

ERISA & DISABILITY BENEFITS NEWSLETTER

ABOUT OUR FIRM

Eric Buchanan & Associates, PLLC is a full-service disability benefits, employee benefits, and insurance law firm. The attorneys at our firm have helped thousands of disabled people who have been denied social security disability benefits, ERISA LTD benefits, health insurance, life insurance and other ERISA employee benefits, as well as private disability and health insurance benefits.

For more Information about Eric Buchanan & Associates, PLLC, visit our website at www.buchanandisability.com.

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Eric L. Buchanan and R. Scott Wilson are certified as Social Security Disability Specialists by the Tennessee Commission on CLE and Specialization.

WHAT IS SUPPOSED TO BE IN AN ERISA DENIAL LETTER? WHAT CAN I DO WITH THIS INFORMATION? - JULIE E. MOYA

When an ERISA administrator denies ERISA welfare benefits, such as long-term disability (LTD) insurance, health insurance, life insurance, or similar types of claims, the ERISA administrator must provide some very specific information, as set out in the ERISA claims regulations. In our experience, most LTD and life insurance denials contain most of the required information, but often not all the information. On the other hand, in our experience, when a health care claim is denied, we find that the denial letters rarely contain all the information required by the regulations. This newsletter will discuss the requirements of what information must be in those denial letters.

When an ERISA administrator, such as an insurance company, denies an employee's benefits, most do so in writing. The DOL ERISA regulations, at 29 C.F.R. § 2560.503-1, also allow for this denial by electronic means, but this is relatively rare. This denial notice must meet several statutory and regulatory standards.

29 U.S.C. § 1133 (ERISA § 503) states that a Plan shall provide notice with specific reasons for denial, written in a manner understood by participants. The DOL regulations provide more detail about what must be in the denial letters or notices. For example, 29 C.F.R. § 2560.503-1(g) sets out what must be in initial benefit decision. Section (j) covers benefit determinations at the subsequent levels of review. The first two requirements under both sections are identical.

First, the insurer must provide "the specific reason or reasons for the adverse determination." 29 C.F.R. § 2560.503-1(g) and (j). Usually, insurers attempt to meet the first requirement

by giving a list of the medical evidence that they collected or obtained. This may include some records from the claimant's treating sources, but often includes the results from a Functional Capacity Exam, an Independent Medical Exam, the findings of an in-house file reviewer, or reports of surveillance of the claimant.

The first section of the denial letter is helpful, because it essentially forces the insurer to admit that certain pieces of evidence are relevant. If your client receives a denial letter that does not specifically state the reasons for your client's denial, you should write a letter to the insurer insisting that it be provided because it is required under the regulations. For example, if the denial letter bases the denial upon surveillance footage, then that footage becomes relevant and obtainable via regulation, especially if the denial letter makes a big deal out of the fact that a physician (usually in-house) reviewed the footage and determined that the Claimant was able to work based on that footage. *Id.*

Second, the denial letter must "reference to the specific plan provisions on which the determination is based." 29 C.F.R. § 2560.503-1(g);(j). Often, insurers attempt to fulfill this requirement by reciting the definition of disability contained in the employee's benefit policy or plan and simply stating that the claimant does not meet it (or no longer meets it). Attorneys should insist that insurers include this information in their denial letters. Not only is it required by the regulations, but it can serve as an additional way to determine that the insurer has sent you the correct policy (once they eventually send it). Believe it or not, insurers do occasionally send the wrong policy.

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The initial denial letter must include (under (g) only):

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”

Most insurers provide this information, which is helpful to attorneys because it is usually different than the language included in the second and/or final denial. District Courts only consider the record that the insurer considered. This language lets attorneys know quickly if new records may still be submitted for the insurer’s consideration.

