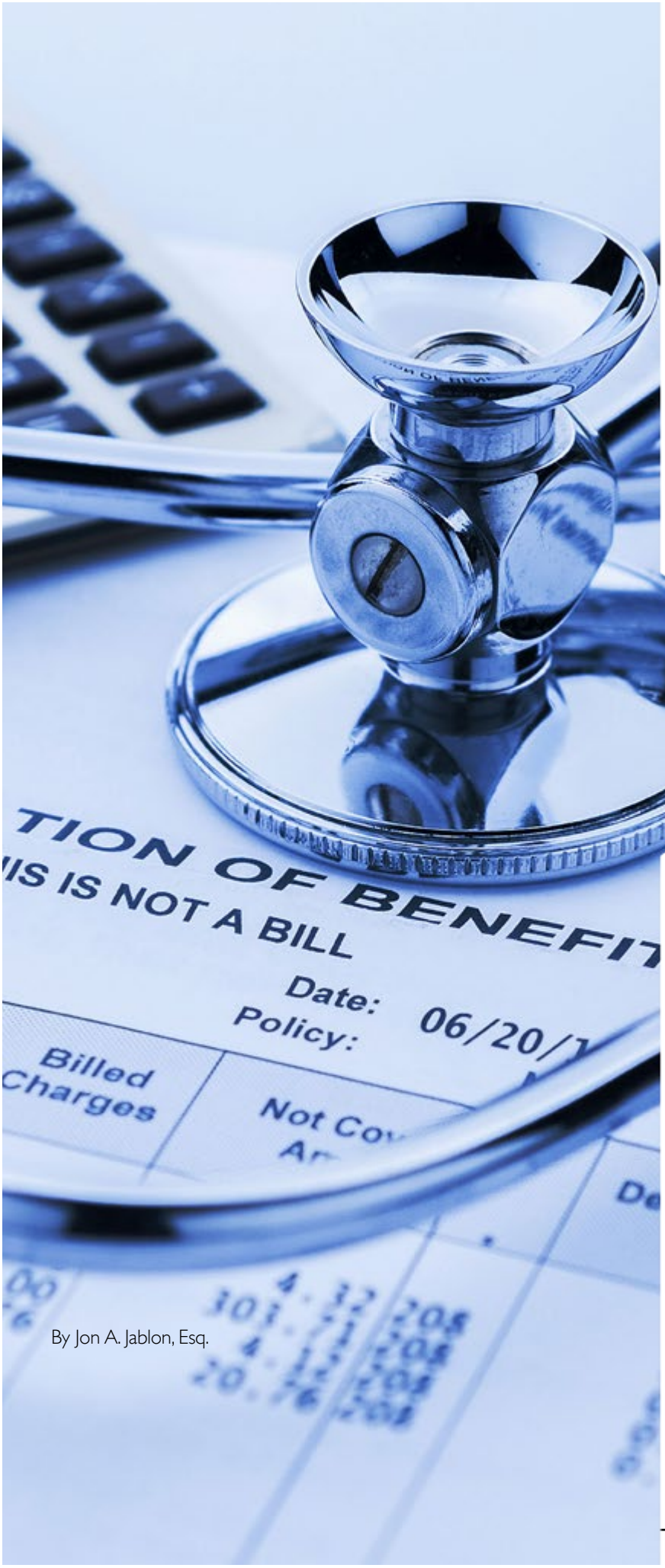

Appealing to REASON

By Jon A. Jablon, Esq.

The language is exceedingly common within benefit plans. We've all seen it; in order to appeal a denial, a medical provider must be specifically appointed by the patient as the patient's "authorized representative." Only members may appeal their own claims, unless they appoint someone to do so. Some third-party administrators and plan administrators even have a form that a member must fill out. These are long-held maxims by many – but are they truly compliant?

In what it has deemed a frequently asked question, the Department of Labor, in its Benefit Claims Procedure Regulation FAQs[1], has asked itself "Does an assignment of benefits by a claimant to a health care provider constitute the designation of an authorized representative?"

