Advisory Council on Employee Welfare and Pension Benefit Plans

Report to the Honorable Julie A. Su, United States Acting Secretary of Labor

Group Health Plan Claims and Appeals

December 2024

NOTICE

This report was produced by the Advisory Council on Employee Welfare and Pension Benefit Plans, usually referred to as the ERISA Advisory Council (the "Council"). The Council was established under Section 512 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") to advise the Secretary of Labor (the "Secretary") on matters related to welfare and pension benefit plans. This report examines group health plan claims and appeals.

The contents of this report do not represent the position of the Secretary or of the U.S. Department of Labor (the "Department").

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ABSTRACT

The ERISA claim procedure regulations (29 C.F.R. § 2560.503-1) set forth minimum procedural standards for the filing of claims, timely notification of benefit determinations, and appeals of adverse benefit determinations to fulfill ERISA's overriding purpose of providing participants with a full and fair review by fiduciaries of any claim denials. Certain provisions are specifically applicable to group health plans, such as appeal deadlines for pre-service and urgent care claims.

Recent studies, including a survey published in 2023 by the Kaiser Family Foundation ("KFF"), along with reporting by ProPublica, the Commonwealth Fund, and other sources, have pointed to the sparse number of appeals of health benefit claim denials and have suggested that some appeal requirements for health benefit claims may be too complex or are not adequately understood by plan participants.

The Council examined the benefit claims process, the reasons behind the low appeal rates, and the extent to which health benefit plan participants may lack information or an adequate understanding of the claim procedure requirements. The Council also examined whether and to what extent claim denials, including Explanation of Benefits ("EOB") forms, and Advanced EOBs ("AEOB") required by the No Surprises Act, adequately inform plan participants of the specific reasons for adverse benefit determinations. Specifically, the Council examined whether claim denials were written in language calculated to be understood by lay persons and what information or assistance may be needed to enable participants to perfect their claims, their appeal rights, and their rights to obtain documents and information. The Council also examined the role that plan administrators, insurers, and claims administrators have in the claims and appeals process. Finally, the Council examined whether there are unique issues or concerns with respect to prescription drug claims and appeals.

The Council considered whether changes to regulations, other Department guidance or education, or the Department's enforcement policies and practices might make it easier for participants to navigate the claims and appeals process for a group health plan.

ACKNOWLEDGEMENTS

The Council recognizes the following individuals and organizations who provided testimony or information that assisted the Council in its deliberations and the preparation of its report. Notwithstanding their contributions, any errors in this report rest with the Council alone. The witnesses are shown in alphabetical order on the date of their testimony. Their submitted written testimony can be found at https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/erisa-advisory-council.

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I. EXECUTIVE SUMMARY

The overwhelming majority of Americans are either participants in or beneficiaries of employer-sponsored health benefits, the administration of which is governed by the Employee Retirement Income Security Act of 1974. Given the importance of health benefits, the Council undertook a study of participant experiences with their health benefits and an examination of whether the claims and appeals process is working as it should.

While many participants expressed satisfaction with their health benefits, the results of a survey published in 2023 by the KFF noted the low volume of appeals of adverse health benefit determinations, often due to a lack of understanding by participants on how to challenge an unjustified denial, along with the complexity of the appeal process.

The Council heard testimony from a variety of witnesses representing various stakeholders in the area of health benefits, which included an industry trade group, the American Medical Association, various patient/participant advocacy organizations, and third-party administrators. The Council also reviewed a sizable volume of published information on health benefit claims. Based on the testimony received and information reviewed, the Council formulated several recommendations aimed at improving the health benefit claims and appeals process:

1. The Department should update its regulations and sub-regulatory guidance to provide that claimants and plans should utilize the internet and electronic means of communications to both send and receive documents and make documents available to claimants such as summary plan descriptions, clinical criteria used to evaluate medical necessity, as well as claim documents.
2. The Department should attempt to develop model language and model forms, including a model explanation of benefits form, for use in the claims and appeals process, inclusive of model language explaining appeal rights.
3. The Department should examine how it might be able to collect useful data on health benefit claims and appeals. One possible means of doing so is by adding additional reporting on Form 5500.
4. The Department should consider whether it can allocate additional resources to enforcement and bring high-profile cases when it encounters systemic abuses or failures to comply with procedural requirements.

5. The Department should update existing regulations relating to urgent care claims to speed the processing of such claims and should consider imposing consequences in situations where regulatory guidelines are not followed.
6. The Department should develop and implement an educational campaign to better inform claimants about their appeal rights and how to obtain assistance from governmental agencies and consumer assistance organizations when needed.
7. The Department should mandate that clinical determinations be made in accordance with generally accepted evidence-based standards of care and treatment.
8. The Department should develop standards for the use of artificial intelligence in claims and appeals determinations.
9. The Department should expand the existing requirement that medical judgments be made by persons with appropriate clinical training and experience which is currently applicable to claim appeals to initial claim processing as well.
10. The Department should issue a new regulation or sub-regulatory guidance clarifying when actions taken by third-party administrators constitute fiduciary rather than ministerial acts.
11. The Department should elicit recommendations from stakeholders regarding documentation retention policies.
12. The Department should impose a requirement that once a documented authorization for a given service or medication is given, plans may not thereafter refuse to reimburse the cost of such service or medication in accordance with plan provisions or recoup payment once made absent fraud or deliberate misrepresentation.

The above only summarizes the recommendations; the full text of each is set forth in Part VII below.

II. PRIOR COUNCIL REPORTS

Three prior Council reports addressed issues which touch upon this year's topic. In 2017, the Council studied Mandated Disclosures concerning Health Benefit Plans. In 2010, the Council studied Health Care Literacy. In 2005, the Council studied Health and Welfare Plan Communications. The Council reviewed these reports to the extent that they bear upon its work.

III. BACKGROUND

Introduction

Prior to ERISA's enactment in 1974, the Department had no regulatory authority over health insurance claims. However, the broad scope of ERISA coverage provided by the law was made applicable to all employee benefit plans established by any employer engaged in commerce, as well as those established by employee organizations, or plans established jointly by both employers and employee organizations.[1] ERISA explicitly provides that employee benefit plans encompassed by the law includes welfare benefit plans,[2] defined in relevant part as:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services…[3]

Thus, both self-funded and insured welfare benefit plans providing medical, surgical, and hospital care were transformed into ERISA-governed employee benefit plans and fell under the Department's regulatory jurisdiction.

The Department's regulatory power included responsibility over the benefit claim process. Section 503 of ERISA[4] provides:

> In accordance with regulations of the Secretary, every employee benefit plan shall –
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

[1] 29 U.S.C. §§ 1003(a)(1) and (a)(2)
[2] 29 U.S.C. § 100(3)
[3] 29 U.S.C. § 1002(1)
[4] 29 U.S.C. § 1133

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Consistent with that mandate, the Department promulgated a detailed set of regulations governing claims and appeals, which has been revised and updated over the years, including a comprehensive revision of the regulations pertaining to health care claims and appeals in 2000.[5] The Affordable Care Act[6] ("ACA") also includes a provision giving the Department authority to promulgate additional regulations applicable to claims and appeals governed by that law.[7]

29 C.F.R. § 2560.503-1

The regulations contained in the Code of Federal Regulations at 29 C.F.R. § 2560.503-1 require employee benefit plans to "establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations."[8] The regulations also prohibit any procedure or administrative practice that "unduly inhibits or hampers the initiation of processing of claims for benefits."[9] With respect to health benefit claims, that includes preclusion of denials based on a failure to obtain a prior approval for a service where it is impossible or where the life or health of the claimant is jeopardized or if the claimant is unconscious and in need of immediate care.[10] The regulations also explicitly allow a patient's health care professional to act as a claimant's authorized representative.[11]

With respect to health care claims, the regulations provide that a claimant is entitled to prompt notice of a failure to follow a plan's pre-approval requirements.[12] Plans also are barred from imposing more than two appeals of adverse determinations before a claimant is permitted to bring a civil action,

[5] 29 C.F.R. § 2560.503-1; 65 Fed. Reg. 70256 (November 21, 2000) ("503 Regulations")
[6] P.L. 111-148, 124 Stat. 888 § 2719 (2010)
[7] 29 C.F.R. § 2590.715-2719 ("2719 Regulations).
[8] 29 C.F.R. § 2560.503-1(b)
[9] 29 C.F.R. § 2560.503-1(b)(3)
[10] *Id.*
[11] 29 C.F.R. § 2560.503-1(b)(4)
[12] 29 C.F.R. § 2560.503-1(c)(1)

although the plan may allow additional voluntary appeals.[13] Mandatory binding arbitration of claim appeals is also prohibited.[14]

The regulations also identify different types of health care claims and the time limits for deciding claims as to each type.[15] Urgent care claims, which are defined as situations where, in the opinion of a physician who has knowledge of the patient's condition, the patient's life or health is in jeopardy, or where the patient is in severe pain that cannot be managed without the care that is being sought[16] must be decided within 72 hours of receipt.[17] Pre-service claims must be decided within 30 days of receipt of the claim, while post-service claims must be decided within 60 days.[18] If a claimant has been approved to receive a course of treatment, which is characterized in the regulations as a concurrent care claim, notification of a disruption in that treatment needs to be given sufficiently in advance of the planned action to allow the claimant to appeal.[19]

