

ADMINISTRATIVE APPEALS OF LONG-TERM DISABILITY AND HEALTH CLAIMS

2018 ABA LTD Litigation

Denise M. Clark
Clark Law Group, PLLC

Al Holifield
Holifield Janich
Rachal Ferrera, PLLC

Peter M. Kelly
Deputy General Counsel and
Chief Employee Benefits Counsel
Blue Cross Blue Shield Association



NOW WHAT?

- The claimant receives a written adverse benefit determination – either a denial of an initial claim or termination of ongoing benefits.
- NOW WHAT?



LTD PLANS IN GENERAL

- **General characteristics of LTD Plans**
 - Generally provide benefits after 6 months of disability until retirement age representing approximately 2/3 of pre-disability earnings.
 - Many have an own occupation standard of disability that shifts to any occupation standard of disability after 24 months.
 - Almost all plans will offset other income or benefits including WC, SDI, SSDI, retirement benefits, etc.
 - Many plans have a 2-year limitation for mental illnesses and other conditions.

TYPES OF LTD PLANS

- Insured Plans
 - Employer purchases insurance policy from insurer to provide benefits to employees who become disabled from work.
 - Often, the insurer who is responsible for paying the benefits also determines eligibility for benefits.
 - The Supreme Court recognizes this as a structural conflict of interest. *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008).



TYPES OF LTD PLANS

■ Self-Funded Plans

- Employer sets aside funds for qualified participants.
- Usually big employers like AT&T or Johnson & Johnson.
- Many hire third-party administrators (often insurance companies) to determine eligibility for benefits.
- Protections afforded by state's insurance laws do not apply.

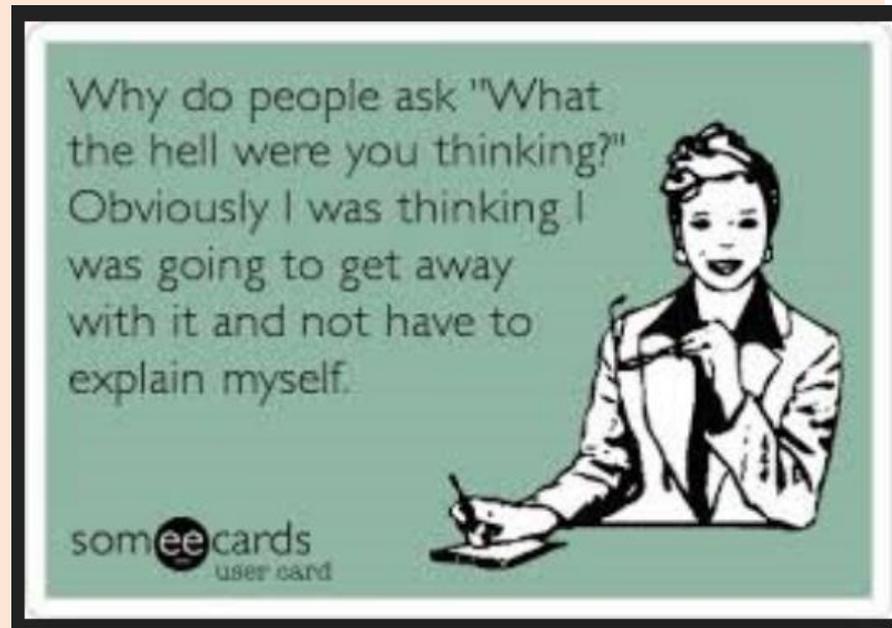


ADVERSE BENEFIT DECISION

- Notification of an adverse benefit determination. 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 DECISION

- What is the plan thinking when it writes the denial letter?
 - What plan provision(s) is the plan relying on?
 - What facts did the Plan Administrator consider?
 - What medical evidence is there?
 - Surveillance of the claimant?



ADVERSE BENEFIT DECISION

- What is the plan thinking when it writes the denial letter?
 - Any contrary evidence indicating that the claimant is not disabled? If so, did the Plan Administrator consider such evidence when making its decision?
 - What is the job description of the claimant?
 - Any *Glenn* or *Amara* concerns?
 - Internal or external review process?

REQUEST FOR REVIEW PROCESS

- ERISA requires a “full and fair review.” ERISA § 503.
- **PRACTICE TIP:** This Review constitutes your evidence in litigation



REQUEST FOR REVIEW DEADLINE

The claimant has
180 days to
appeal.

The clock is
running!



REQUEST FOR REVIEW PROCESS

- 29 C.F.R. §2560.503-1(h) -- Every plan must:
 - Provide claimants the opportunity to submit written comments, documents, records, and other information;
 - Provide that copies of all documents and other information relevant to the claim
 - Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim;
 - Provide claimants at **least 180 days** following receipt of a benefit denial to appeal;
 - 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 on behalf of the plan in making the adverse benefit determination.
 - If the plan does not follow these statutory requirements, the time limits to appeal are not enforced against the claimant. *Counts v. American General Life and Accident Ins. Co.*, 111 F.3d 105 (11th Cir. 1997).