The Department of Labor simply, and helpfully, led its answer with the word "no." To elaborate on this "no," the DOL wrote that "Typically, assignments are not a grant of authority to act on a claimant's behalf in pursuing and appealing a benefit determination under a plan."

But how much does that truly clarify? Without some context, it is fairly unhelpful – and in context, it is revealed that this guidance from the DOL is somewhat inaccurate.

An authorized representative is one who is authorized to act as the representative of another – a description that could scarcely be any clearer. In our sense, an authorized representative is generally used in the context of the right to appeal.

To illustrate the utility of this concept, consider three scenarios; in all three, a plan member has received services from a non-contracted medical provider, and in all three the Plan's available benefits are not quite enough to cover the provider's full billed charges. Appeals will occur – but the difference in the scenarios hinges on exactly who is appealing, and on whose behalf.

In scenario number one, the health plan systemically prohibits all assignments of benefits, and pays benefits directly to the member. The member endorses the Plan's payment to the provider to compensate the provider for its services – but the provider is dissatisfied with the payment amount.

In this scenario number one, the provider may not appeal to the health plan unless the provider appeals on the patient's behalf, since the provider itself was due benefits from the patient, rather than from the health plan, since there was no assignment of benefits – and in such case the provider would need to be appointed by the member as the member's authorized representative, since the provider has no independent right to benefits from the health plan in this scenario.

In other words, the provider would need to appeal on the member's behalf, and would therefore need to be the member's authorized representative to do so.

In scenario number two, there is again no assignment of benefits, but the provider decides to balance-bill the member instead of getting involved in the appeals process. The member, rather than the provider, appeals directly to the Plan. Members, of course, are always claimants and are always entitled to appeal to the health plan if the member feels that a greater amount of benefits should be paid.

In this scenario two, there is no need for the member to appoint the provider as the member's authorized representative, since the member needs no representative if she appeals on her own behalf.

Now, consider scenario number three, where there is a valid assignment of benefits from the member to the provider (as is almost universally the case in self-funded health care). Through the assignment of benefits, the provider is invited to submit its claims directly to the health plan, and receives only partial payment of its billed charges in return. In this scenario three, the provider desires to appeal the denial.

The provider submits an appeal to the health plan – in accordance with all of the plan's written and established procedures – and the third-party administrator answers the provider with a letter stating that only members may appeal, unless the member fills out a specific form to authorize the provider to appeal on the member's behalf. How compliant is that, though? Might the health plan be at risk of noncompliance if it denies providers the right to appeal their own claims?

An authorized representative, as described above, is one who is authorized to be the representative of another. In a case such as this, a medical provider might be authorized to act as the representative of the member, therefore becoming the member's personal representative.

Consider, however, federal regulations that afford all *claimants* the right to appeal; *claimant* is a term of art that explicitly includes *participants* and *beneficiaries*[2]. A *beneficiary* is defined as "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder."

Forget the legalese; the important thing is to note that medical providers, if benefits are assigned to them, are *beneficiaries*, as that term is defined by the regulations – and beneficiaries become *claimants* when they submit claims to the health plan.

If you remember, all claimants are empowered to submit claims to the health plan, appeal a denial of those claims, and even ultimately sue for redress under ERISA. (As one court put it, "there is now a broad consensus that when a patient assigns payment of insurance benefits to a healthcare provider, that provider gains standing to sue for that payment under ERISA § 502(a).[3]")

The same regulation that defines "claimant" also provides that:

> *Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.*[4]

According to these regulations, not only are claimants afforded the right to file claims, but they are also guaranteed the right to appeal, by imposing this responsibility upon the health plan to afford claimants the right to appeal. The relevant regulations unambiguously explain that a claimant may appeal an adverse benefit determination.

Moreover, the text of ERISA itself provides that "A civil action may be brought…by a participant or beneficiary…to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.[5]" To simplify, again, claimants can sue for benefits. Since medical providers are claimants if they are assigned plan benefits, then providers can appeal and ultimately sue if necessary.

