TRUCKER ✦ HUSS

A PROFESSIONAL CORPORATION

ERISA AND EMPLOYEE BENEFITS ATTORNEYS

ERISA Claims & Appeals Procedures: Mastering the Full and Fair Review

Angel L. Garrett

Freeman L. Levinrad

Sarah T. Kanter

Topics

- Legal Framework
- Processing Claims and Appeals
- Benefits Litigation
- Limiting Liability Through Plan Design

Legal Framework

Why is This Important? – It's the Law

- ERISA Section 503 requires every employee benefit plan to:
  - (1) 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
  - (2) 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

Why is This Important – It's the Law

- Department of Labor regulations implement the above statutory language
- 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

Why is This Important? – Benefits Litigation

- "Deemed Exhaustion" 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

Claims Procedures – View from Thirty Thousand Feet

- A claim for benefits is made by a claimant (or authorized representative)
  - But is it actually a claim?
- Plan makes determination regarding claim and notifies claimant
  - Timing and content of notification dictated by the kind of claim
- Claimant (or authorized representative) files an appeal
- Plan makes determination regarding appeal and notifies claimant
- External review (Non-grandfathered group health plans only)
- Additional voluntary level of review (if provided for in plan)

Reasonable Claims Procedures – View from Thirty Thousand Feet

- Procedures comply with the requirements of DOL Reg. §2560.503-1, which include timing requirements, appeals procedures, and notice requirements
- SPD includes description of all claims procedures and the applicable time frames
- The claims procedures do not contain any provision, and are not administered to unduly inhibits or hampers the initiation or processing of benefit claims
- The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of a claimant seeking benefits or appealing a decision
- The claims procedures contain administrative processes and safeguards such that benefit claim determinations 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
- Additional requirements apply to group health plans and plans established and maintained pursuant to a collective bargaining agreement

Reasonable Claims Procedures – View from Thirty Thousand Feet

- To provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination, claims procedures MUST:
  - 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 (broad)
  - 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

Processing Claims and Appeals

Compliance with DOL Regulations AND Your Plan's Terms

- DOL Regulation, 29 CFR § 2560.503-1
- Benefit Claims Procedure Regulation FAQs
- Plan terms
  - They generally mirror DOL requirements, but not always
  - Plans can be more generous to participant – cannot be less generous
  - If your plan is more generous than the regulations, you must comply with your plan (*e.g.*, if the plan provides for a longer time period for filing an appeal, then the plan must comply with the longer period)

Is This a Claim?

- A question regarding eligibility for coverage under a plan unrelated to a claim for benefits is not governed by the DOL regulations.
  - The regulation does not govern casual inquiries about benefits or the circumstances under which benefits might be paid under the terms of a plan
  - Plan may want to document its own procedures for how to handle eligibility inquiries
- Regulations do not apply to a request for prior approval of a benefit or service, when such prior approval is not required under the terms of the plan.

Is This a Claim?

- Some plans will require claims to be filed on a specific form
  - Best practice: Have plan require claim to be in writing
- When to treat a dispute as a benefit claim?
  - Hypo: Participant dies, and plan determines that death benefits are payable to participant's former spouse pursuant to a beneficiary designation that was never revoked. Participant's children send an email to the plan administrator stating that the participant didn't intend anything to go to the former spouse and that they should receive the benefits, but that they will accept whatever the company decides. Benefit claim?

Who Determines Claims and Appeals?

