Unlocking ERISA:
How to Win Appeals When the Stakes Are High

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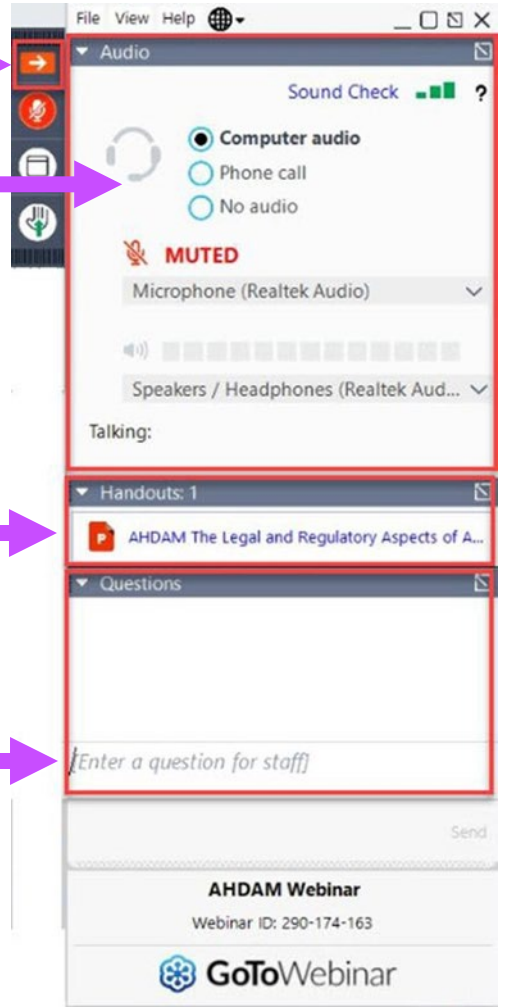

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The Association for Healthcare Denial and Appeal Management

- The nation's only association dedicated to Healthcare Denial and Appeal Management.
- Our mission is to support and promote professionals working in the field of healthcare insurance denial and appeal management through education and collaboration.
- Our vision is to create an even playing field where patients and healthcare providers are successful in persuading medical insurers to make proper payment decisions.

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To obtain CEUs, **you must:**

- **be an AHDAM member.**
- **attend the live webinar for at least 53 minutes.**
- **complete the survey** that will pop up automatically for you at the end of the webinar.

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- **AMEDCO**: physicians, nurse practitioners, physician assistants
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  PENDING: This nursing continuing professional development activity was approved by the Northeast Multistate Division Education Unit, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

AMEDCO: Learner Notification (for physicians)

Association for Healthcare Denial & Appeal Management

Unlocking ERISA: How to Win Appeals When the States are High

June 25, 2025

Acknowledgement of Financial Commercial Support

No financial commercial support was received for this educational activity.

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Satisfactory Completion

Learners must complete an evaluation form to receive a certificate of completion. **You must attend the entire webinar as partial credit is not available**. If you are seeking continuing education credit for a specialty not listed below, it is your responsibility to contact your licensing/certification board to determine course eligibility for your licensing/certification requirement.

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Physicians

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Objectives - After Attending This Program You Should Be Able To

1. Identify an advantage of referencing fiduciary duty in ERISA appeals
2. Identify how ERISA-governed health plans differ from non-ERISA plans, including specific rights, deadlines, and common challenges in the appeals process.
3. Recognize an effective tactic to address improper actions by third-party administrators (TPAs) and escalate concerns to the plan sponsor.

AMEDCO: Learner Notification, continued (for physicians)

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All individuals in a position to control the content of CE are listed below.

Name	Commercial Interest: Relationship
Raymond Kendall Smith	NA
Karla Hiravi	NA
Jo Shultz	NA

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There are no conflicts of interest to declare for any individual in a position to control the content of this presentation.

Learning Outcomes

Learning Outcomes: At the conclusion of the webinar, the learner will be able to identify the steps for successfully writing and ERISA appeal as evidenced by the ability to:

1. Identify an advantage of referencing fiduciary duty in ERISA appeals.
2. Identify how ERISA-governed health plans differ from non-ERISA plans, including specific rights, deadlines, and common challenges in the appeals process.
3. Recognize an effective tactic to address improper actions by third-party administrators (TPAs) and escalate concerns to the plan sponsor.

