Update on ERISA Claims Administration and Litigation

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General Overview

- ERISA Section 503 grants the right to a “full and fair review” of a claim denial, and mandates that denials must set forth the reasons for the denial in a manner “calculated to be understood by the participant”
- Review process has both procedural and substantive components
Basic Rules

- 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;
  
  • Describe what **internal rules, guidelines, or protocols** the administrator relied on in making the adverse decision;
  
  • Afford a reasonable opportunity for a **full and fair review** by “the appropriate named fiduciary” of the denial decision.
Key Issues

• Time frame for submitting a claim
• Time frames for initial decisions/appeals
• Steps for a plan administrator to take when a claim is received
• Steps for a claimant to take to appeal an adverse benefit decision – what to include in the request for review
• General rules to ensure a “full and fair review”
• Exhaustion requirements
One Other Type of Claim: “Concurrent Care” Decisions

- Any termination or reduction in previously approved healthcare benefits is treated as an adverse benefit determination.
- Plans must provide notice of a proposed termination or reduction “sufficiently in advance” of such termination or reduction.
- Claimants have the right to appeal before the termination or reduction takes effect.
Disability Claims

Claim: Disability claims (e.g., long-term disability benefits; disability pension benefits) must be decided within 45 days of receipt (two 30-day extensions are available where necessary due to matters beyond the administrator’s control).

Appeal: Appeals of denied disability claims must be adjudicated within 45 days of receipt (45-day extension available where special circumstances are present).
Appealing an Adverse Benefit Decision

- Required Procedures for Claimants to appeal adverse benefit determinations
- Appeal to “an appropriate named fiduciary”
- For a “full and fair review of the claim and the adverse benefit determination”
- Different requirements for group health plans, disability plans
Appealing an Adverse Benefit Decision

- Appeal procedure becomes forum for establishing the record
- Claimants should ensure all relevant information presented
- Administrators should ensure all procedures documented, including issues related to any potential conflicts of interest
General Rules for Full and Fair Review

- Claimants must have:
  - At least 60 days to appeal; 180 days if group health plan or disability plan;
  - Opportunity to submit additional documents, comments, information;
  - Opportunity to review claim file and to obtain information “relevant” (as defined in 29 CFR §2560.503-1(m)(8)) to claim, upon request—no charge;
  - An appeal process under which all claimant-submitted information is reviewed and considered
Health and Disability Plans: Full and Fair Review Standards

- Claimant must have:
  - At least 180 days to appeal denied claims;
  - Person adjudicating the appeal must be different than the person who initially denied the claim, and not subordinate to the initial reviewer;
  - No deference to initial review—de novo review.
Appealing Adverse Benefit Decision: Timing

- Several rules regarding how much time can be taken to review appeal, generally 60 days, with possible extensions
- Different time frames for pre-service health claims, urgent health claims and disability claims
- Different time frames for plans with boards of trustees that meet quarterly, such as multiemployer plans
Notice Requirements Generally

Notice of adverse benefit determination must include:

- Specific reason
- Reference to relevant plan provisions
- Right to receive documents, information upon request and free of charge
- Right to bring suit, voluntary appeal rights
Notice Requirements for Health and Disability Plans

- If health or disability plans must also include:
  - any internal rules, guidelines relied upon or statement that such provided on request
  - Additional information if based on medical necessity or similar exclusion or limitation
  - Statement of possible alternative dispute resolution options
Claimant’s Steps for Appealing an Adverse Benefit Decision

1. Calculate and calendar date request for review is due.
   - Depends on type of claim; i.e. disability claim is 180 days
   - Best practice: send in the request for review within 180 days of date of the denial letter or else document when the claimant received it.
   - Track the package so you know when the administrator received your request for review
Claimant’s Steps for Appealing an Adverse Benefit Decision

2. Send out a document request to the plan administrator and the insurance company

- Ask for
  - The Plan
  - 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
Claimant’s Steps for Appealing an Adverse Benefit Decision

3. Review the Plan documents, looking for relevant provisions

- For Disability Claims:
  - Definition of disability (“own occupation” vs. “any occupation” and whether % of pre-disability earnings is a factor)
  - Grant of discretion
  - Offsets (may make it unfeasible to take a claim)
  - Whether STD is a prerequisite to LTD
Claimant’s Steps for Appealing an Adverse Benefit Decision

