

**HEALTH PLAN**  
**ADMINISTRATION AND**  
**CLAIMS ISSUES**

## **FREQUENTLY ASKED QUESTIONS ON BENEFIT CLAIMS PROCEDURE**

An important and fundamental part of claim litigation is the claims review process itself.

What happens in the claims process lays the immutable groundwork for what comes later.

Three of the most important effects of an inadequate review process are:

1. The Plan's treasured "abuse of discretion" standard of review may be lost if it does not afford the claimant a "full and fair review;"
2. Most courts will review only the evidence made available during the claims review process but if the claimant was not given a fair opportunity to present such evidence, the court may take such additional evidence itself. If the review process was fair, the claimant normally will be barred from presenting any additional evidence.
3. As with additional evidence, many courts, following an adequate review process, will not consider arguments or theories not advanced during claims review. An inadequate review process will open the door to those additional arguments and theories.

### 1. **THE LAW**

#### A. **The Statute**

ERISA §503 says:

The plan must:

- (1) Clearly explain the specific reasons for denial.
- (2) Give the participant the right to appeal that decision.
- (3) Provide for "full and fair review" of the claim on appeal.

The Supreme Court reminds us that ERISA expresses "the need for prompt and fair claims settlement procedures."

ERISA has no statutory requirement that a claimant must exhaust administrative remedies. However, that requirement was created, and has been uniformly enforced, by the courts. Courts have imposed the exhaustion of remedies requirement:

- (1) To uphold Congress's desire that ERISA trustees be responsible for their actions, not the federal courts.
- (2) Provide a sufficiently clear record of administrative action if litigation should ensue.
- (3) Assure that any judicial review of fiduciary action (or inaction) is made under the arbitrary and capricious standard, not de novo.

**B. The Regulations**

ERISA requires all plans to establish a reasonable claims procedure and explain that procedure in the Summary Plan Description, including how to file a claim and time limits for claims and appeals.

The claims procedures cannot "unduly inhibit or hamper" the filing of a claim – such as the payment of a fee or costs. This is especially important in the case of a plan that provides some sort of ADR, for the plan will have to pay the entire expense of such a procedure.

The procedures must contain "administrative processes and safeguards" to assure that determinations are in accordance with plan documents and that the plan terms are applied consistently to similarly situated claimants.

The regulations say the claimant is entitled to "**relevant**" documents. "Relevant" is specifically, and broadly, defined. In §503-1(m)(8), relevant documents are not only those considered, but also those "submitted, considered, or generated." In addition, a claimant is entitled to those documents that demonstrate compliance – that the plan has been applied consistently to similarly situated claimants. "Relevant documents" includes the claimant's own medical records.

(1) **The Initial Claims Procedure**

A claims procedure:

1. Must be described in the summary plan description.
2. Cannot contain, or be administered in such a way as to contain, unduly burdensome processing procedures.
3. Must provide for timely notifying of participants (in writing) of time limits in which a notice of claim denial must be furnished, time limits for filing a request for review, and time limits applying to decisions on review.
4. Comply with the standards for notice of claims denial and review procedures also set out in the regulations.

And the Plan contain safeguards to assure that decisions are made consistently and fairly.

The Plan can establish "reasonable" requirements for the filing of initial claims. If no such procedures are established, claims shall be deemed filed when a written or oral communication, reasonably calculated to communicate a "claim" is brought to the attention of the person(s) usually in charge of such claims or their employees (or to the insurance company).

A "claim for benefits" is a request for benefits made in accordance with the plan's reasonable procedures. Presumably, if there are no such procedures, then it would be any request for benefits.

In Q & A's A-3, the DOL submitted that an inquiry about eligibility was not a claim and the claims procedures were not applicable. But if a claim for benefits were made and denied on the basis of lack of eligibility, the claims procedures were required to be followed.

A-4 says that where a request for prior approval of a medical claim is made, where no such approval is required under the plan, then the claims procedures need not be followed.

A-5 says that casual inquiries about benefits are not claims and the plan need not follow the claim procedures with respect to them. However, if there is a basis for believing that the inquiry is about a pre-serve claim, the plan is obligated to tell the participant that the inquiry does not follow the plan procedures.

(2) **Notice of Claim Denial**

The “default” rule – essentially that which applies now only to pension plans, is that a denial must be sent within 90 days, still allowing the plan to give itself an extension of 90 additional days.

The denial notice must contain the reasons for the denial, reference to specific plan provisions on which the denial is based and a description of additional information needed to perfect the claim and why that information is needed. The denial must also have a description of the plan’s review procedure including the claimant’s right to bring a civil action if there is an adverse determination on review.

