DOL's Year-End Mic Drop: Final Rule Amending ERISA Disability Claim Procedure Regulations Released

Ammo for Claimants; A Blow to Administrators and Plans
By: Elizabeth A. Venditta
Employee Relations Law Journal, Vol. 43, No. 1
Summer 2017

The long-awaited release by the Department of Labor (DOL) of a Final Rule impacting disability claim procedure regulations under the Employee Retirement Income Security Act of 1974 (ERISA) was published in the Federal Register on December 19, 2016. Touted by the DOL as promoting fairness and accuracy in the claims review process and a start to improving the current standards, the final rule will undoubtedly be viewed with consternation by ERISA disability plan sponsors, employer groups, administrators and insurers, given the sweeping array of additional requirements in the processing of disability claims and appeals. The final rule is effective thirty (30) days after the publication in the Federal Register, i.e., as of January 18, 2017, and the claims procedure changes are generally applicable to disability benefit claims submitted on or after January 1, 2018. Specific note, however, should be made of changes temporarily applicable for disability benefits filed under a plan from January 18, 2017 through December 31, 2017, which have been quoted in subsection 8, below.

CONTEXT

ERISA § 503, (29 U.S.C. § 1133), requires employee benefit plans to provide benefit claim denials in writing, setting forth the specific reasons for the denial in a manner understandable to the claimant, and affording a reasonable opportunity for a full and fair process for review of the claim. The DOL regulations at 29 C.F.R. § 2560.503-1 have, since January 1, 2002, set forth the minimum requirements for disability benefit claim procedures under ERISA. Over a year ago, however, the DOL published proposed regulations which it said were designed to provide additional procedural protections and consumer safeguards for claims for disability benefits, and which were intended to apply many of the more stringent Affordable Care Act (ACA) health plan rules to disability claims. A public comment period was provided through mid-January 2016, during which the Department received 145 public comments from a variety of interested parties. After a year of cogitation by the DOL, and somewhat nervous apprehension within the disability industry, the final rule, just published, amends 29 C.F.R. § 2560.503-1 for disability benefit claims. It requires plans, plan fiduciaries and insurance providers to comply with additional procedural requirements when dealing with disability benefit claimants, largely adopting the proposed rulemaking, but with some additional changes.

HIGHLIGHTS OF THE DISABILITY CLAIM PROCEDURE AMENDMENTS

1. Avoiding Conflicts of Interest – Employment Decisions

Plans providing disability benefits must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions. They cannot be operating under a conflict of interest. Towards safeguarding the independence and impartiality of such persons, the final rule now adds the requirement that decisions made as to the **hiring, compensation, termination, promotion or similar matters** with respect to any such individual, must not be made based upon the likelihood that the individual would support a denial of disability benefits. In other words, persons so involved, such as **claims adjudicators, medical experts or vocational experts**, cannot be hired, promoted, terminated or compensated based upon their likelihood of supporting a denial. A plan cannot contract with an expert, for instance, based upon the expert's

reputation for outcomes of one type or another, rather than upon the expert's professional qualifications.

This new rule appears to include requiring a plan utilizing a third-party service provider to take steps to ensure that that provider **also** complies with the regulation which the Department suggests can be done, for example, by ongoing monitoring or through the terms of the plan's service contract.

Query how this requirement can be monitored or enforced and whether it will spawn additional discovery of claims fiduciaries and experts. In the Department's stated view, this new rule does not change the scope of "relevant documents" subject to the disclosure requirements of 29 C.F.R. § 2560.503-1(g)(1)(vii)(C) and (h)(2)(iii), as amended, nor does it prescribe limits on the extent to which information about consulting experts would be discoverable as part of a conflict of interest evaluation of the claims administrator or insurer.