REQUESTING PLAN DOCUMENTS

- Request Plan Documents

- Don't limit it just to the plan – ask for anything relevant and be specific!

5. Any and all documents reflecting communications, either oral or written, between [Claim Administrator] and Ms. _____, including, but not limited to, all handwritten notes of such communications;
6. Copies of all correspondence or communications from physicians, attorneys, accountants, or other service providers employed or retained to render advice on behalf of the Plan or its fiduciaries regarding Ms. _____'s claim. Please note that no attorney-client privilege attaches to these communications. *Wildbur v. ARCO Chemical Co.*, 974 F.2d 631 (5th Cir. 1992); *Smith v. Jefferson Pilot Financial Ins. Co.*, 245 F.R.D. 45, 47-29, NO. CIV A 07-10228-PBS (D. Mass., Aug. 02, 2007).
7. Identification of any medical or vocational experts whose advice [Claim Administrator] sought for Ms. _____'s claim; copies of the experts' resumes and/or curriculum vitae; a disclosure of the compensation arrangement between [Claim Administrator] and those experts; a disclosure of the number of claims per year that each expert has reviewed for [Claim Administrator] in the last three years; and a disclosure of the number of claims per year for which each expert recommends a finding of "disabled" per year for the last three years.
8. Any other document, record, or any other information relevant to Ms. _____'s claim for benefits.

RESPONDING TO A DOCUMENT REQUEST

- What do plans do when they receive a document request?
 - What documents, records, or other information are “relevant?”
 - 29 C.F.R. § 2560.503-1(m)(8)
 - If it was relied upon in making the benefit determination;
 - Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
 - Demonstrates compliance with the administrative processes and safeguards required under ERISA;
 - Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination

REQUEST FOR REVIEW PROCESS: REVIEW THE PLAN DOCUMENTS

- 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
 - “Objective Evidence” requirements
 - Exclusions and Limitations

REQUEST FOR REVIEW PROCESS: REVIEW THE CLAIM FILE

- Review the claim file for:
 - Internal notes
 - Evidence of procedural irregularities
 - Evidence of conflict of interest
 - Medical reviews
 - Vocational reviews
 - Surveillance reports and videos



ADDRESSING AN ADVERSE MEDICAL REVIEW

- Carefully read the medical reviewer's report
 - Did the medical reviewer speak with the treating physician?
 - What records did the plan provide to the medical reviewer?
 - What records did the plan fail to provide?
 - Did the medical reviewer consider the claimant's job description?
- Try to obtain the treating physician's response to the medical reviewer's report

REQUEST FOR REVIEW PROCESS: PREPARE YOUR APPEAL

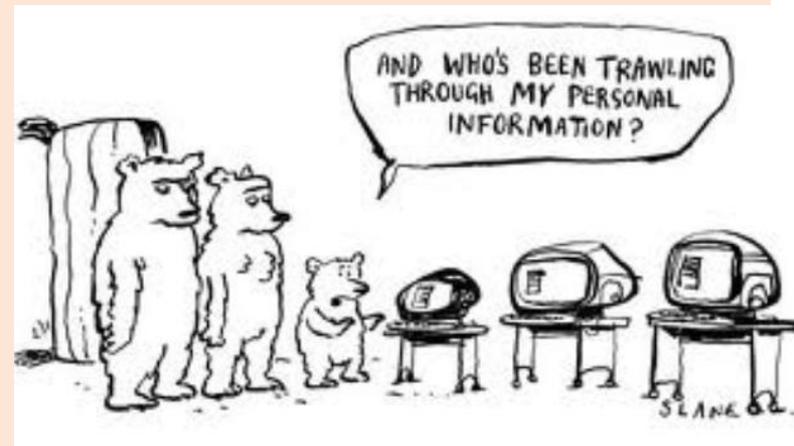
■ What to Submit

- Medical records
- Letters from medical providers
- Address adverse medical reviews
- “Objective” evidence
 - current symptom[s];
 - other medical conditions that might affect or lengthen the recovery period;
 - existing abnormalities or deficiencies;
 - results from physical examinations;
 - observations made by the treatment provider during office visits/therapy sessions;
 - diagnostic tests and their results (for example, lab results, x-rays and MRIs);