At the initial decision, the insurer is supposed to disclose what, if any, internal guidelines or protocols were relied upon (under (g)). Usually, insurers leave this information out. This typically becomes a discovery battle during litigation in which the insurer will likely claim that either 1) they do not have internal guidelines and protocols, or 2) if they do have internal guidelines, that they did not rely on them.¹

On review (rather than the initial denial), the denial letter is held to the first two standards that initial denials are. 29 C.F.R. § 2560.503-1(g) and (j). However, the additional standards are different. The third standard for a denial on review is that the letter must include:

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

29 C.F.R. 2560.503-1(j).

The fourth piece of information the insurer must provide is notification of any “voluntary” levels of appeal that still remain (29 C.F.R. § 2560.503-1(j) only). Typically, a claimant cannot sue until the insurer makes a “final” decision, exhausting administrative remedies. Which denial is the “final” denial is policy-specific. 29 C.F.R § 2560.503-1(c)(3)(iv). Therefore, if the claimant is allowed to appeal again, he/she can do that, but they do not have to exhaust this appeal before bringing the matter to district court. *Id.*

Just like the initial denial, the denials on review must reveal internal guidelines, but usually successfully avoid this (at this stage at least) (29 C.F.R. 2560.503-1(j) only). The only distinct difference is that they are now required to include a statement of the claimant’s right to bring an action under section 502(a) of the Act. *Id.* This is helpful because it is one of the ways that an attorney can tell if a claim is ripe for a district court action. This concludes the overview of what is required in an ERISA denial letter.

In addition to the requirements set out in the ERISA statute and the DOL ERISA regulations, the DOL also has further explanations of what must be provided in responses to “frequently asked questions” on the DOL website.

For example:

When you have a client who has been denied long-term disability benefits, health insurance benefits, life insurance benefits, or other similar ERISA welfare benefits through a policy or ERISA plan provided at work, review the denial letter carefully. If it does not provide all the information you need, review the ERISA claims regulations at 29 C.F.R § 2560.503-1, as well as the DOL website for guidance as to what must be provided.

- 1) Though it does not happen often, if the carrier admits to relying on an internal protocol, they must state what the protocol was. They cannot “generally state that a rule, guideline, or protocol” was relied upon. In fact, they must provide a copy of the guideline. See “FAQs About The Benefit Claims Procedure Regulation, C16-C17,” http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html (accessed 4/9/2012).
- 2) These standards do not apply to a request for information that is not also a claim for benefits. See “FAQs About The Benefit Claims Procedure Regulation, A-3;A-5,”http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html (accessed 4/9/2012). For example, questions regarding eligibility are not covered by these rules. *Id.*
- 3) Insurers cannot avoid these rules just because the denial is a cessation of benefits that the insured previously received. See “FAQs About The Benefit Claims Procedure Regulation, C-18,” http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html

¹At least in the case of internal policies regarding a specific diagnosis, policy statements must be produced even if not relied upon. 29 C.F.R. § 2560.503-1(8)(i) states:

A document, record, or other information shall be considered “relevant” to a claimant’s claim if such document, record, or other information:

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of a policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

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When you have a client who has been denied long-term disability benefits, health insurance benefits, life insurance benefits, or

UPCOMING SPEAKING ENGAGEMENTS

Eric Buchanan will be speaking at the American Association for Justice Annual Convention scheduled for July 28 - August 1, 2012 in Chicago. He will be speaking on social security disability offsets in ERISA disability cases.

NEED A SPEAKER?

The attorneys at Eric Buchanan & Associates are available to speak to your organization regarding Social Security Disability, ERISA Long-term Disability, Group Long-term Disability, Private Disability Insurance, ERISA Benefits, Denied Health Insurance Claims and Life Insurance Claims.

Representing disabled policy holders and people seeking disability benefits nationwide. Eric's disability and benefits team can help your clients!

- ERISA Long-Term Disability
- Private Disability Insurance
- ERISA Benefits
- Life Insurance Claims
- Group Long-Term Disability
- Social Security Disability
- Denied Health Insurance Claims
- Long-Term Care Claims

We appreciate the opportunity to work with you on any of these cases.



" We thank all our clients who nominated us for the 2012 Seal of Satisfaction Award in the attorney category for Chattanooga. We are honored to receive this recognition for the hard work that our disability and benefits team has put into helping our clients move forward in their lives. " – Eric L. Buchanan

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