Bullet Proofing Your Claims Procedures

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Managing your plan's claims procedures to avoid successful challenges requires careful attention to all of the requirements in the regulations and in the applicable plan's or policy's terms and continual review in light of the developing case law. The Fifth Circuit reminded us that when the claims procedure regulations require us to provide all relevant documents when a plaintiff requests "any and all documents you may rely on toward making your decision on coverage so the individual can pursue any and all legal remedies she may have afforded to her by law." The insurer providing the life insurance benefits omitted the report of a doctor that noted it was impossible to estimate the level of the decedent's intoxication when it denied benefits due to intoxication based on the contents of the accident report. This was due to the fact that no additional testing was done on a blood sample drawn close to the time of the accident to look at the quantitative level of the substances found and not just the presence of the substance. Since this testing was not done and the blood samples were disposed of after 90 days had passed, there was no way to know at what level certain substances- amphetamines, cocaine, opiates, benzodiazepine and cannabinoids—were in the decedent's system and if they had impaired him.

The insurer's failure to provide the report to the decedent's wife and even though the Fifth Circuit was reviewing this plan decision using an abuse of discretion standard, the failure to provide the report and failure to address the report in the claim and appeal denials since it was the only expert opinion in the record, resulted in the method that the insurer used to make its decision unreasonable. The court further found that the failure to provide the expert report to the plaintiff in the administrative process after the relevant documents were requested, resulted in the insurer failing to substantially comply with ERISA's procedural requirements, denying the plaintiff a full and fair review. The Fifth Circuit then overturned the lower court's decision upholding the plan's and insurer's denial of benefits. The Fifth Circuit found that considering the insurer's conflict of interest, its procedural unreasonableness, its denial of a full and fair review and the counterbalanced nature of the evidence, that the insurer abused its discretion. *White v. Life Insurance Company of North America*, (5th Cir. June 13, 2018, revised June 14, 2018).

Takeaway- The ERISA claim and appeal procedures need to be followed carefully and claim and appeal denials need to be carefully drafted considering all of the evidence submitted. When there is a request for documents related to a claim or appeal pay close attention to what is requested and what the plan administrator has in its file and carefully assess what is relevant in light of the applicable court decisions. Given the change in the disability claim and appeal procedure requirements that became effective for any disability based benefit claims on April 1, 2018, and the regular litigation over disability claims, it may be prudent to carefully review the forms being used, the process being followed, how document requests are addressed, and how those match with the current requirements.

Pre-Summer Recess Bill Introduction Frenzy

As Congress's summer recess rapidly approaches before the mid-term elections in November, there have been a number of bills recently introduced. These are only bills and some only have explanations and no substantive language provided. At this point they are just bills or ideas and they are far from being laws. A number impact health and welfare benefits and have quick effective dates and this alert highlights some of those proposals.

The proposals include one bill that puts into abeyance the employer shared responsibility tax (a/k/a the employer mandate) for calendar years after 2014 and through calendar year 2018. Many have received the letter notices from the Internal Revenue Service proposing to assess the tax and those notices still must be responded to within 30 days of the letter's date. It is important as you prepare your Forms 1095-C and 1094-C to document the reasons you chose the codes you used so that when someone must respond to the Service's notice in later years, they understand what safe harbors or reasons the tax should not be assessed that were to be conveyed in the coding in such Forms. This bill also proposed to delay the tax on high cost health plans, a/k/a the Cadillac tax, until after 2022. It is currently delayed until calendar years after 2021, so it is a one additional year delay.

Another proposal intends to relax the requirements for high deductible health plans ("HDHP") to allow the HDHP to cover $250 of medical expenses before the deductible is met in addition to covering the preventive services required to be covered by the Affordable Care Act. Another bill proposes to expand deductible HSA contributions to persons who are eligible for Medicare. If these are passed, employers will need to consider whether to change plan design and to review their communications related to the HDHP coverage and HSA contribution eligibility, if it is addressed in the annual benefits enrollment communications.

There will likely be more proposals filed before Congress takes its summer recess and begins campaigning for the November mid-term election. Before any of these proposed changes can be passed, Congress will need to find a way to replace the revenue it loses from each of these proposed changes. This is still very early in the long process of making a bill into a law and they are just proposals without any proposed way to fund the tax revenue loss at this point, so this is just an early heads up before these become part of the news cycle.

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