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- Dr. R. Kendall Smith Jr., MD, SFHM, ACPA-C, is Chief Medical Officer at PayerWatch and Board Member of the Association for Healthcare Denial & Appeal Management (AHDAM). In this role he leads clinical strategy and thought leadership for Veracity™ software and AppealMasters™ services, helping hospitals and health systems overturn denials, optimize clinical validation, and safeguard revenue. He also serves on the Government Affairs Committee of the American College of Physician Advisors.

- Prior to PayerWatch, Dr. Smith spent over a decade at Cleveland Clinic Florida, where he founded and grew the hospitalist program, chaired Clinical Resource Management teams, and partnered with revenue cycle leaders to integrate evidence-based protocols and compliance initiatives. An AHIMA-approved ICD-CM/PCS trainer and ambassador, he's delivered hundreds of workshops on documentation best practices, coding accuracy, and ERISA-based appeals.

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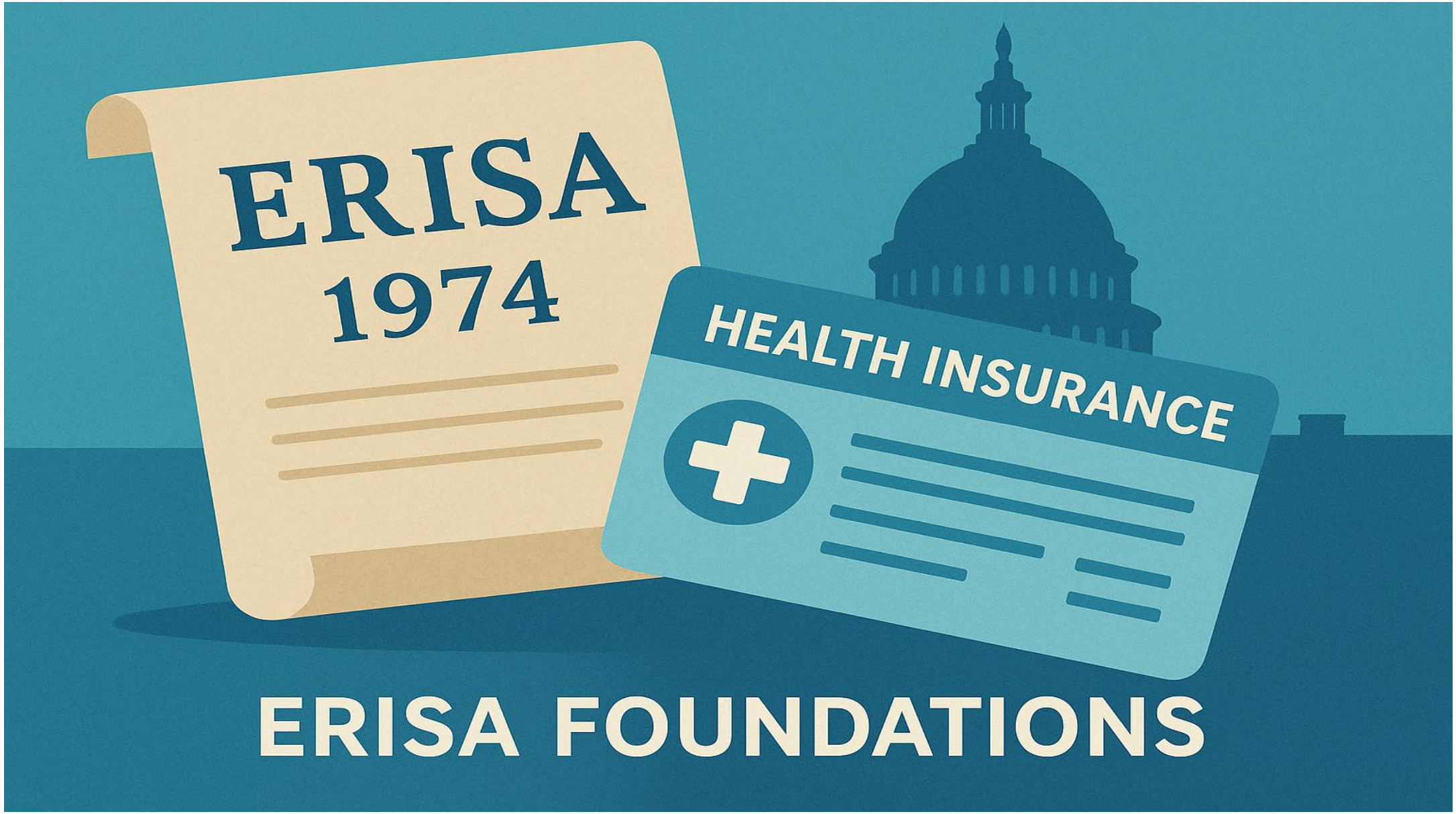
THIS IS NOT LEGAL ADVICE

