ERISA Claims Regulations, the Old, the New, and the "New New," Part I

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Many clients get their health insurance, life insurance, disability and similar insurance at work. For most clients, that means their insurance falls under ERISA[1], and any dispute is covered by federal ERISA law and not state insurance or contract law.

ERISA benefits claims have unusual procedures when they are litigated and also have specific rules that must be followed before someone can sue to recover the denied benefits. Two important examples of special rules under ERISA are that a claimant must "exhaust" administrative claims remedies with the insurance company[2] before the case can go to court (almost always federal court) and that a court will usually only consider evidence related to the claim that was first presented to the insurance company during the claims process.

Attorneys who fail to recognize that their client's claim is an ERISA claim, or who do not understand the requirements of ERISA, might miss issues crucial to the success of their client's case in court. According to a law review article exploring some of the statistics of ERISA litigation,[3] looking at the period 2006-2010, approximately 30% of cases subject to ERISA were originally filed in state court, and 80% of those did not cite to ERISA, implying that in 25% of all the cases filed in court the plaintiff's attorney did not realize he or she was handling an ERISA case.

Attorneys who help clients who have been denied benefits offered through work must understand when ERISA applies. In those cases when ERISA applies, attorneys must understand the ERISA claims regulations[4] that govern what an insurance company can do, and what rights a claimant has during the "administrative claim" process that is required before an ERISA claim can be taken to court.

This article is the first of a two-part series that will help attorneys understand their clients' obligations and rights under the ERISA claims regulations, what an attorney must do under the regulations to exhaust a claim, and what an insurance company must do during that process. The second article will discuss changes in the claims regulations that went into effect in 2018 that are just starting to apply to claims.

What are the General Rules of Exhaustion?

Before digging too deep in the specific regulations, attorneys handling ERISA claims should learn the general rules about how to properly appeal a claim to have the best chance of success once in federal court. As will be discussed in more detail below, the basic rule is that the claimant must appeal in accordance with the plan provisions, so long as those provisions are reasonable under the claims regulations. The claimant must submit all the evidence to the insurance company as part of the appeal process, or at least before the insurance company issues a final denial.

Nothing in the ERISA statute requires that a claimant first appeal his claim to an insurance company before taking it to court, but courts have created a clear rule that before taking a case to court, the appeals must be exhausted. *See e.g., Ravencraft v. Unum Life Insurance Company of America,* 212 F.3d 341, 343 (6th Cir. 2000).[5]

Each ERISA plan or insurance policy sets out its own time to file a claim once a person dies, becomes disabled, etc. The plans/policies also set a time for the insurance company to make a decision, for the claimant to appeal that decision, and for the insurance company to make a decision on appeal. The ERISA regulations discussed further below set out minimum and maximum times for those appeals, but a plan can have different time periods so long as they are more favorable to the claimant.

Once the appeals have been exhausted, a claimant may seek review by a court (usually a federal court). The review in court is treated almost like an appellate review, in that no new evidence related to the merits of the claim will be considered, and the review is limited to the evidence gathered by the insurance company and submitted by the claimant.[6]

Which Version of the ERISA Claims Regulations Apply?

Before digging into the specific requirements of the ERISA claims regulations, attorneys should understand that there are multiple versions of the regulations, so understanding which version applies to a claim is crucial.

The regulations issued by the Secretary of Labor were first issued in 1977 and were updated through 1984, and then were not updated again until 2000.[7] The regulations were over-

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hauled in the 2000 version regulations, and are referred to in this paper as the "new" regulations, or the "2000 regulations," and are effective for most types of claims filed after January 1, 2002.[8] The regulations were amended again November 29, 2017, with new provisions taking effect for claims filed after April 1, 2018; this newest version is referred to as the "new new regulations," or the "2018 regulations." (These 2018 "new new" regulations will be discussed in more detail in the second part of this paper, to be published in the next edition of the magazine.)

Most older claims for life insurance, health insurance, and similar claims are covered under the new regulations, or if filed since April 1, 2018, the "new new regulations." But, it is important to understand that some older long term disability claims might still be covered under the old regulations if the original claim was filed before January 1, 2002. It is not unheard of for a person to have been paid for years, and to be cut off years later, while the more recent regulations are in effect.

