ABA/JCEB
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ERISA BASICS NATIONAL INSTITUTE

BENEFITS CLAIMS PART 1: ADMINISTRATIVE PROCEDURES

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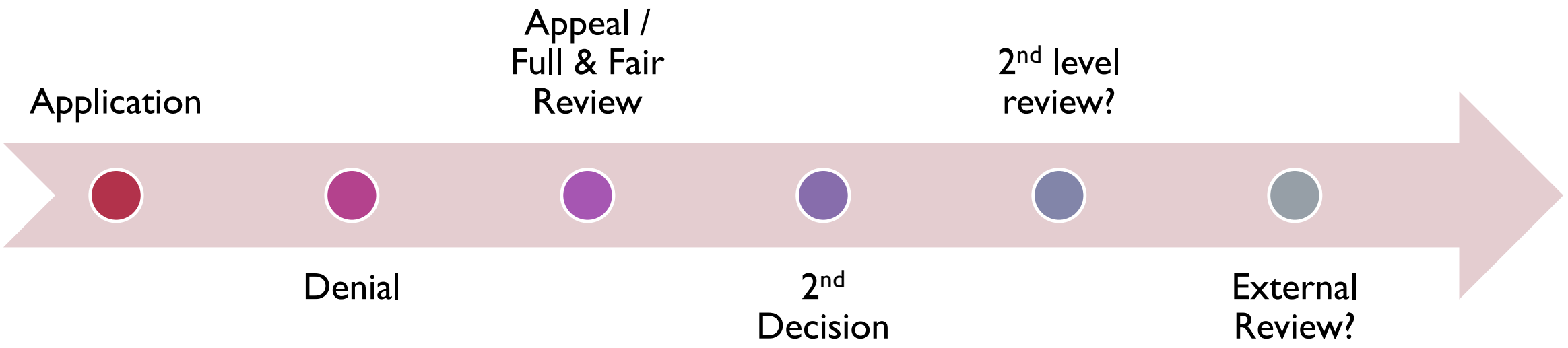
OVERVIEW: TIMELINE + 2018 REGULATIONS



BENEFIT CLAIMS

- Benefit Applications: Contents
  - Is a form enough?
  - Timeline – can it be late? Notice-prejudice rule: Claim filing deadlines are rarely enforceable in insured plans. *See Unum Life Ins. Co. v. Ward*, 526 U.S. 358 (1999)
- Review of an application
  - Who makes the decision?
  - Appropriate medical expertise?

REQUEST FOR PLAN DOCUMENTS

- Next step: get the claim file and plan documents.
  - Claim file, including all documents **relevant to** a claim for benefits per 29 CFR Sec. 2560.503-1(m)(8)
    - Even if not **relied upon**
  - Plan documents pursuant to 29 USC Sec. 1024(b)(4)
    - Document penalties! (29 USC Sec. 1132(c))

BENEFIT CLAIMS – DENIAL PROCESS

- Complete records?
- Consult correct plan document?
- Identify relevant plan provisions
- Review conflicts: walls in place?
- Identify relevant statute of limitations? *See Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604 (2013)
- Fiduciary exception to attorney-client privilege? *See Stephan v. Unum* 697 F.3d 917 (9th Cir. 2012)Contents of adverse benefit decision requirements and the new Regulations
- Following new regulations?

BENEFIT CLAIMS - REGS

Rule	New Regulations Require For Disability Claims filed on or after April 1, 2018	Change from Existing
Independence and Impartiality **29 C.F.R. § 2560.503-1(b)(7) and 29 C.F.R. § 2560.503-1(g)(1)(vii)**	Claims and appeals must be "adjudicated in a manner designed to ensure the independence and impartiality" Decisions to hire, pay, terminate or promote any individual (including medical examiners and vocational experts) cannot be based on the likelihood they will support denying benefits. Initial adverse determination must include a copy of any applicable internal rules, guidelines, protocols, standards or other similar criteria of the plan, or a statement that they do not exist.	New rule. Final adverse determination must notify of the right to receive any documents (including internal rules, protocols, standards) relied upon in the course of making a determination.

BENEFIT CLAIMS - REGS

Rule	New Disability Regulations Require	Change from Existing
Documents that must be provided <u>before</u> rendering a decision **29 C.F.R. § 2560.503-1(h)(4)**	Provide claimant (even when not requested) with a free copy of any "new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination (or at the direction of the plan, insurer or such other person)" in connection with a claim before a decision is made. Claimant must be given a chance to respond to the new, or additional evidence.	After making a final determination, Plan must provide documents relied upon in the course of making a determination, only upon request of claimant.