- This webinar is not intended to provide legal advice.
- I am not an attorney and make no representations of practicing law.
- ***What I am sharing is experience gained as a physician advisor for 20 years on tips, tricks and a PA's experience and understanding of how to use ERISA to your advantage in payment disputes.***


ERISA
1974
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ERISA FOUNDATIONS

ERISA (Employee Retirement Income Security Act) In A Nutshell

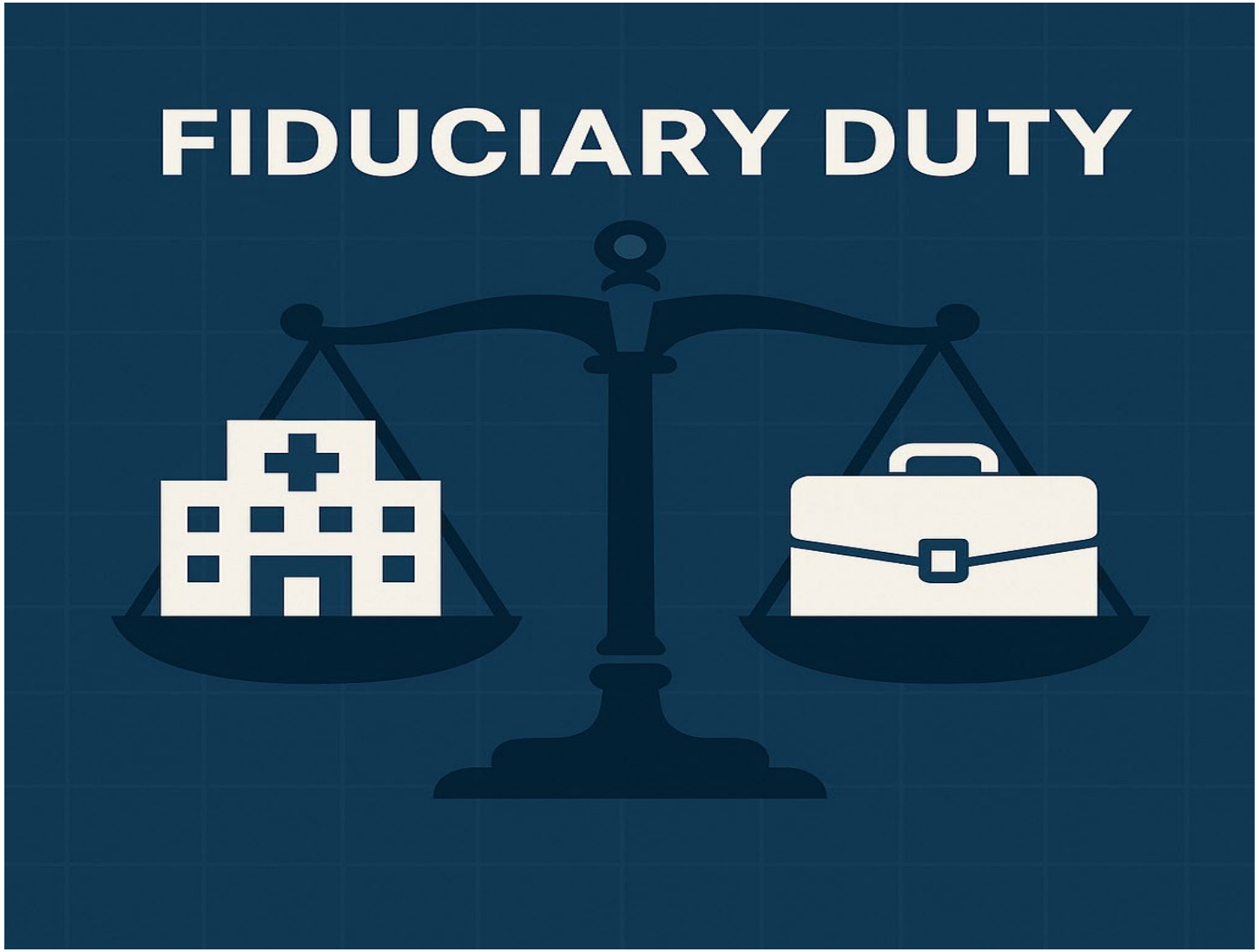
1974 response to failing corporate pensions—protect promised benefits.
Four pillars: disclosure, fiduciary duty, claims-procedure minimums, federal enforcement.
1980s: courts & DOL confirm ERISA applies to health & welfare benefits, not just pensions.
Broad pre-emption (§ 514) creates one national rulebook; ACA & MHPAEA later add layers.
Today ≈ 2.5 M plans; health claims governed by 29 C.F.R. § 2560.503-1 and ACA parity rules.

