ERIC BUCHANAN AND ASSOCIATES

Eric Buchanan & Associates, PLLC
Attorneys at Law

ERISA & DISABILITY BENEFITS NEWSLETTER

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ABOUT OUR FIRM

Eric Buchanan & Associates, PLLC is a full-service disability benefits, employee benefits, and insurance law firm. The attorneys at our firm have helped thousands of disabled people who have been denied social security disability benefits, ERISA LTD benefits, health insurance, life insurance and other ERISA employee benefits, as well as private disability and health insurance benefits.

For more Information about Eric Buchanan & Associates, PLLC, visit our website at www.buchanandisability.com.



Eric L. Buchanan, R. Scott Wilson, and D. Seth Holliday are certified as Social Security Disability Specialists by the Tennessee Commission on CLE and Specialization.

ERISA HEALTHCARE CLAIMS BY: JEREMY L. BORDELON

With limited exceptions, almost all employee benefits claims are governed by the Employee Retirement Income Security Act of 1974 (ERISA). This includes group health insurance obtained through one's employer. The basic framework of law surrounding ERISA health-care claims is largely the same as any other ERISA benefits claim, such as long-term disability benefits. There are some important differences, though, not least of which are the difficulties representatives find in getting paid to work on these cases.

Just like other ERISA benefits claims, the internal appeals process must be completed before filing suit. If the denial is upheld through the mandatory appeals process, there may be additional, voluntary appeal levels available. In court, however, there are only limited remedies available. Most state laws will be preempted, and more than likely the only cause of action available will be one "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." ERISA § 502(a)(1)(B), 29 U.S.C. § 1132. In court, there will likely by no jury trial, no medical testimony, and no "merits" discovery. Normally, a denied claimant will recover no more than the benefit he was owed in the first place. So, for a $50,000 surgery that the medical insurer refused to pay for, the most the claimant will recover in court is likely $50,000. Some courts will allow pre- and post-judgment interest on top of the recovery, but not all.

There are, however, some subtle differences between ERISA healthcare claims and other claims for employee benefits – differences that representatives must be aware of to effectively represent the claimant. First and foremost are the timelines of the internal appeals process – often referred to as the "administrative remedies." Healthcare claims are divided into three different categories by the Department of Labor's ERISA claims regulations: urgent care claims, pre-service claims, and normal post-service claims. 29 C.F.R. § 2560.503-1(m)(2-4). Post-service claims must be decided by the insurer within 30 days, but the insurer is allowed one 30-day extension. Pre-service claims must be decided within 15 days (with a one-time 15 day extension available), and urgent care claims must be decided within 72 hours. No extensions are available for urgent care claims, but if the insurer determines that it does not have sufficient information to decide the claim, it must notify the claimant of the deficiency within 24 hours of receiving the claim, and give the claimant 48 hours to provide the requested information.

In theory (and by regulation), the extensions noted above may only be taken if necessary due to circumstances beyond the insurer's control. Those circumstances must be specifically cited in the notification of extension to the claimant, and the extension notice must

be given before the initial 30-day period ends.

In practice, however, these extensions are taken frequently, with little explanation, sometimes late, and often due to purely internal delays. As a technical point, failure to comply with the regulations in this manner could trigger "exhaustion" of the claim, giving the claimant a right to sue without pursuing any further internal appeals. 29 C.F.R. § 2560.503-1(l). In practice, it is usually best to overlook these minor technical violations and complete the mandatory appeals. In rare cases, a technical exhaustion can be a boon to case, especially where the initial denial was clearly arbitrary and capricious and could be easily defeated in court. Usually, though, you will want to avail yourself of the full 180 day appeal window to develop the medical record. The claimant must be afforded 180 days to appeal an adverse benefit determination.

Which begs the question: what is an "adverse benefit determination?" An outright denial is easy to recognize, but in the healthcare arena especially, there are varying degrees of "denial." An exhaustive definition is available at 29 C.F.R. § 2560.503-1(m)(4), but in essence, anything less than a complete approval of the claim can (and should) be appealed as if it was an outright denial. For example, health insurers may use "post-payment audits" to demand partial refunds of fees paid to providers. While beyond the scope of this article, these practices are adverse benefit determinations, and have generated large-scale class action ERISA litigation by medical providers.