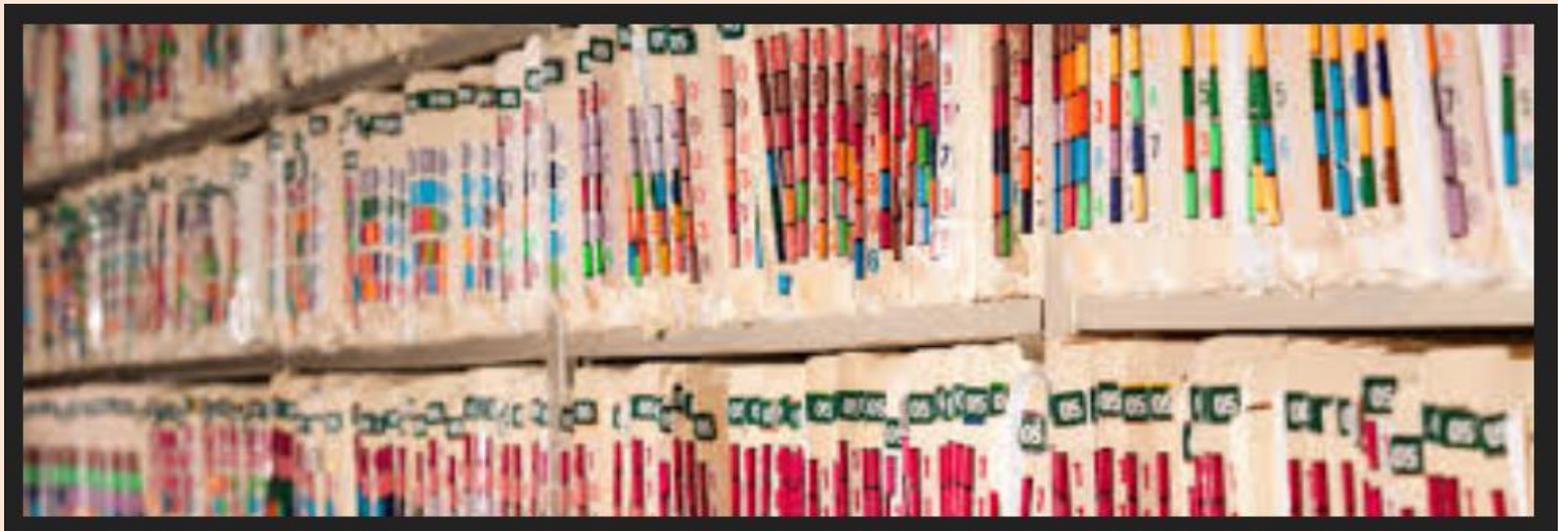
REQUEST FOR REVIEW PROCESS: PREPARE YOUR APPEAL

- Address surveillance
 - Diminish utility of surveillance
 - Review surveillance videos – watch time stamps carefully and compare with surveillance report.
 - Watch for contradictory statements made by claimant regarding the surveillance
 - Review claim file for contradictions/consistencies with activities seen on surveillance.
 - Review medical reports for possibly flawed interpretations of surveillance
 - Obtain client and other statements to “fill in the gaps” of surveillance.
 - Have treating physician or IME review surveillance and render opinion.
 - Investigate whether surveillance was done lawfully.



REQUEST FOR REVIEW PROCESS: PREPARE YOUR APPEAL

- Declarations (claimant, friends, co-workers, etc.)
- Functional Capacity Evaluations and Independent Medical Examinations
- Vocational Analysis
- Medical literature
- Social Security file for supporting information



RESPONDING TO THE REQUEST FOR REVIEW

- Appeal procedures and administrative review must comply with plan documents
 - NO FEES!
 - Have there been similarly situated claimants in the past?
- What does the plan look for in an appeal?
 - Timeliness of the appeal
 - What aspect of the denial letter is the claimant appealing?
 - Did claimant provide additional material or information that was requested?
 - Has claimant requested any new evidence from plan on appeal? If so, has claimant reserved the right to supplement or address the new evidence?

RESPONDING TO THE REQUEST FOR REVIEW

- What does the plan look for in an appeal?
 - Who reviewed the initial claim for benefits and made decision to deny benefits?
 - Was the claim initially denied based in whole or in part on a medical judgment?
 - This includes determinations on whether treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate
 - Must consult with a health care professional who has appropriate training and experience and was not involved in the initial determination to deny benefits

RESPONDING TO THE REQUEST FOR REVIEW

- If the appeal is denied, how does the plan prepare the appeal denial letter?
 - Compliance with plan's claims procedure
 - Was the time period for claimant to respond to request for additional information tolled?
 - Must provide identification of medical or vocational experts whose advice was obtained
 - Do the plan documents further provide for a second appeal, voluntary appeal, or arbitration?

