Benefit Claims – Part I: Administrative Procedures

ERISA Basics National Institute
October 26, 2017

Sponsored by the ABA Joint Committee on Employee Benefits and the American College of Employee Benefits Counsel

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Administrative Procedures: An Overview

- General Considerations
- Claim for benefits (Disability, health, life & pension)
- Adverse benefit decision (When must it be issued? What must it contain?)
- Are you required to exhaust administrative remedies?
- What is a “full and fair review” under ERISA?
- Request for review
  - Build the record – it matters

Administrative Procedures: An Overview, cont'd

- Approve benefits or continue to deny?
  - Medical reviews and rationale
- Second adverse benefit decision letter
- Optional second level of review?
- External review (for health plan claims – rescission, medical judgment)
- New claim procedures for disability benefit claims
- In-house perspective

Benefit Claims

General Considerations, cont'd.

- Proper reviewer
  - Did the party with discretionary authority decide the claim?
  - For health and disability claims, did the proper professional review the claim?
    - Is the same party reviewing the claim on appeal as reviewed the initial determination?
- Proper denial
  - Did it follow the adverse benefit decision requirement under the regulations?

General Considerations, cont'd.

- Are the records complete?
- Was the correct plan document consulted?
- Identify plan provisions that apply to the specific benefit requested
- Review potential conflicts; have walls been established?
- Review applicable contractual and statutory limitations. *See Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604 (2013)
- Fiduciary exception to the attorney-client privilege. *See Stephan v. Unum* 697 F.3d 917 (9th Cir. 2012)

Required Claim Procedures

- 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

Claim for Benefits: Disability

- **For all benefit claims** – Request relevant plan documents and follow claim procedures
  - Timelines for submitting a claim
    - Notice-prejudice rule: Claim filing deadlines are rarely enforceable in insured plans. *See Unum Life Ins. Co. v. Ward*, 526 U.S. 358 (1999)
    - Look to the applicable state insurance regulation. The notice-prejudice rule usually does not apply to self-funded plans, only to insured plans
- Are physicians aware they will have to complete forms requested by the insurer?
- Encourage your client to apply for long-term disability benefits even if short-term disability claim is denied
- Practice Tip: Generally, an initial claim for disability benefits does not require attorney involvement

Claim for Benefits: Health

- 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

Claim for Benefits: Life

- Is this a standard life insurance or accidental death and dismemberment claim?
- Potential relevant documentation:
  - Beneficiary designation forms
  - Autopsy report
  - Death certificate

Claim for Benefits: Pension

- 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 Determinations

Adverse Benefit Decisions

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 – ACA Non-Grandfathered Health Plans

- 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 Claims
  - 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
- 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

Adverse Benefit Decisions: Timing

- Health Claims: Is it an "urgent," "pre-service," or "post-service" claim?
  - **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

Adverse Benefit Decisions: Timing Non-Grandfathered Health Plans

- Rescission of Coverage is:
  - A claim subject to internal and external review
  - Retroactive cancellation or termination of coverage except for fraud or intentional misrepresentation or failure to pay premiums even if cancellation has retroactive effect
    - DOL FAQs II Q-7 confirms loss of coverage for non-payment of COBRA or failure to notify plan of QE is not rescission
  - 30-day notice required before rescission takes effect
    - coverage must remain in effect during 30-days and any appeal of rescission

Exhaustion

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 of Administrative Remedies Non-Grandfathered Health Plan

- 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
    - Plan demonstrates that violation was for good cause or due to matters beyond plan's control and occurred in the context of an ongoing good faith exchange of information between the plan and claimant

Exhaustion of Administrative Remedies Non-Grandfathered Health Plan, cont'd

- Exception not available if part of pattern/practice of violations
- Claimant may require an explanation of the violation from the plan including plan's bases for asserting that internal claims/appeals process should not be deemed exhausted
  - Explanation must be provided within 10 days
- If external reviewer or court rejects claimant's request for immediate review, claimant may resubmit under internal process
  - Plan must provide claimant notice