So, if a claimant has been denied, and has exhausted the mandatory appeals process, then the window in which he can file an ERISA § 502 suit has opened. When that window closes, however, is a more difficult question. ERISA does not contain a statute of limitations for § 502(a) claims for benefits. If there is no contractual provision stating a limitations period, the courts will look to analogous state statutes of limitations, such as for contract actions. Where the insurance contract itself contains a contractual period of limitations, courts will usually uphold those provisions, even if they are shorter than the relevant state-law periods, if they allow claimants a reasonable amount of time to sue. Limitations periods as short as 90 days have been upheld by the courts in healthcare claims. *E.g.*, *Northlake Regional Medical Center v. Waffle House System Employee Benefit Plan*, 160 F.3d 1301, 1303-04 (11th Cir. 1998). These periods are not necessarily tolled while the claimant exhausts the mandatory appeals, either. *See, e.g., Rice v. Jefferson Pilot*, ___ F.3d ___, No. 08-4180 (6th Cir. Aug. 24, 2009).

Once in court, the die is cast. At that point, if you haven't done everything you needed to do earlier, it will all come back to haunt you. The court will likely only be looking at the record that the insurance company had when it made the denial decisions, so if your best evidence was never submitted to the insurance company in support of the claim and/or the appeal, then the court will likely never see it. This is part of what makes these cases so difficult. The client has to know to consult an experienced attorney when denied, rather than filing a simple appeal letter with no evidentiary support, and the attorney must know to fully develop the evidence before saying the magic words, "I appeal." Once the insurance company issues its "final denial," the record might be closed forever.

Since the remedies are generally limited to the amount of the denied claim, unless you've made some agreement with the provider beforehand to protect your fee, you might find that your client's surgery gets paid for in full, but you have no way to collect your fee, unless the client is able to pay it out-of-pocket. In addition to whatever fee you collect from your client and/or the medical provider in cases that go all the way to a judicial decision, you should definitely file a motion for the defendants to pay some of your attorney fees pursuant to ERISA § 502(g). As important as it is to file one of these motions in a disability benefits case to offset the fee your client must pay, it is doubly so in a healthcare claim, where even the prevailing plaintiff usually doesn't receive any cash benefits with which to pay a fee. Depending on how much time you have in the case and the amount of benefits at stake, a well-crafted § 502(g) motion could pay your fee completely, allowing your client the peace of mind and financial security that health insurance was supposed to afford in the first place.

ERISA benefits claims of any kind can be a technical morass, and healthcare claims are no different. With the difficulties involved in collecting a fee on these cases, and the incredibly short deadlines that may be imposed, it is important to know all the ins and outs before taking them on.

JEREMY L. BORDELON

Jeremy Bordelon has worked for Eric Buchanan & Associates since 2004, first as the firm's litigation paralegal while earning his Legal Assistant Studies degree from the University of Tennessee at Chattanooga, and continuing part-time while enrolled in law school. Jeremy has now graduated from the University of Tennessee College of Law, *magna cum laude*. His duties over the years have included research and writing on many aspects of the firm's practice, including Social Security EAJA fees, ERISA discovery, ERISA motions for judgment, and bad faith insurance claims. Jeremy has attended national CLEs on Social Security and disability insurance. Jeremy also spent eight years in the U.S. Navy before law school as an enlisted Cryptologic Technician, achieving the rank of Petty Officer First Class.

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ERIC BUCHANAN & ASSOCIATES, PLLC UPCOMING ARTICLES

The Social Security Administration Has Created a New Malpractice Trap for Attorneys Who Handle Workers' Compensation Cases - By: Eric Buchanan - Published in TTLA 2009

ERISA Subrogation and Recoveries - By: Eric Buchanan - A new chapter to be added to the upcoming addition of Thomson West's Auto Tort Litigation Manual

ERIC BUCHANAN & ASSOCIATES, PLLC UPCOMING CLE SPEAKING ENGAGEMENTS

Eric Buchanan will be speaking at the Tennessee Association for Justice Annual Review & Ethics Seminar on Subrogation claims in Chattanooga, TN November 19, 2009.

Eric Buchanan will be speaking at the Tennessee Association for Justice Seminar on ERISA and Subrogation claims in Johnson City, TN on December 11, 2009.

Eric Buchanan will be speaking at the Tennessee Association for Justice Annual Review & Ethics Seminar on Subrogation claims in Nashville, TN December 17, 2009.

Eric Buchanan will be speaking at the NOSSCR Social Security Disability Spring Conference on ERISA LTD claims to be held in New Orleans, LA May 12-15, 2010.

NEED A SPEAKER?

The attorneys at Eric Buchanan & Associates are available to speak to your organization regarding Social Security Disability, ERISA Long-term Disability, Group Long-term Disability, Private Disability Insurance, ERISA Benefits, Denied Health Insurance Claims and Life Insurance Claims.