



US Department of Labor  
Advisory Council on Employee Welfare and Pension Benefit Plans  
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**Written Witness Statement by Wendell Potter,  
President of The Center for Health & Democracy  
Regarding ERISA**

Thank you for this opportunity. One of the reasons I left my career as a health insurance executive was over an ERISA-related issue that I have written and spoken about frequently. Reforming ERISA has long been a priority of mine, and I am encouraged by your hearings that the Department of Labor might agree that changes are urgently needed.

It is fitting that we are meeting in the Frances Perkins Building, which was opened a few months after President Gerald Ford signed ERISA into law 50 years ago last week. That was just a year after I came to Washington as a young reporter to cover Congress and the White House for Scripps-Howard newspapers. I would later have a career that spanned two decades at two of the largest insurers and third-party administrators (TPAs), Cigna and Humana.

As you undoubtedly know, Frances Perkins tried to persuade President Franklin Roosevelt to push for universal health care as well as to provide financial support for the nation's seniors. Roosevelt, regrettably, decided that was too much to take on. He didn't want to gamble on losing support for what became the Social Security Act of 1935.

I'm sure Perkins, Roosevelt and even Ford would regret not having taken steps to assure that all Americans have access to care that both they and the nation's employers can afford. A solid argument could be made that the biggest beneficiaries of ERISA as it has been amended and interpreted by the courts have been the TPAs, the middlemen that extract billions of dollars from the true payers of health care: employers, consumers and taxpayers.



While it has made it easier for employers with workers in multiple locations to offer subsidized health care benefits, it has also shielded them – but especially the TPAs – from accountability in the courts. Meanwhile, employers’ cost of offering benefits has increased to the point that a smaller percentage of them are able to provide coverage because of rising health care costs and the inability – and unwillingness – of TPAs to effectively control costs in a way that ensures continued access to needed care. In 2000, 69% of U.S. employers offered coverage to their workers. In 2023, only 53% did, according to the Kaiser Family Foundation. For those still offering health care benefits, the cost of doing so increased nearly 50% over the past decade, from an average of \$16,351 for family coverage in 2013 to \$23,968 in 2023, also according to the Kaiser Family Foundation. As we continue to hear about record inflation and a cost-of-living crisis, these rising health care costs are diverting money that could go toward wage increases and lower prices.

Ninety percent of top executives of the nation’s large employers surveyed by the Purchaser Business Group on Health in 2021 said the cost of providing health benefits to employees will become unsustainable in the next five-to-10 years.

Meanwhile, the insurers/TPAs have continued to consolidate, both vertically and horizontally, to the point that they have become some of the largest and most profitable corporations in the country. UnitedHealth Group and CVS/Aetna are now the fifth and sixth largest companies on the Fortune 500 list of American companies. Cigna, Elevance and other for-profit insurers are not far down the list. Last year, the seven largest publicly traded health insurers made a record \$70.7 billion in profits from the money employees and employers pay them to ensure they have health care.

Instead of effectively controlling the unit costs of health care goods and services, TPAs have focused on decreasing the utilization of those goods and services. Year after year, they have systematically decreased the value of health benefits through what industry executives and financial analysts call “benefit buydown.” This means that people enrolled in the health plans they administer not only are paying far more in premiums than they were 10 years ago but getting less care for that money, leading to increased out-of-pocket expenses. Deductibles now average more than \$1,700 per year per person in employer-sponsored plans, again according to the Kaiser Family Foundation. A 2022 KFF survey found that 41% of people in the U.S. — more than 100 million of us – had debt due to medical or dental care, and most of those people had coverage through an employer.



In addition to ever-increasing cost-sharing obligations, TPAs have also put other barriers in place to assure their continuing profitability, including shrinking lists of in-network providers and processes and technology to deny coverage for medically necessary care.

Although ERISA provides a pathway for employees to appeal denied claims, many people simply don't know they have this right. Insurers often bury coverage criteria, denial rationale and appeal rights in complex documents that are difficult to access, understand or act upon. If a patient realizes they can appeal, it's too difficult to determine how to appeal and what criteria should govern decision-making.

Insurers reportedly also are using advanced technology to deny more care and claims. ProPublica reported this year that one doctor at Cigna, in just one month, denied 60,000 claims using a new artificial intelligence (AI) algorithm developed by insurance companies to deny claims without even having to open the patient files. One former doctor at Cigna told ProPublica that claims are denied 50 at a time, taking no more than 10 seconds per batch.

