] That means the policyholder must do much more than prove the insurer wrongfully denied benefits or misinterpreted the policy. In order to prevail, the insured must show the benefit determination or policy interpretation was arbitrary or unreasonable. While that burden may be somewhat mitigated due to courts' recognition that insurers which both administer claims and pay benefits act under an inherent conflict of interest,[4] it may still be difficult to overcome an unfavorable result.

ERISA Preemption & the Hawaii Prepaid Health Care Act

Where ERISA applies, it preempts all state laws that impact upon employee benefit plans except certain laws regulating the content of insurance policies, although laws aimed at regulating insurance are inapplicable to self-funded plans such as union-sponsored plans. ERISA preemption is triggered by an employer's establishment of an employee benefit plan which can be accomplished simply by purchasing a group insurance policy. Thus, if a dentist purchases group health or disability insurance covering all of the owners and employees of a practice, an employee benefit plan is established; and any claim made under that policy will likely be governed by the ERISA law. Likewise, most patients with group insurance coverage or coverage through their union almost certainly are incurring ERISA claims.

Congress did make a significant exception, though, for the Hawaii Prepaid Health Care Act.[5] That law was passed in 1974, in an effort to control the cost of medical care and simultaneously expand medical coverage. Hawaii's Prepaid Health Care Act has been lauded as achieving premium rates and administrative costs that are among the lowest in the nation.[6] Nonetheless, due to the broad scope of ERISA preemption, the law was found preempted, and the mandates required by that law were invalidated.[7] Lobbying by Hawaii's Congressional delegation, along with the support of state officials, convinced Congress to include a limited amendment of ERISA to exempt the Hawaii law as it existed on September 2, 1974, although any amendment of the Hawaii Prepaid Health Care would be preempted to the extent any amendment created more than an adjustment affecting the effective administration of the Act. Consequently, when a 1978 amendment to the Hawaii Prepaid Health Care Act purported to regulate collectively bargained (union) plans, a federal court in Hawaii invalidated that law, finding it preempted by ERISA.[8]

Despite the exemption of the Hawaii Prepaid Health Care Act itself from ERISA preemption, it is crucial to point out, though, that while the State of Hawaii may require employers to provide coverage for their employees, any claims made by those employees are still subject to ERISA since such coverage is still considered an employee benefit plan falling within ERISA's ambit. ERISA is a national law; and Hawaii is not exempted from its preemptive force with respect to claims, regardless of whether those claims arise under a policy established pursuant to the Hawaii Prepaid Health Care Act. The crucial factor is whether an employer is offering coverage to its employees – that act creates an ERISA plan. Nor are any other types of plans in Hawaii exempted from ERISA. Group disability coverage, life insurance coverage, and other types of plans offered as part of an employee benefits package will all be subject to ERISA.

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ERISA and Your Practice

ERISA markedly impacts the practice of dentists with respect to reimbursement of claims under dental insurance plans. When claims are submitted, they are classified as urgent care claims, pre-service claims, concurrent claims or post-service claims. An urgent care claim is one where the claimant faces a life-threatening medical emergency or is in "severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim."[9] Obviously, such claims must be decided by insurers on an expedited schedule. A "pre-service claim" is one where "the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care."[10] A concurrent claim involves an ongoing course of treatment, while a post-service claim is one where a bill has been rendered subsequent to treatment. The Department of Labor has promulgated detailed regulations setting forth the time frames for submission and approval of each type of claim, along with guidelines regarding appeals of denied claims.

If a claim is denied in whole or in part, the ERISA statute allows for a "full and fair review" of the claim disposition.[11] That review is conducted by the insurer or administrator of a self-funded benefit plan; and there are certain requirements that assure fairness in the process. First, the patient can be represented either by an attorney or a medical provider.[12] The patient or authorized representative is also allowed to obtain, free of charge, a complete copy of the claim record upon which the claim determination is based.[13] The benefit plan is not allowed to give any deference to the initial claim decision; and the determination on appeal must be made by persons independent of the individuals involved in deciding the initial claim.[14] In addition, for matters that involve medical judgment, the plan must utilize a consultant possessing appropriate medical or dental training and experience.[15] Another important consideration is that if the plan reduces a payment based on a schedule of usual, customary and reasonable charges, that schedule must be provided on request.[16]

The purpose of these rules is to enable the parties to engage in a dialogue with one another that enables both sides to understand and evaluate the evidence and position taken by the other, and to avoid unnecessary litigation. In a well-known case involving a claimant who needed extensive dental treatment after being kicked in the mouth by a horse, a breakdown in the claim appeals process caused the court to characterize the insurer's conduct as a "failure to communicate," citing the well-known line from the movie *Cool Hand Luke*.[17] That case was a lesson in how the claim appeal process is intended to be an interactive dialogue. The courts also consider the pre-suit claim appeal to be so important that a failure to exhaust pre-litigation appeals will result in a refusal by the courts to entertain any ensuing litigation. Engaging in the benefit plan's pre-suit appeals procedure is almost always considered a prerequisite to bringing suit.