4. Prepare the Request for Review
   - For Disability Claims
     a. Medical records
     b. “Objective” evidence
     c. Letters from all relevant medical providers
     d. Declarations (claimant, friends, co-workers, etc.)
     e. Functional Capacity Evaluations and Independent Medical Examinations
     f. Vocational Analysis
     g. Medical literature
Exhaustion of Benefit Appeals Procedure

- Generally required before filing suit
- Exceptions
  - Futility
  - Denial of meaningful access
  - Irreparable harm
Consequences of Plan’s Failure to Comply with Regulations

- Deemed exhaustion
- Loss of deference
Overview of ERISA’s Civil Enforcement Provisions

- Governed by Section 502, 29 USC § 1132
- (a)(1)(A) – Penalties for failure to provide documents
- (a)(1)(B) – Claims for benefits under terms of plan
- (a)(2) – Breach of fiduciary duty brought on behalf of “plan”
- (a)(3) – Violation of ERISA (including breach of fiduciary duty) or terms of plan brought by individual
Overview of ERISA’s Civil Enforcement Provisions

- (a)(4) – By the Secretary for violation of IRS’s Revenue Registration Statement
- (a)(5) – By the Secretary for violation of ERISA
- (a)(6) – By the Secretary to collect specified civil penalties
- (a)(7) – By a State to enforce compliance with qualified medical child support orders
- (a)(8) – By the Secretary and others to enforce defined benefit plan funding notice requirements
- (a)(9) – By the Secretary or an individual in connection with an insurance contract purchased as part of plan termination
- (a)(10) – By an employer to compel the plan sponsor of a multiemployer plan to comply with terms of a funding improvement or rehabilitation plan
Claims for Benefits

- Section 502(a)(1)(B)
  - A civil action may be brought by a participant or beneficiary
    - to recover benefits due to him under the terms of his plan,
    - to enforce his rights under the terms of the plan, or
    - to clarify his rights to future benefits under the terms of the plan
The “Catch-All” Provision

- Section 502(a)(3)
  - A civil action may be brought by a participant, beneficiary, or fiduciary
    - to enjoin any act or practice which violates any provision of this title or the terms of the plan, or
    - to obtain other appropriate equitable relief
    - to redress such violations or
    - to enforce any provisions of this title or the terms of the plan
Breach of Fiduciary Duty to Make Good Losses to the Plan

- **Section 502(a)(2)**
  - A civil action may be brought by the Secretary, participant, beneficiary, or fiduciary for appropriate relief under Section 409

- **Section 409**
  - A fiduciary that breaches any of its fiduciary duties is personally liable to make good to such plan any losses resulting from the breach
Remedies Under 502(a)(1)(B)

- Benefits wrongfully denied
- Declaratory judgment that a participant or beneficiary is entitled to plan benefits
- Injunction to enjoin the plan administrator from improperly refusing to pay benefits in the future
Remedies Under 502(a)(3)

- “Appropriate Equitable Relief”
  - Restitution
    - Must be in equity, ordinarily in the form of a constructive trust or an equitable lien, where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession (Great West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002))
Remedies Under 502(a)(3)

- “Appropriate Equitable Relief”
  - Backpay
    - A request for backpay, standing alone, is compensatory, legal remedy, not equitable (Millsap v. McDonnell Douglas, 368 F.3d 1246 (2004))
    - But, in theory, may be available if incidental to reinstatement
Remedies Under 502(a)(3)

- Obtaining lost policy proceeds that would have accrued but for a fiduciary’s breach is a form of make-whole damages, not equitable relief (Amschwand v. Spherion Corp., 505 F.3d 342 (5th Cir. 2007))

Remedies Under 502(a)(3)

- Reinstatement
  - Reinstatement of health coverage is equitable relief (Phelan v. Wyoming Associated Builders, 2009 WL 2343739 (10th Cir. 2009))
  - Court order to amend a plan to include plaintiffs as employees entitled to plant closure benefits not equitable relief (Alexander v. Bosch Automotive Systems, 2007 WL 1424299 (6th Cir. 2007))
Remedies Under 502(a)(3)

- Reinstatement
  - In order to be “appropriate,” the reinstatement relief sought must relate to the breach of fiduciary duty
Remedies Under 502(a)(3)