If a claim is denied, the claimant is entitled to receive a written or electronic notification which sets forth the determination in "a manner calculated to be understood by the claimant."[20] The denial must set forth the specific reason or reasons for the denial, the specific plan provisions on which the determination was based, a description of any additional material or information that is necessary in order for the claimant to perfect the claim, and an explanation as to why the material or information is necessary, along with a description of appeal procedures.[21] In addition, if an internal guideline or rule was utilized in rendering the determination, the denial letter must inform the claimant that a copy will be provided upon request without cost.[22] Further, if the denial is based on medical necessity or a claim that the treatment is experimental or investigational, the plan is required to provide "either an explanation of the scientific or clinical judgment for the determination or a statement that such an explanation will be provided upon request."[23]

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[13] 29 C.F.R. § 2560.503-1(c)(2)
[14] 29 C.F.R. § 2560.503-1(c)(4)
[15] 29 C.F.R. § 2560.503-1(f)(2)
[16] 29 C.F.R. § 2560.503-1(m)(1)
[17] 29 C.F.R. § 2560.503-(f)
[18] 29 C.F.R. §§ 2560.503-1(f)(2)(i) and (iii)
[19] 29 C.F.R. § 2560.503-1(f)(2)(ii)
[20] 29 C.F.R. § 2560.503-1(g)(1)
[21] 29 C.F.R. § 2560.503-1(g)(1)(i) – (iv)
[22] 29 C.R. § 2560.503-1(g)((1)(v)(A)
[23] 29 C.F.R. § 2560.503-1(g)(1)(v)(B)

If a claimant wishes to challenge a denial, the claimant must be given the opportunity to submit written comments and additional documents, records, or other information.[24] Claimants are also entitled to receive upon request a complete copy of all records relevant to the claim.[25] The claim administrator is then required to take into consideration all records, documents, and comments submitted by the claimant.[26] Regulations that are specifically applicable to group health plans also require that a review of a claim denial must be conducted by a different person than the individual who rendered the initial determination, and that if the matter involves a medical judgment, the plan must "consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment."[27] Such professionals must also be identified "without regard to whether the advice was relied upon in making the benefit decision;" and plans are also precluded from using the same medical experts for the appeal who were involved with the initial determination.[28]

The regulations also specify the timing for appeal determinations – urgent care claim appeals must be decided within 72 hours of receipt of an appeal, pre-service claims within 30 days, and post-service claims within 60 days.[29]

The benefit determination on review must be provided in writing or electronically and be written "in a manner calculated to be understood by the claimant" setting forth the specific reasons for the denial, reference to applicable plan provisions on which the determination was based, a statement that the claimant is entitled to receive upon request and without charge, access to the claim documentation relevant to the claim decision, and an explanation of the plan's appeal procedures.[30] In addition, if an internal rule or guideline was relied upon in rendering an adverse claim decision, the claimant is entitled to receive a copy of such documentation upon request.[31] Likewise, if the determination is based on a medical judgment, the claimant is entitled to receive a copy upon request.[32]

[24] 29 C.F.R. § 2560.503-(h)(2)(ii)
[25] 29 C.F.R. § 2560.503-1(h)2)(iii)
[26] 29 C.F.R. § 2560.503-1(h)(2)(iv)
[27] 29 C.F.R. § 2560.503-1(h)(3)(ii) and (iii)
[28] 29 C.F.R. § 2560.503-1(h)(3)(iv) and (v)
[29] 29 C.F.R. § 2560.503-1(i)(2)
[30] 29 C.F.R. § 2560.503-1(j)
[31] 29 C.F.R. § 2560.503-1(j)(5)(i)
[32] 29 C.F.R. § 2560.503-1(j)(5)(ii)

The regulations also specify that notices must be given in a culturally and linguistically appropriate manner, which includes a requirement that telephone customer assistance centers need to provide foreign-language speaking personnel in "any applicable non-English language."[33] On request, notices must be supplied in non-English languages, and the claims notices must explain how a claimant can gain access to the language services they need.[34]

If a plan fails to comply with the regulations, the claim is deemed denied and the participant can proceed to file suit in court.[35]

29 C.F.R. § 2590.715-2719

The regulations at 29 C.F.R. § 2590.715-2719 reiterate the requirements of 29 C.F.R. § 2560.503-1, including a requirement that "decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits."[36] The regulations also require continuation of an ongoing course of treatment during a claim appeal.[37] The regulations further set forth standards for independent external reviews both by the states and for federal external reviews (when state reviews are not applicable) that claimants can request under the ACA.[38]

The Issue

In 2023, the KFF published a survey (the "KFF Survey") on consumer experiences with health insurance denials.[39] Among other things, the KFF Survey noted the low volume of appeals of adverse health benefit determinations by claimants and the lack of understanding by consumers on how to challenge an unjustified denial, along with the complexity of the appeal process.[40,41]

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[33] 29 C.F.R. § 2560.503-1(o)
[34] *Id.*
[35] 29 C.F.R. § 2560.503-1(1)
[36] 29 C.F.R. § 2590.715-2719(b)(2)(ii)(D)
[37] 29 C.F.R. § 2590.715-2719(b)(2)iii)
[38] 29 C.F.R. § 2590.715-2719(c) and (d)
[39] KFF, "Survey of Consumer Experiences with Health Insurance," (June 15, 2023); available at https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/
[40] Miller and Ngu, "You Have a Right to Know Why a Health Insurer denied Your Claim. Some Insurers Still Won't Tell You," ProPublica (November 8, 2023); available at https://www.propublica.org/article/your-right-to-know-why-health-insurer-denied-claim
[41] Clark, "I Set Out to Create a Simple Map for How to Appeal Your Insurance Denial. Instead, I Found a Mind-Boggling Labyrinth," ProPublica (August 31, 2023); available at https://www.propublica.org/article/how-to-appeal-insurance-denials-too-complicated

The Council examined the current landscape of health benefit claims and appeals, the reasons behind the low appeal rates, and the extent to which health benefit plan participants may lack information or an adequate understanding of the claim procedure and appeal requirements. This included an examination of whether and to what extent claim denials, including EOBs, adequately inform plan participants of the specific reasons for adverse benefit determinations in language calculated to be understood by lay persons, what information or assistance may be needed to enable participants to perfect their claims, their appeal rights, and their rights to obtain documents and information. The Council also examined the role that plan administrators, insurers and claims administrators have in the claims and appeals process.

The Council considered whether changes to regulations, to other Department guidance or education, and/or to the Department's enforcement policies and practices might make it easier for participants to navigate the claims and appeals process for a group health plan.

IV. WITNESS TESTIMONY

A. Insurers and Third-Party Administrators

1. Adam Beck, Association for Health Insurance Plans, Inc.

Adam Beck, representing the Association for Health Insurance Plans, Inc. ("AHIP"), testified that the essential function of health insurance plans is facilitating access to medical services for plan participants. AHIP, a trade organization representing health insurers nationally, highlighted the commitment of its members to market-based solutions aimed at enhancing the affordability and accessibility of health care. As third-party administrators ("TPA") for employers, AHIP member plans prioritize financial stewardship by negotiating payment rates, reviewing claims, and aligning necessary care with benefit terms.

Despite the generally smooth processing of claims, there are instances of "adverse benefit determinations," where claims may be denied or only partially covered. In such cases, participants and providers have the right to appeal. AHIP member plans are dedicated to ensuring a fair and transparent appeals process, providing clear instructions for filing appeals in the EOBs, and making this information accessible through summaries of benefits and coverage ("SBCs"). Multiple support channels, including customer service representatives and online resources, are available for participants seeking assistance.

The appeals process comprises two main stages: internal appeals, where participants can submit additional information, and external reviews, which involve an independent third-party evaluation if the internal appeal is unsuccessful. Health plans are required to respond to appeals within specified timeframes to facilitate timely decisions, allowing participants to pursue further action if necessary. Mr. Beck testified that health plans offer consumer assistance programs and online resources, such as portals for tracking appeal status, to aid participants in navigating this process.

Mr. Beck noted that health care professionals are integral to both claims and appeals, utilizing their medical expertise to determine the necessity of treatments in accordance with insurance policy criteria. In appeal scenarios, physicians may reassess denied claims, and in cases requiring external review, they can help prepare documentation for further evaluation. Additionally, physicians contribute to developing clinical guidelines that inform coverage decisions, ensuring that policies reflect contemporary medical research and best practices.

2. Ivelisse Berio LeBeau and Karin Peters, National Employee Benefits Administrators, Inc.

The Council heard testimony from Ivelisse Berio LeBeau and Karin Peters of National Employee Benefits Administrators Organization ("NEBA"). NEBA is a nonfiduciary TPA that provides claims and other health plan administration services primarily to Taft-Hartley multiemployer plans.

Ms. Berio Le Beau and Ms. Peters testified that, in their view, claims are generally adjudicated correctly. They stated that claims are generally adjudicated correctly and more consistently as the adjudication of claims has become more automated.

While they acknowledged the length and complexity of the claims and appeals framework, as well as the general need to better educate participants about navigating that process, they attributed low claims appeal rates to reasons other than the complexity of the process. They stated that the health benefit utilization process and the preauthorization requirements has resulted in the provision of fewer services that would not be covered. The witnesses also noted that there are instances where claim denials result in no financial impact to participants and consequently appeals are not pursued.

Another scenario described by these witnesses as possibly having some influence on the low volume of claims appeals is when informal resolutions to claim denials occur. They noted that when participants call in because of a denial made for an administrative reason (e.g. missing information or an incorrect treatment code), administrative corrections are made, the claim is subsequently approved, and those claims are not classified as formal appeals.