BENEFIT CLAIMS - REGS

Rule	New Disability Regulations Require	Change from Existing
New content to include in adverse benefit determination **29 C.F.R. § 2560.503-1(g)(1)(vii)(A)-(D)**	Claim denial letters must discuss, in detail, why the Plan disagrees with: • The view of any healthcare professional or vocation professional consulted during the claim determination (even if not relied upon in making the determination) • The view presented by the claimant to the Plan of any health care professional, who treated the claimant, or any vocation professional, who evaluated the claimant • A contrary disability determination made by the Social Security Administration Note: The Plan does not need to give deference to the SSA determination, but must explain why it disagrees with it Note: The Plan should ask the claimant for the opinion of the ALJ	**New rule**

BENEFIT CLAIMS - REGS

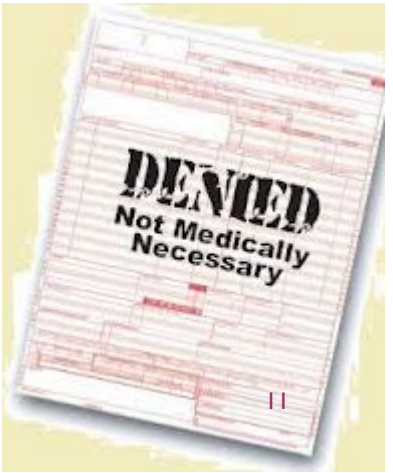
Rule	New Disability Regulations Require:	Change from Existing Regulations:
New content continued.	All adverse benefit determinations must be provided in a "culturally and linguistically" appropriate manner (i.e. translated into a non-English language spoken by the ten percent or more of the population in the county to which a notice is sent). 29 C.F.R. § 2560.503-1(j)(7)	**New rule.**
	An adverse benefit determination must now describe any applicable **contractual time limit** on bringing a civil action under ERISA and clearly set out the deadline date. 29 C.F.R. § 2560.503-1(j)(4)(ii)	Prior regulations only required the adverse benefit determination to inform a claimant of the right to bring a civil action under ERISA.

WHAT IS A FULL AND FAIR REVIEW?

- 29 C.F.R. 2560.503-1 et seq.
- Require establishment and maintenance of reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations
- Contain administrative processes and safeguards to ensure claim determinations are made in accordance with plan documents and plan provisions are applied consistently to similarly situated claimants

CONSIDERATIONS FOR HEALTH CLAIMS

- Is the service specifically referenced or do internal guidelines exists?
- Does the participant need to complete a pre-authorization process?
- When communicating with the plan, address whether the service is in-network, subject to a medical necessity determination, experimental and/or excluded under another benefit limitation
- Give full description of diagnosis, relevant treatment, pre-authorization, and physician information
- Compliance with Paul Wellstone and Pete Domenici Mental Health Parity and Equity Act of 2008 (MHPAEA) or comparable state law? *See* 29 U.S.C. § 1185a



CONSIDERATIONS FOR LIFE INSURANCE CLAIMS

- Is this a standard life insurance or accidental death and dismemberment claim?
- Potential relevant documentation:
  - Beneficiary designation forms
  - Autopsy report
  - Death certificate
  - Work timesheets & premium payment records (coverage)

CONSIDERATIONS FOR PENSION CLAIMS

- Be sure the client clearly states that she is submitting a claim for benefits under the pension plan
- Establish key facts, where applicable
  - Early retirement factors
  - Disability pension factors
  - Retirement date, DOB, types of service credit
  - Spousal rights, forms of benefit, benefit formula