- Different entities should make decisions at the different levels – initial vs. appeal level (example: plan administrator at claims level, plan committee at appeal level)
  - ERISA permits indemnification of fiduciaries
- Claims Level
  - Plan administrator may be able to delegate its authority to review claims to another entity or to specified individuals
  - To limit fiduciary liability, employees who handle claims administration should have limited discretion
    - Work with independent advisors
- Appeals stage
  - Fiduciary who determines appeals should have greater authority (e.g., ability to establish precedent)

Different Kinds of Claims are Subject to Different Rules

- Retirement Plans
- Welfare Plans
  - Group Health Plan
  - Disability
  - Other

Retirement Plan Claims & Appeals –Timeframes

- 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

Group Health Plan Claims – Timeframes

- Urgent Care Claim
  - Claims where the application of the time periods for making non-urgent care determinations would (a) seriously jeopardize the claimant's life, health or ability to regain maximum function or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim
  - Plan must make decision **as soon as possible** but not later than **72 hours** (no extensions)
- Pre-Service Claim (non-urgent)
  - A claim for a benefit with respect to which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care
  - 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)

Group Health Plan Claims – Timeframes

- Post-Service Claim
  - Any claim that is not an urgent or pre-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
  - Involves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments
  - 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.
- Under ACA, an adverse benefit determination includes rescission of coverage (retroactive)

Group Health Plan Appeals – Timeframes

- 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

Group Health Plan Appeals – Timeframes

- 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

Requirements Added by ACA (for Non-Grandfathered Group Health Plans)

- Provide claimants with new or additional evidence or rationale, and a reasonable opportunity to respond to it, before making a final decision on the claim;
- Ensure that claims and appeals are adjudicated in an independent and impartial manner;
- Provide detail in all claims denial notices on the claim involved, the reason for denial (including the denial code and meaning), any available internal and external appeals processes, and consumer assistance information;
- Provide, on request, diagnosis and treatment codes (and their meanings) for any denied claim;
- Provide notices in a culturally and linguistically appropriate manner;
- Allow claimants to begin the external review process if the plan fails to follow the internal claims requirements (unless the plan's violation is minimal);
- Provide for external review of claim denials by an independent party. The external review process used by the plan depends on whether the plan is self-funded or provides benefits through an insurance company

Disability Benefit Claims

- Disability benefit claims are requests for benefits where **the plan** makes a determination of disability to decide the claim
  - If benefits are conditioned on someone other than the plan making a disability determination (*e.g.*, the Social Security Administration) then not a disability benefit claim.
- Example One: pension plan makes own finding of disability to determine whether participant is eligible for disability benefits → **disability benefit claim**
- Example Two: pension plan conditions eligibility for disability benefits on a determination from the Social Security Administration that the participant is disabled → **NOT a disability benefit claim**
- Changes effective in 2017 made procedures for disability claims similar to procedures for group health plans (but not identical)

Disability Benefit Claims – Timeframes

- 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)

Other Welfare Benefit Claims – Timelines

- 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)

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
- Eliminate bias to the extent possible
- Make sure all relevant documents are gathered and considered
- Rely on signed plan documents

Best Practices for Reviewing Appeals

- Generally, it would be best not have the same named fiduciary review the initial claim and review the appeal
- When new reasons are relied upon in denying an appeal, give the participant or beneficiary the opportunity to respond to those reasons

Consistency is Key

- 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 determination

Handling Typical Head-Scratchers

- Incorrect information was provided to claimant during claims process
- Claim was received but not timely processed
- Competing claims (e.g., death benefits)
- Administrative mistakes

Document Requests

- During this process (and at times after the conclusion of this process), the claimant may seek documents related to his/her claim
- 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)

Document Requests

- DOL Regulation, 29 CFR § 2560.503-1(h)(2)(ii) provides that a "full and fair review" includes that 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"
  - *Odle vs. UMWA 1974 Pension Plan,* 777 F. App'x 646 , *2019 WL 2539260* (4th Cir. June 20, 2019)
- Relevant defined under 29 CFR 2560.503-1(m)(8) 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"

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

Checklist for 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

Checklist for Initial Claim Denial Letter

- 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)

Drafting Claim and Appeal Determination Letters – Best Practices

- Be forthcoming about past mistakes
- Address all of claimant's arguments and points, even if "frivolous"
- Consider and write to your audience
  - Writing to claimant or attorney? What is claimant's general level of education?

What Happens After the Appeal Denial?