The ERISA Universe – By the Numbers

- ~2/3 of covered workers in self-funded plans (2023 KFF survey)
- 2.5 M plans / 134 M people
- Provider payment dispute may still hinge on network contract + state prompt-pay law if no assignment.
- Patient level appeals you touch are usually federal, not state
  - Because ~ 2/3 of covered workers are in **self-funded** plans, most hospital denials fall under ERISA's federal rulebook—not state insurance law – from the patient's perspective.

Why ERISA Appeals Feel “Different”

Feature	Fully-Insured Plan	Self-Funded (ERISA) Plan
Who bears the risk	Insurer pays claims; employer pays premiums	Employer pays claims from own assets (may buy stop-loss)
Pre-emption / governing law	State insurance law + ERISA	ERISA § 514 pre-empts most state insurance laws
Primary fiduciary(ies)	Insurer usually fiduciary for claims; employer still fiduciary for disclosures	Employer/plan sponsor is fiduciary; must monitor TPA
Claims-procedure deadlines	ERISA/ACA timelines plus any stricter state prompt-pay rules	Federal ERISA/ACA timelines only
External review path	State DOI external review (ACA-approved IRO)	Federal HHS IRO program (state review pre-empted)
Litigation venue & remedies	May sue in state or federal court; state bad-faith & punitive damages possible	Generally federal court only; remedies limited to benefits, equitable relief, fees
Common appeal pitfalls	State medical-necessity standards, unfair-claims statutes	Failure to monitor TPA; must exhaust unless timelines blown