RESPONDING TO THE REQUEST FOR REVIEW

- Several Courts have articulated that appeal denial letters must provide a clear and prominent statement of any applicable contractual limitations period and its expiration date in the final notice of adverse benefit determination on appeal – Already required? See, *Santana-Diaz v. Metro. Life Ins. Co.*, 2016 WL 963830 (1st Cir. March 14, 2016); *Mirza v. Ins. Admin. Of Amer., Inc.*, 800 F.3d 129 (3d Cir. 2015); *Moyer v. Metro. Life Ins. Co.*, 762 F.3d 503 (6th Cir. 2014)

DOL FINAL RULE FOR DISABILITY PLANS

- On April 1, 2018, the Department of Labor's new regulations to address disability benefit claims and appeals became effective. The new regulations adopt procedural protections implemented for health care claimants under the ACA, including:

DOL FINAL RULE FOR DISABILITY PLANS

- Minimizing financial conflicts of interest
- Full disclosure of all reasons supporting a claim denial
- Claimants have access to their entire claim file, as well as any claim processing guidelines, standards, and protocols, and are allowed to present evidence and testimony during the review process;
- Claimants are notified of and have an opportunity to respond to any new evidence reasonably in advance of an appeal decision
- Final denials at the appeals stage are not based on new or additional rationales unless claimants first are given notice and a fair opportunity to respond
- If plans do not adhere to the claims rules, the claimant is deemed to have exhausted administrative remedies available under the plan (with certain exceptions)
- Notices are written in a culturally and linguistically appropriate manner

DOL FINAL RULE—AVOIDING CONFLICTS OF INTEREST

- Builds on independent review standards for avoiding conflicts of interest – “full and fair” review
- Decisions regarding hiring, compensation, termination, promotion, or similar matters involving individuals involved in making a claim decision must not be based upon the likelihood that the individual will support the denial of disability benefits
- Ex. Plan would not be permitted to provide bonuses based on the number of denials made by claims adjudicator
- Ex. Plan would not be permitted to contract with a medical expert based on the expert’s reputation for outcomes in contested cases, rather than on the expert’s professional qualifications

DOL FINAL RULE—ENHANCED DISCLOSURES

Adverse benefit determinations on disability claims would have to contain:

- a discussion of the decision, including the basis for disagreeing with the disability determination by the Social Security Administration, by a treating physician, or other third party disability payor
- internal rules, guidelines, protocols, standards or other similar criteria of the plan that were used in denying the claim

A notice of adverse benefit determination *at the claim stage* would have to contain a statement that the claimant is entitled to receive relevant documents (current regulations require such statement only in notices of adverse benefit determination denied on appeal)

DOL FINAL RULE—REVIEW AND RESPOND TO NEW INFORMATION

- Claimants would have a right to review and respond to new evidence or rationales developed by the plan during the pendency of the appeal (*as opposed to having a right to such information on request only after the claim has already been denied on appeal*)
- Prior to a plan's decision on appeal, a claimant must be provided:
 - with any new or additional evidence considered (free of charge), relied upon, or generated by the plan as well as any new or additional rationale for a denial,
 - a reasonable opportunity for the claimant to respond

DOL FINAL—REVIEW AND RESPOND TO NEW INFORMATION

Example. Plan denies claim and claimant appeals. Plan causes a new medical report to be generated by a medical specialist who was not involved in developing the first report. Proposed regulations would require that this new report be furnished to claimant prior to the expiration of the decision period (45 days).

- Plan would be required to consider any response from the claimant
- Must allow claimant reasonable opportunity to respond
- Special tolling rules so that a claimant has a reasonable opportunity to respond

DOL FINAL RULE — EXHAUSTION

- Expands on the “deemed exhaustion” provision in the existing DOL regulations in three respects:
- No deemed exhaustion based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant.

DOL FINAL RULE—EXHAUSTION

- Not available if the violation is part of a pattern or practice of violations by the plan
- Claimant may request a written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the plan to be deemed exhausted
- If a court rejects the claimant's request for immediate review on the basis that the plan met the *de minimis* standards, the claim shall be considered re-filed on appeal upon the plan's receipt of the decision of the court
 - Within a reasonable time after the receipt of the decision, the plan shall provide the claimant with notice of resubmission

DOL FINAL RULE—RESCISSIONS

- Proposed regulations would treat rescissions as adverse benefit decisions
- Rescission include cancellation or discontinuance of disability coverage that has retroactive effect
- By treating rescissions as adverse benefit decisions, participants and beneficiaries would be able to utilize the administrative claims procedures under the plan

DOL FINAL RULE APPROPRIATE NOTICES

- Proposed regulations would require that adverse benefit determinations be provided in a culturally and linguistically appropriate manner
- If claimant's address is in a county where 10% or more of the population residing in that county, as determined based on data published by the U.S. Census Bureau, are literate only in the same non-English language, notices of adverse benefit determinations would have to include a prominent one-sentence statement in the relevant non-English language about the availability of language services
- Plan would be required to provide a customer assistance process (such as a telephone hotline) with language services in the non-English language and provide written notices in the non-English language upon request