# Handling Participant Claims and Inquiries


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# What We'll Cover

- Responding to inquiries
- Claims versus inquiries
- Responding to claims
- Protecting attorney-client privilege

# Poll Question #1

Which of the following best describes you:

A. Employer/plan sponsor
B. Third-party administrator
C. Advisor
D. CPA/auditor
E. Attorney
F. Other

# Participant Interactions

- Interactions with participants come in many forms
  - Informal questions and requests for documents
  - Formal requests for documents
  - Claims (and attendant requests)
  - Litigation

# PARTICIPANT INQUIRIES

# Inquiries

- Most common form of interaction
- Generally between participant and HR or third-party administrator
- Routine conversations or emails
  - Providing information/answering questions
  - Providing documents

# Inquiries

- Answering inquiries – best practices
  - Understand the question
  - Be accurate and precise
  - Be complete in information
  - If possible, refer participant to written summaries
    - No need to recreate the wheel
  - If any errors (or obvious misunderstandings) correct information provided
  - Keep a record of any interpretations provided

# Inquiries

- What if incorrect information is provided?
  - Incorrect eligibility information
  - Incorrect benefit statements
  - Other incorrect information

# Poll Question #2

Which of the following might result if incorrect information is provided to a participant?

A. Operational errors in the plan
B. Lawsuit to force plan to honor incorrect information
C. Lawsuit for fiduciary breach
D. All of the above

# Inquiries

- ALL of the following could result if incorrect information is provided:
  - Operational errors in the plan
  - Lawsuit to force plan to honor incorrect information ("Estoppel claim")
  - Lawsuit for fiduciary breach

# Operational Errors

- Did the incorrect information result in an operational error?
  - Telling an employee (incorrectly) that he is not eligible
  - Employee does not defer
- If so, correct under EPCRS

# Estoppel Claim

- Participant argues:
  - Plan told me I would receive $6,000 per month
  - I relied on that statement in deciding to retire
  - Then I found out that I would receive only $3,000 per month
  - If I had known I would receive only $3,000 per month I would not have terminated employment and retired
  - I was harmed because I relied on their statement

# Estoppel Claims

- Possible to have an estoppel claim if
  - Material misrepresentation
  - Participant reasonably and detrimentally relied upon
  - Extraordinary circumstances
- Exact requirements are specific to each jurisdiction

# Estoppel Claims

- Not overwhelmingly successful
- May be more successful
  - With formal, written communications other than benefit statements
  - With issues regarding plan interpretation (rather than contradictions)
- BUT still costly to handle and defend

# Fiduciary Breach Claims

- Plan administrator is a fiduciary
- Fiduciary has a duty to:
  - Not misinform
  - Inform when silence might be harmful (according to some courts)
- Courts have held fiduciaries liable for misrepresentations of its non-fiduciary employees and agents (such as a TPA)

# Fiduciary Breach Claims

- Accurate information in SPD may mitigate liability
- Referring participants to answers provided in SPD may avoid misstatements or misunderstanding

# Poll Question #3

Which of the following should you NOT do when answering inquiries:

A. Clarify the question or information requested (if you are unclear)
B. Provide a copy of the summary plan description
C. Summarize provisions in the SPD that answer the participant's question in your words
D. Keep of record of the inquiry and answer provided

# Inquiries

- Answering inquiries – best practices
  - Understand the question
  - Be accurate and precise
  - Be complete in information
  - If possible, refer participant to written summaries
    - No need to recreate the wheel
  - If any errors (or obvious misunderstandings) correct information provided
  - Keep a record of any interpretations provided

# DOCUMENTS REQUESTS

# Requests for Documents

- In addition to automatic disclosures (such as SPDs) participants and beneficiaries are entitled to certain documents upon request
- Form of request
  - May be informal requests
  - Often see formal requests before litigation

# Requests for Documents

- Only participants and beneficiaries have a right to receive documents
  - Participants and beneficiaries may request through a representative (such as an attorney)
  - Do not have to provide documents to other parties (such as ineligible employees)

# Requests for Documents

- Following documents must be provided upon request:
  - Most recent SPD (and interim SMMs)
  - Most recent annual report
  - Applicable collective bargaining agreements
  - Plan and trust document(s)
  - Other instruments under which plan is established or operated
- Required by ERISA §104(b)

# Requests for Documents

- Documents must be current and readily accessible
  - At the principal office of the administrator
  - At other major work locations that have at least 50 participants within ten days of request