Finally, these witnesses also shared that when participants call to seek assistance with claim denials, it is their belief that those participants have not read the claim denial materials. They surmised that this is typically the case because of the length of the EOBs. Therefore, they recommended that the Council consider recommending something to make EOBs more reader friendly such as shortening them, providing them electronically with only summary information, and including hyperlinks to more details.

They noted that, in their experience, when participants of multiemployer plans submit appeals, it is often based on the belief that the Board of Trustees of the multiemployer plan is more likely to modify the plan or make an exception to permit their claim than under a non-multiemployer health plan.

Specifically, participants have a more direct connection to Board members under a multiemployer plan, and the Board of Trustees who sponsors the plan is a not-for-profit entity and has no incentive to make a profit in connection with the management of assets available for claim coverage.

B. MEDICAL

1. Emily Carroll and Heather McComas, American Medical Association

Emily Carroll, JD, MSW, a Senior Attorney for the American Medical Association's ("AMA") Advocacy Department, and Heather McComas, PharmD, Director of the AMA's Administrative Simplification Initiative, provided testimony on the AMA's views on current barriers to ensuring appropriate health care coverage for medical care, including difficulties in the claim appeal process, as well as the burdens imposed by prior authorization and claim denials. They noted that these problems result in patient harm, administrative and financial burdens to patients, and waste of resources on these administrative processes.

The AMA noted that many patients and providers reported negative experiences in appealing denied benefit claims, which often resulted in reluctance to engage with the process prospectively. In addition, in some cases, the patient is unable to delay treatment to wait for the outcome of an appeals process, and either the physician is forced to select an alternative treatment that may not be as effective, or patients may choose to forgo treatment. The AMA noted that 24% of patients did not receive the recommended care if the claim was denied, and that 26% delayed treatment. They also noted that, in their experience, when participants and providers appeal, they often win.

Also, the AMA explained that incorrect claim denials and excessive prior authorization requests impose financial and administrative burdens on health care providers, which, in turn, increase costs and decrease ease of use of the health care system as a whole. With respect to prior authorization, the AMA noted there are reported delays, negative impact on clinical outcomes, and treatment abandonment as a result. Moreover, the AMA's research has shown that providers and their staff spend approximately 12 hours per week on prior authorizations. In addition, when claims are improperly denied or down-coded after the treatment is provided, physicians suffer financial losses.

Finally, the AMA noted that, in both claims and appeals that turn on medical necessity, it is essential to have physicians who are in the relevant specialty make decisions regarding medical necessity. They noted that evaluation of medical necessity is the practice of medicine, and that currently, the

individuals making decisions regarding medical necessity have not examined the patient and are too often not physicians trained in the specialty that handles the treatment at issue.

The AMA noted that there are many opportunities for reform in this area, some of which can build on the existing work done at the state level. With respect to prior authorization, the AMA cited the 2018 Consensus Statement on Improvement of Prior Authorization Process, co-signed by the AMA, as well as the American Hospital Association, AHIP, the American Pharmacists Association, the Blue Cross Blue Shield Association, and the Medical Group Management Association, which calls for selective use of prior authorization, greater transparency, continuity of care, and review of use of prior authorization to reduce use where it is not necessary.

The AMA also advocated for greater examination of clinical criteria, noting that medical determinations by plans and payors should be evidence based, use nationally recognized standards, and should require clinical peers to review adverse benefit determination at the decision level rather than only at the appeal level. The AMA maintained that there should be greater transparency in plan requirements, including providing specific reasons for claim denials that includes the coverage criteria, and the plan provisions relied upon.

In response to questions from the Council, the AMA witnesses noted that use of artificial intelligence ("AI") and auto adjudication is common in the industry, and that it can be used to automate processes such as routine approvals. However, they noted that there needs to be greater transparency on when plans use AI and how the AI technology is being trained.

C. Other

1. Kaye Pestaina, Kaiser Family Foundation

Kay Pestaina, Director of the Kaiser Family Foundation Program on Patient and Consumer Protection, presented a 2023 Survey of Consumer Experiences With Health Insurance. The KFF Survey touched on many areas of inquiry. Although over 80% of respondents expressed satisfaction with their health insurance, approximately 60% also said that they had experienced problems using their coverage. These problems fell into several different categories and approximately half of the survey participants reported that their problems were resolved to their satisfaction. KFF found that 18% of adults had experienced a denied claim last year but their study made no attempt to determine what percentage of the denials were erroneous. KFF found that, while 84% of the people with denied claims took some action to

resolve them, only approximately 15% filed a formal appeal (and it is unclear what percentage of the remaining 85% had meritorious claims which were not adjusted through other means). The KFF Survey also revealed that more than half of the respondents were unsure whether they had a right to appeal claim denials with a similar number expressing that they found it difficult to understand some aspect of their health insurance. The KFF Survey also found that affordability of coverage is a concern for about half of the respondents.

Ms. Pestaina suggested that the Department has the ability to collect more data, such as adding questions to the Form 5500 regarding frequency of appeals and other useful data. The Department of Health and Human Services ("HHS") is also empowered to collect data under the ACA.

Ms. Pestaina contrasted the data available with respect to employer sponsored health plans with data available regarding Medicare Advantage plans, which is more robust and shows that while only 10% of participants appeal denials, the majority of such appeals are successful. However, even when an appeal is successful, it may still result in delays in patients receiving necessary treatments.

2. Professor Charlotte Tschider, Loyola University School of Law

Professor Charlotte Tschider is an Associate Professor at the Loyola University Chicago School of Law where her primary scholarship examines legal issues in artificial intelligence, international data protection, information privacy, cybersecurity law, and health care medical device technology. Professor Tschider provided written testimony in response to questions from the Council regarding the impact of AI on claims and appeals and best practices going forward.

Professor Tschider noted that AI is used by a wide variety of large insurers, in areas such as initial claim processing and automating interactions with patients for low-stakes questions. She noted that AI is also used to collect information prior to medical visits to include in electronic health records. She added that larger insurers are using AI to identify trends in higher-cost claims and to implement interrupters to reduce claim costs. She noted that AI can be beneficial by reducing treatment cost, increasing efficiency, and potentially reducing appeals, as well as to identify areas where data is missing or even to detect fraud. She also stated that AI can be used to analyze complex patterns of claims data that would not necessarily be picked up by human reviewers or typical automation.

She noted that problems with AI may occur where there is poorly developed AI, including mass claim denials, which a large portion of members will not appeal, noting the recent Cigna mass denial that was reported in ProPublica. She added that there is little disclosure of when AI is used, and that the data sources used to train AI models are unknown. Nor is it clear to what extent humans are used in training such systems. She noted that an effective AI system would use a rich base of cleansed training data (eliminating as much bias as possible, though some will always be included), then feeding the AI many combinations to train it, using humans to spot where it fails and correct it. She opined that given the widespread use of AI in health claims processing, there is no reason to delay government regulation of its use, particularly as the use of more sophisticated AI using neural networks is decreasing transparency.

With respect to possible reforms, Professor Tschider stated that efforts should focus on the "full and fair review" ERISA requirement in denied claims appeals by requiring specific disclosures about whether AI had been used to render the initial claim determination, including specific information regarding inputs that were "important" to the weight of a claim denial. She noted that, given the increased use of automation, plans may have the ability to shrink the period in which plans must determine pre-service and post-service claims. In addition, she opined that participants should be able to elect human review of appeals. Finally, for plans that use AI, she noted that it would be useful to conduct AI audits to ensure that the AI claims determination process is working correctly and to reimburse participants for erroneous claims determinations.

D. Patient Advocates

1. Brian King, Brian S. King Law Office

Brian King, from the Brian S. King Law Office is an attorney who possesses considerable experience litigating cases related to health claims and appeals, particularly in the U.S. Court of Appeals for the Tenth Circuit. Mr. King maintained that "there is a financial interest for [health] insurers to provide as little information as possible to insureds and to make what information they do provide incomprehensible relatively speaking."[42] He noted that when claimants do not have the knowledge or resources to challenge an insurer's decision, the insurer is less likely to be held accountable. Mr. King reviewed recent court rulings he has received that reinforce the requirement under current claims and appeals regulations that claim appeals require a "meaningful dialogue" with the claimant. He noted that

[42] Council Hearing of July 8, 2024, Transcript of Testimony of Brian King, at 137.

there is a need for sufficient explanation of the basis for a claim denial, in a manner that can be understood and addressed by the claimant.

He suggested that the Department examine how EOB forms issued by insurers and plan administrators can be improved to be more "meaningful" in the sense that an average plan participant can better understand the content of the EOB. For example, he noted that an EOB should emphasize that participants must exhaust administrative remedies before their claim can be litigated. He also noted that if a plan implements a statute of limitations to bring claims regarding benefit denials, that should be made clear in both denial letters and EOBs. He stated that artificial intelligence could be used to suggest how an EOB should be written (i.e., articulating the denial, the basis for the denial, and the analysis leading to the denial).

2. Meiram Bendat, J.D., Ph.D., Psych Appeals

Meiram Bendat is an attorney and psychologist with expertise on mental health topics. He attempted to address the reasons for the low number of appeals of mental health claims. Bendat testified that, in his experience, there are two main reasons for coverage denials: (1) wrongful medical necessity denials, and (2) network inadequacy. He also identified two main impediments to the claims and appeals system: (1) timeliness, and (2) providers need to be directly involved on medical necessity issues. He also believes that insurer and administrator websites often are not functional or well designed.