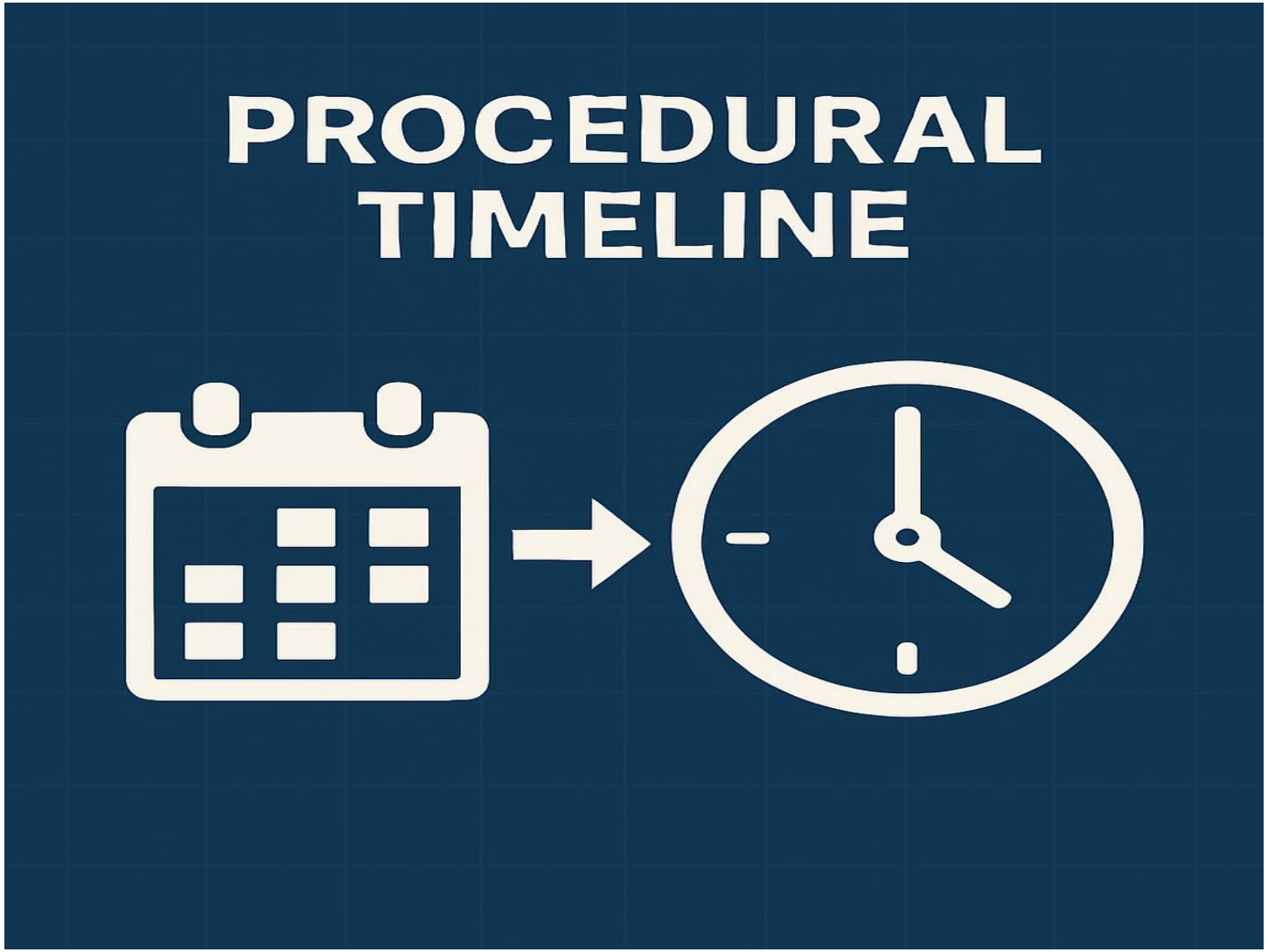

FIDUCIARY DUTY

Fiduciary Duty 101

- **Loyalty & Prudence** – must act solely in participants' best interest and pay only reasonable plan expenses.
- **Duty to Monitor TPAs** – sponsor must track denial patterns and intervene when claims handling violates plan terms or regs.
- **Co-Fiduciary Liability (§ 405)** – a sponsor can be sued if it knowingly assists, conceals, or fails to remedy another fiduciary's breach.

Fiduciary Duty 101

- **Wesco Distribution, Inc. v. Blue Cross Blue Shield of Michigan** (E.D. Mich. No. 2:24-cv-11467), filed on June 9, alleged that BCBSM violated the Employee Retirement Income Security Act by exploiting its fiduciary status in charging excessive, self-determined fees through a so-called "Shared Savings Program." Wesco alleges that BCBSM enrolled self-funded plans into this program without consent and then profited by charging up to 30% fees for correcting administrative errors caused by BCBSM itself.
- "Such misconduct is prohibited by ERISA, which forbids fiduciaries like BCBSM from engaging in self-dealing or ***placing their own interests above those of the plans and plan enrollees they serve***," the complaint states.