Another issue that comes up with frequency is that many union plans and some other policies prohibit assignment of claims. In such cases, even if the dentist is acting as the authorized representative of the claimant in appealing a claim denial, that does not give the dentist standing to bring suit against an insurer or benefit plan.[18] Consequently, the treating dentist's only recourse may be to seek payment from the patient since a suit by the dentist against the benefit plan would likely be dismissed.

ERISA and You

The other principal way in which ERISA may impact you is with respect to employee benefits provided through your practice. While a benefit plan in which only the employer and no employees participate will not be governed by ERISA,[19] so long as at least one employee receives health or disability insurance, or participates in a retirement plan, disputes over those benefits are subject to ERISA. This means that the usual procedures and remedies applicable to insurance claims are set aside. Moreover, if the practice pays the premiums for disability insurance coverage, the benefits will be taxable. Only if premiums are paid with after-tax dollars are the disability benefits themselves rendered tax-free.[20]

ERISA eliminates all claims for extra-contractual damages; i.e., damages beyond the benefits themselves. That means that unlike typical insurance disputes, no damages are available for the consequences of an insurance denial such as injury or even death resulting from a wrongful denial of health insurance benefits.[21] Nor can claims be brought for "bad faith" damages for an egregious wrongful denial of benefits. Other than the benefits themselves, the only possible available remedies are prejudgment interest on overdue indemnity payments and attorneys' fees. Moreover, if the insurer or plan possesses discretionary authority based on language contained in the plan, the claimant's burden is heightened because it is necessary to prove not only that benefits were wrongfully denied, but that there was no reasonable basis for the denial.

Dentists are often prone to disability claims because of the physical demands of the profession. It is typical that when a claim is asserted, the insurer will request appointment records and billing codes to ascertain the actual services that have been performed by the dentist prior to the onset of disability. The reason is that the insurer is seeking to compare the medical restrictions and limitations with the duties performed prior to disability. A dentist who has transitioned into practice administration rather than performing hands-on services will receive benefits only if she cannot perform administrative duties, while a dentist who frequently performs more complex procedures would qualify for benefits with more modest physical restrictions.

Due to the complexities of ERISA, if a claim is denied, it is important to immediately secure the services of an experienced legal representative who can assist in handling both the pre-litigation appeal and litigation if the appeal is unsuccessful. Waiting to retain a lawyer until after all appeals are exhausted could later prove fatal to a successful litigation outcome. In many situations, the pre-litigation appeal is more important than the litigation itself, because that proceeding may prove to be the claimant's last opportunity to shore up the claim record to help assure a likelihood of success in court. Of course, having the services of counsel familiar with and experienced in ERISA litigation is also crucial to pursuing a claim in court.

Conclusion

ERISA has had a huge impact on insurance claims. But for the statutory

exemption to ERISA preemption for the Hawaii Prepaid Health Care Act, Hawaii's efforts to insure universal health coverage would have been invalidated. As the effort to exempt Hawaii's healthcare from ERISA preemption taught, ERISA preemption remains a powerful force that severely impacts the ability to secure coverage and to obtain payment of claims. ERISA gives insurers and self-funded medical plans tremendous leverage over claims and claimants, whereas under state law, the threat of a damage award for bad faith claims handling gives claimants the upper hand in enforcing more careful and accurate claim resolutions.

ERISA also affects situations where the dental provider is also the claimant. ERISA's ability to transform a dental practice's group health and disability coverage from one that affords rights and remedies under state law into a much weaker plan under federal law makes it far more difficult to collect disability and health insurance benefits. ERISA has no respect for the size of the plan; and even a plan covering the owner of a business and a single employee may be subject to ERISA. Thus, any claim arising under such a plan, regardless of the value of the claim, is brought within ERISA's scope and its limited remedies. It is ironic that a law that was passed by Congress with the intention of protecting employees and their beneficiaries has become even more protective of insurers and employers. However, with some basic understanding and foreknowledge of what ERISA means, the limitations of ERISA can be addressed preemptively and some of the more draconian results of ERISA claims and litigation can be avoided. ■

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