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Six Things Insurers Need to Know About the DOL's Proposed Procedural Protections for Disability Claimants

December 8, 2015
Life, Health & Disability Law Alert

The U.S. Department of Labor (DOL) recently published proposed regulations affecting disability claims governed by the Employee Retirement Income Security Act (ERISA). If adopted, the proposed regulations will subject most group disability plans to many of the same requirements currently imposed on group health plans under the Patient Protection and Affordable Care Act.

The proposed regulations affect six main aspects of the disability claim process. Below is a summary of the key changes.

1. Conflicts of Interest: Decisions regarding hiring, compensation, termination and promotion of any individual (*i.e.*, claims adjudicators and medical experts) must not be made based on the likelihood that the person will support the denial of disability benefits.

2. Adverse Benefit Determinations: All adverse benefit determinations must:

- Discuss and include the basis for disagreeing with any disability determination made by the Social Security Administration, treating physician or any other third-party disability payor.
- Contain the internal rules, guidelines, protocols, standards or other criteria used to deny the claim or contain a statement that these do not exist.
- State that the claimant is entitled to receive relevant documents (*i.e.*, plan documents and the claim file) upon request. *Current regulations only require this statement in the decision on appeal and not in the initial denial letter.*

3. Right to Review and Respond to New Information: Claimants must be given the opportunity to review and respond to evidence developed during the appeal (*e.g.*, independent medical reviews) and any new rationale for the claim denial before the final claim decision is made. Any new evidence or rationale must be given to the claimant sufficiently in advance of the 45-day deadline for making a claim determination so that he or she has a reasonable opportunity to respond.

The proposed regulations currently do not provide for a tolling of the 45-day deadline while the claimant reviews and responds to new information. The DOL has requested comments on whether such a tolling period should apply. In making that request, the DOL noted that current regulations already provide for

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two extensions of the 45-day deadline, which is the reason the proposed regulations do not have a tolling provision. However, the claimant's right to review and respond to any new information conceivably creates multiple rounds of further reviews of evidence (as noted in the example in the proposed regulations) and therefore suggests that a tolling provision would be appropriate despite the current availability of extensions.

4. Deemed Exhaustion of Administrative Remedies: The proposed regulations make it easier for claimants to immediately file suit when the plan fails to comply with ERISA and protects claimants who erroneously file suit without exhausting administrative remedies.

- A claimant is deemed to have exhausted administrative remedies and is entitled to immediately file suit if the plan fails to adhere to all of the disability claims regulations. There is a "minor errors" exception to this rule that applies when the plan's error is: (1) minor; (2) nonprejudicial; (3) attributable to good cause or matters beyond the plan's control; (4) occurs in the context of an ongoing good faith exchange of information; and (5) not reflective of a pattern and practice of noncompliance.
- Except where the "minor errors" exception applies, the claim is reviewed under the *de novo* standard of review when a claimant is deemed to have exhausted administrative remedies.
- If the reviewing court determines that deemed exhaustion does not apply (and therefore that the claimant failed to exhaust administrative remedies), the claim is treated as being refiled as an administrative appeal upon the plan's receipt of the court's decision. The plan must then give the claimant notice that the claim has been resubmitted.

5. Rescission — Expanded Definition of "Adverse Benefit Determination": The definition of "adverse benefit determination" is expanded to include any rescission of coverage not due to failure to pay premium.

The current definition only encompasses rescissions occurring in connection with the review of a claim for benefits and therefore does not include rescissions occurring independent of a benefit claim (i.e., rescissions based on an internal audit). The expanded definition is designed to provide plan participants with a mechanism to administratively appeal rescissions that are not made in connection with a benefit claim.

6. Linguistically Appropriate Notice Requirements:If a claimant resides in a county where 10 percent or more of the population is literate only in the same non-English language, a notice of adverse benefit determination must include a prominent, one-sentence statement in the relevant non-English language that language services are available to the claimant. Additionally, the plan is required to provide a customer assistance process (like a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request.

The affected counties are determined based on the American Community Survey (published by the U.S. Census Bureau). The list of currently affected counties is available on the DOL's website.

The proposed regulations are subject to a 60-day comment period, which began on November 18, 2015.

For more information, please contact your regular Hinshaw attorney.