# Requests for Documents

- Must furnish copies upon request
  - May charge reasonable copying charge
  - Cannot exceed 25 cents per page
  - Cannot exceed actual cost to the plan
- Must provide within 30 days of request
  - If document is not in existence, must create it
  - If document is in possession of another party, generally must obtain it

# Requests for Documents

- Failure to provide required document may result in penalties
  - Up to $110 per day
  - In the court's discretion
- Very common addition to claim for benefits or demand

# Requests for Documents

- Often, request is broader than statutory requirement
  - May provide the additional information, but no penalty for failing to do so
  - May depend on claims/litigation strategy

# Poll Question #4

You receive a letter from a participant questioning benefits and requesting copies of several documents, including the plan document in effect when the benefit was paid. What should you do?

A. Ignore it. Participant was a problematic employee and you hope it will just go away.

B. Provide only the most recent plan document.

C. Provide access to your entire plan file. That document is in there somewhere.

D. Locate and send just the plan document requested (and a copy of the plan's claim procedures).

# Requests for Documents

- Best practices
  - Maintain documents in accessible format/location
  - Ensure administrators identify requests for documents
  - Respond in a timely manner
  - Document time of request and time of response

# CLAIMS FOR BENEFITS

# Claims

- Beyond a mere request for information
- Participant requests a benefit under the plan
- ERISA requires the plan to have and follow claims procedures that meet certain requirements.

# Inquiries Versus Claims

- Knowing the difference
- Inquiries
  - Simple questions (“What is the match?”)
  - Requests for the SPD or a notice
- Claims
  - Request to receive benefit (“I am owed a match”)

# Inquiries Versus Claims (Continued)

- Line between inquiries and claims may quickly blur
  - What is the match?
  - 100 percent of the first six percent you defer
  - Okay, I don't think that is what I received last year. So, I think I'm owed additional match.

# Inquiries Versus Claims (Continued)

- Claims procedure may define what constitutes a claim
  - Must be reasonable
  - Commonly, must be in writing and submitted to a certain individual or committee
- Participants have certain rights re: denied claims

# Inquiries Versus Claims (Continued)

- Best practice

  If a participant disagrees with informal statement:

  1. Explain that participant may file a formal claim
  2. Provide copy of the claims procedure
  3. Document conversation (including steps 1 and 2)
     - Email/letter to participant
     - Memo to file

# Claims – Basic Requirements

- General requirement
  - Reasonable procedures
  - Must be described in SPD
  - May not inhibit or hamper claims
  - Administrative safeguards for consistency

# Claims – Basic Requirements

- Procedures must appear in SPD
  - How to file a claim
  - Remedies available if claim is denied
    - Appeals
    - Filing ERISA suit
- Procedures may be in separate document
  - SPD must say procedures will be provided upon request without charge

# Claims – Basic Requirements

- Cannot hamper claims
  - Procedures should not be designed to make it difficult for claimants to file
  - Example:  charging a fee to file a claim
  - DOL also says requiring a participant to share in the cost of arbitration is a violation

# Claims – Basic Requirements

- Consistency safeguards
  - Must have "administrative processes and safeguards" designed to
    - Ensure plan documents are followed
    - Plan provisions are applied consistently in similar situations
  - Form
    - No particular form of safeguard required
    - At a minimum, need history of past claims and decisions

# Claims – Required Procedures

- ERISA requirements focus on claims that are denied
- If participant makes a claim that is granted
  - Document decision (for later consistency)
  - Communicate decision, but no specific form required

# Claims – Required Procedures

- Additional protections for disability benefits
- Disability benefits may include benefits in retirement plans
  - Any benefit conditioned on showing disability
  - For example:  full vesting on disability
- Does not include benefit provided upon determination of disability by a third party

# Initial Claims

- Procedure should state:
  - The form in which to file the claim
    - Any written request
    - Specific form
  - Request to submit all information the claimant would like the administrator to consider
  - To whom the claim should be submitted

# Initial Claims

- If claim is denied, must provide written notice
- Written notice must include
  - Reference to specific plan provisions on which denial is based
  - Explanation of any additional information needed
  - Information regarding claims procedure
  - Right to bring suit under ERISA upon exhaustion of claims procedure

# Initial Claims

- Written notice for disability claims must also include
  - If based on a medical judgment, explanation of the judgment (applying the terms of the plan to the claimant's medical circumstances)
  - If an internal rule, guideline, protocol, etc. was relied upon, a copy of the specific rule, guideline, protocol, etc.
- May instead provide statement that such information will be provided free of charge upon request