Mr. Bendat proposed that the Department should issue an FAQ saying that urgent care claims need not be limited to in-patient cases and that when urgent care claims are not timely adjudicated, they should be automatically approved. He also feels that the external review system should be improved.

3. Mary Covington, FixMyClaim

Mary Covington, who has assisted consumers with health insurance claims and appeals for more than two decades, identified numerous systemic problems she has observed in the claims and appeals process over the years. One systemic problem she identified is when insurers issue pre-approvals and then later refuse to cover the treatment after it has been provided. Another is when claimants are given incorrect information about whether treatment meets the plan's treatment guidelines. She noted that network inadequacy is also a prevalent issue, which necessitates patients having to receive out-of-network care at a lower rate of reimbursement. She also observed that participants often have problems obtaining

necessary information from insurers in order to appeal a denial, along with other issues that delay appeals and impede authorized representatives' ability to assist claimants in appealing denials.

Ms. Covington suggested that better use of the internet would facilitate participants' ability to access necessary information and to permit submission of claim appeals electronically; and she advocated for better communications between plans and representatives to address the basis of the denial, especially when medical judgments are the reason for claim denials. She also testified that even after a denial is overturned, it can take an excessively long period of time before payment is made, which drags out an already lengthy appeals process.

4. Joseph Feldman, Cover My Mental Health

Joseph Feldman is an advocate for mental health treatment who has started an organization, Cover My Mental Health, which provides advice to consumers on how to overcome health care insurers' obstacles to mental health and substance disorder treatment.

He pointed out that nearly a quarter of the U.S. population has mental health issues requiring treatment, but that obtaining approval for needed care is challenging since consumers do not understand their health coverage, lack the expertise to challenge claim denials based on medical necessity, and are unaware of resources that may be available to assist them.

He started Cover My Mental Health after becoming aware that patients and providers have a keen interest in learning how not to take "no" for an answer. He explained that his organization assists treatment providers and patients by providing guidance on how to write a letter arguing medical necessity and offers advice on how to obtain critical documents, such as summary plan descriptions and claim records.

Mr. Feldman advocated the need for more education for patients and clinicians on how to address claim denials; he also recommended that the Department require more reporting by health insurance companies on how claim determinations are made. He also maintained that plans should be penalized for delays.

5. Betty Long, Guardian Nurses; Jacqueline Tulcin, Community Health Advocates; and Julia Underwood, Consumers for Affordable Health Care

Betty Long of Guardian Nurses, Jacqueline Tulcin of Community Health Advocates, and Julia Underwood of Consumers for Affordable Health Care testified on a panel, reflecting the views of professional patient advocates. The latter two organizations are officially designated as the consumer assistance programs in their respective states (New York and Maine). All three panel members explained the services they offered and testified that they have been successful in assisting clients in the navigation of the health care and health insurance systems, and in obtaining recoveries from health plans and insurers. They all expressed frustrations in dealing with insurance companies. The main problems identified include (1) unclear policy language; (2) inconsistent, incorrect or improper application of medical necessity criteria; (3) delays which hinder health care and frustrate patients and providers; (4) decisions made by unqualified people; (5) incorrect or incomplete EOB forms; (6) misinformation given by plan administrator's representatives; (7) inadequate provider networks; (8) failure to permit electronic processing of claims and appeals; and (9) failure to furnish needed information about the claim, including clinical guidelines or criteria.

To remedy those problems, they recommended numerous changes in the law and regulations, including enhanced penalties for noncompliance with the administrator's legal duties in processing claims and penalties for maintaining an inadequate network of providers. They also recommended that electronic processing of claims and appeals and electronic access to important documents be required. They feel that state and federal governments should do more to directly provide and to publicize the availability of well-trained patient advocates, and that more published data on claim denials would assist consumers in differentiating between insurers.

6. Karen Handorf, Berger Montague, PC

The Council heard testimony from Karen Handorf, Senior Counsel with the law firm of Berger Montague, PC, where she has represented plan participants and fiduciaries in litigation against TPAs of ERISA-covered health plans. Previously, Ms. Handorf spent over 25 years at the Department in the Plan Benefits Security Division of the Office of the Solicitor.

Ms. Handorf attributed the small number of health benefit claim appeals to several factors but expressed particular concern about the lack of transparency in the way TPAs process both in-network and

out-of-network claims, and the lack of accountability when TPAs assert that they are only performing ministerial, not fiduciary acts. As a result, plan participants often have little understanding of why their claims have been denied; and especially for smaller value claims, lack the resources to retain counsel. Another issue identified by Ms. Handorf relating to the scarcity of counsel is that fee awards are unavailable for claim appeals. She also testified that providers do not appeal because many plans prohibit the assignment of claims to the providers and on account of ERISA preemption, providers cannot bring state law contract or estoppel claims.

Ms. Handorf recommended that anti-assignment provisions should be prohibited in order to permit providers to bring claims. She also urged that existing regulations (29 C.F.R. § 2509.75-8), be amended to clarify that TPAs are plan fiduciaries, and that attorneys should be able to seek compensation from the benefit plans when they are successful in overturning an unfavorable determination. Claimants should also have the ability to recover damages when a wrongful denial results in adverse health consequences. She emphasized that there needs to be more transparency in the way TPAs handle claims and in their fee arrangements with benefit plans, as well as with respect to the rates paid to providers.

7. Steve Butterfield, Leukemia & Lymphoma Society

The Council heard testimony from Steve Butterfield, the Senior Director of State Public Policy at the Leukemia & Lymphoma Society. Prior to his work at the Leukemia & Lymphoma Society, Mr. Butterfield was a Policy Director at the Consumers for Affordable Health Care in Maine. He currently also serves as a member of the Technical Expert Panel for the Centers for Medicare and Medicaid Services Qualified Health Plan Enrollee Experience survey.

Mr. Butterfield described his organization's experience with patients who have blood cancers and the harmful impact that incorrect claim denials can have on their lives. Mr. Butterfield emphasized the need for more data collection on claim denials, including the rate of denials, the number of appeals, and the outcomes of appeals. He also suggested that automatic appeals of claims would benefit participants and noted that this is already a feature of Medicare Advantage plans.

Mr. Butterfield also raised concerns regarding the use of artificial intelligence to review claims that do not involve routine care for an otherwise healthy individual. He noted that patients with blood cancers often require treatments that are often not typical of what other individuals in their age group would receive, but are medically necessary due to their condition.

Mr. Butterfield also raised concerns regarding the denial of reimbursement for cutting-edge treatments that are not covered due to outdated insurer or plan criteria. He suggested that insurers and plans consider deferring to treatment guidelines issued by the FDA or by major medical associations. He also suggested that insurers and plans should be required to explain their medical necessity criteria, and to the extent it differs from authoritative medical society recommendations, explain why it is inconsistent with guidelines from major medical associations.

8. Wendell Potter, HEALTH CARE uncovered

Wendell Potter is currently the President of the Center for Health and Democracy, was a former executive at Cigna, and is a best-selling author of *Deadly Spin*, which discussed his experience in the health insurance industry.

Mr. Potter referenced statistics from a KFF study that indicated that the cost of offering health benefits has increased. He noted that insurers continue to consolidate and have become some of the largest and most profitable corporations in the country. He stated that in 2023, the seven largest publicly traded health insurers made nearly $70 billion in profits. He opined that insurers have focused on decreasing utilization of health benefits, so individuals are receiving less care despite paying higher premiums.

Mr. Potter identified numerous barriers faced by consumers trying to access coverage, including shrinking networks and the use of a variety of procedures to deny claims. He noted the following: (1) most individuals are not aware of their appeal rights; (2) insurers often bury coverage criteria, denial rationales, and appeal rights in documents; (3) insurers are using artificial intelligence to deny large numbers of claims citing a recent ProPublica article.

Mr. Potter noted that only a small percentage of denied claims are appealed, citing the KFF Survey. He stated that the appeals process is burdened by complexity and insurers further complicate the process by using delay tactics. He stated that many individuals often do not appeal because they lack access to key documents, such as the summary plan description or the claim file. He recommended requiring that all plan documents, appeal rights, and appeal processes be available to the patient online, including any coverage criteria or appeals processes maintained by a third-party. He also recommended requiring health plans to utilize a single, centralized location for submission of claim appeals online, with confirmation of receipt in addition to mail and fax options.

Mr. Potter noted the lack of data on initial claim denials and appeals. He encouraged greater transparency and strengthening ERISA to require publication of such data. Mr. Potter also pointed out the need for federal standards for coverage criteria, noting that insurers are using prior authorization requirements, step therapy, and other medical claim management techniques to deny coverage. He also stated that many claims are reviewed by individuals who are not qualified to make judgments on complex medical cases, or in the case of external reviews, claims are being reviewed by third parties who have financial ties to insurers.

E. Employers/Labor Organizations

1. Brandon Long, McAfee & Taft; Lorrie Jacobs and LaShan Wiley

Brandon Long, an attorney with McAfee & Taft, represents benefit plan providers and, appeared on a panel with Lorrie Jacobs and LaShan Wiley who have experience managing a self-funded health benefit plan that self-administer final level claim appeals, often turning to third-party medical reviewers to assist in rendering clinical judgments in such appeals.