PROCEDURAL
TIMELINE

Timeline Levers – 29 CFR § 2560.503-1

- **New rationale on appeal → 15-day rebuttal pause**
  Plan must disclose the new reason/evidence and give you **≥ 15 days to respond**; the original 30-/60-day deadline is *tolled* during that window (29 C.F.R. § 2560.503-1(h)(4)(i); DOL FAQ 2002-C10).
- **Missed deadline = "deemed exhausted"**
  A material timing violation lets the claimant skip further internal review and may file suit immediately and/or seek EBSA help.
- Courts typically switch to **de novo** review when deadlines are blown—see *Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016); *Gatti v. Reliance*, 415 F.3d 978 (9th Cir. 2005).

Other High-Impact Procedural Violations

- **30-day doc rule & $110/day penalty (**29 U.S.C. § 1132(c)(1) and 29 C.F.R. § 2575.502c-1 (penalty schedule)
- **Boilerplate rationales** – Generic “not medically necessary” language violates § 2560.503-1(g); response must cite specific plan terms & evidence.
- **Hidden reviewer credentials** – ERISA claims rule (29 C.F.R. § 2560.503-1(h)(3)(iv)) requires the plan to give you the **name and professional qualifications** of any medical or vocational expert whose advice was obtained for the denial, upon request.
- **New rationale at 2nd level requires 15-day rebuttal window** – If the plan introduces a fresh reason or evidence on appeal, it must (i) disclose that material and (ii) give the claimant **at least 15 days to respond** before issuing its final decision. *The appeal-decision clock pauses during that 15-day window* (29 C.F.R. § 2560.503-1(h)(4)(i); DOL Claims FAQ 2002-C10)

SPD Power Plays

- Summary Plan Description (SPD) must be distributed
- **Silence / ambiguity is construed for the participant** (*contra proferentem*)
- Misleading SPD → reformation / surcharge
  - Supreme Court explained that courts may **reform** a plan and impose a **surcharge** (monetary make-whole relief) under ERISA § 502(a)(3) when participants are harmed by an inaccurate SPD. *Cigna v. Amara*, 563 U.S. 421, 444-46 (2011)

Assignment of Benefits & Derivative Standing

- **Broad Assignment of Benefits (AOB) transfers ERISA appeal rights**
- A written AOB that covers “payment and all related ERISA rights” gives the provider **derivative standing** to pursue § 502(a)(1)(B) and § 502(a)(3) claims.
- Include language assigning “any and all causes of action” plus the right to recover fees and interest.
- Courts routinely treat providers as the participant’s “authorized representative” once a broad AOB is on file – 5th and 8th circuit are stricter.
- **Anti-assignment clauses & work-arounds**
  - Most circuits enforce clear anti-assignment clauses—but watch for **waiver** (plan pays other assignees) or **equitable estoppel** when the plan fails to raise the clause until litigation.

Assignment of Benefits & Derivative Standing

- **Power of Attorney (POA)** or "Authorized Representative" form can bypass the clause because it appoints the provider to act *on behalf of* the patient rather than transferring the right.
- Keep the patient as a nominal co-plaintiff in high-dollar suits when the clause is iron-clad.
  - Strategy: have patient sign both AOB and limited power of attorney so you can pursue § 502(a)(1)(B) & (a)(3) claims if plan cites anti-assignment.

- **Key case: *N.J. Brain & Spine Ctr. v. Aetna*, 801 F.3d 369 (3d Cir. 2015)**
  - Third Circuit held a broad AOB conveys **ERISA standing** to the provider; dismissed Aetna's argument that only the patient can sue.
  - Court emphasized that requiring patients to sue "would serve no purpose except to impose administrative hurdles."
  - Use this precedent when payers claim your assignment is "insufficient" or "invalid.

