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Administering Benefit Claims: Avoiding Mishaps and Litigation, Compliance Challenges for ERISA Counsel

Modifying Plan Documents and SPDs, Handling Assignment of Benefits, Effective Claims and Appeals Procedures

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Administering Benefits Claims: Avoiding Mishaps and Litigation, and Managing Compliance Challenges

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Topics

- Legal Framework
- Issues that can Arise During the Claims and Appeals Process
- Developing Effective Claims and Appeals Procedures
- Limiting Liability Through Plan Design
- Pre-Litigation Considerations
- ERISA Litigation

Legal Framework

- ERISA Section 503 requires every employee benefit plan to:
  - 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
  - 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

Department of Labor Regulations

- 29 CFR § 2560.503-1 *et seq.* requires every employee benefit plan to establish and maintain reasonable procedures for:
  - Filing benefit claims;
  - Notifying participants of benefit determinations; and
  - Appealing adverse benefit determinations
- The Affordable Care Act also added additional requirements for non-grandfathered group health plans

Issues That Can Arise

- Is it an actual claim?
  - Eligibility or benefits?
  - Clarification of rights?
  - Assignment or Authorized representative?
  - Plan rules regarding form of claim (e.g. written claim)?
- When to treat a dispute as a benefit claim?
- Same entities or individuals making decision at the different levels
  - Additional Voluntary or Mandatory Level of Review (if provided for in the plan)

Issues That Can Arise (cont.)

- Different kind of claims are subject to different rules – retirement plans vs. welfare plans (group health plan, disability plans, etc.)
- Incorrect information was provided to claimant during claims process
- Claim was received but not timely processed
- Competing claims (e.g., death benefits)
- Administrative mistakes
- Deference to SSA determinations
  - *Sevely v. The Bank of New York Mellon Corp. Long Term Disability Coverage Plan, et al.*, No. 18-3247, 2019 WL 6799640 (2d Cir. Dec. 13, 2019).

Requirements For A Full And Fair Review Of A Claim And Adverse Benefit Determination

- Comply with applicable timing requirements for notice
- Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits
- Provide that a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits
- Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination

Timeframes – Retirement Plans

- Initial claim determination: reasonable period, but not later than **90 days** (extension of up to 90 days available if special circumstances apply)
- Time to appeal: At least **60 days**
- Notification of appeal determination: reasonable period, but not later than **60 days** (extension of up to 60 days available if special circumstances apply)
- Plans with a committee or board of trustees who are designated to decide appeals and meet at least quarterly have special timeframes

Timeframes – Group Health Plan Claims

- Urgent Care Claim - Plan must make decision as soon as possible but not later than **72 hours** (no extensions)
- Pre-Service Claim (non-urgent) - Plan must make decision in a reasonable period of time appropriate to the medical circumstances but not to exceed **15 days** (15 day extension permitted if "matters beyond the control of the plan" require it)
- Post-Service Claim - Plan must make a decision within a reasonable period of time but not later than **30 days** (15 day extension permitted, if "matters beyond the control of the plan" require it)
- Concurrent Care Claim - Timeline depends on kind of claim (*e.g.*, urgent, pre-service or post-service)
  - Under ACA, plan must continue coverage for concurrent care pending outcome of the appeals process
  - Claimant can voluntarily agree to a longer extension of time.

Timeframes – Group Health Plan Claims

- Claimant must have at least **180** days from receipt of notice of adverse benefit determination to file an appeal
    - If plan has two levels of appeal, 180 day rule only applies to first level of appeal, claimant given a "reasonable period" after first appeal to decide whether to request a second appeal
- Urgent Care Claim – as soon as possible, but no later than **72 hours** after receiving the appeal
- Pre-service Claim – reasonable period, but no later than **30 days** after receiving the appeal
- Post-Service Claim – reasonable time period, but no later than **60 days** after receiving the appeal
- Multiemployer collectively bargained plans have special timeframes to allow them to schedule reviews of post-service claim appeals for the regular quarterly board of trustees meetings