When experiencing a denial, patients report feeling depression and despair, receiving limited support from overwhelmed providers or pharmacists who are left to deliver the news, and do not believe they have the agency or ability to challenge insurers on their own. Consequently, only a small percentage of denials are challenged. In a 2023 KFF survey, 84% of people whose claims were denied took some action to try to fix the issue, but only 15% actually filed a formal appeal. Another study found, however, that of the few denials that are appealed, 60.5% are eventually overturned. This is evidence that the denials by insurers are not precise nor are they accurate, with more than half being overturned once patients or providers advocate for themselves.

Clearly, we must work to lower the knowledge asymmetry between health plans, health providers and beneficiaries, making it easier for patients, their loved ones, and their providers to challenge denials. We also must be able to show patients that people in similar situations have success in appealing denials to overcome the largest hurdle: belief that the system is stacked against them and nothing they do can change it.



### ***The Appeal Process is Burdened by Complexity***

The process for filing an appeal is needlessly complicated. Insurers frequently use delay tactics, such as claiming not to have received faxes and mail, requesting the same information multiple times, or denying claims without a detailed explanation. 46% of those denied skip or delay care due to cost, driving poor health, lost income and even death.

Some of the issues making the appeals process overly complex include:

- *Lack of timely notice.* More than 50% of patients report not receiving a denial notice when their insurer refused to pay for or approve their care, according to a survey by Claimable, a company that helps patients appeal denials. Most are informed by their provider or pharmacist and don't receive information from their insurer/TPA until weeks later, if at all.
- *No public appeal process.* Many plans do not make patient appeal processes publicly available, which prevents patients and their advocates from building tools to help them understand the process.
- *Too many processes.* Insurers/TPAs have different time frames, addresses, faxes, forms and levels of appeal for different plan types, states or levels of urgency, making it difficult to understand how to appeal, the different levels of appeals, and which state or federal laws apply. That's because **people cannot tell from their insurance cards if they are in a fully insured or self-funded plan.**
- *Too easy to ignore.* Many patients and providers find that their mailed and faxed prior authorizations, claims and appeals are 'never received', 'in processing' or 'in review' for weeks or months. We need a way to hold plans accountable for confirming receipt and following mandated review time limits. Physician offices have told me they often have to send records two or three times before insurers/TPAs acknowledge they received them.
- *Repeat document requests.* Many denials ask patients and their providers to send documents they have previously sent, or that the insurer already has access to, which delays the review.



- *Too many parties.* Insurers are increasingly outsourcing coverage decisions to a myriad of parties: pharmacy benefit managers, other third-party administrators and specialty pharmacies. These parties then employ different processes and criteria not reported to patients or providers.
- *Too difficult to appeal.* Patients often find they do not have access to the coverage criteria, denial rationale, appeal process, claim codes, clinical guidelines, appeal precedents and applicable laws needed to effectively argue when a denial may not be compliant with their policy, when their policy may not be compliant with clinical standards of applicable laws, and when denials ignore information that proves they qualify for coverage.

### ***WHAT IS NEEDED***

To encourage more patients to appeal when they believe they are unjustly denied care, I propose several steps to streamline and expedite appeals:

- Require all summary plan documents, appeal rights and appeal processes be made publicly available in a centralized location — not behind a log-in or only shared upon request — to enable loved ones, providers and advocates to help patients access and understand documents.
- Require coverage criteria or appeal processes maintained by third parties but applicable to plan beneficiaries, as well as in-year amendments to the policy, must be contained within the summary plan document or linked within the document and publicly available.
- Require health plans to have a single, centralized location to submit appeals for patients and providers online that provides receipt confirmation, in addition to mail and fax options.
- Require time-stamped receipts for all claims and appeals, including documents received, to be included in denial notices, improving accountability for review periods.
- Require health plans to report in a standardized way whether a plan is self-funded on the insurance card.

### ***Enhancing Data Transparency***

A critical part of this challenge is that denial data and appeal outcomes are largely hidden. Currently, independent reviews of appeal data are only available in a handful of states (NY, CA, MI and WA), and denial data isn't made public in a meaningful way. Lack of transparency makes it difficult for patients and providers to challenge unfair denials effectively.

Just as the Affordable Care Act requires transparency for claims, ERISA should be strengthened to require that denial and appeal data be published publicly. Data needs to enable claim-level and group-level analysis to monitor denials and appeals for a given health plan group as well as a given service or medication. KFF notes the need to require more data be shared and to enforce existing data requirements more fully.

### ***Adopting coverage criteria standards***

We also need federal standards for coverage criteria related to a growing list of denial situations. Insurers are increasingly using methods such as prior authorizations, step therapy, formulary exclusions, and narrow networks to refuse to approve or pay for care. While exceptions to policies are mandated by the ACA, patients are often not properly informed of this right and lack the resources to effectively argue for exceptions.

