Employment Retirement Income Security Act Toolkit

TMA Employment Retirement Income Security Act (ERISA) Resources Descriptions

For many providers, the prospect of dealing with health plans subject to the federal Employee Retirement Income Security Act, or ERISA, is a bleak one. ERISA requirements apply to most employer-sponsored and self-funded group health plans, which means that any patients who receive their health insurance through some type of employer contribution fall under ERISA.

The regulations are complex, and many health plan administrators actively try to work around the requirements. However, providers can actually use ERISA requirements to their advantage when trying to get claims paid. To that end, the TMA Legal Department has developed a series of resources, including forms and sample letters, for physicians to use when seeking to get ERISA claims paid. The law establishes strict timelines for responding to a claim, as well as what information plan administrators are required to provide in that response. Physicians dealing with ERISA plans should demonstrate that they are not only aware of the legal requirements but that they are also willing to enforce their rights under the law.

Each section below has a brief description of the individual resource and how to use it. The resources are merely samples that practices may replicate and personalize to utilize in their appeals processes. We ask that you ***do not*** simply print the documents out and use them as is with the TMA logo printed on them.

Direct any questions related to the Employment Retirement Income Security Act to legal@tnmed.org.

1. Assignment of Benefits Form

All new patients should sign and date his form. Your practice may already require an assignment of benefits form along with your HIPAA privacy notice and other new patient documents. The assignment of benefits form allows the provider to seek information, pursue appeals for denied claims, and even file litigation on behalf of the patient for payment for services provided as the patient's authorized representative. If your patient does not fill out an assignment of benefits form, you may not be able to effectively use any of the other ERISA resources TMA has developed to resolve any claims issues with ERISA plan administrators.

2. ERISA Appeals Letter: Notice of Denied Claim

Most ERISA health insurance policies require the patient or his/her authorized representative to go through one or two levels of appeals for denied claims before seeking legal action. This is known as exhausting all administrative remedies, and it is required before you may seek legal action. Therefore, it would be best practice to appeal a denied claim at least twice just to cover yourself in the case of future litigation.

This is a sample letter you can use to send as a level one appeal when you have had a claim denied. It outlines the plan administrator's legal requirements for sending a notice of denied claims, including information that the plan is required to include in the notice and the timeline for sending it. It also gives you check boxes for identifying exactly how the plan's notice of denied claim was insufficient under federal law. As you will see in the letter, you are required to attach the patient's Assignment of Benefits form, the original denied claim, and any supporting documentation, such as medical records.

Sending this letter and all required documentation should satisfy any plan administrator's level one appeal requirements. See the "ERISA Appeals Letter: Ignored Claims or Appeals" for a sample letter to use in a second level appeal or if your claims have simply been ignored by the plan.

3. ERISA Appeals Letter: Ignored Claims or Appeals

This is a sample letter practices can use for either a second level appeal or if a claim sent to a group health plan has been completely ignored, i.e. neither paid nor denied. We would recommend tweaking some of the language in the letter depending on your specific circumstance. The letter outlines the plan administrator's federal requirements for responding to the appeal, as well as a reminder that federal law requires the plan to give sufficient reasoning for a denial. It also warns that your practice may have grounds for legal action if the plan does not provide a sufficient response to this second level appeal.

4. ERISA Demand Letter: Response to Recoupment Demand

This is a sample letter for practices to use if, instead of a denial, the plan administrator is demanding a recoupment of payment already made via an audit or some other mechanism. It includes similar information to that in the "ERISA Appeals Letter: Notice of Denied Claim," but it clarifies that the plan administrator may not try to recoup the funds until a full and fair review of the appeal has occurred. It also demands that the plan administrator send certain documents and information to justify the recoupment.

For practices faced with a recoupment demand from a non-ERISA health plan, please review TMA's Law Guide topic titled Recoupment.

5. Filing a Complaint with the Department of Labor

You have probably noticed that all of the sample letters included in these ERISA resources include a paragraph stating that the plan administrator is prohibited from retaliating against your practice or your patient. If a plan discharges, fines, suspends, expels, disciplines, or discriminates in any way against your practice or your patient, you are entitled to file a complaint with the US Department of Labor (DoL). You may also file a complaint with the DoL if your appeals continue to be ignored by the plan administrator. You may also be entitled to injunctive relief if you seek legal action, meaning a court could stop the plan from suspending coverage. Click here to visit the DoL Employee Benefits Security Administration's website, to access the online form for filing complaints against ERISA plans.