Administrative Review

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;
  - 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;
  - Ensure that notice of adverse benefit determination includes the denial code and its meaning;
  - 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. Am. Gen. Life & Accident Ins. Co.*, 111 F.3d 105 (11th Cir. 1997)

What is a "Full and Fair Review"? Non-Grandfathered Health Plan

- In addition, a non-GF GHP or health insurance issuer must:
  - Allow the claimant to review the claim file and to present evidence as part of the internal claims/appeals process;
  - Provide claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the plan or issuer in connection with the claim or any new or additional rationale-must be provided ASAP and sufficiently in advance of the date on which the notice of final adverse internal benefit determination is required to give claimant reasonable opportunity to respond before that date;
  - Ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision;
  - Provide ALL notices in a "culturally and linguistically" appropriate manner;
  - Continue to provide coverage pending outcome of appeal

What is a "Full and Fair Review" for a Healthcare Claim?

- Healthcare professional must be consulted on medical judgments, prior to denying appeal
- Professional must be specialist in appropriate discipline
- Medical and/or vocational experts must be disclosed to claimants, if appeal is denied
- Plans may not require more than two levels of appeal, but do allow more appeals at participant request
- Practice Tip: Identify precisely the claims you are considering

Disability Request for Review: Claimant's Steps

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

Disability Request for Review: Claimant's Steps, cont'd

2. Send out a document request to the plan administrator and the insurance company
   - Ask for:
     - The plan document
     - The SPD
     - All documents that are "relevant" to the claim 29 C.F.R. § 2560.503-1(m)(8)
     - The "claim file," including surveillance, emails, activity logs, medical reports, and vocational reports
     - Claims manuals
     - Information on the reviewing doctors
     - All communications b/w plan fiduciary and plan counsel

Disability Request for Review: Claimant's Steps, cont'd

3. Review the Plan documents for:

   a. Definition of disability ("own occupation" vs. "any occupation" and whether % of pre-disability earnings is a factor)

   b. Grant of discretion

   c. Offsets (may make it unfeasible to take a claim)

   d. Whether STD is a prerequisite to LTD

   e. Self-reported symptoms or other limitations on payment of benefits

Disability Request for Review: Claimant's Steps, cont'd

4. Prepare the Request for Review
   a. Medical records (including "objective" evidence)
   b. "Opinion" evidence from doctors (in the form of letters or questionnaires)
   c. Social Security claim file. *See Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 128 S. Ct. 2343 (2008)
   d. Declarations (claimant, friends, co-workers, etc.)
   e. Functional Capacity Evaluations and Independent Medical Examinations
   f. Vocational Analysis
   g. Medical literature

Disability Request for Review: Claimant's Steps, cont'd

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
6. *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

External Review

External Review – Non-Grandfathered Health Plan

- GHP must comply with either a State or Federal external review process
  - Federal process in DOL Technical Information Release 2010-01, modified by 2011-02
  - Includes both standard and expedited external review

External Review – Non-Grandfathered Health Plan

- Technical Release 2010-01 (Aug. 23, 2010) – Self-funded GHPs
  - Request for external review within 4 months of date of receipt of adverse benefit determination
  - Preliminary review by plan within 5 business days
  - Plan notifies claimant of result within 1 business day of completing review
  - If eligible, referral to Independent Review Organization (IRO)

External Review – IROs Non-Grandfathered Health Plan

- To qualify for safe harbor, plan must contract with at least 3 IROs accredited by URAC or similar organization. TPA may contract with IRO but Plan remains responsible. *See* DOL FAQs I Q-9
- IRO will notify claimant of assignment of claim and that claimant may submit additional information within 10 business days
- Within 5 business days plan must provide IRO documents and information considered in making adverse benefit determination
- Information received from claimant forwarded to plan and plan may reconsider claim but reconsideration will not delay external review. Plan must notify claimant and IRO if denial is reversed

External Review – IROs Non-Grandfathered Health Plan

- IRO reviews claim *de novo*
- Upon receipt of notice of decision of IRO reversing claim denial, plan must pay claim
- Expedited external review may be requested based on claimant's medical condition
- Scope of external review limited to:
  - Rescission
  - Medical judgment

External Review Decision

- External review decision is binding on plan and claimant
- Does not preclude plan from making payment on claim at any time even after decision in its favor
- Plan must pay benefits without delay even if it intends to seek judicial review of the external review decision
  - Plan must pay benefits until external review decision is reversed
- Is IRO a fiduciary?

