Claims and Appeals: Commonplace Issues Facing Plan Administrators

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Today's Agenda

1. Overview of Legal Framework
2. Deviations from Department of Labor's (DOL's) or the Plan's Claims Procedures and Conflicts of Interests
3. Inadequate Denial Notices
4. Failure to Provide "Full and Fair Review"
5. Unclear Plan Terms or Communications
6. Responding to Requests for Documents and the Fiduciary Exception to Attorney-Client Privilege
7. Use of Artificial Intelligence (AI)

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Overview of Legal Framework

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Claims and Appeals: Basic Terms

- **Claim for Benefits**: a request for plan benefits
  - For example: medical treatment, pension, 401(k) distribution, life insurance death benefit
- **Pure Eligibility Claim**: a request for a decision (or determination) that an individual is eligible for plan coverage
  - Includes enrollment disputes, e.g., missing the deadline
- **Hybrid Claim for Benefits and Eligibility**: a request for plan benefits and a determination that one is eligible for plan coverage
- **Adverse Benefit Determination**: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit
- **Appeal**: a request for a review to overturn a denied claim or a denied lower-level appeal

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Background on Claims and Appeals Requirements

- ERISA Section 503 requires every employee benefit plan subject to ERISA to:
  - Provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied in whole or part, 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 in whole or part for a full and fair review by the appropriate named fiduciary of the decision denying the claim

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Background on Claims and Appeals Requirements

- DOL regulations (issued in 1977, 2000, 2010, and 2016) set forth requirements for plans administering and reviewing claims and appeals, which requires plans to establish and maintain reasonable claims procedures for:
  - Filing benefit claims;
  - Providing notification for benefit determinations; and
  - Appealing adverse benefit determinations
- Different types of claims are subject to different rules:
  - Retirement benefits
  - Group health plan benefits (more requirements under the Affordable Care Act)
  - Disability benefits (in certain circumstances these rules apply to other types of benefits that involve disability determinations)
  - Other benefits (e.g., life insurance, AD&D, severance)

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Background on Claims and Appeals Requirements

- What are reasonable procedures? They must:
  - Comply with the minimum procedures established under DOL Reg. §2560.503-1
  - Be described in the SPD and include applicable timeframes
  - Not unduly inhibit or hamper the claims process
  - Allow claimants to authorize a representative to act on their behalf
  - Contain safeguards to ensure and to verify that benefit claim decisions are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants

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Named Appeals Fiduciary

- ERISA requires that a **named** fiduciary hear appeals
- By default, the appeals fiduciary is the ERISA plan administrator
  - The plan document should give the plan administrator full discretionary authority to interpret the terms of the plan
- Plan document must grant plan administrator the power to delegate some or all of its authority (which can include delegation of claims and appeals determinations)
  - Important that entity deciding appeals accepts fiduciary responsibility
- For group health plans and disability benefits, appeals fiduciary must be different person than one who decided the initial claim

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Deviations from DOL's or Plan's Claims Procedures and Conflicts of Interests

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DOL Claims Procedures

- DOL claims procedures, which apply to **claims for benefits** and **hybrid claims**, require plans to do the following:
  - Provide denial notices in accordance with applicable timing requirements
  - Comply with specific content requirements for claim and appeal denial notices
    - These requirements vary depending on the benefit being reviewed (e.g., group health plan, disability, etc.)
  - Ensure denial notices are written in a manner calculated to be understood by the claimant
  - Provide a full and fair review of denied claims (discussed later in webinar)

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DOL Claims Procedures

Benefit Type	Claim Decision	Time to Appeal	Appeal Decision
Retirement Plans, Other Welfare Benefits (e.g., Life Insurance)	90 days	60 days	60 days
Group Health Plans – Urgent Care	72 hours	180 days	72 hours
Group Health Plans – Pre-Service	15 days	180 days	30 days
Group Health Plans – Post-Service	30 days	180 days	60 days
Disability Benefits	45 days	180 days	45 days

Note: time extensions and additional levels of appeal are permitted in certain circumstances

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The Plan's Claims Procedures