States and CMS are rapidly adopting new standards and reforms, but ERISA preemption puts its beneficiaries at a disadvantage. This lack of rights is leading patients and their providers, who play a crucial role in supporting appeals, to lose faith that appeals are an effective tool without clear guidelines to enforce or independent decision-makers.

### **Some examples:**

Step therapy requirements are increasingly more stringent than clinical standards. Without the proposed amendment to ERISA outlined in the Safe Step Act, ERISA beneficiaries continue to face prior authorization denials related to requirements that put their health at risk, change at will, and override decisions by their treating physician. CMS mandates Medicare Advantage plans may not introduce step therapy requirements that are more stringent than its own. A similar standard would help prevent onerous requirements.



Formulary exclusions have grown rapidly, and an analysis of the impact on patients found “almost 50% of the ESI 2022 formulary exclusions have questionable benefits for the patient, potentially forcing the patient and provider to experiment with therapeutic choices that may negatively impact the patient clinically and financially.”

Provider networks are increasingly narrow, even for employer-based plans. CMS found “the proliferation of narrower networks ... presents a number of potential consumer protection concerns including whether a narrow network has sufficient capacity to serve plan enrollees, or whether providers may be too geographically dispersed to be reasonably accessible.” Meanwhile, DOL provides very limited oversight as compared with the states or CMS. Proposed gold carding policies, while often offered as a solution to improve prior authorization by increasing the number of providers who are exempt, are not working in practice. After Texas passed a gold card law, only 3% of providers were found ‘qualified.’ This stems from the ability for insurers to deny claims, even without proper cause, thereby ensuring providers don’t meet the 90% approval criteria.

### ***Lack of Access to Critical Documents***

Many people are unable to appeal because they lack access to key documents, like the Summary Plan Description (SPD), denial notice or claim file. This problem is pervasive. In some cases, these documents don’t even exist or are locked behind complex systems that patients or their providers cannot access.

For example, a denied beneficiary of Amazon’s self-funded plan was recently told no SPD was available for 2024. And when beneficiaries request claim files, they are often ignored, receive few documents, and rarely receive them within the required time frame needed to inform a timely appeal. Other beneficiaries are told their claims were “carved-out” and denied by third parties that use criteria not available to the beneficiary.

Denial notices do not follow a standard format and standard reasons and descriptions for decision rationale. Patients need standards for whether notices are contained within explanations of benefits, as a standalone letter, the time frame for doing so, and the reasons and descriptions that must be included in full within the notice. Appeal rights are also often buried within notices in small print and lack context on legal protections.



ERISA must require timely, full access to documents. By making these documents publicly available, ERISA would also enable advocates and regulators to review coverage criteria and assess their compliance with clinical standards and applicable laws.

### ***Insurers Are Practicing Medicine***

In some cases, the medical decisions insurers make are not only inappropriate but dangerous. Claims and appeals are often reviewed by individuals who are not qualified to make sound judgments on complex medical cases. I've been told of uncovered transplant decisions being reviewed by family medicine physicians who lack the expertise required, and yet deny access despite rigorous transplant list requirements being met. Another common practice is forced non-medical switching related to formulary exclusions, whereby stable patients lose coverage for current treatment without a safe or effective alternative, often resulting in higher out-of-pocket costs for the patient.

We need stronger rules to prevent insurers from practicing medicine without proper qualifications. Furthermore, insurers should face penalties if they issue coverage decisions based on outdated policies or cherry-picked data designed to avoid paying claims.

### ***External Reviews Aren't Truly Independent***

Another issue is the lack of independence in the external review process. Many insurers rely on third-party companies — such as iMedics, MCMC, and Maximus — that often have financial ties to the insurers they're reviewing. This creates a significant conflict of interest. To ensure true fairness, external review agencies must be independent and operate without any financial or organizational ties to the insurers they review.

### ***Enforcing Existing Laws***

Finally, we must enforce the laws that already exist. Under ERISA, plans are supposed to provide certain documents and follow a standard appeals process, yet many violate these requirements without consequence. This leaves patients stranded in bureaucratic limbo.

It is time for stronger enforcement mechanisms, with meaningful penalties for violations and a renewed focus on holding insurers accountable for procedural violations, including failure to provide documents or follow appeal timelines.





### ***Conclusion***

ERISA was designed to protect employees and their health benefits. But in its current form, it leaves too many barriers for those who have been wrongfully denied. We need to take all of these steps to ensure that the law works as intended so that individuals have the tools and the support they need to fight for their care.