ADVERSE BENEFIT DECISIONS: ALL CLAIMS

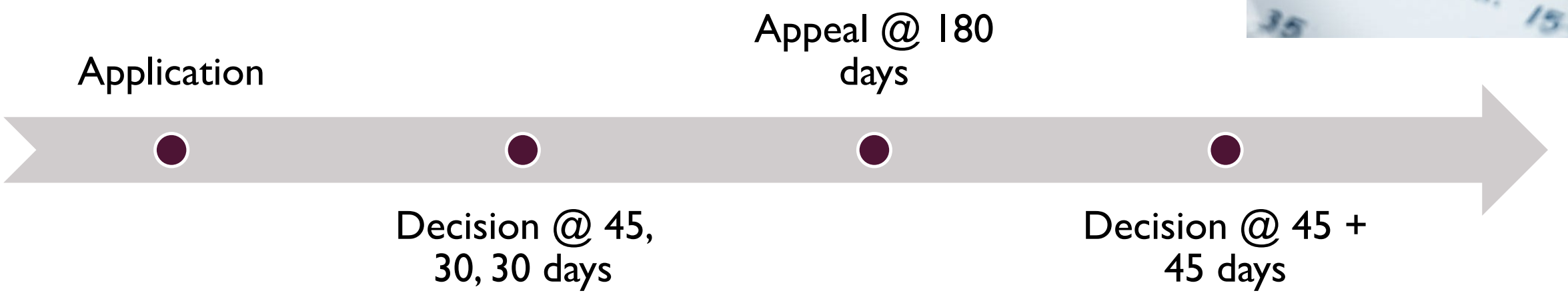
29 C.F.R. § 2560.503-1(g) – **Every employee benefit plan must:**

- Provide **adequate notice in writing** when claim is denied
- Set forth the specific reasons for such denial, referring to the relevant plan provisions
- Describe what information is necessary to perfect the claim and why
- Describe the plan's review procedures and the time limits applicable to such procedures
- Describe what **internal rules, guidelines, or protocols** the administrator relied on in making the adverse decision

ADVERSE BENEFIT DECISIONS: HEALTH

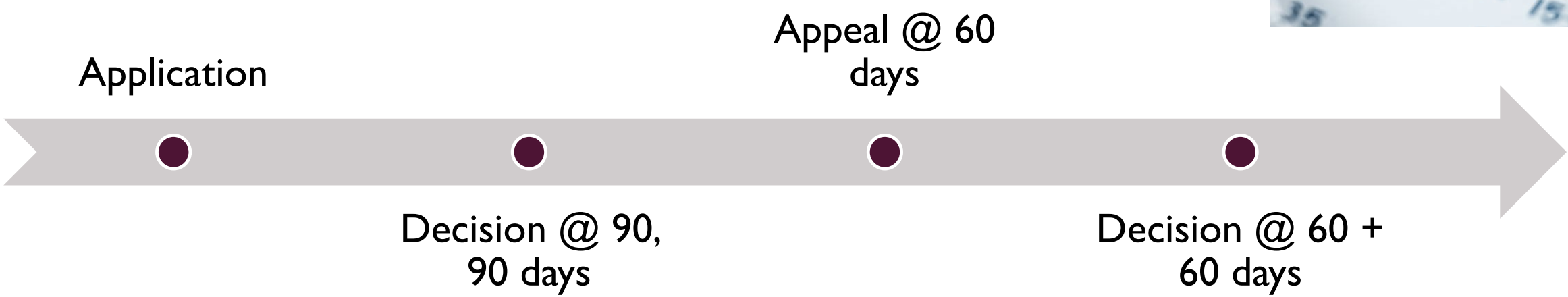
- In addition to existing ERISA requirements, plans must:
  - Provide sufficient information to identify claim including date of service, health care provider, claim amount, and right to receive, on request, the diagnosis and treatment codes and the meanings of those codes
  - Set forth the reasons for the denial of the claim (including the denial code and its meaning) or the rescission of coverage
  - Describe available external appeals, how to initiate them, and applicable filing deadlines
  - Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance to help individuals with internal or external appeals
- Notices must be culturally and linguistically appropriate

ADVERSE BENEFIT DECISIONS: TIMING, DISABILITY



- 45 days to review; two 30-day extensions if matters are beyond the control of the plan – 29 CFR § 2560.503-1(f)(3)
- No less than 180 days to appeal adverse determinations
- Appeals decided within 45 days, but extra 45 days permitted only if "special circumstances" exist and administrator informs claimant of those circumstances prior to taking the extension

ADVERSE BENEFIT DECISIONS: TIMING, PENSION



- Pension Claims
  - Initial review of claim: 90 days to review (90-day extension)-in general – 29 CFR § 2560.503-1(f)
  - Plan must give minimum of 60 days to appeal adverse determinations
  - Decision within 60 days unless "special circumstances" justify one 60-day extension