The witnesses recognized that both summary plan descriptions ("SPD") and EOBs are often difficult for claimants to understand, and do not adequately inform claimants about how to appeal claim denials. Based on their experience, they also noted that participants are often frustrated due to communications breakdowns between participants, providers, and the plan.

Mr. Long, Ms. Jacobs, and Ms. Wiley recommended that EOBs be standardized and contain easily understood language about how appeals can be brought. They also recommended that plans need to facilitate more peer-to-peer communications to resolve clinical issues. Mr. Long also recommended that the Department modify the language of 29 C.F.R. § 2560.503-1(g) to clarify that claimants have the right to receive copies of the clinical guidelines used to render the claim determination. Finally, the witnesses suggested that if a plan decides to make an exception to approve a claim that was previously denied, that the benefit plan be amended to make the benefit uniformly available for all participants.

2. The ERISA Industry Committee (ERIC)

ERIC, a national advocacy organization representing large corporate plan sponsors, submitted written testimony to the Council. ERIC stated that its members retain and rely on insurers to build their health plan networks and negotiate prices with providers. ERIC states that members want to ensure that employees receive the health care they need in the most appropriate and cost-effective manner possible.

ERIC provided three case studies, reflecting comments received from their members regarding the claims and appeals process. In all three cases, the companies felt existing procedures were working effectively and, in two out of three cases, felt that participants had an adequate understanding of how to appeal a denied claim. In one case, the company suggested that insurers could improve their EOB systems to enhance participant understanding of why claims are denied in whole or in part.

ERIC also proposed that the Department should seek to expand the use of electronic communications and, especially, should permit health plans to use default electronic delivery of plan communications in a manner which is now authorized for retirement plan communications.

3. National Coordinating Committee for Multiemployer Plans (NCCMP)

The Council received written testimony from the NCCMP, a national organization devoted exclusively to protecting the interests of multiemployer plans, and the unions and employers that jointly sponsor such plans. Most multiemployer plans are self-insured and self-administered, while some contract with TPAs for all or parts of plan administration services.

The NCCMP noted that a 2021 KFF Survey focused only on individual health insurance policies purchased through the ACA marketplace while another issued in 2023 surveyed participants in different health plans. Although both studies revealed a low rate of appeals, NCCMP maintains that multiemployer plans have fewer issues with appeals than other plans and that a low rate of appeals may also "be evidence of an efficiently operating claims process."

The NCCMP maintains that the current claims and appeals regulations are working well, and that EOBs are functioning as they should in providing information to plan participants. Hence, the NCCMP recommends that the current regulations be retained.

Many claims involve requests for benefits that are "uncommon or involve a new medical procedure," and the NCCMP observes that the Board of Trustees overseeing multiemployer plans have the opportunity to amend the plan documents to provide for benefit payment and can also use the appeal process to provide trustees with information they can use to identify inadequate plan terms and modify them.

The NCCMP requested that the Department conduct customer experience surveys to identify ways to improve the claims and appeals experience for participants. Given the changes in technology and population demographics since the existing regulations were adopted, they noted that gathering more data would be helpful.

Finally, the NCCMP recommends that the cost to plans be considered in any recommendations made by the Council.

F. GOVERNMENT

1. Jeffrey Turner and Elizabeth Schumacher

Jeffrey Turner and Elizabeth Schumacher of Employee Benefits Security Administration ("EBSA") provided an overview of the existing regulations governing claims and appeals, including regulations relating to independent review of claim denials promulgated in the wake of the passage of the ACA. The information they provided is contained in the introduction to this report.

V. DATA

The Council was only able to obtain a limited amount of data regarding the health plan claims and appeals processes in operation, leading to the recommendation by both a variety of witnesses and the Council that further data collection efforts would be beneficial.

The principal survey considered by the Council was the KFF Survey of Consumer Experiences with Health Insurance.[43] The KFF Survey was based on interviews of a nationally representative sample of 3,605 U.S. adults with health insurance, including 978 adults whose primary coverage is under an ERISA plan (with the balance covered by Medicare, Medicaid or private insurance). Although over 80% of respondents expressed satisfaction with their health insurance, approximately 60% also said that they had experienced problems using their coverage. These problems fell into several different categories and approximately half of these participants reported that their problems were resolved to their satisfaction. The KFF found that 18% of adults had experienced a denied claim last year but their study did not attempt to determine what percentage of the denials were erroneous. The KFF found that, while 84% of the people with denied claims took some action to resolve them, only approximately 15% filed a formal appeal (and it is unclear what percentage of the remaining 85% had meritorious claims which were not adjusted through other means). The Council received some evidence from the AMA and other witnesses that over half of appeals were decided in favor of the claimants. The KFF Survey touched on many other areas of inquiry. Among other things, it found that affordability of coverage is a concern for about half of the respondents.

A report by the Commonwealth Fund[44] also provided useful data derived from a survey of 7,873 adults, focused on 5,602 working-age respondents. The survey revealed that more than two of five working-age adults reported being charged for a health service they thought was free or covered by insurance, which the respondents attributed to plan complexity and heterogeneity of benefits across plans. The data also showed that fewer than half of the respondents challenged unexpected bills by contacting their provider or insurer, and over half of those who did not challenge their bills were unsure whether they

[43] Politz, et al., "KFF Survey of Consumer Experiences with Health Insurance" (June 15, 2023); available at https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/

[44] Commonwealth Fund, "Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S." (Issue Briefs August 1, 2024); available at https://www.commonwealthfund.org/publications/issue-briefs/2024/aug/unforeseen-health-care-bills-coverage-denials-by-insurers

had a right to do so. Of those who did challenge billing, 38% of survey respondents reported the bills were either reduced or eliminated.

The Commonwealth Fund survey also found that 17% of adults were denied coverage for care recommended by their doctor. The most common reasons given were that the service was deemed medically unnecessary, involved medication that was not on the plan's formulary, or the procedure was deemed experimental.

The Commonwealth Fund also found that 43% of adults who had been denied claims challenged the denials; and among those, 45% reported they were not sure they had a right to appeal. However, half of those who did appeal denials ultimately had their claims approved, although 60% of adults who experienced a coverage denial reported their care was delayed as a result.[45]

The Council also relied upon the AMA's 2023 Physician Survey on Prior Authorization ("AMA Survey").[46], An overwhelming majority (94%) of physicians who responded to the survey reported that prior authorization requests delay access to necessary care. Meanwhile, patients may clinically deteriorate while they are forced to wait for benefit approval, with 93% of physicians reporting that prior authorization can negatively impact clinical outcomes. Nearly one-quarter (24%) of physicians say that prior authorization requests have also led to a serious adverse event (hospitalization, disability, or even death) for a patient in their care. The AMA Survey further indicated that the administrative burdens of fulfilling pre-authorization request requirements are consuming on average 12 hours per week of physician and staff time, many of the topics which require prior approval are routine, the medical criteria being used by insurers are often ill informed, the personnel making medical judgments for the insurers are often unqualified, the clinical criteria being used are often lacking in transparency, and physicians and their staff are sometimes required to engage in lengthy phone calls or paper document exchanges when electronic communications would be much more efficient and less time consuming. The AMA reports that many physicians are demoralized and discouraged by their unpleasant experiences in dealing with insurance companies (which are increasingly denying claims according to 73% of the physicians surveyed) and, as

[45] The Commonwealth Survey cited a report from the New York Times on the consequences of delayed care resulting from claim denials. Stockton, "What's My Life Worth?: The Big Business of Denying Medical Care," *New York Times* (video, March 14, 2024.

[46] Available at https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

a result, some will forego appealing denials even when the claim is meritorious. The AMA witnesses also referred to various other surveys and data in their written statement.

The Council also noted the Commonwealth Fund's September 19, 2024 Report, titled "Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System."[47] This report attempted to compare health system performance in ten countries to glean insight for means of improving the U.S. health care system, analyzing 70 performance measures in five areas. It found the U.S. underperforms the comparators in dramatic fashion. Of particular relevance to the Council's study, the Commonwealth Fund noted that U.S. "physicians and other health care providers spend enormous amounts of time and effort billing insurers. Denials of services by insurance companies are also common, necessitating burdensome appeals by providers and patients."

The Council also noted the White House Fact Sheet, "Biden-Harris Administration Launches New Effort to Crack Down on Everyday Headaches and Hassles That Waste Americans' Time and Money" (August 12, 2024) and the U.S. Senate Permanent Sub-Committee on Investigations Majority Staff Report on Medicare Advantage Plans, "Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care" (October 17, 2024).