- Claimant can either accept the decision or proceed to litigation

Benefits Litigation

Key Considerations Before Heading Into Litigation

- Exhaustion requirement
- Standard of 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

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)

Limiting Liability Through Plan Design

Limiting Liability Through Plan Design

- When designing ERISA plans, plan sponsors can draft certain types of plan provisions that may reduce litigation exposure and limit liability if a lawsuit is brought by including 4 key provisions in their plans:
  - 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)

Pros

- Provides speedier resolution
- Flexibility and customized dispute resolution rules not centered around statutory and case law rules and principles
- Lower cost to utilize neutral decision-maker
- Ability to select the arbitrator (can choose an arbitrator who has the knowledge and experience pertaining to the issues involved in the dispute)
- Class action waivers are enforceable

Disadvantages of Arbitration

- Appellate review very limited; arbitration awards are rarely vacated
- Claims regulations prohibit the use of mandatory arbitration of benefits claims involving health and disability plans
- Arbitrators not bound by statutory and case law and therefore they may issue an award based upon perceptions of fairness or equity and not necessarily on the evidence or rules of law

Arbitration Provisions – Drafting Considerations

- At a minimum, plan drafters should provide notice of any arbitration clause and its key provisions in the SPD
- Include the entire arbitration provision in the SPD
- Include the full arbitration provision language in the plan document
- Refer to class action waiver in all plan documents, including the SPD

Assignment Clauses

- Assignment is related to whether a party has standing to bring a lawsuit as an ERISA beneficiary or participant
- 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
- Courts have upheld such language. *See e.g.*, *Spindex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc.*, 770 F.3d 1282 (9th Cir. 2014)

DB Healthcare v. Blue Cross Blue Shield of Arizona, 852 F.3d 868 (9th Cir. 2017)

- This decision resolves two cases - one from the District of Arizona and the other from the Eastern District of California
- With respect to the Arizona case, the court held that DB Healthcare lacked standing because it did not hold valid assignments and the governing plans contain anti-assignment clauses that override the purported assignments
  - "The benefits contained in this plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in party, in any manner or to any extent, to any person or entity. . . ."
- As for the California case, the court held that the claims asserted by the providers against the insurers fell outside the scope of the assignment forms they received from the plans' participants/ beneficiaries (*i.e.,* assignments limited to collecting payments)

Contact

Trucker ✦ Huss, APC

One Embarcadero Center, 12th Floor

San Francisco, CA 94111

(415) 788-3111

www.truckerhuss.com

Angel L. Garrett - agarrett@truckerhuss.com

Freeman L. Levinrad - flevinrad@truckerhuss.com

Sarah T. Kanter - skanter@truckerhuss.com

Please register for our next Trucker Huss Webinar:

"Multiple Employer Plans – The Latest Word on MEPs and PEPs"

Date: December 12, 2019 - 10:00 AM PST / 1:00 PM EST

Description: Interest in multiple employer plans (MEPs) continues to grow. As directed by the President, the Department of Labor has issued final regulations permitting employer associations and PEOs (professional employer organizations) to sponsor MEPs. Concurrently, the IRS has issued proposed regulations providing MEP sponsors with a mechanism to deal with the "one-bad-apple rule" — so they can avoid plan disqualification as a result of a defect caused by a single participating employer.

Congress also continues to give serious consideration to legislation that would significantly expand the reach of MEPs by creating a new type of plan referred to as a pooled employer plan (PEP).

Visit www.truckerhuss.com/events to register

Disclaimer

- These materials have been prepared by Trucker ✦ Huss, APC for informational purposes only and constitute neither legal nor tax advice
- Transmission of the information is not intended to create, and receipt does not constitute, an attorney-client relationship
- Anyone viewing this presentation should not act upon this information without first seeking professional counsel
- In response to IRS rules of practice, we hereby inform you that any federal tax advice contained in this writing, unless specifically stated otherwise, is not intended or written to be used, and cannot be used, for the purpose of (1) avoiding tax-related penalties or (2) promoting, marketing or recommending to another party any tax-related transaction(s) or matter(s) addressed herein