ADVERSE BENEFIT DECISIONS: TIMING, HEALTH

Urgent	Pre-Service	Post-Service
Decision: 72 hrs (+24 hr extension)	Decision: 15 days (+15 day extension)	Decision: 30 days (+15 days extension)
Appeal: "not less than" 48 hrs	Appeal: 180 days	Appeal: 180 days
Decision: 72 hrs	Decision: 30 days (even if multi-levels required)	Decision: 30 days (+15 day extension); all appeals w/in 60

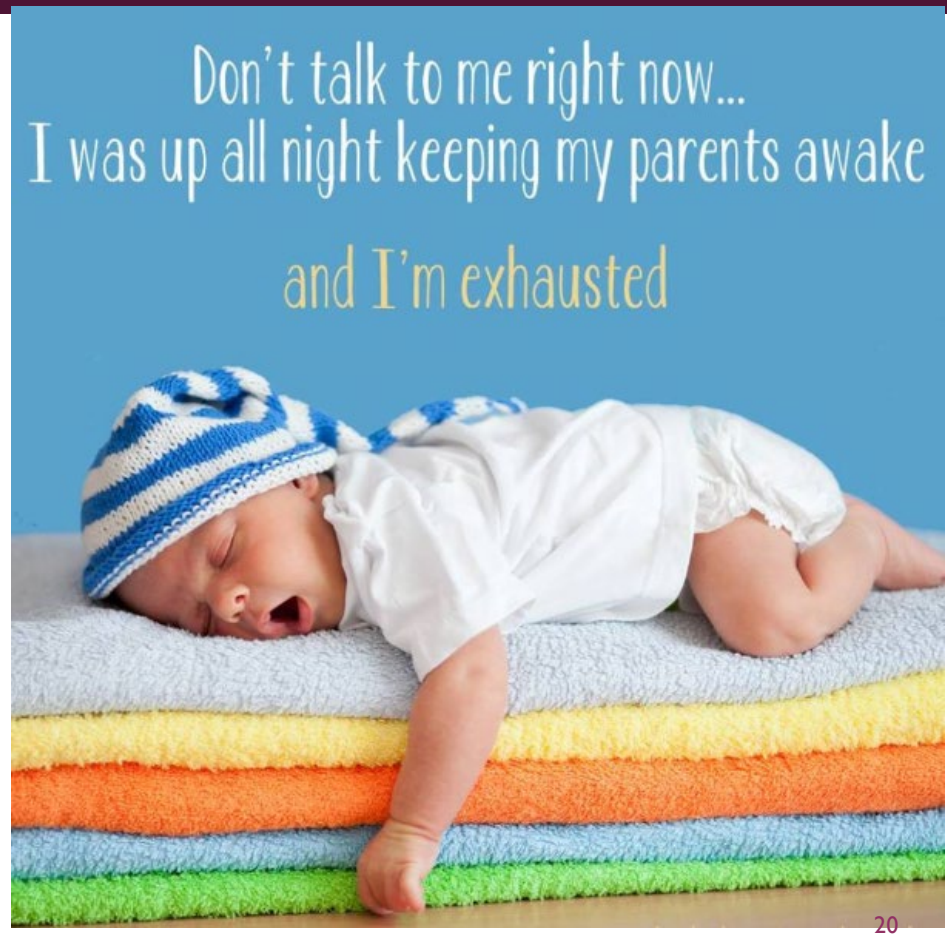
- Urgent: Decision within 72 hours (24-hour extension permitted); claimant has 48 hours to submit additional information. Appeals adjudicated within 72 hours
- Pre-Service: Decision within 15 days (15-day extension permitted). All appeals adjudicated within 30 days (even if multi-levels required)
- Post-Service: Decision within 30 days (15-day extension permitted). All appeals adjudicated within 60 days (even if multi-levels required). A post-service claim cannot be urgent

EXHAUSTION OF ADMINISTRATIVE REMEDIES

- Exhaust?
  - Claims for benefits (generally required) versus breach of fiduciary duty claims (generally not required except in 7th & 11th Cirs.)
  - Exceptions:
    - Futility; denial of meaningful access; irreparable harm
  - Practice Tip: It never hurts to exhaust
- ERISA § 503 requires a "full and fair review" of an adverse benefit decision
  - This is your *only* chance to build your record