- Most plans mirror their claims procedures after the DOL requirements
- Plans can be more generous to participants (e.g., providing a longer timeframe to submit an appeal)
  - However, plans cannot be less than generous than DOL rules
  - In the event your plan's claims procedures are more generous than the minimum requirements in the DOL regulations, you must comply with your plan's terms
- Pure eligibility claims aren't governed by DOL rules, so plans typically create their own eligibility claim procedures

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Deviations from Claims Procedures

- Deviations from the DOL or Plan's claims procedures can pose several issues with respect to the following:
  - "Exhaustion" requirement
  - Standard of review – level of deference court will give plan's determinations

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Deviations from Claims Procedures – Exhaustion

- Generally, a claimant cannot bring a lawsuit claiming benefits under ERISA without first exhausting the plan's claims procedures
- An exception to this rule is when the plan fails to follow the claims procedures in deciding a claim or appeal
  - In other words, a claimant can go straight to litigation without completing the plan's claims procedures when the plan deviates from its procedures
- However, a plan's procedures will not be deemed exhausted where "de minimis" violations occurred that aren't likely to prejudice or harm the claimant where the violation was for good cause or due to matters beyond control of the plan
  - The regulations provide that the de minimis exception only applies to disability claims, however the circuits are not uniform in how they treat this issue

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Deviations from Claims Procedures – Standard of Review

- Standard of review for adverse benefit determinations is generally abuse of discretion or arbitrary and capricious where the decisionmaker has discretionary authority to interpret the plan's terms (*Firestone Tire & Rubber Co. v. Bruch* (1989))
  - Courts will generally defer to the decisionmaker's determination
- This deferential review may be lost if plan failed to follow claims procedures and can warrant de novo review
  - De novo – courts do not defer to plan's determination; claim is reviewed "anew"

"When an administrator engages in wholesale and flagrant violations of the procedural requirements of ERISA, and thus acts in utter disregard of the underlying purpose of the plan as well, we review de novo the administrator's decision to deny benefits" – *Abatie v. Alta Health and Life Ins. Co*., 458 F.3d 955 (9th Cir. 2006)

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Deviations from Claims Procedures – Standard of Review

- Loss of deferential review means there is a higher probability evidence outside of the administrative record will be admitted
- However, evidence outside of the administrative record may still be admitted even with a deferential standard of review (e.g., to analyze whether there is a conflict of interest – discussed later in the webinar)

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Administrative Record

- The evidentiary record put together by the claims administrator and appeals fiduciary in making its benefit determinations, including information submitted by claimant
- Includes documents from the filing of the original claim to the final denial of the appeal
- Includes information submitted during the claims and appeals process
- Includes any documents provided to the claimant during the claim and appeal process
- Includes internal documents such as those generated by the insurance company or claims administrator, such as reports and records

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Conflicts of Interests

- If court finds that the plan had a “conflict of interest” which impacted its benefit decision, then court may give less deference to the plan’s decision
- Conflict of interest is a real or apparent conflict between one’s fiduciary interests and one’s private interests
- Example:
  - Same entity is determining claims and paying the benefits – conflict between doing what’s best for the participant (according to the terms of the plan) and what’s best for the entity’s budget
- Given that there is generally an inherent conflict of interest, the goal is to minimize this conflict and ensure that the conflict does not impact benefit decisions

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Conflicts of Interest

- If there are procedural irregularities or deviations from claims procedures, then this can impact the conflict-of-interest analysis
  - E.g., not providing specific enough reasons for denying claim, not providing claimant with adequate opportunity to respond to administrator's new rationale for denying appeal
- Courts have allowed discovery where the standard of review is abuse of discretion to determine whether a conflict of interest exists
  - This can include the administrator's history of biased decision-making, evidence that the administrator's decision was biased for the case at hand, internal memoranda between the claim analyst and the administrator's in-house counsel

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Inadequate Denial Notices

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Inadequate Denial Notices

- General requirements for denial notices
  - Written in a manner calculated to be understood by the claimant
  - Specific reasons for denial, including reference to applicable plan provisions
  - Description of additional information necessary to complete the claim
  - Description of review (appeal) procedures
  - Statements regarding participants' rights
  - Right to sue following appeal denial
- There are additional requirements for denials involving group health plan benefits and disability benefits