As another court wrote, somewhat more bluntly, "the assignment is only as good as payment if the provider can enforce it.[6]" This is a matter of public policy, and seems fairly intuitive; if a provider has the right to submit a claim, and the health plan has the right to tender a denial of that claim, practically speaking, why should the provider not also have the right to appeal the denial of its claim? According to courts and the regulations, the provider does in fact have this right.

We now know that medical providers who have been assigned benefits can submit claims, appeal denials of those claims, and sue for redress pursuant to ERIA. It should be noted, however, that although the law on the topic may be established, not everyone is on the same page, as is so often the case in our industry.

The DOL's answer to its own question ("Does an assignment of benefits by a claimant to a health care provider constitute the designation of an authorized representative?") continues by specifying that "An assignment of benefits by a claimant is generally limited to assignment of the claimant's right to receive a benefit payment under the terms of the plan."

But how can that be the case? Claimants have the right to appeal, and claimants include anyone "designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." The regulations say one thing, but the DOL's FAQ seems to say the opposite.

The DOL's answer to its own question yields an absurd conclusion: that a provider that has accepted an assignment of benefits and submitted claims to a health plan is not a claimant. According to applicable law, however, either the provider accepts assignment of benefits and submits claims, and therefore earns the right to appeal and sue – or the provider does none of those things. These rights are not discrete; they are a package deal, inseparable from one another. Each right – the right to submit claims, the right to appeal a denial, and the right to sue under ERISA – has "not for individual sale" marked on its label.

The confusion doesn't stop there, though. Coming back to the Department of Labor's answer to its own frequently asked question, the Department has stated that "[t]ypically, assignments are not a grant of authority to act on a claimant's behalf in pursuing and appealing a benefit determination under a plan."

This is a correct statement, although very misleading in context. It is true that an assignment of benefits does not grant a provider authority to act on a claimant's behalf – because a provider who has received an assignment of benefits is a claimant unto itself, and is not acting on anyone else's behalf. The provider therefore needs no authority to act on anyone's behalf.

Where do we go from here? There is conflicting guidance; FAQs are suggestive rather than binding, but most take them as gospel nonetheless, since they are explicitly designed to be written in plain English rather than the legalese of the regulations.

The rules surrounding who has what rights and under what circumstances are undoubtedly confusing at times; guidance provided by our regulators is sometimes confusing, vague, and – at times – even contradictory. This is one of those times, and affording all relevant rights to medical providers is an important topic now more than ever in the face of incoming bouts of regulatory scrutiny of the self-funded industry and the fiduciaries who act within this space.

As health plans struggle to contain costs, health plan administrators, third-party administrators, and brokers should be careful not to handicap themselves by employing the same thinking as prior decades simply because that's what has always been done. Performing an in-depth review of claims and appeal processes – and the rest of the health plan to boot – is the best way of staying ahead of the curve and ensuring compliance and viability. ■

Attorney Jon Jablon joined The Phia Group's legal team in 2013. Since then, he has distinguished himself as an expert in various topics, including stop-loss and PPO networks, focusing on dispute resolution and best practices. In 2016, Jon assumed the role of Director of The Phia Group's newly-created Provider Relations department, which focuses on all things having to do with medical providers – including balance-billing, claims negotiation, general consulting, and more.

References

[1] Benefit Claims Procedure Regulation FAQs, located at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation.

[2] 29 CFR 2560.503-1(a) ("[T]his section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants).").

[3] Brown v. BlueCross BlueShield of Tennessee, Inc., 827 F.3d 543, 547 (6th Cir. 2016) (internal quotations and citations omitted).

[4] 29 CFR 2560.503-1(h)(1).

[5] 29 U.S.C. §1132(a)1)(A).

[6] North Jersey Brain and Spine Ctr. v. Aetna, Inc., 801 F.3d 369, 372-373 (3d Cir.2015).