Timeframes – Disability Benefit Claims

- Disability claims must be decided within a reasonable period, not to exceed **45 days** (with two potential 30 day extensions);
- Claimants must have at least **180 days** to file an appeal;
- Appeals must be reviewed within a reasonable period of time, but not later than **45 days** after the plan receives the appeal (with possibility of 45 day extension)

Timelines for Other Welfare Benefit Claims

- For claims that are not a disability or group health plan claim the following timelines apply *(e.g.*, life insurance):
  - Claim must be decided within a reasonable period of time, not to exceed **90 days** (with possible 90 day extension);
  - Claimant must have at least **60 days** to file an appeal;
  - Appeals must be reviewed within a reasonable period of time, but not later that **60 days** after the plan receives an appeal (with possible 60 day extension)

Developing Effective Claims and Appeals Process

- Plan terms should generally mirror DOL Regulation, 29 CFR § 2560.503-1
- Follow Benefit Claims Procedure Regulation FAQs
- Plans can be more generous to participant – cannot be less generous (*e.g.*, if the plan provides for a longer time period for filing an appeal, then the plan must comply with the longer period)
- Plan may want to document its own procedures for how to handle eligibility inquiries because regulations do not apply to a request for prior approval

Best Practices for Reviewing Claims

- Follow written claims procedures and required timeframes
- Be aware of potential conflict argument when including employees involved in the company's finances on the claims review committee
- Correctly interpret the plan and be fair about answering questions for which the plan does not provide a clear answer
- Do not make decisions based on identity of claimant
- Make sure all relevant documents are gathered and considered
- Have a complete, well-organized record
- Communicate thoughtfully
- Eliminate bias to the extent possible
- Rely on signed plan documents

Best Practices for Reviewing Appeals

- Different fiduciary reviewing the initial claim and reviewing the appeal
- When new reasons are relied upon in denying an appeal, give the participant or beneficiary the opportunity to respond to those reasons

Be Consistent

- Claims procedures must contain processes and safeguards designed to ensure and verify that plan provisions have been applied consistently with respect to similarly situated claimants
- Document prior decisions and review past precedent when determining claims/appeals
- Claimants have a right to request documents, records, or other information that demonstrate compliance with these safeguards in making a benefit determinations

What to Include in the Initial Claim Denial Letter

- Provide specific reasons for the denial
- Reference specific plan provisions in which the denial is based (explain, don't just state conclusions)
- Identify any additional information needed to perfect the claim and an explanation of why the information is needed
- Describe the plan's review procedures and time limits that apply to them
- Include statement of the claimant's right to bring a claim under ERISA §502(a) and any applicable deadlines
- Include a copy of the internal rule, guideline, or other criterion relied on (or statement that such documentation will be provided free upon request)
- If a denial is based on medical necessity or experimental treatment, include an explanation of the scientific or clinical judgment (or statement that such explanation will be provided free upon request)

Best Practices When Preparing Determination Letters

- Be forthcoming about past mistakes
- Address all of claimant's arguments and points, even if "frivolous"
- Consider and write to your audience
- Base your decision on the Plan terms

Handling Document Requests

- During the claim and appeal process, the claimant may make a document request
- ERISA §104(b)(4) requires that the plan administrator provides, upon a written request, a copy of the latest updated SPD, plan document, trust agreement, etc.
  - Failure to do so within 30 days of the result may result in a court rewarding up to $110 per day against a plan administrator. See ERISA §502(c)(1)
- DOL Regulation, 29 CFR § 2560.503-1(h)(2)(ii) – a claimant should be provided "upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information **relevant** to the claimant's claim for benefits"
- Definition of "relevant" documents defined under 29 CFR 2560.503-1(m)(8)

Handling Document Requests

- *Odle vs. UMWA 1974 Pension Plan, 777* F. App'x 646 , *2019 WL 2539260* (4th Cir. June 20, 2019)