- Reinstatement
  - Reinstatement into plan, returning employees to position occupied before a spinoff, not appropriate because sponsor’s decision to spin off is not fiduciary in nature (Paulsen v. CNF Inc., 2009 WL 723996 (9th Cir. Mar. 30, 2009))
  - Retroactive reinstatement of all employees into a health plan was appropriate where the employer’s coverage was terminated in order to avoid payment of a large health claim (Phelan v. Wyoming Assoc’d Builders, 2009 WL 2343739 (10th Cir. July 31, 2009))
Remedies Under 502(a)(2)

- Must be “appropriate” but is not limited to “equitable” relief
- Relief must inure to the benefit of the plan as a whole, not to an individual (Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985))
- Relief is available for fiduciary breaches that impair the value of plan assets in a participant’s individual account (LaRue v. DeWolff, Boberg & Assocs., Inc., 128 S. Ct. 1020 (2008))
Remedies Under 502(a)(2)

- Relief must go to the plan
- Where plan was distress terminated and PBGC became the trustee of the defunct plan, plaintiffs had no Article III standing because any possible recovery would go to the PBGC, not the plan (Paulsen v. CNF Inc., 2009 WL 723996 (9th Cir. Mar. 30, 2009), but see Wilmington Shipping Co. v. New England Life Ins. Co., 496 F.3d 326 (2007) (holding the opposite))
Relief Not Available Under ERISA

- No extracontractual damages
- No punitive damages
- No pain and suffering
- No consequential or compensatory damages
No Remedy At All?

- The “regulatory vacuum” of ERISA
  - Because the Court has coupled an encompassing interpretation of ERISA's preemptive force with a cramped construction of the “equitable relief” allowable under §502(a)(3), a “regulatory vacuum” exists: Virtually all state law remedies are preempted but very few federal substitutes are provided.” (Aetna Health Inc. v. Davila, 542 U.S. 200 (2004) Ginsburg, J., concurring)
In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Court held that when a plan confers discretion to the administrator or fiduciary to determine eligibility for benefits or to construe the terms of the plan, benefit determinations are reviewed under an “arbitrary and capricious” or “abuse of discretion” standard.
Standard of Judicial Review When There is a Conflict of Interest

- In Met. Life Ins. Co. v. Glenn, 128 S. Ct. 2343 (2008), the Court held that the presence of a conflict of interest does not change the abuse of discretion standard of review but is rather just one factor among the several different considerations that the Court will take into account in determining whether the plan administrator abused its discretion.
Implications of MetLife v. Glenn

- What is the internal conflict?
- When is discovery available beyond the administrative record?
- Plaintiff’s interests and how do you pursue it?
- Administrator’s interests and how do you protect it?
Post-Glenn cases

- See e.g., Denmark v. Liberty Life Assurance Co. of Boston, 566 F.3d 1 (1st Cir. 2009) (holding that conflict-oriented discovery may be permitted if the plan administrator has failed to detail its procedures).
- Estate of Schwing v. The Lilly Health Plan, 562 F.3d 522 (3d Cir. 2009) (rejecting the “sliding scale” standard of review post-Glenn).
Post-Glenn cases, cont’d

- Delisle v. Sun Life Assur. Co., 558 F.3d 440 (6th Cir. 2009) (clarifying that conflict of interest may still exist when plan administrator is an insurance company, not the employer/plan sponsor).

- Marrs v. Motorola, ---F.3d---, No. 08-2451, 2009 WL 2477650 (7th Cir. August 14, 2009) (criticizing Glenn as a “rudderless balancing test” and noting “[i]t is not the existence of a conflict of interest—which is a given in almost all ERISA cases—but the gravity of the conflict, as inferred from the circumstances, that is critical.”).
Circumstances Giving Rise to Overpayments

- Pension
- In-service distributions
- Incorrect benefit calculations
- Mistaken QDRO processing
- Violation of suspension of benefits rules
- Health
- Eligibility and other processing mistakes
- Workers’ compensation covered claims
- Subrogation rights ignored
- Failure to notify fund of a divorce
Fiduciaries’ Responsibility to Recover Overpayments

- General Fiduciary Responsibility Provisions
- Section 404(a)(1)(A)
- Section 404(a)(1)(D)