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Inadequate Denial Notices

- Issues we see with denial notices
  - Claimant's arguments aren't addressed
  - Failing to cite to specific plan provisions relied upon in determining the claim
  - When new reasons relied upon in denying an appeal, failing to give the participant or beneficiary the opportunity to respond to those reasons
  - Not including information regarding the appeal process or including incorrect information

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Inadequate Denial Notices - Consequences

- Participants more likely to appeal denied claims
- Participants more likely to file lawsuits
- Courts more likely to adopt de novo standard of review, according no deference to the plan administrator's decision

"While a plan administrator need not address every piece of evidence submitted by a participant in support of a claim for benefits, [the insurer's] boilerplate statement in its final denial letter that [the participant] did not meet the Plan's standard of 'disability' fell far short of providing 'specific reason or reasons' for denying her claim for LTD benefits as required by ERISA."

Collier v. Lincoln, 53 F.4th 1180 (9th Cir. 2022).

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Failure to Provide Full and Fair Review

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Failure to Provide Full and Fair Review

- When a claimant appeals their denied claim, they must be afforded a “full and fair review”, which requires the following:
  - Determination is made by an appropriate named fiduciary
  - Opportunity to submit documents and written comments
  - Reasonable access to all documents, records, and other information relevant to the claim for benefits (will discuss later)
  - Consideration of all claimant’s materials
  - If appeal is denied, claimant must be provided with notice containing similar information to that required of an initial adverse benefit determination (e.g., specific reasons and supporting plan provisions for the denial)
- Additional requirements are imposed for appeals involving disability and group health plan benefits

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Failure to Provide Full and Fair Review

- Courts have held that ERISA requires a "meaningful dialogue" between the plan administrators and their beneficiaries in processing claims and appeals - *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461 (9th Cir. 1997)
- What does meaningful dialogue look like?
  - All the above on the prior slide
  - Engaging in good faith with the claimant – considering and addressing as many of the claimant's arguments as possible
  - As applicable, asking for more information from the claimant to make a reasoned decision

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Failure to Provide Full and Fair Review

- Issues specific to group health plans
  - Is the fiduciary who reviewed the appeal different than individual who decided the claim?
  - Has reviewer afforded deference to claim decision?
  - Did the reviewer consult with a health care professional who has appropriate training and experience in the field of medicine involved in the claim?
  - Did reviewer provide identity of medical or vocational expert whose advice was obtained on behalf of the plan (without regard to whether the advice was relied upon in the determination)?
  - Has the reviewer requested additional medical records from the claimant to assist in making a reasoned decision?

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Unclear Plan Terms or Communications

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When Plan Terms or Communications are Unclear

- Important questions we'll go over:
  - What happens when the official plan document differs from the SPD?
  - What provisions are there for changing plan terms, and how are those changes communicated?
  - What happens when participants are given misinformation verbally or in writing?

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When Plan Terms or Communications are Unclear

- Claims and appeals can arise when the plan's terms, including communications regarding the plan's terms, are unclear
- For example, issues can occur when there's a lack of clarity regarding benefit provisions, the plan's claims procedures, or when there is a conflict between the plan document and SPD

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Comparing Plan Documents and SPDs

- Plan Document:
  - Plan must be established and maintained pursuant to written document
  - Must contain certain provisions (e.g., named fiduciary, funding policy, amendment procedures, etc.)
  - Not required to be provided to participants unless specifically requested
- Summary Plan Description:
  - Document summarizing plan terms and benefits provided under plan
  - Must contain certain provisions (e.g., plan identifying information, plan's eligibility provisions, when benefits terminate, etc.)
  - Required to be provided to participants upon becoming covered under the plan and every 5 years if material changes are made

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Conflict Between Plan Document and SPD