# Initial Claims

- Deadline for decision
  - 90 days after receipt of claim
    (45 days for disability claims)
  - May be extended for additional 90 days
    (Up to two 30-day extensions for disability claims)
    - IF special circumstances warrant extension
    - And, for disability claims, the circumstances are outside the control of the plan
    - And notice is given before expiration of original period

# Appeal of Denied Claims

- Claims procedures must have appeal process
  - Appeal of initial claims
  - AND any other adverse benefit determination
- Adverse benefit determination
  - Any denial, reduction, termination, or failure to make payment of a benefit
  - Includes eligibility determinations

# Appeal of Denied Claims

- Should specify time for filing appeal
  - May not be shorter than 60 days for regular claims
  - May not be shorter than 180 days for claims related to disability benefits
- Should specify form of appeal
  - In writing
  - Must be to an appropriate named fiduciary

# Appeal of Denied Claims

- Must allow claimant to submit materials
  - Comments, documents, records, and other information
  - Procedure should include method of submission
- Decision-maker must consider all submissions
  - Even if not submitted the first time

# Appeal of Denied Claims

- For disability claims
  - Review cannot provide deference to initial decision
  - If plan consulted with medical expert, must disclose the name of the expert
  - If medical judgment is an issue, fiduciary must consult with independent medical expert

# Appeal of Denied Claims

- Must provide claimant "relevant" information upon request free of charge
- Relevant information:
  - Relied on in making the benefit determination
  - Submitted, considered, or generated in making benefit determination (even if not relied upon)
  - Used to demonstrate compliance with administrative processes and consistency requirements

# Appeal of Denied Claims

- "Relevant" information
  - Plan provisions
  - Plan interpretations
  - Policies
  - Consistency guidelines
- Broader than ERISA §104(b) Information

# Appeal of Denied Claims

- Who should review decision?
  - Non-disability claims
    - Must be an appropriate named fiduciary
    - May be reviewed by the same person/committee
    - Often, first claim is decided by staff administrator (HR staff or TPA) and second claim is decided by more senior level HR or fiduciary committee

# Appeal of Denied Claims

- Who should review decision (continued)
  - Disability-related claims
    - Must be an appropriate named fiduciary
    - Cannot be decided by same person who decided initial claim
    - OR a subordinate of that person

# Appeal of Denied Claims

- Deadline for decision
  - 60 days after receipt of appeal (45 days for disability claims)
  - May be extended for additional 60 days (45 days for disability claims)
    - IF special circumstances warrant extension
    - And, for disability claims, the circumstances are outside the control of the plan
    - And notice is given before expiration of original period

# Appeal of Denied Claims

- If appeal is denied, must provide written notice
- Written notice must include
  - Specific reasons for denial
  - Reference to specific plan provisions on which denial is based

# Appeal of Denied Claims

- Written notice must include (continued)
  - Explanation of right to request relevant documents
  - Explanation of an voluntary or required appeals
  - Right to bring suit under ERISA

# Appeal of Denied Claims

- Written notice for disability claims must also include
  - If based on a medical judgment, explanation of the judgment (applying the terms of the plan to the claimant's medical circumstances)
  - If an internal rule, guideline, protocol, etc. was relied upon,  a copy of the specific rule, guideline, protocol, etc.
- May instead provide statement that such information will be provided free of charge upon request

# Appeal of Denied Claims

- Written notice for disability claims must also include
  - "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

# Time for Bringing Lawsuit

- Known as the "statute of limitations" on claims
- ERISA does not provide for a statute of limitations for benefit claims
  - Courts often apply the state law's SoL for contract claims
  - Some apply the ERISA SoL for fiduciary breach claims

# Time for Bringing Lawsuit

- May the plan provide its own statute of limitations?
- Supreme court has upheld reasonable time limits stated in the plan
  - *Heimeshoff v. Hartford Life & Accident Ins. Co*.
  - Upheld provision where participants had three years after proof of loss was due to file suit
- Other courts have upheld shorter limits

# Place for Bringing Lawsuit

- Suit for benefits generally brought in any jurisdiction where the plan is administered
- For large companies, this usually means suit may be brought
  - In any state where they have an office or
  - May be in any state where they have an employee

# Place for Bringing Lawsuit

- May the plan specify that lawsuits must be brought in a specific location?
  - Some courts have upheld provisions that specify venue
  - Supreme court considering venue case in 2015-2016 term

# Poll Question #5

You receive a formal claim. What are your first steps?