This is not a theoretical problem, but can still be an issue years after the regulations were amended. *See, e.g., Knight v. Provident Life & Acc. Ins. Co.,* No. 3:12-CV-01226, 2014 WL 1280278, at *9 (M.D. Tenn. Mar. 27, 2014) (Knight was found disabled by Unum and was paid benefits beginning in 2000 but the benefits were cut off in 2012. Unum argued that the original policy fell under the old pre-2002 regulations, and Unum could only allow Mr. Knight 60 days to appeal, even though they gave him 90 days. The court held that might have been permitted, but that Mr. Knight was entitled to 180 days to appeal Unum's termination of continuing benefits because the plan had been amended to allow that time to appeal before he was denied in 2012.).

What is Covered in the Regulations?

There is a General Requirement of Reasonableness:

These regulations create a general requirement that claims procedures be reasonable. The regulations require that, "[e]very employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations. . ." 29 C.F.R. § 2560.503-1(b).

The Procedures for Filing a Claim Must be Reasonable and Must Follow the Plan:

There are some general rules that apply to all different types of claims. For example, when a person applies for benefits, (referred to as a "claim for benefits") a claim is started whenever a person makes a requests for plan benefits under the plan's reasonable claims procedures. 29 C.F.R. § 2560.503-1(b). However, plans have many choices on what those claims procedures are, so long as they are reasonable.

Under § 2560.503-1(b), for a plan to be reasonable, the plan's procedures must follow the rest of the claims procedure regulations. (b)(1). Also, to be reasonable, the plan must provide a description of the claims procedures for a person to follow and those provisions must be in the plan's summary plan description(b)(2). A plan may not "unduly inhibit or hamper" a claim or appeal (by, for example, charging a fee to make a claim or to file an appeal). (b)(3). A plan must allow a person to act through a representative. (b)(4). The benefits decisions must follow the applicable plan procedures and be applied consistently. (b)(5).

Reasonable Procedures Must Not Require More Than Two Appeals, Cannot Require Arbitration, But May Allow Additional "Voluntary" Appeals.

For claims for health insurance benefits and long term disability benefits, the regulations require that, after a person files a claim, the plan may not require a person to file more than two appeals before the person is allowed to take the claim to court under ERISA § 502(a), (29 U.S.C. § 502(a)). 29 C.F.R. § 2560.503-1(c)(2).

A plan can offer voluntary levels of appeal beyond that, but must agree to waive any claim the person failed to exhaust if they don't take advantage of the voluntary appeal. Also, if a claimant makes the voluntary appeal, any applicable statute of limitations is tolled during any voluntary appeal. A voluntary appeal can only be offered after a person has completed the two appeals that are the maximum that can be required. If offered, the plan must explain who will be deciding the voluntary appeal and whether the decision-maker of the voluntary appeal has any financial or personal interest in the outcome. Lastly, the plan may not charge any fees or costs as part of the voluntary appeal. 29 C.F.R. § 2560.503-1(c)(3)(i)-(v).

Time Deadlines Under the Regulations:

The time deadlines for filing an appeal, and for the plan or insurance company to make a decision, are spread out throughout the regulations, but the highlights are summarized here, because understanding these is a crucial part of the regulations.

In order to understand the deadlines, here are a few important rules to remember: There is a general set of deadlines, but there are more specific deadlines that apply to LTD claims and health insurance claims. Also, if a claim was filed before January 1, 2002, the old 1984 regulations apply. Remember, that the appeal times are a minimum, and the plan can allow for more time.

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LTD Claims Under the "New" (2002) and "New New" (2018) DOL Claims Regulations (claims filed after January 1, 2002):

After the initial LTD claim is filed, the plan/claim administrator must make a decision within 45 days, which may be extended 30 days then by another 30 days. 29 C.F.R. § 2560.503-1(f)(3).

If denied, the time to file an LTD appeal must be reasonable, but not less than 180 days from the date of receipt of the denial. 29 C.F.R. § 2560.503-1(h)(2)(i), (h)(3)(i), and (h)(4).

The decision on appeal must be made within 45 days, which may be extended 45 days. 29 C.F.R. § 2560.503-1(i)(1)(i) and (i)(3)(i).