- Issues can arise when there are conflicts between the terms of the plan document and SPD (e.g., plan document and SPD have conflicting timelines for submitting appeals)
- In *Cigna Corp. v Amara*, the Supreme Court held that the terms of the SPD are not enforceable as terms of the plan itself, in a lawsuit based upon ERISA Section 502(a)(1)(B), where the claimant is seeking to recover benefits, enforce rights, or clarify rights to future benefits *under the terms of the plan*
  - However, under ERISA Section 502(a)(3), where a claimant is seeking "appropriate equitable relief," the claimant may be entitled to the benefits as presented in the SPD, which conflicts with the plan document
- Important to ensure plan document and SPD are consistent with each other, but also need to have language in both documents saying the terms of the plan document control in the event of a conflict

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Plan Changes

- ERISA Section 104 provides a plan administrator must provide notice to participants regarding any “material” modifications to the plan
  - An SMM or updated SPD needs to be distributed within 210 days following the close of the plan year in which the amendment was effective
  - For group health plans, changes that result in a material reduction of benefits and services must be communicated within 60 days of the date the modification was adopted
- SMMs are also required to be distributed whenever there are changes in the required SPD information (e.g., claims procedures)

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Communications Regarding Plan Changes

- SMMs must clearly describe plan change (when it takes effect, who it applies to, etc.)
- SPDs and SMMs must be furnished in a way "reasonably calculated to ensure actual receipt of the material"
  - Hand-delivery, first-class mail easily satisfy this
  - Electronic delivery is permitted if certain requirements are met
- There is a DOL safe harbor for electronic delivery

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Communications Regarding Plan Changes

- When plan changes aren't communicated properly (e.g., participant doesn't receive SMM), some courts have held that plan changes aren't enforceable
  - *Platt v. Sodexo, S.A.,* (9th Cir. 2025): Court found that arbitration provision added to plan did not apply to claimant when claimant did not receive sufficient notice of the change
  - *Spinedex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc.*, 770 F.3d 1282 (9th Cir. 2014): Two-year limitations period for bringing lawsuit was not properly disclosed in SPD and was unenforceable where the limitations provision was located more than 30 pages after the provisions discussing coverage
- Important to determine whether claimants were notified of plan changes that impacted them, otherwise this can impact claim and appeal determinations

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Misinformation

- Claims and appeals often arise when claimants receive misinformation regarding the plan's terms
  - Usually this involves eligibility for benefits or the type/amount of benefits they can receive
- Can be provided verbally or in writing (e.g., inaccurate benefit statement, phone call with TPA or HR representative)
- Claimants will argue that they relied on the misinformation they received
- When reviewing claims and appeals where the claimant was provided misinformation, the decision must be made based on the terms of the plan, not the incorrect information the claimant received

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Misinformation – Equitable Estoppel Claims

- When claimants sue for benefits because they received misinformation, they will argue that the doctrine of equitable estoppel applies
- Under equitable estoppel, a party who relies on a misrepresentation should not be harmed as a result of the misinformation
- ERISA does not explicitly provide for "equitable estoppel" as a remedy for participants and beneficiaries
  - ERISA section 502(a)(3) states that participants, beneficiaries, or fiduciaries can bring civil actions "to obtain other appropriate equitable relief"
  - Equitable estoppel falls under "equitable relief", so nearly all courts recognize equitable estoppel claims under ERISA

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Misinformation – Equitable Estoppel Claims

Different circuits have developed different elements for equitable estoppel claims, but the following elements are required in the Ninth Circuit:

1. a material misrepresentation;
2. reasonable and detrimental reliance on the representation;
3. extraordinary circumstances;
4. the provisions of the plan at issue are ambiguous; and
5. the representations must have been made to the beneficiary involving an oral interpretation of the plan

There's been an increase in estoppel claims against ERISA plans

- However, it is difficult for claimants to succeed on these claims under ERISA because they must meet all elements

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Misinformation

- Why this matters – preventing misinformation can help prevent claims and appeals, and potentially litigation
- If claimant initiates the claim and appeal process due to misinformation they received, it's important that the denial letters clearly explain the plan's terms
  - i.e., explain how the plan's terms contradict the incorrect information they received
- The SPD should say that plan terms control and not oral representations

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Responding to Requests for Documents

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Requests for Documents Relevant to the Claim