- *Wagenstein v. Cigna Life Ins. Co.*, No. 18—55955, 2020 WL 68394 (9th Cir. Jan. 7, 2020)

- *Bustetter v. CEVA Logistics U.S., Inc.,* No. CV 18-58, 2019 WL 6719485 (E.D. Ky. Dec. 10, 2019)

Administrative Record

- Documents from the filing of the original claim to the final denial of the appeal
- Includes records put together by the claims fiduciary in making its benefit determination
- Includes information initially submitted and also submitted during the appeals process
- Includes any documents provided to claimant during the claim and appeals process
- Includes internal documents such as those generated by the insurance company, including reports, records, and other information

The Fiduciary Exception to the Attorney-Client Privilege

- General Rule: Confidential communications between a client and an attorney concerning the provision of legal advice are privileged and not subject to compelled disclosure to adverse parties during litigation.
- Under the fiduciary exception, a fiduciary acting within the scope of his or her fiduciary duty cannot assert the attorney-client privilege against participants or beneficiaries to the extent the attorney-client communication relates to matters of plan administration. *Stephan v. Unum,* 697 F.3d 917 (9th Cir. 2012)

Exceptions to the Exception

- Generally, courts have held the fiduciary exception does not apply in three situations:
  - The fiduciary acts as "settlor" not as "fiduciary" (i.e. plan adoption, amendments or termination)
  - The fiduciary seeks advice relating to personal liability
  - The interests of the fiduciary and beneficiary have diverged (*e.g.* after final benefit decision has been made)
- For claims review process, assume there is no attorney client privilege
- *Advanced Physicians, S.C. v. Connecticut General Life Insurance Company, et al.*, No. 3:16-CV-2355-G, 2020 WL 58698 (N.D. Tex. Jan. 3, 2020)

What Happens After the Appeal Denial?

- Claimant can either accept the decision or proceed to litigation

Pre-Litigation Considerations

- "Deemed Exhausted" if plan fails to establish and follow reasonable claims procedures – claimant can go straight to court
- Standard of Review
  - Arbitrary and capricious, or "abuse of discretion" review
  - De novo review
- Conflict of interest analysis
- Possible ERISA §502(a)(3) claims
- No jury trials
- Recovery of attorney fees under ERISA §502(g)(1)

The "Exhaustion" Requirement

- A claimant generally must exhaust the plan's claims procedures before bringing a suit
- But courts may excuse the exhaustion requirement because of:
  - Futility
  - Claimant denied meaningful access to procedures
  - Irreparable harm to the claimant
- If a claim is "deemed exhausted," the claimant can proceed directly to litigation
- *Spriggs v. Hancock Holding Co. Severance Pay Plan*, No. CV 18-729-SDD-RLB, 2020 WL 364122 (M.D. La. Jan. 22, 2020)

Standard of Review

- *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989) - The Supreme Court held that ERISA claims are reviewed de novo "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan"
- "Arbitrary and capricious" or "abuse of discretion" standard vs. "de novo" standard
- The court will not overturn claims fiduciary's decision unless so unreasonable as to be deemed arbitrary and capricious vs. no deference
- Administrative record vs. "clean slate"

Conflict of Interest

- Was the claims fiduciary impartial?
  - Deferential standard of review may still apply but it must be informed by the nature, extent, and effect on the decision-making process of any conflict of interest
  - Conflicts of interest is treated as a "factor" to be "weighed" in the "abuse of discretion" analysis
  - Court may consider evidence outside the administrative record regarding the conflict of interest
- *Metropolitan Life Ins. Co. v. Glenn,* 554 US 105 (2008); *Abatie v. Alta Health & Life Ins. Co.* 458 F.3d 955 (9th Cir. 2006)

Claims Not Limited to ERISA §502(a)(1)(B)