LTD Claims Under the Old DOL Claims Regulations (for Claims Filed Before January 1, 2002):

An initial decision must be made within 90 days after the application, which can be extended by 90 days. Old version of 29 C.F.R. § 2560.503-1(e)(3).

The time to file an appeal must be reasonable and related to the nature of the benefit but not less than 60 days. Old version of 29 C.F.R. § 2560.503-1(g)(3).

The decision on appeal must be made within 60 days, which can be extended another 60 days. Old version of 29 C.F.R. § 2560.503-1(h)(1).

There are Other Deadlines for Other Types of Claims:

Remember that if you are helping a client with an ERISA claim, other than an LTD claim, there are other deadlines that apply. For example, if you represent a client who has been denied life insurance benefits through a policy provided at work, the general deadline under the regulations would apply.

The general rule is that, when a person files a claim for benefits, the plan has 90 days to make a decision, but can give itself another 90 days to make a decision if it sends a written notice that it has determined it needs more time. 29 C.F.R. § 2560.503-1(f)(1). If denied, the general rule is that the claims procedures must allow a claimant 60 days to appeal. 29 C.F.R. § 2560.503-1(h)(2)(i) Once an appeal is filed in another type of claim, the decision-maker has 60 days to make a decision, which can be extended by another 60 days. 29 C.F.R. § 2560.503-1(i)(1)(i).

Also, remember, there are other different deadlines that apply for other types of claims. Specifically, health care claims have many different deadlines, depending on the type of claim.[10]

Calculating the Deadlines:

When calculating the time to appeal, the claimant has the time set out in the regulations (180 days for LTD claims) from the time of the receipt of the denial 29 C.F.R. § 2560.503-1 (h)(2). But note, the regulations do not build in any assumed time for mailing, so, unless you have the envelope the denial came in, and can prove the denial came in it, and can prove what day the letter was received, the best practice is to file within 180 days of the date of the letter, if at all possible. Also, remember that 180 days is not six months. 180 days from April 15 is not October 15; rather, it is October 12, so be sure to calculate your deadlines accordingly.

For the ERISA administrator or insurance company making a decision, the time deadlines set out above allow for a certain amount of time to make a decision, but that time can be extended. Technically, the rule sets out that the administrator may take an additional 30 days "provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period." 29 C.F.R. § 2560.503-1(f)(3). The administrator may take an additioniol 30 days, "[i]f, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period." The rule also states:

> In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Also, under 29 C.F.R. § 2560.503-1(f)(4) ("Calculating time periods."), the time limit for the administrator starts "at the time a claim is filed. . . without regard to whether all the information necessary to make a benefit determination accompanies the filing." If the administrator determines that more time is necessary and notifies the claimant that the claimant failed "to submit information necessary to decide a claim," then the time period is tolled "from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information."

In the practical, real world, so long as the ERISA administrator or insurance company sends out a letter before the first

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deadline runs, announcing it is taking more time, the administrator gets to take the extra time. But, once the additional time has run, the administrator is out of time. If that happens, the claim is "deemed exhausted" as will be discussed below.

Another important practice tip: When the time comes for a mandatory appeal, always use the words, "we appeal," "I appeal," or, "this is an appeal on behalf of my client" or something similar using the magic word "appeal" before the time to appeal runs. If you are new to the case, or for some reason are still gathering evidence, you can appeal and ask for more time to submit more evidence, which will often be granted. But, if you forget to appeal, your client's case can be dead.

Also remember that if a claim is denied and appealed to court, the court will only review the information in the record, which is the information submitted with the appeals, and information the insurance company added. Remember, voluntary appeals are not always offered, so attorneys should do their best to submit all the evidence supporting the claim early, during the first appeal.

If a Claim Decision is Not Made on Time, it is Deemed Exhausted.

29 C.F.R. § 2560.503-1 (l) (This is a lower case "L") sets out the remedy for claimants if the plan fails to "establish and follow reasonable claims procedures:"

> **(1) IN GENERAL.** Except as provided [in the 2018 "new new" regulations, discussed *infra,*] in the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

In plain English, if the plan or insurance company fails to make a decision on time, or violates the regulations in some other significant way, the claimant has the right to take the case to court, without waiting too long for a decision.