- In order to provide a "full and fair review," plans must provide claimants "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"
- "Relevant" is defined to include documents relied upon in making the benefit determination or 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
  - i.e., the administrative record
- There is no explicit timeframe in which to provide these documents

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Requests for Documents under ERISA 104(b)(4)

- ERISA 104(b)(4) requires a plan administrator to provide to a participant or beneficiary upon written request a copy of the latest SPD, the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or *other instruments under which the plan is established or operated*
- Often there are disputes regarding the "other instruments"
- In the Ninth Circuit, an administrative service agreement does not constitute an instrument under which the plan is operated, etc.
- Penalties may be assessed by a court for failure to timely provide these documents (i.e., within 30 days)

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Requests for Documents – Administrative Record

- Courts differ in what they exclude from the administrative record
  - Some exclude any information submitted after claimant exhausts the plan's review procedures
  - Some exclude any information submitted after commencement of litigation
- As noted earlier, deviation from the DOL or plan's claims procedures can impact whether evidence outside of the administrative record is permitted to be brought into litigation

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Fiduciary Exception to 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)
- Thus, communications between a fiduciary and plan attorney may be subject to disclosure and admissible in court

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Fiduciary Exception to Attorney Client Privilege

- Generally, courts have held the fiduciary exception doesn't apply in several situations:
  - The fiduciary acts as "settlor" and not "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

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Use of AI

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Use of AI

- There has been an increase in the use of algorithms and artificial intelligence in deciding health benefit claims
- An issue is whether ERISA prohibits the use of AI in making claims decisions
  - When plans give discretionary authority to the claim administrator to interpret plan terms, how does AI fit into this?
  - Additionally, appeals must be heard by a named appeals fiduciary (which must be a “person”)

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Who is a Fiduciary?

- Under ERISA section 3(21), a person is a fiduciary with respect to an employee benefit plan if that person:
  - Exercises any discretionary authority or discretionary control with the respect to management of the plan or the plan's assets
  - Renders investment advice
  - Has discretionary authority or discretionary responsibility in administering the plan

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Use of AI – Kisting-Leung v. Cigna Corp.

- A recent federal district court case decided whether the use of AI in processing benefit claims constituted a breach of fiduciary duty under ERISA (Kisting-Leung v. Cigna Corp, 780 F. Supp. 3d 985 (E.D. Cal. 2025)
  - A group of participants in different employer-sponsored health plans filed a class action lawsuit against the plans' common claims administrator (Cigna) for wrongful denial of benefits and breach of fiduciary duty due to Cigna's use of AI to process benefit claims
  - Cigna was using an AI tool called "PXDX" that allowed Cigna to quickly review benefit claims for medical necessity
  - The plaintiffs sued Cigna, claiming its use of AI to process benefit claims was contrary to plan terms. Per plan terms, a medical director was supposed to process benefit claims.

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Use of AI – Kisting-Leung v. Cigna Corp.

- A motion to dismiss was filed by Cigna, in which they argued that they were acting within their discretionary authority in interpreting plan terms to use PXDX
  - Additionally, Cigna further argued that because a doctor oversaw the use of PX, Cigna complied with plan terms
- The court denied Cigna's motion with respect to the breach of fiduciary duty claims
  - "the court finds defendants' interpretation of the plan provision requiring determinations of medical necessity be made by a medical director—as allowing an algorithm to make the decision so long as a medical director pushes the button—conflicts with the plain language of the plan and constitutes an abuse of discretion"

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Use of AI

- With the increase in AI and other technologies in determining claims, we can expect to see an increase in litigation on this front
  - Delegating claim decisions to AI models can risk violating a fiduciary's duty to make plan decisions that are "solely in the interest of participants and beneficiaries"
- This case highlights the need for health plan sponsors to carefully review their vendor contracts regarding AI use

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Takeaways

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Takeaways for Plan Administrators

- Have clear claims procedures and ensure they are followed (e.g., timing)
- Clear plan terms are important – pay attention to drafting
- Communicate accurately about plan terms
- Denial notices need to adequately address claimant's arguments
- Use good judgment – demonstrate a willingness to hear claimant out
- Have the proper controls in place to lessen impact of conflicts of interests

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