The review procedures of which the claimant must be notified must provide:

- (a) A minimum of 60 days to appeal.
- (b) The opportunity to submit comments, documents and information in writing.
- (c) Provide the claimant copies of all “relevant” documents free of charge.
- (d) Provide that the claimant’s information shall be considered even if not considered during the initial claim evaluation.

For group health plans and plans providing disability benefits, additional information must be provided with an adverse benefit determination.

**First**, if there is reliance on an internal rule, guideline or protocol, the claimant must be told of that and given a copy, or have a copy made available. The plan may not use a boilerplate “we may have relied on . . . “ **Q & A’s C-16**. Even if the protocol was developed by a third party, who claims proprietary reasons for not revealing it, the use of it, even the mere review of it, allows access to the claimant.

**Second**, if the denial is based on issues of medical necessity, experimental treatment or “similar exclusion or limit” the claimant must be given or offered the scientific basis for that decision.

(3) **When**

Under the new regulations, health and disability claims have new time limits within which they must be decided and within which appeals must be filed and decided. Because of there now being essentially six different kinds of claims, the various time limits will be discussed together organized by the type of claim.

With respect to these types of claims, you will notice that if the claimant has not provided sufficient information, the plans' response time is tolled. In many cases, the plan may require the claimant to submit to a medical examination. In Q & A's C-4, the DOL, said that the time from the request and the time of the exam may be included in this tolling time.

(4) **Post-Service Claims**

(a) **Initial Claims Review:**

A post-service claim must be decided within 30 days after receipt of the claim by the plan. The plan administrator may self-extend the review period for an additional 15 days. The plan administrator must notify the claimant within the time frame of the reason for the extension and the date by which the plan expects to render its decision. If the plan cannot render a decision within 30 days because the claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan, the notice of extension must describe the specific information needed to complete the claim. The claimant must be given at least 45 days from receipt of the notice to provide the required information. The plan has 30 days from the date of receiving the claimant's information to render its decision.

(b) **Appeal**

The claimant must be given 180 days to appeal an adverse decision. An appeal must be decided by the plan within 60 days after receiving the request for review. If the plan requires two levels of appeal, the decision of any one level must be made within 30 days after receipt of the claimant's request for review.

(c) **Participant Appeals**

**First**, a plan cannot require more than two levels of mandatory appeal procedures. Here, the regulations are explicit and, because these provisions only apply to health and disability plans, as one of the appeal levels, a plan may require mandatory, but not binding arbitration. Q & A's D-6.

**Second**, a plan may allow additional voluntary levels of appeal. If it does, the plan cannot claim that the failure to engage in such voluntary appeals is a failure to exhaust administrative remedies. Why the regulations felt the need to set this out is unclear. Were it otherwise, it would not be a "voluntary" level of appeal.

Further, if a claimant engages in a voluntary appeal, the plan must agree that any statute of limitations or other defense based on timeliness, is tolled “during the time that any such voluntary appeal is pending.” This provision is most problematic for claimants for the clear inference is that the statute of limitations is not tolled during mandatory appeals.

**Third**, the plan must give the claimant sufficient information about the voluntary appeals procedures to enable the claimant to make an informed judgment about whether to engage in them. This includes information about the process for selecting the decision-maker and any circumstances that may affect the impartiality of the decision-maker. A voluntary appeal procedure may include binding arbitration – participation in which of course is voluntary.

**Fourth**, as with mandatory appeals, no costs or fees may be required of the claimant.

**Fifth**, with respect to group health plans and plans providing disability benefits:

- the review on appeal must not afford deference to the initial adverse benefit determination.
- the reviewer on appeal must be “an appropriate named fiduciary” who is neither the individual making the initial determination nor a subordinate of that individual.
- if there are two appeals, the second reviewed again must not be the supervisor of the previous reviewer, nor may she give deference of the previous reviewer. **Q & A’s D-2.**
- if the denial was based on a medical judgment “including” determinations of medical necessity, experimental or investigational treatments, the fiduciary shall consult with a health care professional with appropriate training and experience in that particular field of medicine.
- This consultant cannot have been involved in the initial denial, nor the subordinate of anyone involved in the initial denial. However, the fiduciary is not bound by the opinion of the consultant, but need only consider it as a factor. **Q & A’s D-8.**
- the plan shall identify all medical and vocational experts who were consulted without regard to whether their advice was relied upon. **Q & A’s D-9.** Further, the Plan must reveal the name of the actual reviewer, not just the company for whom the reviewer works. **Q & A’s D-10.**

The notice of denial on appeal must contain the same information as the initial denial, including internal rules, guidelines and protocols, and the scientific or medical basis for decisions based on medical necessity or experimental determinations. Even if they are proprietary. **Q & A’s C-17.**