Limited Remedies — Use to Your Advantage

ERISA Remedy	What the participant/provider can recover	Strategic leverage in appeals
§ 502(a)(1)(B) – Benefits Due	Unpaid medical charges + pre-/post-judgment interest	No punitive damages → plans often settle to avoid fees & interest accrual
equitable relief is **only when § 502(a)(1)(B) is inadequate** (*Varity v. Howe*, 516 U.S. 489 (1996))	Reformation, surcharge, estoppel, injunctions	Invoke when SPD mismatch (*Cigna v. Amara*) or fiduciary breach threatens systemic change
Attorneys' Fees (29 U.S.C. § 1132(g))	Court may award reasonable fees to prevailing party	Threat of double-paying claim **plus** fees pushes sponsors to pay earlier


ESCALATION
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EBSA – The Unsung Ally

- **EBSA = the Department of Labor's ERISA "watchdog."** Regional Benefits Advisors investigate health-plan complaints, request documents, and pressure fiduciaries to fix violations without court action. *** An informed HR director will generally get hives***
- **FY 2023 results:** EBSA's informal interventions returned **$444 million** in health & pension benefits to workers and providers (DOL FY 2023 Enforcement Fact Sheet).
- **How to leverage:** A well-documented complaint (timeline chart + SPD gaps + fiduciary-breach angle) prompts EBSA to send a **factual-inquiry letter**—plans usually pay rather than battle the DOL.

Escalating Above the TPA

- **Fiduciary-breach letter:** cite timeline or SPD violations, explain duty of loyalty/prudence, and request immediate corrective action.
- **5-day sponsor demand:** give the employer *five business days* to pay the claim or show written remediation before you escalate.
- **Copy EBSA & outside ERISA counsel:** CC the DOL regional office and the plan's law firm—heightens fiduciary exposure.
- **Penalty log attached:** include running § 502(c)(1) tally ($110/day) plus document-request dates to quantify potential liability.

What Counts as “Relevant Documents”

- **“Relevant document” (29 C.F.R. § 2560.503-1(m)(8))** – includes *all* internal rules, clinical guidelines, contracts, reviewer emails, claim notes, and even AI decision-support output that were “considered, generated, or relied upon” in making the denial.
- **30-day production rule** – plan administrator must supply those documents **within 30 days** of a written request; failure can trigger a § 502(c)(1) penalty of **$110 per day**.
- **“Proprietary” ≠ valid excuse** – DOL guidance states confidentiality or trade-secret claims do *not* override the participant’s statutory right to the material.

SPD Red Flags & Ambiguities to Mine

1. Silent ≠ exclusion

2. 🧠 SPD usually trumps payer policy (plan docs govern; insurer guidelines mere interpretive aids unless incorporated by reference into the SPD) !!!!!!!!!!

3. Hidden anti-assignment

- Anti-assignment clauses are sometimes buried in the glossary or fine print. If they weren't conspicuous, you can argue ***lack of notice*** or unconscionability and enforce your AOB anyway.

4. Discretionary-authority pitfalls

- Look for clauses granting the insurer "sole discretion." That triggers deferential (arbitrary-&-capricious) review—*unless* the plan missed a deadline or the clause is void under state law (employer **funded** plans exempt).

5. SPD/wrap mismatch

6. Missing MHPAEA (Mental Health Parity and Addiction Equity Act) parity text

De Novo vs Arbitrary-and-Capricious Review

- Default rule from *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989): de novo review unless plan grants “discretionary authority.”
- Timeline breaches **often but not always** flip to de novo
- CA Ins. Code § 10110.6 bans discretionary clauses in insured plans – self funded plans pre-empt statute
- Other states passing legislation removing discretionary clauses - these bans apply **only to insured policies issued or delivered in the state.** Self-funded ERISA plans remain pre-empted, so you must still check funding status before invoking the statute.

	Arbitrary-&-Capricious (Abuse-of-Discretion)	De Novo Review
What it is	Court upholds the plan's decision unless it had **no reasonable basis**. Highly deferential.	Court decides the claim **from scratch**—makes its own factual and legal findings.
When it applies	*Firestone v. Bruch* (489 U.S. 101 (1989))—if the plan **explicitly grants "discretionary authority"** to interpret terms or determine eligibility.	Default standard **unless** the plan has a valid discretion clause **and** follows claims-procedure regs.
How to lose the deference	— Plan **blows a regulatory deadline** or commits a material procedural violation (29 C.F.R. § 2560.503-1(l)).— Discretionary clause **void under state law** in insured policy (e.g., CA Ins. Code § 10110.6; IL, TX, NY, etc.).	N/A (already the standard).
Plaintiff's burden	Must show decision lacked rational support or was clearly unreasonable.	Simply prove, by preponderance, that benefits were wrongly denied under the plan.
Strategic leverage	Harder to win; focus on procedural breaches to switch the case to de novo.	Greater settlement pressure on sponsor—court isn't giving them the benefit of the doubt.