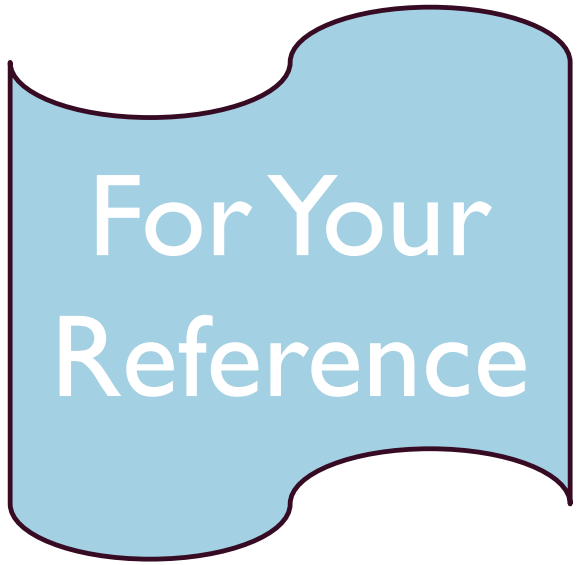
EXHAUSTION – HEALTH CLAIMS

- Requirement of Strict Adherence
  - If a plan fails to follow strictly the requirements of the regulations re: internal claims and appeals, the claimant is deemed to have exhausted
    - Claimant may go directly to external appeal and/or court
  - However, internal claims/appeals process is not deemed exhausted by *de minimis* violations that—
    - Are not likely to cause prejudice or harm to claimant; and
    - was for good cause or beyond plan's control while exchanging information. And not part of a pattern/practice of violations.
      - Claimant can ask for explanation of violation and response is due w/in 10 days



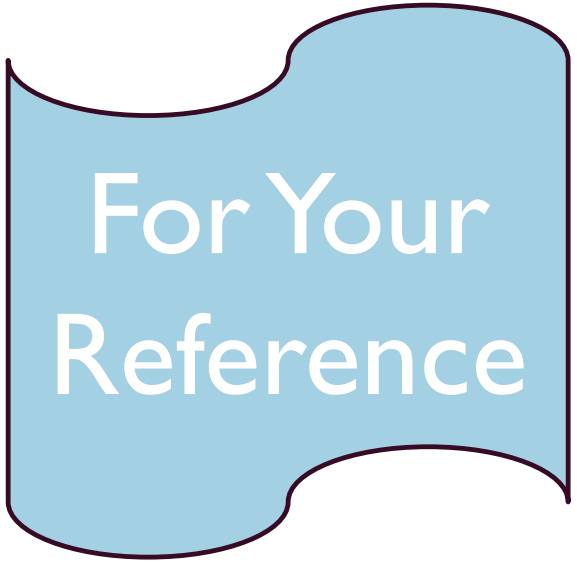
OVERVIEW: WHAT IS A FULL AND FAIR REVIEW?

- 29 C.F.R. §2560.503-1(h) – Every plan must:
  - Provide claimants the opportunity to submit written comments, documents, records, and other information, **and take it into account in the review.**
  - Provide that copies of all documents and other information relevant to the claim;
  - Ensure that notice of adverse benefit determination includes the denial code and its meaning / plan language;
  - Provide for a review that does not afford deference to the initial adverse benefit determination;
  - Provide for the identification of medical or vocational experts whose advice was obtained
  - If the plan does not follow these statutory requirements, the time limits to appeal are not enforced against the claimant. *Counts v. Am. Gen. Life & Accident Ins. Co.*, 111 F.3d 105 (11th Cir. 1997)

