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Comments on ERISA's Claims Review Procedures
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I am a healthcare advocate located in Salt Lake City, Utah.

My career in healthcare began in 1970 at Aetna Life and Casualty. After leaving Aetna in 1978, I worked at a Multiple Employer Trust called United Businessmen's Insurance Trust which sold small and large group policies in 4 states.

I have been a claims processor and supervisor, auditor, underwriter, investigator, and coder and learned most if not all state and federal regulations. I was at Aetna in 1974 when ERISA was born.

My day to day work included working with lawyers at the insurance companies, answering insurance department complaints and dealing with lawsuits when needed. I then rounded out more of my experience working in a Rehabilitation Hospital in Sandy, Utah called Western Rehabilitation Institute.

I was hired at WRI to set up a case management department who had the important responsibilities for pre-authorizations of critical rehabilitation care, credentialing and contracting. I hired and trained nurses and therapists to do pre-authorizations and I personally worked alongside of them as a case manager, discharge planner, and as an appeals specialist assisting families with denials of their inpatient physical rehabilitation following major life events, such as strokes, traumatic brain injuries, spinal cord injuries, Guillian-Barre, and multiple trauma. The work I did at WRI led me to conclude that the insurance playing field was completely inequitable and that something in the industry was changing.

In 1990, I along with 2 plaintiff lawyers opened a healthcare advocacy firm in Sandy, Utah named, Claims Management, Inc. to assist families with their denied insurance claims. I was a Vice President at the firm. I, along with a new partner bought out the lawyers at CMI in 1995.

As we all know, healthcare is quite complicated to the average lay person and it is certainly not something that we learn in school.

Early along my path to being an advocate, I always believed that insurance companies had an obligation to give good service. When I worked in the insurance industry (1970 to 1987), service employees built the goodwill with its consumers and monies were allotted to allow for proper employee training and staff to cover the needs of their insureds, etc. We were trained to take our knowledge and use it for the greater good. We had an obligation and were competent to make good decisions about coverage found in the terms of the policies and plans we managed. We were taught to analyze claims fairly with the interest of the insured at the forefront of our decisions. We became skilled in federal and state regulations as defined by the size of the employers and the type of funding. In 2022, 7 healthcare executives pay topped $335 million while 100 million Americans were saddled with medical debt (Lever News June 20, 2023).

As a healthcare advocate for well over 34 years, I have seen many things developing in the last 3-5 years that are causing major heartburn for all of us who use insurance or assist families with their insurance matters and appeals. They include the following types of unreasonable fiduciary handling by almost all in charge of authorizing, reviewing, investigating, and paying valid claims:

1. Authorization of care being granted then claims are denied after the authorized care is received and claims are submitted.
2. Clinical guidelines/policies used deny services when submitted information shows guidelines/policies have been met.
3. Inadequate/Poor Networks forcing HMO/EPO clients to seek out of network care—network exceptions requested but denied with no thorough review of the patient's needs.
4. Long hold times to check on claims and appeals—1-2 hours of time needed to get responses. Responses are not always adequate.
5. Member portals not updated with current claim data for months—online eob's do not have enough specificity, they are more of a summary in nature, not a full explanation of a denial given- which vary differently from mailed EOB's used in the past.
6. Contracting with foreign (out of country) companies to answer questions and pay claims when those employees are hard to understand and have little insurance knowledge or experience.
7. Taking phone inquiries (made by members/insureds) and medical record submissions (requested by them) as appeals, leaving insureds/members no additional internal appeals if the plan has only one level of internal appeal.
8. Release of Information forms, Authorized Representative Forms, etc. sent with appeals are lost/not accepted causing massive delays on getting timely appeal responses.
9. Losing submitted appeals/key evidence—only scanning in a portion of the documents sent, leaving the insured/member with a useless appeal.
10. Appeal procedures attached to denials (EOB's/Letters) as well as appeal sections in plans have wrong addresses and fax numbers causing appeals to be denied as late even when proof of the error made is articulated in additional correspondence.

11. Requiring that claims be on file before an appeal response will be given—No such requirement is not found in policy/plan.
12. Responding to the provider of service on an appeal that the member/insured sent—generally sent to the provider of service out with a cc to the member/insured.
13. Total non-response to appeals when plan/policy states appeal responses are due within 30-60 days—in some cases causing complaints to have to be filed to obtain responses, even though appeals were sent certified, with their receipt appeal was received by their offices.
14. Short appeal responses (2- 4 sentences) with no specific reference to the 1000-5000 pages included in the appeal. No meaningful dialogue or full, fair, thorough reviews being completed. Conclusory opinions.
15. Changing denial reasons at each level of appeal. Causing additional appeals with the carrier who receives the new appeal and refuses to review stating that all internal appeals have been exhausted.
16. Overturned denials mean claims should be immediately paid. Some payments are taking 6-9-12 months. If the overturned claim is over 2 years old (which many are), the claim data is archived and not available to the member. Sometimes they only receive a check with no explanation.

Let's face it, service metrics by these entities has plummeted horribly over the last 3-5 years causing much more strife and stress in family's lives including medical bankruptcy, depletion of their retirement plans, selling their homes, and the like. These types of practices by the insurance industry are clearly unreasonable. When it comes to appealing a claim denial, they should be mandated to handle everything fairly, honestly, timely, and in good conscience and especially within the parameters set forth in the policies/plans and in state and federal laws.

Unfair Claims Settlement Practices Acts (UCSPA) are well established in almost every state. The NAIC adopted the Act in 1990. This of course, may only apply to full insured plans, not self-funded plans. Most of the 16 points I have made above are indeed related in some way to an unfair settlement/claims practice that we have been a party to.

The 2022 MHPAEA Report to Congress clearly showed that insurers have totally failed to abide by this law written in 2008. They depend on ERISA's ability to let them wiggle out of their responsibilities to their insured's by asking the court's to give them full discretionary authority which unfortunately, is granted in many cases. Their underlying mishandling of the cases in general goes unpunished and the family is left taking settlements for the most part that do not ever reach the claims full payment value.

The insurance industry also relies on the fact that the courts will, as seen in many filings, remand these cases back to them for an additional bite at the claim apple. This is another area that needs some reform.

Why not consider penalties such as found in ERISA and COBRA to persuade the insurance industry to step up to the plate now before another very important federal regulation, like MHPAEA is ignored. There has got to be a way that the families who are hurting so badly

can recoup some of their losses due to these failures to establish and maintain reasonable fiduciary claim practices.

I hope the stories I have shared today will help all of you understand the magnitude of the financial situations plaguing patients and their families.

Thank you for your time today.