2. Denial Letters – Expanded Disclosure Requirements – Right to Claim File and Internal Protocols, but No Treating Physician Rule

As a stated method of reinforcing the need for plan fiduciaries to administer claims procedures in a way that is transparent and encourages dialogue between the claimant and the plan regarding adverse benefit determinations, benefit denial notices must now contain a **more complete discussion** as to why the claim was denied and the standards utilized in making the decision. The new rule requires that the adverse benefit determination include a discussion as to the **basis for disagreeing** with the claimant's treating physician, health care professional or vocational professional. This includes, for example, the basis for disagreeing with a disability determination made by the Social Security Administration if one is presented by the claimant in support of the claim and, as to that determination, boiler plate text about possible differences in applicable definitions, presumptions or evidence would **not** be sufficient. A more detailed justification would be required.

The discussion in the denial letter must also include an explanation of the basis for not following the views of medical or vocational experts whose advice was obtained **on behalf of the plan**, whether or not that advice was relied upon in making the adverse benefit determination, so as to avoid intentional "expert shopping."

The ERISA standard that **no deference** need be given to the opinions of the claimant's treating physician, however, remains. The Department noted that a treating physician rule is not necessary to guard against arbitrary decision-making by plan administrators [and would, also be contrary to Supreme Court authority].

The final rule also expressly sets forth the continuing requirement of providing an explanation of the scientific or clinical judgment if based on medical necessity, experimental treatment or similar exclusion.

Further, "internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination" must be affirmatively provided with the adverse benefit determination, or a statement made that such do not exist. A plan may not conceal such information from a claimant under an assertion that the information is proprietary or confidential business information.

Moreover, the initial adverse benefit determination, not just appeal denials, must include a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents.

3. Claimant's Right to Review and Respond to New Information Before the Final Decision on Appeal

The new final rule prohibits the denial of benefits on appeal based on new or additional evidence or rationales that were not included when the disability benefits were denied at the initial claims stage, unless the claimant is automatically given notice and a fair opportunity to respond. **Plans must now provide** appealing claimants, free of charge, **any new or additional evidence or rationale** that was considered, relied upon, or generated by the plan, insurer or other person making the benefit determination, or made at their direction, during the pendency of an appeal. Such evidence and/or rationale must be provided **as soon as possible**, **sufficiently in advance of, and before**, an adverse benefit determination on review is required to be provided under the current timeframes, to give the claimant a reasonable opportunity to address the evidence or rationale prior to that date. These protections now carried into the disability claims arena, are direct imports from the Affordable Care Act Claims and Appeals Final Rules.

The Department did not agree with commenters who argued that this new regulation would set up an unnecessary cycle of review and re-review leading to delay and increased costs. The DOL noted that that has not been the case in the group health claims context under the ACA. The supposed "endless loop" is necessarily limited, it suggests, by claimants' ability to generate new or additional evidence requiring further review by the plan and the belief that the process resolves itself when the plan decides it has enough evidence to properly decide the claim and does not generate new or additional evidence or rationales to support its decision.

The Department did not change the current timeframes reflecting the maximum period by which plans must make their determinations in the final rule, but indicated that it is open to considering comments on whether sub-regulatory guidance regarding the current provisions on extensions and tolling would be helpful in the context of the new review and response rights.

4. Deemed Exhaustion of Claims and Appeals Processes

The final rule provides that if a plan fails to **strictly adhere** to all the requirements in the claims procedure regulation, (i.e., all the claims processing rules), the claimant is **deemed to have exhausted** his or her administrative remedies on the basis that the plan failed to provide a reasonable claims procedure, and can proceed with litigation. A deemed denial of the initial claim or of the review on appeal would apply unless the violation was (1) de minimus or a minor error, (2) non-prejudicial, (3) attributable to good cause or matters beyond the plan's control, (4) made in the context of an ongoing good-faith exchange of information, and (5) not reflective of a pattern or practice of non-compliance (again mirroring the existing standards under the ACA applicable to group health claims). This new rule is clearly stricter than a mere "substantial compliance" requirement. [Query, again, the impact this new rule could have on discovery in ERISA cases and anticipated increased ERISA litigation.]

The claimant may request a written explanation of the violation from the plan and the plan must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not result in a deemed exhaustion.