- Prohibited Transactions

- Pension Plan Tax Qualification
Recoupment Through Benefit Offset Fiduciary Responsibility

- Responsibility and Ability to Offset
- DOL Opinion Letter 77-32A (April 4, 1977)

- Inapplicability of Anti-Alienation Prohibition
- 26 C.F.R. §1.401(a)-13(c)(2)(iii)

- Contractual Right Under Plan Provisions
- Northcutt v. GM Hourly-Rate Employees Pension Plan, 467 F.3d 1031 (7th Cir. 2006)
Limitations on Recoupment Through Offset

- Plan Document/Participant Hardship

- Ability to Forego Recovery
- DOL Opinion Letter 77-08 (April 4, 1977)

- Multiemployer Suspension of Benefits
- 29 C.F.R. § 2530.203-3(b)(3)
Recoupment Through Benefit Offset
Pension Plan Tax Qualification

- IRS Revenue Procedure 2008-50 (September 2, 2008)
Recoupment By Lawsuit

- Section 502(a)(3) Claim for “Equitable Relief” to Enforce the Plan
- Limitations on Relief
Recoupment By Lawsuit

- Recovery Through Equitable Relief
- Sereboff v. Mid Atlantic Medical Services, Inc.,
- Creation of Equitable Claims Through Plan Documents
Recoupment Against Third Parties

- Offsets Against Future Payments To Health Care Providers
- Claims Against Plan Providers Such As Third Party Administrators
- Claims Against Banks-- Forged Endorsements
COBRA

- COBRA continuation coverage is available to participants and qualified beneficiaries who lose health care coverage upon the occurrence of a qualifying event—
  - Termination of employment
  - Reduction in hours
  - Divorce
  - Death
COBRA

- Under the American Recovery and Reinvestment Act of 2009, the COBRA premium has been subsidized for participants who suffer the qualifying event of termination of employment and reduction in hours which result in the loss of health care coverage.
COBRA

- Types of plans covered.
- Medical, dental, vision, prescription drug, HRAs and certain EAPs.
- Certain retiree plans.
- Multiemployer health plans.
COBRA

- Assistance eligible individuals.
- Qualified beneficiary.
- Elected COBRA.
- Qualify event is an involuntary termination of employment 9.1.2008 to 12.31.2009.
Termination of Employment Includes—

- Termination due to independent exercise of employer authority, without explicit or implicit employee request, where employee willing and able to continue.
- Retired or fired.
- Voluntary severance followed by involuntary severance.
- Resignation after material employment location change.
Termination of employment also includes—

- Employer’s action to end employment of individual absent due to illness or disability.
- Failure to renew contract.
- Layoff with recall rights, temporary furlough, lock out or other suspension of employment with healthcare coverage loss.
- Military reservists called to active duty.
Participants are permitted to remit 35 percent of the plan premium, and the employer subsidizes the balance.

The employer receives a tax credit for the subsidized portion of the premium upon filing a Form 941 with the IRS at the end of the year.
COBRA

- What happens if a subsidy request is denied?
- Appeal to DOL or DHHS
- DOL/ COBRA
- HHS/ Government plan or state insurance law.
State Prohibitions of Discretionary Clauses

- The National Association of Insurance Commissioners have issued a model act to prohibit discretionary clauses.
  - “This model helps ensure that health insurance benefits and disability-income protection coverage are contractually guaranteed, and helps avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due.”
States that have adopted policies against discretionary clauses

- California
- Hawaii
- Indiana
- Illinois
- Maine
- Michigan
- Minnesota
- Montana
- New Jersey
- New York
- Oregon
- Utah
Michigan Rule Upheld

- Michigan rule prohibits insurers and nonprofit healthcare corporations from issuing, advertising, or delivering a policy that contains a discretionary clause.
- Sixth Circuit affirmed W.D. Mich. Decision that the rule regulated insurance.
- The court further held no conflict preemption because the rule does not create an alternate enforcement mechanism.
- (American Council of Life Insurers v. Ross, 558 F.3d 600 (6th Cir. 2009))
Utah Rule Preempted

- D. Utah determined the Utah prohibition applies only to the administrative function of interpreting insurance policies.
- Because the Utah rule does not substantially affect the risk pooling agreement, the court held that it did not regulate insurance and therefore was preempted by ERISA.
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