The Council also took note of numerous press reports on various aspects of the health care system, particularly reports regarding the handling of claims and appeals by insurance companies in a variety of circumstances. Many of these reports were by ProPublica or the New York Times.[48]

[47] Available at https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024
[48] See Observations and Recommendations for specific references

VI. COUNCIL OBSERVATIONS

Consumers have difficulty understanding their plan benefits, claim determinations (EOBs), and their appeal rights

HHS recently issued a statement in conjunction with the current Administration's "Time is Money" initiative[49] which pointed out that "it should be easy for consumers to use their health coverage." Many of the witnesses who testified before the Council, along with many plan participants who participated in the KFF Survey,[50] expressed their belief that even when plan administrators are making an effort to comply with existing law and regulations, employee benefit health plan participants often do not understand their coverage. Furthermore, claim determinations (primarily in the form of EOBs) do not provide adequate information or explain in understandable language why a claim has been denied, how the reimbursable amount, if any, was determined, and how the participant or beneficiary can appeal a denial they disagree with.[51]

Other specific issues raised include the failure to explain to claimants what information they need to submit to perfect their claim (as the ERISA claim regulations require) and that claimants are also not being given adequate access to guidelines utilized to make clinical claim determinations, such as medical necessity standards. Claimants also face frustration due to inadequate explanations given by and difficulty communicating with insurers and TPAs (as illustrated by a recent episode of "South Park").[52] Claimants are also often unaware of resources available to them should they need assistance, such as consumer assistance organizations, governmental resources such as state insurance departments or EBSA, or assistance available from insurers or claims administrators themselves. Such resources are particularly useful in offering assistance when claimants face denials based on clinical determinations regarding medical necessity, pre-approval of treatment or medication, or access to non-network providers; and the testimony presented validated the value of such assistance.[53]

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[49] U.S. Department of Health and Human Services, "Letter to CEOs on Biden-Harris Administration Time is Money Initiative" (August 12, 2024)
[50] KFF, "Consumer Survey Highlights Problems with Denied Health Insurance Claims" (September 29, 2023)
[51] See, e.g., Testimony of Brian King, Meiram Bendat, Mary Covington, Betty Long, Jaqueline Tulcin, and Julia Underwood, as well as Brandon Long; also see, "Clark, "I Set Out to Create a Simple Map for How to Appeal Your Insurance Denial. Instead, I found a Mind-Boggling Labyrinth," ProPublica (August 31, 2023)
[52] Wendell Potter, "South Park Tackles Prior Authorization. It would be Funny if It Wasn't so Damn Deadly," HEALTH CARE un-covered (June 23, 2024)
[53] See, Testimony of Mary Covington, Betty Long, Jaqueline Tulcin, Julia Underwood, and Steve Butterfield.

Patient advocates testified that in their experience, there are inadequate incentives for insurers and TPAs to provide adequate information to participants since the limited remedies available under ERISA do not include penalties or other consequences for failure to provide adequate information.[54] The Council also heard testimony and received other evidence showing that clinicians involved in reviewing claims may work under incentive structures that pay bonuses for denials, the volume of claims processed, and speed in processing claims. The Council notes that this information cannot be verified and is denied by the insurance industry which maintains that reported problems are not widespread and that most claims are decided appropriately.[55] Moreover, the insurance industry expressed its belief that the system is working well, and that insurers are incentivized to act fairly by the risk of reputational harm that could result in a loss of business if they were not appropriately administering claims and appeals.[56] The Council also heard testimony that the issues of concern expressed by patient advocates may not be as prevalent in Taft-Hartley plans or other plans where patients have access to health advocates.[57]

The complexity and fragmentation of the legislative and regulatory framework governing the health care system presents a major obstacle to improved outcomes.

The regulation of the health care industry and of the insurance industry is primarily entrusted to the states, but federal law applies to employee benefit plans and Medicare with divided regulatory responsibility among several agencies, including the Department, the Internal Revenue Service, and HHS with respect to coverage governed by the ACA. Additional complexity may arise from ERISA's broad preemption of state laws relating to employee benefit plans, particularly where self-funded plans rather than fully insured plans are involved. The prevalence of large employers, plan administrators and insurers which operate in multiple states creates additional concerns. The implications of this legislative and regulatory framework are well beyond the scope of the Council's examination but should not be ignored by the Department or by Congress as they seek to improve the experience and outcomes of participants, health care providers and employers.

The Council also heard testimony from multiple witnesses expressing concern about other aspects of the health care system and the health benefit system which appeared to be (partly or entirely) beyond

[54] *Id.,* along with Testimony of Brian King and Meiram Bendat
[55] See, Testimony of Wendell Potter; Rucker, et al., "How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them," ProPublica (March 25, 2023)
[56] Testimony of Adam Beck – America's Health Insurance Plans
[57] Testimony of Ivelisse Berio LeBeau and Karin Peters; Statement of National Coordinating Committee for Multiemployer Plans (October 16, 2024)

the scope of the Department's authority. For example, several witnesses expressed frustration about physician network adequacy (especially mental health providers)[58] and about the consolidation in the pharmacy benefit manager industry.[59] Those issues have resulted in serious harm to participants' health when care is delayed or denied, and in economic harm to participants, health care providers and employers.

Similarly, the Council heard testimony expressing concern about the cost of health care and health care benefit coverage.[60] Health care expenses now represent approximately 17.3% of U.S. GDP and cost approximately $13,000 per person per year. These numbers far exceed the amounts incurred in other countries, including Canada, Germany and the United Kingdom.[61] And, according to a recent study by the Commonwealth Fund, both scholars and numerous U.S. citizens question whether the very high costs in the U.S. result in better health care and in better health.[62] They also question whether our system for providing health care insurance coverage to those who can afford it as well as those who cannot is cost-effective and efficient. While these issues raise broader policy questions about our health care system, they are largely beyond the scope of the Department's authority to address without Congressional action.

The available data is limited, can be difficult to interpret, and is sometimes disputed.

The main source of aggregate data which was brought to the Council's attention was the KFF Survey of Consumer Experiences with Health Insurance,[63] although additional data was also compiled by the Commonwealth Fund.[64] While over 80% of respondents to the KFF Survey expressed satisfaction with their health insurance, approximately 60% said that they had experienced problems using their coverage. Those problems fell into numerous categories and approximately half of these participants reported that their problems were resolved to their satisfaction. KFF found that 18% of adults had experienced a denied claim in the last year studied, but their study did not include data as to what percentage of the denials were erroneous.

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[58] Testimony of Meiram Bendat, Brian King, and Mary Covington; Blau, "Struggling to Find an In-Network Mental Health Provider? Here's What You Can Do," ProPublica (September 8, 2024); Blau, "'I Don't Want to Die': Needing Mental Health Care, He Got Trapped in His Insurer's Ghost Network," ProPublica (September 8, 2024)
[59] Testimony of Wendell Potter
[60] Commonwealth Fund, "Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System "(September 19, 2024)
[61] *Id.*
[62] *Id.*
[63] Testimony of Kaye Pestaina; also see, fn. 2, *infra.* available at https://www.kff.org/affordable-care-act/poll-finding/kff-survey
[64] Commonwealth Fund, "Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S." (August 1, 2024)

A witness from AHIP estimated that only approximately 4% of claims were denied,[65] but AHIP's percentage was derived from a member survey rather than a consumer survey or a compilation of data. The Council understands that there are more than a billion claims for health care reimbursement submitted each year. The KFF Survey indicated that while 84% of the people with denied claims took some action to resolve them, only approximately 15% filed a formal appeal. However, it is unclear what percentage of the remaining 85% had meritorious claims which were not adjusted through other means. An additional reason why the data is difficult to interpret is that a "denial" covers many circumstances, including some circumstances in which the participant is not required to make a payment and some where the denial simply reflects an accurate application of deductibles or co-payments.

The Council received both witness testimony and membership survey data from the AMA indicating that over half of appeals were decided in favor of the claimants.[66] Testimony of several organizations that provide assistance to claimants was consistent with this.[67]

Among other things, the KFF Survey found that affordability of coverage is a concern for about half of respondents.

Several witnesses, including KFF,[68] recommended that the Department or HHS attempt to collect and disseminate greater amounts of data concerning the health benefit system, including the claims and appeals process. Some witnesses believe that additional reporting on Form 5500 filings by benefit plans could be useful in providing greater insights as to gaps in coverage and areas in which administrators may not be meeting their obligations.[69]

The well-documented and credible testimony on behalf of the AMA identified several costly and harmful impacts which often occur in the health plan claims and appeals process especially with regard to prior authorizations.

The witnesses from the AMA testified that their organization has worked for many years to mitigate the negative impacts of the prior authorization process on patient care, physician resources, and

[65] Testimony of Adam Beck
[66] Testimony of Emily Carroll and Heather McComas; 2023 AMA prior authorization physician survey
[67] Testimony of Mary Covington, Betty Long, Jaqueline Tulcin, Julia Underwood, and Steve Butterfield
[68] Testimony of Kaye Pestaina
[69] Testimony of Kaye Pestaina

health care economics.[70] Over 90% of physicians report that the prior authorization process delays access to necessary care and the AMA has shown that the administrative burdens of those requirements are wasting significant resources (consuming, on average, 12 hours per week of physician and staff time).[71] The AMA reported that: many of the procedures and treatments requiring prior approval are routine; the medical criteria being used by insurers are often inconsistent with recognized treatment protocols; the personnel making medical judgments for the insurers often lack appropriate qualifications to render clinical judgments in the area of medicine at issue; the clinical criteria being used are often lacking in transparency; and physicians and their staff are sometimes required to engage in lengthy phone calls or paper document exchanges when electronic communications would be much more efficient and less time consuming.

The AMA reported that many physicians are demoralized and discouraged by their experiences in dealing with insurance companies (which are increasingly denying claims according to 73% of the physicians surveyed) and, as a result, some will forego submitting claim appeals regardless of merit.[72] The AMA also questions whether prior authorization requirements actually save money. They also note that some progress has been made with regard to Medicare Advantage plans through the recent CMS Prior Authorization and Interoperability final rule, but that progress made with those plans does not apply to ERISA plans.[73] The testimony of numerous patient advocates[74] was consistent with the observations and conclusions expressed by the AMA and suggests that further study is needed to address whether pre-authorization requirements need to be curtailed or streamlined.