If the disability claimant is deemed to have exhausted the administrative remedies under the plan, the claim or appeal is deemed denied on review without the exercise of discretion by a fiduciary. The claimant may **immediately pursue his or her claim in court**. Should a court's decision reject the claimant's request for review, the final rule also provides that the plan must treat the claim as re-filed on appeal upon the plan's receipt of the court's decision.

Increased litigation, as noted above, can likely be anticipated as a result of these changes.

5. Coverage Rescissions as Adverse Benefit Determinations

The final rule amends the definition of an adverse benefit determination to include for those plans that provide disability benefits, **rescissions of disability benefit coverage** that have a retroactive effect. In other words, rescissions of coverage due to alleged misrepresentations of fact as a result, for example, of errors in the application for coverage, must be treated as adverse benefit

determinations, thereby **triggering the plan's appeals procedures**. An **exception** to this new rule, however, is rescissions for non-payment of premiums.

6. Culturally and Linguistically Appropriate Notices

Plans are required to provide notices to claimants in a culturally and linguistically appropriate manner under the final rule, adopting the standards already applicable to group health plans under the ACA. Specifically, if a disability claimant's address is in a county where ten (10) percent or more of the population is literate only in the same non-English language (as determined in guidance based on American Community Survey data published by the United States Census Bureau), benefit denial letters must include a prominent statement **in the relevant non-English language** about the availability of language services. The plan is also required to provide a verbal customer assistance process (such as a telephone hotline) in the non-English language and provide written notices in the non-English language upon request.

7. Notice of Any Applicable Contractual Limitations Period and Its Expiration Date

Commenting that the currently required statement of the claimant's right to bring a civil action following an adverse benefit determination on review under § 502(a) of ERISA, 29 U.S.C. § 1132(a), would be incomplete and potentially misleading if it failed to include limitations or restrictions in the plan documents on the right to bring a civil action, the final rule includes a new requirement that the notice of an adverse benefit determination on review must include **a description of any applicable contractual limitations period and its expiration date**.

The Department noted that it did not believe this new requirement, imposing what it calls "a minimal additional burden," will result in confusion, foreclose legitimate argument about the application of the limitations period in individual cases, nor should be viewed as requiring the plan to provide legal advice. It has further commented that a contractual limitations period that does not allow a reasonable period after the conclusion of an appeal in which to bring a lawsuit is unenforceable.

Moreover, though this final rule provision is technically applicable only to disability benefit claims, the Department has expressed its belief that notices of adverse benefit determinations for other benefit types would also be required to include some disclosure about any applicable contractual limitations period.

8. Temporarily Applicable Disability Claim Amendments—January 18, 2017

While the amendments discussed above are generally applicable to disability benefit claims submitted on or after January 1, 2018, the following rule applies to disability claims filed **beginning on January 18, 2017**, covering both initial claim determinations and determinations following appeal:

> (p) Applicability dates and temporarily applicable provisions...
>
> * * *
>
> (4) ...
>
> (i) In the case of a notification of benefit determination and a notification of benefit determination on review by a plan providing disability benefits, the notification shall set forth, in a manner calculated to be understood by the claimant –

> (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; and
>
> (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.
>
> (ii) The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of [current] paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

29 C.F.R. § 2560.503-1(p)(4)(i).

CONCLUSION

Plans providing disability benefits, their insurers, claims fiduciaries and administrators, generally have one year from now to put in place the amended claims procedures as set forth in the Final Rule. Plan language will need to be reviewed and updated, including that in plan documents, summary plan descriptions and other relevant instruments. While promoted by the DOL as strengthening consumer protections for claimants requesting disability benefits from ERISA employee benefit plans—its stated goal—the amendments in many respects mark a significant sea change in the processing of disability claims that will conceivably spawn additional ERISA discovery and disability benefits litigation. This eventuality seems directly contrary to the manifest intent of Congress in enacting ERISA, which was to provide methods to resolve disputes over benefits "inexpensively and expeditiously."

For additional information on the DOL's recently published Final Rule or any ERISA-related matter, contact Elizabeth A. Venditta (215.864.6392; vendittae@whiteandwilliams.com).