Bonus Lever – Mental Health Parity (MHPAEA)

- **CAA 2021 comparative-analysis demand**
  - Plans must maintain a written **NQTL comparative analysis** (more about this on next page) showing mental-health (MH/SUD) utilization-management rules are no more restrictive than medical/surgical.
  - Must disclose the analysis to DOL/HHS—or to you—within **45 days of request** (ERISA § 712(a)(8), added by CAA 2021 § 203).
- **Non-compliance → EBSA corrective action**
  - If the analysis is "insufficient," EBSA issues a **45-day corrective-action letter**; failure to cure triggers **public naming + potential $100/day excise tax**.
  - FY 2023: 87 % of analyses reviewed by DOL were deemed non-compliant—easy leverage point.
- **Use when psych UM stricter than med-surg**
  - Flag tighter prior-auth, shorter length-of-stay, or fewer network options for MH/SUD.
  - Demand the plan's NQTL analysis; most can't produce a compliant document—pressure sponsor to approve rather than risk DOL penalties.

NQTL = Non-Quantitative Treatment Limitation

- It's any benefit limit that **isn't expressed numerically**, such as:
  - Prior-authorization or concurrent-review requirements
  - Medical-necessity criteria or clinical guidelines
  - Provider-credentialing standards and network admission rules
  - Step-therapy protocols, formulary design, fail-first policies
  - Methods for determining usual, customary, and reasonable charges
  - Restrictions on facility type, length of stay, or frequency of treatment
  - Under the Mental Health Parity and Addiction Equity Act (MHPAEA), as strengthened by the CAA 2021, a plan's NQTLs for mental-health or substance-use benefits must be **no more restrictive** than those applied to comparable medical/surgical benefits—and plans must document that with a written comparative analysis.

Checklist for Hospital Appeal Teams

- **Secure plan documents on Day 1** – Request the full plan, SPD, wrap doc, amendments, and current medical-policy manuals; gives you the governing language and triggers the 30-day § 502(c)(1) clock if they stall.
- **Track every statutory clock** – Use a spreadsheet or case-management tool to auto-count 30-/60-day appeal deadlines and the 30-day document-response rule; missed dates = leverage.
- **Log penalty exposure** – For each unanswered doc request, add $110/day starting on Day 31; include the running total in all escalation letters to quantify fiduciary risk.
- **Tight assignment language** – Make sure the AOB covers "payment and all related ERISA rights, including litigation and fee recovery," and get a back-up POA if the plan has an anti-assignment clause.
- **Escalate when rationales flip** – A new reason at second-level appeal violates § 2560.503-1(h)(4); demand 15-day rebuttal window, copy the plan sponsor, and threaten EBSA if they ignore the procedural breach.

Take Away Message

- If you can identify a TPA behaving poorly an informed HR Director generally will often engage informally and work via backdoor channels to resolve issues.
- I have been told by uninformed HR Directors when raising TPA issues to “buzz off” (NSFW language actually used in emails). Looks great when involving EBSA or litigation…..

Share Your Story – #RaiseYourVoice

- We're collecting real-world experiences with health-insurance denials—from patients and the providers who fight for them.
- If you're willing to be interviewed for PayerWatch / AHDAM's #RaiseYourVoice campaign, please email **RaiseYourVoice@payerwatch.com**.
- Follow me on LinkedIn for more tips and tactics: https://www.linkedin.com/in/r-kendall-smith-jr-md-sfhm-acpa-c-344b31157/
- Thank YOU for your relentless advocacy!

Questions and Answers

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U.S. Department of Labor. https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/filing-a-claim-for-your-health-benefits#:~:text=You%20have%20at%20least%20180%20days%20to%20request%20a%20full,can%20contact%20EBSA%20to%20discuss.

National Association of Independent Review Organziations: https://www.nairo.org/assets/docs/NAIRO-QandA-Know-Your-Healthcare-Appeal-Rights.pdf

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Th-Th-Th-That's All Folks