Administrators and Insurance Companies Must Communicate with Claimants.

Another theme of the ERISA claims regulations is that, as part of a "reasonable" claims process, ERISA administrators and insurance companies must communicate with claimants about their claims. For example, the regulations provide a laundry list of information that must be included in a denial of benefits.

Under 29 C.F.R. § 2560.503-1(g)(1), a benefit decision must be in writing, and must include, in language that should be understood by the claimant:

> **(i)** The specific reason or reasons for the adverse determination;
> **(ii)** Reference to the specific plan provisions on which the determination is based;
> **(iii)** A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
> **(iv)** A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;
> **(v)** In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,
>
> **(A)** If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or
>
> **(B)** If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

29 C.F.R. § 2560.503-1 (h)(2)(iii) also requires the administrator or insurance company to offer to provide the claimant a copy of all the relevant documents as defined in (m)(8) of the regulation.

Similarly, if a claimant appeals and is denied, the letter informing the claimant of the denial on appeal must contain certain information. 29 C.F.R. § 2560.503-1(j) states that the decision on review must include:

> **(1)** The specific reason or reasons for the adverse

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determination;
(2) Reference to the specific plan provisions on which the benefit determination is based;
(3) A statement that the claimant is entitled to receive, 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. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;
(4) (i) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act. ...

There are a few other additional requirements in the regulations about what a plan must communicate, and what must be in the decision letters. Any practitioner who is taking on LTD or other ERISA benefits claims should make the time to read the regulations carefully, and review them from time to time.

So What is New in 2018?

As discussed above, the ERISA regulations were overhauled and re-written in 2000, effective in 2002. Then the latest edition of the regulations was issued beginning in 2016, and effective April 1, 2018. These latest "new new" regulations were not a complete overhaul. The timing requirements, notice requirements and information requirements discussed above have remained the same, but there are other significant changes.

Part II of this paper will discuss the new changes to the ERISA claims regulations. As a preview, some of the changes to be discussed are:

(1) plans must ensure the impartiality of decision-makers and experts;
(2) plans and insurance companies must address treating and examining doctors' opinions, the opinions of their own experts favorable to the claimant, and the decision by the Social Security Administration;
(3) plans and insurance companies must explain the time limit to go to court;
(4) claims decisions must be written in a way that is understandable;
(5) significant violations of the regulations can now have consequences;
and other changes that will be discussed in detail in the next part of this article.

ABOUT THE AUTHOR

Eric Buchanan represents disabled people and other policyholders across the United States in both ERISA and non-ERISA disputes, focusing primarily in the areas of disability, life, and health insurance. Eric served as President of the Tennessee Trial Lawyers Association from 2015 to 2016 and is a lifetime member of that organization.

Eric Buchanan regularly chairs conferences and speaks to both national and local audiences on disability insurance, ERISA, insurance law, and social security disability. Eric has represented hundreds of people in social security and ERISA disputes in federal court. Eric is the past-chair (2007-2008) of the AAJ Social Security Disability Section, past chair (2006-2007) of the AAJ ERISA Health Care Finance and Disability Litigation Group, past President of the Chattanooga Trial Lawyers, and past-chair (2005-2006) of the Tennessee Bar Association Disability Law Section.

Eric graduated from the Washington and Lee University School of Law magna cum laude in the top 10% of his class. While in law school he was inducted into the Order of the Coif as well as the Omicron Delta Kappa honorary leadership fraternity. Eric is a graduate of the Virginia Military Institute and served as an officer in the U.S. Navy from 1989 to 1994, where he served as a naval aviator (pilot), plane commander, and mission commander of P-3C Orion aircraft.

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[1] The Employee Retirement Income Security Act of 1974. For a more complete discussion of how to tell if an insurance policy falls under ERISA, please visit the author's firm's website at *https://www.buchanandisability.com/helpful-resourcesandarticles/how-to-tell-if-an-insurance-claim/*.

[2] ERISA also governs disputes over benefits provided through employers' self-funded plans and those provided by unions. However, since the majority of claims are provided by insurance policies, this paper will generally refer to those claims provided through insurance.