The American Psychological Association ("APA") has also expressed concern to UnitedHealth Group's Optum Health about "pre-payment reviews" that require behavioral health providers to submit extensive data such as medical records or treatment notes before clinicians are paid for their services, which delays payment or leads to payment denials.[75] The APA reports that 44% of psychologists surveyed responded

[70] Testimony of Emily Carroll and Heather McComas; 2023 AMA prior authorization physician survey; Shin, et al., "Insurance Denials and Patient Treatment in a Large Academic Radiation Oncology Center," JAMA Network Open, 2024:7(6) (June 12, 2024)
[71] *Id.*
[72] *Id.;* Also see, Waldman, "Why I Left the Network," ProPublica (August 25, 2024)
[73] But see, "Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care," Majority Staff Report, U.S. Senate Permanent Subcommittee on Investigations (October 17, 2024)
[74] Testimony of Mary Covington, Betty Long, Jaqueline Tulcin, Julia Underwood, and Steve Butterfield
[75] Wendell Potter, "UnitedHealth's Optum Sticking Behavioral Health Docs With Payment Delays, Threatening Patient Care and Clinician Solvency," Health Care uncovered November 1, 2024

that such delays threaten their financial solvency and are "driving some clinicians from accepting insurance altogether."[76]

Claims Processing Often Can Be Inefficient

The Council heard testimony that the processing times set forth in the existing claim regulations for urgent and pre-service claims take too long to address patients' immediate needs,[77] and that insurers and TPAs sometimes refuse to accept certain claims as "urgent" even though the existing regulations require that they give deference to the provider's assessment that a claim is urgent.[78]

Some witnesses testified that consumers face excessively long hold times when they attempt to contact their insurer or their plan's customer service department, and that the customer assistance being provided is not always helpful.[79] The Council also received testimony that it often takes longer to get documents from plans than the time it takes to research and write an appeal.[80] In the internet age, claimants and their representatives need to be able to communicate efficiently with their plans by electronic means.[81]

A recent ProPublica report described a situation where an insured who was in immediate need of mental health treatment asked a customer service representative to email him a list of in-network mental health providers in his area, only to be told the list could only be mailed, which would take 7-10 days.[82] Several witnesses recommended that claimants also need to be able to access documents relevant to their claims more easily, and be able to securely upload appeals and other documentation to a web portal.[83]

In an effort to improve efficiency, some providers are accorded "goldcard" status by health plans and their insurers if they have demonstrated a track record of providing medically necessary services;[84] however, those policies are not working effectively in many cases and the goldcard process is still in its

[76] *Id.*
[77] Testimony of Steve Butterfield
[78] Testimony of Meiram Bendat
[79] Testimony of Mary Covington
[80] Testimony of Mary Covington, Betty Long, Jaqueline Tulcin, and Julia Underwood
[81] Testimony of Adam Beck, Mary Covington, Betty Long, Jaqueline Tulcin, and Julia Underwood; Statement from ERIC
[82] Blau, "'I Don't Want to Die': Needing Mental Health Care, He Got Trapped in His Insurer's Ghost Network," ProPublica (September 8, 2024)
[83] Testimony of Mary Covington, Betty Long, Jaqueline Tulcin, and Julia Underwood
[84] Testimony of Emily Carroll, Heather McComas, Adam Beck and Wendell Potter

infancy nationally. According to testimony heard by the Council, the State of Texas passed a law providing such status, but only 3% of physicians who applied for it were found to qualify.[85]

Providers Need to Be More Involved in Claim Appeals that Require Clinical Judgment

Many of the witnesses who testified pointed out that claimants rarely have the clinical knowledge and understanding to adequately protect their rights in challenging claim denials, and that providers need to be enabled to play a more active role in claim appeals.[86] While the additional burden placed on physicians is of concern and has been recognized as leading to physician burnout and frustration,[87] much of that burden can be reduced if physicians had more efficient means of communicating with plans to facilitate more peer-to-peer discussions.[88] The current regulations, at 29 C.F.R. § 2560.503-1(h)(3)(iii), require that plan fiduciaries consult with qualified health care professionals in the relevant field of medicate with respect to appeals, but that requirement does not apply to initial claim determinations.

Existing Provider Networks are Often Inadequate

When insurers utilize networks of providers for patients to receive care at lower cost, those networks are often inadequate and lack sufficient providers in relevant specialties, particularly mental health care, or providers who are geographically accessible to plan participants and their beneficiaries.[89] The Council noted that even the witness from AHIP expressed frustration at the difficulty of finding local mental health practitioners willing to serve on network panels.[90] Other witnesses, as well as information provided by EBSA regarding consumer complaints received by the agency, called attention to single case agreements being used to provide out-of-network care in lieu of expanding networks or coverage.[91]

[85] Testimony of Wendell Potter
[86] Testimony of Meiram Bendat, Mary Covington, Betty Long, Jaqueline Tulcin, and Julia Underwood
[87] Testimony of Emily Carroll and Heather McComas; AMA prior authorization physician survey; ; Waldman, "Why I Left the Network," ProPublica (August 25, 2024)
[88] *Id.*
[89] Testimony of Meiram Bendat, Brian King, and Mary Covington; Blau, "Struggling to Find an In-Network Mental Health Provider? Here's What You Can Do," ProPublica (September 8, 2024); Blau, "'I Don't Want to Die': Needing Mental Health Care, He Got Trapped in His Insurer's Ghost Network," ProPublica (September 8, 2024);
[90] Testimony of Adam Beck
[91] Testimony of Steve Butterfield

Claim Determinations Sometimes Are Not Being Made Using Appropriate Expert Criteria Accessible to Participants and Providers

Despite the existence of evidence-based clinical guidelines specifying generally accepted standards of care and treatment, the Council heard testimony and reviewed other information regarding plans' and insurers' usage of proprietary utilization guidelines to decide claims which may conflict with criteria developed by expert medical bodies.[92] As a result, coverage determinations are being made under standards that are inconsistent with generally accepted standards of care and treatment. Drug formulary exclusions have also proliferated, and sometimes fail to include drugs that have been widely accepted by physicians and medical societies as the most effective drugs available to treat a patient's disorders.[93]

The lack of transparency which has been reported appears to be in violation of existing regulations which mandate that "if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request." 29 C.F.R. § 2560-503-1(g)(1)(v)(A).[94] Moreover, to the extent that health care providers and participants are unable to easily access and view the applicable criteria, the situation appears unacceptable as a matter of both ERISA law and appropriate patient care.

The Use of AI in claim processing raises questions about the accuracy of claim determinations.

While AI has the potential to make claim processing more efficient, the Council received testimony[95] and reviewed other materials that question whether AI has been misused with resulting unwarranted claim denials.[96] AI can clearly be beneficial in expediting claim approvals, but when used for claim denials, the absence of adequate human oversight can be problematic. Standards need to be developed regarding the use of AI in claim processing.[97]

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[92] Testimony of Brian King, Meiram Bendat, Mary Covington, Betty Long, Jaqueline Tulcin, Julia Underwood; Heather McComas, and Emily Carroll; Miller, "'Not Medically Necessary'" Inside the Company Helping America's Biggest Health Insurers Deny Coverage for Care," ProPublica (October 23, 2024)
[93] Testimony of Wendell Potter
[94] Testimony of Brandon Long
[95] Testimony of Adam Beck and Wendell Potter
[96] Statement of Charlotte Tschider; Rucker, et al., "How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them," ProPublica (March 25, 2023)
[97] Statement of Charlotte Tscheider

VII. RECOMMENDATIONS

1. Electronic exchange of documents:

The Department's regulations and sub-regulatory guidance should be updated to reflect the widespread availability and use of the internet as a communications device. Plan and claim administrators should have a duty to provide and receive documents through electronic means. Participants and their health care providers should be able to receive and review SPDs, SBCs, other relevant documents (including medical necessity criteria whether applied by the claims administrator or an entity with which the claims administrator contracts) and claim files electronically. Plan administrators should be allowed to use electronic communications as the default method of complying with disclosure obligations (as is now authorized for retirement plans), subject to a participant's right to request paper documents. Participants and health providers also should be able to submit documents in support of claims by secure electronic means while retaining their right to make requests and submit documents by mail or fax.

Rationale: Numerous claimant representatives[98] who appeared before the Council expressed frustration with the difficulty they have communicating with some plan administrators through electronic means, thereby increasing the time and expense required to perfect claims and appeals. Witnesses for employers and administrators generally did not dispute that electronic communications were efficient and in common use. ERIC, along with a consortium of other stakeholders, including the Blue Cross Blue Shield Association and AHIP specifically advocated that the Department expand the use of electronic communications for health plans.[99]

One Council member did not support this recommendation because they opposed allowing plan administrators to use electronic communications as the default method for complying with health plan disclosure obligations. That member raised concerns about the potential negative impact of such a default on participants given uneven participant access to electronic disclosures, the greater likelihood that participants will overlook electronic disclosures compared to paper disclosures and the rights-determining effects of many health plan disclosures.

2. Model language:

[98] Testimony of Mary Covington, Betty Long, Jaqueline Tulcin, and Julia Underwood
[99] Letter from consortium of stakeholders advocating e-delivery of plan notices and all ERISA-required disclosures

The Department should develop model language and model forms, including a model EOB, for use in the claims and appeals process. This should include, but not necessarily be limited to model language explaining a participant's appeal rights and how to obtain the SPD and other relevant documents.