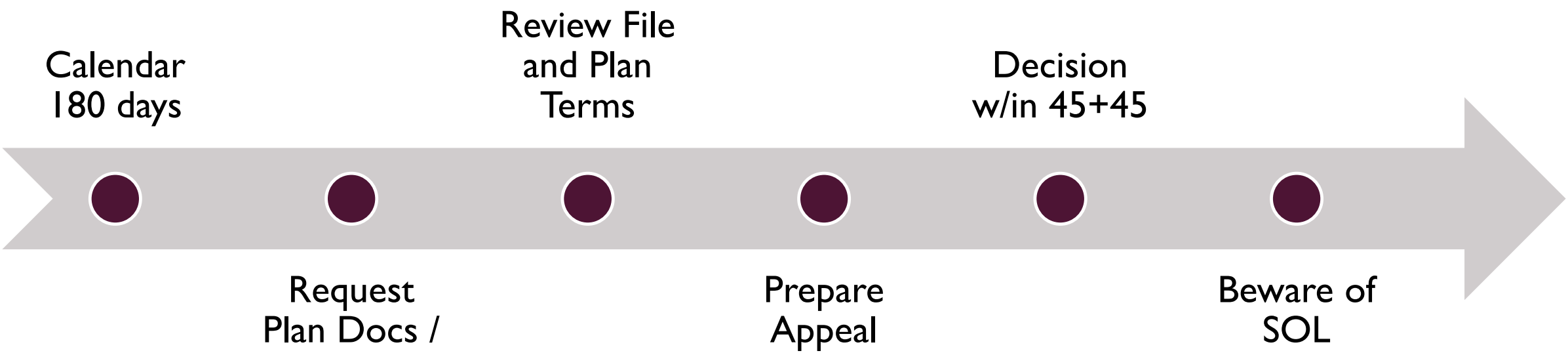


OVERVIEW: WHAT IS A FULL AND FAIR REVIEW?

- Also, health plans must
  - Permit review the claim file and presentation of evidence
  - Provide claimant, free of charge, with any new or additional evidence considered, relied upon, or generated; any new or additional rationale-must be provided ASAP and sufficiently in advance of the denial date
  - Administer claims to ensure independence and impartiality if decisionmakers
  - Provide ALL notices in a "culturally and linguistically" appropriate manner;
  - Continue to provide coverage pending outcome of appeal
  - Consult with medical professional in appropriate discipline and disclose identify if appeal is denied
  - Not require more than 2 levels of appeal
  - Comply with External Review Requirements



DISABILITY REQUEST FOR REVIEW: CLAIMANT'S STEPS



DISABILITY REQUEST FOR REVIEW: CLAIMANT'S STEPS, DETAILED

1. Calendar 180 days from receipt of the denial for when your request for review is due. Best practice: Send in the request for review within 180 days of date of the denial letter or else document when the claimant received the denial letter. Track the package so you know when the administrator received your request for review
2. 2. Send out a document request to the plan administrator and the insurance company. Ask for: The plan document, SPD, all documents "relevant" to the claim , claim file including surveillance, emails, activity logs, medical reports, and vocational reports, claims manuals, info on doctors, communications with plan counsel.
3. Review the Plan documents for: Definition of disability ("own occupation" vs. "any occupation" and whether % of pre-disability earnings is a factor). Grant of discretion. Offsets (may make it unfeasible to take a claim). Whether STD is a prerequisite to LTD. Self-reported symptoms or other limitations on payment of benefits
4. Prepare the Request for Review: Medical records (including "objective" evidence). "Opinion" evidence from doctors (in the form of letters or questionnaires). Social Security claim file. See Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 128 S. Ct. 2343 (2008). Declarations (claimant, friends, co-workers, etc.). Functional Capacity Evaluations and Independent Medical Examinations. Vocational Analysis. Medical literature.
5. Plan has 45 days to decide appeal, or can request one-time extension of 45 days, for a total of 90 days. Failure to timely respond is a "deemed denial" enabling participant to file suit. In some circuits, failure to timely respond may even result in de novo review. Heimeshoff, 134 S. Ct. 604 – No longer the case that statute of limitations is tolled during pendency of appeal (if reasonable)

MAKING THE DECISION TO UPHOLD OR OVERTURN A DENIAL

- What factors lead to a decision to uphold a denial or to overturn?
  - Look at the Plan
  - Double check the medical recommendations
  - Independent Medical Examinations
    - Why they are requested and why they are not
  - Medical reviews
    - External versus internal
  - Vocational consultants/employability analyses

SECOND ADVERSE BENEFIT DECISION LETTER

- Contents
  - Account for all of the records produced
  - Account for rejecting treater's opinion
  - Account for SSD decision, if provided
- Right to sue language
- Contractual limitations language
- Rationale
  - Must include a "because" statement to draw the connection between the decision and the medical evidence. *See Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 511 F.3d 1206 (9th Cir. 2008)

REPRESENTING MULTIEMPLOYER PLANS – UNIQUE ISSUES IN APPEALS PROCESS

- Board of Trustees meetings may be on quarterly basis, which affects timing on appeal determinations
  - Extension to determine appeal can be as late as third meeting after receipt of appeal
  - Notice of decision is a tight turn around – within 5 days of the determination