[3] Sean M. Anderson, *ERISA Benefits and Litigation: an Empirical Picture,* 28 ABA Journal Lab. & Emp. Law 1 (2012).

[4] The Department of Labor ("DOL") and the Commissioner of Internal Revenue have joint authority to issue regulations under ERISA, and the DOL has issued the regulations controlling the ERISA claims process explained in this article, and found at 29 C.F.R. § 2560.503-1.

[5] The *Ravencraft* court explained, "We have held in *Miller v. Metropolitan Life Ins. Co.,* 925 F.2d 979, 986 (6th Cir.1991), that '[t]he administrative scheme of ERISA requires a participant to exhaust his or her administrative remedies prior to commencing suit.' " The court also acknowledged, "This is the law in most circuits despite the fact that ERISA does not explicitly command exhaustion." *Id.*

[6] In *Wilkins v. Baptist Healthcare Systems, Inc.,* 150 F.3d 609 (6th Cir. 1998) the Court of Appeals for the Sixth Circuit explained discovery on the merits of a plaintiff's claim is generally not permitted, because a court's review of an ERISA claim for plan benefits the district court's review is "based on the record before the administrator." *Id.,* at 617-8, *quoting Perry v. Simplicity Engineering,* 900 F.2d 963, 966 (6th Cir. 1990).

There are limited exceptions to the rule "closing the record." *See, e.g., Williams v. International Paper Company,* 227 F.3d 706, 712-714 (6th Cir. 2000) (if the administrator arbitrarily refuses to look at evidence of disability the court can review the evidence itself and order an award of benefits.) and *VanderKlok v. Provident Life and Acc. Ins. Co.,* 956 F.2d 610, 617 (6th Cir.1992) (when a plan administrator fails to give an employee an opportunity to present additional evidence during a claim review, the court will examine the additional evidence). These exceptions are rare, and the author submits that the best practice is to always submit everything that the claimant's attorney wants the court to look at to the insurance company during the claims process.

[7] ERISA was enacted in 1974, and effective January 1, 1975. The first claims regulations were issued May 27, 1977 (42 FR 27426), were amended January 21, 1981, (46 FR 5884), and again on April 30, 1984 (49 FR 18295). As explained above, the 1984 regulations still apply to claims filed before January 1, 2002, and healthcare claims filed before January 1, 2003, and are referred to in this paper as the "old" regulations.

[8] The "new" 2000 regulations were issued Nov. 21, 2000 (65 FR 70265) and July 9, 2001 (66 FR 35887). 29 C.F.R. § 2560.503-1(o) sets out the applicable date for most claims as January 1, 2002, while group health claims were covered under the 2000 regulations effective January 1, 2003.

[9] The 2016 regulations, or the "new new" regulations were issued Dec. 19, 2016 (81 FR 92341) and Nov. 29, 2017 (82 FR 56566). The 2016 amendments were not a complete overhaul, but only added a few additions to the existing regulations, primarily focused on disability claims. The amendments that make up the 2018 new rules are set out in 29 C.F.R. § 2560.503-1 (p)(3). The amendments originally were to take effect on or after January 1, 2018; however, the amendments were put on a temporary hold during the change of administrations, and eventually the final version of the rule made those changes effective for claims filed after April 1, 2018. 82 FR 56566.

[10] For example, for "urgent care claims"[10] under group health plans, the plan must make a decision in 72 hours. However, if the plan administrator determines that the person did not provide sufficient information, then the plan administrator must notify the claimant of what specific information is missing within 24 hours. The claimant then has 48 hours to provide the specific information. The plan then must make a decision within the earlier of 48 hours from the time the information was received or the end of the 48 hours the claimant had to submit the information.

For "concurrent care decisions" (where the plan has approved ongoing health care treatment over time or has approved a number of treatments), when a plan chooses to reduce or terminate benefits before the end of the time or number of treatments previously approved, the plan must give notice of its adverse benefits determination in time for the person to appeal and for a decision to be made before the benefits is reduced or terminated.

There are several other deadlines that apply to healthcare claims, and it is worth pulling out the actual regulations to review them, if you handle such a claim. See the copy of the ERISA claims regulations, 29 C.F.R. § 2560.503, attached as Appendix 1 to this paper.