New Claim Procedures for Disability Benefit Claims

Background Information

- Last major revision in 2000
- DOL recognized that disability benefit claims account for 64.5% of employee benefit claim litigation under ERISA
- Effective dates
  - Published December 19, 2016 (at 81 FR 92316)
  - Effective January 18, 2017
  - Applicable only to claims submitted on or after January 1, 2018

Impartiality in Decision Making

- 29 C.F.R. § 2560.503-1(b)(7)
  - "Decisions regarding hiring, compensation, termination, promotion, or similar matters with respect to any individual must not be made based upon the likelihood that the individual will support the denial of disability benefits"
    - Includes vocational experts and third-party vendors

Enhanced Requirements for Adverse Benefit Decisions

- 29 C.F.R. § 2560.503-1(g)(1)
  - Denial letters must include
    - "A discussion of the basis for disagreeing with the health care professional's views"
    - All medical and/or vocational opinions obtained regardless of whether they were used in rendering decision
    - If there is a Social Security disability benefit award, "a more detailed justification…where the SSA definitions were functionally equivalent to those under the plan"
- "Internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making an adverse benefit determination must be provided with the adverse benefit determination"

Other Key Provisions

- 29 C.F.R. § 2560.503-1(j) – post-*Heimeshoff*, 134 S. Ct. 604, limitations period for filing suit cannot expire during appeals
  - Denial letter must also state date on which plan believes that limitation period would expire
- 29 C.F.R. § 2560.503-1(l) – Violation of rules sufficient to establish a deemed exhaustion unless violation is *de minimis*, non-prejudicial, or not attributable to plan's conduct
  - Deemed exhaustion requires courts to apply *de novo* standard of review?
- 29 C.F.R. § 2560.503-1(o) – Decisions must be written in a culturally/linguistically appropriate manner consistent with Affordable Care Act requirements

In-House Perspective

In-House Decisions Set the Stage for any Subsequent Litigation

- Plan administration actions and governance oversight are factual backdrop for any subsequent ERISA litigation
  - How we perform our responsibilities and degree of honesty and fair dealing we bring to our work will be tested
- Cannot know which specific decisions & practices will be challenged
  - Like a feature film, our work is “in the can” before our audience, the folks in the black robes offer their judgments about our efforts
    - Only then will we know if we earned a judicial Oscar, Razzy or routine obscurity

Best Practices and Continual Improvement

- Paradox: Better prepared for litigation, less likely to be sued
- ERISA imposes minimum standards, but our most successful strategy is to employ best practices and to lead not follow in doing so
  - What is adequate to satisfy ERISA's minimal fiduciary standards today may not be sufficient tomorrow
  - Today's Best Practices tend over time to morph into tomorrow's minimum standards
    - Recent DOL Disability Claims Regs a perfect example
  - Continual improvement is the best strategy to stay ahead of this progression

Role of Good Governance

- Disciplined application of even handed ERISA processes starts with good governance practices
- Good governance is itself a process that requires continual process improvement
  - You can't fake it, authentic commitment is required
  - Good governance is hallmark of fealty to ERISA fiduciary duties, including oversight of the full range of ERISA administration, including benefit determination, claims adjudication and disclosure practices

Administrative Diligence (Benefit Claims)

- Most frequent type of ERISA Litigation (most involve disability)
- Our most successful decisions are never evaluated by judges
  - Benefit grant decisions are not usually difficult since paying a benefit is the plan's objective
  - Our toughest decisions involve claimants who also approach the claims process honestly, but who for one reason or another are not entitled to the benefit they seek
  - Our most successful tough decisions result from careful and respectful adherence to the ERISA claims procedures including a well-reasoned denial letter that does not rely on last minute surprise evidence
    - If claimant is not convinced by the rationale, at least he or she has every reason to believe the process was fair

Questions?