- The Supreme Court in *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, (2011), the Supreme Court confirmed that ERISA § 502(a)(1)(B) did not permit a court to award benefits not provided for in the plan, but that ERISA § 502(a)(3) authorized forms of equitable relief against a plan fiduciary (estoppel, surcharge, reformation)
- Since then, courts have allowed plaintiffs to proceed with claims under ERISA § 502(a)(1) (i.e. claim for benefits) and 502(a)(3).
- *See, e.g.*, *N.Y. State Psychiatric Ass'n v. UnitedHealth Grp.*, 798 F.3d 125 (2d Cir. 2015); *Moyle v. Liberty Mut. Ret. Benefit Plan*, 823 F.3d 948, 965 (9th Cir. 2016), *as amended on denial of reh'g and reh'g en banc* (Aug. 18, 2016)
- *Kazda v. Aetna Life Ins. Co.,* No. 19-CV-02512-WHO, 2019 WL 6716306 (N.D. Cal. Dec. 10, 2019)

The Court's View of the Claims and Appeals Process

- Plan language controls over all other concerns
- Fiduciary exception
- No evidence concerning other documents is allowed in court if:
  - No ambiguity, and
  - Plan language is clear
- Interpret plan wording as a layperson would
- Limited to the reasons given in decision
- If similarly situated plan participants treated differently, a court may find conduct arbitrary and capricious

Limiting Liability Through Plan Design

- Contractual Limitations Periods
- Forum Selection Clauses
- Mandatory Arbitration Clauses
- Anti-Assignment Clauses

Contractual Limitations Provisions

- ERISA plans can include provisions that reasonably limit the time during which a claim for benefits may be filed in federal court. *See Heimeshoff v. Hartford Life & Acc. Ins. Co.,* 134 S.Ct. 604 (2013); *see also, e.g., Smith v. The Boeing Co.*, 2016 WL 892749 (N.D. Tex. 2016)
- Contractual limitations provisions can help reduce benefit claims
- Contractual limitations provisions should be in SPDs, plan documents, and appeal denial letters. *See e.g.*, *Santana-Diaz v. Metro. Life Ins. Co.*, 816 F.3d 172 (1st Cir. 2016).
- The statute of limitations for ERISA benefit claims is governed by analogous state law; in CA, it is 4 years

Forum Selection Clauses

- ERISA §502(e) provides that suit may be filed
  - Where the plan is administered
  - Where the breach took place
  - Where a defendant resides or may be found
- Plan sponsors may gain efficiency from centralizing litigation in one court which also helps to foster greater predictability for plans
  - But plans may still have to litigate motions to transfer cases originally filed in distant courts
- Courts have upheld forum selection clauses. *See e.g., In re Mathias*, 867 F.3d 727 (7th Cir. 2017)

Arbitration Provisions

- Before including an arbitration provision in the plan, consider the pros and cons of arbitration
- Plan sponsors may want to hold off on adding arbitration and class action waiver language in their plans because the Supreme Court may take it up for review in *Dorman v. Charles Schwab Corporation*, No. 18-15281, 2019 WL 3939644 (9th Cir. Aug. 20, 2019)
- At a minimum, plan drafters should provide notice of any arbitration clause and its key provisions in the SPD

Anti-Assignment Clauses

- Assignment is related to whether a party has standing to bring a lawsuit as an ERISA beneficiary or participant
- Anti-Assignment Clauses seek to prevent the assignment of benefits and/or the right to bring an ERISA benefits or fiduciary claim
- Anti-Assignment clause issues generally arise in situations involving healthcare providers who are seeking payments from the plan pursuant to assignments from an ERISA participant/beneficiary
- Whether the healthcare provider has standing depends on the scope of the assignment, which is based on the language of the assignment, the language of the anti-assignment clause, and the payment practices of the Plan

Assignment Clauses

- *Spindex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc.*, 770 F.3d 1282 (9th Cir. 2014)
- *Air Evac EMS, Inc. v. Usable Mutual Insurance Co.*, 931 F.3d 647 (8th Cir. 2019)
- *Dialysis Newco, Inc. v. Community Health Sys. Grp. Health Plan*, 938 F.3d 246 (5th Cir. 2019)

Thank You

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