Rationale: Several witnesses who testified on behalf of claimants, plan administrators, and employers[100], as well as a 2010 Council report, recommended that model language explaining a participant's appeal rights and model language for EOB forms be developed (although no one made any specific proposals for such model language).

3. Data collection:

The Department should examine whether and how it might be possible to collect more robust, useful data on claims processing by plan administrators (on an aggregate basis and on an individual plan administrator basis) to better understand the specific areas in which participants' rights may require additional protection. The Department should consider whether Form 5500 can be modified to collect some or all of this data. The Department should also work with stakeholders to determine what data would be useful and how to collect it.

Rationale: Several witnesses,[101] including a witness from the KFF,[102] recommended that the Department or HHS attempt to collect and disseminate greater amounts of data concerning the health benefit system, including the claims and appeals process. A survey issued by the Commonwealth Fund made the same recommendation.[103] The purposes behind more robust data collection are to improve both transparency and accountability and to better evaluate what, if any, further action should be taken by the Department.

[100] Testimony of Brandon Long, Brian King, and Mary Covington
[101] Testimony of Wendell Potter and Steve Butterfield
[102] Testimony of Kaye Pestaina
[103] Commonwealth Fund, "Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S." (Issue Briefs August 1, 2024); available at https://www.commonwealthfund.org/publications/issue-briefs/2024/aug/unforeseen-health-care-bills-coverage-denials-by-insurers

4. Enforcement:

The Department should consider whether it can allocate additional enforcement resources to investigate and, if appropriate, to prosecute high visibility cases of alleged abuses and systemic failure to follow existing procedural requirements.

Rationale: Patient advocates testified that in many instances EOBs do not communicate the requisite level of information currently required by existing regulations.[104] In addition, the Council took note of media reports alleging abuses in claim processing, such as one that alleged that Cigna was engaging in mass claim denials without human review,[105] which appeared to be suitable for the Department's investigation.

5. Reviews of Urgent Care Claims:

The Department should revise existing regulations relating to urgent care claims and appeals to reduce the 72-hour timeframe wherever possible. The Department should consider whether and what type of remedy may be appropriate for failure to adhere to the timelines.

Rationale: Patient advocates and the AMA testified that in some instances, the 72-hour timeframe contained in the existing regulations is too long for providers to wait when treatment decisions for urgent care need to be made more quickly.[106] Patient advocates also testified that they do not receive benefit decisions timely in urgent care situations.[107]

6. Claimants Need to Be Better Informed About Available Resources:

The Department should consider developing an educational campaign to better inform participants about consumer assistance organizations and governmental agencies they can turn to for assistance.

Rationale: Patient advocates noted that individuals who are able to access advocacy resources are often successful in obtaining coverage for the care they need.[108] Under the ACA, each state is required to

[104] Testimony of Mary Covington, Betty Long, Jaqueline Tulcin, and Julia Underwood
[105] Rucker, et al., "How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them," ProPublica (March 25, 2023)
[106] Testimony of Meiram Bendat, Seve Butterfield, Betty Long, Jaqueline Tulcin, Julia Underwood, Emily Carroll, and Heather McComas
[107] *Id.*
[108] Testimony of Seve Butterfield, Betty Long, Jaqueline Tulcin, and Julia Underwood

have an ombudsman,[109] and some states have additional resources available. In addition, some plans contract with patient advocates to assist participants in obtaining care.[110] Given the success of these programs, informing participants of the availability of assistance would be beneficial.

7. Claim Determinations Should Be Consistent with Generally Accepted Standards of Medical Care and Treatment:

All insurers, TPAs, or other persons deciding or reviewing claims (including but not limited to third parties with whom insurers, plans, and TPAs contract) should be required to use clinical criteria and make determinations consistent with current existing standards of care and/or treatment guidelines adopted by professional medical societies and to assure that claim determinations are made on a nondiscriminatory basis. Any internal clinical criteria which are used must be cited in any claim or appeal denial and readily accessible to participants and health care providers on the plan's website.

Rationale: The Council heard testimony and received other information regarding plans' usage of proprietary guidelines to determine claims that may conflict with criteria developed by expert medical bodies.[111] As a result, determinations are sometimes being made under standards that are inconsistent with generally accepted standards of care and treatment.

8. The Use of AI to Make Benefit Determinations:

When using AI, plans should keep in mind the requirement under 29 C.F.R. § 2560.503-1(h)(2) that they undertake a full and fair review of each claim and adverse benefit determination. Therefore, the Department should require disclosure of whether AI was used to make a benefit determination. Additionally, the Department should consider, in consultation with stakeholders, what, if any, additional disclosures regarding AI should be made.

Rationale: The Council received oral testimony,[112] written testimony[113] and reviewed media reports[114] asserting and claims are being denied by AI in batches without adequate human supervision as

[109] Testimony of Jeff Turner and Elizabeth Schumacher
[110] Testimony of Betty Long
[111] Testimony of Brian King, Meiram Bendat, Mary Covington, Betty Long, Jacqueline Tulcin, and Julia Underwood
[112] Testimony of Steve Butterfield and Wendell Potter
[113] Statement of Charlotte Tschider
[114] See fn. 8, infra.

a cost savings measure, that the criteria used in determining claims by AI are unclear, and that there is manipulation of algorithms to achieve certain claim denial thresholds.

9. Plans must use individuals with appropriate clinical training and experience to conduct peer review of claims:

The ERISA regulations mandate that when making medical judgments on claim appeals, the plan shall "consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment." 29 C.F.R. § 2560.503-1(h)(3)(iii). The existing claim regulations should be revised to assure that appropriate medical expertise also be required for initial claim determinations that involve medical judgment. In conjunction with this revision, the Department should consider whether, and if so under what circumstances, a different health care professional would be required in consideration of a claim appeal.

Rationale: The Council heard testimony that claims are often reviewed by a clinician who is not an expert in the medical specialty pertinent to an individual's claim.[115] Examples included an orthopedic surgeon who specializes in foot surgery used to evaluate coverage of spinal surgery, or a pediatric doctor used to evaluate coverage of a gynecological issue. The Council also heard testimony that claims are also reviewed by individuals who are not medical professionals.[116] Witnesses testified that evaluations by individuals inexperienced or unfamiliar with a particular medical specialty often result in incorrect claim denials, particularly in complicated medical cases, because the evaluator does not have up to date knowledge or experience in that area of medicine.[117]

10. Fiduciary Status of Claim Administrators:

The Secretary should issue either a new regulation or sub-regulatory guidance making it clear that insurers and TPAs making claim determinations involving discretionary clinical judgments are acting as fiduciaries. The Secretary should continue filing amicus briefs in appropriate cases asserting that insurers and TPAs are fiduciaries under the facts of the case.

[115] Testimony of Wendell Potter, Mary Covington, Betty Long, Jacqueline Tulcin, Julia Underwood
[116] *Id.*
[117] *Id.;* also see Testimony of Brian King and Meiram Bendat

Rationale: The Council heard testimony that insurers and TPAs who make claim determinations need to be held accountable for their decisions as claims fiduciaries.[118] Witness testimony indicated that insurers and TPAs have claimed that they are not acting as fiduciaries, because they are only performing ministerial acts, in order to immunize themselves from litigation regarding claims decisions.

11. Preservation of files:

The Council recommends that a document preservation requirement be put in place to maintain the integrity of claim records and that plans be required to preserve all files and documents relevant to a claim until the claim has been paid. The Council further recommends that where claims have been denied or for which less than the full amount has been paid, records be preserved for a minimum period of time after denial of a request for review.[119] The Department should solicit input from relevant stakeholders on the appropriate time period.

Rationale: Witness testimony from claimant representatives and consumer organizations expressed concern that documents submitted by claimants and providers are often lost,[120] precluding a full and fair claim review taking into consideration the relevant evidence presented.

12. Estoppel With Regard to Prior Approvals:

The Department should require in the case of a service for which a plan requires prior approval, that where a documented authorization has been given, a plan may not subsequently fail to pay for that service in accordance with plan terms or recoup payment absent fraud or other deliberate misrepresentation.

Rationale: Witnesses from the AMA,[121] as well as from claimant representatives and consumer organizations,[122] addressed the burden of pre-authorization requests and complained that even when pre-authorization has been given, plans may later renege on the initial authorization and deny reimbursement for the services provided. Once a provider provides a pre-authorized service, a subsequent denial places the financial burden on either the patient or provider for the cost of such services if they are not reimbursed.

[118] Testimony of Karen Handorf
[119] Testimony of Mary Covington
[120] Testimony of Wendell Potter, Mary Covington, Betty Long, Jacqueline Tulcin, and Julia Underwood
[121] Testimony of Mary Covington; Testimony of Emily Carroll and Heather McComas
[122] Testimony of Mary Covington, Steve Butterfield, Betty Long, Jacqueline Tulcin, and Julia Underwood

The Council endorses a rule of estoppel that requires plans to reimburse providers and patients for the services they have pre-approved. The amounts of such payments should remain subject to plan provisions, including deductibles and co-insurance. With respect to out-of-network services, the AEOB required by the No Surprises Act may alleviate some of these issues as well.

One Council member dissented from this recommendation asserting that the requirement "that where a documented authorization has been given" lacks specificity. The member recommended that estoppel is appropriate only where there is written documentation of mutual assent to the same terms, conditions, and subject matter.