A. Review claim and materials submitted
B. Review claims consistency procedures
C. Calendar deadline for response
D. Contact appropriate decision-maker
E. All of the above

# Claims and Appeals

- Best practices
  - Train administrators to identify claims
  - Ensure benefit denials meet claims procedures requirements
  - Document all material presented in claims process and decisions made by fiduciary
  - Specify time and place for filing lawsuits in procedures

# Importance of Claims Procedures

- Claims process may avoid costly litigation
- Plays important role in any future litigation
  - If claims procedure not established or followed
    - Participant may skip administrative review
    - Deadline for filing suit may be extended
  - May entitle plan administrator to more deference from court
  - Establishes a record of the facts for the court

# Importance of Claims Procedures

- If plan does not have procedures (or does not follow them), claimant can skip administrative review and file suit directly.
- If plan does not follow procedures, deadline for filing a lawsuit may be extended

# Importance of Claims Procedures

- Deference
  - If plan document grants plan administrator discretion, courts should apply a deferential standard of review
  - Plan administrator's determination will be upheld as long as it is reasonable
- If claims procedure is not established or followed, no final decision is made, and deference may not apply

# Importance of Claims Procedures

- Claims procedure creates administrative record for court to consider
  - Usually, only facts in the administrative record are considered by a court
  - Often, discovery is not permitted (which saves time and cost in litigation)

# Importance of Claims Procedures

- Developing the record
  - Everything the claimant submitted
  - Everything else the fiduciary considered
  - All communications with claimant
  - Evidence of consistency

# Poll Question #6

What is the most important reason in your mind to follow the claims procedure?

A. Avoid litigation
B. Prevent premature/delayed litigation
C. Ensure deference to decision
D. Opportunity to create record to litigation

# ATTORNEY-CLIENT PRIVILEGE

# Attorney-Client Privilege

- Denied claims may result in litigation
- Certain information discussed prior to litigation may be protected from discovery by attorney-client privilege
- BUT attorney-client privilege in retirement context is limited

# Attorney-Client Privilege

- Basics for privilege:
  - Holder of privilege sought to become a client
  - Person to whom information was communicated is a lawyer *and* was acting as a lawyer
  - Communication relates to a fact the attorney
    - Was told by a client
    - Without the presence of strangers
    - For the purpose of securing legal advice (and not for the purpose of committing a crime)

# Attorney-Client Privilege

- In non-retirement plan scenarios
  - Communications with attorney are broadly protected from discovery
  - For example, investigations conducted at the direction of legal are not discoverable by employees
- In retirement plan scenarios
  - Advice may be discoverable

# Attorney-Client Privilege

- Advice a fiduciary obtains to perform fiduciary duties may be discoverable
- Fiduciary exception
  - Plan administrator is a fiduciary that must operate in best interests of participants and beneficiaries
  - SO, any advice given to administrator is for the benefit of participants and beneficiaries
  - THEREFORE, such advice is discoverable by participants and beneficiaries

# Attorney-Client Privilege

- Fiduciary exception (continued)
  - Especially clear when the advice is paid for by the plan trust
  - Has been asserted by the Department of Labor (under the theory it stands in the shoes of the participants)

# Attorney-Client Privilege

- Fiduciary exception does not apply
  - To advice re:  settlor decisions
    - Designing the plan
    - Amending or terminating the plan
    - Funding decisions
  - To advice in anticipation of litigation
    - After decision to deny claim

# Attorney-Client Privilege

- Privilege does not exist if information is discussed in the presence of third parties
- Privilege may be waived

# Poll Question #7

Assume you are a non-attorney consultant or administrator. You are attending a routine committee meeting along with their attorney when the conversation turns to a recent contentious claim denial. What should you do?

A. Nothing. Sit and listen. This might be interesting.

B. Participate actively in the discussion

C. Ask if they need any information from the non-attorney consultants and suggest that you (and the other non-attorney consultants) be excused.

# Attorney-Client Privilege

- Best practices
  - Segregate or identify discussion items so that all parties are aware of fiduciary versus settlor decisions
  - If a claim is being discussed, ensure no third party is present or copied
    - If input from the TPA is needed
    - Obtain information and then excuse TPA
    - Document who attended discussions

# Attorney-Client Privilege

- Best practices (continued)
  - Keep documentation of fiduciary decisions separately
    - To the extent possible, do not “mix” advice in single files or communications
  - If trust assets may be used, ensure only advice regarding administration is paid from trust assets
  - Do not circulate written advice from an attorney

# Questions?